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Screening for foetal anomaly: what do women know?

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Background. Ultrasound has become a routine part of the package of prenatal care offered to pregnant women in most developed countries. Scientific evidence demonstrates that ultrasound scanning is effective in confirming fetal viability, assessing gestational age and determining the number of fetuses. However in some areas, there is an impetus to determine the most clinically relevant and cost effective programme to be offered not only for the indications stated but rather to ensure the most effective form of fetal anomaly detection.

Aim. The aim of this study was to explore the perceptions of low risk women who had received a diagnosis of fetal anomaly in relation to a) their preparedness for an adverse diagnosis when taking part in a routine USS screening programme, b) their recommendations for the provision of pre USS information, with the intention of providing appropriate information for others.

Methods. A grounded theory study (n=24) in a single tertiary referral maternity unit in Dublin, Ireland. Ethical approval was obtained and women gave written consent to participate. Data were collected by means of an in-depth interview within 4-6 weeks of the diagnosis of the anomaly. Data were analysed using constant comparative analysis.

Findings. The findings presented in this paper represent women’s views of their level of preparedness for diagnosis of a fetal anomaly at a routine ultrasound in pregnancy. The data describes the influencing factors and provides suggestions for provision of information for women partaking in a routine ultrasound screening programme.

Conclusion. Data suggests that the drive to inform all fully women of ultrasound detection rates for specific anomalies may be counter-productive as it will enhance the worry pregnant women already feel in relation to the health of their unborn baby.

Keywords. Antenatal, ultrasound, fetal anomaly, screening, information, grounded theory.
Clinical facilitators’ and post-registration student nurses’ perceptions of the role of the clinical facilitator.

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Background
An Bord Altranais (2000) acknowledges that assigning students to practice settings is based on the necessity to integrate theory and practice. In order to facilitate nursing students make this vital link, the past two decades have borne witness to various personnel under various titles been introduced into the clinical areas. However, despite the evolution of various clinical support personnel, an identifiable theory-practice gap remains with a degree of ambiguity over who has prime responsibility for clinical teaching (Lambert & Glacken, 2004). Now, a new position has emerged, that of clinical education facilitators (CEF) (Rowan & Barber, 2000; Kelly et al, 2002; Ellis & Hogard, 2003; Clarke et al, 2003). They are meant to be the key linchpin in the clinical area for reducing the theory practice gap, however, it is clear that currently there is no consensus in the literature about the role of the CEF. This paper reports the findings of a study that sought to explore the role of the CEF within the Irish practice setting. The purpose of this study was to explore the role of the CEF from the perspective of clinical education facilitators and post-registration paediatric nursing students.

Methodology
An exploratory descriptive design was employed. A non-probability sampling strategy namely volunteer was employed. The total population (n=10) of clinical education facilitators working in 2 of the 3 institutions in Ireland responsible for training post-registration paediatric nurses were invited to participate in the study. All agreed to participate. Post-registration paediatric nursing students from four different groups were also invited to participate, with five students volunteering. Data was collected by focus group interviews. The interviews were transcribed verbatim directly onto a computer file using a word processing programme. Data analysis began with open coding by examining data line by line. As the data was analysed, themes and categories emerged and were refined. Subcategories that were not robustly supported were discarded. The criteria for establishing trustworthiness in qualitative studies were employed. Approval to conduct the study was granted from the relevant
Research Ethics Board. Permission to access the participants was obtained from the Director of Nursing and Principal Tutor of the each research hospital site.

Findings
The clinical education facilitators’ role emerged as one that is diverse, complex and multifaceted with the clinical education facilitator orchestrating factors in the clinical environment to make it function as an effective learning environment for students. The four main strategies employed were: facilitating students’ transitions into the clinical learning environment, maximising learning opportunities, preparing the clinical environment and providing support whilst in the clinical learning environment.

Facilitating Transition
CEF's were seen as instrumental in assisting students make a successful transition from one clinical area to another. This involved two facets, assigning staff nurses as ‘link’ nurses for students and orientating students to practice placements.

Maximising Learning Opportunities
A multitude of opportunities that CEFs drew upon to heighten learning within clinical settings were identified. Clinical teaching sessions were seen as invaluable in enabling students to make effective links between theory and practice. Some students commented on how they were facilitated to learn clinical skills through demonstration and rehearsal. Clinical facilitators perceived themselves as role models with a huge opportunity for teaching to take place. Finally, the ability of the students to discuss their learning objectives with the clinical facilitator was perceived as influential in developing their knowledge base.

Preparing the environment for learning
Clinical facilitators had a pivotal role in creating the learning environment through the manipulation of both human and material resources. Clinical facilitators detailed their in-depth involvement in the formulation and introduction of clinical guidelines, and policies to the clinical areas. Students felt that they derived great benefit from formulated policies and guidelines. They enabled them integrate evidence into practice and enhanced their ability to deliver consistent care. Student participants believed that the CEFs played a key role in instilling confidence and preparing staff and potential link nurses for their arrival to the clinical area.

Providing Support
The provision of instrumental and emotional support emerged as an important aspect of the CEF role. The clinical facilitators neutrality was viewed as a key factor here with some facilitators affirming that they did not perform clinical assessments because this would conflict with the supportive facilitative aspects of their role. The clinical facilitators believed that at times they acted as advocates for students. Some facilitators believed that at times they were required to engage in a counselling role. However, the student cohort did not perceive the CEF’s provided them with emotional support.

Communication emerged as a key factor underpinning all the CEFs activities. Effective communication was required for the successful functioning of any of the activities alluded to previously with both CEFs and students recognising this.
Challenges to role
CEFIs face a number of challenges in executing the role effectively. CEFIs postulated that profuse role perceptions, excess workload and concerns over clinical visibility were related to the larger predicament of the whole definition of what it is a clinical facilitator should do. Facilitator participants recognised the importance of inventing a more defined portrait of their role.

Conclusion
This study offers preliminary evidence towards clarification of the nature and purpose of the clinical education facilitator role. Overall, the findings exemplify that the role of the CEF is to orchestrate factors within the clinical environment in order that it functions as an educational environment to facilitate learning. The key themes to emerge were, *facilitating transition, maximising learning opportunities, preparing the clinical environment and providing support*. In order to execute the role effectively there was a need for effective communication. A number of concerns raised by clinical facilitators were also highlighted. The central recommendation from this study is the urgent need to define the role so that all stakeholders share a common understanding of the activities of the role holder.

References


Let’s go! Exercise for the older adult in the long-term care setting – nurses knowledge on its' benefits

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A personal interest developed in this area for the author from an early age when two maternal grandparents lived in the family home into their eighties. They were always involved in the family team and not a burden of care, Nan was chief child-minder and baked her two loaves of brown bread daily, whilst Pop fed the fowl and helped with light yard chores. The authors' memories of 'old-age' resultantly are very wholesome and holistic but unfortunately the author realises from personal experience and an extensive literature review completion that similar holistic care is not prevalent in all care settings.

Statistics have shown that our elderly population are set to increase dramatically in future years (National Council of Ageing and Older People, 2001) and the recent 2000-2005 Health Promotion Strategy outlined the 36% of older people surveyed reported taking no exercise and for those over 75 years this figure rose to 51%

A review of the literature on the benefits of maintaining exercise intervention for the older adult in the long-term care setting, reveals that many such benefits result. Results included increased agility levels for exercise participants (Aitchison, 1999 & Harahousou, 2003), generally more contented patients (Brugman & Ferguson, 2002) with a greater ability and interest in socialising with piers and family. Shepard, (1993), suggest that 'physical activity should be a priority in care of the older adult setting as it has more potential for promoting active old age than anything science or medicine can offer'.

To proceed with promoting this element of care within the care setting, the author first felt it absolutely necessary to ascertain Nurses knowledge on the benefits of such intervention. Thus a quantitative descriptive study of nurses' knowledge was completed. A convenience sample of all nurses working in the nineteen community hospitals in the local health board, whom met certain inclusion criteria, were included in the study.
NURSES’ KNOWLEDGE OF CHEST DRAIN CARE

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Abstract
Chest drains are a common feature of patients admitted to acute respiratory or cardio-thoracic surgery care areas. These are either inserted intra-operatively or as part of the conservative management of a respiratory illness or thoracic injury (Welch, 1993). Whilst chest drains are usually inserted and removed by the medical team it remains the responsibility of both the nurse and the doctor to care for the patient throughout the course of the treatment (Laws, Neville and Duffy, 2003). Anecdotally there appears to be a lack of consensus among nurses on the major principles of chest drain management. Many decisions tend to be based on personal factors rather than sound clinical evidence (Tang et al 1999). This inconsistency of treatment regimes, together with the lack of evidence-based nursing care, create a general uncertainty regarding the care of patients with chest drains (Parkin, 2002). This study aims to identify the nurses’ levels of knowledge with regard to chest drain management. The research objectives of this study were (i) to describe nurses’ levels of knowledge regarding the care of the patient with chest drains and (ii) to identify how nurses acquire and update their knowledge on chest drain management. The choice of design for this study is a descriptive survey, which is considered useful to categorise information and to describe what exists (Polit and Hungler, 1999). Ethical approval and access to the sites were established at the early stages of the research process. In order to select a sample that is most representative of the population, questionnaires were distributed to nursing staff working in acute care, respiratory, cardiac and thoracic surgery wards of two hospitals in Dublin. The participants were selected by convenience sampling, as a register for respiratory or cardio-thoracic surgical nurses does not exist in Ireland. The data was collected using a specifically designed questionnaire. The results of the study indicated that deficits exist with regard to nurses’ knowledge in this area. In service study-days as well as ward-based tutorials are recommended to inform local practice in this area.
Need for and availability of harm reduction and drug treatment in Irish prisons

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Between 1997 and 2000, the Irish Prison Service commissioned a number of studies to examine the prevalence of blood borne viruses\textsuperscript{1,2} and health status of the prison population.\textsuperscript{3} Independent qualitative studies were also conducted.\textsuperscript{4,5,6}

In the late nineties, two studies \textsuperscript{1,2} estimated the prevalence of antibodies to hepatitis B, hepatitis C and HIV among the prison population and described the risk factors associated with testing positive for each of the antibodies.

Among 1,193 prison inmates in 1998,\textsuperscript{1} the prevalence of antibodies to the hepatitis B core antigen was nine per cent, the prevalence of antibodies to hepatitis C was 37 per cent and the prevalence of antibodies to HIV was two per cent; two-fifths prisoners tested positive for one or more of the infections. Of the 1,178 inmates whose injecting status was known, 43 percent (509) had ever injected. Of those who ever injected, one-fifth started injecting in prison.

Among 596 prison entrants in 1999,\textsuperscript{2} the prevalence of antibodies to hepatitis B core antigen was six per cent, to hepatitis C was 22 per cent and to HIV was two per cent. One third of the respondents had never previously been in prison (197); these had the lowest prevalence of antibodies to hepatitis B core antigen (2%), to hepatitis C virus (3%) and to HIV (0%, 0%).

In total 173 (29%) entrants reported ever injecting drugs. Only 7 per cent (14/197) of those entering prison for the first time reported ever injecting drugs compared to 40 per cent (157/394) of those previously in prison. Of those who ever injected and had spent time in prison, 19 per cent started injecting in prison.

In the two studies,\textsuperscript{1,2} the overall pattern of injecting drug use was similar among both inmates and re-entrants. The prevalence of antibodies to all three viruses was significantly higher among both inmates and entrants who reported injecting drug use (Figures 1 and 2).
Figure 1 Prevalence of antibodies to hepatitis B, hepatitis C and HIV among prison inmates, by injector status, in 1998

Figure 2 Prevalence of antibodies to hepatitis B, hepatitis C and HIV among prison entrants, by injector status, in 1999

After adjusting for other risk factors in both studies, injectors who had shared needles in prison were over four times more likely to test positive for hepatitis C than injectors who had not shared needles in prison. Injectors who started injecting more than three years prior to the survey were also more likely to test positive for hepatitis C than injectors who had not injected in the month prior to the survey. Injectors who had spent more than three of the last 10 years in prison were also more likely to test positive for hepatitis C than their counterparts who had spent less than three months in prison.
The authors of the two studies concluded that hepatitis C was endemic in Irish prisons, injecting drug use was the most important risk factor and being in prison would seem to increase the risk of acquiring it.

Long and colleagues described and explored injecting practices, strategies taken to deal with risk of infection and actions necessary to address this situation; 31 (16 injectors and 15 non-injectors) were interviewed.

Injectors reported and non injectors observed that injectors take a number of risks taken during detention that they would not take outside prison. For example, the low availability of heroin encouraged the change from smoking to injecting; the scarcity of injecting equipment meant that sharing circles were far wider than outside prison; cleaning practices were inadequate for injecting equipment, and those who owned a syringe and needle rented them to other injectors as a means of acquiring the drugs to maintain their habit. The non injectors in prison said they knew which prisoners were current injecting drug users. Almost all non injectors have observed injecting drug use in prison and their reported observations of injecting practices were consistent with those reported by respondents who had injected in prison.

During the in-depth interviews, prisoners (both injectors and non-injectors) were asked how they dealt with the risk of either contracting or testing positive for hepatitis C. Two dominant themes emerged, denial and fear.

Injector respondents deal with the possibility of contracting or experiencing consequences of infection with hepatitis C by: living in the moment; distancing its effects in time; generalising the condition to all injectors; and comparing its consequences to those of HIV. This process allows them to continue injecting without considering the consequences. According to most injector respondents, hepatitis C is common among those who inject drugs and to date its consequences have not been serious.

The fears expressed by injectors and non-injectors were in the main well founded. Fear of or actually contracting blood-borne viruses deterred a number of heroin users from starting to or continuing to inject heroin. Similar numbers of non-injector and injector respondents reported that they feared contracting blood-borne viruses while in prison.

All respondents were asked “what action is required by the prison authorities to deal with drug use in prison?”

Respondents suggested a number of interventions including the variety and organisation of daily activities in prison, drug awareness programmes, individual counselling sessions and harm reduction services. Non injectors were sympathetic to the plight of injectors, and both non injectors and injectors support harm reduction interventions in prison and think that the range of drug services in prison should mirror that currently available in the community, although half opposed or had reservations about needle exchange.

Prisoners view time in prison as an opportunity to address substance misuse and stabilise viral infections; health professionals should not miss this opportunity.
Hannon et al (2000) documented the health status of prisoners in Ireland including their mental health status. The high rate of lifetime drug use (72% males, 83% females) occurs in a population that report many mental health problems. In the clinical history section of this study, 30 per cent of male and 49 per cent of female respondents stated they had spoken to a health professional about anxiety, depression or about a mental, nervous or emotional problem in the past 12 months. Of these, 42 per cent of males and 58 per cent of females had sought help for depression, 13 per cent of males and four per cent of females for anxiety, and 14 per cent of males and 29 per cent of females for drug-related problems. Overall, 24 per cent of male prisoners and 34 per cent of female prisoners reported attending a health professional at the time of interview; of these, 17 per cent of males and 37 per cent of females were attending a psychiatrist. The association between psychiatric illness and problem drug use among prisoners was not examined in this study, but there is anecdotally evidence of a clear overlap between problem substance use and mental illness.

During 2000 and 2001, the Irish Prison Service along with other agencies have examined the findings of these studies and developed both drug treatment service plans and health care plans for the prisoners. By the end of 2002, the Irish Prison Service was at an advanced stage of drafting an Irish Prison Drug Service Policy that would be in line with the current Irish drug strategy ‘Building on Experience: the National Drug Strategy 2001 to 2008’ (Department of Tourism Sport and Recreation 2001) and the World Health Organization’s ‘Health in Prisons Project: Prisons, Drugs and Society 2002’. This policy is awaiting approval from the Minister of Justice, Equality and Law Reform.

A number of positive developments have ensued such as the introduction of evidence based methadone treatment services that can be accessed by the majority of opiate dependent prisoners. The Irish Prison Service is to be commended for its attempts to vaccinate a significant minority of prisoners against hepatitis B, something very few prisons and indeed community health services have managed. The employment of registered nurses facilitated the separation of disciplinary and health care role, although more needs to be done. The increased availability of drug free units is also to be commended.

There is, of course, much more to do, such as, harm reduction methods for those who continue to inject, and the management of morbidity (hepatitis C and sexually transmitted infections) associated with drug misuse. Counselling and psychological services are also necessary in Irish prisons and the feasibility of introducing the therapeutic community model of care for those who wish to address their substance misuse should be considered. The high levels of psychiatric co-morbidity are also worrying and indicate that a mental health strategy that is linked to drug treatment service is urgently required.

The prison authorities and their health care staff have made large strides to improve access to drug treatment and health care services, but sadly, there is very little evidence of this because of their failure to use conventional health information systems; this is a missed opportunity.


*(Jean Long)*
Outcomes of a randomised control trial of skin care following radiotherapy

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Current understanding indicates that moist desquamation (MD) is caused by the basal layer being sterilized and rendered incapable of timely regeneration (Hopewell 1990 Glean et al 2001). Some 10-15% are expected to develop MD with risk factors being identified (Barkham 1993). A randomised controlled trial using dry dressings and ‘Intrasite’ (Mak et al 2000).

Some 366 suffering from head and neck, breast or anorectal cancers, were randomised to groups of 176 dry and 181 to hydrogel dressings. All used Simple soap to wash. The patients recorded the degree of erythema (RTOG) and its effect on their quality of life in diaries. Weekly, researchers measured the erythema using erythemameter and RTOG. Were skin broke measurements continued for 10 weeks

Higher rates of MD than literature with 28% (100/ 357) shown. Confirmed MD occurred at 32 mean days. In 47% this happened before the end, with 38% in the week after radiation. Imbalance in 50-59 age group showed with more in hydrogel dressing group. More smokers and ex-smokers developed MD. In those randomized to gel dressings MD was confirmed earlier p=0.084. Both the patient’ and researcher' assessments significantly worse for those assigned to gel dressings. Other factors associated with earlier occurrence of MD were: bolus, higher doses of radiotherapy per fraction and concurrent chemotherapy. To examine the effect of the dressings, comparison of 40 patients with confirmed MD allocated and using dry dressings or no dressings with 54 allocated and using gel dressings (DLQI). Only significant difference between the groups was the improved dry or no dressings MD score. No evidence that either dressing affected any other aspect of subjective reaction including itch, pain, sunburn or sleep. The reactions of those assigned to gel dressings healed significantly more slowly (p=0.03).

The results were clear but unwelcome except that washing with soap had no effect and dry dressings were more beneficial. However, patients continue to suffer but staff members believe in the efficacy of hydrogel dressings and so continue to use them.


Mak SSS Molassiotis A Wan WM Lee IYM Chan ESJ 2000 The effects of Hydrocolloid dressing and Gentian Violet on radiation-induced moist MD wound healing Cancer Nursing 23(3):200-229


The construction, implementation and evaluation of an instrument for assessing undergraduate nursing students' clinical competence

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The education of undergraduate nurses in the Republic of Ireland has changed radically over the past 2 years (An Bord Altranais 2000). These changes have required extensive reorganisation of clinical sites with significant re-education of clinical staff at all levels. It has also necessitated a move away from the nationally applicable standard assessment of undergraduate nurses' clinical competence commonly known as the Proficiency Assessment Form (PAF). Each Higher Education Institute in Ireland along with the affiliated Health Service Providers were obliged to devise and implement a system of clinical competence assessment of undergraduate nursing students.

In this presentation, we outline the cooperative developmental process undertaken to construct, implement and evaluate an instrument for assessing undergraduate nursing students' clinical competence.

A group of nurses from both the Health Service Providers and the School of Nursing and Midwifery Studies convened as the Clinical Competence Assessment Sub-committee to carry out this work.

Literature was reviewed so as to derive a framework assessment. The work of Kathleen Bondy (1983) was used to construct such a framework. The Domains of Competence as elucidated in the Requirements and Standards for Nurse Registration Education Programmes (An Bord Altranais, 2000) were used to populate Bondy's framework. Bondy's five-point rating scale for evaluation of student clinical performance used in the assessment can be applied to any professional behaviour and provides the student with diagnostic feedback as well as a fair assessment of performance. It was also necessary to define the types of evidence required in the assessment process to support any assertion (positive or negative) the assessor makes about the students' clinical competence. These forms of evidence included Direct Observation, Special Tasks Tests, Questioning and the contents of the students' personal and professional development Portfolio. The resulting assessment framework was then piloted among undergraduate diploma students and amended according to feedback from assessors and students.

As part of the implementation process it was necessary to develop a training and education package for (potential) assessors. This package was developed by the Clinical Competence Assessment Sub-committee and consisted of an 8 hour workshop. These Clinical Competence Assessment workshops where delivered in tandem with a preceptorship training and education package to further prepare nursing staff for the supervision and clinical education of the new undergraduate nursing students.
The assessment process commenced with the first intake of undergraduate nursing students. The assessments that were undertaken were then audited using a 47 question questionnaire which elicited the opinions of students regarding their experience of the assessment process. The assessors were also questioned.

The data were analysed using the Quasar Clinical Audit tool and this analysis informed the development of the assessment process for subsequent academic years including the undergraduates' year long rostered placement.

The development of the assessment process and the associated documentation is an iterative process and the members of the Clinical Competence Assessment Sub-committee are now involved in a critical review with the aim of continuous development.

References


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A comparison of the change strategies utilised in transforming pre-registration nurse education in Ireland in the last decade

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Pre-registration nurse education in Ireland has undergone two significant changes in the last decade. The first was the implementation of an undergraduate pre-registration Diploma in Nursing Studies programme in the mid-nineties, and the second being the commencement of the pre-registration Bachelor of Nursing Studies degree programme nationally in 2002. These developments required significant planning at corporate, business and operational level in both the health and higher education sectors. The aim of this paper is to compare and contrast the strategies that were employed in the actual planning, development and subsequent implementation of these programmes and highlight the significant differences between both.

An environmental analysis will be utilised to explore the differing external and internal drivers for change that include professional, national and international developments and how they influenced these strategic processes and the resultant outcomes. In 1998, two influential reports were published: The Report of the Commission on Nursing (1998) and the Nurse Education and Training Evaluation in Ireland (1998). The Commission on Nursing advocated a change in the direction of nursing education in Ireland. This led to the establishment of the Nursing Education Forum and the development of a strategy for a pre-registration undergraduate nursing degree programme. This strategy made specific recommendations in relation to pertinent issues, including the role of the higher education sector, the implications for health service providers and service provision, and the concomitant change management processes. The impact of this strategy will be delineated. Critical success factors in any strategic process also include effective communication, consultation and the use of change agents. The disparity in how these factors were addressed in relation to the planning, development and implementation of both programmes will be highlighted. Finally, it is proposed to compare the industrial relations mechanisms in both processes, most specifically in relation to the role of nurse educators.

References


Anne-Marie Malone
NURSES VIEWS ON HOW NURSE MANAGERS INFLUENCE THE USE OF ASSERTIVE BEHAVIOUR BY NURSES IN THE WORKPLACE

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Nurses have historically been regarded as acquiescent and submissive helpers of doctors. However, as nurses move away from this stereotypical role, it is clear that nurses need to use assertive behaviour more consistently in the workplace in order to provide patient-centred care, develop professionally and contribute on an equal footing to the formulation of health care policy and strategies. Assertiveness is necessary for effective communication with patients and other health care workers and it is suggested that its development may also aid the confidence of the profession as it develops. Although nurses are regarded as a group that lack assertive skills, the evidence suggests conflicting views on this issue. There is some evidence that education in assertive behaviour can improve nurses' use of assertive behaviour, however, certain barriers exist in the workplace to using assertive skills consistently.

This large-scale study explores the views of a random selection of 1,500 nurses and midwives registered in Ireland in relation to their assertive behaviour in the workplace and identifies the factors that support or inhibit assertive behaviour. Data were analysed using SPSS and thematic analysis. One key area that nurses reported having difficulties using assertive behaviour in was with nursing management colleagues. The most frequently reported assertive behaviour that nurses use with management colleagues was allowing them to express their opinions (81%). The assertive behaviours that were used less frequently were making suggestions (50%), providing constructive criticism (29%) and saying no (40%). The main barrier to the use of assertive behaviour by nurses was identified as nursing management. They reported that nursing management was hierarchical and unsupportive of nurses and did not value their opinion or their role as nurses. Mutual respect and a team approach were considered important factors in encouraging and supporting nurses in using assertive behaviour. It is essential that nurses receive education and training in the use of assertive behaviour in the workplace at undergraduate and postgraduate level. The consequences of this are that nurses who will eventually become nurse managers will not view nurses as subordinates and regard the use of assertive behaviour as a challenge to their position or power and a negative communication skill. Instead they will consider assertive behaviour as a positive and valuable communication skill and would actively support and encourage its consistent use by staff nurses in the workplace.
Best practice in end of life care for persons with intellectual disabilities and dementia.

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Abstract Aims: (1) To identify best practices in preparing for rather than responding to end of life care issues in end stage dementia

Background: An increased number of persons with ID who are aged, a growing concerns about dementia care needs for this population and a continued desire to serve people with ID in community settings have focused greater attention on end-of-life care. Little is known about the extent of hospice and other palliative care agency involvement with ID service providers, of the training and regulatory barriers to providing palliative care in such settings or of the willingness and ability of ID providers and hospice and palliative care providers to work together to better meet end-of-life care needs.

Method: Twenty providers in New York state currently serving persons with intellectual disabilities and dementia were surveyed to understand related agency procedures and the state of death and end of life education for staff, families and consumers. Also local hospice, Alzheimer disease and palliative care providers were surveyed on their knowledge of and extent of service delivery to persons with intellectual disabilities. Focus groups were organized to develop approaches to improving practices.

Sample: In person interview protocols were completed by 20 administrators and by 80 direct care and professional staff in ID service providers in two regions of New York state. A separate protocol was completed by 4 administrators and 20 staff from regional hospice organizations. Three focus groups were also organized involving 30 key staff from ID services, hospice organizations and Alzheimer's Association chapters.

Data Analysis: Results from the interview protocols were summarized and combined with the results of a cross-comparative analysis of themes identified in focus group interview notes to develop an understanding of critical issues in end of life care for persons with ID and advanced dementia.

Results: Pockets of poorly disseminated best practices were identified and the related educational and regulatory barriers. Recommendations for staff training for both ID service providers and hospice staff also emerged. An organized regional approach to these issues was developed.

Conclusions: There is a willingness by hospice and other palliative care providers to work with intellectual disabilities providers to improve end of life care in advanced dementia for persons with intellectual disabilities.
Longitudinal follow up of persons with Down syndrome and dementia: Risk factors and impact on survival of tube feeding.

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Aim: To determine the risk factors and impact on survival of feeding tubes in persons with Down syndrome and advanced dementia.

Background: There is considerable controversy about the efficacy and appropriateness of artificial nutrition and hydration (ANH) for persons in end stage disease, particularly advanced dementia. Use of ANH is a well-established and life saving intervention for some younger persons with ID, but its usefulness and consequences in persons with ID and advanced dementia (AD) has yet to be considered. Such consideration is warranted as the numbers of persons with ID and advanced dementia increases.

Method: This was a retrospective study of now deceased of persons with DS and AD (n=40) over the age of 35 years who did or did not undergo feeding tube placement. Using a structured protocol, data was gathered on reasons for feeding tube placement and the health history of subjects before and after placement. Similar health histories were gathered on those for whom no feeding tube was placed.

Sample: Convenience samples of now deceased persons with DS and AD (n=40) over the age of 35 years was located at service provider in Ireland and the U.S. Through a systematic review of subjects’ case notes 20 subjects were identified who underwent feeding tube placement and 20 who did not.

Data Analysis: Descriptive statistics were generated on reasons for and health consequences after feeding tube placement in advanced dementia. Predictors of survival time for persons with ID and AD were estimated.

Results: Clinical characteristics, survival and related health consequences were identified for subjects who were and who were not tube fed. Factors that were associated with feeding tube placement and with survival were also identified.

Conclusion: The data here will provide guidance for health care providers and families making decisions regarding tube feeding for persons with advanced dementia.
Translating Person-centred Care: A Case Study of Preceptor Nurses’ and Their Teaching Practices in Acute Care Areas

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Abstract

Background

Person-centred care (PCC) is a concept that is becoming widely used in contemporary nursing discourse and in health care literature (Nursing Education Forum, 2000; Department of Health and Children, 2001). PCC focuses on the individualisation of the patient and his/her values and beliefs. As preceptors have been identified as key people in the education of students in clinical practice, it was considered important to explore how preceptors promote PCC to current undergraduate nursing students in clinical practice.

Aims
The aims of this study were to explore how preceptors interpret, operationalise, document and teach PCC as they guide students within an acute surgical environment.

Method
Using a case study design and a qualitative approach, six preceptors were chosen to participate in this study. Data was collected by means of participant observation, review of nursing care records and semi-structured interviews. Data was analysed in two stages. The first stage involved the identification of themes. In the second stage data was analysed using a number of propositions to examine and explain what was gleaned from the data in the context of what was originally identified in the literature.

Findings
Findings highlighted that preceptors had a limited conception of PCC. Care measures reflected the traditional approach to nursing. Beyond that preceptors expressed care in terms of good manners or respectful etiquette toward patients. In addition the teaching of students focussed on mastering the art of clinical skills. Preceptors expressed the importance of being skilled in undertaking clinical procedures in a manner consistent how they were taught themselves, in the traditional model of nurse training and education.

References

Documenting pathways to dementia care: relative validity of questionnaire, interview, and medical record formats

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Purpose: One of the shortcomings of the pathways – to –care literature is the lack of empirical support for the validity of the data collection methods. This study uses three common formats to collect retrospective pathways – to – care data for adults who have been diagnosed with possible or probable Alzheimer’s disease and then makes comparisons between indicators or their relative validity.

Methods: Forty family caregivers of adults diagnosed with possible or probable Alzheimer’s disease were recruited from the caregiver registry of the Boston University Alzheimer’s Disease Core Center (BUADCC). Questionnaire, structured interview, and medical record review were collected regarding four key events in the pathway to dementia care. In a consensus meeting, data collected in these three formats were reviewed and a consensus on the most likely answers to all questions was recorded and compared to data collected in each format.

Results: The results suggest that the three formats are not equivalent in terms of concurrent validity. While substantial agreement is found between data collection methods, the validity of the structured interview format and the medical record review is most consistently supported by the current data. Questionnaire data resulted in underestimates of delays and correlated poorly with other data sources, including the consensus judgment.

Conclusions and Implications: These data suggest that to achieve optimal levels of validity, the best strategy may be to combine two formats in the data collection: structured interview for information about who took what step in the pathways to care, and the medical record review for information about when those steps took place. Current data suggest that caution be used when interpreting pathways – to – care studies that use only one of these formats, particularly those of questionnaire.
Is Student Support Extended To Breast Feeding Mothers

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Background
It has been the author’s intention to identify the real support available to mothers who wish to continue their studies, despite becoming parents during an academic course of study. Different areas of student support have been explored, including availability of crèche facilities on campus, and Colleges financial assistance in supporting mothers whose babies can be cared for in registered child minding facilities. The option of promoting breast feeding as a best method of infant feeding has also been explored, by trying to identify what services are required to ensure the choice to breast feed is supported. In particular students, tutors, and institutional views have been sought, on how best to allow a mother continue to breast feed her infant if this is her choice.

Design
The author has conducted research by a triangulation of quantitative and qualitative design into students and tutors views on what might be two suitable support mechanisms to assist a breast-feeding mother. These have been
1. Facilitating a mother and infant by allow both to come to class, with the explicit understanding that the baby if causing distraction is removed from class, and
2. Proving a facility of e learning for the student who may need to stay at home to breast feed her baby, by lecturers sending lecture contents and back up support by email.

Sample
The questionnaires used were piloted first on the author’s own peers and tutors, many of whom are from a nursing and health educational background. Once refined, the revised questionnaires were redistributed to a population of students not confined to Health Science faculties. This was thought to eliminate any bias and give a more honest reflection of students and staff views.

Data Collection
Data was collected by using questionnaires and interview

Analysis and Results
Data was analysed by using a package Exel and results showed that although nobody thought that breast-feeding was not the best option, one sixth of all student female respondents and one third of all male student respondents preferred that the mother of the breast feeding baby should make other arrangements in caring for her child rather than bringing her to class. All students would facilitate the mother learning by bringing relevant material to her. All tutors preferred that the student mother would attend class, bringing baby if necessary. Creche facilities were wholly inadequate in making provision for newborn breast fed infants. Web CT was not available in all colleges on all courses, and so more administrative work on behalf of the colleges would be necessary in order to facilitate distance learning, even though tutors agreed that if the mother wished to stay at home, that the lecture notes could be e-mailed to her. On the whole needs of new mothers must be better addressed in the realm of student life, in order to retain women in third level education.
References
Life Experiences of Cambodian-American Refugee Women: Segmented Life Stories

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Of the estimated 50 million international refugees and displaced persons (U.S. Committee for Refugees, 2003), 80% are mothers with children (Women’s Commission for Refugee Women and Children, 2003). There is a paucity of research that explores either refugee experiences with organized violence or the nature of healing following such events. When available, this research most often addresses the sociopolitical acts of domination and oppression rather than the contextualized life stories of individuals. Individual behavioral responses are typically examined through the medicalized lens of psychotraumatology, and are most often clinically labeled as Post-Traumatic Stress Disorder. An alternative socialized view proposes that exposure to trauma and its aftermath is not a private experience and holds that the refugee experience of organized violence, the flight to safety, and life in a new land weaves a complex web of traumatization, loss, and healing. This paradigmatic shift offers an alternative conceptualization in which the notions of human loss and bereavement rather than the Western psycho-diagnostic categories of mental illness create a less sociocentric lens of analysis.

The aim of this study was to explore the life stories of three female Cambodian-American refugees in order to understand what their lives had been like since their arrival in the United States, how and if they had experienced personal healing in their lives, and their thoughts of how nurses and other health care providers could be part of the healing process. The research design included a form of narrative analysis, a segmented version of the Life Story Interview (Atkinson, 1998). The interviews were kept intact, complete stories of individuals were analyzed, and similarities in themes within and across interviews were identified. This method was utilized in order to draw attention to the contextualized nature and experience of healing within the lives of these women since their arrival in the United States through indepth, semistructured interviews.

All of the women spoke of the personal value of telling their stories in this forum. Their narratives revealed a sense of disruption in psychological states, social-interpersonal interactions, and adaptation to culture. In each of the stories, trauma and disruption to familial social order, a value steeped in Cambodian culture, was highly problematic and strongly influenced their sense of wholeness and well being. These findings were related to their successes and failures with personal healing. Responses to the suggestion of enhancing nursing and health care interventions underscored the importance for transcultural understanding and communication, tolerance for differences in world views, recognition of survival and growth in the face of adversity, and finally the power of human connection and mutuality through the act of listening to individual and community expressions of meaning. Implications for nursing practice, education, administration, and research were proposed.
The nurse’s perspective of the miscarriage experience- “You are actually tailoring your care to how they react.”

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The primary aim of this research study was to gain an understanding of the lived experiences of nurses caring for women who have had a miscarriage. In other words, the purpose of this study was to understand the nurse’s perspective of the miscarriage experience and hence, to gain more knowledge in order to enhance the quality of care for women who have had a miscarriage.

There appears to be a scarcity of nursing literature on the miscarriage experience, despite miscarriages occurring in approximately 15% of all pregnancies (Bansen and Stevens, 1992). In 2001, in the Republic of Ireland, there were 60,521 births of which approximately 9,078 were miscarriages (Department of Health and Children, 2001). Previous studies focused mainly on the perspectives of women who have experienced a miscarriage (Thapar and Thapar, 1992; Lee et al., 1996; Engelhard et al., 2001); on anecdotal accounts of nurses who have had miscarriages themselves (Borg and Lasker, 1982; Oakley et al., 1984; Wright, 1994; Blake-Barlow, 1998; Lloyd, 2000; Moulder, 2001) and some studies have emphasised the male perspective of miscarriage (Miron and Chapman, 1994; Murphy, 1998). To date, there is a lack of research on the nurse’s perspective of miscarriage, particularly within the Republic of Ireland. Thus, a need for this study was perceived in order to enhance the quality of care provided to women who have had a miscarriage.

Several studies have highlighted the sensitive nature of miscarriage and the traumatic effects it has on women’s lives (Wall-Haas, 1985; Bansen and Stevens, 1992; Thomas, 1995; Ritsher and Neugebauer, 2002). Research has highlighted the fact that some women are so distressed by miscarriage that they can develop psychological or psychiatric conditions, such as depression, anxiety or post traumatic stress disorder (Friedman and Gath, 1989; Cordle and Prettyman, 1994; Lee et al., 1996; Conway and Russell, 2000). Miscarriage warrants appropriate care and support from nurses in order to assist women and their families to come to terms with the loss of their baby and to enable women to go through the grieving process and move positively on to the next stage in their lives. Notably, several studies have highlighted that management and communication problems exist between what nurses perceive a women’s needs to be and the actual needs of women who have had a miscarriage (Bansen and Stevens, 1992; Cecil and Leslie, 1993; Fleuren et al., 1998; Evans et al., 2002).

The author of the present study expected that a study investigating the nurse’s perspective of miscarriage would bridge the gap between nurses and women who have had a miscarriage. Thus, this study focused on understanding the nurse’s perspective of the miscarriage experience and attempted to develop more knowledge in order to assist nurses in supporting women through the grieving process and to facilitate women in moving positively on to the next stage of their lives. Further, Swanson’s (1986-1999) middle range theory of caring, which has been inductively derived and validated through phenomenological research investigations, is scrutinised and used as a framework for caring for women who have had a miscarriage on a gynaecological ward in an Irish maternity hospital.
The researcher’s initial interest in miscarriage originated from the personal experience of losing one twin through miscarriage and the professional experience of differences of care that existed between various hospitals throughout Northern Ireland and the Republic of Ireland. Further, after having worked on a gynaecological ward, for the first time, the researcher surmised that general nurse training and midwifery training did not provide the necessary knowledge, skills or attitudes to provide adequate care to women who have had a miscarriage. The researcher concluded that it was through observing experienced nurses and listening to their stories regarding their clinical experiences of delivering care to women who have had a miscarriage that vital knowledge, skills and attitudes were acquired. By adopting a Heideggerian approach within a phenomenological methodology, the researcher attempts to put into language, the knowledge and array of caring practices, the meanings and concerns of nurses who care for women who have had a miscarriage.

Five themes emerged from the data, they were: “Getting to know a woman”, “Being present for a woman”, “Helping a woman to move on with her life”, “Performing duties for a woman” and “There is life after a miscarriage”. The theme “Getting to know a woman” involved the nurses adopting an individualistic approach, underpinned with an empathetic attitude to ascertain each woman’s perception of a miscarriage. This initial process of ‘knowing’ incorporated a sensitive, probing, assessment process where touch was utilised by nurses as a form of communication to convey support to a woman. This ‘knowing’ process was inhibited due to nurses having insufficient time to enact their role properly, which was related to the burden of carrying a heavy workload. However, it was notable that by avoiding conversing with nurses on issues concerning miscarriage women inhibited nurses from carrying out their facilitative role.

The theme “Being present for a woman” involved nurses entering into a woman’s world and being emotionally open to a woman’s reality. This ‘presencing’ is suggestive of special ways of ‘being there’ that encompasses communication and understanding and is evident even when the nurse is not in close proximity with a woman. An intricate part of ‘presencing’ encompasses listening to a woman’s story in a non-judgmental way. This attentive listening strategy results in validating a woman’s story and has a positive effect on the woman’s journey to recovery.

“Helping a woman to move on with her life” is a theme that describes the various strategies that the nurses’ employ to facilitate a woman to go through the grieving process and move positively on with life. It was suggested that, in the past, through women’s feedback and the media coverage, improvements were made to certain aspects of the care provided to women who have had a miscarriage. The nurses’ proffered advice and information to each woman to instill confidence and to empower the woman to cope with the various problems she would encounter.

The theme “Performing duties for a woman” included carrying out technical skills, such as the administration of medicine or preparation for theatre. The importance of performing social or domestic tasks was highlighted, such as making a cup of tea or a phone call to check the welfare of the rest of the family. These acts of caring were classified by the nurses as ‘tender loving care acts’ and signified the gravity of sincere caring that is embedded in the therapeutic nurse–patient relationship.

The final theme, “There is life after a miscarriage” reflects the importance of the nurse’s optimistic attitude for a woman’s future. This optimistic attitude has a pivotal role in encouraging a woman to go through the grieving process and to move on with her life. There is a sense of hopefulness for the future, underpinned by the affirmation of the individual worth of each woman. The nurse adopts an unconditional acceptance
and understanding of each woman’s perspective on miscarriage. This non–judgmental attitude possesses a therapeutic value and forms the basis for hope and inspiration for each woman to move on with her life. The nurses acknowledged the presence of inner strength and resilient coping capabilities within women to overcome formidable circumstances they encountered in life. Interestingly, other older women on the ward, who were described as the “natural born philosophers” rallied around the women who had a miscarriage and gave them the courage and support to move on with their lives. The researcher concluded that underpinning the nurses’ shared stories of clinical experiences there existed a wealth of knowledge and an array of caring practices that appeared invisible. Thus, it became apparent to the researcher that the nature of the nurses’ informal community-based stories of clinical knowledge and practices were therapeutic in themselves (Benner et al., 1996). Thus, it is crucial that within a managerial climate of efficiency and cost control, the ‘hidden bedrock’ of caring practices are understood and put into language, and that these essential ways of ‘knowing’ that support health, recovery and well-being are validated (Benner, 2000).

References


Mature Students Air Their Concerns Prior To Embarking On A BSc Nursing Programme

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Any student entering third level education will no doubt have concerns in relation to some aspects of their new lifestyle. For some it may be no more than fear of the unknown, for others these concerns may be of a more significant nature. Maynard (1992) states that for the mature student, she/he may present with added concerns over and above that of their younger counterparts, McElwain (2002) concurs with this, when she concluded that, mature pre-registration/diploma nursing students do in fact feel that they have added unique concerns, some of which require addressing prior to they embark on their programme of study.

The purpose of this study was to examine the questions/topics mature BSc students embarking on the nursing programme would like addressed at a one-day induction course.

A total of 42 mature students embarking on the BSc nursing programme were invited to attend a 'one-day mature learners support programme'. To ensure the day was organised around the student's needs, each student was invited to participate in organising the agenda for the one-day programme. Students were informed that they were not obliged to fill out the form, but by doing so, they would find the one-day programme more beneficial as their particular needs would be addressed on the day.

The number of replies to attend the one-day course was 32, and 25 of these students completed the form which asked for 'Question(s) or Topic(s) for the One-Day Programme'. Of the returned forms, there were 2 blank forms and the information on the remainder forms ranged from one word to a full page.

There were a number of similarities between the questions and topics on the forms. Broadly speaking, the subjects fell into three categories. The first category was called 'General Questions' and these were questions that required fairly straightforward answers e.g. "when will we be going out on the wards? ". The second category was called 'Non-Academic Topics', e.g. "the timetable" and the third category was called 'Academic Topics' e.g. "exams, writing essays ". When the information was divided between the different themes, this information was then used to structure the one-day programme for the students.
References

Return to Practice programmes – meeting the needs of adult returner nurses

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Abstract

Since 1999 The School of Nursing and Midwifery at The University of East Anglia (UEA) in collaboration with local Trusts, has provided programmes that prepare nurses to return to practice. Lecturers at the University have demonstrated that designing courses based on family friendly work patterns and negotiated clinical hours can induce nurses to return to the work place. Their research has also established that once in the work force, most returners remain in the National Health Service and many go on to further their nurse education (McGouran 2003; Blomfield and Horne 2001; Worby and McGouran 1999).

A retrospective evaluation of the current Return to Practice (RTP) programme was undertaken to ensure that it meets the changing needs of returners to Adult nursing. The evaluation used quantitative and qualitative approaches and sought the opinions of previous students by means of a questionnaire. The questionnaire was designed to be completed by responding ‘yes’ or ‘no’ to several questions. Space was also left for additional comments. The questionnaire was piloted on 10 nurses outside of the sample who had previously completed a RTP programme. Following this, minor amendments were made. A group of nurses were chosen for the study who had completed a programme in 2003 and had been practising for six months. The UEA
returns approximately 20 nurses a year to practice. The sample comprised 21 nurses in the 2003 group, 15 of these returned the questionnaire. The data was analysed using a thematic approach.

The results suggest that attendance times of the programme were convenient, that sufficient time was allowed for self-directed study, and that clinical placement experience began at a suitable time. The nurses all felt that the programme updated them on current nursing issues. However, the evaluation also indicated that the length of the programme (in terms of theory) could be extended beyond the fifteen days and that although the content prepared them to return to practice, various influences in the clinical environment did not always help them gain the necessary confidence and competence. Moreover, their assessment of practice documentation was regarded by some as being too lengthy and in parts, difficult to understand.

Whilst generalisations from this small study are inappropriate the findings indicate that the programme is meeting the needs of nurses returning to practice although further thought is required on the length of the course, the suitability of some clinical areas and the format of the current assessment of practice.

References


Using action research to introduce the concept of learning through reflective practice

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Abstract
The purpose of this action research project was to introduce reflective sessions as a teaching method. This research project evolved from personally reflecting and theorising on current teaching practices. In addition, students’ were requested to identify areas of my teaching practice they felt required further development. They indicated that reflection should be incorporated as a teaching method in ones teaching practice. Therefore, a collaborative identification of the problem area was the first step in the process of change (Heslop, 2000). The research paradigm chosen to guide this research project was that of action research developed by Lewin (1946). This approach incorporates a series of cycles, each cycle involving; planning, acting, observing and reflecting in relation to a central issue, which for the purpose of this research study was the introduction of reflective practice as a method of teaching on one module of an assess diploma in nursing programme. The action research paradigm used in this research is both responsive and replicable and its transferability to other nursing educational settings is evident. The methodology chosen and potential ethical issues are also discussed. Two cycles of action research are detailed in this study. Each cycle of action was analytically reflected on. The interpretation gleamed from the cycles indicated that the interventions were to some extent successful. The findings suggest: Reflective practice is an effective means by which to teach however, highly developed facilitation skills are required. Students’ required more grounding in the fundamental components of reflective practice. Issues in relation to group dynamics, previous educational experience and vulnerability of students had a significant impact on the process. Participants and the researcher found the intervention extremely beneficial to their areas of practice. The concept of teaching through reflective practice is one, which is indeed worth considering.

References

The distribution of risk factors in cardiac rehabilitation patients: implications for practice

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Introduction

Cardiovascular disease is one of the main killers in Ireland today (Department of Health & Children 1999a). There has been a shift over the last 20 years to more emphasis in both primary and secondary care on prevention (Shelley et al 1995). The identification and targeting of risk factors is the core business of many sectors both primary and secondary care, including cardiac rehabilitation. Risk prediction charts/calculations, levels of risk factors and number of risk factors are continuously changing (www.bhsinfo.org).

As part of a larger study to evaluate the effectiveness of cardiac rehabilitation we surveyed the risk factor profile of patients who enrolled on the Phase III cardiac rehabilitation programme.

Methodology:

During the time frame of the study 329 undertook cardiac rehabilitation, 187 patients of these fulfilled the inclusion criteria for the study. The inclusion criteria were

- Patients who completed the cardiac rehabilitation programme
- Patients who were able to do the exercise component of the cardiac rehabilitation programme
- Patients who returned questionnaires for the effectiveness study at at least one time point

All data was collected prior to 2003. There is some missing data and the exact numbers used in each group is recorded below. Simple descriptive statistics are used to describe the data.

- The following risk factors were recorded in interview with a member of the cardiac rehabilitation team: History, stress, diabetes, and smoking.
- The following risk factors were recorded from patient notes:
  - Fitness
  - Body mass index
  - Total cholesterol
  - LDL levels
  - Blood pressure

The levels used to determine risk for total cholesterol, LDL and Hypertension (Table 1) are the most recent recommendation of the European Society of Cardiology (www.bhsinfo.org 2004). Body mass index (BMI) was derived from weight/height², 25.0-29.9 indicates overweight and levels of >30 indicates clinically obese (ACSM 2000, European Society of Cardiology www.bhsinfo.org 2004). Fitness was measured in METS (metabolic equivalents). METS were recorded in this study using a modified Bruce exercise stress test. One MET is the average oxygen consumption at rest (3.5ml/O₂/kg/min) (ACSM 2000), METS of ≤5 is considered unconditioned and
≤ 10 is the average sedentary value (ACSM 2000). In this study the patients were divided into those ≤10 METS: sedentary and unfit and ≥10 METS: fit. Ethical permission for this study was granted by the hospital’s ethics committee.

Results and Discussion:

Population demographics: The sample was made up of 134 males and 53 females. From a diagnosis point of view the sample included
- 80 Myocardial infarctions
- 56 Coronary Artery Bypass Grafts (CABG)
- 34 PTCA
- 4 other surgery patients
- 13 others.

The age profile of the sample ranged from 30-81, the average age being 59.33±9.71. Table 1 show the dominance of the different risk factors in this cardiac rehabilitation population.

Table 1: Incidence of the major coronary artery disease risk factors in the cardiac rehabilitation population

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Number with risk factor present</th>
<th>Percentage of sample with risk factor</th>
<th>Sample number</th>
<th>How criteria determined</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 LDL</td>
<td>114</td>
<td>78%</td>
<td>146</td>
<td>≥ 3.00mmol/l (^1)</td>
</tr>
<tr>
<td>2 Total cholesterol</td>
<td>105</td>
<td>68%</td>
<td>153</td>
<td>≥ 5.00mmol/l (^2)</td>
</tr>
<tr>
<td>3 Overweight</td>
<td>73</td>
<td>66%</td>
<td>111</td>
<td>BMI ≥ 25 kg/m</td>
</tr>
<tr>
<td>4 Fitness</td>
<td>89</td>
<td>54%</td>
<td>166</td>
<td>METS ≤ 10</td>
</tr>
<tr>
<td>5 Family history</td>
<td>91</td>
<td>49%</td>
<td>187</td>
<td>Interview</td>
</tr>
<tr>
<td>6 Smoking</td>
<td>47</td>
<td>25%</td>
<td>187</td>
<td>Interview</td>
</tr>
<tr>
<td>7 Stress</td>
<td>39</td>
<td>21%</td>
<td>187</td>
<td>Interview</td>
</tr>
<tr>
<td>8 Hypertension</td>
<td>29</td>
<td>16%</td>
<td>178</td>
<td>Diastole ≥ 90 (^3)</td>
</tr>
<tr>
<td>9 Diabetes</td>
<td>12</td>
<td>7%</td>
<td>175</td>
<td>Interview</td>
</tr>
</tbody>
</table>

1. LDL levels of ≥ 3.00mmol/l and those patients with levels ≤ 3.00mmol/l on lipid lowering drugs
2. Cholesterol of ≥ 5.00mmol/l and those patients with levels ≤ 5.00mmol/l on lipid lowering drugs
3. Diastole BP levels of ≥ 90 mmHg and those patients with levels ≤ 90 mmHg on antihypertensive drugs

Cholesterol: Total cholesterol and LDL cholesterol levels are primary risk factors in coronary artery disease. As expected in this study of cardiac rehabilitation patients there is a high percentage of patients with higher that normal lipid levels: 78% having above the recommended LDL levels and 68% having a total cholesterol level above recommended. The Kilkenny study (Shelley 1992) showed the occurrence of above recommended levels of total cholesterol (over 5.2mmol/l) in 60% of the population as a whole.

Of the individuals with elevated cholesterol 67% were not on lipid lowering drugs. Up until recently the recommended guidelines were lipid lowering therapy were for individuals with >20% risk of a coronary heart disease related event in the next ten
years or total cholesterol that remained >5mmol despite dietary advise (Department of Health & Children 1999) and those whose LDL cholesterol of >3.37mmol/L (Department of Health and Children 1999). Routine monitoring of lipid levels post cardiac rehabilitation is currently limited to patients on lipid lowering drugs, this prevented analysis of post cardiac rehabilitation figures. In conclusion not all patients with elevated cholesterol were treated pharmacologically. One of the contributing factors to this may be that by the time of the completion of the study the guidelines levels had further reduced. The effectiveness of both pharmacological and dietary interventions on patients needs to be routinely measured both for individual outcomes and programme audit purposes.

**Body mass index:** In this study 66% (Table 1) of the patients were overweight or above, this is above the average occurrence of this category: overweight, for a sample Irish population (50% Shelley 1999, 42% Department of health and Children 1999b). One of the dietary goals for those with coronary artery disease (Department of Health and Children 1999b) is weight reduction however the levels of exercise prescribed to most individuals in cardiac rehabilitation may not be extensive enough to cause significant weight loss. Is this a risk factor that needs to be more aggressively targeted in the future?

**Fitness:** In this study 54% (Table 1) of the patients had exercise capacity only equivalent to sedentary lifestyle. Although the same measurement tool was not used this is still well above that levels of fitness recorded in the Irish population as a whole (Department of Health & Children 1996, Department of Health & Children 1999b) this may reflect overall population changes in exercise practices or in this instance the effect of earlier interventions (Phase I and Phase II cardiac rehabilitation). The main trust of most cardiac rehabilitation programmes (Vanhees et al 1999) is exercise. In this study of all the patients who attended their end of programme stress test (N=121) there was an improvement in their exercise capacity in 53%. Of the pre cardiac rehabilitation sedentary group (n=68) 6% had moved out of this sedentary category into a higher category of fitness >10 METS. The beneficial effects of exercise are well promoted within primary prevention and also in cardiac rehabilitation.

**Smoking:** 25% of the study group smokes. This does not include those individuals who have given up smoking since their cardiac event (another 8%). There has been a decreasing trend in smoking in the Irish population overall over the last few decades, in 1999 it was up to 34% (Department of Health & Children 1999a, Friel et al 1999) Smoking cessation is an aggressively targeted risk factor, classes for this are given as an option within cardiac rehabilitation programme and are usually only taken up by those who have not as yet given up smoking. Again monitoring of smoking post cardiac rehabilitation and long term should be routine as maintenance of cessation is always a problem.

**Hypertension:** Elevated blood pressure has always been considered as one of the principal risk factors for coronary heart disease. Previous Irish studies of the whole population reported that less then one in 5 participants have elevated blood pressure (Healthy Heart National Survey 1992, Irish Heart Foundation 1994). In this study only 16% of this study group has elevated diastolic BP, this probably reflects the increase in proactive treatment of hypertension in secondary and primary prevention in recent years. Of the 16% of the study group with elevated diastolic BP, 59% of
these were already on anti hypertensive treatments. In the post rehabilitation records (n=66) a total of 27% had BP elevated above normal and 81% of these were not on anti-hypertensive treatment. A proportion of there would have fallen within the recommended guidelines for the time. Of the patients with initial elevated BP, 81% had decreased to within the recommended normal range. Routine measurement of this parameter at the end of the programme assisted in revealing individual outcomes, overall occurrence and improvements

**Family History:** Risk of coronary artery disease is further elevated if there is evidence of coronary artery disease in a close family member. The underlying causes of this incidence is likely to be genetic but may be compounded by poor lifestyle habits within families. The presence of this risk factor like the presence of diabetes increases the overall risk of a patient having a cardiac event.

**Stress:** Stress is a much-documented risk factor of coronary heart disease however it is both hard to measure and improve. In a recent work on changes in stress, exercise and diet in Phase III cardiac rehabilitation and post cardiac rehabilitation (McKee et al in press) we have shown significant improvements in stress but of the it was evident that stress was the factor that was hardest to change. In interview in this study 21% of the study group had stress recorded as a risk factor.

**Limitations:** There are three major limitations with this study.

- For the original survey all patients were invited to partake but only 187 out of the 325 completed it.
- Some risk factor recommended intervention levels changed over the course of the study
- Although current guidelines advise the monitoring of risk factors both before and after rehabilitation for certain factors this is not always achievable.

**Overall discussion and conclusions:**
Previous studies (Eurospire 1997) have shown that substantial numbers patients have risk factors that are still above target levels on entry to of Phase III cardiac rehabilitation. Although some risk factors recommended intervention levels changed over the course of this study there this study confirms these findings. Audit figures at the end of rehabilitation are needed for all parameters to confirm if this deficit still remains after this intervention. Although most guidelines in cardiac rehabilitation (Coats et al 1995, WHO 1993, Vanhees et al 1999, Lewin et al 2004) recommend the monitoring of risk factors both before and after cardiac rehabilitation, practice constraints probably influenced by cost may prevent this from occurring. If we to truly audit effectiveness of any practice, the end points achieved need to be measured.

“Cardiac rehabilitation programmes should be based on patient’s individual needs and should be menu driven” Lewin et al 2004. In this rehabilitation programme both group work and individual work is used. As we have here the recording of risk factor levels is important, and in previous studies we have shown the stages of change a patient is at with regard to a risk factor (McKee et al in press) is also important, there is little use in giving a patient a low fat diet unless they first see the need for change. Simple recording of level and occurrence of risk factors and the stage of change a patient is at with regard to this risk factor could lead to more effective intervention and improvement in risk factors.
The population in Ireland has changed in many ways over the last 10-20 years. The profile of the population is increasing in age and the Celtic tiger of the 1990’s has lead to changes in lifestyle far removed from the “laid back” relatively “poor” Irish of earlier in the 20th century with possible overall increased stressful working habits, less physical activity, greater affluence leading to increased intake of luxury foods and drink. Do the above changes in the Irish population lifestyle hint at increased incidence of risk factors in the population as a whole? Coronary artery disease becomes evident in the older age group but it is developing throughout our life. Is the number of obese sedentary children in Ireland at the present time an omen of the future, a time bomb waiting to happen with regard to CAD? More follow up epidemiological studies the Kilkenny (Shelley 1999, Friel et al 1999) are needed to give us some idea of the extent of the problem.

The recent initiatives in primary prevention need to be facilitated, maintained and further built on or the incidence of CAD and resultant dysfunction will continue to escalate during this new century.

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Shelley E (1992) The Kilkenny Health Project, Kilkenny, Kilkenny Health Project


WWW.bhsinfo.org(2004) 23.08.04 Joint British Societies cardiovascular Risk prediction chart
Promoting evidence-based practice through practice development: getting started, getting involved?

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The term practice development (PD) has become synonymous with evidence-based practice, quality and modernisation (McSherry, 2004). However limited activity has been devoted to deciphering why this is the case and what the potential benefits of PD is in promoting evidence-based practice and modernisation. Despite the positive upsurge in activity from the government, professional disciplines and personnel in health and social care, evidence-based practice and modernization remains difficult, challenging and slow. This seems to be associated with the fact that health and social care professionals, teams and organisations are finding it challenging to start advancing and evaluating innovations or changes in practice or services in busy, stressful and time-conscious environments (McSherry and Bassett, 2002). A possible solution to advancing and evaluating practice within the context of existing drivers, policies and reforms is by focusing on an essential aspect ‘Practice Development’.

The aim of this paper is to encourage individuals in getting started and getting involved in practice development and why and how practice development may provide a recipe for evidence-based practice within the context of modernisation by:

- defining the terms practice development and evidence-based practice
- explaining the fundamental principles and components of practice development and where these fit to evidence-based practice (practical focus)
- outlining the debates surrounding practice development the potential impact on evidence-based practice and modernisation.
- describing the benefits of PD to an employing organisation so that adequate support/resourcing is provided to promote evidence-based practice.

It could be argued that health and social care staff by virtue of their professional accountability and contracts of employment have a responsibility to enhance and evaluate practice(s). Whilst this may be true, government documents on health and social care reforms over the past six years are associated with improving quality by the delivery of evidence-based practice. Practice in this context relates to modernisation, which is about improving the efficiency and effectiveness of services so that individual patient outcomes or the performance of individuals, teams, and organisations can be demonstrated. If an organisation changes its attention to understanding more about exploring the hidden ingredients locked within the key components of PD a truly remarkable recipe for evidence-based practice and modernization may be found!

References
The experience of midwives caring for the breastfeeding mother

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ABSTRACT
The purpose of this study was to explore and gain an understanding of the experience of midwives caring for the breastfeeding mother. A review of the literature indicates a dearth of material relating to the experience of midwives caring for the breastfeeding mother, despite the fact that the midwife has been identified as the key person responsible for this aspect of maternity care (Department of Health, 1994). A purposive sample of ten registered Midwives was chosen for this study. The midwives worked in a large teaching hospital in the Republic of Ireland. A qualitative research approach, using Heideggerian phenomenology was chosen for this study. Data was collected using unstructured interviews. The interpretation of the text for this study was guided by a phenomenological hermeneutic analysis method. Analysis of the interview data revealed seven themes which reflected the phenomenon under investigation. The themes were as follows; “You have to have your heart in it”, ”Intimacy”, ”It’s the ultimate”, ”Being realistic”, ”Breastfeeding is a process”, ”Determination”, ”Frustration.”

The study findings suggested that midwives need to address the psychosocial aspects of breastfeeding in order to facilitate the breastfeeding mother. Intimacy was identified by the participants as an important aspect of breastfeeding success. Lack of resources was identified as an impediment to delivering care to the breastfeeding mother.

The study findings indicated that the focus on breastfeeding to date places emphasis on promoting the physiological health advantages of breastfeeding and potentially ignores the reality of the breastfeeding process. Recommendations arising from this study are made in an attempt to acknowledge the importance of the psychosocial aspects of breastfeeding and its contribution to successful breastfeeding.

Department Of Health (1994) A National Breastfeeding Policy For Ireland Dublin: Department Of Health
Merging Time Zones: Promoting International Communication Through Videoconferencing

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Abstract

Background: Nursing is viewed increasingly from an international perspective. Communication between nurses from different countries and cultures is becoming an important feature of nurses’ education as well as their professional lives. While it is often not possible for nurse educators and students to visit their counterparts in other countries, it is possible for them to engage in personal contact and discussion through videoconferencing technology. The purpose of this study was to enable educators to further their knowledge of videoconferencing as a teaching method, and enable students to meet in a videoconference class and discuss common issues in nursing education and practice with their counterparts in another country.

Design: Two exploratory international videoconferencing case studies. Convenience sampling was used to select two groups of registered nurse students, one higher diploma and bachelors degree and one master’s degree, from the Department of Nursing, University of Scranton, Pennsylvania, USA and the School of Nursing and Midwifery, University College Dublin, Ireland. The groups were bought together for one case study class each. The case studies are presented in the context of videoconferencing in higher education. Descriptive analysis was used.

Results: The practical and pedagogical considerations of implementing the classes are described. Lecturers’ and students’ experiences and evaluations of the videoconference classes are presented. Recommendations are made for further use of videoconferencing to foster communication and help students in different countries to develop greater international awareness of nursing practice and health care.
The Other Side of the Buzzer: Roles and Relationships between ICU Staff and Family Members

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This study describes the roles and relationships that exist between intensive care medical and nursing staff and family members of critically ill patients. A qualitative approach using a grounded theory design was adopted to best suit the purpose of this study. Seven participants were invited to discuss their experience of visiting a loved one in the intensive care unit, with particular focus on their perceived informational and psychosocial needs during this time.

Many ICU patients are unable to communicate with staff due to ill health. Family members play an important role as patient advocates when the patient’s ability to communicate is compromised. Patient contact with ICU staff, particularly nurses is intimate and may be highly intrusive. Family diversities require flexibility of attitude and approach by ICU staff. Therefore, there is an important need for ICU staff to recognise the importance of ensuring open communication channels with family members. The development and maintenance of this relationship is essential as it has the potential to affect patient outcomes.

The strategies used by families and ICU staff to help or hinder the development of nurse-family relationships in this study were similar to and yet expanded on those identified by Hupey (1998). Families spent time trying to evaluate staff, often comparing one nurse against another for signs of competence, kindness and the presence of a genuine interest in the care of their loved one. Frequently the ‘gut feeling’ they got on meeting a nurse at the patient’s bedside was a deciding factor as to whether the patient was going to be well cared for and whether or not the family were going to receive information. Assessment of the nursing staff would frequently continue in the waiting area through discussion with other family members. Most families attempted to establish a relationship with ICU staff as they assumed it would go towards a closer bond between staff and their loved one. However, this relationship did not always develop to its full potential, due to staff rotation, distancing and avoidance strategies employed by nurses and doctors and may have impeded the development of holistic and open relationships.

Finally, recommendations are made to promote the development of therapeutic and supportive interventions in the delivery of family focused care in the ICU. It is suggested that a collaborative approach to patient care benefits all individuals involved in caring for the critically ill patient.

Reference
New Postgraduate Course Developments: An Educational Pathway towards Clinical Nurse Specialist

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The Commission on Nursing (1998) recognised the need for a coherent approach to the progression of specialisation and the development of a clinical career pathway for nurses. The Postgraduate Diploma in Specialist Nursing recognises the contribution nurses have made to advancement of nursing practice in their chosen field of specialty and incorporates the core concepts of caring for patients/clients in a specialist area of nursing practice.

Specialist nursing is highly valued as a clinically focused scholarly professional service which enables nurses to deliver highly competent/expert care to patients/clients. It requires advanced cognitive, psychomotor and affective skills in partnership with the ability to foster critical thinking, discerning ability and decision making. Such characteristics enable the specialist nurse to deliver research based, holistic and innovative specialist nursing care in partnership with the patient, family/significant others and the multi-disciplinary team. Other aspects of the role include participation in nursing research and audit, act as a consultant in education and clinical practice and as a patient/client advocate in collaboration with other professional and community resource providers. Students on this programme are recognised as practicing professional nurses with substantial clinical experience. This course aims to facilitate the enhancement of their knowledge and skills in their chosen area of specialty to an advanced level.

In order to meet the challenges of nursing in a specialist area, the School of Nursing and Midwifery Studies, TCD in partnership with associated Healthcare Providers are offering a number of new strands to the existing Postgraduate Diploma in Specialist Nursing. New course developments for 2004 include: Haematology Nursing and Care of Persons with Severe and Enduring Mental Illness. Proposed new strand development for 2005 include: Cardiothoracic Nursing, Acute Care Nursing, Intensive Care Nursing and Coronary Care Nursing. This course fulfils the requirements for a postgraduate course as outlined by the National Council for the Professional Development of Nursing and Midwifery (2002) and may be taken in preparation for a clinical nurse specialist pathway in the course participant’s area of clinical expertise.

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Clinical Nurse/Midwife Specialists and Advanced Nurse/Midwife Practitioners. 
Dublin: National Council for the Professional Development of Nursing and Midwifery.
A review of harm reduction approaches in Ireland and evidence from the international literature

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One of the trends evident in problem-drug-use research is the increasing emphasis on measures to limit sharing of equipment used in drug administration. Illicit drug use is a behaviour that exposes the drug user to a variety of risks. All of the routes for administering illicit drugs lead to increased risk of HIV, Hepatitis B and Hepatitis C transmission, when equipment is shared.

In September 2002, the NACD commissioned a review of national and international harm reduction research as part of its responsibility under Action 100 of the National Drugs Strategy, the report was published in May 2004. This paper presents the main findings of that report, a review of the research literature and the findings of an exploratory empirical study into the harm reduction practices of Irish drug services. An extensive literature review was conducted of research publications published in the English language up to July 2003 and an exploratory empirical study using a telephone questionnaire was conducted to obtain information directly from service providers.

The effectiveness of international and Irish harm reduction strategies in reducing the transmission of HIV, HCV & HBV is considered. Specific reference is made to the organisation and delivery of harm reduction services in Ireland.

The literature reviewed and the results of the study indicate that harm reduction messages need to highlight risks of sharing equipment such as spoons, water and filters as well as needles and syringes and promote safer ways of using drugs. Sharing of equipment occurs where access to harm reduction services is limited, poor or not available. Those at greatest risk of infection are young drug users, those with a shorter injecting history and those in an intimate relationship with another users

References;
KEEPING THE CREDO COHERENT

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The aim of this paper is to report on a pragmatic, evolving approach to the delivery of teaching & learning materials & support on an Introduction to Mental Health unit (for mainly non-mental health students) in the workplace by electronic means for large student numbers.

The work utilised a mixed strategy of delivery, co-ordinated by the unit leader & the IT manager (along with practice-trainers, PTs), the materials & mode of delivery reviewed flexibly.

The results indicate a developing successful strategy, maintaining a coherence in the materials through the flexibility brought to the exercise by the IT manager. In dealing with large numbers of students (up to 450 per year in three cohorts), many of whom were not working in mental health, challenges were raised & met by integrating online materials (on the course website), workbooks, PT involvement, alongside electronic support from the unit leader & IT manager. An integral component in the delivery is the specific support given by the IT manager to students in allowing them to become confident in the use of electronic delivery, such as online discussion groups. Student groups covered the whole range of health & social care arenas from surgical wards to forensic outreach. Reviews of the efficacy of the programme have proved positive, the role of the PT in support being highlighted by their lack of involvement when students have consistently failed to achieve.

It is proposed that the learning through work approach, supported by intensive electronic provision can be successful for subjects not familiar to the student in their normal environment. It is also proposed that the role of the IT manager is essential to the future planning, delivery & success of such programmes.
UNDERSTANDING WOUND CARE IN IRELAND: LESSONS FOR EUROPE

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Introduction: There are currently no standardised policies or strategies for the provision of wound care in Ireland. The costs associated with wound care are considerable and the lack of standardised education approaches and policies compound this cost and contribute to increased morbidity and mortality of patients. In order to deliver effective wound care services in Ireland, knowledge must be gained of how wound care is currently being provided.

Aims and objectives: The specific aims of the study were:
1. To identify the nature of wounds managed
2. To establish who is providing wound care advice
3. To establish if there are policies/guidelines pertaining to wound care
4. To examine costing issues associated with wound care

Methods: A cross-sectional survey was conducted using a pre-piloted questionnaire as the data collection tool. Data were collected from Directors of Nursing/Public Health Nursing in all community care areas and hospitals, with a capacity of greater than 40 beds, in Ireland. Anonymity of the study participants and the institutions was guaranteed. One hundred and twenty one questionnaires were circulated. Data analysis was carried out using SPSS version 11.

Results: 116 questionnaires were returned (response rate 96%). Leg ulcers, diabetic foot ulcers and pressure ulcers were the most commonly encountered wound types. Advice was primarily sought from the doctor or ward manager pertaining to wound care however; a company representative was also used as a source of advice by 43% of respondents. 46% of respondents had no pressure ulcer policy, despite 95% identifying their involvement in the management of pressure ulcers. 60% of respondents did not know how much was spent on pressure ulcer prevention or wound management annually, despite nursing being identified as the decision makers regarding the availability of wound management products in over 70% of responses.

Discussion: This study provides an insight into the provision of wound care and will form the basis for the development of best practice guidelines in Ireland. The study also prompts questions about wound management practices across the EU member states. There is an urgent need for the development of a national strategy for the prevention and management of wound related problems, in order to ensure equity and accessibility of services for all users of the Irish health care system.

Acknowledgements: This study was a joint project between The Faculty of Nursing & Midwifery and the School of Pharmacy, Royal College of Surgeons in Ireland. The study was funded by a research grant from the RCSI and an unrestricted research grant from Convatec, Ireland.
REDUCING PRESSURE ULCER PREVALENCE – MYTH OR REALITY?
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Background: Pressure ulcers are not a plague of modern man. However, despite the increasing expenditure on pressure ulcer prevention, pressure ulcers remain a major health care problem. Although nurses do not have the sole responsibility for pressure ulcer prevention, nurses have a unique opportunity to make a significant impact on this problem.

Aims and objectives: The specific aims of the study were: -
- To identify staff nurses’ attitudes towards pressure ulcer prevention
- To identify the behaviour of staff nurses’ in relation to pressure ulcer prevention
- To identify staff nurses’ perceived barriers towards pressure ulcer prevention

Methods: In this study a quantitative research design was selected. A cross-sectional survey was used to collect responses from a randomly selected sample of staff nurses (n=300) working in an acute care setting in an urban location in Ireland. Data were collected using a pre piloted questionnaire. Data analysis was carried out utilising the statistical package for social scientists version 10 and SPSS Text Smart version 1.1. Differences in responses between sub-groups were analysed using Mann Whitney or Chi-square.

Results: The nurses surveyed demonstrated a positive attitude towards pressure ulcer prevention. However, despite this, prevention practices were demonstrated to be haphazard and erratic and were negatively affected by lack of time and staff. These barriers prevented the nurses’ positive attitude from being reflected into effective clinical practice. Education, though poorly accessed, or made available, was rarely cited as impeding practice in this area.

Discussion: The nurses identified barriers to practice that are real problems of nursing today. Disappointingly, lack of education was not considered to be important. Without providing staff with the necessary skills and knowledge to correctly identify those in need of prevention strategies it is futile to spend large amounts of money on prevention equipment. If this situation continues much needed resources will be poured into pressure sore prevention without the desired outcome being achieved that is a reduction in pressure sore prevalence for those whom prevention is a realistic goal.

Conclusion: From this study it would appear that positive attitudes are not enough to ensure that practice change takes place, reinforcing that the complex nature of behavioural change is a fundamental issue. Therefore, implementation strategies should introduce ways in which key staff can be empowered to manage barriers to change.

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What do we mean by a nurses work? Rethinking the conceptualisation of nursing workload.

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Abstract
The current review of nursing workload literature considers the concepts that have traditionally been discussed when researchers have endeavoured to measure nursing work. The main focus of the review is on the way in which nursing care intensity and nursing care dependency have been considered to be conceptually similar to nursing workload in the assessment of the staffing requirements. A model of nursing workload is put forward to advocate that these concepts cannot be considered in isolation when measuring the complex whole that is nursing work.

Introduction
There are many ways in which researchers have attempted to conceptualise and measure the work of the nurse. These include the conceptualisation of nursing work in terms of nursing intensity, nursing care dependency, clinical acuity or the severity of patient illness as well as the complexity of care required and the time taken to administer patient care (Prescott, P.R., JW; Soeken, KL; Castorr, AH; Thompson, KO; Phillips 1991; Needham, 1997; Dijkstra, A.B. G; Dassen, T, 1996). Most studies have cited these concepts as independent concepts that capture the work of the nurse while few have considered the way in which they might be used together to offer a fuller description of the process of delivering nursing care. The focus of the current research is to bring these concepts together to gain a clearer picture of what they mean and how they relate in the context of nursing workload.

One of the challenges in reviewing the literature on nursing work relates to the use of language across the main body of research papers reviewed. It seems that within the nursing research literature, a number of terms are used interchangeably to describe similar concepts. Within the current review it is noted that the terms nursing workload and nursing intensity are frequently used to describe the same or similar concepts. It is also noted that measures of patient dependency are used to calculate nursing workload. However, as will be seen, measuring nursing workload using intensity measures yields different information to the measurement of nursing workload using dependency measures.

Because of the language difficulties encountered, concept definition forms an important part of this review. Nursing workload is defined and its relationship to other similar concepts is outlined. Furthermore, the concepts that have been previously
reviewed in relative isolation are brought together to put forward a conceptual process of nursing workload.

**Research Sources**

In order to conduct a preliminary review of the literature on nursing workload a search was undertaken using electronic databases, reference lists and other available literature. Articles were sourced from the Medline, Psychlit, Cinahl, Cochrane databases and through the general search engine Google. The key words in the literature search focused on nursing workload, nursing intensity, patient dependency. The search terms used for the review included: nursing care/resource intensity, nursing/patient dependency, nursing care dependency, complexity of care, nursing skills mix, severity of illness, acuity of illness, nursing work and nursing workload.

**Defining Nursing Work**

Previous research into the work of the nurse has been preoccupied with the concept of ‘nursing workload’. There is no common definition of workload in the literature. Arthur and James (1994) provide the broadest perspective of workload as the ‘volume and level of nursing work’ (p. 558). Needham (1997) defines nursing workload as ‘the totality of the need for nursing time from all work that must be carried out over a defined period of time’ (1997, p. 84).

Much of the research in the area of nursing workload is conducted with a view to quantifying nursing activities to assist in nursing resource allocation, and ultimately contribute to financial management in hospital settings. Over the last decade research on the measurement of workload in nursing has turned towards the consideration of the time needed for direct patient care and the time needed for indirect or all other work. Prescott et al (1991) define both direct and indirect care whereby direct care accounts for all nursing activities carried out in the presence of the patient and/or family and indirect care accounts for any work carried out away from but on behalf of a specific patient. Taken together, direct and indirect care are patient assignable time (Sovie and Smith, 1986), which is distinct from the time that might be involved in managing the nursing unit.

Using these definitions and considering the linkages that exist between them, a preliminary model of nursing workload is put forward in Figure 1.

**Nursing Workload**

O’Brien et al (2002) describe the measurement of nursing workload as a complex process aimed at providing a range of data, which will enable rational decision making in allocating resources to both nursing and patients. They note that when measuring nursing workload it is essential to distinguish between ‘nursing’ and ‘non-nursing’ work, and to then link this distinction to an ideal skill mix. Others argue that this is very difficult to achieve as there is no clear delineation of what is nursing and what is not. For example, Jacques (1993) talks about visible aspects of nursing care such as feeding the patient and administering medication and ‘invisible’ elements such as relationship building and education.

**Nursing Care Intensity as a Measure of Nursing Workload?**
In reviewing the literature it was noted that definitions of nursing workload range from defining the concept of nursing workload in terms of ‘ALL’ work activities carried out by nurses to considering workload as conceptually similar to that of nursing intensity. For example, The Canadian Nurses Association (2003) use the terms nursing workload and nursing intensity to describe the same concept. They describe nursing workload measures in terms of measuring nursing resource intensity or the intensity of the nursing response to the conditions in the patients that create the demand for nursing care (O’Brien-Pallas et al, 1997). The Canadian Nurses Association thus describe nursing workload as a measure of the nursing resources used in terms of a) time and b) level of nursing staff involved in the delivery of care to different types of patients under different conditions.

O’Brien-Pallas et al (1997; 2001) suggest that the gold standard in measuring nursing resource intensity would be a valid and reliable system that measured elements of the nurses work that influence nursing workload and patient outcomes. These factors include the nursing condition of the patient, the medical condition of the patient, the characteristics of the care provider, the nursing interventions used and the work environment. A gold standard process would also include having nurses who are providing the care interpret objective workload data based on their actual experience.

**Operationalising Nursing Care Intensity; the measurement tools**

Fagerstrom et al (2000) define nursing intensity as the relationship between patients’ caring needs and the available staff resources. In their research they describe nursing care intensity as being indicative of nursing workload on the ward and they developed the Professional Assessment of Optimal Nursing Care Intensity Level – PAONCIL (Fagerstrom et al, 1999) to assist in the allocation of staff resources.

The PAONCIL is an extension of another instrument designed by Fagerstrom et al (1998), the Oulu Patient Classification (OPC). Using the OPC intensity measurement instrument Fagerstrom et al (1998; 1999; 2000) calculated a daily nursing care intensity level expressed in scores per nurse. They advocate that gives the nurse managers a good picture of current workload and can therefore be used in staff allocation.

The OPC instrument was developed further by Fagerstrom et al (1999) to measure the levels of nursing care intensity per nurse that were possible without endangering the quality of care provided and risking that the patient might not receive adequate care according to his/her needs. This instrument became the Patient Assessment of Optimal Nursing Care Intensity Level (PAONCIL) (Fagerstrom et al, 1999) which aims to calculate the maximal, minimal and optimal levels of nursing care intensity scores for different wards. Within this method, the OPC values are predictive variables and the PAONCIL values are outcome variables.

The OPC, and consequently, the PAONCIL are based on the assumption that nursing care comprises: planning and coordination of care, breathing, blood circulation and symptoms of disease, nutrition and medication, personal hygiene and excretion, activity, movement, sleep and rest as well as teaching, guidance in care and follow-up care and emotional support. Taking these assumptions into consideration, the PAONCIL and the OPC appear limited in their ability to capture elements of social and psychological support including relationship building, which make up so much of
the nurses’ work (Jacques, 1993). Furthermore, according to the PAONCIL method, Fagerstrom et al. (1998a; 1998b) define assessment of nursing care intensity in terms of gauging the patients’ individual caring needs and the acts and measures of nursing staff to satisfy these care needs during a given period of time. From this it seems that Fagerstrom et al define nursing intensity in the same way as other authors have defined nursing workload. If nursing intensity gauges the patients’ individual care needs and the acts and measures of nursing staff to satisfy these care needs during a given period of time, as the authors say it does, then one would assume that it gauges all activities involved in the nursing process. Furthermore, this system of calculating workload and staffing requirements in nursing is similar to the concept of nursing hours per patient per day as a means of assessing staffing levels. This concept has been criticised by the American Nurses Association (1999) for its’ limiting, one size fits all methodology.

In developing the Patient Intensity for Nursing Index (PINI), Prescott et al (1991) defined nursing intensity as a combination of the amount of care and the skill level at which that care is provided. The Patient Intensity of Nursing Index came about in response to the failure of patient classification systems to account for the complexities of decision-making and the level of the nursing care provider associated with nursing care (Prescott et al, 1991). There are four conceptual dimensions of the PINI. These are the severity of the patient’s illness, patient dependency, the complexity of tasks, procedures and the nursing process and the time taken to deliver nursing care. Interestingly, Prescott (1991) states that complexity of care relates to the skill level of the care provider and salary costs (relating to skill level) and is an important dimension of nursing intensity. Goosen et al (2000), on the other hand define complexity of care as consisting of a mix of medical characteristics, patient problems and nursing activities. Within the measure of nursing complexity Goosen et al (2000) included calculation of nursing intensity, defined as the number of patient problems and nursing interventions per patient per day. This illustrates the differences in the way in which complexity of care and nursing intensity have been defined. The question here relates to whether intensity is a component of complexity of care or whether complexity of care is a component of nursing intensity?

Herein the argument is put forward that Prescott’s model of nursing care intensity is preferable to the other scales discussed above because it considers the clinical aspects of the nurses’ work as distinct from the non-clinical aspects. This allows us to view the work of the nurse in terms of patient specific work as distinct from non-patient specific work. Taking this perspective, intensity relates to:

A) Nursing interventions, both direct and indirect - A direct intervention is an intervention performed through direct interaction with the recipient of care while an indirect nursing intervention is an intervention performed away from the recipient of care but on behalf of that recipient. It is carried out to support a direct care intervention (adapted from NIC, 2000) and

B) Non-intervention work, which is carried out by a nurse to support the maintenance or further development of the health care organisation. It contributes to the care environment through coordination or a related function.
Figure 2 takes into account Prescott’s model of nursing intensity and her observation that both direct and indirect care are patient assignable time, distinct from time spent managing the nursing unit.

**Comments on Nursing Care Intensity Measurement**
Prescott argues that her definition of intensity encompasses decision-making and clinical judgement – most notably in the complexity of care required. Inclusion of the complexity of care makes for a more sophisticated and worthwhile definition and measurement tool of intensity. Although similarities are noted between the work of both Fagerstrom and Prescott, the PINI is a more sophisticated tool for the purpose of intensity measurement. As noted, Prescott et al (1991) do not consider non-clinical activities part of the make-up of intensity as Fagerstrom (2000) does. Therefore, according to Prescott, intensity relates only to clinical work or work carried out on behalf of the specific patient. In addition, the use of hours per patient per day as a means of calculating nursing workload has been questioned (American Nurses Association, 1999). This is reflected in Firestorm et al’s (1999, 2000) work.

**Nursing Care Dependency as a Measure of Nursing Workload?**
A second concept that was noted to be closely related to nursing workload is that of nursing care dependency. In the literature reviewed, patient dependency is often cited as being indicative of workload measurement (Arthur et al, 1994; Carr-Hill et al, 1995; 2003; Hughes, 1999). For example Carr-Hill et al (2003) state that 'workload' refers to the number of patients in a variety of wards multiplied by the dependency group. These authors talk about dependency driven methods of workload measurement, where workload requirements are based mainly on the dependency of ward patients on a certain amount of nursing care in order to perform the basic activities of daily living (Carr-Hill et al, 1995). Arthur and James (1994) discuss ‘bottom-up’ dependency methods of workload measurement stating that they are based on the belief that the dependency of the patient on the nurse is a good measure of the demand on the nurses’ time. It is argued here, however that dependency is not an adequate measure of workload as it only captures one aspect of the nurse’s work.

In reviewing the literature on nursing care dependency it was noted that few studies attempted to define the concept of dependency and how it should be interpreted in the nursing environment. Authors seemed less concerned with the conceptual underpinnings of dependency than with devising a method assessment for the concept.

Dijkstra et al. (1996) did define ‘dependency’ in the context of nursing care. They first examined the use and meaning of the word ‘dependency’ in its everyday use. In doing this they drew on the work of Van den Heuvel (1976) who considered the concept of dependency to be a practical, almost physical helplessness which necessitates attention or care by others, a helplessness or powerlessness in a social/personal relationship and a psychological need to be looked after, controlled or nurtured. This implies that there are physical, psychological and social dimensions to dependency.

decreased and whose care demands make him/her to a certain degree dependent, with the aim of restoring this patient's independence in performing self-care’ (p.15).

**Operationalising Nursing Care Dependency; the measurement tools**

Scales reviewed in the dependency literature indicated that they are most likely to be patient group specific and are predominantly used to measure what are more commonly termed ‘activities of daily living’. The Katz Index of Independence in Activities of Daily Living (ADL) (Katz, 1963) is used to assess functional status as a measurement of a patient’s ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring, continence, and feeding. The Katz Index of Independence in Activities of Daily Living (Katz, 1963) does not explicitly measure patient dependence on nursing care but it has served as a base from which dependency measures have developed. Furthermore, this scale measures only physical aspects of independence and fails to consider the social and psychological dimensions of independent living.

One of the earliest measures of dependency, still commonly used, was the Barthel Index (Mahoney et al, 1965), based on the Katz (1963) ADL Index. It contains 10 items that measure daily functioning, including feeding, moving from wheelchair to bed and return, grooming, transferring to and from a toilet, bathing, walking on level surface, going up and down stairs, dressing, continence of bowels and bladder. The assessment can be used to determine a baseline level of functioning and can be used to monitor improvement in activities of daily living over time.

The Barthel Index is considered useful in measuring rehabilitation of people who are chronically ill. Like the Katz Index, it measures only physical aspects of independence and fails to address psychological or social aspects. Unlike Katz (1963) it does specifically measure nursing care dependency.

The Functional Independence Measure (FIM) (Service UDM, 1990) assesses physical and cognitive disability in terms of burden of care. It is used to monitor patient progress and to assess outcomes of rehabilitation. It is a rating scale applicable to patients of all ages and diagnoses, by clinicians or by non-clinicians, and has been widely adopted by rehabilitation facilities in the United States and elsewhere (Hamilton et al, 1987).

The FIM was developed in the USA and forms part of a Uniform Data System for Medical Rehabilitation (UDS) to estimate payments in rehabilitation medicine (Service UDM, 1990). Within the FIM, the level of a patient’s disability indicates the burden of caring for them and items are scored on the basis of how much assistance is required for the individual to carry out activities of daily living (Service UDM, 1990). Several stages of rehabilitation are identified and efficiency of care may be estimated by dividing the increase in life function (e.g., measure by improvement in FIM scores) by the cost of the rehabilitation services.

The FIM includes 18 items covering independence in self-care, sphincter control, mobility, locomotion, communication, and social cognition (Granger et al, 1991).
Ratings consider performance rather than capacity and may be based on observation, a patient interview, or medical records. The FIM has not been developed for any specific patient group and can be used across diagnoses and ages (Hamilton et al, 1987).

In an attempt to measure nursing care dependency, Dijkstra et al (1996) translated Henderson’s (1966, 1985) 14 human needs into a nursing care dependency scale. These 14 human needs are laid out on a continuum to assist the nurse to move a patient from a state of dependence to a state of independence. Items on the scale start with physiological functioning and move to psychosocial aspects of basic needs. The result has produced the Care Dependency Scale (Dijkstra, 1996, 2000), which is used to assess dependency levels among psycho-geriatric patients.

**Comments of Nursing Care Dependency Measurement**

Overall research into nursing care dependency has not addressed the vital issue of concept development and analysis. Many authors have considered nursing care dependency to be an adequate measure of workload (Arthur et al, 1994; Carr-Hill et al, 1995; 2003; Hughes, 1999). Furthermore, scales discussed tend to be designed with specific patient populations in mind, such as elderly patients or people with a chronic illness.

Nursing dependency scales all seem to measure activities of daily living, using the Katz Index of Activities of Daily Living (Katz et al, 1963) and the Barthel Index as a starting point. The consequence is that social and psychological aspects of experience are relatively neglected in assessing dependency needs, leading to an incomplete picture of requirements placed on nurses to provide various types of care. The Functional Independence Measure (FIM) (Service UDM, 1990) was noted to be the only scale that was neither age nor diagnosis specific. The physical items on this scale are based on the Barthel Index.

Dijkstra’s (1996, 2000) care dependency scale is specifically designed for the carers’ of psycho-geriatric patients from both intellectual disability and demented patient groups. It is an exception to the trend to focus on the concepts first captured in the Barthel Index or the Katz ADL Index. Like the FIM, it does consider social and psychological aspects of independence in particular, due to its designed use among patients with mental health difficulties, it focuses more on intellectual ability in learning and social contexts.

It seems that the activity and participation section of the Functional Independence Measure, which is not specifically designed to measure the patient’s dependency upon the nurse, captures a more holistic or complete picture of patient dependency as it considers the psychological and social aspects of dependence as well as the more visible and quantifiable physical aspects.

It is argued here that existing dependency measures fail to capture this information adequately and there is a need for a more comprehensive instrument to be designed.

**Conclusion - Proposing a Model of Nursing Workload**

This research attempts to bring together the major concepts identified in the literature that relate to nursing workload. The most notable difficulty in doing this was to
reconcile the conceptual basis of ‘nursing intensity’, ‘nursing care dependency’ and ‘nursing workload’, concepts that are commonly used to describe nursing workload. While these concepts are different from one another, a distinct relationship exists between them. In order to illustrate this relationship a conceptual model of their relationship is presented in Figure 3.

This model serves to illustrate the relationship that exists between nursing workload, nursing intensity and nursing care dependency. Nursing workload is broken down into nursing interventions and non-intervention work carried out by the nurse. Nursing interventions are broken down further into direct and indirect care interventions. These relate directly to the patient and are distinct from non-intervention work required of the nurse such as administration, unit specific tasks, teaching/education, supervision, professional and industrial time. In line with the thinking of Prescott (1991), nursing care intensity is related to nursing interventions and should not encompass non-intervention nursing work. Under the umbrella of nursing intensity fall the concepts of dependency, severity of illness, complexity of care and time.

This paper thus puts forward the argument that nursing workload should be the term presented to refer to ‘ALL’ nursing activities. Nursing intensity is a component of nursing workload and nursing care dependency is a component of nursing intensity. Therefore, use of these concepts in isolation as a means of measuring nursing workload is rejected as they must be considered in a relational context in order to form a holistic picture of the nurses’ work.

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Appendix A

Figure 1

Nursing Workload

- Direct care interventions
- Indirect care interventions
- Non-intervention related nursing work e.g. organisational functions and tasks carried out to support the maintenance or further development of the organisation

Figure 2.

Nursing Workload

- Direct interventions
- Indirect interventions
- Non-intervention related nursing work e.g. rostering, admin, teaching etc.

Nursing Intensity

- Nursing care dependency
- Severity of illness
- Complexity of care
- Time

Figure 3.

Organisational/environmental context in which the work of the nurse takes place
Critical Incident Analysis: challenges and opportunities for students and lecturers

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Easier to describe a thing than to do it!  

Shang Shu

Abstract
Critical incident analysis is a dynamic and potent teaching and learning strategy for developing students’ reflective ability and bridging the gap between theory and practice. However, implementing this reflective learning tool in the classroom is complex and challenging. This paper describes how it was used with graduate students in Hong Kong and examines some of the ways it contributed to transforming an educational experience for both students’ and lecturer.

Introduction
The use of teaching and learning strategies that enhance the process of reflective learning, practice and sense of meaning is a central component in the education of professionals (Biggs, 1999). One strategy that has been advocated as a valuable and potent method of promoting reflective clinical practice is critical incident analysis (CIA). Despite this, there is minimal research about its application with undergraduate student nurses in Hong Kong. Against this background this study was initiated because it was not known in what way if any, the use of CIA was helpful to students as a learning tool.

Literature
As an educational tool CIA not only provides a framework to develop students’ reflective ability, but also facilitates the integration of theory with practice by turning an ordinary or typical experience (incident) into a potentially valuable learning opportunity (Benner, 1984; Smith and Russell, 1993; Chambers, 1999). Although the incident itself is the starting point for reflection, the experience alone does not necessarily lead to learning (Boud, Keogh and Walker, 1985). For learning to take place, the incident must be made conscious, reflected on and contribute to a change of understanding. While most of the literature supports and values the use of CIA, it has also received some criticism highlighting potential problems. Some of these include the lack of appropriate teaching skills, the possibility of participants feeling threatened by the process of disclosure (Farrington, 1993) and the lecturer’s moral and legal responsibility to disclose information about activities (incidents), which may be detrimental to patient care.

Historically, critical incident technique originated from Flanagan’s (1954) work with WWII pilots as a classification and training method about effective or ineffective behaviour during aircraft combat missions. Since then, it has been adopted within nursing as a valuable educational tool. In the literature its application has been described in a variety of ways such as, assessment of practice, examination and change of attitudes, curriculum development, and both as an assessment and evaluation strategy (Beattie, 1987, Crouch, 1991, Smith & Russell, 1993, Chambers, 1999). Similarly, procedures for implementation of CIA also vary, for example Smith and Russell described using selected incidents submitted by students in advance of
workshops, while Burnard (1989) suggested using pre-determined incidents such as breaking bad news, or exploring fictional or real incidents presented by the lecturer. Teaching and learning approaches employed following the collection of incidents may include asking students to elicit non-effective behaviours, role-playing of fictional scenarios (Burnard, 1989) and group exercises (Smith and Russell, 1991).

As an assessment tool, CIA involves both reflecting on and writing about an experience/incident, which occurred in the practice setting. In itself, it provides a framework for reflection. The critical incidents may be considered as typical every day experiences but to the student they are significant. The cornerstone of CIA is reflection. The latter takes place when the student recalls the incident, identifies feelings, thoughts and/or behaviours and through the analysis of the experience/incident makes inferences and evaluations that are translated into concepts. This in turn may illuminate future experiences (Ghaye & Lillyman, 1997; Parker, Webb & D’Souza 1995; Wong, Loke, Wong, Tse, Kan & Kember, 1997). As such, it brings together both practice and knowledge in nursing and as a result the student may demonstrate learning outcomes from the experience within any of the educational domains - affective, cognitive or psychomotor skills.

Reflection is widely accepted as an important part of the ‘nurse’s repertoire of skills’ (Rolfe, 1997: 94). It consists of the ability to examine one’s own thoughts, feelings and actions and think purposefully about clinical experience in order to gain new ideas, perspectives and understanding about their practice (Atkins & Murphy, 1993; Boud & Walker, 1985). Two separate types of reflection are commonly described, reflection-on-action and reflection-in-action (Schön, 1991), the latter being more suited to more experienced practitioners. As an active personal process, reflection helps to turn each experience into another learning experience. However, learning how to reflect is a complex, demanding activity and generally involves higher-order mental processes at a conscious level. While all of us have the potential to reflect (Jarvis, 1992) it is not an innate or tacit ability (Perry, 2000). Facilitating reflection in the classroom requires support, structure, guidance and time to enable students to explore and acquire a new or revised meaning of the experience (Johns and Freshwater, 1998).

Although the author of this study was familiar with using CIA as an educational tool with qualified nurses, she had less experience of its application with student nurses who were novices to this approach of learning. In contrast to more traditional styles of teaching and learning, CIA often engenders feelings of uncertainty, confusion and limited competence for students and at times lecturers. As an experiential learning approach it also changes the role of the lecturer to that of a facilitator of learning and resource person.

**Purpose**

The purpose of this exploratory study is to introduce CIA in the classroom and to explore student nurses’ experiences of its educational value as a teaching and assessment strategy.
Methodology

Context

This exploratory qualitative study involved twenty (14 females and 6 males) Bachelor of Nursing third year students undertaking a 13-week elective course on Human Relationships and Nursing at The Chinese University of Hong Kong. At the outset of the course, a general introduction of the philosophy and methods of experiential learning together with an explanation of the use of critical incident analysis as a teaching and learning approach was provided. A 3000 word CIA formed part of the required theoretical assessment for this course. Permission was obtained for material from the classroom and assignments to be used for research purposes, assuring students that all incidents would remain anonymous.

Implementation of CIA

Using Benner’s (1984) guidelines (Appendix 1), students were asked to keep a record of incidents in their reflective diaries concerning any aspect of Human Relationships that had occurred during their clinical experiences both in the wards and community settings. Permission was given to use an incident that took place outside of their clinical experience, as long as the incident could be linked to nursing practice. Drawing from the lecturer’s previous experience, students were advised from the outset that there were no ‘right or wrong’ incidents, as each student’s experience was unique to him/her. On identifying and incident, students were then requested to identify what was significant / critical about the incident, i.e. the rationale for choosing this particular incident.

From the outset, ground rules were negotiated and agreed upon to provide a safe and supportive learning environment. Although time was allocated for students to disclose their incidents with peers and the lecturer during weekly reflective sessions, few students volunteered to share their incidents in front of the whole group. Those that did present were facilitated in a supportive and non-judgmental manner. Using guiding questions the student was asked to identify and examine significant issues arising from the particular incident and its relevance to nursing practice. During this process, key issues emergent from the incident were illustrated diagrammatically by using spider grams and the analogy of an iceberg on the white board. Visually demonstrating this process combined with the lecturer’s facilitation skills helped the student to begin the process of identifying and understanding the emergent issues and incident from a broader multidimensional perspective and beyond that of a descriptive factual experience. Interestingly, using the analogy of an iceberg facilitated students to identify issues that were outside of their awareness at the time of the incident. Throughout this process, negotiation also took place over how best to explore and analyse the incidents further, for example, through the use of role-play or reading relevant literature. Other teaching methods used included brainstorming, small group work and theoretical input. Individual or group tutorials were provided on students’ request. All but two students availed of tutorials throughout the course. Given the lecturer’s time constraints and belief that students would benefit from listening to their peers, tutorials were generally carried out in pairs or groups of three. Only one student requested an individual tutorial as he ‘was too embarrassed to discuss his incident in front of his peers’.
Data collection

Data was collected informally at the end of each teaching session and formally at the end of the course through the use of a semi-structured questionnaire (Appendix 2). It was recognized that some bias might be present because of the researcher’s (lecturer) familiarity with the students, however it was hoped that using questionnaires and promised anonymity would reduce bias. The questionnaires were distributed and collected by the class representative. Following each session, the lecturer also kept a record of the content, processes and teaching strategies used. For the purpose of this study no attempt was made to assess students’ levels of reflective thinking demonstrated in their written assignments, however the overall high quality of the final written assessments cannot be ignored.

Data analysis

An exploratory descriptive approach aims to discover and describe new facts about the situation as it is and can be used to assess current conditions and practice, or to make plans for improving them (Mc Cormack, 1991). The researcher and another nurse educator who was familiar with the use of CIA but who had not participated in its application read all the questionnaires independently. Key themes were identified separately and agreed upon.

Findings and Discussion

The data presented consists of a summary of the themes of the incidents and informal comments and observations collected throughout the course. The three themes that emerged from the semi-structured questionnaires comprised the use of CIA as an educational tool, benefits and challenges and the learning gaining from CIA, and the process of understanding CIA. The lecturer’s personal reflections will also be presented. Quotes illustrating the findings are presented throughout the discussion.

Themes and content of the incidents

The content of the incidents reflected a range of different experiences, which took place in various clinical settings and whereby the student was directly or indirectly involved. Two students chose incidents that took place outside of their clinical setting as they had significant learning to their clinical practice. Similar to Smith and Russell’s (1993) finding, most incidents represented interpersonal or interactional situations rather than clinical procedural issues. Only one student described an incident that was perceived as having a successful outcome. Although the incidents described a range of different experiences a number of recurrent themes emerged from the incidents. These were:

- Feelings of incompetence/helplessness
- Prejudice
- Student status
- Theory-practice conflict
- Lack of assertiveness
- Communication with angry patients/relatives

All students reported no difficulties in identifying a critical incident from their clinical experiences. Interestingly, for one student the difficulty was due to the fact that she had ‘so many incidents and did not know which one was the most meaningful’.
The use of CIA as an educational tool

Students’ informal comments at the beginning of the course described the use of CIA as ‘very difficult, confusing, strange too broad’. Through the course, these descriptions changed to ‘creative but challenging, interesting, useful’. At the end of the course, while the majority of students still viewed CIA as a challenging learning tool, they all viewed it as an appropriate and relevant learning and assessment strategy. However several stressed that this was dependent on the teaching methods employed and the number of students in the group. As one student pointed out;

‘The CIA is good only if there are chances for discussion and time to share our experiences with each other and the lecturer, usually we have lectures and it’s very difficult to form groups and discuss things that happen in clinical practice. We are not use to speaking in front of the class’.

Data from the questionnaires identified the lecturer’s input as being an important backdrop for the understanding and application of CIA as an effective learning experience. The use of the visual demonstrations (iceberg analogy) was identified as a very helpful strategy in explaining how to analyse the incident, together with the tutorials and discussion with peers. Interestingly, only one student commented on the use of student guidelines as beneficial.

The Benefits and Challenges of CIA

For the majority of students, freedom to choose an incident and the personal nature of the learning gained were seen as one of the key benefits of CIA. It is interesting that this sense of individuality helped students to give meaning to their learning and experience, despite the fact that for many, analysis of the incidents had evoked feelings of discomfort by challenging their beliefs and behaviours, as described by three students:

‘Although it was difficult for me see that my attitude was negative to the client, the freedom to choose our incidents, allows imagination (space for thinking). We need not be restricted to do the topics we don’t like. It’s more personal and interesting for me’.

‘This assignment is different - no similarity with other course work, it’s good to look at things that are significant to us’.

‘It’s better that doing an essay, it’s quite individualised and it allows me to express my feelings in this assignment rather than just presenting theoretical materials’.

For one student, the fact that each incident was different had a more pragmatic advantage in that there ‘was no need to borrow the same books’.

Learning how to think about an event ‘deeply’ and knowing more about self were identified as key benefits from undertaking CIA. For the majority of students having an increased awareness and understanding of self was viewed as an important component of their personal and professional development. However, such awareness also evoked feelings of embarrassment, guilt and incompetence for some students. Being aware of negative feelings, thoughts and actions was challenging as reported by two students:
‘Before the incident I wasn’t aware that I have a darker side – I know I treated the patient differently because she was from the mainland (China). I hope I won’t do this again but I am afraid it might happen again. I feel bad about this’.

‘I was embarrassed when I told the lecturer about my feelings towards the patient, but she didn’t scold me and I learnt to understand myself better. I know this will help me to be a better nurse in the future’.

As with all teaching and learning strategies, CIA also presented challenges for the students. Given that students had no prior experience of CIA either as a learning approach or assessment, it was not surprising that these challenges concerned how to analyse the incident and apply the literature to underpin their analysis as these two students reported.

‘How to analyse the incident and link it to theory is the most difficult part. I don’t know which area to focus on and how to link the different areas together’.

‘I don’t know how to think deeply – no previous experience of this assignment, it sometimes confusing and difficult to relate the critical incident to the literature’.

Issues for the Lecturer

Using critical incident analysis as an educational tool has been rewarding both personally and professionally. Facilitating students to make the transition from a traditionally didactic style to a more student-centred experiential approach was at times challenging and required extra support and guidance to alleviate students’ feelings of anxiety and uncertainty. Facilitating students to disclose and discuss incidents about their practice demands a safe and supportive environment. Even then, without prior knowledge of students’ incidents the use of CIA in the classroom will always involve an element of the unknown and at times unpredictability (Beattie, 1987). On a few occasions, I was aware that I was at risk of imposing my perception of the significant issues emerging from the incident onto the student. Fortunately, I was aware of this at the time, however it is important to be mindful of this in the future. Failure to do so may detract from or hinder the personal meaning and learning unique to this educational tool. Given that this was the first time students had undertaken this type of learning and assessment, their motivation and willingness to adopt a new approach to learning was impressive. However, the fact that all students had elected to undertake this course and perhaps more significantly CIA was an assessed piece of work cannot be ignored as key influencing motivators. Listening to some critical incidents often meant hearing about issues that which reflected ‘poor practice’, this in turn prompted feelings of concern and potential ethical dilemmas for the lecturer in terms of what action to take whilst protecting the student’s anonymity. Finally, one of the great joys of marking critical incidents is that each paper is unique but more importantly CIA provides the lecturer with a wealth of information about students’ real experiences and challenges in clinical practice which can be utilised as a vehicle of narrowing the theory practice gap.

Conclusion

Critical incident analysis is a flexible, dynamic teaching and learning strategy, which enhances the learning process and the potential for promoting reflective clinical
practice. As an educational approach students reported that it helped them to develop their reflective ability and bridge the gap between theory and practice. Although challenging and anxiety provoking at times, students generally found it an interesting and rewarding approach to learning. It enhanced their learning by encouraging them to think more critically about their clinical and personal experiences as well as increase their self-awareness. Freedom to select a critical incident and its personal meaning and learning was a key motivator for its use as a valuable learning strategy. However, the student-lecturer relationship also plays an important backdrop for the effective use of critical incident analysis in the classroom. It is hoped that this small exploratory study will add to the body of knowledge of CIA and its application in nurse education. Clearly, further research is warranted in terms of evaluating its educational value over a longer period of time and with different lecturers.

References

Appendix 1 Guidelines for identifying Critical Incidents:

A. What constitutes a critical incident
An incident in which you feel your intervention really made a difference in patient outcome, either directly or indirectly by helping other staff members
• An incident that went unusually well
• An incident in which there was a breakdown (i.e. things did not go as planned)
• An incident that is very ordinary and typical
• An incident that you think captures the quintessence of what nursing is all about
• An incident that was particularly demanding

B). What to include in the incident
• What was the context of your incident?
• A brief description of what happened?
• What makes this incident ‘critical’ (significant) for you?
• What your concerns were at the time?
• What you were thinking about as it was taking place?
• What were you feeling during and after the incident?

C) Reflection in and on action
• What is the key issue / theme(s) within the critical incident?

Appendix 2
Evaluation of Critical Incident Analysis

Instructions
I wish to evaluate the use of critical incident analysis as a learning and assessment strategy for this course and would therefore appreciate if you would complete this evaluation form. All answers will be confidential and anonymous.

1. One aspect of critical incident is to share, reflect on and discuss your incident in the classroom - how useful did you find this process?

2. What aspects of using critical incident analysis did you find challenging?

3. What have you gained from using critical incident analysis?

4. What helped you to understand the use of critical incident analysis?

5. Would you recommend this type of learning approach / assessment for this course next year and why?

Any other comments

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The development and evaluation of a web-based diagnostic tutorial on statistics

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Introduction

A basic knowledge of research methodology and statistics is a requirement for entry to most taught masters programmes in the UK. Although students will have previously completed study (generally as part of a primary degree or equivalent) in this area it may have been completed a number of years ago and they may have had no recent experience of its application. Thus some students experience difficulty with modules requiring this knowledge following registration to a Masters course. Although there is some research into the use of web based learning in nursing (Atack, 2003) and into using the web to teach research (Moore & Hart, 2004) and on formative assessment during a course of study (Henly, 2003) there does not appear to be any looking at self assessment prior to starting a programme of study. Therefore it was decided to design and evaluate a diagnostic tutorial using WebCT for students to evaluate their own performance.

Aim

To provide an interactive tutorial using WebCT for students to evaluate their performance and achieve the required level of competence in statistics and research before beginning their postgraduate programme.
To allow staff to be able to identify students who may have difficulty with this element of the module.

Objectives

To produce an interactive tutorial running on WebCT that will:
♦ Identify competence in understanding of statistics and research methodologies
♦ Provide study materials to assist student learning

Methods

A convenient sample (n=45) of students, studying on a Masters of Health Sciences degree in the West Midlands of the UK, was approached to participate. Thirty-seven took part, a response rate of 82%. Quantitative (n=12) and qualitative (n=14) evaluation took place on the content, accessibility, and relevance of the material. The mainly multiple-choice questions (128 in total) covered six main areas including statistical testing and ethical considerations. The tutorial was developed using respondus and question mark software to provide objective questions. Data were analysed using a combination of SPSS and content analysis.
Results and Discussion

The mean score on the tutorial was 55%, with a standard deviation of 18. Scores ranged from 8% to 77%. On the individual tests students did best on the research methods section with a mean of 76% and worst on the descriptive analysis with a mean of 38.29. Cronbach’s alpha was computed as 0.74. Friedman’s chi squared was significant.

Students were asked to rate on 20 scales how useful, helpful, interesting, and enjoyable they found the content, the timing, the self-assessment and the linked reading. In addition they were asked how anxious the aforementioned made them. In general students were happy with the content, the timing, the self assessment and the linked reading and overall not very anxious.

The qualitative evaluation was very positive with students highlighting the importance of self-assessment as a way of targeting their further study.

Of the negative comments the most common was that the session took place without warning which scared some respondents.

Future Work

The tutorial may be appropriate for other postgraduate courses as a student self assessment tool. The bank of questions could be increased to include examples relevant to other disciplines. Students with inadequate understanding of the topic will achieve a low score and they will be directed to sources of information on appropriate topics.

The stereotypes held by student nurses of nurses and physiotherapists

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Stereotypes exist about nurses and physiotherapists. Stereotypes can result in restrictions on what nurses can do and on what they are (Youngblut, 1997). In addition a recent research report found that teenage girls would rather be physiotherapists that nurses (Anon, 2002). Research comparing physiotherapists to occupational therapists found that professionals viewed themselves more positively than they did other professionals (Streed & Stoecker, 1991) Some research would suggest that nurses know little about physiotherapists (Reed, 1993) and see the worth of the physiotherapist in terms of their support of the nursing role. The concept of central traits has been used successfully in investigating stereotypes between groups (Hicks, 1996) and was used in this study to investigate the stereotypes held by nursing students about physiotherapists and nurses.

Two questionnaires were designed based on Asch’s central trait theory. The questionnaire asked participants to rank on visual analogue scales how they would rate the applicants for a job. There were 31 scales covering a wide range of traits. These included ‘organised-disorganised’, and ‘kind-unkind’. The characteristics were chosen in consultation with nursing and physiotherapy staff and after an extensive review of the literature (e.g. Takase, Kershaw, & Burt, 2002). The questionnaires were exactly the same in all ways with one exception. The 1st questionnaire asked participants to rate a nurse applicant, the 2nd a physiotherapist applicant.

Sixty-eight questionnaires were distributed to a convenient sample of first year students; the second questionnaire was distributed to the same group a year later. A total of 51 pairs of questionnaires were collected, giving a response rate of 75%. Related t tests were performed. Five differences were found, on the attributes ‘diffident-confident’ (p=. 043); ‘rational-irrational’ (p=. 001); ‘organised-disorganised’ (p=. 004); ‘graduate-non-graduate’ (p=. 002) and ‘disciplined-undisciplined’ (p=. 015). In all cases the mean score for the nurse applicant was higher than for the physiotherapist. The impact of these stereotypes is considered in light of the relevant literature. Consideration is given to why these attributes and not others differ between the two groups.

ARE INDIVIDUALS BEING PROVIDED WITH EVIDENCED BASED BRIEF INTERVENTION FOR SMOKING DEPENDENCE DURING THEIR ATTENDANCE AT OUTPATIENT CLINICS?

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Research study

Background Cardiovascular, respiratory and cancer diseases are the main causes of mortality and morbidity in Ireland. They contribute to over 75% of total Irish annual mortality (Department of Health and Children, 2001). Epidemiological research consistently concludes that individuals who smoke have a higher relative risk of developing the aforementioned diseases making smoking a significant modifiable risk factors (Doll et al, 1994).

Presently 27% of the Irish population smoke (Kelleher et al, 2003). The majority of people who smoke want to stop smoking however giving up smoking is difficult, because smoking is physiological and psychosocially addictive. An extensive amount of high quality research has been conducted on various strategies that aim to help individuals to stop smoking (The Cochrane Library, 2003). This research has informed the WHO Evidenced Based Recommendations on the Treatment of Tobacco Dependence (Raw, 2001). It recommends that health care professionals conduct routine brief interventions with clients in daily practice.

Aim and design The aim of this study was to describe the care provided to people attending outpatient clinics in a general hospital in Dublin, in relation to the WHO Evidence Based Recommendations on the Treatment of Tobacco Dependence. A descriptive quantitative design was used for the investigation.

Sample selection method Included clinics were stratified into those clinics that treated conditions highly associate with smoking and all other clinics. A convenience stratified random sample of 25% of clinics was used for the study.

Data Collection and analysis Data was collected using a highly structured self-administered questionnaire and the results were analysed using SPSS.

Results The study found that:

19.8% of individuals were asked about their smoking status,
19.6% of smokers were advised to stop smoking and also assessed for their motivation to stop smoking,
14.3% of smokers were provided with assistance to stop smoking and
5.4% of smokers had a follow up appointment arranged.

Those who attending the clinics treating conditions highly linked with smoking as a risk factor were more likely to receive elements of the brief intervention.

References
Senior student nurses perceived self-efficacy beliefs about practical nursing skills

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A number of concerns relating to the preparation of nurses for clinical practice are evident in the literature, specifically outcome studies from United Kingdom and Australia. Additionally, in practice many practical nursing skills are being devolved to other grades of health care worker with the nurse remaining professionally accountable. Yet, the nursing profession is fundamentally a practice-based profession, anchored in the effective performance of practical nursing skills, as a means of delivering quality nursing care to patients. Therefore, to appraise senior student nurses perceptions of their sense of confidence in performing practical nursing skills is appropriate. Hence, the aim of this study was to describe the perceived self-efficacy beliefs of senior student nurses about perceptions of their abilities to perform practical nursing skills.

A quantitative descriptive study was designed to examine the research question. The conceptual framework for the study is based on Bandura’s self-efficacy theory (1977), and the theory of practical nursing skill performance as conceptualized by Bjork (1999). The researcher designed a new instrument titled the Practical Nursing Skill Perceived Self Efficacy Questionnaire (PNSPSEQ) representing a 26 item self-administered questionnaire served to collect data. Face and content validity was sought and the instrument demonstrated reliability using Cronbachs alpha (.9437). Instruments were pre-tested and a pilot study was conducted prior to the main study. A convenience sample (n=45) senior student nurses completed and returned questionnaires. The data generated was inputted into Epidata and exported to Statistical Package for Social Sciences (SPSS) for analysis.

The finding of the study was the discovery of convincing perceived self-efficacy beliefs about perceptions of ability to perform practical nursing skills. The main conclusion drawn from this study was that this sample of senior student pre-registered nurses rated themselves as having high perceived self-efficacy beliefs about practical nursing skills.

The implications of the study findings were considered to include recommendations for practice, education and further research

Key References
Creating Effective Participation Strategies for Women Representatives on Maternity Service Consumer Panels and Committees: results from a pilot project in the North Eastern Health Board

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Abstract

The paper describes a pilot project held in the then North Eastern Health Board in 2003. The objective of the pilot was to develop a working model for training to assist women wanting to become representatives on maternity service consumer panels. The project arose from concerns about

a) the lack of informed choice for women in relation to their antenatal, intra- and postpartum care
b) the lack of effective representation of women on statutory committees about maternity services development
c) the care packages generally on offer in the Republic of Ireland which have been characterised by high levels of intervention in vaginal birth and rising rates of Caesarean section.

There have been calls by the Department of Health and Children for consumer involvement in relation to health services, including maternity care provision. Calls for reform of maternity services to include evidence-based maternity care have been voiced by professionals and by consumer action groups providing support and information to women.

This project sought to bring all these issues together to test and evaluate a model for training to

a) extend women’s expertise about appropriate maternity care services
b) create effective strategies for their participation on local and regional consumer committees

The project aimed to build core strengths of women to enable them to participate fully in decision-making and to challenge professional control over policy-making in relation to the way maternity services are organised and delivered. A central element was the inclusion of critical appraisal skills of current healthcare research. The paper describes the model for delivery of this education programme that was developed in three one-day training sessions with women in the North Eastern Health Board, Irish Republic in May, 2003.
EXPLORING DIPLOMATE STAFF NURSES' HEALTH PROMOTION PRACTICE IN THE ACUTE HOSPITAL SETTING.

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Background: It is suggested that nurses are in a ideal position for health promotion practice since they occupy a position of close, continuous contact with patients and are the largest component of the health care professional workforce. Nurses who have undertaken the diploma in nursing have received greater curriculum input on health promotion compared to nurses who were educated in the traditional programme. The diploma programme places greater emphasis on primary and community care. Yet there is no attempt in the Irish context to explore diplomate staff nurses' experience of health promotion practice and their role therein.

Aim: to explore the understanding and extent to which diplomate hospital staff nurses perceive themselves as promoters of health.

Method: A phenomenological approach from a Gadamerian perspective was used. Ten diplomate staff nurses were interviewed. A modified version of thematic analysis and the assumptions of hermenutics provided the overall framework for data analysis.

Findings: Diplomates appear to be embracing values of the newer paradigm in health promotion practice, viewing health promotion as an approach and philosophy of care integral to everyday practice. Yet descriptions of practice appear to be embedded in the traditional paradigm. Nurses are eager to embrace their role, playing a key role in mediating on the patient's behalf, co-ordinating and liaising with the multidisciplinary team. Nevertheless, they appear to assume a secondary role in terms of referring, reinforcing or 'gatekeeping' information given by the multidisciplinary team.

Factors, which facilitate health promotion practice, include having an educational input on health promotion, a supportive environment where the nurses felt trusted and valued as a team member and work organised on the basis of allocation of patients. A culture where the working ethos emphasised ward organisation and physical care as high priorities hindered the diplomates in their health promotion practice. Other structural constraints include staff shortages, the need to get the work done, lack of role models, and the traditional attitudes of staff.

Conclusion: It appears that diplomates are eager to embrace their role as health promoters but require the presence of a supportive environment to do so. This relates to receiving an educational input on health promotion, feeling trusted and valued as a team member and work organised on the basis of patient allocation.
An evaluation of an induction programme for mature students undertaking the Bachelor in Science in Nursing programme.

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Evidence suggests that mature students are apprehensive prior to commencing any course of study. Nursing has traditionally attracted a high level of mature applicants and this trend has not altered with the introduction of the Bachelor in Science in Nursing degree in 2002. These fears are generally centred on the lack of knowledge of what is expected of them during the course. This paper discusses the evaluation of a one-day induction programme for mature students prior to commencing their course in 2004.

Following accepting a place on the Bachelor in Science in Nursing course, all mature students (n=72) were written to by the course coordinators and invited to participate in the one day induction course for mature students. All students who intended participating in the induction day were asked to return a questionnaire to ascertain what they would like to be covered during the day. The structure of the day was based on these suggestions. Following the completion of the sessions a questionnaire was administered to the students. The students were asked to indicate their level of agreement/disagreement on a five point Likert type scale. Students were also free to make any comments if they wished to do so.

Forty students completed the questionnaire. Overall the students found that the theoretical component did familiarise the students with what was expected of them prior to the commencement of the course. The students also found the format of the day encouraged them to participate in the learning process. Input from mature students currently in the second year of the programme, also rated highly in the student feedback. The results indicate that mature students benefit from the support they receive from attending an induction programme which was designed to meet their exclusive needs.
An exploration of a part-time undergraduate nursing programme: perceived personal and professional benefits to students and student perceived stressors & stress reduction methods.

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Abstract

Within the literature on stress, part time nursing students, who are undertaking continuing education programmes, appear to have received little attention. Stress amongst nurses is evident within the nursing literature but little information is available on the specific stressors that affect registered nurses who attend further academic study. Anecdotally, students attending part-time studies while working full time report high levels of stress. The aim of this study is to explore and describe the perceived stressors identified by a group of seventy students who undertook a part-time degree at one Irish University. The authors used quantitative methods to gather a large amount of objective data on the topic. While many instruments exist that measure overall stress, this study aimed to explore student’s perceptions of specific stressors associated with academic study. The authors used a questionnaire, developed from the literature on the topic, which was deemed valid and reliable. Factors related to writing assignments at degree level, fulfilling personal needs and academic demands were perceived as major stressors by these students. Factors of little concern were financial concerns and attendance at the programme. Individual items receiving highest mean scores include: trying to balance work commitments and the required study received (mean 3.89 SD=1) and the prospect of the final examination (mean 3.86 SD=1). Open-ended items indicated that students perceived many personal benefits from the programme including increased confidence and knowledge. Professional benefits included improving career prospects and improving research knowledge. Self-report methods reported to manage personal stress included better time management. The implications of the study for all involved in the delivery of nurse education programmes are the need to consider the impact of the workload on student welfare, and to prepare students for demands of the programme. Imparting specific time management skills to students also needs attention.
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Title: Accessing a sample – issues emerging and experiences gained.

The presenter will use the experiences gained from her research study and outline some of the issues that emerge when mothers are the focus for data collection in research. The nurse researcher often wishes to include what are perceived as “vulnerable individuals or groups” in nursing research studies. This researcher is currently involved in a study of mothers who are caring for their life limited child at home. The issues that have emerged when accessing a sample of mothers from two jurisdictions will be developed. Discussion of other issues that have arisen from the researcher’s experience including, building trusting relationships and sensitivities in terminology will be provided.

This presentation will also address some the challenges that need to be considered when attempting to access mothers, “a potentially vulnerable group” in research studies.
CHILDREN WITH LIFE LIMITING CONDITIONS - WHO DO WE MEAN WHEN WE SAY “LIFE LIMITED”?

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Within the literature on children with life limiting conditions there are large number of terms which are associated with the care of children with life limiting illnesses. These terms vary from a child with a chronic illness to life threatening disorders, multiply complex needs or a child with a specific medical diagnosis. Given the increasing number of these children and the specific nature of their care it is important to investigate the terminology which is used to refer to these children in health care environments.

The aim of this paper is to discuss the findings from a literature review on the topic and to identify the terms that are used within the literature when this group of children are referred to.

Literature searches have been made using CINAHL, Proquest and Synergy as well as internet searches. To date at least twenty terms have been found within the literature.

The implications of using this terminology for the child, the family and the Registered Children’s nurse will be discussed.
A REVIEW OF ACCREDITATION OF PRIOR EXPERIENTIAL LEARNING: IN THE CONTEXT OF ACCESS TRANSFER AND PROGRESSION IN HIGHER EDUCATION

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Abstract

This paper will give an overview of a research project funded by the Higher Education Authority (HEA) to investigate mechanisms for Accreditation of Experiential Learning (APEL) as applied to access, transfer and progression. The objective of this work was to report a strategic plan of recommendations for a policy within third level education for Accreditation of Prior Experiential Learning (APEL). The project was a descriptive survey using interviews, focus groups and questionnaire and was initiated parallel to the development of the National Framework for Qualifications (NQAI 2002). The research process is not the focus of this paper, instead the author wishes to give a picture of APEL nationally and internationally and an overview of issues in policy development and the corollary for nurse education in Ireland. The conclusion leads towards key issues for further discussion, enquiry and action.
“Women’s views of the information they receive prior to elective caesarean section” a descriptive study.

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The literature suggests that a discrepancy exists between women’s perceptions and health professionals perceptions of what information women need to know prior to elective caesarean section. Evidence from the literature suggests that when women try to gain information from within the current maternity services from health professionals, it is often unsatisfactory (Department of Health, Great Britain 1993, Churchill and Benbow 2000, Department of Health, Ireland, 2001). To access information they require women often rely on other sources, such as the internet, books, friends rather than health professionals (Singh et al 2002). Previous studies have identified the informational needs of women for pregnancy and childbirth, which has provided some insight into the informational needs of women delivering by caesarean section. The aim of this study is to explore women’s views of the information they receive prior to elective caesarean section. This focuses on issues such as what women and their partners thought of the information they received. How much information do women receive? What percentage of women access other sources of information? What role do midwives play in providing information regarding caesarean section to women?

A quantitative research design was utilised owing to the uniqueness of the research area in Ireland, enabling the researcher to compile data that maybe quantified and measured. A descriptive survey was chosen as the most appropriate method for developing the knowledge to answer the research questions. A convenience sampling technique was the most appropriate method as this method facilitated acquiring the largest possible sample. The sample consisted of seventy-two women. The study was conducted in two research sites. The research instrument, a questionnaire was constructed by the researcher and was tested for reliability using Cronbach’s Alpha coefficients. A pilot study was conducted with ten women over a two week period. This ensured there were no difficulties in data distribution, data analysis and assessed the research instrument for face validity and content validity. SPSS version ten was used for data analysis using Chi-square analysis, the Mann-Whitney U test and Kruskall-Wallis H test. The results found that more than fifty percent of women would have liked more information. Women undergoing their first caesarean section were more likely to be dissatisfied. More than fifty percent of women accessed book/magazines, for information this was also the primary source of information for thirty seven percent of women. Midwives were the primary source of information for seventeen percent of women. Sixty-five percent of participants responded to the open-question “how services could be improved?” More than half of the participants suggested more information should be provided, over twenty percent suggested booklets/leaflets should be provided. Eleven percent suggested a separate antenatal class should be provided to women undergoing an elective caesarean section.
PREPARING IRISH STUDENT NURSES TO WORK WITH MINORITY ETHNIC COMMUNITIES: AN EXPLORATION OF BSc PRE REGISTRATION NURSING PROGRAMMES AS REPORTED BY NURSE EDUCATORS.

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Abstract
'The Irish population comprises 160 nationalities'. There is evidence to suggest that the Irish healthcare system has failed to meet the needs of minority ethnic groups, a factor attributed to communication barriers and lack of cultural knowledge between the healthcare providers and the recipients of care. If Irish society is to respond effectively to cultural diversity and ensure that health care is equitable and accessible, then nurses must have cultural knowledge, awareness, sensitivity, anti racist attitudes, and effective cultural communication skills. With the recent transfer of Irish pre registration nurse education to third level institutions, it seems an opportune time to examine how nursing students and nurse lecturers are prepared for their practice in a multiethnic society.

This study reports on the educational and clinical preparation of BSc pre registration nursing student nurses to work with minority ethnic communities, as reported by nurse educators. The United Kingdom (UK) and United States (US) nursing literature suggests that nurse educators are not adequately prepared to teach aspects of cultural diversity, that nurses do not feel prepared to meet the needs of minority ethnic communities. Patients from multi or minority ethnic communities confirm that that nurses are not adequately prepared to meet their needs. Education and facilitation programmes that incorporate reflective learning and relevant clinical opportunities have been suggested as a means to address these deficits. In an Irish context a dearth of research exists in relation to all aspects of nursing in a multiethnic society.

67 nurse educators (n=67), representing six Institutes of Higher Education in Ireland, returned a postal questionnaire, which consisted of 28 questions designed to explore various curricular issues in relation to preparing nursing students to practise in multiethnic environments.

The findings, which provide baseline data on the curricular content, cultural clinical placements, and the teaching and learning strategies utilised in BSc pre registration nursing education programmes in Ireland, suggests that nurse educators' educational preparation was found to be ad hoc and that nurse educators with relevant education and experience of cultural care were not utilised to their full potential. The recommendations include, the integration of aspects of cultural diversity throughout curricula as opposed to fragmented or stand alone modules and cognisance must be afforded to nurse educators preparation and development in relation to teaching aspects of nursing care appropriate to the needs of minority ethnic communities.

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Myocardial Infarction care pathways – are delays gender-specific

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Abstract

Background: Although coronary artery disease is the major cause of death amongst Irish women, this condition is frequently considered a male phenomenon. Consequently, Irish women are unlikely to see themselves as victims of this disease, and delay in seeking help for cardiac conditions, such as myocardial infarction. As the success of treatment for myocardial infarction is time-dependent, any delays to its initiation may limit survival opportunities. Aims: (1) To identify any gender specific care-pathway delays or treatment opportunities amongst Irish women and men hospitalised with myocardial infarction in Dublin. The study employed a feminist methodology and a sequential across-method triangulation approach, which involved a 1-year prospective Census of 277 (31%) female and 613 (69%) male MI patients consecutively admitted to the six Major Academic Teaching Hospitals in Dublin, Ireland. Results: Women were more likely than men to experience prolonged ‘initial symptom-onset to A&E delays’ (14hrs versus 2.8hrs p=0.0001), and ‘intense symptom-onset to A&E delays’ (3.1hrs versus 1.8hrs, p<0.0001). Advancing age was associated with greater pre-hospital delays (p<0.0029), whilst patients with private health insurance had shorter delays than public patients or those with medical cards (p=0.0001). Women experienced greater ‘Triage to 1st Medical Assessment’ delays than their male counterparts (p=0.002), and waited a median of 30 minutes for their 1st medical contact compared to 20 minutes experienced by men (p=0.0001). The median ‘door to needle’ time for women was 70 minutes in comparison to 52 minutes experienced by men (p< 0.020). Female patients waited longer than male patients for Aspirin (p=0.020) and Primary PTCA (p<0.040), whilst men received a bed in the Coronary Care Unit (CCU) almost 1 hour sooner than women (p<0.0001). Despite these delays to treatment, women and men experienced similar rates of reperfusion treatment opportunities. Conclusion: The gendering of coronary artery disease to a male phenomenon has resulted in sub-optimum treatment for Irish women experiencing myocardial infarction. Women are mainly unaware of their personal risk for MI, and have difficulty attributing their ‘atypical’ symptoms to a cardiac cause. They delay seeking treatment for this condition thus limiting their opportunities to avail of optimum therapeutic benefits. There is an urgent need to correct the erroneous image of this disease and to increase women’s awareness of their personal risk.
JUVENILE IDIOPATHIC ARTHRITIS AND QUALITY OF LIFE

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Juvenile idiopathic arthritis (JIA) is a heterogeneous group of conditions which begin in childhood and involve persistent inflammation in one or more joints. This review explores the impact of juvenile idiopathic arthritis on affected young people. The incidence of JIA is approximately 10 per 100 000 (Davidson, 2000; Cassidy & Petty 1995). Andersson Garre, (1999) suggest the incidence rate is 6-19 per 100 000 with a prevalence of approximately 1-1000, comparable to that of childhood diabetes. Statistical variations may result from genetic variations and possible disease triggers (Woo, 1998). The detection, treatment and monitoring of juvenile idiopathic arthritis are of great significance as this condition can be seriously disabling. Impaired function, joint destruction, reduced growth and osteoporosis are potential complications. Chronic pain and loss of education can impact on career choices and prospects (Johnson, K. & Gardner-Medwin 2002). Reducing the psychosocial impact of this condition is of critical importance to strengthen social inclusion and avoid marginalisation.

Lack of specialist knowledge and appropriate treatment can cause a delay in treatment. Classification of childhood arthritis continues to be an evolving process which is yet to be clearly delineated with predictable outcomes and responses to treatment (Hofer, M. 2002). In some cases the condition arrests in late childhood. Approximately one third of children affected, however, will continue to have problems into their adult life. The Chief Medical Officer’s Report (2000) acknowledges that issues in relation to prognosis and long term implications of a disability create high levels of distress and anxiety in families. Currently, there is no dedicated paediatric rheumatology service in Ireland (ISR 2003). Cuneo and Schiaffino (2002) examine adolescent self-perceptions of adjustment to childhood arthritis with particular interest in the influence of disease activity, family resources and adjustment. This review focuses on quality of life issues and interventions utilized to reduce the impact of this condition.

References


The Diet of Pre Registration Student Nurses who are undertaking a Diploma in Nursing at a University and the Implications for their future role as Health Promoters

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Background: Diet is one of the major aspects of lifestyle that influences the risk of death from cancer and cardiovascular disease (World Health Organisation, 1990), as well as risk factors for obesity, diabetes mellitus, osteoporosis and gastrointestinal disease (Irish Universities Nutrition Alliance, 2001). College students are a unique group, and their lifestyle habits and circumstances are the focus of many studies (Mary Immaculate College, 2001; Irish Nutrition Alliance, 2001). As a group, student nurses have also become the focus of studies (Woods, 2001).

Aim: The aim of the study was to examine the diet of pre registration student nurses in 2nd and 3rd year of the Diploma in Nursing programme.

Method: The study was a descriptive survey using a convenience sample of 200 students. A structured questionnaire and a modified food frequency questionnaire were used to obtain information on the dietary intake and habits of student nurses.

Results: The average age of female nursing students was 20 years. Of the respondents, 2.8% were underweight, 35.2% were overweight and 11.7% were in the obese category. 96.8% of the respondents consumed alcohol and an alarming 20.1% of the respondents consumed greater than the recommended intake of alcohol (14 units) per week for females. Nearly a quarter of respondents were current smokers. The uptake of folic acid, vitamins and other supplements was poor.

Conclusions: Compliance with the recommended servings from the food pyramid was not evident in this study, with 60-90% consuming below the recommended servings in the five food groups. This data suggests that student nurses have inadequate health behaviours in relation to diet, but are no different to other students attending college in similar circumstances. This has implications for their future role as Health Promoters.
The experiences of parents of infants admitted to neonatal intensive care

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The aim of the study is to explore parents’ experiences of having their baby cared for in a neonatal intensive care unit (NICU). The impact of the NICU environment and the circumstances surrounding the birth or unexpected admission of a baby to a neonatal intensive care unit are thought to affect the psychological and social adjustment of parents. A baby’s hospitalisation and uncertain survival can affect the transition to parenthood. No published Irish study was found that explored both parents’ experiences of having a baby cared for in a NICU.

Design: This phenomenological study explored the experiences of parents whose baby was cared for in a Neonatal Intensive Care Unit. Methods: Unstructured interviews were used to collect data from a purposive sample of eight sets of parents. Research ethical issues related to informed consent and confidentiality were addressed. Colazzi’s (1978) method facilitated data analysis. To establish trustworthiness in this research credibility, fittingness and audibility are the criteria that are used. Findings: This research serves to illuminates some of the experiences of parents. Themes that emerged were loss, fear, anxiety and happiness. Conclusions: This study provides an insight to understanding the experiences of parents of having their baby cared for in a Neonatal Intensive Care Unit in the Republic of Ireland which can possibly contribute to a broader knowledge of how these experiences may influence nurse’s caring for these babies as well as facilitating future research efforts.
The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland.

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Much research has been done in other countries surrounding the experiences of nurse graduates. The aim of this study was to explore the lived experiences of newly qualified nurses on clinical placement, during the first six months following registration, in the Republic of Ireland. A phenomenological, Heideggerian, hermeneutic approach was used for this study. Ten diplomate staff nurses were interviewed. The data was analysed using a framework devised by Colaizzi (1978).
This study revealed that, similar to other research, newly qualified nurses in the Republic of Ireland, describe their initial experiences of being on the ward as stressful. This stress is primarily related to the multi-dimensional responsibilities associated with the new role and to managerial/organisational/clinical skills deficits. However the diplomates’ abilities to recognise their limitations and to seek help when needed, demonstrated their commitment to safe practice.
Rostered duty was identified as being of great importance in aiding the transition from student nurse to staff nurse and a sense of achievement, feeling valued, making a difference and financial reward were cited as being the positive aspects of the new role. Whilst ward sisters and staff nurses provided informal support to the novice nurses at ward level, there was no formal method of structured support, such as preceptorship, in place.
To help alleviate the problems associated with the staff nurse role, the pre-registration nurse education curriculum needs to be developed in specific areas. In addition, effective supportive systems need to be put in place for newly qualified nurses. This will help to ensure that newly qualified nurses are prepared for and supported in their professional role and will help to retain nurses in the health services.
Multidisciplinary Team Working and Applying Action Research Methodology to Practice

Sub Title:

How useful is Action Research as a Process for the Multidisciplinary Team Working Required for the Implementation of the Accreditation Care Standards in an Oncology Unit?

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Abstract:

This action research project explored team development, resulting from participation, using appreciative inquiry. The methodology facilitated team exploration of the service, which acted as a catalyst developing a positive perspective, appreciating that the quality of the service currently provided was good and following Continuous Quality Improvement (CQI) principles could improve. An effective team developed as the project evolved, using their insider knowledge of the service, identifying opportunities for change which resulted in creative solutions to issues specific to the oncology service in question. The context for this project was to prepare for the initial peer review by the Irish Health Services Accreditation Board in 2003. Applying theory to identify the team dynamics and using reflective practice within the group during the research period, facilitated in incorporating effective working methods into practice. Communication issues were addressed with success. The team learned that they needed to listen to each member’s perception of issues and problems. Then, through reflection, planning for action and participation in implementing the changes, improvements that were innovative, practical, creative and accepted across disciplines were incorporated into the oncology service. The team learned from each other and the interdisciplinary relationships, across the oncology service benefited from these insights. The action research cycles provided a framework for team working. The team evaluated its own effectiveness on completion of the research, identifying that as a result, a clearer vision and shared values had developed for the team members. The review provided triangulation for this research project. It emerged that initial sceptics were responsible for positive comments regarding the process. The oncology team developed skills in each member that will influence effectiveness in team working in the future.

Introduction

This action research project is built around the oncology service becoming involved in the accreditation project. The hospital, one of the group of Major Academic Teaching Hospitals (M.A.T.H’s) was preparing for ‘peer review’ in advance of the Irish Health Services Accreditation board inspection. Accreditation was seen as a positive development, it would allow for measurement of service quality, for the hospital and the service, against the other hospitals in its group. This research project was exploring the development of the team as it worked toward reaching a state of preparedness for the peer review. The Health Strategy ‘shaping a healthier future (2001)’ placed emphasis on quality, reflecting on the development of continuous quality improvement identified as the expectation of the health services by Leahy and Wiley (1999), the establishment of the Irish Health Services Accreditation Board is another step towards placing the patient at the centre and establishing a
quantifiable measure of quality in the health services moving forward. This is the national context in which this project is taking place with its emphasis on establishing a measurable quality service that is patient centred, and delivers on equitable care for all its service users.

The team in the oncology service agreed to participate in the action research project as this process evolved. Therefore throughout the period when the team was working they were participating as co-researchers with the author, the author was exploring what was happening within the team and linking these dynamics to theory. This provided learning for the author and team members as these findings were shared with the team. The research period explored the development of the team in the preparatory phase, the working phase and also during the self assessment phase when linking to the accreditation care standards, identifying where the standards were met and where change was needed to meet the teams interpretation of the standard. The team members participated in a voluntary facilitated review of the team working process and outlined how this team worked differently to other teams they had worked with, they identified many positive aspects of this experience that resulted from the structure provide by the action research process and also from the clear focus provided by the context of the Irish Health Services Accreditation Care Standards.

**Action Research and Appreciative inquiry**

The action research methodology, was in many ways a familiar working method for healthcare staff as it mirrors the structure used when assessing patients, namely that of identification /diagnosing of a problem, planning the action to address the problem, implementing the action plan, evaluating the outcome of the action and finally reflection on the outcome and identification of learning. This is the action research cycle, otherwise known as the Discovery, Dream, Design and Destiny phase referred to in Coghlan & McAuliffe, (2003) and McGruder Watkins & Mohr, (2001), these cycles continue until all issues are addressed to the satisfaction of the participants (Morton-Cooper, 2000).

Action research cycles occur in ever increasing circles (diagnosing, planning, implementing and evaluating) that occurs within a specific environment or work place makes the solutions uniquely relevant to that specific issue in the context of that environment (Hart & Bond, 1995). It is very difficult to replicate an action research project as the team contributes so much, as individuals, and bring their own subconscious values, beliefs and attitudes to bear in exploring the issue. These core values, the individual’s own beliefs, the organisation culture, the relationship developed within the group of participants who develop a shared set of values, all impact on the solutions reached (Coghlan & Brannick, 2001). The solutions as outlined by Winter & Munn Giddings (2001), are applicable to the environment where the issue is identified and may not be the best solution in another environment.

**Rigour**

The systematic analysis of the group processes and the objectivity of the researcher must be clear and any inherent biases must be acknowledged (Coghlan & Brannick, 2001). Each team member declared his or her pre-conceived personal beliefs in respect of the issues being addressed.

The progress of cycles is recorded contemporaneously, the data gathered is reflected upon and the plan developed. The cycles have a clear four stage process, each stage facilitates participation and involvement of all participants enabling openness and
sharing of understanding and making sense in respect of the issue being explored (Pedler, 1995). Action research places emphasis on careful observation of the action that occurred in the behaviour of the group. This occurred by the author carefully noting behaviours and reflecting on how the cycles of diagnosing, planning, action and evaluation shape the change in organisations. The study of the effects of the action research cycles, with the application of careful data collection, alongside evaluation and reflection on what is happening in the light of current theory, provides rigour in the research process (Coghlan & Brannick, 2001).

All action research inquiry methods shared elements that could have been applied. However as appreciative inquiry optimised the needs and focus of the project, namely reaching a state of preparedness for accreditation peer review survey, the other inquiry methodologies were dismissed.

The rationale to utilise appreciative inquiry was that it provided a “collaborative and highly participative system wide approach to seeking, identifying and enhancing the life giving forces that are present when a system is performing optimally in human, economic and organisational terms” (McGruder Watkins & Mohr, 2001: 14).

Historically, Appreciative inquiry developed as a theory building process and not as a means of organisation change, but it facilitates learning from the more positive occurrences in its development. The model developed by Srivastva, Fry and Cooperrider in 1990 called appreciative inquiry described the action research cycle as “Discovery, Dream and Destiny”. It is more than a tool; it becomes a philosophy, a way of approaching change that can help reshape practice, in a constantly improving way, within an organisation. This is why it was selected as the inquiry method for this project. As you might expect the term ‘Appreciative’ comes from increasing value and ‘Inquiry’ is the process of seeking knowledge and understanding of how something functions through questioning, using questions with a positive emphasis results in issues being addressed are regarded as opportunities for improvement (McGruder, Watkins & Mohr, 2001).

**Team acceptance of appreciative inquiry**

A very attractive element of appreciative inquiry for the team was that it allowed recognition that the services provided were already of high quality. Appreciative inquiry offered a way to improve, enhance and add quality and value to work already being undertaken and, linked in with the ethos of Continuous Quality Improvement (CQI) that the accreditation process demands.

The identification of opportunities to facilitate the change process required to achieve these goals is key to a methodology that will add quality to services provided (Hart & Bond, 1995). Cunningham (1993) recognised that looking at a ‘problem’ created a negative mind set with implications of wrongdoing and punishment, whereas appreciative inquiry looks at what already works and seeks to improve it, looking at opportunities instead of problems. The presentation of a positive opportunity for improvement, results in more creative, innovative solutions to enhance the process being examined (Hart & Bond, 1995). The accreditation care standards allow this element of flexibility of interpretation that encourages creative thinking in participants. The team were happy to use this methodology as it supported the team’s inherent belief that the service being provided was of good quality and that it could be improved.
The strength of appreciative inquiry is that it is a combination of a practical change process and a pattern for how the future is shaped (Coughlan & McAuliffe, 2003; McGruder Watkins & Mohr, 2001).

The very initiation of an inquiry or action research project causes a shift in thinking and the focus of the inquiry causes anticipation, expectation of positive inquiry and, ultimately, positive action (McGruder, Watkins & Mohr 2001). This is even more applicable when using appreciative inquiry; anticipatory images are created in the discovery phase that spill into the dream phase, resulting in positive inquiry and the development of positive images for the destiny phase of the inquiry (McGruder Watkins & Mohr, 2001). This was critical to development of this team and appreciative inquiry supported the growth and effectiveness of the team, resulting in a positive experience for all team members as demonstrated with the facilitated review with the team.

The role of organisational climate and culture
The organisational culture was well positioned for the employees to take the accreditation process forward. There has been significant growth in the integration of staff into the organisation since 1994, with focus on developing shared vision and values being driven by the Senior Management Team. The management valuing its staff and encouraging the development of knowledge based organisation allowed for innovation and flexibility, which is effective in exploiting situations to achieve desired outcomes.

The Team selection
This research project explores the development of the team, the emergence of a core-empowered team and how this team functioned. The team dynamics were linked to theory as the research period evolved and resulted in learning for the author and the team members.

The team working by using the accreditation care standards to identify areas to be examined, in relation to quality of service, provided many issues to be explored. Action research is an exploratory research method and appreciative inquiry a way of looking at the service that was positive and opened up opportunities for improvement that the team could choose themselves. The accreditation standards provided a review date, clear identifiable goals, a direction for the team and a deadline to work towards. The research project itself proved these to be key contributing factors to achievement of goals.

The core values of each staff member and also the values of staff working in the oncology service provided the vision for the team. The team saw accreditation as positive and a desirable development. The team identified that moving forward peer review and accreditation will allow measurement of services against other providers.

Brower (1995) identified four criteria of ability, ableness, accountability and alignment as essential for an empowered team. The team members needed to have authority, decision making ability, accountability, control / power / influence and a recognition of the individual needs as part of the group to develop a “comfortable level of mutual respect and acceptance” (Schein, 1998:44).
The core team selected from within the Oncology service were team members who had worked together in the past and met the above criteria. This was the factor that facilitated the development of an empowered core team. The empowered team worked, as it was established in a climate that provided clear support for the expected outcome of the teams work. It provided access to information, support for team functions and leadership. Leadership was provided by the chair’s clear understanding and vision of the work required to achieve a state of preparedness for ‘peer review’.

The core team facilitated the newer team members and also the members who joined for short periods of time.

**Communication**

Communication was an area that the team addressed as part of its ground rules. Openness, honesty and listening to each other’s views were the bedrock on which the team’s effectiveness developed. ‘Mutual respect’ was already established and each team member had a voice and would be heard. Mutual accountability was accepted and facilitated inclusion of external members for short periods for consultation and input into specific areas. All team members were expected to give opinions on issues identified as to how it would impact on their own aspect of the service. It was discovered that many disciplines had similar problems with the same issue and integrated interdisciplinary solutions were identified in some cases.

**The Team development throughout the research project**

The key role for the team was to make the accreditation process work. They focused on performance and set goals and targets to be achieved (Katzenbach & Smith, 1993). The team was motivated to demonstrate that the service they were providing was of the highest quality. Evidence of a high performing core team was identified when the team began coaching and supporting new members, encouraging participation, innovation and creativity, and espousing the ethos of integration across the whole service.

This enabled flexibility, decision making at the front line and fully utilised the innovation, creativity and insider knowledge of the employees participating in the project. These are identified by Wageman cited in Johnson, Heinmann & O’Neill, (2000) and also in Hart & Bond (1995) as critical factors for team success. It also generated the effect of weakening the bureaucratic pre-existing communication pathways and resulted in a level more co-operative, consultative work environment with more horizontal communication and less hierarchy.

The core team provided consistency, commitment and open communication. There were no hidden agendas. When the team identified an issue that required restructuring or change it was acknowledged and all team members were involved in gathering evidences and identifying and implementing the solution. The team success rests on the team having a common meaningful purpose, specific performance goals to achieve and a set timescale (Katzenbach & Smith, 1993).

**Action research as a management ethos**

Action research is an exploratory research model that is naturally occurring in our work, if we are motivated to analyse why and what is happening around us. It facilitates opportunities for reflection on situations that arise in a rapidly changing work environment and, most importantly, it facilitates the formulation of effective
responses to complex issues as they arise (Winter & Munn Giddings, 2001). This is referred to as the ‘so what’ question as when a problem / issue arises (Coughlan & Brannick, 2001) this question will assist in deciding what action, if any, needs to be taken to identify the solution to the issue.

**Conclusion**

The research project worked well in the oncology area and has developed strong team links and working methods in the participants. The anticipation of peer review and the potential to measure against other oncology units was a critical motivational factor for the team members. All team members stayed with the project. This is significant and at the review they all identified that the method of operating was effective and they learned with more clarity what each member’s role was in relation to care provision for the patient. The central focus was the patient and this has remained so.

Communication has improved and consultation has become the norm. Instead of the team members feeling isolated they have a voice that has gained strength through the partnership developed in the team.

Problems are more often regarded in a positive light and as opportunities. Problem solving has become innovative and flexible, with input from all disciplines welcomed and expected.

The core team still meet and are effective advocates for the oncology service; their focus on quality and continuous quality improvement has remained strong.

The team development has not stopped on completion of the research project. The action research cycle approach to managing change, either as a method of choice or because it has been recognised as an effective method of exploring issues, is still evident. It continues to be a useful, practical and effective management tool. The level of participation of all staff in decision-making and change initiatives remains very high. The communication has remained open and consultative and the work climate has and continues to be dynamic and innovative.

Action research has therefore proved that it can be a powerful, purposeful way to involve staff in looking, with new insight, at situations they have accepted heretofore, of developing a participative team relationships and of implementing meaningful change.

**References:**


THE USE OF VIDEO ASSESSMENT IN THE CLINICAL SIMULATION LABORATORIES AS A WAY OF FACILITATING NURSING STUDENTS LEARNING

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The overall aim of the study was to evaluate the use of video assessment in the Clinical Simulation Laboratories (CSL) as a learning tool for the development of practice competencies in nursing students. The use of videos as a way of both assessing and learning has not been widely used in nursing education. However, the development of practice competencies is seen as a central issue in nursing with assessment of practice hotly debated nationwide.

As part of their assessment of practice, 323 nursing students were asked to perform an essential nursing skill on a peer in the CSL. Their performance was filmed and each student given a copy of their video which they reflected upon. They were required to compare their performance to current and appropriate published work and submit a written critique.

The purpose of the study was twofold. Firstly, using a quantitative approach and Criterion Referenced Observation as a methodology, the use of video cameras was compared to in vivo observation. Some qualitative analysis of comments by facilitators during the marking of students’ work was also undertaken.

The second part of the study focused on nursing students’ and nurse teachers’ experience of the video assessment. A qualitative approach using discussion groups was used. Findings showed that the actual experience of being filmed provoked some anxiety amongst both students and teachers. However the opportunity to observe and then critique their own practice in relation to published work, provided a rich and empowering experience for students.

The use of video cameras to record and assess student nurses’ performance proved to be superior to in vivo observation as it provided the opportunity for the marker to rewind and review. The video also provided permanent records open to scrutiny by external examiners.

It was recommended that marking criteria include students’ ability to communicate, obtain client consent, respect client privacy, dignity and comfort and to ensure that infection control is effectively practiced.
The development and validation of physiological measures of pre-sleep arousal suitable for use in nursing research: preliminary findings from a pilot study.

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Introduction:
Disturbed sleep is common in adults during acute care hospitalisation (1,2). This is a significant source of stress and adversely affects patient outcomes (3,4). Identifying and responding to the sleep needs of patients should therefore be a goal for nursing practice and a priority for nursing research (5). Sleep promoting interventions are utilised by nurses but their mechanism of action has yet to be clarified (6). It is proposed that nursing interventions decrease arousal therefore permitting sleep to occur. Measuring arousal levels in hospital patients is problematic. However it is essential that a suitable measure be found if an evidence base for nursing interventions is to be developed. This measure must be sensitive and specific but also practical and robust for use in acute care settings.

Aim: The aim of this research is to investigate whether the startle response and/or autonomic markers could be used to quantify arousal and level of sleepiness.

The startle reflex is a fast twitch of facial and body muscles and may be elicited by sudden, moderately intense stimuli of several modalities. The startle response has been shown to vary with attention and affect – directing attention towards the stimulus facilitates the response, fear and anxiety also heighten the response (7). For this reason startle may be useful as a probe of levels of arousal and attention. The startle response has two properties; it habituates and exhibits prepulse inhibition. Startle habituation is a reduction in response amplitude following stimulus repetition. Prepulse inhibition is a reduction in the startle response by a prepulse (e.g. auditory stimuli of low intensity) preceding the startle stimuli by 30-150ms. Manipulation of these properties will allow close study of the effect of decreasing levels of arousal on the startle response.

We propose to investigate the possibility that the startle response and/or prepulse inhibition will change in a reproducible manner during the arousal continuum from alert wakefulness, to drowsiness and sleep. At around sleep onset the stage of arousal changes rapidly (8). Prepulse and startle stimuli must therefore be delivered rapidly to monitor this change. However it is not clear from the literature how often one can deliver startle stimuli and not have the response reduce or disappear due to habituation. Furthermore, it is not known how intertrial interval affects prepulse inhibition. Therefore this study was conducted to examine in normal awake subjects the behaviour of the startle response at frequent (15-23s) and less frequent (2-3 minutes) intertrial intervals.
Method:
Participants: The participants were 17 college students (4 male, 13 female), (mean age 34yrs, range 18 to 51 years) who volunteered to participate in this study. Participants reported no history of hearing deficit, diabetes, neurological, cardiovascular or sleep disorder, nor history of significant psychiatric disorder in self or first degree relative, were non-pregnant, and not on medication (except oral contraceptives). Participants consumed less than two units of alcohol the previous night and abstained from caffeine products the day of the study.

Stimuli:
The startle stimulus consisted of a 50ms, 108dB (A), white noise burst, with a near instantaneous rise/fall time. Prepulse stimuli were 30ms tones, with a rise/fall time of 5ms, an intensity of 71dB (A), and a frequency of 1000Hz. Startle and prepulse stimuli were produced by a Grass Click Tone precision signal generator. All auditory stimuli were presented binaurally through headphones. Stimulus onset asynchrony (from prepulse onset to startle stimulus onset) on prepulse trials was 120ms.

Apparatus:
The reflex eyeblink response may be used to quantify the startle reaction. This was measured as periorbital EMG activity from orbicularis oculi (Sensor Medics, Ag/AgCl electrodes, 4-mm diameter contact surface). The EMG activity was amplified (Iso-Z preamplifier and a BMA 931 amplifier, Charles Ward), filtered between 30 and 1000Hz. and digitized at 5000Hz. Recordings were continuous throughout the study.

Procedure:
Participants were asked to complete an informed consent form and a health questionnaire. Subjects sat upright during the startle sessions and were directed to stay awake and to keep their eyes open. To record startle activity two electrodes were positioned on the skin below the right eye, one directly below the pupil and the other just lateral, over the orbicularis oculi muscle. A ground electrode was placed behind the left ear over the mastoid.

Sleep staging was done to confirm wakefulness throughout the study. Bipolar electroencephalographic (EEG) activity was recorded with Grass gold cup electrodes at Cz/A1 and Oz/A2 positions and amplified with a Grass EEG amplifier (Model 7P511J). Electroculargram (EOG) activity was recorded with electrodes located 1cm below the right and 1 cm above the left outer canthus and referenced to the nasium. Two chin electrodes were placed 2cm apart over the belly of the submental muscle. All electrode resistances were less than 10 kOhms.

The test session began with a 5-min acclimation period. Participants were randomly assigned to receive first either Test A or Test B. In Test A intertrial interval (ITI) averaged 20s (range 15-23 seconds). In test B the intertrial interval averaged 150s (range 2-3 minutes). Both tests consisted of 30 stimuli; a block of 10 prepulses alone, 10 startle stimuli alone and 10 startle stimuli preceded by prepulses. The order of blocks of stimuli within tests was randomly selected.

Data Analyses: The intensity for the acoustic stimuli inducing the startle response was 117dB. This failed to induce consistent startle responses in 3 subjects.
additional subjects were excluded due to excessive electrical noise in the recordings. As a consequence, a statistical comparison was done with the data gathered from the remaining 10 subjects.

Startle data were analysed using wave-form averaging software (Spike 2 v4.19, CED, Cambridge, UK). The baseline prestimulus activity was assessed by measuring the total activity in a window, measured from 50msec prior to, up to stimulus onset. The startle response was measured as the total activity between 20 and 120ms post stimulus onset. The magnitude of the startle response was calculated as poststimulus total activity – (2 x prestimulus total activity); the prestimulus total activity had to be doubled as it was measured over a shorter time window. Peak magnitude (the difference between the mean amplitude in the –50 to zero period and the maximum amplitude in the +20 to 120msec period) was also calculated.

Statistical Analysis:

Data were analysed using repeated measures analyses of variance (ANOVA) with Student-Newman-Keuls post-hoc test.

Results:
Startle responses were reliably evoked by stimuli at both long and short intertrial intervals. In fact there was no significant difference (P >0.05, ANOVA) between startle responses at the different intervals used. Prepulse inhibition occurred at both intertrial intervals (P <0.0001). However prepulse inhibition was more marked at short ITI compared with long ITI (P<0.02).

Conclusion:
Contrary to expectation, startle responses were reliably evoked at short intertrial intervals. These exhibited powerful prepulse inhibition. This implies that it is valid to apply startle probes at frequent intervals, so establishing the feasibility of using startle to probe the dynamic process of sleep onset.

Acknowledgements:
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References:


Figure 1. Peak (A) and total (B) startle response for 10 subjects for each trial type.

A and B. Reducing the intertrial interval from 2-3 minutes to 15-23s did not significantly alter the startle-alone response. The startle response is significantly reduced at both long (2-3 minutes) and short (15-23s) intertrial intervals when the startle stimuli is preceded by 120sec by an acoustic prepulse (71dB). However, reducing the ITI did significantly alter the the startle response in startle + prepulse trials: at short ITI the startle response is significantly reduced. a.u., arbitrary units.
Figure 2. Typical startle response of one subject measured in the orbicularis oculi following a startle-alone stimuli of 116dB, intertrial interval range of 2-3 minutes.

Figure 3. A startle response in 1 subject close to sleep onset. A K complex is seen in the EEG tracing indicating sleep onset.
WHAT IS THE LIVED EXPERIENCE OF NURSES WORKING IN ADVANCED PRACTICE ROLES IN THE REPUBLIC OF IRELAND?

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The introduction of advanced nursing practice in the Republic of Ireland has followed a trend started in the United States in the 1960s. Nurses involved in advanced practice roles have broken the boundaries of traditional nursing and have expanded their practice to become autonomous practitioners, providing a service targeted at specific groups in society. In 1996 the first advanced nurse practitioner (ANP) service started in the Republic of Ireland in emergency nursing and since then advanced nursing practice has developed. While the development of this role has occurred in response to a change in societal needs it has brought mixed responses from nurses and other health care professionals as some feel that the caring concept could be lost and important boundaries are being overstepped as these nurses take on roles and duties heretofore the domain of the medical profession.

The focus of this study is to capture the lived experience of a group of nurses working in advanced practice roles in the Republic of Ireland. A qualitative design using a phenomenological approach is chosen and unstructured interviews were used to gather data from the participants. The participants were chosen using purposive sampling from the population of accredited advanced nurse practitioners and nurses working in advanced practice who have completed their Master’s programme and are in the process of seeking accreditation.

A review of the literature presents a detailed description of the historical development of the role of advanced nurse practitioner and its subsequent development in the Republic of Ireland. The concept of caring within advanced practice is considered presenting the issue of the nursing component within the advanced practice role.

Using a process of hermeneutic analysis, incorporating the metaphors of the hermeneutic circle and fusion of horizons, themes within the data are identified. These include ‘Working in advanced practice’, ‘Positive experiences’, ‘Stresses of the Job’, ‘Patient benefits’ and ‘Breaking new ground’.

The nurses who took part in this study expressed high levels of job satisfaction within the advanced practice role. All the nurses admitted to feeling low levels of confidence and self-esteem during the early stages of the role but feel with experience they have grown confident and appear to embrace the autonomy and higher levels of responsibility. Negative points include a perceived lack of support from their managers in terms of the nurses’ responsibilities to the other aspects of the role such as research. Many feel they are not being supported in securing protected time. Lack of standardised remuneration is also an issue among these nurses.

The role of the nurse working in advanced practice roles in the Republic of Ireland is still in its infancy in terms of development and while it appears to provide high levels
of job satisfaction and a patient-centred approach to care, strategies must be put in place to provide ongoing support of nurses working in advanced practice roles.
Situations of Overtaxation in Everyday Nursing Care

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Introduction

In this presentation, a project will be introduced that was developed and realised to specifically create an opportunity for the University of Applied Sciences Health in Freiburg, Switzerland, and its practice partners to collaborate. At present, the nursing education system in Switzerland is undergoing radical change. Until recently, nursing education was conducted on secondary level. With the ratification of the Bologna declaration, as well as the development of the bilateral treaties between Switzerland and the European Union, it was necessary to reconsider nursing education on secondary level in nursing. Since 1997, nursing education is expected to be provided on tertiary level with the possibility of completing basic nursing education with a bachelor’s degree. The University of Applied Sciences Health in Freiburg has embraced these new structures early on and is now one of the sites to offer a bachelor degree in nursing education in both French and German. Situated on the boarder to the French speaking part of Switzerland, the University of Applied Sciences Health in Freiburg has the unique opportunity to offer nursing education in French and German. The institution has firmly subscribed to being bilingual.

The University of Applied Sciences Freiburg emerged from a well established school of nursing that was already running nursing education courses at basic level in French and German. For both programmes, i.e., French and German, the school had close ties with French and German speaking healthcare institutions in the area of the town and county of Freiburg. The ties with these practice partners were however based mainly on the education of nursing students. Hardly any other exchange between the school and its practice partners existed such as expertise or research projects.

Research constitutes an inherent part of a university of applied sciences in Switzerland. The University of Applied Sciences Health in Freiburg therefore has a Centre for Research and Services that is constituted of one French and one German
unit, as well as a unit for further education. The project presented here has been developed and realised by the German Research Unit under the direction of Maya Shaha, PhD. The project is perceived to inscribe itself in the new missions for the Research Centres at the University of Applied Sciences in Switzerland:

- educating nursing students at bachelor degree level,
- enhancing nursing education programmes on site through applied research, and
- contributing to nursing practice in the form of innovations and expert solutions.

**Project development and realisation**

In order to develop a project that took into account the above stated missions, it was imperative to engage in discussions with the practice partners of the University of Applied Sciences Health in Freiburg. Since the project was expected to be in German, only the German practice partners were approached. These discussions revealed the difficulty of the nursing staff in these practice institutions to manage situations of overtaxation. The practice institutions experienced profound changes in their missions, which impacted on the kinds of patients that the nursing staff encountered in their everyday nursing care. These changes were experienced as chaotic, provoking feelings of uncertainty and helplessness in the staff. It was therefore decided to look at these burdensome situations in more detail in order to discern the kinds of support the nursing staff would need to manage the situations better. Addressing these issues and providing support for healthcare professionals in these situations of overcharge was perceived to eventually enable healthcare professionals to move towards incorporating research results and new trends into nursing care. Improving problems of overtaxation was also perceived to take up the new missions for research at universities of applied sciences as stated above. Therefore, the project’s aims and objectives were a) to explore the situations of overtaxation from the perspective of the nursing staff in these practice institutions, b) to discern areas for improvement, c) to develop interventions to improve the situations of overtaxation tailored to the needs of the nursing staff as revealed in the exploratory study, d) to evaluate these interventions as to their effectiveness, and e) to establish connections beyond those of educatory institutions including the possibilities of research and expertise provided by the University of Applied Sciences Health Freiburg.

The healthcare institution that agreed to take part in this project is a regional hospital with an obstetric, medical and surgical ward. In addition, the hospital provides emergency care all year round. There are approximately 100 beds. This particular healthcare institution is facing a profound change in its mission from acute care institution to rehabilitation and chronic care institution, including care for mental health problems. These proposed changes contribute to high overtaxation from the nurses’ point-of-view. Both, the medical and the surgical ward participated in the project. Only the medical ward took part in the interventions provided by the German Research Unit of the University of Applied Sciences Health in Freiburg.

**Overtaxation**

The term ‘Overtaxation’ is not frequently employed in the literature. By contrast, the notion of ‘burden’ has been described in family care and the effects of overtaxation,
namely stress and burn-out, have been discussed in detail. Both effects of overtaxation impact nurses and their everyday work profoundly (Benner & Wrubel, 1997). Nurses are perceived to experience significantly more stress than people in general. British statistics even reveal that nurses are more likely to commit suicide due to stress and burnout than any other professionals (McGrath, Reid, & Boore, 2003). It has also been demonstrated that stress and burnout contribute to a high turnover of nurses in their respective areas of work. They are less likely to stay on, which prevents successful incorporation of experience-based knowledge and provision of continuity of care (McNeese-Smith & Crook, 2003; McVicar, 2003). Situations of overtaxation that lead to stress and burnout have been identified in the literature. High potential to promote stress and burnout are problems among the team colleagues and restructuring of work conditions (McGrath et al., 2003). It has also been revealed that situations with patients may promote stress and burnout. Particularly, problems of patient compliance or care for patients’ families are perceived to lead to situations of overtaxation that may result in nurses’ stress and burnout (Duxbury, 2002; Zimber & Weyerer, 1999). However, identifications of the exact problems in these situations nurses encounter and the potential remedy to improve the situation have yet to be detailed. In addition, efficient actions to diminish or prevent overtaxation in nursing care need to be identified and developed. They remain understudied to date. Evidence indicates that combinations of specific actions on different levels, namely implicating individuals, as well as the organisation, are most likely to be successful (Schlüter, 1992).

**Project Procedure**

The project was conducted in two phases. At first, it was necessary to explore the nurses’ perspectives about situations of overtaxation. Six semi-structured group interviews, three per ward, were conducted, transcribed and analyzed by following views on action research (Denzin & Lincoln, 1998; Meyer, 2001) and focus groups (Kean, 2000). The majority of the wards’ nurses participated in the interviews. The analytic procedure involved the use of the computer programme Atlas Ti Version 4.2. Only an identification of the areas for potential improvement needed to be obtained. Therefore, the analysis stopped at an open coding and thematic grouping of codes. Memos were written, though, to allow for cross-checking of thematic groupings. This rudimentary analysis was enhanced by a thematic analysis conducted with Mind Manager. These results clearly indicated two areas for improvement of the overtaxation per ward, as well as for the whole institution. All results were presented to the director of nursing, the ward managers, as well as the nurses themselves. They all had to consent to participate in the development and implementation of the interventions

Secondly, the interventions to the areas were developed. As time constituted a severe restriction, it was imperative that the nurses of the wards agreed to work on one of the areas identified for improvement. Only the medical ward consented to participate in this second phase. Currently, the interventions are being implemented. They involve three consecutive team meetings with the nursing team, including the ward managers during a time-span of approximately two hours. In between the meetings, there are approximately four weeks to implement the intervention. An evaluation of the effectiveness of the intervention is being carried out by employing the SALSAA-
questionnaire that has been developed by Ivar Udris, Federal Polytechnic in Zurich (Udris & Rimann, 1993).

Results and Discussion

The analysis exposed 14 categories per ward that led to the identification of two major areas for improvement based on the quantitative statements only. Subsequently, three categories will be presented in lieu of all others.

Experiences of overtaxation

The politically changing, as well as the uncertain situation of the hospital affects the nurses on both wards. They experience strong feelings of anger, helplessness, injustice and fear for their future. Increased tension in the overall institution coupled with de-motivation and discouragement result.

Uncertain political situations are reported to impact nurses’ perception of workload. Such situations are considered to be highly stressful. As the nurses are not necessarily the decision making body in relation to the new missions of a healthcare institution, they lack sufficient responsibility to consider their work worthwhile. Such a perception leads to high stress and burnout eventually (Rieder, 1999; Schlüter, 1992).

In the nursing team of the surgical ward internal team tensions that stretch their cohesion lead to overtaxation. Rumour-mongers and latent inter-generational conflicts are identified. Stress and burnout are considered to be closely linked to psycho-social conflicts within healthcare professional working teams (Hillhouse & Adler, 1997; Jansen, Kerkstra, Huijer Abu-Saad, & Van Der Zee, 1996). To deal with such problematic situations, it is imperative that the individual coping strategies to deal with stress are well-developed (McGrath et al., 2003). Although the results clearly delineate areas for improvement, the surgical nursing team declines further participation in the project fearing to loose their actual precarious equilibrium within the team.

Working conditions are identified as major causes for overtaxation by the medical nursing team. Currently, there is a policy by the management not to replace departing staff. They not only hope to cut on expenditures, but also to prevent too much expenditure before a final decision about the future of the healthcare institution has been taken. In addition, the emergency unit is only manned by extra personnel during daytime. After 5 p.m. all other wards of the institution are in turn in charge of the emergency unit. Therefore, the nursing teams in charge of the emergency unit also need to handle their usual workload on the unit. Working conditions are therefore subjected to high fluctuations, which are difficult to manage.

“When I know I'm responsible for the emergency ward all my warnings lights turn on red”.
“You start work at 7 o'clock in the morning, and then you receive the message that one colleague will be absent, you know that the whole day will be bad.”

Too many patients and lack of time contribute to overtaxation as has been described in the literature (Benner & Wrubel, 1997; Demerouti, Bakker, Nachreiner, &
Schaufeli, 2000; Forsgräde, Westermann, & Jansson, 2002). The recurrence of a difficult situation contributes to nurses’ experience of overtaxation as demonstrated in the statements above. Situations that occur always and only little change can be perceived provoke instant loss of motivation and an increased level of stress. Once in this frame of mind, little can be done to alleviate the situation to the nurses’ advantage.

“If you have a patient with an unstable heart condition that needs to be monitored, you need to find time for the six other patients. This is not stress as such, but it’s unsatisfactory. Communication is falling short.”

Some nurses do not consider it acceptable, if patients notice their dire situation. They try to preserve patients from their stress. Coping with stress and burnout in the face of patients has not been detailed explicitly in the literature. By contrast, coping strategies have mainly an individual focus empowering nurses to deal with stress by themselves (Hornung & Lächler, 1999; Jansen et al., 1996; McGrath et al., 2003). It is however a very interesting question whether the patients should or should not notice the stress of the nursing staff. Ethical issues may be raised through it.

“In the corridors you speed up, and in the patients rooms you try to slow down. The whole day you speed up and slow down.”

“I try to work faster, but then I get more impatient... not the best way to deal with patients.”

Nurses have become aware that working in situations of continuous overtaxation increases the risks of errors and leads to vicious circles. These experiences have also been described in the literature. They constitute one of the most dangerous effects of stress and burnout in the nursing profession (McGrath et al., 2003; McVicar, 2003). Severe stress and burnout is also connected to serious physical harm such as beating patients and excessive aggression from the healthcare professionals towards patients (Selye, 1978; Zimber & Weyerer, 1999). Such effects need to be prevented at all costs.

“On stressful days the team-meeting for organisation is often skipped, when it would be most useful.”

Even if there are potentially alleviating measures in place nurses no longer use them in fear of not being able to catch up on all their tasks. They cut on these positive structures hoping they might get a moment of respite. Similar descriptions exist in the literature about the reaction of the human being to stress and its effect (Schlüter, 1992; Selye, 1978).

Complex patient situations are another source of overtaxation. Nurses cite caring for dying patients, being confronted with supporting patients’ families, as well as patients with mental health problems, suffering from drug-addiction or suicidal patients among the most difficult and taxing situations in their everyday care.

“It's the uncertainty; you don't know what will happen.”
There are indications that situations of patient non-compliance are a stressor for nurses. It signifies complications and a threat to the patient’s well-being (Duxbury, 2002). Although only a few statements dealt with the interdisciplinary working conditions, working together with physicians is difficult and taxing. The hierarchical structure contributes to overtaxation. Nurses are often not part of the decision making process, which becomes problematic and taxing for the nurses as soon as ethical-moral dimensions are involved. In the medical team involved in this study, limited and not actualised knowledge about patients’ diseases and potential outcomes contribute to their experience of overtaxation. The lack of actualised and evidence-based knowledge in nursing care has not been identified as an important stressor.

**Coping with overtaxation**

The medical ward nurses have already developed a number of coping strategies to deal with overtaxation. One of the most supportive and stress reducing factors is the team cohesion of the medical ward nurses. They consider their team to be “great”. Other team-members are perceived to be the most valuable resource. Senior members of the team are a source of confidence for junior nurses. Part-time working contributes to reducing stress and the burden of responsibility. Team-meetings are ideal places to share the burden. The importance of the team and its cohesion has been described in relation to stress and burn-out (Rieder, 1999; Wohlfender, 2000). By contrast, the stress reducing effect of part-time work has not been highlighted as a powerful anti-stressor in nursing care.

Some nurses confided that they are experience difficulties at having to leave their work behind when going off duty. Problems at work are carried into private life and the leisure time is used to cope with overtaxation. Due to their partners and families, these overlaps have not yet led to major problems in the private life. The importance of personal resources is recognised in the literature, as stress and burnout are considered to have a strong individual psycho-social dimension. From this point-of-view, the individual coping can only be reinforced, if the private life and relaxation provided through it can be strengthened (Hellgren, Näswall, Sverke, & Söderfelt, 2003; LeBlanc & Peters, 2003).

**Development and Implementation of Interventions**

Based on the findings of the explorative process above, areas for interventions were identified per ward, as well as for the institution as whole. The medical unit’s management of complex patient situations, as well as their work organisation, including documentation, were perceived to be areas in need of improvement. Their main complaint was: “We lack sufficient time to do our work”. In particular, the late shift emerged as a highly stressful and problematic situation. Nursing staff during the late shift was severely reduced. In addition, accident and emergency admissions were handled by the nursing staff from 5 p.m. It was therefore decided to use late shift scenarios as basis to develop potential measures to alleviate the burden of overtaxation. Three consecutive meetings with representatives of the medical ward were scheduled working on ‘quality of care’, ‘patients’ needs’ and the concept of ‘holism’. These three themes emerged as key points from the mission statement of the institution. During the meetings, critical evaluation of late shift scenarios in the light of these three themes was conducted and a list of potential measures to alleviate
overtaxation was composed, also including evidence-based study results. Feasibility and realisability of the proposed measures were evaluated in a discussion and a decision was taken to implement one measure. Advantages and disadvantages of the measure were qualitatively evaluated in the following meeting.

Conclusion and Outlook

The nursing development project has looked at a highly researched area. Many correspondences with literature can be identified such as political situations and restructuring of healthcare institutions are stressors. However, it has also revealed that situations with patients can revert into stressors for the healthcare professionals. Nurses face the dilemma of whether or not it is helpful or ethically acceptable to inform patients of an actual stressful situation. In addition, areas for improvement for each ward, as well as the healthcare institution can be identified. They allow for development of interventions tailored to the nurses’ needs in this particular healthcare institution.

As the number of the participants is limited, it is doubtful, whether conclusive evidence can be produced about the effectiveness of the intervention. However, an ideal situation has opened itself as the surgical team has declined participation in the intervention. Therefore, it is hoped – by comparison – to elicit a more conclusive result.

A number of problematic issues can be raised regarding the project. It has involved a whole project team of three people to explore the nursing teams’ views about overtaxation. In future, such an involvement of work-power is no longer feasible. It will be important to reduce the size of the project team and to improve the speed of data collection, nevertheless maintaining its quality regarding the identification of the areas of improvement. The approach used in this particular project was considered necessary in order a) to provide a learning effect for the project team, b) to involve all members of the nursing teams and c) to reinforce the link between the University of Applied Sciences Health and the healthcare institution involved.

Despite the drawbacks, the nursing development project has revealed the necessity to develop, realise and evaluate the effectiveness of interventions to reduce stress in everyday nursing. In addition, the discussion about stress and burnout may benefit from a review of the underlying situations of overtaxation in nursing. Thus, it will become possible to develop even better interventions to support nursing personnel.

Literature


SUPPORTING LEARNING THROUGH WORK WITH INFORMATION/COMMUNICATION TECHNOLOGIES

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Abstract

This paper offers a new way of developing skills based education in health and social care (HCS). There is an urgent requirement to develop new workers in HSC throughout the UK. Traditional programmes that remove the workforce from practice were unacceptable to employers. Consequently, I developed a Foundation Degree (FdA) that could be delivered by way of work-based learning. However, a key factor for student support was engagement with ICT. The programme delivered all input through its own web-site and offered electronic support by way of e-mail and telephone links. This, of course, relied on a collaborative partnership with employers and required the provision of ICT workstations in fourteen sites outside of the Manchester Metropolitan University (MMU).

The first year, 2003, indicated the importance of ICT within the support network. Although students had tutor support in the workplace, link tutors and practice trainers, I discovered that 96% of failing students never visited the web-site, identified by the, in-built, student tracking system. Interestingly, most student hits occurred during the weekend between midnight and three a.m. The tracking system proved beneficial to both tutorial staff and students. Tutors were able to identify those students at risk, i.e. those not hitting the web-site, and counsel them about the risk. During this ‘at risk’ period less than 60% of students were using the web-site (n = 420) and at the first progression point 146 (35%) failed, with 140 (96%) of this group never having used the web-site. Following publication of this finding, to both faculty and students, the use of the web-site rose to 87% (365) of students using the site regularly. The next progression point indicated that the failure rate reduced to 11% (n = 47). This rate referred to new units and not re-sits. It is my contention that ICT has a significant impact on student progression rates and improves the delivery of education and training in the workplace.

A further, positive, outcome of using ICT in the programme is that students were more willing to seek electronic tutorials that their counterparts on traditional programmes who had to rely on face to face tutorials. The major outcome of the programme is that: whilst students struggled to engage with the programme initially, once they took control of their own learning their achievements far exceeded those students on traditional programmes. Unfortunately, those who did not engage with the ICT aspects of the programme were more likely to fail and attempts to facilitate engagement with this group was rarely successful.

Introduction
This paper offers a new way of developing skills based education in health and social care (HCS). The programme delivered all input through its own web-site and offered electronic support by way of e-mail and telephone links.

The provision of skills for the delivery of health and social care is very topical given future short fall in the workforce (DH, 2001). Certainly future service providers will need to consider a mixed economy of care. Since overlapping areas of work are likely to be absorbed by the most powerful professional group (Corrigan and Garman, 1999). There is tension here, between what service managers want and that which educational institutions deliver.

Several studies have indicated that ‘industry’ wants to employ ‘graduates’ who have the necessary skills to engage with the workplace; or to ‘hit the ground running’ (Harvey, 1996). Saunders (1995) argues that such abilities cannot be fully developed in the classroom. In terms of mental health practice this has been the case for some 20 years (Skidmore and Friend, 1984; Holenstein, 1992). However, recent work has identified a flaw in such studies (Skidmore, Brooker and Linde, 2002) suggesting that skills have to develop in the workplace which often occurs post-classroom. Their study identified a definite difference between new ‘graduates’ and those who had been under supervision (through work) for several months. New completors failed to recognise the worth of new skills whereas those having had protracted supervision recognised their value.

This would reinforce Burgess’s (1986) claim that education (in the sense of developing capable skills) can only take place in the workplace. Sangster and Marshall (2000) suggest that this is because practice and theory merge and support each other.’..ensuring that the development of any new theory will be truly ‘grounded’. This certainly sends a broadshot over the bows of those who support a separation ‘….between knowledge and doing….’ (Brown, Colin and Douglas, 1988). Bourdieu (1976) suggests that practice is bound up in ‘Habitus’; this produces and perpetuates collective practices and, subsequently, history. In other words, the Habitus becomes self-perpetuating maintaining the status quo because practitioners, teachers and managers expect it to work even though some ‘actors’ may express dissatisfaction with the methods used.

The literature led us (the learning through work team) to conclude that skills could only be developed in the workplace using learning through work supported by e-learning. Given that ICT literacy was a key outcome of the Department for Education and Skills (UK) brief for Foundation Degrees it was decided to develop such a programme:

**The Foundation Degree in Health and Social Care.**

Whilst attempts to increase nursing students were not very successful recruitment to health care assistant and support worker posts were very successful, often 100 applicants per vacancy. However, these had no formal skills or training. I shared the idea of the FdA and the ‘Delivering the Workforce’ project was born. The employers required several key themes from any educational programme:

**KEY POINTS:**

- STEP-ON/OFF POINTS
- MAPPED AGAINST NVQ/NEBS AWARDS
- OFFERS A FLEXIBLE PROGRAMME FROM CertHE TO DEGREE
- WORK-BASED LEARNING
- ELECTRONIC LEARNING
- ELECTRONIC SUPPORT
- PRACTITIONER-TRAINERS
- PRACTICE LED – THEORY FOLLOWS
- CONCENTRATES ON SKILL DEVELOPMENT
- ETHICAL PRACTICE
- EFFECTIVE REPORTING
- EFFECTIVE PARTNERSHIPS
- CLINICAL LEADERSHIP
- IT SKILLS

From an educational point of view it was felt to be important to use several members of single teams in order to harness the habitus, working from inside, as it were. There would be little formal teaching and delivery would rely upon directed study, e-learning and learning by doing. To this end, it was felt to be crucial that a ‘trainer’ would be on hand to facilitate engagement with the programme. To this end a Practice-Trainer would be responsible for each site. This, ideally, would be a member of the university staff who had a credible practitioner profile and worked with the practitioners. The team had a vision of an ideal support structure and this involved a significant amount of ICT. We placed workstations within each area of practice we had engaged with: approximately one workstation for every 20 students.

*First problem: The FIREWALL!*

The NHS firewalls the portals that offer access to chat rooms. These are a crucial part of the site that supports the FdA. With the sterling efforts of Jim Sale these were liberated.

*Second problem: ACCESS*

This worked on two levels: i. the workstations were located in obscure areas that discouraged students from seeking them out and ii: students often felt guilty about using work-stations when patients were present. The patient need was paramount.

*Third problem: THE THREE BAD HITS (STRIKES) phenomena.*

It appears that when students experience three bad hits they are unlikely to return to ICT. In this situation they had access, resorted to either internet cafes or personal PCs, encountered the firewall (thinking that nobody was in the chat room) tried again, and then gave up.

**Method**

Four hundred and twenty students enrolled onto the programme and all were given login IDs for the website. This permitted us to track students every time they made a hit on the site. Students were monitored for a period of two years and the number of hits compared and contrasted with individual success of progress through the programme.
Every three months records were reviewed and staff, delivering the programme, were alerted to ‘failing’ students. Records were subsequently reviewed to identify any change in access due to feedback.

Of those students ‘failing’ 30% (n = 45) were interviewed (opportunistically) in order to identify why they were not engaging with the web-site.

**Results and analysis**

The first year, 2003, indicated the importance of ICT within the support network. Although students had tutor support in the workplace, link tutors and practice trainers, I discovered that 96% of failing students never visited the web-site, identified by the, in-built, student tracking system. Interestingly, most student hits occurred during the weekend between midnight and three a.m. The tracking system proved beneficial to both tutorial staff and students. Tutors were able to identify those students at risk, i.e. those not hitting the web-site, and counsel them about the risk. During this ‘at risk’ period less than 60% of students were using the web-site (n = 420) and at the first progression point 146 (35%) failed, with 140 (96%) of this group never having used the web-site. Following publication of this finding the use of the web-site rose to 87% (365) of students using the site regularly. The next progression point indicated that the failure rate reduced to 11% (n = 47). This rate referred to new units and not re-sits. It is my contention that ICT has a significant impact on student progression rates and improves the delivery of education and training in the workplace. Indeed, the top ten achievers visited the site on a daily basis. Statistical analysis indicated that there was a positive correlation between the number of hits and successful achievement (ρ = 0.87); i.e. those students who visited the sight most (in a constructive way) were likely to experience most success in assessments.

The FdA programme is competency based and seeks to develop a generic Assistant Practitioner who can work across various disciplines. In Greater Manchester (UK) alone the workforce will be in deficit by some 3,000 workers within three years unless action is taken. This programme is viewed as positive way of resolving the shortfall. Learning through work, with ICT support, facilitates the integration of theory with practice. For example: students are provided with the technical skills of cardio-pulmonary resuscitation (CPR); they become skilled in technique but have no underpinning knowledge of trauma, disease or healthy systems. These can be accessed by way of the internet and the programme web-site. The beauty of this system is that it acknowledges that students learn in different ways and at different rates.

A further outcome of using ICT is that students were more willing to seek electronic tutorials that their counterparts on traditional programmes who had to rely on face to face tutorials. The major outcome of the programme is that: whilst students struggled to engage with the programme initially, once they took control of their own learning their achievements far exceeded those students on traditional programmes. Service managers have indicated that students’ confidences in their abilities significantly increased during year two to the extent that they can challenge the decisions of qualified practitioners. Many students are entering professional programmes, although the majority (85%) have indicated that they would prefer ‘practitioner degrees’ that continued this style of learning. This, however, did little to attract those students who had initially withdrawn from ICT engagement.
The interviews indicated that certain tutors had facilitated non-engagement with ICT. It is not possible, at this stage, to identify the motives involved here, although those involved with delivery have suggested:

- A response to student technophobia
- Poor access to workstations
- Tutor ICT illiteracy
- Tutor use of traditional methods negated need to use ICT
- Poor understanding of the role of ICT of both tutors and students
- An inter-relationship between all the above

The engagement with ICT indicated that students:

- Had more opportunity to succeed at the end of the programme
- Developed the ability to take control of their learning
- Were more likely to engage with life-long learning
- Interacted more with peers and academics

Consequently, it was important that action could be taken that would stimulate students to make use of the ICT opportunities this programme offered.

**Action taken to bring them on board**

In an attempt to encourage engagement with the website I agreed, at the behest of Jim Sales, to enter a dedicated chat-room so that students could offer their views of the programme. Two sessions were arranged but, unfortunately, only those students who were already engaged with the site entered. A great deal of information about why the programme was successful was gathered by way of this strategy and reinforced the importance of ICT support. This data, however, offered no solutions that would facilitate ICT engagement. Consequently, I sought to identify the factors that stimulated non-engagement. The factors that indicated ICT engagement to be important are manifest (above) and the issues that facilitate non-engagement may be stronger in reality.

**Fixated messianic tutor**

The major problem we experienced with this programme is that we were all on a steep learning curb (Jim would say wall!) and assumed that everyone involved shared the same notions about delivery. We were wrong! Some of the practice-trainers, it turned out, were frustrated lecturers and desired to hand feed their charges. This was in conflict with the underpinning philosophy of the programme, where students should have their learning facilitated. I refer to these tutors as being fixated in the messianic syndrome; i.e. enjoying the feeling of being the educational prophet who leads the ‘uneducated flock’. The flock becomes dependant upon the prophet.

**Fixated ICT heretics**

Conversely, some students became fixated in the notion that ICT could do nothing to help them, in much the same way as one might denounce a prophet. In true belief system style they had secondary explanations for why they should not use ICT. This belief was reinforced by the messianic tutors who substituted ICT activity for more traditional methods. Consequently the two groups mutually reinforced each others fixations.
The three bad hits phenomena

It has already been stated (above) that this is a known problem in ICT. If a user has three negative experiences when engaged with ICT they are likely never to use the system again. We recorded several negative aspects within the system:

- Poor access to workstations
- Technophobia
- ICT illiteracy
- Firewalls
- Systems not ‘talking’ to each other
- Traditional methods negating need to engage with ICT
- Systems crashing
- Poor internet access at home (prolonged time to connect)

This aspect often acted as a catalyst, or cement, for fixation. Any combination of the three bad hits often led to a ‘what’s the point?’ reaction. Indeed, several subjects commented that ‘…we never had these problems with paper and pens!’

Discussion

The ‘three bad hits phenomena’ was cured, workstations were installed in every trust that ‘talked’ to the University’s system, firewalls were demolished, extra sessions upon ICT literacy introduced and frequent ‘drop-in’ centres offered with no success. It appears that fixation is stronger than reason. Whilst it could/can be demonstrated that success equates to ICT engagement advertisement failed to turn students around. The fixated heretics and the fixated messianic tutors constantly demanded the introduction of formal teaching sessions. Such actions flew in the face of that which a foundation degree is about. Traditional methods place all the power for learning and teaching in the gift of tutors. Foundation degrees seek to utilise learning through work so that students engage with lifelong learning and take control themselves. It seems that, with the growth of Foundation Degrees we are heading for a clash between two educational cultures. Unfortunately, without ‘learning through work’ advocates student controlled learning, and with it ICT, is doomed to failure.

Liberally paraphrasing, and maybe restructuring, Nietzche’s (2003) stance that men really desire to control their own destinies but are thwarted by the actions of society’s most powerful men (obermenschen) who enforce their own ideals upon the ordinary, one can see how a learning wall is erected. It is safe to accept the traditional (Marris, 1974). Education over the years, I argue, has been predicated upon the messianic tradition: teachers know more than pupils, what pupils know is irrelevant unless verified by a teacher, to question the system is to be disruptive…see headmaster! In addition, some students develop a deep mistrust of ICT and fixate on a belief that it can not help them. The ‘three bad hits’ phenomena ensures that there will be a ready supply of both groups. Consequently, ICT must be effective from the onset of any educational programme. More importantly, education and training programmes that seek to develop tutors must facilitate open minds and the will to take risks, rather than relying on the traditional method. Failure to do this will, inevitably, lead to negative outcomes and an inability to extend education and training. To extend the biblical metaphors:

- We can not rely on the road to Damascus; i.e. sudden revelations are unlikely. Most of us are blind and have to be coaxed, gradually, to see the big picture.
• Failure to engage effectively with new methods will cause people to be ‘eyeless in Gaza’ and eventually pull the temple (of learning) around them into meaningless rubble.
• Some tutors will give in to lack of reasoned argument and display the ‘Pilate syndrome’: I wash my hands of this method of learning and teaching.
• The temple (of learning) should attempt various methods to draw in learners; only fixated ‘prophets’ will turn over the tables of new endeavour.
• The law and the prophets should be questioned: traditional education encourages people to ‘hide their lights under bushels’, thereby devaluing their view of the world. Only a forgiving prophet will welcome criticism of his/her creation. Equally this could be the ‘John the Baptist’ response: no, it is I who should be educated by you!
• Messianic fixation can negate learning: ‘if you want to enter life obey the commandments’ (Matthew 19, 17 & Mark 10, 18) and the warning lies in ‘Watch out for the teachers of the law. They like to walk around in flowing robes and be greeted in the market and have the most important seats…’ (Mark 12, 38-39).
• Finally heretic fixation: ‘These people honour me with their lips but their hearts are far from me.’ (Mark 7, 6)

I am in no sense religious but believe that we all have much to learn from many sources. My father drummed into me:
‘If you have enough humility you can learn something from anyone.’
Even the lowliest ICT. Unfortunately, many teachers and pupils prefer to be eyeless in Gaza and reduce the temple of learning to rubble. The safety of the familiar stimulates the attitude:
‘If I don’t understand it then it must be wrong!’
In order to facilitate lifelong learning, let us challenge the law and the prophets of learning and teaching and embrace new methods. After all, Philistine has become synonymous with ignorance (or enemies of culture) and it was the Philistines that Samson tried to destroy in Gaza! Unfortunately, those two middle pillars of knowledge and truth existed in four other cities: Ashkelon, Ashdod, Ekron and Gath…there’s still a lot of pulling to do!
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Using information technology to support an MA in solution focused brief therapy

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The use of Information Technology (IT) is part of the governments agenda for Lifelong Learning, computer access in the home, work or in public libraries is available to significant numbers of people. IT in healthcare is integrative to the planning and delivery of client care, and most Trusts have intranet services and a drive towards training of staff in use of IT.

Solution focused Brief Therapy (SFBT) is a collaborative form of therapy that builds upon the client’s competencies and resources. Its optimism has won for it considerable following among members of the caring professions. The MA is aimed at professionally qualified individuals who want to increase their knowledge and skill in the use of SFBT. The course was designed for the part time student who is in working in their chosen field of Nursing, Counselling, Psychology, Social Work, Education or Management and has reduced attendance at university a required component of online participation.

The Programme takes into account the needs of people who are in employment and who live at a distance from the University campus. The course is now completing its fourth academic year; and with limited attendance at the university the use of IT via WebCT is a significant part of the learning and teaching methods and offers information on course content, reading materiel and links to relevant sites.

Access to a computer is a compulsory requirement of the programme. The students are introduced to WebCT within the first four-day block of attendance. Guided reading is given and the students then prepare to take active part in a lecturer facilitated online discussion. The online sessions happen every two weeks in the evening and 80% attendance is required. The module that is in process influences the reading material; or it can be negotiated and provided by the student participants. As the course progresses these sessions can be used to discuss clinical and research issues and we have the facility to invite visitors to participate.

Alongside the tutor facilitated chat room discussion the students are required to take part in ongoing discussion activity on the Bulletin Board, these discussion themes can be very diverse with topics such as the philosophical underpinning of SFBT to case discussion or requests for literature or research material.

Although many students find the use of IT and chat room discussion a daunting prospect initially they are usually fully on board in a relatively short period of time. In line with other findings (Atack 2003) the evaluations are positive with students valuing the online contact that they have with lecturer staff and peers in a programme that has face-to-face contact every two months.

Reference
Healthcare in a Women’s Prison: Introducing Solution Focused Interventions:
Maureen Smojkis: University of Birmingham. Centre for Lifelong Learning
Simon Reeves & Sally Burgess, Brockhill Women’s Prison.

Introduction

This study is being carried out in a Healthcare Centre of a Women’s Prison. With a focus on holistic client care, the aim is to introduce the theory and practice of Solution Focused Interventions (SFI), to the nursing team, to offer Clinical Supervision for a specified period of time and to evaluate the process.

The provision of healthcare to prisoners by healthcare practitioners who are not employed by Her Majesties Prison Service (HMP) is a relatively new concept. Health care provision within the Prison services has moved forward considerably during the last decade and in line with this modernisation the healthcare team in the specified Women’s Prison, which is funded by the local Primary Care Trust, is growing and developing to meet the identified needs of the population.

Health care in prisons has traditionally been the responsibility of the prison service. Prison officers who had completed a short course in general health care were given the grade of Hospital Officer. Recent developments have changed the configuration of staff and by 1996 there were 422 RGNs, 110 EN (G), 228 RMN, 20 EN (M), 10 RNMM and 3 EN (MH) employed as nurses within the prison service in the UK (Polczyk-Przbyla & Gournay 1999). With the increase in the prison population and in particular the increase in mental health and drug and alcohol problems these numbers are inadequate to meet the needs, and the recruitment of nurses is an ongoing process. There is a skill mix within the prison healthcare nursing establishment in which reflects the numbers above.

Health Care centres in prisons must provide a full range of primary health care services; this includes Dentist, Medical cover, Pharmacy. In 1997 having identified a lack of qualified healthcare professional within the service, The Health Advisory Committee for the Prison Service (1997) stated that the aim was to give prisoners access to the same range and quality of health care that the general public receives from the National Health Service. The Prison in which the study took place previously housed men, with the increase in Women in the prison population this facility was re-commissioned; with considerable work under way to modernise existing healthcare facilities and to provide inpatient beds for clients with severe and enduring mental health problems and people who are going through a period of detoxification because of addiction to drugs or alcohol. There is some division of responsibility related to area of qualification, but in the main each nurse is multi-skilled in order to be able to carry out a menu of care, and communication is fundamental to all care delivery. At present all nurses are involved in greeting and assessing new people on entry to the prison, and all will be responsible for assessing initial and ongoing risk of self-harm.

Solution Focused Interventions

Solution Focused Brief Therapy (SFBT) has evolved over the past thirty years, a process which was developed in the United States by the Mental Research Institute and built upon by Steve de Shazer in Milwaukee. The approach was developed through observing Insoo Kim
Berg working with families and noticing that some questions appeared to be more useful that others, from this the group continued to ask these types of questions and the approach was developed further. Essentially SFBT is a strengths based approach that builds on the person’s resources, the person is considered to be the expert in their own life and the worker/counselor/nurse works alongside the person to explore and discover their preferred future and what they are already doing that is keeping them okay. This approach has been developed in the UK and written about by Bill O’Connell who gives the audience an introduction to SFBT and also edits the Handbook of Solution Focused Therapy in the UK showing the usefulness of the approach in a variety of health, education and social care settings, (O’Connell, 1998, 2003).

Women in Prison
In 2002 19% of known offenders were women, the most common indictable offence of women (57%) was theft and handling. Women prisoners make up 6% of the prison population, the numbers of women in custody rose by 173% as against 50% for men in the 10 years between 1992 and 2002 of those who were sentenced the main offence groups are drug related (41%). Among the women prison population, 20% have spent some time in care and 37% had previously attempted suicide, 60% rated their general health as fair, very fair or poor and 15% have had a previous mental health admission (HM0 2003). The population within the prison in the study reflect the statistics, the prison is low category, which means that they are in the main a fairly transient group; the age range of the women is from 17 to 80+ with the majority of the group being in their 20-30s. The nurses who work in the healthcare center stressed the high level of social and emotional issues that the women bring.

Self harm is a frequent occurrence in the prison system and the Prison Service have a policy for assessing and managing risk, however the Prison Reform Trust (Rickford, 2003) highlighted women’s expectations of service responses to self harm, ‘no one ever asked me what I wanted in terms of self harm or what would make a difference in terms of seriousness or frequency of self harm’. The use of SFI with people who self-harm has proved of value, (Callcott, 2004) and ways of using SFI with this population was included in the introductory work-shop and is significant in the ongoing study.

Communication Skills and Nursing

Communication is fundamental to nursing and is integral to the provision of effective care, however, there is no benchmark for effective nurse-patient communication, Bowles, Mackintosh and Torn (2001). There is little doubt that work in the human services inevitably involves providing emotional care as well as more practical support, (Gibson, Swartz and Sandenbergh 2002) however it is in the area of communication and emotional support that many nurses, regardless of qualification, lack confidence and feel inadequately prepared.

The importance of communication verbal, non-verbal and the written word is implicit within the Code of Professional Conduct (NMC 2002) and the values of SFI compliment the code. Kagen and Evan (1993) emphasise the importance of professional interpersonal skills in nursing and suggest that what may be considered to be professionally skilled in one interpersonal situation may not be in another. Whilst acknowledging that nurses may have existing interpersonal skills, they stress the requirement of flexible adaptation to changing circumstances and different people in a range of different situations in order to achieve clear nursing goals. SF practice offers the nurse an approach that can be useful in a variety of settings because it challenges the notion of expert by emphasising respectful curiosity in the
development of the therapeutic relationship. Bowles et al (2001) suggest that SFBT is culturally congruent with nursing practice as it focuses on wellness and health, not pathology.

Nurses working in the UK provide healthcare to a multicultural population, Holland and Hogg (2001) stress the importance of nurses having knowledge of cultural practices when providing healthcare to women because of their position in society of mothers, carers and workers. 29% of the female prison population is from ethnic minority groups and 20% of those sentenced in 2002 were foreign nationals (HMO 2003). Solution Focused practice takes the stance that the client is the expert in their own life (O’Connell 1998) and that making assumptions about a person based on gender, age, culture, ability or social position is unhelpful. Whilst having a general overview of cultural practices, it might be considered useful to ask a question such as ‘what do you think it would be useful for me to know about you as a person?’ to generate information on how the person views themselves rather than making judgments or assumptions based on the nurses own values or beliefs.

Process

Following a meeting with the Healthcare manager and a discussion about the client group a two-day Introduction to SFI was carried out. At the end of the two days forms were made to use in the self-harm assessment process and self-rating scales for the clients, the following plan was made in collaboration with the Health Care Manager members of the nursing team.

The two-day introduction to Solution Focused Intervention was planned following a review of the literature from the information about the nurse group given by the healthcare manager and building on the authors previous knowledge and experience of working as a staff nurse in a male prison.

The content of a two-day introduction (Appendix 2) needed to be meaningful and realistic and to take into account individual styles of learning. The use of experiential exercises was maximised and organised to incorporate breaks in activity. Using a Solution Focused approach to delivery the nurses would be asked ‘what would they hope to get from the two days?’ How would they know that the two days had been useful?’

In order to carry out this project, it was important to research the current literature and to engage in discussion with the healthcare manager to have an overview of the skills and background of the nurses in the centre. For the majority of nurses involved the prison was a new clinical arena. The Adult nurses felt more confident in their duties in doctors surgery which happened every morning and in dealing with minor injuries, including the physical aspects of self harm, their confidence was less when talking to the women who may have self harmed or had a problem with addiction. The following process was carried out:

1. A meeting with the healthcare manager to discuss the needs of the team
2. Literature review to include
   • Information on working with women
   • Statistics on women in prison
   • The role of the nurse in prison
   • Nurses existing knowledge of SFBT interventions
   • Solution Focused work with women
   • Solution Focused work in secure environments
Four specifics of Solution oriented therapy were identified as being of particular value in this Prison Healthcare setting and these were incorporated into the two days.

**Problem-Free talk:** The idea of problem free talk encourages the nurse to connect with the person and to begin to identify in the conversation the person’s skills, resources and strengths that they have used in the past and may be useful in the present. The nurses would have time to engage in problem free talk with the women during their daily activities e.g. waiting for appointments in the healthcare centre.

**Exception Seeking Questions:** In relation to virtually every issue of concern there are exceptions or times when the issue is causing less concern if the problem takes up 40% of the persons time then for 60% of the time they will be problem free, (O’Connell 1998). Exceptions are often the beginning of the process of shifting the power the problem seems to have over the persons’ life. Once exceptions have been identified the person and the nurse will be able to identify; ‘what are you doing differently during those exception times?’ and ‘what are others doing that is different at those (exception) times?’

**Scaling Questions:** Scaling questions within SFT are flexible and can be used in many ways. For example they can be used to measure change, the more a person has a sense of change, the more they know they are moving forward. This will facilitate a sense that they have the ability to take control. For example; ‘On a scale of 0-10, with 0 being the worst that things have been in your life and 10 representing how you want things to be, where are you today?’ Scaling questions can be used to identify where the person wants to be, with further exploration the nurse would be able to assist the person to identify what would be different when they have achieved their target on the scale and their confidence that they will reach it.

**The Miracle Question:** The Miracle Question (MQ) is usually asked in the first session and can be used as an evaluation in later sessions. The following is the standard MQ but the person leading the session can change this and other examples were given in the workshop and are on the presentation handout.

> “Suppose that, while you are asleep tonight, a miracle happens. The miracle is that the problem that brought you here today is solved. Only you don’t know that it is solved because you are asleep. What difference will you notice tomorrow morning that will tell you that a miracle has happened?” De Jong & Kim Berg (2002)

De Jong and Kim Berg state that in Solution Focused work, questions should be used for the client to develop well-formed goals, (De Jong & Kim Berg 2002) That when using the Miracle Question it is the clients perception of their life when the miracle has happened or life without the problem, and reminds the person using the Miracle Question to be patient and persistent.

The introduction was delivered using Power Point and a copy of the handout given to the nurses who participated is included, Appendix 1, the prompt sheets are as Appendix 5A-5D.

**Supervision and Reflective Practice**

Bond & Holland (1998) differentiates between management supervision and Clinical Supervision, nursing in the present healthcare system is increasingly stressful; it is of benefit to clients, colleagues and nurses themselves that they take advantage of the use of Reflective
Practice and Clinical Supervision. Gibbs Reflective Cycle (1988) fits into the framework of SFI and was integrated into the Reflective Practice process meetings. Because of the nature of nursing in a Prison Healthcare Setting it has been important for the process of Clinical Supervision to be flexible, in a real world environment the there may be occasions when things are changed at short notice, nurses and supervisors have collaborated in a productive way to ensure that the Clinical Supervision is realistic; this is an ongoing process.

Traditional health services are established in a problem-focused frame. Research indicates that Solution Focused Interventions (SFI) is of value in the healthcare arena, (Wilgosh, Hawkes & Marsh, 1992; Barker, 1999; Wales, 1998). Solution focused Therapy (SFT) can offer nurses a robust framework on which to build appropriate and effective nursing interventions Wales (1998). Solution Focused Interventions (SFI) are client focused, they aim at staying as close to the clients agenda as possible, finding what works for them by developing a strong collaborative relationship and a clear picture of client goals. An evaluation of the impact of solution focused communication training programme for registered nurses and health visitors was carried out by Bowles, Mackintosh and Torn, they found that the approach increased the nurses confidence and led to more solution oriented communication rather than focusing on problem talk, (Bowles, Mackintosh and Torn, 2001).

One of the central assumptions of SFI is that the individual and people around them may already possess the solutions to the issues which are causing them dis-ease, and the interactions between the client and the nurse, in this context, involves assisting the person to rediscover these solutions through the narrative process.

- People have the resources to make changes
- People define the Goal
- There are always exceptions to problems

The two-day introduction to Solution Focused Interventions was carried out twice, with the majority of nursing staff attending, thirteen in total. The weather conditions on one of the days was very bad, with snow fall causing great problems with the traffic, however everyone who was expected to attend managed to get there, showing commitment on the part of the staff. The workshops were very interactive, with role-play and practice making up a significant part of the activity, it is to be noted that the participation level of all was high and many questions were asked during the process.

At the start of the two-day programme each nurse was given a questionnaire, (Appendix 3) which was completed at the end of day two. Only two nurses had completed any communication training post qualifying, an introduction to Cognitive Behavioural Therapy and one person was trained by the Samaritans. The information gathered indicates that all the nurses felt their knowledge and confidence in using SFI had increased by the end of the two-day introduction, on average a move up the scale of between 4 and 7 points. That all nurses felt that SFI would be useful with this client group with the majority rating from 8-10 on the scale with the lowest point being 6.

The Adult nurses felt in the beginning that they were at a disadvantage to the mental health nurses when talking to the clients, their confidence was low and they felt their knowledge was more useful in a physical health setting. However they appear to have benefited considerably from the study and have taken the interventions on board, one Adult nurse made
some cards with the specific interventions written on them, had them laminated and takes them with her to use as prompts for interventions when talking with clients.

Arthur (1999) developed a tool for Assessing post qualified nursing students’ basic communication and interviewing skills that were studying a two-year bachelor of nursing programme in New South Wales. His findings showed some interesting results, following the observation of the student nurses interviewing on video, it was noted by Arthur that the types of questions being asked by the nurses were not particularly helpful. With some students trying to solve issues rather than building rapport and helping the client to move toward problem identification and solution, also the closed questions being asked by some of the nurses only allowed for one-word answers. Some students asked questions which led the clients e.g. ‘do you think you have a problem?’ Within this study there was an indication that the nurses felt similar difficulties, but were keen to change their communication patterns and notable changes were observed during the introductory period.

Although at an early stage, the evaluation to date, concurs with some of the findings of the study carried out by Bowles et al (2001); the nurses could choose not to play the role of the expert, that the nurses feel that their confidence has increased particularly, in the prison healthcare setting when talking with clients who have self harmed. Bowles suggests that within their study, the dynamics of the nurse-patient interaction had shifted from being negative and problem oriented to being positive and solution focused, (Bowles et al 2001). The nurses who took part in this process have stated this in each subsequent meeting.

Women users of mental health services state that they want more access to a range of ‘talking therapies’ and less reliance on medication (DoH 2002). Within the prison population assessment of risk to self is an important factor, in particular during admission and following sentencing. Self-harm is of significant concern with the women, during the initial study-day although stating that they strove to be non-judgmental with the client groups, labels were used to identify some of the women which may not have been substantiated with fact, for instance borderline personality, complex case etc. These terms can lead to negative stereotyping and as a consequence affect the nurse-client therapeutic relationship. By reinforcing the values of SFT, which move away from labelling and the guidelines from the NMC Code of Professional Conduct (2002), emphasising the importance of the therapeutic relationship and working alongside the client, these stereotypes were challenged in a non-threatening way.

As with the programme developed by Barker (1996) the introduction to SFI emphasised the value of listening for talk about ‘strengths’ and ‘abilities’. The nurse was encouraged to seek these out from the client using language aimed at;

- Empowering the client, finding out what had or had not worked in the past.
- Seeking the client’s view of their future without their present difficulties.
- Assisting the client to find examples of times when the problem is less.

In discussion in the supervision sessions it is these changes from problem-focused language that causes the nurse to reflect most on their practice, but through further role-play and talking about possibilities it will become more part of their everyday process and this is of significance to the client group. Based on the work of Greene, Mo-Yee Lee, Trask and Reinschsheld (1996) and Callcott (2003) including their recent experience of using SFI the team has developed a self-harm assessment tool and this is currently being audited (Appendix
6A, B & C) with a plan to disseminate the information to a wider audience. Some of the Prison Officers have observed the nurses using Solution Focused language in their assessment and as a consequence have partially taken it on board, in particular the Scaling Questions.

Looking forward, the nurses who are taking part in this study have embraced the holistic nature of SFI and the assessment tool they have developed is clearly client focused in its language and intent, they are keen to continue using the approach and developing their practice, and have continues to develop further assessment tools incorporating SFI language. The process of Supervision will continue and a further evaluation will take place within the near future when a full report will be written and disseminated to a wider audience.
References


Department of Health, (1998a) A First Class Service: quality in the new NHS. HMSO. London:


Appendix 2

Working with Women in Prison Healthcare
Introduction to Solution Focused Interventions

Day One

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.30</td>
<td>• Introductions</td>
</tr>
<tr>
<td></td>
<td>• Women inn Prisons myths &amp; reality</td>
</tr>
<tr>
<td></td>
<td>• Exploring objectives</td>
</tr>
<tr>
<td>10.30</td>
<td>Break</td>
</tr>
<tr>
<td>11.00</td>
<td>• Problem Free Talk</td>
</tr>
<tr>
<td></td>
<td>• A good day</td>
</tr>
<tr>
<td>12.30</td>
<td>Lunch</td>
</tr>
<tr>
<td>1.15</td>
<td>Exception seeking</td>
</tr>
<tr>
<td>2.30</td>
<td>Break</td>
</tr>
<tr>
<td>3.00</td>
<td>What can we take into practice?</td>
</tr>
<tr>
<td>4.00</td>
<td>Finish</td>
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</table>

Day Two

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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</thead>
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<tr>
<td>09.30</td>
<td>• Thoughts from yesterday any questions?</td>
</tr>
<tr>
<td></td>
<td>• Scaling</td>
</tr>
<tr>
<td>10.30</td>
<td>Break</td>
</tr>
<tr>
<td>11.00</td>
<td>Scaling</td>
</tr>
<tr>
<td>12.30</td>
<td>Lunch</td>
</tr>
<tr>
<td>1.15</td>
<td>Miracle Question</td>
</tr>
<tr>
<td>2.30</td>
<td>Break</td>
</tr>
<tr>
<td>3.00</td>
<td>What can we take into practice?</td>
</tr>
<tr>
<td>4.00</td>
<td>Finish</td>
</tr>
</tbody>
</table>

Maureen Smojkis 2004
Appendix 3

Day One morning

1. What is your Nursing background? Adult/General Mental Health Other
   If other, please specify.

2. Have you done any communication/counselling skills training since qualifying as a nurse? Yes No
   If Yes, what?

3. On a scale of 0-10 with 0 being nothing and 10 being a lot, how much do you know about Solution focused Brief Therapy?
   
   0…1…2…3…4…5…6…7…8…9…10

4. What would you like to take from this two-day introduction to Solution focused Brief Therapy?

Day Two afternoon:

5. On a scale of 0-10 with 0 being nothing and 10 being a lot, how much do you know about Solution focused Brief Therapy?

   0…1…2…3…4…5…6…7…8…9…10

6. On a scale of 0-10 with 0 being of no use and 10 being very useful, how useful do you think Solution Focused Interventions can be when working with women in prison?

   0…1…2…3…4…5…6…7…8…9…10

7. What will you take from this two-day introduction and apply in practice?
Appendix 4

Group Work One

How does the public view women prisoners?

How does the prison service view women prisoners?

How do the women prisoners view themselves?

Group Work Two

How does the public view nurses who work in prisons with women?

How do the prison service view nurses who work in women’s prisons?

How do nurses view their role when working with women in prison?

Maureen Smojkis 2004
Appendix 5A

A Good Day

Tell me about a day recently when you felt that things were going well

What was happening on that day that makes you say things were going well?

What else was happening?

Who else was around on that day?

What were you doing on that day?

What were you thinking when things were going well?

What did it feel like for you on that day?

Who else would notice that things were going well on that day?

What would they say about you on that day?

Are there any parts of your good day that are happening now?

Maureen Smojkis 2004
Appendix 5B

**Scaling Questions**

Imagine a scale from zero to ten with zero representing the worst that things have been and ten representing the way you want things to be when the problem is resolved.

0 1 2 3 4 5 6 7 8 9 10

**Key Question: What else?**

Read all the questions, they do not necessarily follow a sequence. Ask them in your own way.

- Where do you see things right now on the scale?

- What is it that has helped you to get from 0 to where you are now?

- What is it that tells you that things are at that point on the scale and not at 0?

- What will tell you that you have moved up one point on the scale?

- What will represent ‘good enough’ for you?

- How will you know you are there?

- How will you know you are at 10?

- What is one small thing that you would like to do over the week that will take you up one point on the scale?

*Maureen Smojkis 2004*
Appendix 5C
Exception Seeking Questions

Read all the questions they do not necessarily follow a sequence. Ask the question in your own way. Practice putting the questions into your own language to match the person you are asking them of.

Key questions to ask once they have given an answer is ‘what else?’

Or you can elaborate by asking ‘what would other people notice?’

Or specify a person by name, ‘what would **** notice about you when you have forgotten about the problem?’

- You were telling me about how difficult it was to get through this, has there been any time over say the last month when you have thought things might be a little better?

- Tell me about the times when, for you, the problem seams less?

- Tell me about the times you manage to cope despite the problem?

- You said there where times when you forget about the problem, tell me about them. What’s happening during those times?

- When things are feeling tough, how do you manage to get through the day?

Maureen Smojkis 2004
Appendix 5D

**Miracle Question**

Imagine when you go to sleep one night a miracle happens and the things we’ve been talking about disappear. As you were asleep, you did not know that a miracle had happened. When you woke up what would be the first signs for you that a miracle had happened?

What else would you notice?

How would that make a difference?

Who else would notice that a miracle had happened?

What would be happen as a result of that?

Has there been a time when even a small part of this miracle has happened?

How did that come about?

---

*Maureen Smojkis 2004*
Appendix 6A

F2052SH: Nursing Assessment: Date: Time:

We would like to ask some questions to check out how safe you are at the moment.

1. You must have had a good reason for doing this. How come this has happened now?

2. Have you done anything like this before? If yes: how was doing this useful to you before?

3. On a scale of 0-10 with 0 being you would harm yourself at the first opportunity and 10 being you have no intention to harm yourself; how safe would you say you are?

   0 1 2 3 4 5 6 7 8 9 10

4. What’s happening right now that makes you say you are at this point?

5. What keeps you going right now?

6. On a scale of 0-10 how able do you feel you are to get through this next few hours without attempting to harm yourself? Where 0 means you have no chance and 10 that you feel you are able to keep yourself okay

   .0 1 2 3 4 5 6 7 8 9 10

7. What makes you feel you are at this point

8. What needs to happen for you to move nearer to 10?

9. Is there anything else relating to what’s happened that you think it’s important for us to know?

Maureen Smojkis 2004
Appendix 6B
Self Assessment

Date:    Time:

On a scale of 0-10 with 0 being you would harm yourself at the first opportunity and 10 being you have no intention to harm yourself; how safe would you say you are?

  0   1   2   3   4   5   6   7   8   9   10

Date:    Time:

On a scale of 0-10 with 0 being you would harm yourself at the first opportunity and 10 being you have no intention to harm yourself; how safe would you say you are?

  0   1   2   3   4   5   6   7   8   9   10

Date:    Time:

On a scale of 0-10 with 0 being you would harm yourself at the first opportunity and 10 being you have no intention to harm yourself; how safe would you say you are?

  0   1   2   3   4   5   6   7   8   9   10

Date:    Time:

On a scale of 0-10 with 0 being you would harm yourself at the first opportunity and 10 being you have no intention to harm yourself; how safe would you say you are?

  0   1   2   3   4   5   6   7   8   9   10

Maureen Smojkis 2004
Appendix 6C

Evaluation Form

Name:

Date: Time:

On a scale of 0-10 with 0 being you have found using these scales of no use and 10 being you have found them to very useful; how useful have you found the scales?

0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10 with 0 being you would never use the scales again and 10 being you would definitely use them, how likely do you think you are to use the scales again?

0 1 2 3 4 5 6 7 8 9 10

Please add any other comments

Maureen Smojkis 2004
ENQUIRY BASED LEARNING

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The aim of the poster is to highlight a teaching innovation/strategy called Enquiry based learning. An Bord Altranais (1999) notes that nurses’ work in an environment where change is constantly taking place. Particularly highlighted are the effects of demographic and epidemiological changes, the growth of information technology and the changing social and education base of the population. Practice is becoming increasingly specialised and complex. Practitioners need to be able to respond this complexity and flexibility. Therefore to ensure that Quality health care is cost effective and delivered at a high standard it is important that clinical actions are based upon research evidence. Enquiry based learning (EBL) appears to offer an ideal method of addressing these concerns within a dynamic and responsive curriculum.
THE INTERDISCIPLINARY TEACHING MODEL: A CASE FOR MIDWIVES AS EDUCATORS OF MEDICAL STUDENTS AND RESIDENTS.

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Providence, Rhode Island 02905 USA

Background: Midwives have often practiced in the same place at the same time with medical students and residents. Until approximately ten years ago very little was published about their formal interaction. Since 1993, when articles first appeared describing the subject of midwives educating medical students, a growing body of literature on interdisciplinary education has emerged. Midwives educating medical students and residents can be part of a strategy for teaching hospitals to comply with mandated changes in philosophy of education and resident working hours.

In the current health care climate, professional education needs to equip future physicians with knowledge and skills to function efficiently in an increasingly complex network of interdisciplinary teamwork. Institutions need to provide a learning environment that is safe for both learner and patient. Midwifery involvement in medical education can add value to medical student clerkships and residency programs. At the same time midwives may be able to increase their own marketability in this niche and promote excellent care of women.

Design: In this presentation, the US and some Great Britain literature on interdisciplinary education will be reviewed. The question of midwifery's role in the education of medical students and residents will be discussed. Several models that exist in the US will be described.
Psychiatry of Old Age - Review of Consultation Liaison referrals 2002

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INTRODUCTION (incl. Background, aims & objectives)

With the appointment of a new Consultant in Psychiatry of Old Age in October 2001 for Sligo/Leitrim/West Cavan/ South Donegal, and the continuing development of a multidisciplinary team, we felt it timely to review consultant liaison referrals to date with respect to age profile, sex, demography, location, referral agent, diagnosis and clinical need. This is to address future service planning and true needs assessment.

In a review of twenty-eight studies over 15 years, (10 from the U.S., 7 from the U.K, 2 each from Australia and Ireland, 1 each from Hong Kong, Italy, the Netherlands, Sweden and Switzerland) Draper concluded "formal service evaluation has found that the benefits of geriatric psychiatric consultation liaison service include reduction in lengths of hospital stay and costs, increase in depression recognition, improved physical functioning, fewer nursing home transfers and increased utilisation of community services post discharges.

METHODOLOGY:

Retrospective case note review of all consultant liaison referrals to the new Psychiatry of Old Age service between January 2002 and December 2002, paying particular attention to age, sex, demography, location, referral agent, diagnosis and unmet need. We looked at Sligo General Hospital referrals and community settings - 3 Community Hospitals and ten local residential care settings.

RESULTS

The referrals from community hospitals were looked at by area. 51(53%) of community hospital referrals were from St. John's Hospital.

<table>
<thead>
<tr>
<th>TOTAL NUMBER OF CONSULTANT/LIAISON REFERRALS = 152</th>
<th>MEAN AGE 79 -84 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females 84</td>
<td>Males 68</td>
</tr>
<tr>
<td>SLIGO GENERAL HOSPITAL = 56 (37%)</td>
<td>ST. JOHN'S HOSPITAL = 51 (53%)</td>
</tr>
<tr>
<td>45% Medical Wards</td>
<td></td>
</tr>
<tr>
<td>30% from Geriatrician Dr. P. Hickey</td>
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</tbody>
</table>

Consultant/liaison referrals were over-referrals in the total number due to the way the service was set up initially.

DIAGNOSIS

<table>
<thead>
<tr>
<th>Organic illness 43%</th>
<th>Functional psychiatric illness 48%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia 33%</td>
<td>Depression 35%</td>
</tr>
<tr>
<td>Delirium 48%</td>
<td>Psychosis or other psychiatric diagnosis 13%</td>
</tr>
<tr>
<td>Dual diagnoses 13.5%</td>
<td>Community support would benefit 36% - 61</td>
</tr>
<tr>
<td>Day Hospital intervention necessary 20% - 33</td>
<td></td>
</tr>
</tbody>
</table>
CONCLUSION: The types of referrals received are in keeping with studies elsewhere. The results should be interpreted with caution as the service is limited at present, but we are already identifying a need for community support, psychology intervention plus day hospital as planned. It will serve as a useful baseline for future review.
A Proposal for a Symposium on Sure Start from Professor Roger Ellis and Dr Elaine Hogard of University College Chester.

This is a proposal for a symposium of five papers addressing the topic of Sure Start and its Evaluation. Sure Start is the major single UK Government initiative devoted to improving the start in life of children born in socially and economically disadvantaged circumstances. Local groups are encouraged to bid for government support based on a needs analysis of an area and indicating the structures that would be established to bring better health, social and educational support to under fives and their parents/carers. Proposals must demonstrate how they would meet 23 government objectives including the enhancement of social, health and educational provision, better integration between services and community development.

At present 534 schemes have been supported by the government and they are, by definition, concentrated in areas of disadvantage. Typically a scheme has an annual operating budget of £. 5 million and a capital investment of £2 million. Schemes usually employ around 15 staff including a programme manager. It is a condition of funding that the scheme commissions an independent evaluation.

This symposium addresses Sure Start, its origins, nature, achievements and problems and the distinctive problems faced in evaluating local schemes. A novel approach to evaluation, the Ellis-Hogard Trident, is described in detail and related to levels of evaluation within schemes. Three evaluation studies are presented one addressing interprofessional communication using a novel communication audit; one considering the cost effectiveness of two schemes, and one considering the role of the Sure Start Midwife. The latter role is typical of Sure Start appointments, which are intended to develop innovative practice that can then be mainstreamed into statutory provision.

The five papers in outline are as follows.

**Sure Start: Worthy but Complex**
Professor Roger Ellis UUC

This paper describes the origins, nature, objectives practices and problems of the 500+ Sure Start schemes, which aim to improve the educational, health, and social status of disadvantaged families during the early years of life. In particular the paper examines the relationship between Sure Start and statutory health provision including health visiting, district nursing and midwifery.

**Using the Trident Model to Evaluate Sure Start**
Dr Elaine Hogard SHEU UUC

This paper describes the novel trident model of evaluation that focuses on outcomes, processes and multiple stakeholder perspectives and its application to the evaluation of local sure start schemes. The paper describes mini-projects within an overall evaluation that address specific forms of delivery; whole scheme issues; and comparative studies across schemes. Various forms of data gathering are described including the involvement and training of community volunteers.
Interprofessional Working? A Communication Audit to Assess Communication between Sure Start Staff and the Statutory Social and Health Services.
Dr Elaine Hogard

This paper describes the novel use of a communication audit to assess the positive and negative aspects of communication between and within Sure Start and the statutory social and health services. The audit reveals aspects of good and relatively dysfunctional practice and leads to recommendations for improvement.

Cost Effectiveness of Sure Start Schemes
Katrina Stredder SHEU UUC

This paper describes the development of a model to assess the cost effectiveness of Sure Start schemes including the identification of focus; direct and indirect costing; indices of effectiveness; and comparison. Examples are given from the comparative study of two Sure Start schemes.

The Role of the Sure Start Midwife.
Adele O Keefe SHEU UUC

This paper describes the evaluation of a Sure Start Midwife using the trident approach to address outcomes and the extent to which they are met; process including the activities of the Midwife; and multiple stakeholder perspectives including those of parents and kindred professionals. The Sure start Midwife is a good example of a fixed term Sure Start appointment who is expected to innovate in bringing support to disadvantaged parents and whose work may, if successful, be mainstreamed into statutory provision.
Evaluating Sure Start: Exploring Outcomes, Processes and Stakeholder Perspectives in a Complex Interprofessional Initiative

Professor Roger Ellis OBE DSc MSc BA CPsychol ABPsS TCert Director of Research, University College Chester

Dr Elaine Hogard PhD MSc MA BA Director Social and Health Evaluation Unit, University College Chester

This paper describes an independent evaluation of a major government initiative in the UK, Sure Start, aimed at improving the social, health and educational status of disadvantaged children under the age of 5. There are over 500 approved schemes in the UK each of which aims to provide support services to parents carers and children in socially and economically deprived areas through an integrated approach involving statutory social and health services, specially appointed Sure Start staff and community volunteers. Typically each scheme has a budget over a five year life of more than £3 million so in total this represents the major single government investment attempting to address social inequality and exclusion Each scheme must commission an independent evaluation and the paper describes a distinctive approach to this using the Trident method developed by the authors. This focuses on measurable outcomes; processes of delivery; and the perspectives of multiple stakeholders affected by the scheme. Three levels of evaluation are described focusing on specific forms of delivery; aspects of the organisation and management of the scheme as a whole; and comparative strategic evaluations across schemes. Three exemplary case studies are presented including evaluation studies of interprofessional communication; cost effectiveness; and the role of the Sure Start Midwife.
The sources and communication of information by nurses caring for older adults in forty-eight simulated clinical situations

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Background: A comprehensive review of the literature indicated that nurses when making clinical decisions and judgements would use information of some type. Some of this information will be stored in the decision-maker's memory, other will be obtained as part of the decision making process (Thompson and Dowding 2002). Research by Lamond et al (1996a) found that the information sources used by nurses when making decisions at work, included the patient, other nurses, doctors, the patient's family, written evidence, the nurse themselves, and others. However, if nurses are to make informed decisions based on information from others, it then follows that this information would first have to be made available to that nurse by means of some form of communication. The literature indicates that this information may not be adequate. For example, there are differences in the type of information communicated in verbal hand over reports and in written patient records (Lamond 2000). This suggests that not all information concerning patients would be made available to all other nurses involved in their care - information only communicated verbally at handover report will necessarily be available to fewer personnel than that recorded in the notes. The notes themselves may be less than comprehensive, and not adequately describe the patient's status and condition (Taylor 2003).

The research questions: Are there differences and/or inconsistencies in the seeking of information, and the communication of the information obtained when a nurse observes the same 'minor' and 'significant' condition changes in a patient both known, and not known to them?

The study design: The study was conducted by means of a structured interview. The respondents were presented with forty-eight cards in turn. Each described a simulated scenario that the nurses were asked to imagine that they had encountered during the course of a working day. The cards described twenty-four different scenarios twice - once involving a patient that the nurse had to pretend that they knew well, and again for a patient that the nurse did not know well. These were further divided into twenty-four describing a 'minor' change in the patient's condition, and twenty-four representing more 'significant' changes in condition. The nurses were asked to state for each scenario where they were most likely to go for the information that they would need to deal with the situation, and how they would then communicate that information.
The sample: The study was conducted on a non-probability sample of twenty-eight Registered Nurses. The sample nurses worked in either independent care homes, or NHS hospitals, and were all involved in the provision of care for older adults.

The analysis: Data were analysed quantitatively using SPSS 9.0 for Windows.

Results: It was indicated that where nurses go for information will depend very much on the type of decision that they need to make. However, the patient was strongly promoted as an important information source. When a nurse knew a patient they were more likely to rely on their own knowledge and experience when making decisions, than if they did not know the patient well. The most common mode of communication was that of documentation. But it was also shown that the nurse might not communicate even quite significant changes in patient condition in any way. This information, and that only communicated verbally to the small number of nurses present at shift handover, in effect will be lost and not available to others caring for that patient.

Information needs of myocardial infarction patients

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Purpose: The main objectives of this study were to information needs of MI patients and to compare these with their perceptions 6 weeks after the event and also with their nurse educators.

Method: The data were collected by a questionnaire, the Cardiac Patients Learning Needs Inventory (CPLNI) that was administered to both patients and nurses. It comprised 37 ‘needs’ items grouped into 7 categories, each item to be scored into one of five levels of importance. There were 27 patients interviewed on the first occasion, of whom 18 responded to a postal questionnaire on the second occasion. A census of three groups of nurses was taken in the study, namely all nurses employed in one coronary care unit and in a cardiac ward at a large Dublin Hospital and all nurses employed as cardiac rehabilitation nurses/officers in Ireland at the time of commencement of the study. Sixty eight nurses responded, a response rate of 80%.

Results: A key finding was that the responses were highly skewed, with two thirds in the top grade (very important) and less than 1% in the two lowest grades. The overall response score distribution of the patients differed somewhat from that of the nurses, but this difference was accounted for by mainly 3 items, all in the ‘physical activity’ category, namely ‘when to resume driving’, ‘when to resume sexual activity’, and ‘when to resume work’, which the nurses scored high and the patients low. Both patients and nurses gave the highest mean scores to four items, namely ‘what to do when in chest pain’, ‘what are the symptoms of a heart attack’, ‘when to call a doctor’, and ‘what to do to reduce the chance of another heart attack’. The first three of these are in the ‘symptom management' category.

Conclusion: These findings of this study are significant as it is the first survey of this kind that includes the views of a large sample of cardiac rehabilitation nurses. In addition, it is the first to reveal consistencies between nurse and patient views, and highlight symptom management as a priority. The findings also highlight methodological issues with the use of the CPLNI hitherto not reported in the literature.
IS IT EVER RIGHT TO USE COERCION IN PATIENT CARE?

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The aim of this paper is to investigate coercion and its use in patient care. A case study was used to ground the analysis in clinical practice. Edwards (1996) proposes nurses use a principle based approach (first espoused by Beauchamp and Childress 1983), to analyse ethical problems encountered in their practice. This approach consists of four key principles: the principle of respect for autonomy, beneficence, nonmaleficence and justice. The obligations one has under these principles will be examined in context of the case study, that is, respect for others, prevention of harm and treating others fairly. The conclusion drawn from the analysis suggests there is a duty as a healthcare professional to collaborate as much as possible with patients concerning their care.

References:

INTRODUCTION OF A PAEDIATRIC POST-OPERATIVE PAIN ASSESSMENT TOOL IN A SURGICAL DAY UNIT (WITHIN A GENERAL HOSPITAL)

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Clinical Placement Co-Ordinator
NPDU
Mid-Western Regional Hospital
Limerick

BACKGROUND
Paediatric pain assessment and management is a complex phenomenon. Therefore, it is important that consistent methods for assessing and evaluating pain are used. Pain is a subjective experience and according to McCaffrey cited in O’Keefe (2002), it can be defined as “whatever the patient says it is, and exists whenever he says it does”. However, in children, this is influenced by many other factors, including developmental level, cognitive function and language ability of the child (McRae, et al 1997). Therefore, effective management of any child’s pain requires that it is accurately assessed (Nethercott, 1994).

The aim of the assessment is to identify all factors that can effect the patient’s perception of pain (Marsden Manual, 2000). Following assessment, the intervention required can be either pharmacological (analgesia) or non-pharmacological (psychological and physical techniques) or a combination of both.

SAMPLE OF SELECTION METHODS
• Literature Review
• Presentation of findings to staff
• Questionnaires pre and post presentation
• Retrospective Admission Statistics (to assist in choosing appropriate tool).

RESULTS
• No formal assessment tool in use
• 27% Admissions were children (1,380 in 2003)
• Mean age profile of child = 6yrs
• 70% staff felt a “tool” would be beneficial (10 staff in the sample group)All staff felt parents should be involved in the assessment (partnership approach)

CONCLUSION/RECOMMENDATIONS
The outcome of the research is that an assessment tool (Wong/Baker Faces Pain Scale) is currently in the process of being introduced as a pilot project in the day ward. This is to give staff an opportunity to critically analyse its’ utility and assess how user-friendly it is for staff, patients and their parents. Following on from this pilot, which, will last approximately one month, the final draft will be confirmed and introduced, with a view to auditing it on a regular basis.

As other members of the multi-disciplinary have been involved in the discussions about this project from the start (i.e. anaesthetists), their continued support and advice will be much appreciated.
The impact of education on handwashing practices

Presenter:  
Ms Teresa Wills, MSc, BNS, RM, RGN,  
College Lecturer, School of Nursing & Midwifery, University College Cork.

Modern healthcare has to contend with the major problem of infections which constitutes one of its greatest challenges and occurs due to lapses in accepted standards of practice. Handwashing is a practice with a clearly demonstrated efficacy and remains the cornerstone of efforts to reduce the spread of infection.

The aim of this quasi-experimental study was to evaluate the effectiveness an educational programme had on the handwashing behaviours of student nurses. Data was collected using observation from a simple random sample of forty participants. A combination of descriptive and inferential statistics was used to describe and explore relationships in the data.

Findings indicate that there was no significant difference between the experimental and control group in the pre-intervention period. However, in the post-intervention period there were significant increases in all aspects of handwashing behaviours following the educational programme for the experimental group while in the control group there were no changes.

This study highlights the need for
- Nursing curriculum development with emphasis on microbiology and handwashing.
- Clinical workshops on handwashing and prevention of infection to be provided for all health care professionals in clinical areas.
- Health care professionals to be aware of current research pertinent to handwashing.
Can we say it was tested for construct / content validity, internal consistency / reliability etc.?

How did this happen? Has anyone got the questionnaire?

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Gerry Moore to check spelling