School of Nursing and Midwifery
Trinity College Dublin

7th Annual Interdisciplinary Research Conference

Transforming Healthcare Through Research, Education & Technology

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An Evaluation of an On-Line Learning Support Package for Post-Graduate Nursing Students.

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Background and context
In response to a request from health care service providers an online learning support package was developed for post-graduate nursing students prior to commencing their course. The students to whom this was made available had diverse educational backgrounds and anecdotal evidence from previous years suggested that many of these students found their course challenging. The on-line learning support package provided information on study skills, writing skills and computer skills. It was anticipated that the provision of the e-learning resources would help these students address their learning needs prior to commencing the course.

Aim of the study
This study evaluated an on-line learning support package for post-graduate nursing students.

Methodology including research design and sampling
A questionnaire was developed to determine the demographic details of the students, the user-friendliness of the package and the relevance of the package’s content. The questionnaire was distributed to all members of the target population who were present on the selected day of distribution. The questionnaire was completed by 54 students.

Analysis
Data were analysed using excel.

Summary of key findings
Of the students who enrolled on the course, 18.5% of the respondents accessed the course prior to commencement. They reported that the package was easy to use, easy to read and simple. Some students did however indicate difficulties with accessing the course initially. Of the three skills available on the course the most used were the computer skills and the study skills. Writing skills were least frequently accessed.

Of those who did not access the course the primary reason given was lack of time.

Conclusions
Although it has been reported that students often encounter difficulties with study, computer and writing skills, the findings of this evaluation suggest that many students may not avail of a preparatory course when available. There may be several explanations for this. Students stated a lack of time to work through the material as their main reason for not using the online package. Another possible explanation may be that the educational
profile of students on post registration courses is changing to one where more of them have studied at degree level and therefore believe they do not need support with developing these skills.

Given the fact that some students did perceive a need for help in relation to study, computer and writing skills and that they found the online package beneficial, underlines the effectiveness, efficient use of resources and flexibility of online learning materials. Having these resources online freed up class and lecturer time to deliver actual course content. The majority of students undertaking the programme did not have to attend sessions on skills they would have considered irrelevant to their own learning needs, however students who did need support in this area had resources available to them before and throughout the programme.
The Regulation of Ethical Issues in Research Involving Human Subjects: A Review

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Aim of review
To review the development of systems for the ethical regulation of research involving human subjects with particular reference to the contribution of the philosopher Onora O’Neill (O’Neill 2002).

Summary of key findings
- Current concepts of informed consent have their origins in the Nuremberg Code (1949)
- Research scandals involving lack of informed consent (Tuskegee, syphilis experiment; Porton Down, biological warfare; Alder Hey, organ retention) are said to have undermined public trust in the probity of researchers
- International and national organisations have attempted to provide reassurance to the public by means of ever more prescriptive and bureaucratic systems
- There is perceived to be a serious risk that restrictive regulatory regimes will stifle worthwhile research

Conclusion
Onora O’Neill has argued that society needs to re-consider the application of the concept of personal autonomy as it relates to research subjects, because the quest for total information-giving and complete transparency in the research process has no obvious end. She also argues that it does little to restore public trust in researchers, yet trust is an essential aspect of life in human societies.

Reference
An Evaluation of the Higher Diploma Student Nurses’ Perceptions of their Clinical Learning Environment

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Background and Context
The clinical learning environment is responsible for developing student nurses' skills, knowledge and professional socialisation. From review of the literature currently available, it is evident there is a scarcity of research available that evaluates the Higher Diploma student nurses’ perceptions of their Clinical Learning Environment. However, the literature identifies five main characteristics of the clinical learning environment. These five characteristics are: - nurse manager commitment, preceptorship role, facilitator role, staff student relationships and student evaluation.

Aim of the study
This study aimed to evaluate the effectiveness of these clinical learning environments from a Higher Diploma student nurses' perspective.

Methodology
The perceptions of the Higher Diploma student nurses were evaluated by means of a postal survey. A Probability sample of ninety-six participants, all of who had completed a Higher Diploma nursing programme with the National University of Ireland, Galway, participated in the survey.

Analysis
Data was analysed using the Statistical Package Social Sciences v.12, which incorporated both correlational statistics and descriptive statistics.

Summary of key findings
The findings were largely positive towards the clinical learning environment, however, a number of problems were identified which hindered the Higher Diploma student nurses’ clinical learning. These problems were related to students being primarily accepted as
workers as opposed to learners, poor clinical preceptorship, lack of facilitator involvement in students’ clinical learning and inadequate students evaluations. However, these findings did indicate that the Higher Diploma student nurses’ perceptions of their clinical learning environment were similar to that of undergraduate student nurses.

Conclusion
The emphasis on clinical learning and the development of experiences from practice is an essential component in student nurses’ education. However, it is evident from the research results that a number of factors hinder this clinical learning. These factors need to be addressed through the restructuring and re-prioritising of student nurses clinical learning.
Values-based Nursing Education and Practice: Practicing What We Preach

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Background and context

In 2004, a school of nursing and health studies introduced a five-year program to embed values in education, research, and service. This program responds to a concern that, with increasingly diverse populations, there may be a belief that it is difficult to discern and instill in nursing education and practice values that are both reflective of this diversity and that are generally applicable. It was also seen as fundamental that nursing research have a values-based foundation, and that institutional practices be reflective of these values.

Aim of the study

The aim of the study is to determine mid-term progress of the initiative toward the goal of embedding values in the school’s educational, research and service activities.

Methodology including research design and sampling

The qualitative methods include: interviews with all department chairs, a 20% sample of fulltime and five part-time faculty, 10 undergraduate and graduate students, and 5 administrative staff; review of syllabi for all nursing courses; and observation of 3-5 faculty meetings. The focus of the interviews is on respondent perceptions of the utility of the values-based initiative, its impact on their particular role (e.g., nursing education), and its likely longer-term impact on nursing practice and research.

Analysis

Atlis.ti will be used to analysis the qualitative data.
Summary of key findings
The initiative has thusfar devised a core set of values that have been agreed-upon by the faculty through a participatory process, reviewed curricula to determine the degree to which these values are embedded, and initiated a process of assessing research and service activities against these core values. The interviews will be completed by August 31, and data analysed by September 30.

Conclusions
The values-based initiative has already had impact on the engagement of faculty and staff in the process of determining shared values – itself positive in terms of identifying shared concepts of common good and other values, and their implications for nursing practice.
Does the Teaching and Assessment of Midwifery Emergency Skills using Simulated Scenarios in Midwifery help Newly Qualified Midwives to feel that they could deal with a Real Life Situation in a Proficient Manner once Qualified?

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Background and Context
Clinical skills lie at the heart of midwifery practice but teaching and assessing their competence has been the subject of much debate. Within midwifery education it is imperative that we teach our students to deal with all the complexities of clinical practice and as such how to deal with an emergency situation if it arises. One recent much applauded approach to tackle this problem has been the introduction of simulated scenarios culminating with an Objective Structured Clinical Examination (OSCE). However currently there is no research to substantiate this approach. This study sought to explore the effectiveness of this approach.

Methodology including research design and sampling
To fit with the aim of the study a phenomenological approach was implemented utilising purposive sampling. Data was obtained from nine participants using a semi-structured interview.

Analysis
Using the framework developed by Colaizzi (1978) significant statements from each question were identified and extracted from the data; meanings extrapolated and aggregated into Theme clusters and subjected to thematic analysis.

Summary of key findings
This approach is well suited for skill acquisition both as a learning and assessment tool improving clinical decision-making and confidence in practice. Other important factors identified was the need for partnership in training between the Trust and the Higher Education Institutes and how the vital role that support that the newly qualified receive in practice is crucial in facilitating them applying these skills to the reality of practice.
**Conclusion**

In conclusion this study demonstrated that simulated scenario teaching culminating in an OSCE achieves the goal in equipping future midwives to deal with the complexities of emergencies in clinical practice. Therefore educationalists need to consider this approach when devising midwifery curriculum.
Recogniton of student nurse contribution to the daily workload of a registered nurse (RN) preceptor within a clinical preceptorship model of clinical education.

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Current perception, within clinical settings, is that the student nurse brings with them a burden of time to the registered nurse (RN) preceptor. Each preceptor normally has a patient load in addition to the responsibility of facilitating the learning of the student nurse. Of concern is anecdotal evidence suggesting that the preceptorship role, in educating undergraduate nursing students brings with it a burden that leads to stress, burnout and increase absenteeism amongst RNs. 

In 2004 Monash University in collaboration with a major Melbourne teaching hospital undertook a preceptorship model of clinical education for undergraduate nursing students. In partnership with the Nurse Unit Managers on each participating ward, students were preceptored with a Division 1 RN for either 2 or 3 weeks clinical experience. Student reports, clinical assessments and significant clinical teaching were conducted by these preceptors within the daily workload time. 

The aim of this paper is to:-  
1. Determine what time preceptors spend with their undergraduate nursing students in teaching and skill development 
2. Time nursing students are working independently of their assigned preceptors undertaking care usually performed by the preceptor. 

A descriptive quantitative methodology was used incorporating a spreadsheet that the student nurse completed during their clinical placement identifying time spent undertaking tasks with the preceptor.
Data was quantified by the hours of work the student completed. The data demonstrated that the students’ contributed xxx amount of time assisting with the preceptor’s workload. It was found that with increasing knowledge and skill base that the time students worked independently increased as the clinical evolved.

This paper will describe how undergraduate student nurses contributed to a preceptor’s workload during the time the students were present.
Midwives’ Experience of Personal Pregnancy Related Loss

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Midwives are frequently asked whether they have children, and often report difficulties in answering, particularly when they have experienced pregnancy related loss. The aim of this study was to explore the effects of pregnancy related loss on midwives and to see how this influenced relationships with their clients and colleagues.

A grounded theory approach was used. The sample was a self-selected, self-reporting group of forty female midwives from the United Kingdom. The midwives provided written, narrative accounts of their experiences using a structured framework. Ten purposively selected participants took part in further in-depth interviews. The findings suggested that midwives’ own pregnancy related losses, including infertility, miscarriage, termination of pregnancy, stillbirth and neonatal death, influenced their personal and professional relationships. In common with non-midwives in similar situations, some midwives found it difficult being with pregnant women or babies, although most differentiated between longing for their own baby, and envy of other babies. Some found difficulty working in particular areas, for example labour ward, although there seemed to be no link between the type of loss, and problematic areas. Most participants spoke of their love for midwifery, and their determination to continue despite difficulties. At work, participants valued practical and emotional support. Some participants suggested that their experiences had increased their practical knowledge and understanding and motivated some to improve support systems for clients and for colleagues. Many participants mentioned the therapeutic value of involvement in the study.

Midwives in the study could not avoid evidence of others’ fertility in their work. However, how they addressed this influenced their approach to work. Recommendations based on the findings include the need to establish supportive management and teaching strategies, and for further research and awareness raising, which might help midwives and others in similar occupations following personal experience of pregnancy related loss.
Two professional worlds of palliative and continuing care delivery: district nursing and social work

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Abstract

Background: The provision of palliative care requires professional groups to work together to meet the needs of individual service users and their informal carers. The increasing number of older people has seen a concomitant increase in the number of people with chronic conditions who require continuing and palliative care increasing the need for the relevant professional groups and organisations to work together.

Aims: The study aimed to explore the worlds of work of district nurses and social workers through comparing their professional interactions in providing palliative and continuing care packages in the United Kingdom.

Methods: A multiple case study design comprising cases of the palliative or continuing care packages for eight individuals. Data were collected using patient records, semi-structured interviews and non-participant observation of case conferences.

Findings: The service user was at the centre of care provision for both district nurses and social workers. Each professional group operationalised their care differently across five themes: assessment, care delivery, focus of care, place of care and funding of care. The importance of balancing the organising of care with the delivery of care were found to be key in ensuring that the package of care met the individual needs of the service user and their informal carers.

Conclusion: The balance between care organisation and care delivery needs to be addressed within emerging primary care
delivery structures as primary care nursing moves towards case management for long term conditions.

Key words: district nurse, social worker, case study, palliative and continuing care, organisation of care
The Practice of Nursing as a Human Science

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In this presentation we explore links between the practice of nursing, narrative knowing, and nursing education. Alasdair MacIntyre’s (1984) *After Virtue* put forward a philosophical argument that professions such as nursing could be understood as a *practice*, where professionals not only possess technical knowledge but also live by a moral framework that compares humanized standards of excellence to mere technical efficiency. Knowledge of these standards is passed from senior practitioners to junior colleagues through a formalized education process that educates as well as acculturates practitioners. Standards of practice are conveyed through personal narratives informed by professional experience and subsequent reflection and introspection.

A more specific case for this narrative process in helping professions like nursing is made in Donald Polkinghorne’s (1983, 1988, 2004) arguments for *human science*, the scientific study of human and social phenomena. Polkinghorne’s *human science* differs from the traditional scientific study of the natural, empirical world in its ontology and method. Specific to this presentation we use Polkinghorne’s (1988) call for *narrative knowing*, a kind of knowing passed along through narratives that validates the shared experiences of professionals such as nurses, teachers, social workers, and psychotherapists, and which has proven helpful in training physical activity practitioners as health care professionals.

The idea of developing techniques for health care professionals supported by research methods more appropriate to face-to-face practitioners is not new. In arguing for more efficacious practices Polkinghorne (2004) argued, “Effective practices of care require that practitioner actions are decided by … situated and timely judgments … in which practitioner and person served are engaged in face-to-face interaction.” The question needs to be asked, “Why does the case for nursing as a human science – as opposed to positive science - need to be made?”

Polkinghorne and others engaged in “helping professions” began to notice in the 1970s that there was a significant difference, or what he called a “discontinuity,” between academic research and professional practice in psychotherapy. Other academics training professionals in social sciences noticed a similar breach. These professionals and academics further noted that there is significant pressure to develop therapeutic techniques that are based on “empirically verifiable” modes of inquiry, or research that is conducted within a framework that maintains a form of skepticism about knowledge that insists that there be no possibility of error. In practice this means that one ought not to claim knowledge about anything unless one is absolutely certain about its reliability and...
validity (Polkinghorne, 1984). This level of scientific skepticism, fundamental to natural science, is problematic for developing a body of knowledge in the professions like nursing, psychotherapy, education, and social work (Polkinghorne, 2004).

Generally speaking, the limitation of positive science is that it minimizes or delegitimizes entirely types of knowledge that could be used in judgment based professions such as psychotherapy, education, social work, and relevant to this argument, nursing. Polkinghorne’s argument applies to practices that involve direct person-to-person interaction and require situated and timely actions and responses. In practices such as nursing, human interaction is critical to the success of the therapy. It is our argument that nursing education, like health fitness and dance therapy, can utilize concepts of culture building, embodiment, embeddedness, narrative knowing, and other holistic concepts of physical activity to justify judgment based nursing activities.

At one time positivist methods were thought to be the salvation of the human and social sciences. Auguste Comte proposed that the study of human phenomena be conducted in a manner similar to the study of the natural world. Comte argued that “All fictitious or ‘negative’ philosophical speculation about the human realm...should be given up, and instead, the ‘positive’ or scientific study of human beings should be undertaken” (Polkinghorne, 1983, p.17). John Stuart Mill (1843/1936) provided the philosophical foundation for the positivist understanding of the natural world, and while Mill’s assumptions were adjusted and evolved throughout the 19th and 20th centuries they continue to inform and provide the basis for contemporary research. In practice positivism is a philosophy and world-view that is assumed to best study the “natural world,” and creates a hierarchy of sciences that recognize a “positive” conception of truth (Toulmin, 1990, 2001). Positivist methodologies purport to establish knowledge that is absolute and indubitable, and of which the researcher can be “positively certain” because knowledge claims are either empirically or rationally (such as in mathematics or physics) verifiable. This argument has been applied to the human sciences. As the argument goes, if a researcher can make claims that meet this standard then practitioners are in good position to make therapeutic decisions based on this knowledge.

The problem occurs when there is a loss of faith in the ability of research in the human sciences to create solutions that help solve human and social problems. And many health care practitioners have lost faith. Post-positivists argue that the almost total reliance on positivist methods of research in the human disciplines has led to a schism between researchers and practitioners, and that more
appropriate techniques should be investigated. For instance, it is common for practitioners to tell stories to students in internships to “...forget everything you learned in school...now real education begins.” Yet narratives are perceived to be doxa, what Plato and the Greeks called mere belief, and do not have the necessary philosophical status of episteme, knowledge that we know to be true. The solution, as Polkinghorne, Toulmin, and other post-positivists argue, is to develop arguments that validate appropriate techniques that inform professional practice in the helping professions, and narrative knowing is one such technique.

This call is not unprecedented. Toulmin noted that human knowledge was much more valued during the early Renaissance, when knowledge that was local, timely, particular, and oral was more valued than their modern polar opposites: the universal, timeless, general, and written knowledge that came to characterize modern thought (1990). Toulmin goes on to call for a “democracy of methods” that would include human methods such as casuistry, narrative, and authority when appropriate (2001). In a post-positivist world, methods appropriate to the question are created and disseminated, and are judged by the community of practitioners. MacIntyre (1984) argues that a “practice” constitutes a framework for not only technical standards of care but also constitute a moral framework for behavior in the contemporary world. Central to his argument is the concept of a community that informs the profession of the standards of excellence and the very traditions of excellence that constitute the culture of the practice. This concept of a community is passed along orally and in writing, and creates the culture of the practice. MacIntyre’s practice can accommodate Polkinghorne’s “judgment-based approach” to developing a body of knowledge for the practices of care, one that is based on practitioner judgments that occur in direct person-to-person interactions and require situated and timely actions and responses, and which can be characterized as “post-positivist.”

What are the characteristics of post-positivist knowing? We argue that embodiment, embeddedness, narratives, an emphasis on the whole individual rather than only the observable (bodily) component, and an understanding of the contingency of human existence constitutes post-positivist methods. These perspectives are useful in placing the specific types of knowledge that health care professionals can use in a context, and in evaluating these perspectives for their efficacy. Specific to our argument here is what Polkinghorne calls “narrative knowing,” the transmission of knowledge by telling meaningful stories, and which Macintyre (1984) argued was one of the bases of moral community. The community involved in the narrative measures the utility of the
knowledge gained through narrative knowing, and the meanings gained through the narrative can be articulated in a systematic process of analysis. Polkinghorne argues,

The recognition that humans use narrative structure as a way to organize the events of their lives and to provide a scheme for their own self-identity is of importance for the practice of psychotherapy and for personal change. Self-help groups, such as Alcoholics Anonymous, stress the telling of “one’s story” to the group as a means of publicly acknowledging that one is someone whose story has lacked the element of self-control. The telling of the story in itself is held to have therapeutic value, and sharing one’s own narrative with others helps bring cohesion to the support group. In emerging friendships, a person chooses to reveal to another person his or her personal story. (Polkinghorne, 1988, p.178)

This process extends to the development of the professional community as well (Estes, 1990). The formation of ideas that guide excellence in professional practice and, more specifically, the roles of individuals existing in a professional culture as well as the profession’s role in society can be contextualized and examined for efficacy by the members of the professional culture. Similarly, common themes that define the profession and the professional can be expressed by symbolic and metaphorical expressions embedded in narratives and analyzed by using therapeutic methods to process them (Estes, 1990).

Block and Kissell assert, “Increasingly, modern western medicine has come to acknowledge that the Cartesian understanding of ourselves as bifurcated body/spirits falls short of a comprehensive understanding of health, disease and wellness (Block and Kissell, 2001, p.13).” They encourage medical professionals to consider embodied knowing in professional practice, which includes “... neural elements, efforts, memory, language, perception and attunement found integrated throughout the body, not just in the brain. It is the way we process the experience of life and select or reject others (Block and Kissell, 2001, p.6).” They argue that wellness; illness, disease, and recovery are all- encompassing and extend beyond a physio-chemical alteration in the body (Block and Kissell, 2001, p.13). Block and Kissell’s argument is not just a refutation of the Cartesian mind/body polarity, but is also an argument about our existence in the world – our culture, our language, our art, our profession. “To be human entails existing in a world of symbolization and meaning that is essentially tied to the material, the physical, the kinetic, the spatial, the temporal (Block and Kissell, 2001, p.8).”
The process of separating out the intricate elements of personal and professional codes embedded in narratives is complex. The process includes an understanding of symbolic interactionism and symbolic convergence (Estes, 1990), metaphorical pluralism and cross-domain mapping (Lakoff & Johnson, 1999), and cultural relational psychology and dialoguing (Block, 2001). These three methods of narrative analysis provide meaning and order in the processing of narratives.

Estes studied myths and the symbols embedded in them as “abstractions of a generalized pattern that explains one’s life in a culture, both to the individual and to the anthropologist” (1990, p.29). Estes noted that researchers who are not intimately involved in a profession should recognize that their own personal and cultural orientations would most likely be imposed on the culture they are studying. In contrast, those intimately involved in a profession should know that they as well possess personal and cultural orientations that bias interpretations; they should also identify and analyze the embedded symbols in the stories they live and tell. Both new practitioners and senior practitioners fit these explanations.

Symbolic interactionism and symbolic convergence are the tools Estes used to “unravel the codes” that exist in myths (Estes, 1990, p. 35). These types of symbolism are inherent in the process of analyzing narratives. Symbolic interactionism, put forward by pragmatist George Mead (1936) and refined by social psychologists, is a description of the process of how individuals converse with symbols to understand themselves and their relationship to culture. Symbolic convergence is the process of how myths are communicated between individuals and culture. Estes explains, for example, that individuals “chain” into dramas, gain motivation from them, sustain their sense of community, and are impelled to action by them. Symbolic interactionism avoids the dichotomy of subject/object by studying symbols. Symbols connect with motives, values, culture and most importantly with self. The connection with self through narratives forms an inextricable link with standards of excellence and the professional culture, and is discussed later in this paper as an outcome of using cultural relational psychology.

A basic assumption of narrative knowing is the idea that the embodied subjective self is involved in the interpretation of reality. Health care professionals are in a unique position to identify and explain embodiment, reality, and excellence in practice through the stories we tell. Reason and explanation of experience is embodied and explained in terms that relate back to the metaphors that are
used in stories. Lakoff and Johnson (1999, p. 7) note, “Metaphorical thought is the principal tool that makes philosophical insight possible and that constrains the forms that philosophy can take.” They go on to explain that each of us is a metaphysician capable of interpreting our own individual realities. “It is through our conceptual systems that we are able to make sense of everyday life, and our everyday metaphysics is embodied in those conceptual systems” (Lakoff and Johnson, 1999, p. 10).

Lakoff and Johnson (1999) help us understand individual subjective realities by analyzing the phenomenon of embodiment and metaphors. Phenomenological embodiment is a mechanism of perceiving “self” that arises from the way we schematize our own bodies and things we interact with daily. Neural embodiment characterizes the neural mechanisms that give rise to concepts (i.e., color cones bringing color into existence and characterization of the structure of color categories). Lakoff and Johnson claim, “the very properties of concepts are created as a result of the way the brain and body are structured and the way they function in interpersonal relations and in the physical world (1999, p. 37).” These concepts are communicated through metaphorical thought, gesture, and language. “Metaphor allows conventional mental imagery from sensorimotor domains to be used for domains of subjective experience (1999, p. 45).”

Understanding types of metaphorical thought is important to the understanding of analyzing and processing individual subjective experience. There are five distinct types of conceptual metaphors that Lakoff and Johnson (1999) analyze in relation to subjective embodiment. All types of metaphors are pervasive in both thought and language. The most complex type of metaphorical thought is metaphorical pluralism and is the focus of this discussion.

Metaphorical pluralism is characterized by multiple metaphors for a single concept. These metaphors are structured from inferences and language that cross conceptual domains (Lakoff and Johnson, 1999, pp. 70-71). Metaphorical pluralism is the norm: “…our most important abstract philosophical concepts, including time, causation, morality, and the mind, are all conceptualized by multiple metaphors, sometimes as many as two dozen” assert Lakoff and Johnson (1999, p.71). Cross-domain conceptual mapping is common in philosophy and is important to the discussion of bringing meaning to narratives for the purpose of understanding excellence in professional practice.

The identification and analysis of symbols and metaphors that are embedded in narratives inform the subjective self-in-community
and embodied-self. Symbols unite self and the professional community, whereas metaphors explain how one interprets embodied subjective realities with individual abstract philosophical concepts. Symbols describe self-in-relationship to culture, one’s sense of community, motivating factors that connect the individual with cultural values and professional affiliation. Metaphorical pluralism is the vehicle that an individual uses to express and interpret individual realities by paying attention to language and how one tells the story. Researchers in a profession can begin to unravel the complex codes that inform excellence in professional practice by analyzing and interpreting the elements of symbolism and metaphors embedded in narrative expression. Practitioners in a profession can address the messages and meanings of narratives by using the therapeutic methods of cultural relational psychology. And the ability of one to do this is what marks one as a member of a profession, or in MacIntyre’s argument, a member of the “practice” (MacIntyre, 1984).

Cultural relational psychology is a postmodern psychological perspective that challenges the traditional Western psychological ideals of individuation and separation. The basic tenets of this psychology are that people can learn and grow by understanding cultural parameters and expectations and to value and respect the growth that comes through connections made in relationships (Block, 2001, p.118). The methods of cultural relational psychology have been successfully used to analyze and evaluate the narratives clients tell in therapeutic and educational settings. Senior practitioners may also use these methods with novices to help them see the profession through different lenses for the purposes of assessing cultural and professional bias, expected and inappropriate professional behavior, and excellence in professional practice.

The therapeutic techniques of cultural relational psychology can be used to process the narratives of health care professionals. One of the most imposing therapeutic techniques of this psychology is empathic attunement. Empathic attunement is “the dynamic cognitive-affective process of joining with and understanding another’s subjective experience (Jordan, 1997, p.15).” The fellow practitioner attempts to identify with the storyteller’s narrative and clarify her own subjective experience in the context of the professional narrative. She may either accept or reject the narrative as evidence of excellence in practice. The narrative can be a useful tool to her professional growth if it includes similarities that relate to her subjective reality. Narrative knowing with another practitioner can contribute to mutual growth and trust and create a
relational bond that allows both to grow in connection with the other.

Contextualizing accepted narratives in terms of professional practice and subjective reality is a way that the practitioner can learn and grow from thinking about the narratives she believes to be relevant and true to her own experience. First, the practitioner will be able to identify or reconcile her place in the professional community by identifying the role that she plays in the narrative. Second, the practitioner will be able to distinguish between fantasy, reality, fear, and hope if the narrative is analyzed and compared with factual data. Third, the practitioner’s personal motives and goals may be analyzed in relation to how strongly she believes in the authenticity of the message relayed in the narrative. And finally, the narrative may also serve as a source of affirmation or anxiety if the practitioner feels a strong emotional attachment to the message.

The analysis of narratives with other practitioners is also a useful way to learn and grow as a professional. Relationship authenticity is a technique of cultural relational psychology that involves understanding one’s own needs and the needs of the other, and communicating those needs in an honest, authentic manner. Communicating authentically is a way that senior practitioners can help novice professionals join the professional community and feel part of it. Sharing narratives will help open lines of communication between senior and novice professionals. For example, sharing narratives in an honest authentic manner will allow novice practitioners the opportunity to admit and address problems in professional practice that may not have been ordinarily addressed.

Tolerating tension and conflict is a major component of cultural relational psychology where each person in the relationship should “... risk change and the uncertainty which accompanies growth... real growth of an individual can occur only in the context of a real, mutually responsive relationship” (Jordan, 1997, p. 143). This type of dialoging gives senior practitioners occasions to speak openly and freely about solutions to problems without seeming to preach or talk down to the novice. Narrative analysis will also help draw the novice practitioner into the conversation and the “sisterhood” of the profession of nursing and create an opportunity for her to derive meaning from the symbols that clarify the professional values and culture of nursing.

Senior practitioners may also deconstruct narratives and use the deconstruction process to help novice practitioners grow and develop as professionals. Dealing with disconnections and disempowerment is a component of cultural relational psychology.
that deals with the recognition and overcoming of internalized and imposed cultural ideas about self and others that lead to the loss of empowerment. One way the senior practitioner could deal with a sense of loss of empowerment would be to ask the novice to change roles in the narrative – to become the heroine of the story. By role-changing the novice will be able to practice excellence vicariously and hopefully create an attitude of confidence. Another outcome of the deconstruction process would be to create an alternative course of action or an action plan for professional growth based on the characters in the narrative in a non-threatening way. These techniques can help novices develop and grow while at the same time relieving the emotional and mental pressures that accompany professional growth.

These therapeutic techniques honor individual differences and the uniqueness of the individual with equality and authenticity. Connectedness occurs through the telling, hearing, and processing of narratives and creates an atmosphere of mutual growth and trust in an emotionally connected, authentically honest manner.

Summary
The arguments for using narratives to organize one’s professional practice are helpful in that they justify and organize many of the activities that go on in our professional lives. Nurses, like other professionals, regularly discuss their profession and their role in it. Recognizing that these discussions take place, and learning how to partake in them in an appropriate manner, is a real benefit to being part of a quality profession. Not being limited to knowledge that is empirically verifiable frees nurses to explore, discuss, and disseminate knowledge and techniques that may be of benefit to patients; nurses are best positioned to discuss what these situations are, how to act, and analyze their own behaviors. Furthermore, this knowledge can and should be disseminated to young professional nurses.

Assuming that only knowledge that is derived from empirically verifiable sources limits knowledge that nurses actually use in their professional lives. Not limiting professional practice to the methods of positive science is important to the health of our patients, and any technique that demonstrates its efficacy should be listed among the methods of good professional practice. Practitioners should not be surprised that the techniques that work well on patients work just as well on practitioners. We are not “above” our patients in any professional or philosophical sense as a positivist perspective implies; rather, we are part of humanity and we should recognize and utilize this understanding.
Good professional practice will also call for the recognition of the limitations of narrative analysis. It is important to apply appropriate levels of rigor to our professional lives so that we are not merely gossiping, or in a worst-case scenario passing along traditions that may be as unhealthful as the pathologies we treat. Narratives are appropriate to the extent that they humanize professional practice. They are inappropriate in situations where other methods are more efficacious such as didactic learning, and it is up to practicing professionals to use appropriate techniques that define and disseminate standards of excellence. In the end it is up to nurses to define good nursing, and making this happen is one of the rewards of professional practice enjoyed by all of the helping professions.
References


Teaching hand washing to student nurses: a comparison of two teaching interventions.

Poster Presentation

Summary for conference proceedings

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This study was undertaken to compare the effectiveness of two educational strategies for teaching hand washing to student nurses at King's College London. A randomised pre-test/ post-test design was used. Participants (n = 236) were voluntarily recruited to the study and randomised into two intervention groups for the purpose of learning the theory and practice of hand washing. Participants in the classroom (CLR) group (n = 123) were taught using conventional, teacher- led didactic methods. Those in the computer assisted learning group (CAL) (n = 113) learnt using an interactive, self-directed computerised package. The learning objectives for both interventions were identical and both covered the same content and utilised similar teaching resources that included a videoed demonstration of the recommended hand washing process.

Cognitive gain and retention was measured using a 20 item multiple-choice test. The ability of participants to perform the skill of hand washing was measured by assessors using a criteria based competency checklist. The study design utilised a prospective framework with data collected at multiple points during the research timeline. These included: Baseline (participant questionnaire and pre-test), Time 1 (post-test 1), Time 2 (post-test 2 and hand washing assessment 1) and Time 3 (post-test 3 and hand washing assessment 2).

Analysis of the data revealed no significant differences (p >0.05) in the pre-test scores between the groups. Although the test scores demonstrated that knowledge improved for both groups following the educational intervention, cognitive test scores at Time 1, 2 and
3 also revealed no significant differences between the groups. However, when groups were compared with regard to their ability to demonstrate the skill of hand washing, significant differences were found (p<0.05) between the groups at Phase 3 with the CAL group achieving higher scores. These findings suggest that learning hand washing through CAL methods may have a positive impact on both skill acquisition and retention.

Preliminary findings from this study lend support for CAL as a viable method for teaching the theory and practice of hand washing to student nurses and contribute to the limited empirical evidence on the use of CAL for skills teaching. Further research to explore the effects of CAL for the acquisition and retention of other clinical skills is indicated.
Evaluation of pilot 1b of the REACH project

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**Abstract**

The REACH project is an integrated professional and practice development programme aiming to provide a Clinical Careers Framework for nurses within the Royal Hospitals Trust in Belfast. Participating in REACH enables lifelong learning for nurses and enables the development of nursing and nurses.

**Aims**

- Describe the mechanisms of the REACH framework
- Evaluate the usability of the framework from the perspective of key stakeholders
- Identify contextual issues that impact on the way the mechanisms are used
- Identify potential areas for outcome measurement in the ongoing evaluation of the framework.

Methodology is Pawson and Tilley’s (1997) realistic evaluation. Two stages, Stage 1 theory generation phase, has taken the form of two
pilots, leading to the generation of hypotheses around ‘what might work for whom in what circumstances’. Convenient and purposive sampling techniques were used for the interviews with participants. Data from the interviews has been thematically analysed using the 10 point plan by Ely and revised by McCormack.

**Preliminary findings from 1b evaluation**

- The new appraisal course meets participants’ needs.
- Participants find the REACH appraisal more valuable and focused on their development needs.
- Staff found completing self assessment challenging.
- The document is user friendly and provides a more structured approach for appraisal.
- A number of challenges were identified, including: time commitment; change, the fact that REACH is new; motivation; language in relation to the attributes.
- Facilitation is pivotal to the success of REACH with requirements evolving as staff progress along the learning journey.
- Outcomes include: increased reflection; developing patient-focused activities; increased audit activity; supporting new staff; staff feel more valued; increased self confidence.

This evaluation to date has shown REACH to be an effective framework for enabling professional development of staff alongside developing nursing practice.

**References:**
Leisure Time Activities and Obesity of School-Aged Minority Children

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Abstract
This descriptive-correlational study investigated three research questions:

a) what are the leisure time activities (LTA) of school-aged minority boys and girls, b) what are their body mass index (BMI) distributions, and c) what relationships exist between total activity scores of LTA and BMI in these children, and for boys and girls analyzed separately? The convenience sample consisted of 78 children, aged 9 to 14, who were in the fifth to seventh grades of two elementary schools. They responded to a modified version of the Know Your Body Health Habits Survey to assess LTA; BMI was calculated based on child height and weight. Results indicated that the LTAs of minority children and their distribution of BMIs were similar to those of non-minority children, and that no appreciable relationships existed between LTAs and BMI in the sample as a whole or boys and girls analyzed separately.

Obesity is fast becoming a major health problem in the United States (CDC.gov.2002) and throughout the world (World Health Organization, 2002), affecting all ages and segments of the population. The prevalence of obesity is increasing in young children, raising serious concerns about their health and well-being (Ogden, Flegal, Carroll, & Johnson, 2002). Childhood obesity has been linked to childhood asthma in minority children (Gennuso, Epstein, Paluch, & Cerny, 1998; Luder, Melmik, & DiMaio, 1998), and with chronic health problems, such as hypertension and diabetes in middle age (Cheung, Machin, Karlberg, & Khoo, 2004).

Many factors have been identified as contributing to obesity in children, such as diet (James, 2004), lack of exercise and activity (Marshall et al., 2002; Riddoch et al., 2004), and location of family residence, meaning urban versus suburban settings(Fox, 2004). In contemporary society, children are spending more time in sedentary activities, such as watching TV and playing video games, rather than in high aerobic activities, such as running (Fox, 2004), making lack of exercise and activity an important area of study regarding childhood obesity. Harrell, Gansky, Bradley, and McMurray (1997) studied the relationship between leisure time activities and obesity, in a sample of mostly white third and fourth graders, ages 7 to 12. Their work needs to be extended to other age and ethnic groups of children. Thus, using a sample of mostly minority boys and girls in grades five through seven, the purposes of this study were: (a) to describe the leisure time activities of boys and girls, (b) to describe their BMI distribution, and (c) to examine the relationship between leisure time activities and BMI in the sample and in girls and boys separately.
Literature Review

Harrell et al. (1997) examined the relationship between total leisure time activity scores, as measured by a modified questionnaire from the Know Your Body Health Habits Survey, and obesity, as measured by both body mass index (BMI) and skin fold thickness. Harrell et al. found that the total leisure time activity scores did not significantly predict the children's BMI or skin folds, after adjusting for gender, in a sample of 2,200 mostly white third and fourth grade children. However, more non-obese boys and girls reported high intensity activities than their obese counterparts. Using similar methods, the present study examined this same relationship in mostly minority children in grades five through seven.

Maffeis, Talamini, and Tato (1998) studied the influence of physical activity on obesity in a sample of 298 pre-pubertal Caucasian children participating in a longitudinal study. Children’s activity levels were assessed with a questionnaire completed by parents along with their pediatricians. Obesity was measured by BMI. The researchers reported that sedentary behavior was associated with overweight at the age of 8, but not age 12. Obese eight-year old children spent more time watching TV and less time engaging in physical exercise and vigorous play than non-obese children.

Ball et al. (2001) studied the relationship between physical activity and body fatness in 106 Australian children, ages 6 to 9 years. Physical activity was assessed by total energy expenditure and body fatness was measured by BMI. Based on the findings, the researchers concluded that in boys, but not girls, percentage of body fat was inversely related to physical activity level.

Proctor et al. (2003) studied 106 children from pre-school years to early adolescence, examining the relationship between TV viewing and change in body fat, measured by BMI, triceps skinfolds, and sum of five skinfolds recorded annually at clinic visits. Based on their analyses, Proctor et al. concluded that children who watched the most TV during childhood had the greatest increase in body fat over time.

Trost, Sirard, Dowda, Pfeiffer, and Pate (2003) examined the physical activity levels of 245 overweight and non-overweight Australian children, ages 3 to 5. Physical activity was assessed using direct observation and accelerometers; children’s weight and height status were assessed in private settings. The researchers reported that overweight boys, but not overweight girls, were far less active that their non-overweight counterparts during the
Wake, Hesketh, and Waters (2003) studied 2862 Australian children, ages 5 to 13, to investigate the relationship between parents reports of children’s television and video game/computer habits, as reported by parents, and children’s BMI, measured from height and weight. Wake et al. found that a small proportion of variance in children’s BMIs was related to television time, but not to video game/computer time.

In contrast, Vandewater, Shim, and Caplovitz (2003) found that while television use was not related to children’s weight status, video game use was related to higher weight status. The researchers studied a nationally representative American sample of 2831 children, ages 1 to 12; on average, the children were 6 years old. About 49% of the children were white, 39% black, 7% Hispanic, and 2% Asian; the remaining 4% were other ethnicities. The researchers reported that higher weight status, measured by age-normed BMI ratings, was associated with moderate amounts of playing with electronic games, while lower weight status children played either very little or high amounts of electronic games.

Using a nationally representative sample of 7216 Canadian children, ages 7-11, Tremlay and Willms (2003) examined the relationship between children’s physical activity, as reported by parents, and BMI measured by parents reports. Three different statistical models were analyzed; two models are relevant to the present study. In Model I, participation in organized and unorganized sports was inversely related to obesity, when controlling for age and gender. In Model III, children who participated in unorganized sports and those who watched TV less than 2 hours a day were less likely to be obese or overweight.

Several recent studies have been done on high school students. Lowry, Wechsler, Galuska, Fulton, and Kann (2002) studied a nationally representative American sample of 15,349 high school students in grades 9 to twelve to examine the association between watching TV and being overweight, measured by BMI ratings. Logistic regression analysis revealed that watching TV more than 2 hours/day was related to being overweight among white boys and girls and Hispanic girls. Watching TV more was associated with greater participation in physical activity for black boys. These findings suggested a cultural influence on the relationship studied. Elkins, Cohen, Koralewicz, and Taylor (2004) studied 5436 low-income, inner-city public high school students, ages 14 to 19, who were African American. The researchers found that, after controlling for age, grade, and playing football, both boys and girls
who participated in increasing number of athletic activities had lower BMIs.

In summary, only several of the studies above have reported negative findings. Wake et al. (2003) found that only a small proportion of variance in children’s BMIs was explained by spending time watching TV, in children aged 5 to 13, and Maffeis (1989) reported that sedentary behavior was not related to being overweight in children aged 12. In contrast, more involvement in organized and unorganized sports was related to less obesity in children, aged 7 to 11 (Tremlay & Willms, 2003) and in African American adolescents, aged 14 to 19 (Elkins et al., 2004). Decreased physical activity levels were related to increased body fat in boys, but not girls, aged 3 to 5 (Trost et al., 2003) and at aged 6 to 9 (Ball et al., 2003). Increased time spent watching TV was associated with increased body fat in children studied from pre-school to early adolescence (Proctor et al, 2003), with obesity in children aged 7 to 11 (Tremlay & Willms, 2003), and with being overweight in children in grades 9 to 12 (Galuska et al., 2002). In children aged 1 to 12 (average age was 6 years old), playing electronic games was associated with being overweight (Vanderwater et al., 2003), and sedentary behaviors were linked to being overweight in children, aged 8 (Maffeis et al., 1998).

As might be expected, the preponderance of accrued evidence suggests that less physical activity and more sedentary behavior, such as watching TV, is associated with being overweight or obese, as measured in a variety of ways across studies of children spanning in age from pre-school to high school. In two studies, physically inactive boys, but not girls, had increased body fat (Ball et al., 2003; Trost et al., 2003), making physical activity important to study in relation to obesity in boys. Recent research has included participants from the United States, Canada, and Australia, but few studies have examined the relationship between activity levels and obesity in different racial/ethnic groups within these English-speaking countries. By studying mostly minority fifth to seventh graders, the present study aimed to extend an earlier study by Harrell et al. (1997) who studied mostly Caucasian third and fourth graders. Although Harrell et al. found that leisure time activities were not appreciably related to BMIs in their sample, the relationship needs further study in different subgroups of children, especially minority children in whom the association has been under-examined.

**Research Questions**

1. What are the leisure time activities of school-aged minority boys and girls?
2. What is the distribution of BMIs in school-aged minority boys and girls?

3. What are the relationships between total activity scores of leisure time activities and BMI in school-aged minority children, and for boys and girls analyzed separately?

**Methods**

**Setting and Sample.** Students in the fifth through seventh grades were accessed in two inner-city schools, one of which was public and the other was parochial. Authorities in both schools approved the project. Both schools are located in Abbott (impoverished) districts as defined by criteria set forth by the state, such as limited resources, old schools, crowded classrooms, low scores of students on standardized tests, and so forth. The schools are approximately sixty miles apart in the same state. School #1 is a parochial school located in a large coastal city, whereby School #2 is a public school located in a major inner city. Both schools share similar demographics in that they are located in cities that have culturally diverse populations in which approximately 65 to 80% of the residents are African American and Hispanic.

A non-probability sample of convenience was obtained. The sample consisted of 78 children in grades five through seven attending two inner city schools; of these children, 60.3% (n = 47) were in fifth grade, 17.9% (n = 14) in sixth grade, and 21.8% (n = 17) in seventh grade. There were 35 boys and 43 girls in the sample. Of these, there were 19 boys and 28 girls in the fifth grade, 5 boys and 9 girls in the sixth grade, and 7 boys and 10 girls in the seventh grade. Their ages ranged from 9 to 14 (M = 10.92; SD = 1.30). Relative to grade, their ages ranged from 9 to 11 in fifth grade, 11 to 12 in the sixth grade, and 12 to 14 in the seventh grade. Ethnic representation was 48.7% (n = 38) Hispanic students, 46.2% (n = 36) African-American students, and 5.1% (n = 4) European-American students. In school #1, there were 13 Hispanic students, 28 African-American students, and no European-American students. In school #2, there were 10 Hispanic students, 23 African-American students, and 4 European-American students.

**Measures.** Body mass index (BMI) was used as a measure of relative weight. To obtain BMI in this study, the weight and height of each child was obtained by an RN to BSN student nurse using a counterbalance portable scale. Weight was assessed in pounds on the scale (converted to kilograms in the computer program used) and height was assessed in inches (converted to meters in the computer program) using a measuring bar on the scale. All
children wore their school uniforms at the time of measurement, but removed their shoes during the procedure. Using a computer-based formula, BMI was calculated by dividing the weight in kilograms by height in meters, squared.

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BMI = \frac{\text{Weight in Kilograms}}{\text{Height in Meters} \times \text{Height in Meters}}
\]

A BMI of 24.9 or less places the child in the 85th or less percentile, a BMI of 25 to 29.9 in the 90th percentile (overweight), and a BMI of 30 or greater in the 95th percentile (obese) (CDC.gov./nccdphp/bmi/cal-bmi, September 28, 2005).

A modified version of a questionnaire adapted by Harrell et al. (1997) from the Know Your Body Health Habits Survey (Williams, Carter, & Eng, 1980) was used to assess Leisure Time Activities (LTA). The questionnaire consists of an alphabetized list of 25 activities expected to be commonly performed by elementary school children, as modified by J. Harrell (personal communication, April 18, 2000). Harrell called all activities on the questionnaire leisure time activities, such as gym classes and organized and unorganized sports, including baseball, basketball, and football. In the present study, one activity related to farm work was eliminated because it was not relevant to inner city children. Activities on the list range from very vigorous (running) to very sedentary (watching TV). Each activity is accompanied with a frequency scale ranging from Never (0), Not Much (1), Sometimes (2), A Lot (3).

In the present study, the participants were instructed to circle the frequency with which they performed each of the 24 activities on the questionnaire. Following the recommendations by Harrell et al. (1997), based on judgments by exercise physiologists, each of the 24 activities was assigned an estimated metabolic equivalent (MET) to obtain four categories of activity-intensity ranging from a high (8METs), moderate (5METs), low (3METs), to very low (2METs). Eight items are designated as high activity-intensity, 7 items as moderate, 5 items as low, and 4 items as very low. Then, a total activity score for each participant was calculated via the computer by multiplying the MET for each activity by the frequency score for each participant for each activity. Total activity scores can range from 0 to 366.

Research Design and Procedure. This study reports on cross-sectional, descriptive-correlational data examining children’s weight in relation to leisure time activities obtained prior to the implementation of an educational program about children’s health behaviors. This educational program was conducted by RN to
BSN/MSN students and consisted of weekly lectures for one class period on making healthy choices about nutrition/diet, and exercise. This program lasted for 12 weeks and was delivered by the same RNs assigned to each class. Data collected after the educational program was implemented are not reported here.

Parental consents for child study participation were obtained at the start of the project. Consent forms were sent home with the children and returned to teachers. Students gave assent to participate. At the start of the project, which was at the beginning of the school year, two or three RN to BSN students measured the children’s heights and weights in a screened area in the school’s hallways. Each child was called out individually from the classroom and assessed privately in the screened area. Then, the children were administered the LTA scale (along with other instruments not relevant to this report) in the classroom during the time usually allotted for health education. Demographic data, such as age, gender, and grade in school, for each participant were obtained from school records.

Results
Data were analyzed using means to answer the first research question. Frequency distributions were used to answer the second research question. The Pearson correlation coefficient, with a two-tailed level of significance, was used to answer the third question. Relative to the first research question, “What are the leisure time activities of school-aged minority boys and girls?” the results are presented in Table 1. As can be seen, the group as a whole spent a majority of their leisure time (with a mean of 2 or greater) in five activities: Watching TV (MET = 2), Gym Class (MET = 5), Video Games (MET = 3), Running (MET = 8), and Homework (MET = 2). Thus, a majority of their leisure time activities were spend in low to very low activity-intensity activities.

When looking a girls and boys separately (see Table 1), differences in time spent in leisure time activities are apparent. Girls spent a majority of their leisure time (with a mean of 2 or greater) in six activities, noted in descending order of means: Watching TV (MET = 2), Gym Class (MET = 5), Homework (MET = 2), Running (MET = 8), Video Games (MET = 3), and Cleaning House (MET = 3). In contrast, boys spent a majority of their leisure time (with a mean of 2 or greater) in seven activities, noted in descending order of means: Watching TV (MET = 2), Video Games (MET = 3), Gym Class (MET = 5), Running (MET = 8), Swimming (MET = 8), Homework (MET = 2), and Basketball (MET = 8). Thus, girls spent more of the majority of their leisure time activities in low to very low activities, whereby boys spent more in high to moderate
activities. However, all children, boys and girls, spent most of their leisure time watching TV.

Relative to the second research question, the distribution of BMI was analyzed according to the sample as a whole and boys and girls separately, and according to grade. For the sample as a whole, BMIs ranged from 14.3% to 34.5%, with about 20% of the sample ranging from 25% to 34.5%. For girls, BMIs ranged from 15.7% to 34.5%, with about 20% of the sample ranging from 25% to 34.5%. For boys, BMIs ranged from 14.3% to 31.9%, with about 20% of the sample ranging from 25% to 31.9%. For children in the fifth grade, BMIs ranged from 14.3% to 31.9%, with about 12% ranging from 26.7% to 31.9%, in the sixth grade, BMIs ranged from 14.6% to 34.5%, with about 35% ranging from 25.8% to 34.5%; and, in the seventh grade, BMIs ranged from 18.5% to 30%, with about 12% ranging from 25% to 30%.

Relative to the third research question, a Pearson correlation with a two-tailed test of significance was used to examine the relationships between total activity scores of leisure time activities and scores for BMI for the sample as a whole and girls and boys separately. The Pearson correlation for the sample as a whole was $r = .184, p = .11$; for girls, the $r = -.174, p = .27$; and, for boys, the $r = .122, p = .49$.

Discussion

With respect to the first research question, and using mean scores, watching TV was the most common activity of the school-aged children in this study, followed by gym class, running, video games, and homework. Using percentages, Harrell et al. (1997) reported that homework, bicycling, watching TV, and video games were the most common activities of school-aged children. The children in the Harrell et al. study ranged in age from 7 to 12 (Mean age = 8.9), while the children in the present study ranged in age from 9 to 14 (Mean age = 10.92). The children in the Harrell et al. study were mostly white, while the children in the present study were mostly minority. Clearly, however, the most common activities across the two samples of school-aged children were watching TV, video games, and doing homework, all of which are low to very low activity-intensity activities, and all of which are sedentary.

When girls were examined separately in this study, their most common activities were watching TV, gym class, homework, running, video games, and cleaning house, in that order. Girls in the Harrell et al. (1997) study reported homework, bicycling, watching TV, reading, and dancing as their most common activities, in that order. Even though they differed in age and ethnicity, the
most common activity for girls in both samples was a very low activity-intensity activity (watching TV or homework), and, in general, both samples participated in more low to very low activity-intensity activities than in moderate to high activity-intensity activities for their most common leisure time activities.

When boys were examined separately in this study, their most common activities were watching TV, video games, gym class, running, swimming, homework, basketball, in that order. Boys in the Harrell et al. (1997) study reported video games, football, bicycling, watching TV, basketball, homework, running, and baseball as their most common activities, in that order. While the most common activity of boys in both samples was a low or very low activity-intensity activity (watching TV or video games), most of the other activities that the boys engaged in were of high to moderate activity-intensity leisure time activities.

When comparing this present sample of older and mostly minority school-aged children to the younger and mostly white school-aged children studied by Harrell et al. (1997), it is apparent that sedentary activities, such as watching TV or homework, are the most common leisure time activities participated in by elementary school children. In general, girls tend to be more sedentary than boys by engaging in activities that demand less energy expenditure, such as homework, watching TV, and reading, which is offset to some extent by them engaging in activities such as running or dancing. Although boys most commonly spend time in leisure time activities such watching TV, video games, and homework, they offset these sedentary activities more so than girls by participating commonly in more vigorous activities such as basketball and football.

Relative to the second research question, about 20% of the sample as a whole (including fifth, sixth, and seventh graders) in this study could be classified as overweight or obese, and this same percentage applied to both boys and girls. Harrell et al. (1997) reported that the prevalence of obesity for their overall sample of 2,200 children was 26%; for girls it was 24.6%, while for boys it was 27.4%. In the present study, however, the sixth graders had the highest percentage (35%) of overweight or obese children, which may be a finding specific only to the present sample. That is, a fair portion of the sixth graders in the present study had a serious weight problem, which is probably atypical of sixth graders in general. About 12% of the fifth and seventh graders were overweight or obese, which is probably more reflective of most children in these grades.
No appreciable correlations were found between total activity scores and scores for BMI for this school-aged, mostly minority sample as a whole, or for boys and girls analyzed separately. These findings are consistent with those reported by Harrell et al. (1997) for a younger and mostly white sample of school-aged children. In their study, Harrell et al. found that total activity scores did not predict BMI or skin folds. Taken together, the findings suggest that either the leisure time activity instrument is not the best way to measure children’s activities levels or that BMI is not the best way to measure overweight or obesity, especially for boys. For example, even though non-significant, the correlations between total activity scores were inverse for girls and positive for boys. Thus, boys who have high total activity scores may also have more developed muscles, which might increase their BMI. These ideas need to be considered in future research, with larger samples, so that firmer conclusions can be drawn.

**Implications for Nursing Practice**

As stated earlier, obesity in children is fast becoming a national health crisis, as evidenced by reports in the media and in the lay and professional literature. Of all health care professionals, pediatric nurses in primary care and school nurses are in the best position to help school-aged children avoid or overcome obesity by managing their leisure time activities, and to teach them how to balance sedentary activities with more vigorous activities during their leisure time. Clearly, homework, which is a very low intensity activity, should be encouraged to replace watching TV and video games, which were the low intensity activities the mostly minority school-aged children in the present study engaged in most; spending excessive time on computers and playing Nintendo should be discouraged. Gym class, however, was also a very popular activity for these children, whereas it was not in the Harrell et al. (1997) study. Therefore, nurses should work with gym teachers to plan programs of leisure time activities for children which reflect moderate to high intensity activities. These programs should take into account the sex of the child, their grade in school, and their BMI. Girls need to practice leisure time activities that reflect their gender-specific interests, but that are equally as vigorous as those as boys. Younger children should progress to more vigorous leisure time activities with age and according to their physical ability to engage in high intensity sports like football. Special consideration needs to be given overweight and obese children when planning a program of leisure time activities. That is, overweight children may find it difficult to participate in vigorous, high-intensity activities until they lose weight. A program inclusive of diet, exercise, and counseling would be most appropriate for these school-aged children, who are most at risk to short and long-term health
problems. All children should be encouraged to keep diaries to record their daily activities and food intake and these diaries should be shared discreetly in health classes.

When planning activity programs, pediatric and school nurses also need to consider the community resources available for selected leisure time activities for school-aged minority children, such as those selected for this study. For example, tennis courts may not be commonly found in poor cities and impoverished urban areas. If this is the case, nurses can provide the leadership in contacting politicians in these communities to encourage them to seek funds to broaden the resources available to children for exercise. In addition, the practice of some leisure activities, especially sports, may be culture-specific, as found by Lowry et al. (2002) and, if so, nurses should consider the interests of children from different cultures when planning leisure time activities.

Even though leisure time activity scores and BMI scores were not appreciably related in the present study or in the study by Harrell et al. (1997), participation in moderate and high intensity activities on a daily basis probably plays some role in helping children avoid obesity. Therefore, pediatric and school nurses should make every effort to join the national campaign to help school-aged children maintain normal weight by engaging in moderate to high intensity activities on a planned and daily basis.

References


Table 1. Means on Leisure Time Activities on Boys and Girls

<table>
<thead>
<tr>
<th>Activity</th>
<th>Estimated</th>
<th>Overall Mean Boys' Mean</th>
<th>Girls' Mean</th>
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<tbody>
<tr>
<td></td>
<td>MET</td>
<td>N=78</td>
<td>N= 44</td>
</tr>
<tr>
<td>Watching TV</td>
<td>2</td>
<td>2.60</td>
<td>2.45</td>
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<tr>
<td>Gym class</td>
<td>5</td>
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<td>2.41</td>
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<td>3</td>
<td>2.29</td>
<td>2.07</td>
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<tr>
<td>Running</td>
<td>8</td>
<td>2.20</td>
<td>2.14</td>
</tr>
<tr>
<td>Homework</td>
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<td>2.16</td>
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<tr>
<td>Cleaning house</td>
<td>3</td>
<td>1.98</td>
<td>2.00</td>
</tr>
<tr>
<td>Reading</td>
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<td>1.98</td>
<td>1.95</td>
</tr>
<tr>
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<td>1.95</td>
<td>1.91</td>
</tr>
<tr>
<td>Swimming</td>
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<td>1.91</td>
<td>1.70</td>
</tr>
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<td>1.70</td>
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<td>1.55</td>
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<td>Cost 2</td>
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<td>-------------------------</td>
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<td>--------</td>
<td>--------</td>
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<tr>
<td>Music lessons</td>
<td>3</td>
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<td>1.02</td>
</tr>
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<td>.98</td>
</tr>
<tr>
<td>Skate Boarding</td>
<td>5</td>
<td>.67</td>
<td>.61</td>
</tr>
</tbody>
</table>
A qualitative exploration of pregnancy-related symptoms suggestive of the Couvade Syndrome in expectant men

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Overview of the Syndrome
The term “Couvade” was first introduced into the anthropological literature by Tylor in 1865, whose literal translation is derived from the French verb “Couver” meaning to brood, nest or hatch. Trethowan and Conlon (1965) were the first researchers to investigate the Couvade Syndrome in the U.K. proposing that it was a state of somatic and psychological symptoms experienced by male partners of pregnant women. Its symptoms have no pathological basis (Klein, 1991; Mason & Elwood, 1995). However, one case study has reported a Couvade syndrome equivalent in an African-American woman (who was not pregnant) during both pregnancies of her twin sister (Budur et al 2005). Conner & Denson (1990) identified 3 main groups of symptoms commonly associated with the syndrome. The first group included the gastrointestinal symptoms nausea, heartburn, abdominal pain, and appetite changes. The second group comprised upper respiratory disturbances like colds, breathing difficulties and epistaxis, in addition to pains like toothache, leg cramps, backache and urogenital irritations. In the third category, psychological symptoms such as changes in sleeping patterns, anxiety and worry, depression, reduced libido and restlessness were reported. Two of its most interesting symptoms are toothache and abdominal distension. Toothache, euphemistically known as “love pain”, receives mention in Shakespeare’s (1600): Much Ado about Nothing and was acknowledged by Wilkins (1609) in his book The Miseries of Enforced Marriage ...

"I have got thee with child in my conscience and like a kind husband, ‘methinks I breed it for thee."
For I am already sick in my stomach and long
ong extremely” (p.42).

Abdominal distension (pseudocyesis or “phantom pregnancy")
whose presence has been linked to the Couvade syndrome (Mayer
and Kapfhammer 1993; Koić et al 2004) includes a progressive
swelling of the abdomen. Benvenuti et al (1989) propose that the
symptoms most commonly take the form of loss of appetite, nausea
and vomiting, toothache, renal and abdominal colic, sore throat and
weight gain. They argue that their origin and meaning are not often
recognised. The symptomatological course of the syndrome appears
to follow a U-shaped pattern throughout the pregnancy cycle
(Schodt, 1989 with symptoms commencing in the first trimester,
subsiding in the second and reappearing again in the third
trimester. This has been confirmed by the timing of medical
consultations (Lipkin & Lamb, 1982; Quill et al 1984). The
symptoms classically cease abruptly at birth or shortly within the
postpartum period.

Early accounts tended to medicalise the syndrome as a
psychosomatic disorder (Trethowan & Conlon 1965; Trethowan,
1968). Enoch et al (1967) refer to it as an “uncommon psychiatric
syndrome”. Despite this, the syndrome does not appear in the
nosologies of the DSM-Version IV, (American Psychiatric
Association 2000) or the International Classification of Diseases:
ICD-Version 10, (World Health Organisation 1993). The reason for
this is unclear, but the syndrome is idiopathic and, according to
classic definitions, is not specifically related to physical,
psychological illnesses or injury. Furthermore, the symptoms of the
syndrome are by definition non-specific and transient, which
hamper attempts to discriminate them from symptoms that do have
a pathophysiological basis. Its diagnosis is principally made by
exclusion (Schodt, 1989; Mason & Elwood, 1995). In 1991 Klein
argued that the syndrome was a poorly understood phenomenon;
which might be explained by problems of definition, inconsistencies
in its criteria and the use of multiple and varied measures across
studies. Moreover, the fact that the syndrome is an unconsciously
and involuntarily determined phenomenon (Klein 1991., Brennan et
al 2006a) may complicate efforts by physicians to explain it, and
attempts by those affected to understand it. Therefore, one could
summarise the presumptive definition of the Couvade syndrome as
a psychosomatic phenomenon with little or no recognised
physiological basis, that affects male partners mainly during the
first and third trimesters of gestation and disappears early in the
Incidence and Socio-demographic Factors
The syndrome's incidence has a wide international variation, and early reports from the U.K. have a wide range of 11-50% (Trethowan & Conlon 1965; Dickens & Trethowan, 1971). Bogren (1984) found an incidence of 20% in Sweden. In the USA, Clinton (1987) and Brown (1988) reported a much higher incidence of 94-97%. Khanobdee et al (1993) estimated an average incidence of 61% among Thai males; while Tsai & Chen (1997) reported a similar incidence of 68% among Chinese men. The global incidence of the syndrome has also been demonstrated by reports of its presence in France (Sizaret ‘et al.’ 1991), South Africa (Chalmers & Meyer, 1996), Russia (Marilov, 1997) and Serbia (Koić ‘et al.’ 2004). However, one country where the syndrome has sparsely been reported is Australia (Condon, 1987), where admission of symptoms might be an anathema in what some claim to be a “macho” culture. Its relationship with socio-demographic factors such as age (Bogren, 1989), educational level (Lipkin & Lamb, 1982), social class (Strickland, 1987), number of previous children (Sizaret et al, 1991) planned or unplanned pregnancy (Bogren, 1983, 1984; Clinton, 1986; Strickland, 1987) all show inconsistent findings. The only exception is ethnicity where a higher incidence among black men has been consistently reported (Munroe & Munroe, 1971, Munroe et al, 1973, Clinton, 1986). These disparate findings might be explained by problems of sample size variation, cultural and age differences across studies, socio-economic class variability and geographical distributions (Brennan et al 2006b).

Theoretical Perspectives
A myriad of theories reflecting varied orientations have been proposed to account for the origins of the syndrome. These include psychoanalytical, psychosocial, sociological, paternal and hormonal perspectives. Psychoanalytical theories propose that it emanates from the man’s envy of the woman’s procreative ability (Bohem, 1930; Raphael-Leff, 1991). Another perspective maintains that it occurs because pregnancy for the expectant man acts as a catalyst for the resurgence of ambivalence and Oedipal conflicts (Gerzi & Berman, 1981; Barclay et al 1996; Bartlett, 2004). Other psychoanalytical theories propose that the syndrome is a consequence of the man’s rivalry with his unborn child (Malthie et al 1980; Kapfhammer & Mayer in Brahler and Unger 1996). Studies exploring a psychoanalytical basis for the syndrome are mainly case reports, which might be prone to subjective interpretation and difficult to generalise. However, It is not surprising, that male partners reported in such studies are often referred to psychoanalysts or psychiatrists for treatment given the idiopathic nature of the syndrome and its failure to be diagnosed by physicians.
Psychosocial theories propose that the syndrome is a reactive process to the marginalisation of men during pregnancy (Mayer & Kapfhammer, 1993; Chandler & Field, 1997). However, the feminist perspective rejects this, and argues instead for the increased and active participation of men during pregnancy and birth (Masoni et al. 1994; Polomeno, 1998). Psychosocial theories also propose that the syndrome arises because of men’s transitional crisis to prospective parenthood (Jordan 1990; Imle, 1990; Klein, 1991) mainly emanating from the ever-changing notions of fatherhood and the “new man” discourse in recent years which leaves men unclear and confused about their parenthood role. Sociological theories propose that contemporary reconstructions of fatherhood have pressured men to shed their traditional masculine roles with health consequences. Male gender roles within the parenting context are riddled with contradictions, a legacy of opposing theoretical perspectives which are conflicting and confusing for the man. Even more bewildering is the blurring of masculinity through androgyny where feminine traits need not be the opposite of masculine ones. Androgyny theorists (Bem 1979, Taylor & Hall 1982) argue that the androgynous male is able to muster both masculine and feminine responses according to the demands of various social contexts which clouds the issue of masculinity even further. Gender role strain and culturally influenced notions of masculinity especially during pregnancy can affect men’s psychological health possibly making them susceptible to the syndrome.

Paternal theories propose a relationship between men’s involvement in the pregnancy, role preparation and the syndrome (Weaver & Cranley, 1983; Raphael-Leff, 1991; Drake et al 1998). This might imply that a transitional crisis is less likely to occur if the male partner is better prepared for his new role but the fact that he is, still predisposes him to the syndrome, which contradicts psychosocial theories. Other paternal theories propose an association between the syndrome and anxiety (Trethowan & Conlon, 1965; Strickland, 1987; Brown, 1988). It is difficult, however, to determine whether anxiety is the cause or consequence of the syndrome. To date only two studies by Storey et al (2000), and Berg & Wynne-Edwards (2001) support a hormonal basis for the syndrome. The findings of both indicated a significant increase in men’s hormonal levels of prolactin and oestrogen but lower levels of testosterone and cortisol. These hormonal changes were associated with the display of paternal behaviours as well as Couvade symptoms.
Study Approach, Aims and Objectives

A phenomenological approach was chosen for the study based on the lived experiences of male partners with the Couvade syndrome. The aim was to explore the emotional, physical and psychological characteristics of the syndrome and their explanations, as perceived by men with pregnant partners. Its specific objectives were to:

- Explore male partners' experiences of pregnancy, including their feelings and aspects of involvement, to assess concurrence with current theoretical propositions for the Couvade syndrome.
- Explore the nature and duration of male partners' physical and psychological symptoms experienced across the three trimesters of pregnancy and labour as defining criteria of the syndrome.
- Explore male partners' accounts of whether and how these symptoms are investigated and managed making comparisons with the published literature.
- Identify the timing of symptoms and their cessation in male partners and compare with those reported in published literature.
- Explore male partners' explanatory attempts for their symptoms, to determine their meanings and possible social and cultural influences.

A sample of 12 men was recruited from the Foetal Medicine Unit of a large teaching hospital in London which serves a large Asian and Afro-Caribbean population. A further 2 were recruited from an Internet website specifically designed for the study namely, www.pregnancyandfathers.com. A non-probability purposive method of sampling was used. The investigator approached the men when they attended pre-scanning information sessions with their partners around the tenth week of the pregnancy, which provided them with details of the ultrasound scan procedure, potential pregnancy anomalies and details of antenatal care. Participants were offered the opportunity to ask questions about the study and provide their contact details. Fourteen male partners agreed to participate, eight who had no children, four who had 1 child, and two who had 2 or more children. Inclusion and exclusion criteria were established to reduce the likelihood of confounding symptoms.

The inclusion criteria were:

- Over 18 years of age.
- Can read, speak and understand English at a level suitable for the full completion of the interview.
- Partner has a confirmed pregnancy for which the recruited person is the biological father.
- Be willing to be interviewed.
- 52 -

- Have experienced a minimum of 4 physical or psychological symptoms whose onset coincided with the pregnancy.

   The selection procedure also involved completing a short questionnaire requesting information about male partners’ symptoms. The questionnaire contained a list of 27 physical and 8 psychological symptoms developed from the literature by Brennan et al (2006b). Men with four or more symptoms whose onset coincided with the pregnancy were included.

   The exclusion criteria were:

   - Under 18 years of age.
   - Unable to speak or write English at a level suitable for the full completion of the interview.
   - Receiving current treatment for illnesses that might produce physical symptoms similar to those of the Couvade syndrome, e.g., inflammatory bowel disease, viral infections like chronic fatigue syndrome, herpes, glandular fever, meningitis, thyroid problems, any form of cancer, anaemia or relevant chronic disease.
   - Receiving current treatment for any form of mental disorders that might produce psychological symptoms similar to the Couvade syndrome, e.g. depression or manic phases of affective disorder, anxiety disorders, schizophrenia and other relevant psychoses or neuroses.
   - Partner has confirmed medical problems with her pregnancy, e.g., gestational diabetes, hypertension, pre-eclampsia or other relevant maternal disorders.
   - Partner has a high-risk pregnancy, e.g. antenatal haemorrhage, foetal/maternal blood group incompatibility and similar conditions.

   The socio-demographic characteristics of the study population are summarised (Table). Social class was classified according to the National Statistics Socio-Economic Classification – (NS-SeC, DoH 2003).
<table>
<thead>
<tr>
<th>Category</th>
<th>Study Population (N)</th>
</tr>
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<tr>
<td><strong>Age</strong></td>
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<td>41-48</td>
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</table>
Ethical Considerations
Permission for the study was sought from the Local Research and Ethics Committee. Men who indicated their interest and satisfied the study entry criteria were invited to participate. They were provided with a study information sheet and a written consent form for audio-interview recordings to be performed in their own homes. It was made clear that their decision to participate or opt out of the study would not affect the subsequent care that they or their pregnant partners receive. Anonymity was preserved during the interviews and other aspects of the research process, through the use of pseudonyms for study participants and their partners if they referred to them by name. All forms of data were kept on a computer protected by a security password. Tapes/magnetic discs and other documents related to the interviews were stored in a locked cupboard in a secure room. Data was treated with strict confidentiality. The researcher was mindful that discussion of symptoms might be distressing for some participants. In these cases informants would be offered the opportunity for the interview to be terminated and referral to an antenatal councillor if they so wished.

Methods
Data Collection
Study participants were telephoned to arrange a suitable time for the interview. The purpose of the study was described to participants whose aim was to explore their feelings about the pregnancy, experience of physical and psychological symptoms and accounts of how these were managed and attempts to understand their symptoms. Details of the interview procedure were provided concerning its location, length of time, method of recording, management of interruptions and instances where clarification was needed. The interviews were conducted in the participants’ homes during the evening time and lasted between 60-90 minutes. Female partners were requested not to be present lest this affect male partners’ level of disclosure. A male researcher carried out all the interviews to take account of potential gender interaction effects between the interviewer and informants. This was in keeping with Levine & DeSimone’s (1991) observation that men often confide more readily to an interviewer of the same gender and report less to someone of the opposite sex. Moreover, the same researcher throughout also helps promote consistency and uniformity across the interviews. Prior to data collection, the researcher spent considerable time examining aspects of the pregnancy experience for men to increase awareness of personal prejudices, viewpoints and assumptions. These were then “bracketed” (Ashworth 1999) or set aside, so as not to influence the process and maintain neutrality and objectivity. An open-ended conversational stance was used
along with field notes to capture the interview context. An interview guide piloted prior to data collection was also used for the systematic sequencing of topics or issues.

**Methods**

**Analysis and Rigour**

An inductive approach based upon the analytic procedures of Colaizzi (1978) and Boyatzis (1998) was used namely thematic content analysis which ran concurrently alongside the process of data collection. A professional transcriber undertook transcription of the tape-recorded interviews, and the interviewing male researcher performed the analysis. The data was processed using the qualitative software package WinMAX Professional (Udo Kuckartz, BSS, Berlin, Germany 1998). The individual interviews were labelled M1-M14 (M1 = first interview, M14 = last interview). All the transcripts were scanned line-by-line and potential labels describing respective data segments were assigned manually and then later by the above programme. Categories and sub-categories were generated based on participants’ recurrent words or phrases within the data sets. Data segments were cross-indexed with the original interview transcripts that were re-read and checked against field notes to ascertain the contextual meaning of the data. Key categories and sub-categories with their appropriate data segments were then organised in a meaningful sequence, reflecting the aim of the study. This was followed with the identification of relevant concepts prior to establishing possible relationships between these. Three key themes emerged, which were used to describe the participants’ accounts, supported with verbatim examples. This was followed by attempts at interpretation of the meanings from the data sets. The personal meanings of participants’ experiences were interpreted using their “lived perspectives” to represent their reality and seek possible justification. Conceptual meanings were interpreted by making reference to individual participants’ social and cultural contexts as well as the pregnancy in explaining their perceptions and experiences. Two independent researchers were invited to read the interview transcripts in order to validate the sub-categories and themes. Three participants also reviewed their transcripts to ensure trustworthiness, accuracy and confirmability of the data prior to analysis.

**Findings**

Three themes emerged from the data, namely “Emotional Diversity in Response to Pregnancy”, “Nature, Duration and Management of Symptoms”, “Explanatory Attempts for Symptoms”.

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1. Emotional Diversity in Response to Pregnancy

Men’s experiences of the pregnancy from its announcement up to the birth, were demonstrated through their feelings, worries and concerns, their response to demands and involvement with partner and unborn child. A myriad of mixed feelings were expressed, which varied in intensity over time. Twelve men indicated their sense of excitement at the news of conception, especially in cases where it was their first child,

... Wow it was am-a-a-zing when I first heard that Sarah was pregnant as we’d only been married for a short time. I remember announcing it in the pub to all my friends the next evening that I was to become a new father I was really elated. I was excited for about four weeks afterwards... (M: 2).

In addition, three men expressed ambivalence where the pregnancy was unplanned,

... Yeah well it was a delight and in a way horror as well... (M: 12).

Feelings of shock to unanticipated pregnancy and a transitory reluctance to accept it also surfaced,

... It was a bit of a bombshell mate since we was using some prevention at the time you know what I mean? Later on I took it on board I guess ... (M 8).

After the period of announcement the initial excitement gradually lessened. Nevertheless, positive feelings continued for nine of the participants as the pregnancy progressed and even intensified during the third trimester. Six men indicated that the pregnancy precipitated feelings of closeness and intimacy with their partners especially during and after the period of the first ultrasound scan,

...We actually got very close after that period my wife and I, we hadn’t been married very long, and it sort of really brought us that much closer...(M:13).

While the pregnancy generated positive feelings it also precipitated worries and concerns. These were mainly in response to the demands of the pregnancy, what it signified in terms of its potential effects on the health of the partner and unborn, its impact upon the conjugal relationship and other siblings, financial commitment, accommodation space, prospective parenthood, antenatal preparation and maternal care. The demands of pregnancy were largely pragmatic, emotional and financial. Men's practical support such as shopping, lifting heavy items, care of siblings and housework increased as the pregnancy progressed and the women’s
physical capacity declined. Many men responded empathetically and sensitively to their partners’ emotional state especially in cases where they were tearful, anxious and vulnerable. Male partners also seemed to have a contextual understanding of the woman’s emotional state,

...There were times when Eileen would start crying for no reason and need a big hug from me and the boys to cheer her up. I suppose that was her hormones tough at the time...(M: 6).

While many men were responsive to demands demonstrating awareness of their partners physical and mental stresses as the pregnancy progressed, their feelings were not always congruent with their actions. For example, some men harboured feelings of resentment, lack of patience and irritability although these were not expressed directly to their partners,

...There was definitely ‘a shortness’, an anger, a lack of patience and irritation because there’s too many things that I was thinking that I had to do for her...(M: 13).

Another participant expressed his frustration with his partner’s increasing demands across the stages of pregnancy and felt that she should be able to do more for herself despite her condition.

Worries and concerns centred on the health of the partner and unborn child, whether the pregnancy would go to term, prospective parenthood and its responsibilities, how other siblings would react to the newborn child, insufficient accommodation space and financial commitments especially among those whose salaries were low or who were unemployed. Three participants expressed worries concerning the health of the unborn based on their lay conceptions when the first ultrasound scan was performed,

...I was worried ‘cos I thought he wasn’t right he might be..what ya’ call it..a Mongol or something...(M: 8).

When it came to prospective parenthood and its anticipated responsibilities eight men expressed mixed feelings. These included positive anticipation and longing for fatherhood, a realisation of its responsibilities and the sense of meaning it created in their lives,

...Becoming a father I think of many responsibilities I have for wife and child, it also give meaning to my life. I knew that have child change everything for me and family...(M: 9).
Conversely, prospective fatherhood led to feelings of worry, uncertainty and apprehension for others who were expecting their first child,

...Well I guess I was worried about becoming a dad...it’s a lot of responsibility ya’ know what I’m sayin’...(M: 8).

The majority of men participated in antenatal preparation such as attending ultrasound scans and antenatal classes but the feelings that these invoked were again mixed and seemingly influenced by cultural expectancies on some occasions. On one hand there were those who actively and willingly participated in antenatal classes with their pregnant partners but on the other hand there were those who seemed reluctant to do so because of the impact on their feelings. Others questioned their relevance and even led to a sense of empathic distance from the pregnancy,

...Oh ‘yeh’ I went to a few of those mother classes as well. I mean they ‘was getting’ me to do some exercises that Hope was ‘doin’. I just felt like a bit of a plonker man. I mean it wasn’t ME ‘havin’ the kid was it? ...(M: 3).

On some occasions antenatal classes were perceived as not being inclusive for the man,

...The focus of antenatal classes in my view is always on the woman and not on the man...(M: 10).

Men also contrasted their position with that of their pregnant partner when it came to antenatal care and felt their feelings were overlooked in the process,

... I did feel a bit of an outsider at the time...I mean it’s not as if I felt I should be the centre of things then but I sometimes wondered if people really know what its like for the other half when a baby comes along ...

(M: 2).

The feelings of the twelve men who attended the ultrasound scans varied and were sometimes influenced by cultural expectancies. For three men the scan unveiled the reality of the unborn baby through direct visual confirmation. For others it created feelings of apprehension about whether the health of the unborn was “normal”. Other men reported that it drew them closer to their partners. Not all men wished to know the gender of the baby but those who did displayed contrasting feelings when it was confirmed. This was classically illustrated by two Asian participants where a boy was confirmed in one case and a girl in the other. The former stated,
...I felt very exhilarated when it was confirmed that we were going to have a boy... (M: 7).

The other indicated,

...Well if I’m honest with you I felt a little disappointed since I was hoping for a boy... (M: 10).

Men’s emotional responses were sometimes linked to aspects of their involvement with the pregnancy and/or their unborn child. Their involvement in both took a number of forms which included commitment to demands, attendance and participation in antenatal care, preparation for the baby and choosing names, seeking confirmation of the unborn baby and evidence of paternal-foetal attachment. Men’s involvement with, and vicarious confirmation of, the unborn mainly occurred through the ultrasound scans and when they felt or listened to their partner’s abdomen for evidence of the baby kicking. Both the reality of the unborn baby and prospective parenthood were reinforced in such instances. For one participant the audible evidence of his partner’s “quickening” early in the second trimester confirmed,

...I used to try and listen to the baby in Sarah’s tummy. What I do remember is feeling the kicking ...am-a-a-a-zing and it really brought home to me that I was a dad or would be very soon... (M: 2).

2. Nature, Management and Duration of Symptoms

This theme centred on the men’s experiences of physical and psychological symptoms and their time course over the pregnancy, with accounts of the ways in which they were managed, and by whom, in addition to their cessation patterns. The identification of symptoms by men revealed insights into the ways in which these were experienced and their reality, intensity and level of distress. The most commonly reported physical symptoms were gastrointestinal, genitourinary, and musculo-skeletal and some other symptoms which could not be classified anatomically. Gastrointestinal symptoms included stomach pains/cramps (N-13) vomiting (N-7) and appetite disturbances (N-6). Men described their stomach pains as distressing and varying in intensity from an “ache” or initially “mild” to getting progressively “stronger”,

...My stomach pains were very much like a build up of a woman’s contractions as she’s giving birth, they start mild and then get stronger and stronger and stronger. That’s exactly what these stomach pains were like for
me, you know they started mild and got stronger and stronger and stronger... (M: 13).

Vomiting mainly occurred in the mornings and on some occasions was also displayed concurrently by pregnant partners,
...I was throwing up and retching a lot and couldn’t keep anything down both Beverly and me... (M: 8).

Appetite disturbances took the form of either increased or decreased appetite with some participants experiencing both alternatively. Some indicated that their appetite was insatiable and that hunger continued no matter what had been eaten. Occasionally, increased appetite and specific food cravings were linked,

...I was constantly hungry all the time and had an unstoppable craving for chicken kormas and poppadams. Even in the early hours of the morning I would get up and prepare myself one. It was strange to say the least... (M: 14).

The most common genitourINARY symptom was difficulty with micturition \( n = 5 \). Men reported that it took them a long time to urinate especially at night and that it was painful. The most commonly reported musculo-skeletal symptom was back pain \( n = 5 \). Among the other symptoms was tiredness \( n = 10 \), which some men described as disabling and accounted for their lethargy.

Less commonly reported symptoms were gastrointestinal including abdominal distension \( n = 3 \), diarrhoea and constipation \( N = 3 \), food cravings \( N = 2 \). Musculo-skeletal comprised leg cramps \( N = 1 \). Upper respiratory symptoms such as sore throat \( N = 3 \), colds \( N = 1 \), cough \( N = 1 \) and epsitaxis \( N = 1 \). Oral-dental symptoms were toothache \( N = 3 \) and sore gums \( N = 2 \). Other symptoms included lethargy \( N = 4 \), weight loss \( N = 4 \), weight gain \( N = 2 \), fainting \( N = 1 \).

In contrast to physical symptoms, psychological ones were less common, and included insomnia \( N = 12 \), feelings of depression \( N = 6 \) and irritability \( N = 3 \). Men described their insomnia as difficulty in getting off to sleep coupled with nocturnal restlessness and short intermittent sleep. Insomnia appeared to be linked to other symptoms such as tiredness and lethargy, or pregnancy-related worries and demands while feelings of depression were related to irritability,

...Well I suppose I felt quite low about the problems with my health ... (M: 14).

Less commonly reported psychological symptoms included those related to sleep, mood disturbance, emotional affect, motivation,
cognition and coping ability. One unexpected result was that a mere three men reported anxiety each within one of the trimesters of pregnancy only.

Symptoms were managed by men themselves and/or by those whom they consulted. In addition to visiting their doctors six men initiated self-management of their physical symptoms, four of whom sought advice or treatment remedies from their local high street pharmacy. One Chinese participant initiated his own dietary remedy which appeared to be in keeping with his cultural beliefs,

...My appetite was very bad and it was very important to have hot food to make the dampness go away... (M: 9).

Men only requested help in relation to their physical but not psychological symptoms. The people consulted were health professionals (general practitioners (GP) and/or dentists), one complimentary therapist (Chinese Herbalist) and one church minister. A total of eleven men consulted their GPs during the first and third trimesters for symptoms such as stomach pains, painful micturition, episodic fainting and respiratory problems and their dentists for toothache (N=3). Participants perceived that their GPs took their symptoms seriously, as indicated by the thorough assessment and the number and type of investigations performed. Assessment included physical examinations, blood or/or urine tests, blood pressure monitoring, computerised tomography (CT) scan and electroencephalography (EEG) to check brain activity. Management strategies included medical advice, referral to a counsellor and prescriptions, mainly in the form of analgesics. In each case no underlying pathology for symptoms was found and hence no definitive diagnosis made. One participant illustrates the idiopathic nature of his symptom of episodic fainting despite a multitude of investigations,

...He did an examination and a blood test and referred me to the hospital for a number of other tests. I had some done on my head, for one of these I had a scan of my brain but when the results came back they were all clear and my doctor seemed quite puzzled... (M: 14).

For men who had dental examinations a similar trend was evident causing one participant to temporarily doubt the reality of his symptom,

...I had a lot of pain in one of my back teeth. I thought it was the one where I had a filling so I went to my dentist and she told me that my tooth was OK and did not need any work doing on it. When this happened I
began to think I was imagining everything but I know I didn’t imagine it and I was very frustrated that no one thought that anything was wrong with me except myself…(M: 5).

In relation to the time course of symptom development, the onset of physical symptoms was mainly in the first trimester of pregnancy. Many of these symptoms temporarily disappeared in the second trimester and re-emerged again in the third trimester, often with greater intensity. The symptoms seemed to cease temporarily during the second trimester, and permanently at birth or shortly in the postpartum period as reported by eleven men. One of these confirmed the abrupt cessation of his stomach pains at the moment of his partner’s delivery,

…It went, literally. The baby had started to come and that was the point where I had to leave the delivery room and I couldn’t have walked more than 10 or 15 yards and it just went totally, like someone turning the light off, the pain just went. I thought it was very strange because it had just gone, so I went back into the delivery room and I had a son… (M: 13).

Psychological symptoms displayed a similar time course of start / cessation pattern, although a greater number of symptoms either commenced in, or persisted, during the second trimester. Some symptoms, e.g., insomnia and early morning waking, persisted well into the postpartum period.

3. Explanatory Attempts for Symptoms

Men’s attempts in making sense of their symptoms and acquiring meaning were illustrated in the explanations they provided, sometimes influenced by cultural beliefs and conventions like religion, alternative medicine or through the enlightenment by health care professionals in the process. All the men interviewed provided explanations for their symptoms referring to them individually and generally. Some men revealed insights into the contextual meaning of their symptoms, as did their partners,

…Well the stomach pains were like aching especially in the mornings. There was me and Marcel comforting each other about our tummy pains and you know what she said to me one time, ‘which one of us is pregnant you or me’?…(M:4).
Men also reflected on the onset of their symptoms and acknowledged these as coinciding with their partners’ pregnancy. In one case a participant made a comparison between the periods before and during pregnancy in assessing the onset of his symptoms,

...Yes I had a lot of things wrong with me then. I just couldn’t understand what was happening to me at the time I mean I had none of these problems before and then they all seem to come at once during my wife’s pregnancy... (M: 5).

Other men acknowledged their symptoms arose as a consequence of the worries and concerns which the pregnancy generated and in some instances being “in sympathy” with their partners. Men perceived that symptoms such as food cravings, abdominal pains and insomnia, arose because their partners had also experienced them. In other cases male partners drew analogies between their abdominal pains with those of their pregnant partners during the pregnancy and labour. In doing so one participant attempted to make sense of this symptom by comparing its intensity with that of his partner and attributing its transfer from her to him,

...I think I was in more pain than she was. It seemed like my pain was worse. It was almost as if she was transferring the pain on to me that sort of transferral thing you get sometimes. It was very much like that because she was in pain, her contractions were fairly strong but she couldn’t push and as that was happening my stomach pain was building up and up and getting worse and worse... (M: 13)

On another occasion a participant resorted to his religious beliefs to explain the meaning of his symptoms. He subsequently attempted to verify his spiritual perceptions with his church minister, who subsequently prayed for him and his partner,

...I have often tried very hard to think why all these things happened to me. When I look back I think that the problems with my health came about because of the forces of the enemy (Satanic) attacking us and making me sick. Satan hates Christian families you know!... (M: 4).

Men’s explanations for their symptoms were also influenced by their cultural beliefs and dietary patterns. For example, a Chinese participant attributed his poor appetite to ingesting too many “damp foods”. He consulted an herbalist who confirmed the same and suggested that he should include more “hot or spicy foods” in his
diet. On another occasion an Asian participant explained his indigestion and diarrhoea by eating too many chillies the evening before. Causal explanations for physical symptoms were most common where one symptom gave rise to another. In this context, weight gain was interpreted as resulting from increased appetite while weight loss occurring, from decreased appetite. Symptoms were also perceived as arising from common viruses and infections such as breathlessness from colds and stomach pains from a transient viral infection or food poisoning. Sometimes health professionals shared participant’s explanations for these symptoms but without confirmatory evidence. However, dentists consistently based their failure to provide explanations for toothache on their dental examinations, all of which confirmed no underlying cause.

While participants did not consult for psychological symptoms they still tried to make sense of them which they perceived as arising from the financial, physical and emotional demands of pregnancy as well as concerns about the health of their partner and unborn baby during gestation. Other participants perceived that psychological symptoms occurred because of physical ones and seemed preoccupied with their impact on general health. Feelings of depression, anxiety, preoccupation and irritability were all explained in this way. Only in one case did a health professional interpret physical symptoms as having a psychological basis by a suggested referral which appeared to negate the participant’s experience,

...He said there was nothing else he could do and suggested that he could arrange for me to see a counsellor. This made me REALLY angry. It was as if he did not believe that I had all these problems with my stomach and getting sick... (M: 14).

Six men showed difficulty in their attempts to understand their symptoms, as did the health professionals they consulted. In these instances men often resorted to supposition or conjecture in the process,

...As I’ve already said they might have had something to do with my wife’s pregnancy but I don’t know what exactly... (M: 7).

For some men their symptoms still constituted a sense of “mystery”, “confusion” and “puzzlement” when considered in hindsight,

...I don’t know mate it’s still a mystery to me... (M: 3).

In these cases they continued searching for answers and even sought enlightenment from the interviewer in doing so,

...Well I’ll tell you now I am baffled by the
whole thing, I mean if you or my doctor couldn’t tell me, who could... (M: 6).

Those GPs who were unable to definitively diagnose or explain symptoms often made broad or generalised, non-descript diagnostic statements instead such as, “you’re run down”, “you’re stressed” or “you’re generally under the weather”.

Discussion

Pregnancy triggered a mixed range of emotions for the men in the study especially at the news of their partners’ conception. Men expecting their first child unsurprisingly exhibited initial feelings of excitement but others displayed ambivalence, feelings of shock and reluctance precipitated by an unexpected or unplanned pregnancy. Lewis (1982) acknowledges this diverse display by proposing that news of the partner’s pregnancy often evokes a broad range of emotions in men. As the pregnancy progressed so too did its reality, significance and impact on the conjugal relationship, its physical and emotional demands, the realisation of prospective parenthood triggered by different aspects of its care and related health concerns. These unsurprisingly led to a myriad of different feelings and opposing emotional responses some of which men kept covert from their partners. Men may have felt that by expressing these openly they would have caused their partners further distress at a time when they were emotionally labile. Pregnancy-related financial demands generated worries for those men who were unemployed or on low salaries.

Men’s varied feelings about prospective parenthood, its roles, responsibilities and demands, were most likely influenced by first-time parenthood (N-8) or previous parenting experience (N-6). Certainly those who were first-time parents were more apprehensive and uncertain but whether this made them more susceptible to a transitional crisis and thereafter the syndrome as psychosocial theories suggest (Jordan 1990; Klein 1991), is unclear. Nevertheless, it was curious that all men displayed known features of the syndrome despite their parenthood status.

Men did not always feel that antenatal preparation was inclusive for them but one needs to carefully consider the evidence to determine whether this arose out of choice or fact. During antenatal classes some felt marginalised because of the attention their partners received, or felt on the periphery because of what they perceived as a specific gender focus on women, while others showed a reluctance to participate in them. Exclusion out of choice probably reflected cultural or traditional expectancies of gender roles and caused some men to question and curtail their participation accordingly. These feelings of exclusion for whatever reasons, may have contributed
men’s susceptibility to the syndrome as some psychoanalytical theories suggest (Mayer and Kapfhammer 1993; Masoni ‘et al.’1994).

Men’s feelings to the ultrasound scans were mixed for a variety of reasons but those in relation to the gender confirmation of the unborn appeared to be the result of cultural pressures or expectancies. For a number of men ultrasound confirmed the reality of their baby where previously this was vicarious. The ultrasound scans also unveiled men’s innermost concerns about the health of the unborn. Indeed, their degree of attachment to the unborn may have conditionally rested on this confirmation through ultrasound, although there was no direct evidence for this in the study. Weaver and Cranley (1983) have acknowledged this as part of the process where men through technological visualisation attempt to make contact with their unborn child which in itself constitutes a significant indicator of paternal attachment and involvement. Men’s involvement as well as the reality of imminent fatherhood was also demonstrated when they attempted to listen for signs of the unborn baby’s kicking during the period of the woman’s “quickening”. Since the majority of men demonstrated involvement and varying degrees of attachment to their unborn these may have been related to the onset of the Couvade syndrome as Weaver and Cranley (1983) have shown.

Many of the physical symptoms which men experienced were identical to those of the Couvade syndrome confirmed in a number of investigations (Chalmers and Meyer 1996; Tsai and Chen 1997; Thomas and Upton, 2000). Men’s stomach pains and vomiting in particular, commonly compares with those most prominently displayed by pregnant women. Evidence for their concurrence between both partners seems suggestive of men’s attunement to, or identification with, their partner’s display of them (Mayer & Kapfhammer 1993; Magalini & Magalini 1997). Alternatively, men’s vomiting might simply have occurred because of smelling or hearing the sound of their partners vomiting which caused them do likewise. This is feasible in the first trimester but it would not explain its persistence in the third when the pregnant woman’s morning sickness ceases. The finding of an alternative occurrence of increased and decreased appetite for some men replicates a similar trend reported by Conner and Denson (1990) and Khanobdee et al (1993). Some men indicated that their increased appetite was linked to food cravings while decreased appetite might have arisen because of vomiting and anxiety. The less commonly reported symptom of abdominal distension, especially in the third trimester coincided with a time when women are most heavily pregnant but weight gain was the most probable cause. Alternatively, it might
have indicated pseudocyesis or “phantom pregnancy” whose presence has been linked to the Couvade syndrome (Mayer and Kapfhammer 1993; Koić et al 2004).

The most commonly reported psychological symptom was insomnia which men explained resulted from worries and anxieties concerning their physical symptoms and the pregnancy itself. Its reoccurrence in the third trimester may have been additionally affected by their partner’s nocturnal restlessness due to being heavily pregnant at that time. Feelings of depression are difficult to compare or contrast with other work given the dearth of literature on antenatal paternal depression. However, there was some evidence to suggest that the number and distress of men’s physical symptoms were the cause. Few men reported anxiety which was surprising as this finding contrasts with other studies confirming its prominence and relationship with the syndrome (Strickland 1987; Brown, 1988). Overall, the physical and psychological symptoms which men experienced closely identified with those of the Couvade syndrome reported in the literature. In addition, their presence across a heterogeneous and culturally diverse but rather small sample was confirmed.

Consultation and accounts of symptom management were partially influenced by socio-cultural and religious beliefs. The fact that many men consulted their G.P.’s suggests that they perceived their physical symptoms as serious and/or distressing. The fact that none consulted for psychological symptoms does not mean that they were perceived less so but most likely reflected reticence to admit them because of social or cultural taboos. The timing of consultations, mainly in the first and third trimesters, confirmed similar trends for those of the Couvade syndrome in the Lipkin and Lamb (1982) study. The failure to specifically diagnose or show a physiological basis for physical symptoms is consistent with the defining criteria of the syndrome identified in other studies (Klein, 1991; Mason and Elwood 1995). Their onset and cessation periods demonstrate the same (Trethowan and Conlon 1965; Clinton, 1987). However, the persistence of sleeping problems and tiredness for some men into the postpartum was unsurprising given the likelihood of the newborn baby’s nocturnal crying.

**Limitations**
The main limitations of the study were its small sample size and generalisibility of findings given the unique nature of the data. Men may have reported more symptoms because they volunteered for the study while those less commonly reported may simply have arisen within one of the sample’s sub-groups. Demographic influences such as culture, social class and reproductive history on
symptom reporting were likely to be influential and in some cases may have led to underreporting. Selective recall of distressing symptoms is also likely to have affected reporting, a common methodological problem in symptom reporting research, acknowledged by Pennebaker (1982). The study’s results are compared with literature on the Couvade syndrome some of which is dated for reasons mentioned earlier. The interpretations of the findings, which at times may be speculative, also uses supporting evidence confirming the syndrome in these men. The nature, time course, consultation outcomes and explanations for symptoms compare favourably with those documented for the Couvade syndrome and its criteria, but others might cast doubt on this, implicating men’s normal responses to pregnancy instead.

**Conclusion**

This was the first phase of a three-part study exploring pregnancy-related symptoms of the Couvade syndrome among a highly heterogeneous but small group of men within the U.K. Using an inductive analytic approach, the findings of the study demonstrated men’s mixed display of emotional responses to pregnancy and different aspects of their involvement within it. Men identified a range of physical and psychological symptoms including their reality, intensity, duration and cessation many of which closely resembled those of the Couvade syndrome. Patterns of men’s consultation were influenced by socio-cultural factors and religious beliefs. Men’s accounts of how symptoms were managed confirmed that health professionals treated them seriously but failed to definitely diagnose or find a pathological basis for them as confirmed in previous reports of the syndrome. Explanatory attempts for symptoms revealed that some men had contextual insights into their relationship with pregnancy while others resorted to lay, cultural and religious beliefs in making sense of them. There were those who experienced difficulties in explaining them and resorted to supposition or conjecture in the process. Health professionals showed similar difficulties.

From a theoretical standpoint the feelings that men experienced in response to, and during, pregnancy highlights their emotional vulnerability during this period. The event of pregnancy signals many changes in men’s lives some of which are perceived apprehensively. Health professions need to be mindful of the socio-cultural and emotional contexts of antenatal care for male partners where they may be confronted with the reality of prospective fatherhood including concerns about its roles and responsibilities and gender of the unborn. If men’s emotions are overlooked in antenatal care this might contribute to, or exacerbate, somatic symptoms as suggested by psychoanalytic and psychosocial
theories. Men’s active involvement in the pregnancy does not necessarily serve as a protective factor but may make them equally susceptible to those less involved. Expectant men’s physical and psychological health needs need to be addressed in current antenatal care provision. A greater awareness of the syndrome is warranted given its physical and emotional consequences not only for the man but also his pregnant partner. Future attempts to understand, explain and manage the syndrome may be best served if socio-cultural and psychological contexts are considered as they have in this study. Future clinical interventions should aim toward increasing men’s understanding of the transitory nature of symptoms and their spontaneous disappearance despite their distress.
References


A PHENOMENOLOGICAL RESEARCH STUDY: YOUNG MEN’S EXPERIENCES OF BEING CARED FOR IN HOSPITAL FOLLOWING A ROAD CRASH

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Introduction:
Admission to hospital as a result of a road traffic crash can have serious physical, psychological and social implications for patients and their families. The role of the nurse in caring for these patients is vital in promoting their recovery both physically and psychologically.

Aim of the Study:
The aim of the research study was to examine the male adult’s (18-30 years old) experience of being cared for in hospital following a road crash.

Methodology:
This qualitative research study utilized the phenomenological approach. Unstructured interviews were conducted with six participants and audiotaped. The interviews were analysed using Colaizzi’s (1978) seven-step procedural framework.

Findings:
Participants’ descriptions revealed four themes: Telling the story; caring; fear; realisation and resolution.

Discussion:
Open communication between the nurse and the patient had a positive influence on the participant’s recovery and is central to realising the essence of caring in nursing practice. The participants in this study identified the attitude of the nurses as important in developing the nurse-patient relationship. The six participants acknowledged that their hospital experience was difficult to come to terms with due to their loss of independence and sudden loss of control in their lives.
**Recommendations:**

- The development of an effective health education programme with a multi agency approach targeting young male adults in relation to road safety.
- Further research from the patient’s experience is recommended. Knowledge gained from patients can enhance nursing practice.
- Continuous evaluation of current road safety programmes.

Self-referral to the Emergency Department: an exploratory analysis of reasons for attendance in people assessed to be in triage categories four or five on presentation.

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Abstract

Background and context
While literature is developing in the field of appropriateness of attendance in over-crowded Emergency Departments, fewer studies have focused on the significant area of self-referral.

Aim of the study
To evaluate reasons for self-referral to an Emergency Department (ED)

Methodology including research design and sampling
- Target group was self-referred adults attending the Emergency Department and assessed to be in triage categories four and five
- Target group surveyed by questionnaire using modified form of cluster sample method

Analysis
SPSS statistical package utilised to analyse 226 responses

Summary of key findings
- Four primary reasons for self-referral identified:
  1. pain (41.74%)
  2. accident (34.86%)
  3. anxiety over symptoms (17.89%)
  4. shortness of breath (5.51%)
- Over three quarters of those surveyed considered their need for medical attention to be urgent, despite being assessed in triage category four or five.
• Less than half the attendees surveyed (43.11%) considered alternatives such as a General Practitioner, or an after-hours service, before deciding to present at ED.

• Among this sub-group, six predominant reasons for self-referral were:
  1. Perception that ED treatment would be superior to General Practitioner treatment (21.97%)
  2. Perceived need for Hospital Services e.g. Radiology or Orthopaedic clinic (17.59%)
  3. Ease of access to ED (17.59%)
  4. Perception that General Practitioner would refer them to ED anyway (16.49%)
  5. Financial cost (15.38%)
  6. Dissatisfaction with General Practitioner (10.98%)

Conclusions
Attendance at the Emergency Department in self-referred people was not only related to physical symptoms, but also to the perceived need for access to Hospital Services, and perceived urgency of the need for medical treatment (despite being in triage categories four and five). These factors impacted on the decision to attend the Emergency Department regardless of the availability of other options.
Implementing Planned Change: the introduction of Nurse-Initiated Discharge across Medical and Surgical Services of a 720-bed Acute Tertiary Level Hospital in New Zealand.

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Abstract

Background and context
Bed flow problems in this organisation were intensified by high average bed occupancy rates hospital wide (up to 97%), Emergency Department overcrowding issues and audit-identified unnecessary delays to discharge.

Aim of the study
‘Nurse-Initiated Discharge’ focused on improving collaboration between members of the multi-disciplinary team to enhance service quality during the discharge process, and in particular, to minimise unnecessary delays. The hospital wide rollout followed on from the success of an initial pilot project conducted in three clinical areas: Cardiology, General Medicine and Neurosurgery.

Methodology including research design and sampling
• Business case approved with a phased implementation over 6 months across Medical and Surgical division
• Dedicated Project Facilitator for 6 months
• Phased approach occurring across 3-5 wards at one time

Analysis
Evaluation of impact was determined through both quantitative measures (length of stay, weekend discharge rates and readmission rates) and qualitative measures (staff and patient satisfaction surveys)

Summary of key findings
• Decreased Length of Stay (average of 0.30 days**)
• Increased weekend discharge rates (average 40.6%**)
• No impact on readmission rate (0.02% readmission rate for Nurse Initiated Discharge patients within first 1-7 days**)
• Increased staff satisfaction with the discharge process
• Increased patient satisfaction and increased awareness of discharge plan

** Due to on-going status of nurse initiated discharge, the data will continue to be evaluated and updated between abstract submission date and conference date.

Conclusions
Registered nurses have the necessary knowledge, skills and competence to facilitate discharge appropriately supported by defined criteria, policies and procedures that have been endorsed by the Consultant and members of the multi-disciplinary team responsible for clinical service provision. Success Factors in creating this solution to an identified need in our organisation included:
• Effective Steering Committee
• Concept researched
• Tested through consultation and pilot locally
• Multidisciplinary collaboration
The Waiting Game: Delayed Discharges of Older People from an Acute Hospital

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Abstract

The aim of this research was to explore the factors believed to contribute to delays in discharging older people from acute hospitals. The focus on discharge planning and procedure reflects the hypothesis that there is an urgency to ‘free up’ beds, regardless of whether appropriate facilities or supports exist, to which older people could be transferred.

Negotiated Order theory enabled the researcher to explain the neglected dimensions of conflict and tension that exist between the care professionals involved in the discharge of patients. These relationships co-exist, in theory, to facilitate each other to reach a common goal. However, as this study has shown, occupational roles have to be actively negotiated on a daily basis. Etzioni’s theory of Goals in organisations was used both to underpin and guide the direction of the research. With this theory it was possible to understand the pressures on staff to set aside their ‘ideal’ goal of providing health care to their patients, while fulfilling the ‘real’ goals of ‘freeing up’ beds.

To understand the experiences and observations of staff dealing with the discharge from hospital of older people, twelve nurses and seven doctors were interviewed. A qualitative case study methodology was used and Nvivo - a software package that supports qualitative data, aided analysis.

Data revealed that often older people are being kept in hospital because there is nowhere else to send them. Community supports and services vary greatly between geographical locations and there are vast areas of unmet needs, both inside and outside the hospital. Economic factors determine where and by whom dependent elderly
receive care. One of the greatest stresses for patients and their families is endeavouring to meet the cost of long term care.

Discharge planning and communication between hospital and community sectors, as well as communication with patients and their families, were identified as needing urgent consideration if effective solutions are to be found.
"We Want To Be Nurses, Too":
Living Through an Accelerated Nursing Program

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Background:
Accelerated nursing programs for those with another bachelor’s degree have been in existence since the mid-1970s. Existing literature is replete with rationale and documentation of quantitative outcomes of these nursing programs. There is almost no information about the experience of being a student in one of these programs.

Aim:
The purpose of conducting this study was to document various aspects of the experience of being a second degree student in an accelerated nursing program. A secondary aim was to provide feedback for quality improvement of the newest nursing program at a regional university in South Georgia.

Methodology:
Using a focus group technique and purposive sampling, the first group of 11 second degree students (as a separate cohort) at a regional university in South Georgia were interviewed via e-mail and group session about their experiences during the academic and clinical nursing program. To avoid any bias or personal knowledge of individual responses, a Sociology Department faculty member familiar with focus group techniques was asked to collect all e-mail responses and conduct the focus group interview session. The interview session was audiotaped and transcribed by an independent transcriptionist who did not know the participants.

Analysis:
Upon completion of the transcription and compilation of the e-mail responses, each transcript was analyzed by the researcher and student assistants who had helped develop the study. Transcripts were analyzed for themes and patterns using Colazzi’s data analysis methods. Data statements were clustered into patterns and then into major themes.
Conclusions:
Several themes emerged from the data, including: survival; communication; interpersonal relationships; and a sense of time urgency. Findings from this study are being used to assist in end of the year evaluation of the program with plans for quality improvement in the coming year as the second cohort enters the accelerated program.
Aim of review:
Living in culturally diverse areas of the U.S. over the last decade, the author has noted an inherent assumption that because the area is culturally diverse, health care providers must be culturally competent. However, direct observation in clinical practice has indicated that this is a faulty assumption. Therefore, an extensive review of literature was undertaken to provide models or guidance for developing culturally competent students and practicing nurses.

Search and review methodology:
Selections for this review were generated from a computerized search of nursing literature from 1980 through 2005; cumulative indexes of the professional literature over the same period; the “invisible college” of experts in cultural competence in health care; and the ancestral approach generated by the database search. Keywords used were culture, healthcare, cultural competency, nursing research, and combinations of these words. Materials reviewed were limited to widely circulated journals, printed in English, with education or clinical implications for providing culturally competent care. Over 40 sources were available for review.

Summary:
Cultural competency in nursing practice is one of the issues that has taken the stage over the last two decades, evolving as a professional mandate for the delivery of quality patient care to a multicultural global community. The majority of the literature reviewed was theoretical or anecdotal. A few pieces presented models for cultural care, but most were not broad enough to provide significant guidance in educating nurses on providing culturally competent care.

Conclusions:
Since there were few guidelines for education or practice, a search of historical materials and contemporary anecdotes was used to provide some guidance for educational sessions. A further outcome
of this review is the initial development of a conceptual model that may assist in developing the educational sessions needed within the academic and clinical community.
THE USE OF A BRIEF SCREENING MEASURE BY PRIMARY CARE NURSES TO DETECT LATE LIFE DEPRESSION

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Background: Depression is the most common psychiatric disorder among the elderly. Although primary care nurses are an important resource in its detection, it is still under recognised. To date few International and no Irish studies have reported on outcomes with respect to training primary care nurses in late life depression.

Design of the Study: A repeated measure design was used to examine the impact of a two day training programme and the use of a brief screening protocol following training. Nurses knowledge about depression symptoms and their confidence to assess older persons were measured pre and post training.

Sample Selection: The total population of primary care nurses in the Mid West region of Ireland (n=253) were invited to participate in this study, 73 of whom commenced training and 66 completed the programme.

Data collection: A self-report questionnaire was developed specifically for the study. Data was analysed using SPSS (version 11.0). Symptoms of depression were scored (1) for correct response that matched any of the nine DSM IV diagnostic criteria for depression and (0) if incorrect. Descriptive statistics were use to evaluate the use of the screening tool in practice. Inferential statistics including McNemar’s test and Chi square were used to assess for significant relationships between pre and post measures of symptoms and confidence levels respectively.

Results: After training nurses knowledge of the symptoms of depression were statistically significant for 6 of the 9 DSM-IV criteria (p<0.05). They were also more confident in their assessment ability (p<0.0005). Subjects had screened 20% of older patients at one month and 16% at three months after training.

Conclusions This two day training programme on late life depression was effective in producing both knowledge and confidence change. However, the uptake of the screening measure in practice was disappointing. Further studies need to examine issues surrounding the promotion and sustaining of practice changes secondary to training.
Title: Identifying midwifery research priorities for Ireland

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Background: In 2004 the National Council for the Professional Development of Nursing and Midwifery commissioned a study to identify research priorities for nursing and midwifery in Ireland (Meehan et al 2005). This presentation reports on the findings in relation to midwifery research priorities.

Aim: To identify overall short-term, medium-term and long-term research priorities, related to clinical, managerial and educational issues for midwifery in Ireland.

Design: A three-round Delphi survey was used to identify and rate the importance of clinical, management and education research issues, followed by a one-day workshop to identify short, medium and long-term priorities.

Sample: 142 midwives working in clinical, managerial and educational settings across Ireland agreed to participate in the research. Midwives who participated in each round were invited to participate in the following round and those participating in round 3 were invited to participate in a one-day workshop. A small group of midwifery service users also participated in the workshop.
Data collection and analysis: In round 1, participants were asked to identify five clinical, management or education research issues and to rate the importance of these. Analysis of the data from round 1 was used to generate the items for inclusion in the questionnaire used in round 2 where participants were asked to rate items using a 7-point likert scale. The ratings per item in round 2 were then fed back to respondents in round 3 for further rating. This was then followed with a one-day workshop where participants were asked to identify which of the final set of items were short, medium and long-term priorities.

Results: Eleven research priorities in relation to midwifery research, 8 research priorities in relation to midwifery management and 7 research priorities in relation to midwifery education were identified. The following six high priority issues were identified for midwifery research to be conducted in the next three to five years: 1) Promoting woman-centred care; 2) Promoting the distinctiveness of midwifery; 3) Satisfaction with care; 4) Care in labour; 5) Preparation for practice; and 6) Promoting research/evidence-based practice. A further three high priority issues were identified to be researched in the medium-to-long term. Also a range of other issues, which although of lower consensus or importance, were identified as important issues to be addressed through research.

Conclusions: While the research priorities identified for midwifery in Ireland reflect many of the priorities identified in other countries, the approach used here also identified priorities for midwifery education and management. This set of priorities will serve as a guide for the focus of future research activity in midwifery and the allocation of funding by research funding agencies.

References:

The Validity and Reliability of the Irish Nursing Minimum Data Set for General Nursing

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Background and Context:
A nursing minimum dataset is a data collection tool designed to capture essential nursing data to describe the nursing contribution to patient care (Goosen 2001). A standardized nursing database will enable the grouping and comparison of nursing care across different clinical populations, settings, geographical areas and time (Werley et al 1991). The Irish Nursing Minimum Data Set (I-NMDS) was developed using qualitative and quantitative techniques to identify the core elements of nursing care in Ireland. The I-NMDS comprises of three main dimensions: patient problems, nursing interventions and co-ordination of care activities.

Aims:
1) To explore the validity of the I-NMDS
2) To establish the reliability of the I-NMDS

Method:
Data collection was conducted in five acute hospitals in Ireland from the areas of cardiology, coronary care, oncology, surgery, medicine and orthopaedics. Data was collected for a period of five consecutive days on each participating ward/unit. This resulted in the collection of 1,629 days of data.

Analysis:
A variety of methods were used to test the validity of the I-NMDS. Construct validity was explored using exploratory factor analysis to determine a factor structure for the I-NMDS. Discriminant validity was tested using RIDIT (Relative to the Identified Distribution) analysis. The inter-rater reliability of the instrument was tested using Cohen’s Weighted Kappa and percentage agreement scores.

Findings:
Analysis suggests that the bio-psycho-social model of care is endorsed by the emergent factor structure. The inter-rater reliability
of the instrument was established to a satisfactory level with the issue of prevalence affecting some of the reliability scores.

Conclusion:
The validity and the reliability of the I-NMDS was established.
Student nurses’ perspectives of learning fundamental nursing skills prior to their first clinical placement.

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Background
Learning is enhanced when the teaching environment mirrors the real world. Clinical skills laboratories simulate a clinical setting; consequently, they provide a safe and an appropriate environment for students to learn and practice skills. Utilising appropriate educational strategies such as, experiential learning and reflection facilitate skills teaching and prepare students for clinical practice.

Aim
The poster represents student nurses’ perspectives of learning fundamental skills and how the use of clinical skills laboratories enable them to link theory to nursing practice.

Methodology & Analysis
A quantitative design using an on-line semi-structured questionnaire was undertaken with the entire population (n=96) of first year student nurses in order to establish students’ views regarding skills.
based teaching sessions in the laboratories and how they prepared them for clinical practice. Several issues emerged regarding the students’ learning.

Summary of Findings
The module content prepared the students for clinical practice. Skills based sessions enabled students to understand and practice clinical skills. The student teacher ratio was viewed in a positive light. Practicing skills such as, measuring body temperature on each other augmented the students’ learning. The students enjoyed learning and practicing skills in the clinical skills laboratories and believed the equipment in the laboratories enhanced their learning. Measuring blood pressure using an aneroid sphygmomanometer and administering an intramuscular injection provoked the greatest learning challenges for the students. For some students this increased their anxiety level and they required additional teaching sessions to master the skills and overcome their anxiety.

Conclusion
Matching the teaching environment to the clinical setting enhances students’ learning. Utilising clinical skills laboratories for teaching practice based sessions facilitates the learning process. When theory is linked to the practice of nursing, students are adequately prepared for practice and their confidence is increased.
Nursing assessment of the healthcare needs of the elderly living in the community

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Background and Context
Ireland has an ageing population and the elderly formed eleven percent of the total population in the 2002 census (Central Statistics Office 2003), the majority of which live in the community (National Council on Ageing and Older People 2005).

The vision of Irish healthcare policy for older people is to support and maintain people in their home environment (Department of Health and Children 2000, Department of Health and Children 2001), with a concomitant provision of community health and social services. The recent job description of the PHN states that the role of the PHN is “to provide regular preventive services for older people with a view to maintaining older people in dignity and independence at home in accordance with the wishes of the older person” (Department of Health and Children 2000: 2). Recent
reports have outlined that the public health nursing service is the most frequently used community service by the elderly (Garavan et al. 2001, Hin et al. 2002). However, some of the elderly who were in receipt of the public health nursing service requested greater input. There is a need to identify clients with high needs in order to prioritise care and allocate nursing resources appropriately.

Aims of the study-
To identify the health care needs of the elderly using a patient classification system and to ascertain the relationship between needs level and nursing time.

Methodology including research design and sampling
A quantitative approach was used. Forty-four nurses, a convenience sample, assessed the needs of 1,482 elderly they cared for during four weeks, using the community client need classification system (CCNCS). The CCNCS was developed by Begley et al. (2004) to measure the workload of Irish public health nurses. The participants recommended that that some of the criteria be merged (Byrne et al. 2006). The revised CCNCS consists of seven criteria and these were ‘nursing assessment’, ‘physical care requirements’, ‘teaching and health promotion needs’, ‘psychosocial needs’; ‘case management’, ‘carer and family support’, ‘environmental needs’ and travel time. Each criterion is scored one to five and an additional five is allocated to clients where nurses spend in excess of twenty minutes travelling to see them. The total CCNCS is calculated by adding all of the scores. Level 1 Needs level is clients who score less than seven, level 2, 8-14, level three 15-21, level four 22-28, and level five is between 29 and 40.

All of the participants attended a workshop on the CCNCS and received a pocket guide to facilitate assessment of the clients.

Analysis
The data was analysed using SPSS V 12. Descriptive statistics was used. Spearman’s Correlation was used to correlate nursing time and total needs score. Kruskall Wallis test was utilised to ascertain if there was a significant difference in nursing time between clients assessed according to the different needs levels.

Summary of key findings
The setting for this study was a health board region comprising of a city and sparsely populated rural regions. The majority of the nurses described their community care area as a rural setting (n=18, 40.85%) while four nurses described it as an urban setting and a further 18 stated that they worked in both rural and urban settings.
The hospital (n= 414, 32%) and the Gp (n= 318, 24.6%) were recorded as the two main sources of referral to the public health nursing service. The majority of the clients were assessed as needs level 2 and a minority (n= 41, 4.1%) were assessed as high need (level 5).

The least frequently used criterion was ‘physical care requirements’ while the most frequently used was ‘nursing assessment’. 45 clients (3.1%) were identified as high need regarding their living accommodation and the environmental factors (1.91) had the lowest mean score of all of the criteria. The highest mean score was recorded for case management (2.33). The most frequently selected score for case management was 3 (n= 543, 37.3%) and only 37 clients (2.5%) received a rating of 5.

353 (23.8%) clients were recorded as requiring the additional weighting for travelling by the nurses.

Nursing time was recorded as PHN Home Visiting Time, PHN Clinic Time, PHN Indirect Time and RGN Time. All time was recorded in minutes per month. Total PHN time was calculated by the addition of the three PHN categories.

PHNs spent the largest component of their time ( 71.78% ) on home visits in comparison to 5.34% in clinics and 22.88% on indirect time, A small minority of the elderly (10.9% n= 159) were seen in the clinic while the remainder (85%, n= 1250) of clients were visited by the PHN in their home.

Inferential statistics were used to ascertain if there was a significant difference between the amount of nursing time that clients received among the different needs levels. The data did not meet the criteria for parametric tests and thus the Kruskal Wallis test was used to ascertain if the difference in time between clients of different needs levels was significant. As the needs level rises, the mean PHN total time increases and this was statistically significant (Kruskal Wallis $\chi^2 = 236.684$ df= 4 $p<0.001$). There was also a significant correlation between total PHN time and total CCNCS score ($r= 0.432$, $p<0.001$).

Nurses were asked to document the involvement of the multidisciplinary team with their clients. The mean number of healthcare professionals documented as being involved in the care of the elderly, in addition to the PHN, was 1.89 (Standard Deviation 1.026). The majority (n=580, 39.1%) were seeing just one other
health care professional, 32.6% (n= 483) two, 18.4% (n= 273) three, 5.2% (n= 77) four, 1.6% (n= 23) five and two clients were being cared for by six health care professionals. These two clients were assessed as level four in terms of client need.

Conclusions
The limitations of this study include the use of a convenience sample of nurses and the self-reporting of nursing time. However the participants reported that this classification system helps nurses to identify elderly clients with high needs and thus assists them in planning the appropriate resources to meet their needs.

References
Begley, C. M., Brady, A.-M., Byrne, G., Macgregor, C., Griffiths, C. and Horan, P. (2004) A Study of the Role and Workload of the Public Health Nurse in the Galway Community Care Area, University of Dublin, Trinity College, Dublin
An exploration of the practice of portfolio development in a post registration specialist nurse curriculum as both a learning tool and an assessment method

Presented by

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Background and Context: Whilst much has been written in the nursing academic press in relation to the assessment of competence, there remains no universally accepted instrument for this purpose. Therefore the importance of clinical performance of nurses cannot be overestimated as the developments of their clinical competence depends on it.

This work explored narrative accounts of students in the first and second years of a BSc(Hons)Specialist Nursing Practice(Cancer Nursing) programme whose views on portfolio development were sought for the purposes of progressing teaching and learning of this course. This gives this work a clear androgogical focus (Knowles, 1978).

The origin of the enquiry is derived from the authors’ activities and involvement with the development of specialist practice students’ portfolios which are tripartly assessed by the student, clinical mentor and course tutor.

Aims of the study: The aim of this project is to explore the practice of portfolio development in a post registration specialist cancer nursing curriculum, as both a learning tool and an assessment method.

Methodology: This preliminary enquiry followed a qualitative research methodology presenting narrative accounts, collected via focus groups, of a group of first (6) and second (3) year students (n=9) on a BSc(Hons)Specialist Nursing Practice(Cancer
Nursing) programme. All students are already registered nurses working in cancer settings.

**Analysis:** Content analysis was selected as the analytical method as it helped categorise data into meaningful themes. Data was collected by using semi-structured interviews at two focus groups. It was then coded by theme and thereafter analysed and presented.

Summary of key findings: The following themes emerged: developing clinical skills, developing educational skills, developing leadership and management abilities along with enhanced research and audit awareness. Whilst these attributes are well recognised as key components of the work of clinical nurse specialists (CNS), it was pleasing to note that these aspects of their roles were being developed. Two other findings emerged which were not anticipated yet encouraging, and these were that they had developed more confidence in their abilities as a CNS and that they engaged in reflective practice which they felt enhanced their work.

**Conclusion:** Findings from this small scale study indicate that the use of portfolios which are tripartly assessed are an effective method for teaching and assessing specialist practice nursing skills. Additionally, they help develop intuitive practice and professional artistry which is arguably a key characteristic of the CNS. Reflection in and on practice is an effective method of developing these skills which may also help with higher levels of decision making, another important feature of the specialist nurse.
Factors influencing first post-registration job choices for a group of third year adult nursing students

Presented by

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Background and Context: Limited research on influential factors on job choice for third year student nurses is available. Findings from a literature review have established that the employment and employability of newly qualified nurses, which is embedded within Higher Education curricula, are complex processes with many variables.

It would therefore appear that any curriculum model that hopes to enhance student employability considers its teaching, learning and assessment strategies in its development if it is to achieve its goals.

Aims of the study: This research was undertaken as part of a Masters in Teaching and Learning in Higher Education. The aim of this study was to identify the factors that influence career decision-making by a cohort of NHS funded adult nursing students in their final year of pre-registration study.

Methodology: The methodological approach to this study is descriptive. The 68 participants of this study (n=68) commenced their course in February 2001. As part of the course they undertook a practice module where preparation for employment is an explicit outcome in terms of securing their first job.

Data collection methods included a survey questionnaire inviting qualitative and quantitative answers followed by telephone interviews with selected subjects.
Ethical approval was sought from both the participants and the educational establishment.

**Analysis:** The statistical package SPSS was used for analysing for numerical data whilst content analysis of interviews and qualitative data from questionnaires was selected as the analytical method.

**Summary of key findings:** Findings confirm that having an interest in a clinical speciality and the experience of clinical placements throughout their course has a strong influence on job choice.

Interestingly, findings indicated that the placement process plays a big part in how student nurses make choices regarding their first post registration jobs. Influential factors are concerned with the support and learning opportunities afforded them and that experience in clinical placements is instrumental in arriving at this decision. Ostensibly students can make this decision from as early as their very first placement but that most consolidate this decision when they are allowed to choose their final placement, which tends to be to return to where they have had a positive learning experience at an earlier stage in their course.

Other key findings from these studies also indicated that experiences and support from clinical staff received during the course all feature heavily on career choices.

Findings from this study reveal that students were generally satisfied with the universities approach to supporting them in this process. They found CV writing to be the most helpful, followed by action planning for future careers and hosting Trust Representative discussion about jobs.

**Conclusion:** Findings yielded were interesting although not generalisable from this small scale study to a wider population of nursing students. However, the placement allocation process seems to be important in shaping student nurses potential long term plans for job choices upon completion of their course. The importance of the support from all staff in that area cannot be underestimated and may even form an important part of their long term recruitment strategy. As well as being educated to be a qualified nurse, students also need to be ‘educated’ to secure their first post through activities such as CV writing and interview preparation. Students value this aspect of their educational journey.
A QUALITATIVE STUDY OF PAEDIATRIC PAIN AND ITS MANAGEMENT IN HOSPITAL

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A QUALITATIVE STUDY OF PAEDIATRIC PAIN AND ITS MANAGEMENT IN HOSPITAL

INTRODUCTION
The relief of a patient’s pain has often been cited as being the essence of what it is to deliver nursing care and is felt to be the cardinal principal of compassionate care. Apart from the humanitarian benefit of relieving pain, unrelieved pain has adverse physical and psychological consequences (Howard 1993). Physically, pain may impair the cardio-respiratory system, produce adverse neuro-endocrine effects, impair mobility and may even adversely affect patient outcome (Anand et al 1987; Franck 2003). The psychological consequences of unrelieved pain may include increased anxiety and less co-operation with future procedures. Although pain is a universal experience that has been described, studied and treated for many centuries, pain relief in children is perceived to be a major challenge for health-care professionals.

In order for pain to be recognised and managed appropriately and effectively in children, it is important to attempt to understand more fully how children perceive and react to pain. This is particularly important for hospitalised young children, given the fact that they may not always be able to report pain through self-report scales or verbal messages (McGrath & Craig 1989). In order to effectively manage paediatric pain, it is important that health care providers closely examine how pain is experienced or expressed by children in hospital settings. Children’s pain is frequently assessed and treated from an adult perspective, which is inappropriate. Children have a very different view and interpretation of the world than that of adults. Logic is less important, fantasy and irrational thought assume a greater significance. A logical cause and effect theory in the adult world may assume a totally different explanation, when treated with a child’s logic. Therefore, a qualitative study using phenomenology was undertaken to elucidate the meaning of pain in the child’s world, while in hospital.

PAEDIATRIC PAIN AND RESEARCH
The effects of untreated pain are wide ranging and detrimental to individuals (Eland 1990; Howard 1993; Mayer et al 2002; Weatherstone et al 2003), yet research indicates that pain is under-treated and under-assessed in the paediatric population (Asprey 1994; Tesler et al 1994; Broome et al 1996; Bennet-Branson & Craig 1998; Beyer 2000; Kotzer 2000; Kotzer & Foster 2000). Only a fraction of research regarding pain focused on the child, until a number of studies in the late 1970’s and early 1980’s made it clear that children’s pain was neglected and under-treated, and that pain
relief in children was a low priority (Eland & Anderson 1977; Beyer et al 1983; Mather & Mackie 1983). Over the following 20 years interest in paediatric pain increased dramatically, (Carter 1994), as evidenced by the increasing volume of research and literature published on the subject.

In many studies, researchers relied on parental report or healthcare provider assessment of children’s pain (Alderson 1995; Dunbar et al 1995), which did not provide children opportunities to express their own thoughts and feelings (Ireland & Holloway 1996). Children need to have a voice to express views on issues of relevance to them, (Carter 1998) especially since children’s self-report is the most reliable source of pain level (Acute Pain Management Guidelines Panel 1992; Hester 1993; Management of Cancer Pain Guidelines Panel 1994). Indeed it has been noted that children’s accounts of health matters in general have often been neglected by health researchers, who may see them as incompetent or irrational reporters (James 1993; Mayall 1996; Collier 1997). Studies in other fields demonstrate how children’s own testimony can provide great insight into their experiences and opinions (Newman et al 1997; Green & Hart 1998; Kirby 1999; Kitchin 1999; Worrall 2000).

PROFESSIONAL SIGNIFICANCE OF THE STUDY
The central purpose of this study was to provide children with the opportunity to describe what it is like to experience pain, while in hospital. The overall study question was as follows: How do school children, aged seven to eleven years of age, interpret their experience with acute pain? Specifically, the study explored the following research questions: How do children interpret pain? How can the healthcare provider interact with the child to assess and relieve pain? What interventions are effective in relieving pain?

FRAMEWORK FOR STUDY
Melzack and Wall’s (1965) Gate Control Theory of pain suggests that response to pain is a dynamic process which includes the existence of sensory, affective and cognitive dimensions in children. The dilemma of inadequate relief of children’s pain may relate to the complexity of the pain phenomenon. The Gate Control Theory, therefore, provided an appropriate theoretical perspective for guiding this study.

MOTIVATION FOR THE STUDY
This study originated from my personal experience of nursing children in Emergency Departments for a number of years. Attendance at Emergency Departments was generally a particularly traumatic experience for children and was often the first, and in many instances, the only experience children had of a hospital
environment. While working in Emergency Departments I came to know intimately the most distressing symptoms of human suffering and one that was particularly obvious and disturbing was pain.

Often children admitted to the Emergency Department had sustained acute traumatic injuries such as burns, lacerations or fractures, or they were often subjected to many inevitable painful and frightening procedures during treatment. Therefore, children frequently experience pain, but pain management often receives low priority in the emergency setting. Regardless of the clinical setting in which I practiced, pain was one of the problems most frequently encountered by me as a nurse, and thus served as a stimulus for this research. Emotions from seeing children in pain provided the motivation for the hard work of research that was to follow. There were times when a worrying lack of analgesia of any form were provided for young children. It is important that all children who experience pain receive appropriate analgesia, in order to reduce the emotional and psychological trauma of the whole experience. Hospitalised children often undergo painful procedures, which they describe as the most distressing part of disease or hospital stay (Broome et al 1994).

In nursing practice, pain is a widely experienced and expressed phenomena. Inadequate knowledge has allowed inaccurate and inadequate information to persist hence the problem of under-treatment of pain, discovered in the 1980’s, still persists to the present day. Any apparent ineffectiveness in pain control may be inextricably linked with the fundamental difficulty of understanding the pain experience from the child’s perspective, rather than an intentional undermining of competent management. In order to help a child cope it is necessary to understand how the child perceives the situation. Children respond to pain according to the meaning that the experience has for them, such meaning being a highly subjective experience.

Improved understanding of children’s interpretation of their pain experiences will result in improved clinical management of children’s pain. Children interpret their worlds differently to adults. Children’s views should be sought and taken seriously, (Mahon et al 1996), as it is clearly necessary to know more about what pain experiences mean to children. In addition to providing analgesia for the physical sensation in a timely and effective way, using psychological and cognitive tools may significantly ameliorate the pain experience for children.
METHODOLOGY
A qualitative phenomenological approach describes hospitalised young children’s experiences of acute pain. A phenomenological approach was utilised since it was felt that it would enable a wealth of rich data to be obtained from the participants, about the meaning they attach to their perception of pain. The most basic premise of phenomenology is that knowledge of human truths is only gained through individual understanding (Cohen 1987; Burch 1989). The phenomenological research method focuses on describing subjects’ lived experience, as they interact with their environments. They identify focal meanings or themes by describing, analysing and validating subjects’ worlds. From these processes, researchers develop rich, detailed descriptions of subjects’ lived experiences.

DATA COLLECTION METHODS
Creative and imaginative methods are often required to elicit children’s views, in order to overcome difficulties that may otherwise prevent their involvement. The researcher is responsible for finding a means of communication accessible to the child, taking cognitive and emotional development into account (Ireland & Holloway 1996; Doorbar 1997). Children’s drawings, observations of play scenarios and interviews, combined with a reflective diary, were deemed to be appropriate research instruments in illuminating, interpreting and documenting the multiple subjective realities and perspectives of the research participants.

This helped to increase the accuracy, completeness and understanding of the phenomena under investigation and therefore the trustworthiness of the findings (Lincoln & Guba 1985).

SAMPLE AND SETTING
The study was conducted in a large paediatric hospital. As the aim of phenomenology is to highlight individual experiences, the sample size is generally kept small (Hammersley & Atkinson 1983). Therefore, a purposeful sample of eleven participants was identified who had experience of acute pain within the previous three days. The participants in the study were children between seven and eleven years of age who were of normal cognitive development and who were willing to talk about their experiences.

DATA ANALYSIS
In data analysis, for phenomenological enquiry, the researcher aims to uncover and produce a description of the lived experience (Holloway & Wheeler 1996). Once the interviews had been transcribed verbatim the next step was analysis in order to interpret the data and draw meaning from it. “Confronted with a mountain of
impressions, documents and field notes, the qualitative researcher faces the difficult and challenging task of making sense of what has been learnt” (Denzin & Lincoln 1998, p. 313). Phenomenological reflection involves two major steps: conducting thematic analysis and then determining essential themes (Van Manen 1984). Each transcript of the children’s experiences of pain in hospital was analysed using the phenomenological process of analysis described by Giorgi (1985) and Colaizzi (1978). Additional procedures were implemented, to facilitate the intuitive process, to uncover meaning in the data and to ensure accuracy. Giorgi (1985) maintained being faithful to the phenomenon did not mean capturing the totality of the phenomenon in every aspect. Rather it is necessary to set limits on one’s analysis, and to make explicit only particular aspects of a more complex reality.

FINDINGS

In this study, the focus was on the day-to-day experience of pain in hospital among school-aged children. Categories, which emerged, related to the strategies and factors influencing care as well as the feelings experienced by the children, as they coped with the pain. Based on textual analysis, expressions and descriptions were grouped into five theme clusters which emerged in the final phase of the analysis: how children perceive their pain experience; how pain is dealt with by the care of others; how pain is dealt with through extrinsic rewards; how pain is dealt with through individual coping mechanisms; children’s pain coping strategies. These theme clusters describe the nature of the experience of pain and depict an overall sense of what the experience means to those who have lived it. This is illustrated through direct quotations from the participants.

THEME CLUSTER – HOW CHILDREN PERCEIVE THEIR PAIN EXPERIENCE

All of the children were able to explain that pain is a hurt or discomfort and describe specific pain episodes, such as a car accident or surgery. It was clear that the experience generated an array of negative feelings for the children such as ‘sad’; ‘frightened’; ‘angry’ and ‘worry’.

Pain is a subjective experience which was reflected by the children as they described their experiences of pain as both physiological and psychological feelings. The example below demonstrate a child’s attempt to verbally describe her pain:

Em it’s unreal really cause you, it’s very sore, you just em you feel like you are getting pushed really really hard in you would. It’s not as much em like stingy pain but I’d often get a stitch in my back like and it would be sore like going up the
whole way, it’s really sore and then I’d have it in my chest here as well.

Another participant used her teddy drawing to describe pain:

Yeah definitely, em like it hurts, it’s real stingy and he thinks like there’s someone poking something in his leg.

It was sometimes difficult for children to convince others that they were in pain as was illuminated when the children also described emotions they felt. One child told about her feelings in the following way:

Oh my God it’s like in agony, it’s very very very very painful. When you get pain like no one knows what it’s like because they like haven’t got your feelings. I know like you go that couldn’t hurt you, it couldn’t but it would hurt you honestly it would. And you’d be very scared you know.

The children experienced pain individually and in a variety of ways. The data showed unequivocally that young children do experience pain and can provide a wealth of information about their concept of pain.

For some children these feelings were overwhelming with anger being particularly notable for one child:

I broke my two thighs up here and sometimes I do be in very bad pain and it just gets me very angry and I can’t walk.

Other emotions that were described were related to sadness, which were expressed in both visual and verbal ways. One of the participants drew a picture of a girl representing herself and said:

...she’s really really sad cause cause I really can’t take the pain any more.

Most children indicated a relationship between pain and anxiety, which was the state of mind that the children most frequently reported when suffering pain. During the painful episodes, most of the children expressed some sort of fear with one child producing a drawing with his description focusing on his fear:

On the day of the operation it was really bad and cut open and a lot of blood came out the tube but then this was like a few days later not so much blood came out the tube and I think it was orange then so it was like this boy in the picture.
I didn’t like it. I didn’t like seeing all the blood coming out. It made me very scared.

One child expressed her pain related anxiety by a threat to her body integrity and physical well-being by stating:

Because like your legs are funny and they look different and you don’t know how they’ll hold you up.

This child expressed her relief visually at a later stage by drawing a very colourful picture of a child on crutches and revealed how the crutches could now hold her up and said how much happier she was now.

Interestingly, in contrast to the negative feelings expressed by many children interviewed, the children’s experience differed once they were getting better:

I’ll tell you the truth because he had an accident .....and he is quite happy because ..... the doctors have been in to see him and told him that his x-rays are good and that he is going to be fine and that he is going home this weekend.....he’s better and then he’d be happy again.

THEME CLUSTER – HOW PAIN IS DEALT WITH BY THE CARE OF OTHERS

How others take care was the major category that emerged describing how others responded to and cared for children in pain. The support from their own social network and from the professionals whom they were in contact with was beneficial.

Almost all of the children believed that the physical and psychological support from the parents and having them present was especially necessary when children were in pain. They reported asking their parents to perform a variety of comfort interventions such as asking for more medication, massaging or rubbing body parts as well as keeping them company:

Sometimes me Mam would rub it where it’s sore and that would help because the soreness wouldn’t be as bad.

Significant other visitors were also comforting to the children, and some of the children felt that having them present helped them relieve the pain:

Or maybe like if you are talking to your sisters or your brother, you wouldn’t be concentrating on the telly, you’d
Jacob and Puntilllo (1999) pointed out that nurses do not consistently assess pain and pain assessment is often ineffective (Lawlor 1997). Most of the children reported that nurses asked them if they hurt. Most said that when nurses asked about pain, they asked only whether the children felt any pain and if the child wanted or needed any pain medication:

*I don’t……no. No only if you had a pain.*

and another child said:

*She’d say if it was really sore or just sore or painful.*

An associated finding was that after administering analgesia, nurses frequently did not reassess the patient’s pain to determine if the medication was effective:

*No she never asked me again if the pain went.*

*No sometimes the pain didn’t go away but the nurse didn’t ask you again until maybe like dinner time.*

Such things as the quality and intensity of the pain were rarely discussed. Only one child reported that he was asked about the pain intensity:

*No she would just say em ‘what’s sore 1 or 10’ and like I picked 10 she would say ‘that is very sore’ and she would give me something.*

but none of the other children reported any questions regarding the pain intensity.

Children reported an important means of coping with their pain was care from the nurses and doctors:

*The thing I like about hospitals is that the nurses and doctors are very nice…..I kind of like the nurses and I like the doctors so that is good.*

Most of the children believed that the nurses did a good job of helping them feel more comfortable when they had pain:
They’re here to help you through the pain like the nurses…….she helps the pain because she’s trying to help. She’s trying to help me arm so like I’d tell her and it helps with the pain cause she gives me a tablet or something. She’s great like that you know.

Nurses are accountable for administering medications as ordered, but are not as accountable for other pain relief interventions, or for justifying non-interventions. When dealing with the children’s pain, nurses rarely performed other non-pharmacological nursing measures. The most likely outcome of such techniques is that pain will be more tolerable, not necessarily less severe in intensity (McCaffery & Wong 1993). Most of the children appeared to think that the nurse’s role was only to administer analgesia for pain, and it was the most commonly reported nursing action:

Yeah looking away from my legs would help like or sometimes if I gave them a little massage like rub them but talk to me and give me medicine please.

He is in pain…. And he’s talking to the nurse at the moment for some painkillers and he is quite happy because he says ‘I am getting them’.

I said it was very sore and they give me special stuff to take away the pain.

No she just gets the medicine….. and does nothing else.

The children appeared to benefit enormously from the simple process of receiving information and concerns about hospital were often reduced by explanation and also appeared to play a role in perception of pain:

The pains not here anymore, it’s just the soreness from the operation is here and it’s not too bad so that really helps when the doctors especially tell you things. And then you wouldn’t be afraid anymore.

Some of the children did not understand what the doctors were telling them:

I suppose the doctor language is very weird. They use such big words so it’s not much good .. it’s good they tell you even if you haven’t a clue what they are saying.
...it’s not much good .......... Without Mammy or Daddy telling me.

When young children do not understand the explanations about their illness or a procedure from health care professionals, they use their parents for translation, thus the importance of ensuring the presence of parents and their understanding.

When children were asked about pain relief some of them said that it did not always work and the children had to wait prolonged periods of time before receiving repeat analgesia:

*But you mightn’t be able to get a tablet if you have one of these six hour tablets.*

*No she mightn’t be able to give you a tablet for another six hours.*

Utilising the skills of the play therapists is important, as they have a vital role in implementing non-drug methods as well as recognising the hospital experience for the children:

*...the girl over in the playroom....... They came over and brought me books and things to play with... yes that helped a lot cause it took my mind off it.*

**THEME CLUSTER – HOW PAIN IS DEALT WITH THROUGH EXTRINSIC REWARDS**

Children respond well to rewards such as certificates, stickers and sweets. Interventions other than medication are occasionally used for pain and the children identified these points as being vital. Attempts to relieve the pain were achieved through specific rewards:

*They gave me stickers and that was good and helped me get better. They were of Looney Tunes and I really like those so that was really good.*

Rewards are important and are beneficial when used to supplement pharmacological interventions.

**THEME CLUSTER – CHILDREN’S PAIN COPING STRATEGIES**

Interesting activities appeared to be a means of putting pain on the edge or periphery of awareness. Attention is focused on stimuli other than that of pain, making it more bearable. Utilisation of these activities were helpful to the children throughout their pain experience.
For example they would participate in activities such as watching the television, resting, sleeping, reading, colouring and playing games to focus their attention away from the pain they were experiencing:

Yeah, reading would definitely help and drawing would help a lot because it’s nice to be doing things.

The play station is good because you press the buttons so hard you kind of get the pain out.

However the ability to be distracted from pain should not be confused with total relief of pain:

Em the only thing I could really do is sit down and not move it and oh playing with the lego I can still feel it.

DISCUSSION
As depicted in the Gate Control Theory of Pain, pain is a complex entity involving the interaction of many processes. Factors within the individual and existing in the external environment sometimes played larger roles in the pain experience than the physical trauma. As well as being able to discuss pain, the children described strategies they used to cope with pain. There were accounts of professional assistance, and descriptions about the emotional aid extended by relatives and friends. Most important were parents’, other children’s and health care professionals interactions with the children and how they cared for them. These were welcome respite, and provided a sense of emotional support and comfort for the children.

The understandings which have emerged from this research have grown out of a real account of an experience in hospital, as told by the participants verbally and using visual illustrations. The themes identified are those that emerged from the process of interpretation. The responses were factual and characteristic of concrete logical thinking. There was little evidence of fantasised or illogical thought in their responses.

Children’s vocabulary can be limited and this can be an impediment in trying to communicate and track the intensity of pain to others. Drawing and painting are excellent media for expression. In using drawings, communication is guided by the images of the participants, and therefore overcomes the problematic nature of verbal responses. The drawings were a suitable tool for highlighting issues related to pain that were considered to be important and
relevant in this study. An important lesson learned might be that children can communicate by graphic means information they often cannot communicate verbally.

**SUMMARY**

McCaffery’s (1983, p. 14) definition of pain, “pain is whatever the experiencing person says it is, existing whenever the person says it does”, implies a very important attitude towards patients – that they are believed and listened to. Only the child experiencing the pain can know and describe what their pain is like. Nurses need to consistently obtain children’s self-reports of pain, based on well-documented discrepancies between caregiver and children’s assessments of children’s pain (Eland 1990; Pederson & Parran 1997). This requires a consistent approach among nurses, to ask about pain and listen to children, when they describe their pain. Alternative methods of communication may have to be provided for the children.

Optimal assessment necessitates a multidimensional approach and requires that the assessment may include family members, who are normally involved in the care and support of the child. Health care professionals should be able to recognise the expression of pain and be aware of the need for skillful assessment in children.

The available evidence supports the fact that for the most effective pain management, a multi-modal approach using combinations of interventions that exert their effect at different levels of the peripheral and central nervous system should be considered. The evidence also supports the fact that the complex nature of pain requires complex assessment. Despite knowledge of the interplay of the three dimensions described, analgesic administration continued to be the most common, and often the only intervention used in the management of pain in this study. There is little doubt that pharmacological management can be effective, but because pain is more than just a sensory experience, pharmacological management alone may be inadequate. Non-pharmacological advances in the management of pain have been documented to be effective in making the pain more tolerable. The training for such strategies is not formalised, but a little training could go a long way towards the psychological management of pain. Because of children’s irrational fears and fantasies, cognitive explanations can also have a huge positive impact on children’s interpretation of pain.

Pain is a complex entity involving the interaction of many processes. Factors within the individual and existing in the external environment sometimes played larger roles in the pain experience than the physical trauma. As well as being able to discuss pain, the
children described strategies they used to cope with pain. There were accounts of professional assistance, and descriptions about the emotional aid extended by relatives and friends. Most important were parents’, other children’s and health care professional’s interactions with the children and how they cared for them. These were welcome respites, and provided a sense of emotional support and comfort for the children.

This study shows that awareness of children’s pain existed in clinical practice within the study setting. However, the prevalence of pain in the children’s recollections indicated that pain management was incomplete. Many valuable improvement strategies, as evidenced in the analysis above, emanated from the perspectives of the children involved in the study. The challenge for us is to recognise that each child is unique with special needs, which we as professionals must meet.

CONCLUSION
Before commencing the research I thought about the philosophical and methodological research process. A clear understanding of the philosophical basis of the research was important for me. It helped to clarify the research design and provided grounding for research methods within an accepted epistemological paradigm. This early stage of the research study involved much thought, reflection and planning and consideration was given too many approaches.

Children can provide rich and meaningful information regarding their experiences and opinions of health. Throughout the study, such information was sought using appropriate methods. The question arose as to how the participants, in this instance children, perceive pain. The aim of this study was to hear what such children had to say about pain and how they felt it affected them.

In conclusion the use of phenomenology as a research method with children, provided an informed insight into their perceptions, opinions and values. I believe that the research enhanced my understanding of children in pain. It is enlightening to take the opportunity to talk to children individually and to listen to their stories and concerns about care.
REFERENCES


Personal Planning for people with Intellectual Disabilities: 
A Person Centred Irish Perspective

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Background
For many years, the promotion of person centred planning for people with intellectual disabilities has been the core objective for every service provider. Guided by this objective nursing staff in a residential centre in the Midwest region of Ireland devised a new approach to care: St. Vincent’s Approach to Care (SVAC). This study reviewed service understanding of person centred planning by describing and analysing processes of SVAC, which implemented personal planning for the service user.

Method
This was one part of a wider study. The aim of this part of the study was to describe and analyse processes of SVAC used to implement personal planning for the service user. A qualitative component, of a focus group interview informed a quantitative study. Findings from the focus group interview combined with aspects from an instrument devised by Holburn et al (2000) led to the construction of a new instrument: Indicators of Processes of Person-Centred Planning Scale (IPPCPS), which was distributed to N=147 care employees. 103 completed questionnaires were returned. Data was inputted in SPSS statistical package and analysis of the data was carried out.

Results
Analysis of the processes highlighted issues, which could be improved to enhance the quality of personal planning for the service user.
Conclusions
This residential centre needs to endorse a culture of listening. A more coordinated evidenced based approach to identifying and portraying the preferences and perceptions of service users in relation to quality of life issues is advocated. These findings have implications for the role of the RNID as a facilitator of person centred planning.

Reference
Title of Poster: A Three-Year Review of Women Referred to a Drug Liaison Midwife attached to the Coombe Women’s Hospital in Dublin.

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Background and Connection to Conference Theme: The Drug Liaison Midwife (DLM) service was first introduced to Dublin in March 1999. This DLM works between the Obstetric Services at the Coombe Women’s Hospital and the local Addiction Services and depending on clinical circumstances liaison also occurs with the Genito Urinary Infectious Diseases (GUIDE) Clinic at St James Hospital, Hepatology Services at Dublin Teaching Hospitals and local General Practitioners. The DLM works to ensure the pregnant drug using women are followed up and facilitates communication between teams involved in the ongoing care process. The DLM also offers individualised support, advice and information to these women.

Objective: To profile pregnant women referred to the DLM and to document maternal and neonatal outcomes over a three year period 2002 to 2004. Comparison is also made to a previous cohort of patients who attended the DLM over the period 1999-2000 (Scully et al 2004)

Method: Retrospective review of case notes held by DLM.

Analysis: This research highlights the ongoing need for this specialist post, with numbers of pregnant drug dependant women remaining high. Majority of drug-dependant women stabilise during their pregnancy, with some reducing their Methadone Dosage on an individual basis. The obstetric and neo-natal outcomes are in line
with the improvements shown in the previous study. Mothers receiving prenatal care generally have higher birth weights and a decreased incidence of premature birth and other medical complications. (Finnegan 2000)

**Outcome:** Two hundred and seventy women were referred to the DLM attached to the Coombe Women’s Hospital over the three-year period. The majority of women engaged with the DLM and the Obstetric Services. The majority of women entered or continued in drug treatment. The majority of women stabilised their drug use and were on methadone maintenance therapy during their pregnancies. The majority had opioid and cocaine free urine samples pre delivery. Obstetric and neonatal outcomes have improved for this population associated with the ongoing provision of this specialised Drug Liaison Midwife post.
Workforce planning project in Two Dublin Academic Teaching Hospitals

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Aim
To ascertain the number of whole time equivalent staff required according to nurse dependency scoring.

Background
This project is unique. Whilst dependency scoring has been recorded in numerous organisations in Ireland, no attempts have ever been documented to match the dependencies to whole-time equivalent staff numbers.

With this purpose in mind, the nursing service in two Dublin Academic Teaching Hospitals collaborated in a joint project on nursing workforce planning.

Method
There were four components to this project, collated over a four-week period:

- Patient dependency
- Nursing activity analysis
- Nursing quality audit
- Staffing levels

Three clinical areas in each hospital were chosen for the purposes of data collection. Over a period of four weeks data relating to the dependency of patients on each of the 6 chosen clinical areas, was recorded and collated. Simultaneously, thirty-six hours of observation, divided into six occasions, comprised the nursing activity analysis, which was performed in each of the 6 chosen clinical areas. As a direct result of the completed patient dependency, it was possible to correlate the nursing activity and the length of time for the activity with the dependency of the patient, for which the activity was being performed. In addition, a nursing quality audit was conducted in order to elicit the quality of the nursing care during the four week period, for which the study was being conducted. Finally, data outlining the staffing levels for this four week period was also collated.
Analysis
Being completed at time of submission.
The project will be completed by July 2006

Summary
Will be based on the analysis

Conclusion
Will be based on the analysis
The process of information leaflet generation reviewed using Six Sigma Methodology

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The generation of information leaflets for patients and staff was reviewed using six sigma methodology. This process was reviewed as part of the hospital accreditation process.

Aim of the study
To define the process of information leaflet generation. To improve the process of information leaflet generation.

Methodology
A Six sigma methodology process was used. The purpose & goals of the team were defined, the problem process to be addressed, the process customers & their critical requirements were listed. The magnitude of the problem was measured. The best / most appropriate solutions were generated and implemented. To ensure that the problem did not reoccur, through the use of an appropriate level of measurement, documentation & on going designated process ownership.

Analysis
A significant number of information leaflets were in circulation
The process was varied, readability scoring varied as well as authorisation.

Summary of key findings
Guidelines are in place as well as a committee to provide support and direction to staff generating information leaflets. This improves the process and reduces variation

Conclusions
Six-sigma methodology is transferable to numerous projects, creates a business approach to process improvement and generates results.
The Nursing Documentation process reviewed using Six Sigma Methodology

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The generation of nursing documentation was reviewed using six-sigma methodology. This process was reviewed as part of the hospital accreditation process.

Aim of the study
To measure compliance with guidelines on the Nursing Documentation process. To obtain the viewpoint of the user.

Methodology
The Six Sigma process improvement methodology was used to examine the current process that nurses use to document nursing care provided to patients in the Adelaide and Meath Hospital, Incorporating the National Children’s Hospital. The team included nurses in clinical, educational and managerial roles. A tool was developed to audit the inpatient adult areas. This was combined with a questionnaire that facilitated nurses to express their opinions. A statistical package was used to analyse the audit data while a thematic qualitative analysis was used to analyse the results of the questionnaire.

Analysis
A demand for standardised care plans exists. Use of existing care plans requires improvement

Summary of key findings
As above
The presentation will expand on results of both audit and questionnaire, which generated very interesting findings for the nursing service in AMNCH. Plans for the future of this project will be outlined.

Conclusions
Six-sigma methodology is transferable to numerous projects, creates a business approach to process improvement and generates results.
Changes in nurse education: the personal account of nurse teachers

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INTRODUCTION
Nurse training moved into higher education without acquiring the profile of a typical university subject, a situation has not changed substantially during the last decade (Sastry 2005). The last college was incorporated in 1996, in a move born from a desire to increase the ‘professionalism’ of nursing and one that coincided with the introduction of ‘free market’ principles into the NHS (Crow, Pope et al. 2002). The introduction of education-led diploma nursing programmes has been successful in increasing the academic status of pre-registration nursing (Glen and Clark 1999), even as we continue to admit the majority of nurse students on the basis of sub-degree qualifications (Sanders 2005). This paper explores the role of the nurse teacher and the impact that higher education has made upon their working lives. This research focuses upon pre-registration nurse training and does not explicitly explore developments within post-registration and primary care.

METHOD
The professional lives of nurse teachers are based on culturally accepted practices and use forms of tacit knowledge not always readily explained by theoretical constructs (Benner 1984; Benner and Wrubel 1989; Eraut, Alderton et al. 1995; Eraut 2003; Hall 2005). This requires us to understand the social context of nursing and strengthens the argument for a phenomenological approach (Abbot and Sapsford 1998). This research is based on 37 in-depth interviews with nurse teachers within a central London Healthcare Faculty who responded to an email invitation to share their views about nursing education with the researcher. The interviews took place over an eight-month period between August 2003 and March 2004 and totalled 34.4 hours or 305,736 words. There were thirty female and seven male participants, who shared 1,015 years of nursing experience, averaging at 27.4 years (min 7 – max 42). These nursing years were supplemented by 552 years of teaching practice, the average time being 15 years (min 0.5 – max 29) giving a rough 2:1 ratio of nursing and teaching. This study followed the usual processes of consent required by a research study within the faculty. To ensure anonymity a coding system was applied to all interviews based on the number of years since each participant began training for their nurse registration combined with the year each began teaching. For example, N32/T10 identifies a participant with 32 years of nursing experience and 10 years as a nurse teacher.

Transcribing is a key stage in any attempt to create a coherent, and believable interpretation, but one with considerable potential for data loss, distortion and reduction in the overall complexity of the data (Sjöström 2002). The prefix trans indicates a change of state.
or form, identifying that transcription is a process of selective transformation (Cohen, Manion et al. 2000). There is no ‘single’ correct transcription, the issue is how useful is each towards the overall research (Cohen, Manion et al. 2000). To ensure that the transcripts used within this study were a fair and accurate account of each interview, all participants were emailed a transcript for their approval before it was included in the analysis.

Miles and Huberman (1994) offer a content analysis framework for qualitative data analysis that arises from transcripts, which I have used in previous studies (Miles and Huberman 1994; Carr 1995; Gould, Carr et al. 2004). The categories that were developed from the content analysis of the interviews and are presented in three constructs entitled: being a nurse teacher, delivering the curriculum and being a nurse. Finally, all participants who could be contacted by email (n = 33) were sent the final version of the data analysis and requested to make comments about its validity. Their replies showed their interest and enjoyment in reading the data analysis and the recognition of their lives within the work. This internal recognition among participants provided veracity of the selected comments/quotes and the meanings attributed to them.

1. BEING A NURSE TEACHER
The need to be an experienced clinician remains a central tenet of employment in the role of a nurse teacher. Figures from 2003-4 identify 8,113 academics as employed within English nursing departments. The final time the Nursing & Midwifery (NMC) council published a figure of how many nurses held a recordable teaching qualification was in 2002, this figure identified was 12,948 or 7% of all nurses. A figure that suggests, nursing departments employ the majority of nurses with recorded teaching qualifications.

The current influences on nursing education
Participants were to identify the current influences on nursing education and they made 66 comments that identified four key bodies with influence over the decisions made about nursing education. The first group of comments related to the government for whom healthcare was viewed as a political tool (44%). The second, related to the Workforce Confederation and NHS Trusts, who plan the healthcare workforce, commission the nursing students and provide practice placements (21%). The third set related to the Universities, who develop and deliver nursing awards (18%) and finally, a small group of comments were about the Nursing and Midwifery Council who validate and quality assure the fitness of these professional awards as preparation for registration (12%).
Twenty-nine participants identified the government as being the most significant force in deciding how the education of nurses is structured and funded. Participants' views were collapsed into twenty-two sets of comment (see figure 1). These identified how the NHS is essential to the government in meeting its political goals (24%) whilst keeping costs down (21%). To achieve this, the government promotes a managerial style based on tight control of financial resources often in opposition to the desires of the healthcare professionals it employs (13%). Because the NHS is a huge financial commitment, the government combines this expenditure with other targets, such as the widening of access to higher education (21%). Achievement of all its aims must occur whilst maintaining a low cost base per student nurse and the meeting of local employment targets through NHS Trusts (21%). The comments by N32/22 describe how in targeting nurses the government is achieving these multiple political goals.

N32/T22) I think the government want to save money and they want to change the way things are the easiest way to do it is to get the biggest group and alter them and that's nurses. If they can reduce that training, if they can reduce the money that goes into that because that's the biggest spend that's one way. They can't get people to be nurses so that's why they've opened the entry gate. So we've got this problem with nurses and the second is that the government is really looking at how can the NHS be cheaper

Participants considered nursing a ‘soft’ target, with its ethos of traditional nursing being of little consequence when set against the business model of the NHS promoted by the government who
wishes to increase its control over delivery and running costs. Not all comments about the government were negative as several participants identified the value of setting targets and the use of practice competencies. It was clear however, that this group of nurse educators believed they lacked any significant control over nursing education and its direction. This final comment is an accurate description of the feelings about their relationship with the political masters. I don’t think nursing is being driven I think it’s being kicked. I have grave concerns we are being kicked by people who don’t understand what it is they’re kicking (N29/T1.5). Workforce Confederations plan the healthcare workforce and in response to government targets commission nursing students. Forty three sets of comment were made relating to the Workforce Confederations and the NHS Trusts (see figure 2). Participants considered the Workforce Confederations as an extension of the government, viewing their major function to be the development and provision of a workforce able to achieve the government’s aims. The relationship with the NHS Trusts was more considerably more collegiate with a number of comments stressing partnership arrangements and the need for closer working relationships (7%), especially in relation to practice placements (7%).

The majority of comments (57%) related to the changing working practices of nurses and the problems this raised when planning the future NHS workforce. Participants described how nursing roles are simultaneously expanding and contracting. The role contraction is due to HCAs or other helpers, who perform a number of traditional nursing tasks. The expansion comes from the myriad of new roles such as the clinical nurse specialist or the nurse consultant. This expansion is also driven in part by nurses taking over the workload of junior doctors following a reduction in their working hours, and nurses being made responsible for achieving local or national Trust targets. Both patterns reflect a managerial style connected to financial resources and cost containment as the nursing workforce is shaped to fulfil the needs of the NHS.
Participants made 45 comments on issues about nurse training being within higher education (see figure 3). The majority were connected to the student population. These identified the ongoing impact of the large increase in student numbers (34%). They also identified issues of student bursary fee arrangements and the high attrition rates among students (20%). Changes in the student population (20%) were identified and how the large numbers in each intake have caused a change in the traditional teaching methods used in nursing education (11%). Interestingly, control of the student bursary was viewed as a political issue with government responsibility, whilst the high attrition rates within nursing courses were a University-based issue.

The comment by N37/T29 is a fair summary of this section on Universities, since it identifies the pragmatic and managerial values that participants viewed as dominating their working lives at present.

Figure 3: Issues for Higher Education
(n = 45 comments)

Number of comments

- No Role for NHSu
- Interprofessional Emphasis
- Student Attrition rates
- HE has mixed benefits for nursing
- Student Fees & Bursary Issues
- Numbers drive Teaching Methods
- Change in Student Population
- Student Numbers

N37/T29) We’re being led by management. A lot of what we do is pragmatic, numbers we deal with and things of that nature. There are some very good student nurses. The trouble is we are holding them back by keeping the trash without getting rid of them. That doesn’t help our good student nurses. It just irritates and annoys them and lowers our standard.

These teachers identify the mismatch between the working practices of higher education and how they believed nurses need to be trained. This mismatch reflects the tension between the NHS and
the HEIs encapsulated by the differences in vocational and academic methods used to prepare nurses.

Since 2002 the Nursing & Midwifery Council (NMC) has been the professional regulating body. Only eight participants identified the NMC as having any role or influence in nurse education, and all comments were negative. The twelve comments identify the low status of nursing and the lack of autonomy in deciding our future educational and working practices (42%). The belief that the NMC was controlled by the political desires of the government (50%), and finally, that the NMC offered little support and guidance to them as nurses teachers (8%). No participant had any positive comments about the governing body of nursing in the UK.

The final comment by N32/T22 is lengthy but encapsulates most of the key issues arising throughout this theme.

N32/T22) Professional policy? I think is selling us down the river. I think Government policy actually doesn’t have enough people up there telling them what nursing is all about to actually have any real clear idea of what’s going on. I think that we are still dictated to by the medical profession and always will be when money is in the way that it’s in and the way that the government have set up the money. It’s never going to change for nurses. Everybody acknowledges that nurses are the biggest spenders of the NHS but are not prepared to put in some infra-structure really to make sure that what they’re getting is value for money. They keep saying, well we’re short of nurses. The NMC are now saying we don’t mind how you take anybody into nursing they’re not even bothered all we want to know is that you sign a document at the end of the day that they are literate, numerate, can communicate and have undertaken a programme that meets our requirements and what you do with them beforehand is nothing to do with us. So, that we’re absolving any responsibility and they’re only concentrating on those that are going to go on the register.

This participant’s comments reflected the many external factors they viewed as beyond their control. All considered themselves as stalwarts or gatekeepers of nursing standards and its traditions. Yet many felt under siege, reactive rather than proactive in the making of important decisions about future registered nurses.

**Practicing as a nurse**

Only twelve participants (32%) had undertaken some form of

![Figure 4: Years since last nursing practice](image)

(\( n = 37 \) participants)
nursing practice in the previous year (see figure 4). Most of these had worked in ad hoc activities, including brief periods updating themselves in practice, the occasional agency shift or some external employment or activity that required use of their nursing skills. Five of this ‘practice’ group were the most recent entrants to teaching (less than 2 years). They all undertook regular practice as agency nurses. N7/T0.5 typifies this small group of nurse teachers resolute in their wish to maintain their nursing skills. *It’s been a struggle but I realise that ultimately I will go back into nursing practice* (N7/T0.5). Such practice was mainly in the settings from which they had moved into higher education. Only three of the more experienced nurse teachers (5-10 years teaching experience) maintained any regular nursing practice (one shift per week). They achieved this, either as part of their current working role or through heroic personal efforts. Below N23/T10 highlights the sacrifices she makes in order to practice.

N23/T10) I practice the equivalent of one day a week. I actually fought very hard to retain my clinical practice ….because I saw so many of my colleagues become out of date extremely quickly. Because something has to give I’ve really felt that I haven’t been able to give as much time to publication or research as I would like to do. If there’s one thing that I consistently say on my appraisal, I need some time to do that. Often what’s told to me is you’ll have to give up your practice time to do the research time and I’m not prepared to do that.

For twenty-five participants it had been at least 2-5 years since they had last nursed. The reasons offered are shown in figure 5. There was no single reason why these teachers did not practice as nurses. For some it was a personal choice (23%) or their current role (24%) and contractual arrangements with NHS trusts did not allow it (14%). Others had
different priorities, such as the need to complete postgraduate teaching qualifications or advanced academic studies (24%). The only common factor was that it was possible to be a nurse teacher in higher education and put your nursing practice on temporary or permanent hold.

Visiting practice areas
Twenty-eight participants visited practice areas (76%). These visits are an educational process and not viewed as a form of nursing practice although there are considerable personal gains. Participants made 53 comments about placement visits. The reason for these visits include the preparation of mentors and explaining the value of the placement (22% & 23%), the facilitation of practice, (24%) and encouragement of student reflection (19%). As N28/T20 describes, the placement visit is a problem solving activity largely about how to evidence student development in the practice placement. Its main function is to prepare and support the registered nurses who act as mentors and assessors to students (see figure 6).

N28/T20) You see all the students in your clinical areas. You talk to them. You see how they’re getting on. We’ve got a reasonably structured lot of questions about how they’re getting on at the time. Have they got a mentor? Are they happy with their clinical documentation? Are there any problems? Some time to talk to mentors because you are there as mentor support as well as student support. To make sure that the mentors are happy with the students and that they’re aren’t any brewing problems because it’s those that you need to be there to iron out if there are.

The most common benefit identified from such visits are that they enrich and update the teaching anecdotes teachers use to explain the links between their subject and nursing practice. N32/T20
identifies how important this is and the reasons for using such anecdotes.

N32/T20) It makes the teaching more meaningful for the students because you are not somebody who has no idea what’s going on in the clinical area. You’re current with the latest practices and issues etc. I use it as a source of stories for my students to highlight why they need to know this and that thing. A story serves to make a point. If students haven’t got the experience themselves and you can tell them a story it makes it more meaningful for them.

Other benefits from placement visits identify the variety of ways that these nurse teachers stayed ‘up-to-date’. Participants made 35 comments about the strategies they used to remain abreast of changes in clinical practice (see figure 7). These methods include holding conversations with nursing or medical staff (30% & 22%) that enable them to update their teaching anecdotes. By maintaining their awareness about new medication or new equipment (20%) and ensuring, they are informed, about changes in policies or working procedures (20%). Finally, the visits also increased their empathy for students by remaining aware of the difficulties within clinical settings (8%). It is however an interesting observation that a profession that places practice at the heart of its self-identity should find itself in a situation where the majority of its teachers no longer practice nursing.
2. DELIVERING THE CURRICULUM

Participants were asked to identify the major changes in nursing education and their fifty-nine comments formed three broad categories shown in figure 8. These are that the nature of nursing has changed (25%) the selection of future nurses is problematic (34%), and the large numbers of students are straining the fabric of the nursing education system (41%).

Nursing has changed

Fifteen participants expressed the view that nursing had altered considerably during their working lives and changes in working practices have altered the traditional relationship between a nurse and her patient. Whilst student nurse applicants continue to report a desire to ‘care’, care appears to have evolved from its historical tradition of a virtuous practice, to a personal investment in the professional (and paid) competencies needed within the modern healthcare system. Several teachers argued that students viewed undertaking nurse training as a personal activity rather than the joining a profession with its tradition of public service, in effect making nursing a commodity to be sold and not a gift that is offered freely. The result as identified by N33/T22 is double-edged.

N33/T22) I think underneath it and I certainly think from working with student nurses, I think some of them do have a genuine desire “to care”. They do actually care about their patients. Well I think its evolved, yes! Grown up perhaps.

N21/T2) I don’t think that what nurses do anymore is necessarily care for the patient. Medicine has become very sophisticated. There’s a lack of doctors and so nurses are taking over a lot more of the sophisticated roles and I don’t think that nurses or anyone value the caring element. There are unique and special people out there that nurse and some of them are nurses but in terms of nursing they don’t nurse anymore.

Firstly, a more realistic adult form of caring but also a change in the nature of nursing, this change may mean that the traditional term of ‘nurse’ for a healthcare worker doing such work may become redundant (N21/T2).
These teachers frequently returned to the nature of ‘caring’ and the meaning of modern day nursing. The modern nurse spends a considerable part of her day undertaking managerial functions combined with advanced technical skills. In previous work I have referred to this working pattern as ‘pills and paperwork’. (Gould, Carr et al. 2004) This change has led to the nursing care provided by some registered nurses, becoming in effect a non-touch technique. This raises the question of whether nursing is an eternal concept or as N23/T10 suggests, merely a way of describing the working practices of a wider variety of people who now nurse.

N23/T10) *Nursing today has a different attitude and is deciding well that’s what nurses do and these are the jobs that we don’t like or are what other people do. Some of us still want to provide basic care, still want to go to pharmacy and other of us don’t want to. We are confused and conflicted. We don’t know what nursing is you see. Are HCAs nursing? Are nurses nursing? If we’re all nursing then what’s different about it? What is a nurse?*

Whilst the teachers were clear about the qualities of a good nurse, what was less clear is what the nature of modern nursing practice. This group expressed a distrust of intellectualism about nursing practice. The theoretical evidence for nursing models remains weak with the intellectual movement driving development of such theory now acquiescent. This leaves nursing as a discipline reliant on intuitive forms of knowledge unable to challenge the more pragmatic medical or organisational needs of the modern NHS and raises the question of whether nursing can continue in its historical form.

**Student selection is problematic**
The selection and recruitment of future nursing students generated 34% of the comments. The comments about selection issues were in the main about student maturity and academic abilities. The assumption being that a greater life experience brings considerable benefit to students within an applied social science (Glackin and Glackin 1998). However, the targeting of mature entrants also bring an increase in the number of students with dependants (Worthington 1990). The mean age of our current pre-registration student is roughly 30 with at least half of all new entrants being mature students. Nursing follows a 24-hour cycle with shift patterns that do not easily suit child-care arrangements. N36/T22 gives an example to show the impact of this shift in student population.

N36/T22) *A student said to me last week; she was arguing that she couldn’t possibly travel to this particular place for her practice. Didn’t I know that she had young children and a baby of so many months? You*
knew you were supposed to be at the University. I couldn’t afford it and I’ve got to do this and I’ve got to do that for my children and I said do you think this might be a moment where we re-think what you’re doing. Do you think that this is the right time for you and your children - for you to be taking on being a full-time student? She shouted at me - I have a right to be a student! So the needs of the organisation don’t come into it and the needs of the patient certainly don’t. It’s that individuals right to do what they choose.

In addition to increasing maturity among students, the numbers using non-traditional or vocational based entry routes into our University has doubled to roughly 40% of each intake. The consequence for academic management is immense, as there is substantial research to support the view of N13/T5 that such students often struggle to meet the academic demands of higher education (Glackin and Glackin 1998).

N13/T5) I understand why we have to widen the entry gate but we’ve probably widened it too far and the calibre of the person that we’ve attracted is not always sufficient to meet what we need them to do by the end of the programme. Increasingly some of the students struggle because they’re not up to it.

Nursing students have 6 weeks holiday per year, this means that the teaching year for nursing courses is 48 weeks with no period during the year when students do not require some teaching input. Students who lack confidence in their literary and numeric skills find the transition to the higher education setting difficult and they rightly seek support from the nurses employed to teach them. Increasing the number of non-traditional entrants has had considerable consequences for these nurse teachers in terms of their academic workload and is a continuous pressure that shapes their working day.

Large numbers of students
Twenty-four participants (41%) made comments about the size of student intakes (see figure 8). Within the Health Faculty that employs these teachers, bi-annual intakes range from between 200 – 400 students. Large intake numbers cause problems in terms of the required academic and practice supervision. As N33/T18 identifies, the activities of a student nurse in practice placements are public and nursing education relies heavily on the integrity and personal ethics of students.

N33/T18) I just see this thing of having 300 students, how do you know what they are all doing and if they are turning up at their placements and that they are reliable people.
We’re letting them loose on the public at the end of the day in a way that you don’t with somebody that’s got a degree in history. It’s something I wonder if you might have smaller groups and more to do with the placement areas.

The comments by N33/T18 and N28/T17 typify the concerns raised by participants in this study. The students are of a lower educational standard than of previous times combined with the considerable difficulty of providing rigorous individual supervision. This questions whether nursing with its tradition of adult-centred learning can be taught effectively too such large groups.

N28/T17) I can see that the educational quality of students has dropped considerably. That’s a generalisation because we’ve got some very good students. But the nature of teaching changes when you’ve got 400 in the cohort rather than 40. You cannot teach in the same way. The pressures and the issues we face are largely being driven from that end rather than allowing us to perhaps design a future curriculum in a way that we’d like to.

N17/T1.5) We are encouraging them to be adult learners but the problem with it is because we have such big numbers. Nursing cannot be taught in these big numbers that we have. Nursing is small group training.

The identity of being a nurse remains central to the participants teaching role and yet few of this sample of actually practice which makes the relationship between nursing practice and its education unclear. The principles of nursing education reflect humanistic approaches to adult education yet nursing practice uses pragmatic, problem solving skills. The theories of practice and education are not the same, this confuses the relationship between being a nursing student and a higher education student, a confusion that extends to the nurse teacher role and the value practice plays in a career based in higher education.
3. BEING A NURSE

Nearly all participants entered nurse training as teenagers, at an average age of twenty years old, only 6% entered over the age of twenty-five. Participants gave three broad reasons for entering nursing - a childhood interest in nursing, a desire to help others and/or escape from their domestic or familial life. The qualifications used to gain entry reflect both traditional and non-traditional (see figure 9). Eight (11%) had used direct entry or vocational qualifications, the rest held more conventional academic qualifications including previous graduate status. Over half (54%) held significantly higher entry qualifications than were actually needed. Overwhelmingly participants (92%) undertook a ‘traditional’ style of training.

The qualities of a good nurse

There is a difference between the craft-based or artisan qualities shown by practicing nurses and the healthcare science upon which they draw when providing nursing care. Nursing is defined by its actions, Cash puts this in simple terms by arguing that ‘nursing is what nurses do’ a succinct statement, but one that is supportive of the argument that practice (i.e. what nurses actually do and how they do it) is the most defining attribute of nursing (Cash 1990).

All participants referred to a common history of nursing being based on a virtuous practice that relies on traditional nursing skills. Nursing demands technical, cognitive and interpersonal skills and involves a variety of ways of understanding people and their needs (Cash 1990; Kitson 1999), these nurse teachers were very articulate when describing what nurses do in their practice, creating a description or even a set of prescriptions of someone who functions as a nurse. Participants generated a total of 81 comments about the qualities of a good nurse (see figure 10). The five qualities most commonly cited were caring (19%) or those fundamental, personal care skills (N33/T21) that provide comfort to the ill or frail. This was followed by communication and interpersonal skills (17% & 11%) or those skills that enable a nurse to talk and relate to the patient and sense when a patient needs something (N17/T1.5). Nursing competencies (14%) are the
portfolio of day-to-day technical or ‘doing’ skills needed by any modern healthcare professional. Reflective skills (14%) were those shown by someone that’s prepared to change - to review what they’re thinking (N23/T10). To do this they must also have the knowledge base (14%) upon which to review their practice and to make new judgements. These descriptions have been organised into a set of behaviours labelled the 4Cs model of nursing, namely: caring, communication, competence and contemplation.

The 4Cs of nursing
Caring is how a nurse shows her interest in a patient and their health concerns. Caring has public, professional and personal aspects, with the public aspect manifesting itself whilst she is working as a nurse. The professional and personal aspects that show the required moral and ethical integrity can also be demonstrated within discussions, essays or academic assignments. But, it is the public manifestation during practice that enables another nurse (or indeed a patient) to make the judgement that a nurse is caring.

Communication is the interpersonal skills that allows care to have personalised purpose and meaning. Packages of nursing care remain a set of generic healthcare competencies until they are tailored to an individual patients needs. Participants describe how nursing skills demonstrate the dual qualities of performance and intention. Performance is the actual nursing action that is undertaken which may be linked to an advanced technical task - such as giving a blood transfusion. It is the more occult quality of intention that requires her communication skills to make the
performance fit the needs of the patient. This personalisation is what makes it your blood transfusion, rather than a blood transfusion. If a nurse's behaviour does not show understanding or insight into the specific needs of a patient, it is merely a performance and lacks the personalised element which makes it nursing care (Bassett 2002; Phillips 2003).

Competence is the mastery of the discipline skills that constitute the day-to-day work of healthcare professionals. Patient needs are identified using the nursing process based on a loose interpretation of Maslow’s hierarchy. Care commences with stabilisation of the patient’s condition, then nutrition, shelter, safety and so on can be addressed, moving from acute needs towards longer-term goals. Advanced technical skills often constitute the public face of medical or nursing care i.e. providing pain relief, wound care, phlebotomy, IV therapy and medication. However, not all nursing skills are so public and there are many clinical problem-solving and administrative skills that the public rarely become aware of – unless of course they go wrong!

Contemplation is the reflective process that integrates theory and practice which is then made manifest in a nursing repertoire. The subjects taught in the academy serve as a foundation for reflection, but it is the repeated exposure to the practice environment that enables a learner to use theoretical knowledge to explain and describe nursing care. This includes the development of problem-solving skills and reflective practice itself. For example, the nursing process is a practice-based problem solving model which encourages identification, solution and resolution of client problems and serves as a model to reflect upon successful nursing actions (Takemura 2003).

Whilst academic or scientific knowledge is needed in nursing; other attributes such as communication skills, self-awareness, problem solving and authenticity of self are equally important (Leach 1988). So that while technical skills form the most public part of nursing, for this group of nurse teachers it was interpersonal skills and professional values that remain their primary focus (Kitson 1999). This often means that the real work of nursing is submerged either within a bio-medical or resource management model of healthcare. This can make nursing appear to be either a form of medical cure or if a nursing a chronic condition, a form of cost containment or enhanced productivity with increased reliance on sophisticated technology and surveillance(Chan 2002). This has led Walker to write so movingly about the sad banality and the poignant insignificance of much of our work (Walker 2000).
The HCA and basic nursing care

Who provides the frontline support for the frail and ill is a significant nursing issue. The public value the registered nurse: her personal qualities, attitude, manner, personality, and her being readily available to the patient (Bassett 2002). One consequence of the move to a university based nurse education system has been the introduction of the Health Care Assistant (HCA). This change has transformed the nursing workforce into a professional core, and a significant body of semi skilled workers. The HCA role was designed to replace the labour previously supplied by student nurses within the ‘traditional’ model of training (Gould, Carr et al. 2004). Participants made thirty-seven comments about the HCA role (see figure 11).

A great deal of nursing work is described as essential or ‘basic’ nursing care. Some participants objected to the term ‘basic’ nursing, so the term is used to refer to a set of core nursing skills which include giving intimate day-to-day care in such areas as, hygiene, excretion, nutrition and basic clinical observations. These nurse teachers were clear that ‘basic’ nursing care was now viewed as an HCA function (59%). However, as N8/T1 shows, they question whether the HCA has the knowledge required to give basic nursing care (26%). One of the major differences as far as I’m concerned between a trained nurse and an HCA is your ability to assess a number of things by only doing the most basic thing. (N8/T1) For nurses trained in traditional nursing practices, the giving of basic care is the opportunity to observe the emotional and physical well being of a patient, with basic care intimately linked to providing physical comfort and emotional support (N36/T22) and is one of the pleasures of being a nurse.

The final comments participants made were about the negative opinions expressed by current students towards their role in providing basic nursing care (15%). A viewpoint described by N36/T22, HCA’s don’t think that registered nurses get their hands dirty and I think students don’t think that registered nurses get
their hands dirty either. This led 16 participants to question the commitment of student nurses towards our traditional nursing values based on the meeting of people’s intimate physical needs. When you hear them talking, they tell you what they are doing is behaving as a HCA. They believe all those things I hold dear is what a HCA does, not what a nurse does. (N36/T22) This raises the question of whether basic nursing care is different when undertaken by a registered nurse, and do the future generations of ‘modern’ nurses want to undertake this role. (N32/T22)

The future of nursing
Participants were asked for their views and comments about the future direction of nursing. The only universal theme they were able to identify was now a constant. As N26/T13 comments, stability in nursing is not likely to happen while its voice lacks any power.

N26/T13) Oh yeh. I don’t think nursing education or practice will ever settle down. I don’t think we have enough of a voice in how things are, I know government directives are government directives but they’re also implemented by doctors who are managers in hospitals.

Whilst many participants were critical of many aspects of the current situation in which nursing finds itself in, none had lost their passion for being a nurse. They had however become resigned to their present being very different from their own past. The historical romantic image of the nurse being a ‘mother’ to the world’s sick was a model that more easily fitted when the actions of a nurse were low-tech and domestic in nature. New responsibilities and role expansion have brought radically different criteria from which to judge the actions of nurses. Based on the comments of N21/T2, the future nurse is coming, but she may not be a nurse as we might recognise her.

N21/T2) I suspect there’s going to be a huge raft of bright articulate nurses who are leading the way in pseudo-medical jobs. I hope to God that they retain their nursing routes and do those pseudo-medical jobs in a thoughtful, concerned and informed way. I look round at ward nurses and with the possible exception of the ward sisters they seem to be ground down. They don’t seem to take a pride and a joy in being a nurse. They’re always looking for something else, the next promotion or going to a specialist area or doing something else. There is no pride in being a nurse and being just, just ah! see even I do it! a ward nurse. There’s no pride in being a carer. If you stay as a ‘D’ grade for all of your life then you’re obviously a failure.

Conclusion
Nursing has significantly changed during the last 40 years, many of these changes sought to make nursing more ‘professional’ a process
that has accelerated following our entry into higher education. Its teachers identify a number of positive elements in the move into higher education, but they also express many concerns about the core values of nursing and a perception that these were no longer central to nursing education. On a fundamental level human beings have not altered whilst this group of nurse teachers have been nursing. When we think of nursing, it seems obvious that nursing is what nurses do - nursing however is not a single entity, but rather a family of resemblance (Cash 1990). Nurses past and present are not identical and the work they do is both contextual and varied, but in the same way that I look like my siblings; all nurses share a familial resemblance. How nursing care is described and recorded arises from pragmatic descriptions of the working role rather than any extension of theory underpinning nursing practice. Being a good nurse is both a set of actions and a description of the personal qualities needed to practice nursing. Changes in working practice have meant that nursing has given over some of its traditional areas of ‘basic nursing’ to HCA’s whilst the registered nurse is taking on extended roles and responsibilities. It was also clear that the current trainee nurses hold a view of nursing that challenged the more traditional view held by nurse teachers.

References:


A Researcher’s perspective on conducting health research in a socially deprived area

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Research suggests that people in poorer communities suffer poorer health than those in wealthier communities but various studies have also suggested that disadvantaged groups are under-represented in surveys. I hope to illustrate some of the difficulties researchers face in carrying out research in a disadvantaged area.

Ballymun in North Dublin is one of the ten sites chosen to pilot a model of primary care delivery as outlined in the present government’s Primary Care Strategy. Ballymun has been classified as an area of extreme deprivation. It is approximately two miles in size but contains a population of over 16,000 people. The population profile is atypical in that there is a disproportionate number of females aged 20-49 in the area and a low proportion of 65 year olds. Almost half of all children are reared in lone parent families and the area is also characterised by high levels of unemployment and early school leaving.

I was involved in a study which sought to evaluate a new multi-disciplinary consultation style between members of the primary care team and patients who were mothers (aged between 18-65) and who had multiple health and/or social problems. The aim of the study was to develop a new model of primary care consultation and to assess its impact on participants. Structured interviews were conducted in participant’s home on three occasions, the initial interview and at six month and yearly periods.

Logistical and research obstacles emerged in the course of the study. Logistical obstacles included safety concerns, difficulties in making and maintaining contacts with interviewees and navigating a socially deprived area. Research obstacles included the differing expectations and understanding of participants and the impact of social, economic and psychological factors on patients. Both sets of obstacles will have an impact in future planning of research in socially deprived areas.
The factors that contribute to patients leaving an Emergency Department without being seen: A descriptive exploratory survey.

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Background and context
Emergency Departments (ED) supply an important public service by providing emergency care 24 hours a day, 365 days per year. A phenomenon that is frequently seen in the ED is that a certain percentage of patients leave without being seen (LWBS). Several international studies have shown differing LWBS rates, which vary from 0.36% - 4.7% (Fernandes et al, 1994; Stock et al, 1994; Fernandes et al, 1997; Lee et al, 1998; Monzon et al, 2005), to greater than 15% (Bindman, 1991). This group of patients who LWBS are a potential risk-management issue for all hospitals and are at risk of important and avoidable adverse outcomes related to a lack of timely assessment and treatment, worsening symptoms and decreased patient satisfaction (Fernandes et al, 1994; Lee et al, 1998; Monzon et al, 2005; Polevoi et al, 2005).

Different reasons have emerged in the literature as to why ED patients LWBS. These include patient characteristics, hospital factors, and dissatisfaction with the service. However, prolonged waiting times are repeatedly shown to be the most common
reason why patients LWBS. Several studies have found that the majority of patients who LWBS are from the less urgent triage categories, and do not suffer any adverse outcomes by leaving prematurely (Fernandes et al, 1994; Mc Namara, 1995; Fry et al, 2003; Goodacre and Webster, 2005; Lee et al, 2006). Conversely, other studies (Baker et al, 1991; Bindman et al, 1991) challenge these assumptions and believe that these patients may be ill and therefore may not receive appropriate or timely medical care. Collectively the literature suggests that an enhanced understanding of the demographics and social characteristics of LWBS patients, their reasons for leaving, their subsequent outcomes along with the hospital characteristics and the barriers to patient satisfaction is a logical step towards improving care.

Whilst the problems relating to EDs have been highlighted in the media, the literature relating to this phenomenon in Ireland would appear to be currently unavailable or unpublished. In the ED where this study was carried out, a previous audit demonstrated that an average of 20% of patients had left each day without being seen or assessed by a doctor or an advanced nurse practitioner. As the LWBS rate in this ED was higher than in the international published research, it was hoped that by investigating this cohort of patients, the various factors that contribute to this phenomenon would be identified, thereby providing evidence to improve the service and reducing the amount of patients who LWBS.

**Aim and Objectives**
The overall aim of this study was to investigate the factors that contribute to patients leaving an inner city ED without seeing a doctor or an advanced nurse practitioner. The objectives were to firstly ascertain the profile of these patients, secondly to explore the reasons why patients LWBS, thirdly to determine the outcomes of LWBS for the patient, and finally, to assess the level of information they receive from ED staff prior to leaving.

**Methodology**
Following receiving the required ethical approval and permission, a quantitative descriptive exploratory research design was employed in this study utilising a self-administered questionnaire. Permission was obtained to adapt Fernandes (1994) questionnaire for the purpose of this study. This adapted questionnaire was subject to validity and reliability testing. A pilot study was carried out two weeks before the study on sixty-five patients who LWBS over a five day period, with a response rate of 12.3% \( n=8 \). Probability sampling was employed, with 650 patients being systematically sampled from 1300 patients who left without seeing a doctor or
advanced nurse practitioner over a two-month period. The participants were recruited through the Quality Manager to ensure the anonymity and confidentiality of participants. The Quality Manager also posted the questionnaires, cover letter and patient information sheet. A total of 118 questionnaires were returned, representing a response rate of 18.15%. Data analysis was carried out using the SPSS version 12 and involved using descriptive and inferential non-parametric statistics.

Findings:
The LWBS rate in this study was 24.2% and is significantly higher than the rates reported in the literature. Findings for this study are presented in four sections corresponding to the four objectives of the study.

The profile of patients who leave without being seen:
The data from this study suggests that the majority of those who LWBS were male and aged between 18 and 39 years. Patients were more likely to leave on Fridays and Mondays during evening shifts. The majority of the patients were self-referred and were self-paying. Although most had presented because of an injury, a significant percentage met the triage criteria for high-risk conditions with over two thirds belonging to the triage 3 category. Half of the participants had the problem for less than 24 hours before attending the ED, however, 21.2% of the participants reported having their problem for more than 7 days, which may suggest that some patients are using the ED inappropriately as a source of primary health care.

The reasons why patients leave without being seen:
The commonest reason for leaving was because of long waiting times (58.3%). Many felt too sick to wait and this was reported to be the second most popular reason for leaving (14.2%). Several respondents were unhappy with hospital staff, and this was the third most popular reason for leaving (10.4%).

The outcomes of leaving without being seen for the patient:
Two thirds of the participants sought further medical attention after leaving without being seen. The majority of these patients sought follow up with their general medical practitioner within the next 24 hours.

The level of information patients receive from ED staff prior to leaving:
Although most participants had enquired about when they would be seen it appears the initial explanation from staff was not sufficient and more communication was anticipated.
Limitations
There are several limitations to this study. This study was carried out in one urban hospital in the Republic of Ireland and therefore the conclusions may not be generalised to other hospitals or other healthcare systems. The response rate to this study was low and there are several possibilities for the poor response. It is possible that the participants’ address may have been incorrectly documented when they registered in ED; the study was carried out in a poor socio-economic area where literacy may be a problem; and it is possible that several non-English speaking recipients may not have understood the content. As the questionnaire maintained the anonymity and confidentiality of the participants it was impossible to match respondents with their ED visit. Instead, the findings relied on the respondents’ self-rating of presenting complaint and waiting time.

Conclusion
The main reason for leaving was the prolonged waiting time and more than half the patients were too sick to wait any longer. In addition, over half the patients surveyed stated that they would not return for future care to the ED mainly because they were unhappy with the service. Corresponding with the previous literature, these findings suggest that potentially ill patients are leaving the ED without being seen. These patients are a potential risk-management issue for the hospital and are at risk of important and potentially avoidable adverse outcomes.

It is hoped that the findings in this study may create national interest in this phenomenon and result in additional research to identify aspects of practice were increased education and improved management strategies may reduce the amount of patients who LWBS, thus, improving and enhancing the quality of ED care provided to our citizens.

References:


Resolving Socio-Cognitive Conflict in Children.

A comparative observational study (between subjects): Exploring the effects of children’s age, and ability to resolve socio-cognitive conflict developing shared understanding.

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Background: Far from being an automatic reaction to an environmental stimulus, children are active processors of the experiences that they encounter. Thus in any social situation children are making vigorous attempts to make sense of what is happening to them, by monitoring, reflecting and evaluating the information that they are presented with. Furthermore, long before children enter school they are learning higher order cognitive and linguistic skills and their learning takes place in the everyday interactions of domestic life, where they acquire and learn the accumulated wisdom, cognitive and communicative tools of their culture.

For most children a certain amount of assertive behaviour and aggression is normal. However, for some children to play collaboratively they must learn to subdue their own desires in the interest of joint play, thereby learning to modulate their emotions. Collaboration therefore marshals all these skills and allows children to engage in a social world. The concept of socio-cognitive conflict is described as the facilitation of cognitive development through peer interactions, facilitating cognitive growth and development though the revision of knowledge and explaining individual views to another.

Aim: This research project was undertaken as part of a bridging module between a Masters in Education (M.Ed) and Doctorate in Education (Ed.D). The aim of this small scale comparative exploratory study was to explore how children engage in, and resolve socio-cognitive conflict and develop shared understanding in children, paired by age and gender (n =4). Therefore the study sought to answer a single research question ‘How do children between the ages of 4-7 years resolve socio-cognitive conflict and develop shared understanding? Cognitive –developmental theory postulated by Piaget provided the central theoretical framework whilst acknowledging competing views. The dependent variable
being measured was behaviour, and the independent variable was age.

**Method:** The project design was cross-sectional between subjects and the method was observational using a video camera to collect data. Engaging children in research brings with it its own ethical dilemmas, but ethical approval was sought mainly through parents. This was coupled with full written details of the project including storage of the video data and transcriptions, which were all copied to parents. An ‘ethical opt-in’ approach was engaged whereby parents could choose for their children to opt in or out of the project. Data were collected on two separate occasions and the context was informal and the children’s relationship was symmetrical. Data analysis was organized using the age of the children and involved quantifying and coding data based upon ten minute frames of footage, utilizing a framework from the literature.

**Findings:** The results yielded some very interesting data although not generalizable from this small-scale project to a wider population of children. Overall the children engaged in 280 behavioural activities and the collaborative activities were greater in the older children, whilst the younger children scored highest in their unfavourable comments but physical assaults in the form of hitting scored the lowest.
This paper presents the findings of an initial qualitative research study conducted to identify how the collaborative Nurse Research Consultant role could fulfil the research needs of the nurses in the Emergency Department and reflects on the achievements and challenges experienced over a twelve-month period.

The initial research consisted of distributing short answer questionnaires to nursing staff in the department. Following analysis of the responses semi-structured interviews were completed with ten Registered Nurses. Content analysis was utilised to identify themes and sub-themes. This explorative research aimed to provide the Nurse Research Consultant with an increased understanding of the Emergency Department nursing staff perception of the role and the ways in which the role could assist them.

Data analysis identified three main themes: Role of the Nurse Research Consultant in the research process, hindering the research process and assisting the research process. Within each of these themes several sub-themes emerged. The findings highlighted that Emergency Department nurses were reluctant to become involved in research because of their perceived lack of knowledge base and skill level. Furthermore, they identified departmental and time constraints and motivation as reasons for not participating in research.

The outcomes achieved by the department, since the initiation of the role, have reflected the findings of the initial research. That is that the implementation of the NRC role has enhanced the ED environment by improving clinical skills and support and nursing education. Furthermore, the NRC has assisted clinicians to conduct and participate in research projects and encourage those same
participants to present their findings at international and national conferences. In 2005, 10 presentations and 2 posters were presented by JHC ED staff. All of the projects undertaken by clinicians were aimed at improving nursing care and resulted in enhanced patient experiences and outcomes.
THE LIVED EXPERIENCES OF GENERAL STUDENT NURSES ON THEIR FIRST CLINICAL PLACEMENT: A PHENOMENOLOGICAL STUDY.

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Background

The clinical environment is an integral and essential component of the programme that can be challenging, stressful and unpredictable (Kleerhammer,1990; Randle, 2003). It provides nursing students with opportunities to acquire professional knowledge and skills on how to perform in the professional situation. Diplomates considered clinical placements to be the most influential aspect of their programme (Macleod Clark et al. 1997), while Yong (1996) reports the first clinical placement to be the point of confirmation in relation to the choice of nursing as a career.

During the mid 1990’s nursing in Ireland experienced an educational transformation with the development of links to higher education and the introduction of a Diploma in Nursing course. A major evaluation report (Simons et al. 1998) identified major problems with the programme similar to the United Kingdom, such as linking theory to practice, poor acquisition of practical skills and students left feeling vulnerable and lacking in confidence (Mc Evoy, 1995; Hislop et al. 1996; Trnobranski,1996; White,1999). Urgent revisions were implemented to address these concerns which meant an earlier exposure to the first clinical placement that lasted five weeks with supernumerary status. With these changes in place it was vital to identify student nurses’ experiences on the first clinical placement.

Aims

This study aimed to uncover the ‘lived’ experiences of general student nurses on their first clinical placement through the following:  
Interpret descriptions of students’ textual experiences.  
Acquire nursing knowledge of the first clinical placement to inform future curriculum planning.
Provide valid data on which to base the preparation of nursing students for clinical practice.

**Methodology**

A phenomenological approach was utilized to explore the human experience of the phenomena under scrutiny. According to Koch (1995) descriptive phenomenology represents the ‘participants’ truth’, a description of their ‘life world’. The philosophical underpinnings take the perspective from a Heideggerian approach that facilitates the exploration of participants’ interpretations of their experiences.

Purposive sampling was employed. The total population of this cohort was 52 and all were issued with invitation letters. The profile consisted of direct school entrants, mature entrants with previous experience and both female and male status. The age range was from 18 years to 47 years. In the sample three participants were direct school-leavers, five participants had 1-3 years experience in health care after leaving school and two participants had different careers before choosing nursing as a profession. The total sample was twelve, of which two were used for piloting purposes.

Ethical approval was approved. Purposive volunteer sampling was undertaken and in-depth interviews were conducted with nine female student nurses and one male student nurse. Data from the interviews were tape-recorded and analysed using Coliazzi’s (1978) 7-stage framework.

**Summary of key findings**

Five core themes emerged: self awareness, confidence, anxiety, facilitation and professional issues. The findings indicate that the presence of mutual respect and regard for others had a positive impact on the students’ self esteem. The acquisition of knowledge led to an increase in confidence levels that subsequently reduced anxiety. This enhanced the learning process but was dependant upon the collaborative support and facilitation in the clinical learning environment.

**Conclusions**

The conclusions revealed that the preparation for the first clinical exposure was viewed positively. The curriculum needs constant evaluation in relation to the preparation of undergraduate students and towards meeting their learning needs. The findings prepare the way for further research that could continue to develop and maximize the educational value and clinical experience for undergraduate nursing students.
Key words: undergraduate, facilitation, learning, preparation for practice.


References


New parents’ and health visitors’ (UK public health nurses) experiences of postpartum needs and care provision

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New parents’ and health visitors’ (UK public health nurses) experiences of postpartum needs and care provision

Based on a growing volume of literature, policy makers have proposed that home visitation is a means of targeting health inequalities and improving maternal and child outcomes. A broad overview of this literature shows inadequacies in existing home visiting and family needs theoretical frameworks. The study aim was to identify the common experiences of early parenthood for co-parenting couples and to explore the postpartum care provided by health visitors (universal family home visitors) in order to develop conceptual frameworks of family needs and care provision.

In this qualitative study, undertaken in Northern Ireland, the researcher selected a purposeful sample of ‘routine care’ families (n=17) with 8-16 week old infants. Health visitors (n=8) also took part. Participants’ opinions were collected by focus groups (n=4) and interviews (n=6). Information gathered was categorized using thematic analysis. Manifest and latent concepts were coded; NVIVO was used to help structure the data. To ensure credibility, coding was verified by two independent experts and findings were cross-validated with existing literature.

Parents described varied baby nurture and life changes that occurred in early parenthood. Families drew upon a range of coping resources (personal, social and health service) that they drew upon post-birth. Mothers were the chief family contact point with the community nursing service. In accordance with health visitors, they agreed key elements of routine health visitor care: assessment, support, relationship building, and health advice/promotion. The author developed theoretical frameworks of parental postpartum development and health visitors’ practice. Thus, the current investigation contributes to the understanding of the complex and interactive factors affecting family wellbeing and health visiting care. It also forms a bedrock for a subsequent quantitative study.
Title: An New model of Nursing and Spirituality: a physical spirituality using theological knowledge

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Background and Context: Nursing has been pre-occupied with spirituality for at least three decades. This has resulted in a model of spirituality which is often mechanical, emulates the work of chaplains, is ambiguous, negative about religion and religious knowledge and which is disconnected from the core of nursing which is itself rooted in physicality and relationship. Nurses seem aware that they should address spiritual needs but seem to neglect what is considered to be ‘spirituality’ in their care (Swinton & McSherry 2006). These are the findings of the critical review which formed the first part of this, now completed, PhD doctoral research.

Aim: To explore the current approach to spirituality to establish how appropriate it is to nursing. To describe an alternative and more appropriate approach.

Methodology and analysis: The most common form of research in nursing, the empirical approach in either the qualitative or quantitative domain, is eschewed in this work in favour of a reflective analysis. The research purposely uses knowledge from anthropology and theology in order to broaden nursing’s approach to the issue.

Summary of key findings: Some emergent themes: There was an emphasis on universality at the expense of exploring specific religious traditions; the needs based, problem solving model in use objectified the person; religion and theology were treated negatively and reductively (Clarke 2006a,b); there was an emphasis on talk and a neglect of the physical; there was no substantive model of the spiritual person to draw on. Theological knowledge was thought to have something to offer in providing an alternative approach to spiritual care in that it described models of the spiritual person which related spirituality to the body and which were innately relational.
Conclusions: A model of a spiritual person was formulated which drew on theological knowledge. This enabled an approach to spiritual care and spirituality to be described which is built upon relationships and which allows caring and, in particular, care of the body to be actually spiritually therapeutic.

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Emotional Intelligent Stress Management for Nurses

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This review aims to critically examine the current theoretical arguments and research on Emotional Intelligent approaches to stress management and demonstrate why this needs to available to all nursing and health care staff.

Search and review methodology

A broad strategy and systematic review approach was adopted covering several separate electronic databases through Ovid including PsychINFO, Web of Science, BNI, MEDLINE and CINAHL. The search terms were ‘emotional intelligence’, ‘stress’, ‘nurses’, ‘education’. A hand-search of relevant journals and significant references added to the data. The essential elements of the systematic review include identifying literature to an explicit search strategy, selecting according to defined criteria and evaluating selected papers against consistent methodological standards.
Summary of key findings

Nurses are involved in the daily care of patients and their families and provide significant psychological support to them and their carers but the nurse role is much wider than this and is very varied and demanding and although often very rewarding, psychological stress is a major occupational health risk for nurses. In a recent large scale survey (RCN, 2006, 2003), thirty-percent (30%) of nurses reported that they would leave nursing in the next two years because of stress and ill health, this compares to 27% in 2003. This finding, along with the fact that nursing workforce is aging and an increased number of nurses will be retiring in the near future, suggest that there is a need to address occupational stress and psychological well-being for nurses as these factors seem to have a huge impact on staff recruitment and retention in health care settings.

So what can be done? Emotional intelligence (EI) is defined by Goleman (1998) as “the capacity for recognizing our own feelings and those of others, for motivating ourselves and for managing emotions well in ourselves and in our relationships”. Individuals with well developed EI skills may benefit from greater understanding of themselves, the way they relate to others, are more able to interact effectively with others and are better equipped emotionally to deal with highly charged situations.

Accumulating research on emotional intelligence approaches to innovative leadership, stress management interventions and improving individual work performance, subjective well-being and personal and work relationships offer various insights for achieving success in the work place at individual and organisational levels.

However, despite the emotive nature of nursing and the demanding service-oriented delivery context, so far little attempt has been made to evaluate possible benefits of implementing an emotional intelligence stress management educational and work-based strategy to reduce the physical and emotional labour of nurses and other healthcare workers. This paper explores and argues the case for developing such an approach.
Background

A recent survey of the wellbeing and working lives of nurses in 2005 (RCN, 2006) found that nurses’ levels of psychological wellbeing have lowered since a similar survey in 2000. The responses from 2,790 RCN members in the UK found that nurses’ psychological wellbeing is lower than the general population. Wellbeing varies between different specialities and employer setting with those working in the NHS, particularly A&E or working in learning disabilities or school nursing having the lowest wellbeing scores. Experiences of bullying or harassment in the last year (23% of the sample) and preferences for not working shifts were also associated with lower levels of wellbeing. Overall, nurses who agreed or strongly agreed with the statement “I find my job stressful” (52%) also tend to have poorer psychological wellbeing than those who do not.

Nursing by its very nature is emotive and the fast changing demanding service-oriented delivery context now characterised by the growing focus on individualised and personalised care requires nurses to skilfully manage their work demands and staff and patient relationships. In addition to this, current NHS cash crisis, threat of redundancies, decreasing workforce and increased patient expectations, places nursing in a stressful working environment.

Caring and supporting patients and their families is now only one aspect of the nursing role. Nurses are professionals, educated at university, often to degree level and are now also expected to provide leadership and direction in service changes, research and education and take a leading role in health promotion in the community. However, research on sickness at work has shown that health professionals in the UK have higher absence and sickness rates than staff in other sectors (Nuffield Trust, 1998). In a study by Wall, Bolden, Borrill and Carter (1997) it was suggested that twenty-seven percent (27%) of health care staff has suffered serious psychological disturbances compared with the 18% of the general working population which in effect can have huge impact on the sustainability of health care services (Sainsbury Centre for Mental Health, 2000). Health care professionals such as nurses, health care assistants and other support staff have the highest rates of ill health retirement with one fifth of nurses retiring on the grounds of ill health for psychiatric reasons (Pattani, Constantinovic and Williams, 2001). These findings, along with the fact that the nursing workforce is aging and an increased number of nurses will be retiring in the near future suggest that there is an urgent need to address nurses health and wellbeing at the workplace in order to
have a sustainable nursing workforce for the near future and face the new challenges in healthcare settings (Arnold, Loan-Clark, Coombs, Park, Wilkinson, and Preston, 2003).

Stress, as defined as the equivalent to a “three way relationship between demands on a person, that person’s feelings about those demands and their ability to cope with those demands” (Richards, 1989), tends to occur in situations where the demands on the person are high and that person’s control over those demands is limited. Work-related stress now appears to be a major occupational health risk for health care professionals and a contributing factor may be a lack of communication or ineffective communication (Ramirez, Graham, Richards, Cull, & Gregory, 1995).

In the USA health care professionals appear to be working under equally stressful conditions. Vitello-Cicciu (2003) argues that the current nursing shortage is driving countless recruitment and retention initiatives. However, to mitigate the number of nurses leaving the profession dissatisfied or due to ill-health, a more effective approach should focus on reducing the physical and emotional labour of nurses. Vitello-Cicciu’s (2001) study of emotional intelligence in nursing leaders found that those higher on emotional intelligence were more likely to engage in practices to manage their emotions, adopt stress management approaches and emphasize with others. They were also more self-aware and other-aware compared to those low on emotional intelligence. This approach was found to promote a less stressful working context. More recently, McQueen’s (2004) analysis of the literature suggests that the modern demands of nursing now draw on the skills of emotional intelligence to meet the needs of direct patient care and co-operative negotiations with the multidisciplinary team. Clear, comprehensive communication and advanced interpersonal skills appear to be essential competencies for professional health care delivery, as patients’ feedback on their health care experience appears to demonstrate. Emotional intelligence is being promoted as an ability worthy of investment and development in health care professionals to meet the challenges of the health care service.

**What is Emotional Intelligence (EI)?**

The concept of EI was labelled by Salovey and Mayer (1990) as being a form of social intelligence, separate from general intelligence which lies at the intersection between emotion and cognition (Mayer, Salovey & Caruso, 2000). Although emotional intelligence is a concept well known within the business arena, it appears to be gaining rapid recognition now within the healthcare field (Herbert & Edgar, 2004). According to Goleman (1998 pp. 317)
Emotional Intelligence is “the capacity for recognising our own feelings and those of others, for motivating ourselves and for managing emotions well in ourselves and in our relationships” and it is argued that these skills may be more influential than cognitive abilities for successful performance in the workplace. Therefore, it is anticipated that individuals with greater understanding of themselves and the way they relate to others, will be more able to interact effectively with others and better equipped emotionally to deal with highly charged situations.

Supporters of Emotional Intelligence argue that EI may have significant impact on individuals’ general well-being, job satisfaction and coping behaviours as well as overall successful leadership skills and behaviours (Dulewicz and Higgs, 1998; Goleman, 1998). It is also suggested that EI increases with age and may be linked to maturity (Goleman, 1995) and consequently through practice and commitment EI can be learnt, developed and improved (Bar-On, 1997; Goleman, 1995; Dulewicz and Higgs, 1999).

In particular EI is considered a significant competency worthy of development in occupations which requires frequent interaction with people and the public, such as policing and nursing (Davies, Stankov and Roberts, 1998). According to Mayer and Salovey (1993) EI involves verbal and non-verbal assessment and expression of emotions, control of emotions and the use of emotion in solving problems, and nursing and police work, in particular, rely on self-awareness and awareness of other’s feelings as central to work performance (Bellack, 1999). In addition, nursing entails emotional labour due to the direct interface with the public and because nurses are expected to demonstrate the ability to care as an integral part of their work performance (Hochschild, 1998). Therefore, it is essential for nurses to be able to detect their own emotions, anxieties and stresses before they can successfully help their patients resolve and cope with their complex physical, social, psychological and spiritual problems of their illnesses. Nurses need to be aware of their own emotions and know how to respond, before they can identify emotions, anxiety and stress in their patients and help them deal with their emotions and anxieties.

Academic research underpinning the concept of EI is largely drawn from physiological research developments, educational based research and studies in the therapy field. The organisational applications of EI tend to be based on derivative arguments and anecdotal case descriptions (Landy, 2005 and Locke, 2005). So is there any evidence to support the claims made for EI and its role in organisations and in promoting well-being and social behaviour? And does this evidence extend to the field of nursing?
Evidence that emotional intelligence is related to performance at work has been sparse but forthcoming in recent years in relation to transformational leadership (Daus and Harris, 2003; Rubin, Munz and Bommer, 2004; cited by Daus and Ashkansy, 2005), job performance of police officers (Daus, Rubin, Smith and Cage, 2004; Daus, Rubin & Cage, 2004; cited by Daus and Ashkansy, 2005), and emotional labour (Cage, Daus & Saul, 2004; Daus et al, 2004 and Janovics and Christensen, 2002; cited by Daus and Ashkansy, 2005). Lam and Kirby (2002) have also found that Emotional Intelligence increases performance in excess of that attributed to general intelligence. People with this additive intelligence have been shown to have better interactive skills, be more co-operative and form closer relationships (Schutte et al 2001).

Two empirical studies, (Barling, Slater and Keloway, 2000) in the USA and (Stough, Palmer, Walls et al 2001) in Australia, have reported significant correlations between emotional intelligence and three aspects of transformational leadership, namely idealized influence, inspirational motivation and individualized consideration. These findings are supported by Barbuto and Burbach’s (2006) study of USA public officials who found that the emotional intelligence of these leaders was related to their transformational leadership behaviours as rated by their staff.

There is also a suggestion that EI may have some impact on individuals’ general well-being, coping behaviour and job satisfaction (Cockerton, Guppy and Moxham, 2002). In their study, carried out with police officers, it was found that there is a relationship between emotional control and communications in the police work, coping strategies, satisfaction and psychological wellbeing. Further empirical support is provided by Slaski and Cartwright (2002) who investigated the relationship between emotional intelligence, stress, health and performance amongst managers in the retail industry. The rationale underpinning this research is that, if such a relationship exists, then programmes aimed at increasing emotional intelligence may be useful avenues to explore as a means of stress reduction and health promotion. Although the researches found a significant link between emotional intelligence and health and performance, the correlational analyses do not establish the direction of causality. However, the findings are encouraging in that emotional intelligence may play an important role in moderating the stress process and increasing individual resilience. More recently, results from Gohm, Corser and Dalsky’s (2005) study of students suggest that EI is potentially helpful in reducing stress for some individuals and those who have average emotional intelligence but not appear to use it, presumably because
they lack confidence in their emotional ability. Perhaps more importantly, if EI can be developed through training, then it has significant potential as a stress management technique.

**So how may nurses benefit from Emotional Intelligence?**

In the field of nursing, the association between the length of time in mental health nursing, emotional competency and stress has been explored by Humpel and Caputi (2001). They found that nurses with over six years of experience had higher levels of emotional competency and this relationship was stronger for female nurses. However nurses with less than two years experience experienced significantly more personal self-doubt than more experienced nurses. It seems then there is a need for developing emotional competencies with trainee and newly qualified nurses to assist them with the stressful and emotionally demanding role. Similarly, McQueen (2004) argues that while emotional labour is important in establishing therapeutic nurse-patient relationships, it carries the risk of ‘burnout’ if prolonged or intense. To prevent this, nurses need to learn and adopt strategies to protect their health and the potential value of emotional intelligence in this emotional work is an issue that still needs to be explored.

However, Farmer’s (2004) small scale study of nurses in early nursing practice revealed that overall emotional intelligence may have a minimal role in the prevention or amelioration of burnout. In addition, Tjong’s (2000) study of 123 registered nurses also found no evidence of job stress relating to emotional intelligence scores although job stress was also not linearly related to hardiness but emotional intelligence and hardiness scores were significantly correlated as expected. The small sample of nurses had an overall group job stress index mean higher than the normative group mean score suggesting this sample were quite stressed to begin with.

More recently, Carson, Carson, Fontenot and Burdin (2005) found that the best performing health care employees are high on intelligence, and the most socially competent employees are high on emotional intelligence. Emotional intelligence was found to be related to organisational citizenship behaviours and also tend to exceed formal role expectations and positively influence organisation outcomes. However, Gerits, Derkson, Verbruggen and Katzko’s (2005) two-year longitudinal study on the emotional intelligence profiles of 380 nurses caring for clients with highly frequent and extremely severe behaviour problems found that female nurses with high emotional intelligence profiles reported the fewest symptoms of burnout, but also tended to have low social
skills. Males with higher problem-solving and stress tolerance skills, (two sub-scales of EI) also showed less burnout.

The case for EI for stress management in nursing has also been made by Reeves (2005) in relation to occupational health nurses who often work within the complex bureaucracy of multinational companies. However, the approaches she suggests rely on bibliotherapy (i.e., the use of self-help books) to aid self-reflection and self-awareness, talking to others about what's occurring in one’s life and workplace, including one’s feelings or recommending therapy.

Savage’s emotions in practice study (2004), explores the application of Balint seminar training as experiential learning for qualified psychosexual nurses and in particular focuses on the potential of nurses’ emotional experiences as a form of nursing knowledge. For Savage the relationship between feelings and knowing were of primary interest and emotions were not regarded as value-free. Emotional experience was used by seminar members as a way of gaining insight into their clients’ worlds on the basis that the emotions that nurses were experiencing were those of their clients. The knowledge nurses developed was concerned with understanding the nature and source of the emotions experienced during practice, together with how to use such emotions to therapeutic effect.

In relation to leadership, findings from Vitello-Cicciu’s (2003) research on nurse leaders suggest that emotional self-awareness of self and others is the cornerstone that underlies an individual’s ability to become emotionally intelligent. Successful nurse leaders were found to be empathetic to their staff members, enhancing individual and group relationships and recognising the individual contributions of each member of the health care team. Vitello-Cicciu also found these same leaders able to adeptly analyse the emotional side of issues, anticipating how people will react and creating programmes that will assist staff with the emotional impact of work-related issues.

Support for promoting EI in nursing also comes from Cummings, Hayduk and Estabrooks (2005). Their large scale study of over 6,000 Canadian nurses found that those working for resonant leaders reported significantly less emotional exhaustion and psychosomatic symptoms. They also experienced better emotional health, greater workgroup collaboration and teamwork with physicians, more satisfaction with supervision and their jobs and fewer unmet patient care needs than did nurses working for dissonant leaders. Resonant leaders’ styles appeared to mitigate the impact of hospital restructuring on nurses, while dissonant
leadership intensified this impact. The resonant and dissonant leadership styles were established from 13 leadership competencies founded on emotional intelligence theory.

Perhaps the more appropriate starting position for introducing emotional intelligence strategies in nursing is at the point of training. Evans and Allen (2002) argue that incorporating emotional intelligence into the curriculum will give nurses a greater understanding of themselves and the way they relate to others, enabling more effective interactions with patients. It will also equip them emotionally to deal with highly charged situations.

Rochester, Kilstoff and Scott (2005) provide evidence that while capability in technical skill is necessary for successful practice as a nurse, it is not sufficient. Instead a range of emotional intelligence capabilities were identified by graduate nurses and their nursing unit managers as being significant factors for successful practice. Therefore these authors argue that it would be important for a curriculum to provide a range of learning experiences that included content related to emotional intelligence. However, Freshwater and Stickley (2004) argue that although many curricula include reference to emotional intelligence and the need for developing emotional intelligence practitioners, this approach is rarely developed beyond an uncritical descriptive level.

In conclusion, nursing is universally acknowledged to be a complex profession requiring high level communication skills for a high degree of interaction with a variety of individuals including professional colleagues, clients and families in a high-stress environment (Reeves, 2005). However, while Goleman (1998) argues that emotional intelligence matters more as the complexity of the work increases and evidence is accumulating to support this, there have been few attempts to systematically integrate and develop emotional intelligence for the benefit health care workers. This may be due to the belief that interpersonal skills and empathy are already among health care employees, but research has shown that nurses do not always have sufficient skills in these areas (Baille, 1996; cited by Reeves, 2005). What is needed now, perhaps more than ever before, is a programmatic attempt to implement an EI awareness and development scheme for leadership and stress management as part of an educational and work-based strategy, which is appropriately evaluated.
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A Health Needs Assessment of Nurses Working in an Acute Hospital Setting

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The workplace setting is an important health determinant and can influence the bio-psychosocial health status of employees. Hospitals are considered to be dangerous workplaces, as the determinants in this setting can have an immediate health impact on those who work there. This study aims to examine the health determinants and health needs for one particular group of employees – the nursing staff.

A cross-sectional study design has been utilised and the data has been collected with the use of a self-report questionnaire. A random sample of 150 nurses was chosen to participate in the study, from an acute hospital setting. Data analysis was conducted using Statistical Package for the Social Sciences.

The results of this study have found that:
- The health behaviours of smoking, drinking alcohol and a lack of exercise are frequent among nurses
- Engaging in shift work impacts negatively on all aspects of nurses lives
- Sources of stress are common for Clinical Nurse Managers and Staff Nurses, but Staff Nurses report these sources to be of higher importance.

The identification of health needs from these findings will guide the integration of health promotion into aspects of the hospital and contribute to individual and organisational change.
“Ward nurse perceptions of support needs caring for high dependency patients discharged from ICU”

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Background and context
The limited number of intensive care beds and the demand for these beds often patients are discharged earlier than is clinically indicated. Consequently, many patients are being discharged from the intensive care unit (ICU) requiring critical care skills by nurses on the general wards. There is limited focused research on support needs of ward nurses caring for high dependency patients, and any which could be found are British studies. In an era where there is an escalating nursing shortage it is important that nurses needs are identified and are met, as they are in the front line in caring for the critically ill patients. Although many studies have identified the need for education of nurses in caring for these patients, support has been identified as necessary if patients are to be cared for on the general wards.

Aim of the study
The aim of this study is to explore the perceptions of ward nurses support needs caring for high dependency patients discharged from ICU.

Objectives
To describe ward nurses experiences in caring for high dependency patients discharged from ICU.
To identify the support available to ward nurses caring for high dependency patients discharged from ICU.

Methodology
A descriptive exploratory design was used to give an authentic insight to ward nurses experiences. Using purposive sampling the researcher selected twelve nurses who have cared for high dependency patients discharged from ICU. The population in the writers study consisted of twelve staff nurses working in two surgical, one urology, one orthopaedic one respiratory and two medical wards within one of the Dublin Academic Teaching Hospitals (DATHs).

Data was collected using semi- structured interviews. Semi-structured interviews were used to facilitate more focused exploration of a specific topic, using an interview guide. The questions were contained in an interview guide with a focus on the issues to be covered. The questions were developed from the themes that emerged from the literature review and were essentially designed to address aims and objectives of the study. Thirteen interviews in total were carried out. Two of these were pilot studies. One interview was being omitted from the study as it was only ten minutes long and it did not generate any data. The interviews lasted from twenty-five minutes to one hour.

Data Analysis
The data was analysed using the Coliazzi seven-step framework for data interpretation and description. Interview transcripts were read several times in order to develop a general understanding of the data as a whole. Further reading of the data during which significant words and sentences were extracted followed. Following rigorous analysis of the data the researcher developed five main themes.

- Transition from Intensive Care to the ward
- Misuse of the term “High Dependency Area”
- Experience
- Support
- Need for support

Discussion
An objective of this study was to identify the support available to ward nurses caring for high dependency patients discharged from ICU. Nurses are calling general ward areas, “high dependency areas” although they have no extra staff or equipment. Nurses are therefore caring for high dependency patients in areas that are clearly inadequate to meet the patients’ needs. This has a huge impact on the workload of ward nurses and increases their support needs. At present nurses, rely on other staff members,
management and the medical teams for support. They also rely greatly on the staff of ICU. However all participants feel that this is not adequate and requested formal support and continuous competency based assessment.

Conclusion
The findings of this study suggest that all ward based nurses, including those who care frequently for high dependent patients have support needs caring for high dependency patients. The provision of outreach or liaison nurses may be an appropriate method to help support and bedside education as requested by participants, to these ward nurses.
Challenges and Strategies in Conducting Focus Groups

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Context and Rationale
Nurses frequently use focus group interviews to collect data. Published accounts on focus group interviewing can give the impression that this is a relatively straightforward way of collecting data. In contrast, the authors believe that focus group interviewing is complex and requires practice to develop ‘good’ skills.

Aim
The aim of this poster is to provide a guide to conducting focus group interviews.

Content
Topics addressed:

- Why and when to use focus group interviews.
- Strengths and limitations of using focus group interviews.
- Practicalities of conducting focus group interviews:
  - Recruiting participants
  - Developing focus group questions.
  - Preparing the venue.
  - Facilitating focus group interviews.

Conclusions
This poster outlines why, when and how to use focus group interviews. It will aid novice researchers in planning and effectively using focus group interviewing as a method of data collection.
Comparison of multiple choice question and written question results in first year biological sciences.

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Background
First year students in the School of Nursing and Midwifery, Trinity College Dublin, are examined in biological sciences using multiple choice question (MCQ) format and written format. Both exams comprise knowledge based questions (not case histories or problem solving).

Aim
To determine if students perform better in multiple choice question or written questions.

Methodology
Results were correlated from Michelmas first year biological science exams in 2004 and 2005 for all disciplines. The multiple choice question paper consisted of 35 questions with no negative marking. Each question had one correct answer out of four choices. The written paper consisted of 3 questions and marked from 0 –10 with the full range of marks allowed. Both exams comprised knowledge based questions (not case histories or problem solving).

Analysis
The results from each exam were converted to percentages. For each student, the difference between the MCQ result and the written result was calculated and compared against the average for the two results.

Results
Students performed better in the multiple choice question exam compared to the written exam over both years. Average difference between a student’s MCQ and written result was 7% for the general nursing students.

Conclusions
Possible reasons for better student performance in the MCQ exam compared to written may be:
1. Students not studying parts of the course which may penalise them more in a written exam compared to an MCQ exam.
2. Overall writing skills are not good. (not answering question asked, poor answer planning, poor answer structure)
3. MCQ exam standard may be easier.
Vaginal Douching, Bacterial Vaginosis, and Preterm Labor

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Background: Vaginal douching is common among women in many countries. The practice is associated with negative health consequences including increased incidence of tubal pregnancy, higher rates of HIV transmission, bacterial vaginosis (BV), cervical cancer, preterm birth, and low birth weight infants.

Purpose: To document knowledge, beliefs, douching practices, prevalence of BV, and preterm births in women who douche

Methodology: Self-administered questionnaires about douching and medical record review

Research Design: Descriptive, cross-sectional non-experimental

Sample: 483 women ages 14-45 in eight Florida county health departments and 6 private midwifery/nurse practitioner offices

Analysis: Chi-square analysis ($p < .05$) was used to assess the association between select questionnaire responses and race, other demographics, and history of vaginal douching. Odds ratios were determined using Mantel-Haenszel Common Odds Ratio estimate. SPSS 12.0.2 for Windows (SPSS Inc., Chicago, IL) was used for data analysis.

Summary of findings: Seventy-six percent of women had douched, and 43% practiced douching once a month or more often, and these women were 2.5 times more likely to have a history of BV than women who did not douche ($p < .001$). Women douching weekly were 2.75 times more likely to have BV than those not douching($p = .004$). Black women were more likely to report douching than White or Hispanic women. Of 409 clients with medical records available, 32 had preterm births of which 69% had a history of BV ($X^2 = 4.5$, $df = 1$, $p = .034$). Among women with preterm births who doused regularly prior to pregnancy ($n = 14$), 87% had a history of BV ($X^2 = 7.14$, $df = 1$, $p = .008$).
Conclusions: Associations of douching with BV and BV with preterm labor were significant. Health care professionals should initiate discussions to discourage douching.

Recommendations: Health care providers should assess clients for douching practices while providing well-woman care, family planning, sexually transmitted infection treatment, preconception care, and prenatal care. The practice of douching should be discouraged and written information regarding health risks of douching provided. Women in their reproductive years should have easy access to care for prompt recognition and treatment of infections to prevent fetal/infant loss and preterm births.
**ABSTRACT**

**Background and context**
Overcrowding in Accident and Emergency departments is an ongoing problem that impacts on patients, relatives/significant others, nursing and medical staff. Despite the ongoing nature of this problem no Irish based research studies were found that explored the impact of this long waiting period on patients and relatives/significant others. Media sources consistently highlight the plight of the patient waiting for a bed following admission in the Accident and Emergency Department in Ireland. Areas of concern include: overcrowding, lack of privacy and dignity, dirty environment, poor sanitary conditions and understaffing.

The aim of this study was to explore the experiences of patients and relatives/significant on overcrowding in Accident and Emergency. The objectives of the study were to explore patients and relatives/significant others perceptions of:

- the quality of care offered while waiting in Accident and Emergency for 12hrs or longer for admission to hospital
- the effects of waiting on the study participants.
- the conditions in the Accident and Emergency department, in which patients have to wait for admission to hospital.

**Methodology including research design and sampling**
A qualitative approach was used to guide the study. Semi-structured face to face interviews were used to collect the data. Participants were invited for interview through contact with the patients together group and posters displayed on public
noticeboards. Three relatives and five patients volunteered to participate in the interviews. The data was transcribed and analysed using content analysis. The finding will be discussed under the following four heading: Demographics; Experience of waiting in Accident & Emergency for admission to a ward; waiting conditions in Accident & Emergency; Suggestions for improving the care offered in Accident & Emergency
A National Survey of Irish Nurses Attitudes to Death and the Care of Dying Patients.

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ABSTRACT

The multidimensional and complex nature of attitudes towards death and dying is evident throughout the literature. Such attitudes have been identified as key factors influencing the behaviour of health care professionals. The aim of this study was to provide the first national investigation of Irish nurses attitudes towards death and caring for dying patients.

The study used a descriptive and correlational design. Participants completed three measurement tools, a demographic data tool, the Death Attitude Profile-Revised Scale (DAP-R) (Wong et al 1994), and the Frommelt Attitudes Towards Care of the Dying Scale (FATCOD) (Frommelt 1991). A random sample of 1500 registered general nurses was extracted from An Bord Altranais nurses register. The sample size was based on a power equation assuming a questionnaire response rate of 30%. There was a 57.6% response rate to the survey, of which 47.7% were valid.

Data Analysis:
Descriptive statistics of the sample including frequencies, means and reliability estimates were computed. Bivariate correlations were computed to examine the relationship between demographic variables (clinical practice area, nursing experience, nursing education, age, sex, religious affiliation, spirituality, personal bereavement experience, specific death education experience and frequency of caring for dying patients) and scores on the FATCOD and DAP-R subscales. Data analysis used SPSS® version 12 software (SPSS Inc., Chicago, IL). The alpha level for each test was set at $p \leq 0.05$
Participant Profile:
The participants in this sample were predominantly female (97.6%) and Catholic (93.7%), with 53.4% perceiving Spirituality as being very important in their personal lives. 85% of participants were over 35 years old. 90% of the sample had experienced a personal bereavement, and for almost 27% this occurred less than 2 years ago. 50% of the sample was educated beyond nursing certificate level. A broad spectrum of clinical practice areas was represented, with the majority of the sample (56.7%) having more than 20 years nursing experience. 67% of nurses in the sample either frequently or occasionally cared for dying patients, with 20.3% having completed an educational course that dealt specifically with issues related to death and dying.

Descriptive Analysis:
Descriptive analyses were computed on the FATCOD and DAP-R subscales. In general nurses in this study demonstrated a positive attitude towards caring for dying patients (\( \bar{X}=124.65, \ SD=11.23, \ range=92-150 \)). Participants believed that it is beneficial for dying patients to verbalise their fears and that it is possible for nurses to help patients prepare for death. They demonstrated no hesitancy in forming relationships or providing care to dying patients. Participants also acknowledged that families need emotional support and help and that nursing care should extend to the families of dying patients.

Nurses’ mean scores on the DAP-R were as follows: Fear of Death (\( \bar{X}=3.70, \ SD=1.21 \)), Death Avoidance (\( \bar{X}=3.18, \ SD=1.38 \)), Neutral Acceptance (\( \bar{X}=5.21, \ SD=1.33 \)), Approach Acceptance (\( \bar{X}=4.93, \ SD=1.02 \)), Escape Acceptance (\( \bar{X}=4.00, \ SD=1.27 \)). On average Nurses’ in this study did not fear death viewing it as neither good nor bad but a natural aspect of the process of life. Belief in an afterlife provided comfort in facing death, with death being considered a deliverance from pain and suffering.

Bivariate Analysis:
Missing data on the FATCOD and DAP-R subscales were examined and no systematic pattern found. Only complete data sets were used in the final computation. Negative items on the FATCOD scale were reversed so that high FATCOD scored represented a positive attitude to caring for dying patients. Analysis (using independent-samples T-Test and ANOVA) found no significant relationship between FATCOD scores and nurses’ area of clinical practice, sex, past personal bereavement experience or time since personal bereavement occurred, religion or the importance of spirituality in nurses’ personal lives. Significant relationships were found to exist between mean FATCOD scores and years of nursing experience (\( p= \))
0.009), level of nursing education ($p = 0.002$), age ($p = 0.027$), experience of death education ($p=0.015$) and frequency of providing care to dying patients ($p=0.00$).

No significant relationship existed between any of the demographic variables and Fear of Death, Death Avoidance, or Neutral Acceptance. Significant relationships were found between Escape Acceptance and years of nursing experience ($p=0.01$), age ($p=0.00$), importance of spirituality ($p=0.03$), and frequency of providing care to dying patients ($p=0.25$). Statistically significant relationships were also found between Approach Acceptance and area of clinical practice ($p=0.011$), religion ($p=0.00$), importance of spirituality ($p=0.00$).

No statistically significant relationship was found between Neutral Acceptance, Approach Acceptance and Escape Acceptance and mean FATCOD scores, however statistically significant negative correlations were found between Fear of Death ($p=0.00$, $r = -0.223$) and Death Avoidance ($p=0.00$, $r = -0.315$) and mean FATCOD scores.

Conclusions:
Several factors including nursing experience, education and contact with terminally ill patients, fear of death and death avoidance influence nurses' attitudes towards care of the dying. However, regardless of nurses' demographic characteristics or death attitudes providing quality end-of-life care is salient.

Implications for Nursing:
Nurses frequently care for dying patients and play a key role in providing quality end-of-life care. Death education should be incorporated in all nursing programmes and should include strategies designed to increase positive attitudes towards death thus reducing fear or death and death avoidance.

References.

Paediatric Critical Care Nurses’ Perceptions of Family-centred Care

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Abstract

Paediatric Critical Care Nurses’ Perceptions of Family-centred Care

Background: The profile of paediatric critical care nursing has undergone extensive change in recent years. The families of critically ill children are now encouraged to be present with their child at all times and to actively participate in their child’s care while in hospital. For the paediatric critical care nurse embracing this change and successfully providing family-centred care poses a number of challenges, requiring a flexible approach to patient care delivery.

Objective: the purpose of this study was to explore the perceptions of a small group of paediatric critical care nurse’ perceptions of family-centred care, particularly as it related to the delivery of family-centred care in the paediatric critical care unit.

Method: the study participants comprised six paediatric critical care nurses who had been employed in a paediatric critical care unit for between two and nineteen years. A qualitative approach using grounded theory was utilized and data were collected using semi-structured interviews. The data were analysed using the constant comparative method.
**Findings:** The participants described what they were of the opinion were critical components of the concept of family-centred care; viewing the family as the unit of care, promoting the family’s prominent position in the child’s life, recognition of differing family roles and structures and family-centred care as a practice continuum. Relationship building involved orientating family members to the critical care environment, assessing the families coping strategies and demonstrating concern for family members’ wellbeing. Empowerment was regarding as a critical attribute of family-centred care. Parents were encouraged to become involved in their child’s physical and emotional care, kept informed of their child’s progress and treatment decisions and facilitated to become in patient care decisions. The participants believed that organization structures and policies, balancing work requirements and family-centred care and the difficulties encountered when the child’s condition deteriorated provided challenges to the paediatric critical care nurses ability to successfully provide family-centred care.

**Conclusion:** A family-centred philosophy of care requires that critical care nurses shift the balance of power from the nurses towards the empowerment of families of critically ill children.
PERCEPTIONS OF ORGANISATIONAL CLIMATE: ARE NURSES IN THE REPUBLIC OF IRELAND SATISFIED WITH THE CLIMATE OF THEIR ORGANISATIONS?

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Background: This presentation is based on a large study which examined organisational climate and job satisfaction among nurses in the Republic of Ireland.

Organisational climate refers to the collective perceptions of employees about the internal environment of an organisation and is a major determinant of employee performance. A substantial amount of research on organisational climate has been carried out in educational institutions and business organisations. Few research studies, however, have examined this important topic within healthcare. Moreover, no known studies of this kind have been completed within healthcare in the Republic of Ireland.

Aims: The study had several aims but only two are relevant to this presentation. These are: to determine nurses’ perceptions of the climate in the organisations where they work and to identify which of six organisational climate factors nurses considered to be satisfactory and which they regarded as unsatisfactory.

Method: This presentation represents the descriptive findings of a study that utilised a mixed method design. Data relevant to organisational climate were collected by means of a postal survey and probability sampling was used to select the sample. This sampling approach was used because it offers more accurate generalisation to the target population.

Findings: Findings confirmed low to moderate satisfaction with organisational climate. Specifically, respondents were moderately satisfied with climate components such as humanistic thrust (behaviour by the leader to move the organisation forward) and disengagement (behaviour that describes a group that is not
focused on the tasks in hand) and less satisfied with components such as *esprit* (morale) and *hindrance* (tasks that employees feel are unnecessary “busy work”).

**Conclusion and Implications:** This is probably the first study of its kind to be completed in the Republic of Ireland. Therefore, the findings are significant and relevant to nurses and the nursing profession in this country. Creating a climate that offers interesting and challenging work and where employees are informed, involved, and respected is no doubt a major challenge for all managers. Nevertheless, it is incumbent on them to design and implement strategies that will promote a climate high in *humanistic thrust*, *esprit*, and *intimacy* and low in *aloofness*, *disengagement*, and *hindrance* within their organisations.
Women who are infected and negatively affected by HIV rely on a number of means to cope with the stressors associated with being HIV-positive. Spirituality has been identified as an important factor in health and well-being among women with HIV/AIDS. Spirituality is a resource used by HIV-positive women to maintain psychological well-being, and it also may have a positive impact on physical health and health-related quality of life.

The purpose of this cross-sectional study is to assess the interconnection between spiritual well-being, depression, CD4 count, and health-related quality of life among women living with HIV/AIDS. Methods: A non-random sample of women were recruited from an infectious disease clinic in metro Atlanta. Correlations and hierarchical regression statistics were used to examine those interrelationships. The spirituo-psychoneuroimmunology (SPNI) framework, developed by the author, based on McCain’s PNI based framework (2005), served as a guide to facilitate the examination of those relationships. The qualitative component used a phenomenological approach to interview women in focus groups and individual interviews about their lived spiritual experience. This component of the study helped to inform and add meaning to the quantitative findings.

The findings of this study showed significant inverse associations between spiritual well-being, and its components, and depression. There were also significant, but weak positive associations between existential well-being and immune status. Existential well-being and depression were the only two significant predictors of health-related quality of life.

The qualitative study findings revealed the spiritual views and practices of 20 women living with HIV. The following themes emerged: connection to God or Higher Power; prayer, helping others, having faith or belief in God, and church attendance; health
or healing; a second chance; spirituality is a process or journey and its sub-theme: HIV brought me closer to God; spiritual, social, or mental health support; and finding purpose.
Stoma Care Basics
Experiential Learning in Nursing Concept Seminar

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Patients with ostomies come from across the lifespan and present the healthcare team with a full gamut of physiologic and psychologic needs. When faced for the first time with caring for a patient who has an ostomy, students are usually apprehensive that they will do or say the wrong things. The Stoma Care Concept Seminar is an experiential learning exercise that facilitates students in learning the mechanics of stoma care and in understanding the physical, emotional, and social concerns of ostomates of all ages in a safe, non-threatening and fun environment. Inspired by Kurt Lewin’s theoretical work on adult learning, David Kolb and Roger Fry created the Experiential Learning Model. Experiential learning is a form of adult education that allows students to gain knowledge and insight about something being studied through direct participation.

Guided by this model, the Stoma Care Concept Seminar begins with a brief overview of the different types of diversions, ostomy supplies, and general care of the ostomy patient. Issues related to stoma care across the life span are addressed at this time. Concerns pertinent to the older adult and to children are also discussed. This is accomplished through a combination of teaching modalities including Power Point presentation and lecture. In the nursing lab, students practice measuring, cutting and fitting appliances to stoma models, then pair up and actually “don the ostomy”.

“Donning the ostomy” refers to students’ role playing both as nurse and patient. As nurse, the student applies the pouch to their partner, demonstrates how to empty the pouch, and provides patient teaching in basic stoma care. Roles are reversed so each student has an opportunity to demonstrate, teach, and experience a little of what it is like to live with an ostomy.

Once applied, the ostomy bags are filled 1/3 full with a pudding or an oatmeal mixture to simulate the consistency of ileostomy
effluent. Students are encouraged to do what they would ordinarily do...go to class, the gym, go shopping, take public transportation, etc. At the end of the day they are to empty the pouch as they have been instructed in class, and if they wish, remove it before going to bed.

When students return to class they are asked to share their experiences with each other. In general, students have found this to be a very positive learning experience, as well as a very revealing and humbling experience. They have reported an increase in their confidence when faced with caring for ostomy patients in the hospital, and they have also reported having acquired a degree of empathy that they might not have known had they not worn the pouch and experienced some of the difficulties and inconveniences for themselves.
A pilot study exploring the use of a Life Story Book (LSB) with Residents in a Nursing Home Setting

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ABSTRACT

Background
Attention to stories or using life story books to capture life history provides a holistic view of an older adult and offers the potential for quality nursing intervention. The Life Story Book involves collecting and recording aspects of a person’s life both past and present and consists of photographs and materials relating to their life (Heathcode, 2005). Life story work offers the potential to promote and enhance person-centred care (Clarke, Hanson and Ross, 2003; Nolan et al 2004; Coker, 1998) and personal stories are a means by which individuals establish and maintain intimacy with one another (Hirst, and Raffin, 2001). The benefits of using Life Story Books include greater family involvement, improved relationships with staff, a sense of belonging and attachment for older people and a more person-centred approach to care (Clarke, Hanson and Ross, 2003; Anderson, Hobson, Steiner and Rodel, 1992).

International evidence on the use of life story work is immature, leading to the recommendation for more research. No research has been published in Ireland which explored the views and experiences of residents in compiling their life story.

Aim:
To introduce Life Story Book to residents (n= 6) in a nursing home setting and then to explore the views and experiences of those residents in compiling their life story.
Design and method:
A descriptive qualitative design was utilized for the study. This involved focus groups using semi-structured interviews with residents and review of Life Story Books. The interview data was thematically analysed by initially coding the data, then identifying categories and key themes.

The findings from this study provides data on the use of life story books with older people and the difficulties encountered in engaging people in developing the life story book and possible implications for future practice.

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Abstract

Background and Context

Moral distress is experienced by nurses who are morally constrained: they make a moral judgement as to the right course of action to take in a situation, but they are unable to act upon their judgement.

Moral distress usually impacts negatively on nurses and, in turn, on nurse employers and patients. It is associated with negative emotional, psychological and physiological responses. In addition, nurses cope with moral distress by working fewer hours, changing career, blaming nursing administration, blaming the hospital system, and avoiding patient interaction.

Studies to date have largely focussed on the experiences of general nurses working in critical care or acute settings. Other nursing disciplines have received more cursory attention. However, concern that Irish Psychiatric Nurses may be experiencing ‘moral discomfort’ finds support in the findings of a recent study (Deady 2005).
Aims of the study:

1. Ascertain the dimensions of moral distress experienced by psychiatric nurses working in an acute setting
2. Explore the situations that give rise to moral distress among.
3. Describe ways in which psychiatric nurses cope with the experience.

Methodology: 8 Irish registered psychiatric nurses working within an acute care setting will be asked to voluntarily take part in one or more one-on-one tape recorded interviews and validation of those recordings. The study is currently underway following ethical approval and will be completed by October 2006.

Analysis:

Analysis will use Collaizzi’s seven steps of data analysis where the relevant themes will be extracted, validated and commented upon.

Conclusion:

The presence of moral distress may have implications for the retention of nurses in employment and the quality and standard of care that clients receive. This study should better enable the recognition of this phenomenon and shed light on the precursors that give rise to moral distress, as well as, suggesting procedures to alleviate or diminish its impact.
Title: Health promotion in mental health nursing: an exploratory study of the perceptions of mental health nurses in one geographical region.

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Background and context
Much has been published regarding the nurses’ role in health promotion generally. However, there remains a paucity of research, which considers mental health nurses’ understanding of and engagement in health promotion.

Aim of study
To explore mental health nurses understanding of health promotion and the role it currently plays within their professional practice.

Methodology
Sample: A convenience sample of nurses employed by the Mental Health Service in one Irish county was invited to participate in this qualitative study.
Data collection: involved two phases, focus group and interview. The focus group, which comprised of seven participants, explored the health promotion issues in their professional practice, which were followed up in depth with nine semi structured individual interviews.

Analysis
Data was analysed using thematic analysis. Through repeatedly listening to the audiotapes and reading the transcriptions themes emerged. The most commonly occurring words or phrases formed sub themes which were further clustered together to form main themes which best described the voices of the participants.
Summary of key findings
Participants were positive regarding health promotion and their role as health promoters and health promotion role models however, their understanding of health promotion was limited and many used an educational rather than a health promotion approach. Health promotion practice for this group encompassed education regarding lifestyle behaviour, client empowerment and advocacy. Their work presented them with opportunities to promote health; conversely barriers and challenges existed, including lack of time, staff shortages, access to information, motivation, stigma, mental illness, institutionalisation and a lack of education in health promotion.

Conclusions
While mental health nurses perceive that they have a role in health promotion the role is underdeveloped and their understanding of health promotion is limited. Barriers and challenges must be addressed to ensure that health promotion is central to practice.
Discovering the future of school nursing: the evidence base

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Background and context

This study, funded by the Department of Health, was published in March 2006. It is a scope review of literature in the field of school nurse practice.

Aim of the study

The aim was to clarify the evidence base for school nurse practice in the four countries of the UK at the outset of 2006 for use as a planning tool by managers and school nurses.

Methodology including research design and sampling

We conducted a scope review of all the research we could find on the subject of school nurse practice – policy papers; descriptions of practice; peer-reviewed research; and grey material (unpublished work).

We used five key words, more than thirty databases, eleven main websites, and we hand searched two university libraries.

Exclusions included articles in languages other than English; mainly (but not wholly) pre-1990 publications; specific child health reports.

Analysis

Over a period of five years we extrapolated recurring themes and issues and identified gaps in knowledge.
Summary of key findings

We found a considerable body of research about school nurse practice but studies tend to be published within a narrow range of professional journals and keyword searching tends to uncover published work on children’s health rather than on school nurse practice itself.

We found a surfeit of research that described interventions in localities. The patterns of development in school nurse practice indicate fairly radical change in practice over the last decade.

School nurse practice has been difficult for most people to describe because school nurses work to a variety of contracts and in a variety of settings. They also work in the community, with families, and on school premises.

Despite widespread innovations in practice by highly committed school nurse leaders, it remains the case that the service is still somewhat invisible.

Conclusions

School nursing remains a service without legislative requirement, without a regulatory framework of its own, and without a consensus about its education and training platform. Yet, if the service were lost, there is no health professional group who could replace the work that these staff do for school age children and young people.
Health care in the 21st century can be characterised as an environment of dynamic and fast paced change from which nursing, in terms of practice development and diversity of new roles, is not immune. Such speed of change poses a major challenge to educators to ensure that undergraduate nurses are fit for practice and fit for purpose when they first qualify from third level education. In this regard, educators need to employ a range of teaching and assessment strategies that are both speedily adaptable for an ever-changing practice environment, yet professionally robust in terms of practice based content and assessment rigour. Information technology and the use of web-based learning has the potential to provide a flexible mechanism for both teaching and assessing to meet these challenges. This paper reports on a study, conducted by one third level department of nursing in Ireland, of its employment of Webct, a virtual learning environment, to deliver a formative assessment, through a
structured multiple choice questionnaire (MCQ), to one group of nursing undergraduates.

The sample consisted of 4th year undergraduate BSc nursing students undertaking the subject Social Psychology. Employing a purposive sampling strategy, ninety-eight students completed a standardised pre-tested MCQ assessment. Using across method triangulation, data was collected utilising questionnaires and focus groups to evaluate this assessment modality. Quantitative data was analysed using SPSS-version 14; Qualitative data was analysed utilising a ‘frameworks approach’. Results indicated that this assessment method was evaluated favourably by the sample.

The students demonstrated competency in terms of cognitive, affective and psychomotor skills.

The potential benefits of this approach relate particularly to the development of critical thinking and reasoning, and their transferability to decision making in nursing practice. An awareness of the merits and potential of contemporary information technology as a means of promoting learning is vital in nurse education today.

**Key Terms:** Key words: WebCt assessment strategies; social psychology; student learning.
**Reasons for self-referral to the Accident and Emergency Department**

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**Introduction**

The Accident and Emergency (A&E) department is often the gateway to hospital services for patients, regardless of whether they have visited their general practitioner. The main priority of the A&E department is the assessment and treatment of patients with major injuries and illnesses (Jones, 2000). However, the A&E department also has a role in providing a service for patients with minor injuries and illness (Jones, 2000).

Overcrowding is a problem of note in A&E departments worldwide, causing pressure on the hospital services and often resulting in increased waiting times (Koziol-McLain, Price, Weiss, Quinn and Honigman, 2000; Wellstood, Wilson and Eyles, 2005). This problem of overcrowding is ever-present in A&E’s in Ireland in recent years. One factor attributed to the worsening overcrowding is the attendance of patients to the A&E, who could be treated by a General Practitioner (GP) or other primary care sources. These patients are often referred to as “inappropriate” attenders (Walsh, 1995; Murphy, 1998a; Sanders, 2000). This researcher does not agree with the negative term “inappropriate” and argues that the service, rather than the patient is inappropriate.

Self-referred patients are those patients who present themselves at the A&E, having bypassed all primary care sources. The two A&E departments involved in this study (referred to as Hospital 1 and 2 throughout) have a rate of self-referrals of greater than 60 percent (Comhairle na nOspidéal, 2002). Hospital 1 had an overall attendance of 27,026 patients in 2000, 67 percent of which were self-referred (n=18,447). Hospital 2 had an overall attendance of 58,807 in 2000, 64 percent of which were self-referred (n=37,636) (Comhairle na nOspidéal, 2002). This researcher was interested in exploring the reasons for such high rates of self-referral to the Accident and Emergency departments. These reasons have not been documented widely from an Irish perspective.
Literature Review

According to Murphy (1998a) and Semper-Selva, Peiro, Sendra-Pina, Martinez-Espin and Lopez-Aguilera (2001), there is no accepted absolute definition of the term ‘inappropriate,’ when referring to attendance of patients at A&E. Liggins (1993) and Dolan (1999) claim that patients attending A&E with conditions which could be treated in a primary care setting, rather than a hospital, are considered to be inappropriate attenders. Murphy (1998a), in a meta-analysis of the subject, states that patients who refer themselves to the A&E department for conditions that are neither accidents nor emergencies are often portrayed as ‘inappropriate’ attenders. There is a belief amongst some health care professionals that these people should be given longer waiting times and verbal admonishments (Dolan 1999) and this negative attitude can impact negatively on patients’ experiences of A&E (Palmer, Jones, Jones, Polacarz and Evans, 2005). Indeed, the term ‘casualty’ department was changed to ‘Accident and Emergency’ department following the UK’s Platt report in 1962 to discourage the “casual” use of the service (Liggins, 1993; Cocks, 2000).

Murphy (1998a) outlines some of the language used by healthcare professionals to describe patients with primary care needs, who attend the A&E. Terms, such as ‘abusers’ of the service, are negative, bordering on prejudicial (Murphy, 1998a). With regard to negative feelings towards patients by healthcare staff, Murphy (1998a) discusses the fact the comments by health professionals such as “most of the people don’t belong here” creates an impression that these patients are not welcome or not worthy of treatment. Sanders (2000) came to a similar conclusion that the literature showed a philosophy of ‘blaming the patient’. Deterrents to attending A&E for primary care problems include the introduction of higher charges for A&E services by the Irish government, for those patients who are liable for funding their own health care (Murphy, 1998b). Another initiative to relieve the supposed burden on the A&E, due to attendance by patients with primary care needs, is the establishment of primary care facilities within the A&E.

Several reasons for patients referring themselves to the A&E have been cited in the literature. Walsh (1995), using the Health Belief Model, explains that these patients, who refer themselves to the A&E, are not purposefully abusing the service but are exercising their best rational judgement. Walsh’s (1995) qualitative study with a sample of 200 A&E attenders, divided equally between male and female, used structured interviews as the research method. A mix of open-ended and closed questions was used to determine the reasons for these people choosing to attend the A&E (Walsh, 1995).
These patients were interviewed before their examination by the A&E doctor. Some themes to emerge from Walsh’s (1995) study are: “A&E would be more appropriate or better than GP”; “GP would send me here anyway”; “Quicker/wait too long for GP appointment”; “Sent by GP after initially going to GP”; “Advised to go to A&E by others than GP”; “More convenient than GP”; “GP surgery closed/GP not available”; and “No GP or GP> 25 miles away”. Patients own perception of health and illness may differ from the perceptions of healthcare staff (Finfgeld, Wongvatanyu, Conn, Grando and Russell, 2003; Finnegans, Marion and Cox, 2005). The Health Belief Model, as explained by Walsh (1995), introduces the notion of a “cost-benefit analysis.” The patients make a cost-benefit analysis of whether it is more beneficial to attend hospital for reasons, such as financial or time-related issues than to attend elsewhere (Walsh, 1995). This is a rational approach rather than a random approach to choosing the A&E for treatment.

According to Lowe and Bindman (1997), triaging away patients from the A&E occurs because there is a belief that trained health professionals agree on what constitutes a real emergency. However, Lowe and Bindman (1997) argue against the practice because they argue that professionals do not agree on the meaning of the word ‘emergency’.

People have been shown to attend A&E for a variety of reasons. Convenience of access is considered to be a significant factor for attendance by a number of researchers (Walsh, 1990; Beland, Lemay and Boucher, 1998; Boushy and Dubinsky, 1998; Cooper, Simpson and Hanson, 2003). One aspect of convenience for patients is their proximity to the hospital. Geographical factors are considered important by Walsh (1990), following his retrospective analysis of the case notes of 2,000 patients who attended the Bristol Royal Infirmary and were discharged home on the same day. Walsh (1990) found a strong link between distance travelled and attendance, with those people living further away from the hospital less likely to attend.

Howard et al. (2005), in their descriptive qualitative study of 31 patients attending A&E for non-urgent reasons, propose that the service, rather than the patient is inappropriate and that hospitals should consider providing primary care services to suit patients’ needs. This is a view echoed by Steel (1995); Crouch, Haverty, Westcott and Dale (1997) and Sanders (2000). Comhairle Na nOspidéal (2002) concluded that those hospitals which set up nurse-led minor injury and illness areas could improve the hospital experience for patients with non-urgent problems and the staff who care for them. In light of health service reform, the Department of
Health and Children (2001), in the Health Strategy, undertook to establish nurse-led minor injury and illness areas (MIU) to address these concerns.

There is a gap in the literature. Although a medically focussed study of the literature was carried out in Ireland by Murphy (1998), there is still a paucity of research on the phenomenon from an Irish nursing perspective. Much of the literature is focussed on analysing the appropriateness of patients' attendance at A&E. There is a lack of studies analysing the reasons for self-referral to A&E. Much of the literature is judgemental, without consideration for patients’ opinions. The topic is relevant at present in the writer’s opinion, due to the overcrowding problems in A&E’s in Ireland. In order to approach the challenge of increased demand for emergency services, it is important for nurses to understand the reasons why patients attend A&E. The way the service is organised may require radical change in light of the focus on consumerism.

Methodology
The purpose of this research study is to identify the reasons why patients self-refer to the A&E department, rather than attending their GP or other primary care sources.

The objectives of this study were based on the findings of the review of the literature. This study has the following objectives:

- To identify if patients attend A&E because of convenience
- To ascertain if patients attend A&E due to financial issues
- To understand if patients attend A&E because they believe the standard of care is better than that in the community
- To identify if patients attend A&E because they believe there is a dearth of adequate primary care alternatives available to them
- To understand if patients referring themselves to the A&E perceive that their condition is an emergency
- To identify if patients attend A&E because they believe that they need the facilities of the hospital
- To identify if age, gender, educational attainment, medical card status or concurrent diagnosis have an influence on self referral to A&E.

This researcher used a quantitative survey design for this study; in order to ascertain the reasons for self-referral to the A&E. Not much is known about the reasons for self-referral. Survey research is often a more cost-effective and quicker process than other methods of research (Alreck and Settle, 1995). A positivist approach, using quantitative data, rather than a naturalistic approach using qualitative data, was used because there is a paucity of published
quantitative studies using patients as the research sample. Hence this researcher used a non-experimental descriptive design in this study. This researcher did not use an experimental design because it would have been impossible to control the factors causing patients to choose A&E as their primary care source (Brink and Wood, 2001). Examples of the factors which this researcher could not control were urgency reasons and accessibility reasons.

Data was collected using a questionnaire developed by this researcher, which the participants completed themselves. The questionnaire was structured, with closed-ended questions, based on the findings of the literature review. The statements in Part 1 of the questionnaire were grouped together as 8 variables, according to their similar themes: convenience, financial, time, urgency, facilities, qualification, accessibility and anxiety. These themes emerged from the literature.

Face validity was verified by comparing the items in the survey with the findings of the literature review (Polit and Beck, 2004). The tool was pre-tested. The target population in this study was patients who attended the A&E departments of two city hospitals in southern Ireland. This researcher will refer to these two hospitals as Hospital 1 and Hospital 2. Systematic sampling is a type of non-probability sampling, which is used to eradicate the risk of investigator bias (DeVellis, 2003). In systematic sampling, every “nth” person is included in the sample (Brink and Wood, 2001). This type of sampling was used in this researchers study. The assessing nurses in Hospital 1 and the triage nurses in Hospital 2 were requested to give questionnaires to every second patient registering at A&E. This researcher decided to access a sample of 100 patients, who referred themselves to the A&E for inclusion in this non-experimental study.

**Findings**

Polit and Beck (2004) state that a response rate of 65 percent is sufficient for most studies. Badger and Werrett (2005) declare that 60 percent as an acceptable response rate for nursing and social science research, following their analysis of response rates in three peer-reviewed nursing journals in 2002. The response rate of 90 percent for this study is extremely high. Considering that Badger and Werrett (2005) discovered that only 25 percent of nursing research published in 2002 involved the study of patients, this researcher believes that the choice to study patients was justified.

Respondents were asked whether their perceived need for hospital facilities led to them self-referring to the A&E department. Items 14, 20, 21 and 22 on the questionnaire were used to measure the importance of facilities as a reason for self-referral. Most
respondents reported median and high levels of agreement with the statements regarding **facilities** as the reason to attend A&E. This means that reasons related to the perceived need for hospital **facilities** were significant factors in this study. These findings are similar to the findings of Coleman *et al.* (2001), Walsh (1995), Guttman *et al.* (2003) and Wood and Cliff (1998) who also found that patients make decisions to attend hospital because they believe that they need the services, which only the hospital can provide. Table 4.4 shows the result of a t-test to explore the level of agreement to **facilities** for those patients with concurrent medical conditions. A significant result was not found (p = 0.298) meaning that patients with pre-existing medical conditions did not attend A&E primarily for reasons of **facilities**.

**Anxiety**, as a reason for self-referral to A&E was measured by item 10 on the questionnaire. The majority of respondents (60.9 percent) agreed with the statement regarding **anxiety**. This is a result of note, which highlights the significance of patients’ anxiety as a reason to self-refer to the A&E department. This result is similar to the findings of Walsh (1995) who discovered that patients often attend A&E because their medical condition is a cause of **anxiety** to them. Nystrom, Nydén and Petersson (2003) also found that patients attended the A&E department with worries about their health. Nystrom, Nydén and Petersson’s (2003) finding that being in hospital gives these patients a sense of security was further strengthened by this result.

**Conclusion**

This study to ascertain the reasons why patients self-refer to the A&E department was carried out because of a gap in the literature. There is presently no published research on the subject from an Irish nursing perspective. Most of the literature dwells on analysis of the appropriateness of patient attendance at A&E, rather than the reasons for attendance. For this reason, this researcher developed a tool to record the reasons why patients attend A&E, in preference to primary care sources. Moreover, there is a paucity of quantitative studies, using patients as the research sample. Hence this researcher aimed, by employing a quantitative tool, to redress this paucity by analysing patients’ reasons for attending A&E.

The assumed reasons for self-referral to the A&E investigated in this study were obtained from an extensive literature review. The main findings of this study were that **anxiety** and **facilities** were the most cited reasons respondents offered for having self-referred to two Accident and Emergency Departments in Southern Ireland. Moreover, the findings of this study contradict the most quoted findings in the literature. For instance, **anxiety** is rarely cited in the
literature as being a reason of note for self-referral to A&E. Considering that 60.9 percent of patients in this study agreed that they had attended due to reasons of anxiety, this researcher believes that patient anxiety deserves more attention by researchers and clinicians. Of note is the fact that *convenience* is the most often quoted reason for self-referral to A&E in the literature. However in this study, convenience was not shown to be a statistically significant reason for attendance.

Considering the response rate of 90 percent for this study, this researcher concludes that this group of patients were motivated to express their reasons for attendance at A&E. Health professionals have a responsibility to serve the needs of the sick in our communities. Considering the negative impact of A&E overcrowding, improved primary health care facilities and the alteration of A&E departments to meet patients’ needs is an urgent requirement. It is essential that the health service is configured for the benefit of the public and should reflect the current requirements of society.

**Recommendations**
The following recommendations are separated into 3 separate groups: recommendations for research, clinical practice and education.

**Recommendations for Research**
- In order to generalise the reasons why patients self-refer to the Accident and Emergency department, a further nationwide study is necessary with a larger sample.
- The majority of respondents (60.9 percent) expressed that they attended A&E because of worries about their health. A study focussed specifically on anxiety experienced by A&E patients is supported by this study.
- Registration with a GP was low amongst respondents who stated they were non-Irish in this study (43 percent). Considering that the number of non-Irish patients was low in the sample (7.8 percent), a wider quantitative study examining whether non-Irish people are registered with a GP is warranted. If the results were replicated, a qualitative study examining the reasons why these people are not registered with a GP is warranted.
- A study to ascertain if Irish healthcare professionals have prejudicial views of patients who self-refer to the A&E department is warranted.
- This researcher did not have enough time to carry out a factor analysis before carrying out the study due to academic
deadlines. This researcher constructed a novel inventory to quantitatively examine why patients refer themselves to A&E. Resulting from this innovation, two items on the inventory showed poor internal consistency. This is an invariable consequence of the trial and error nature of developing such novel tools. This should not detract others from further developing this tool or from developing their own tools for examining the reasons for self-referral to A&E.

Recommendations for Clinical Practice

- Setting up of nurse-led minor injury and illness units should be a priority. The employment of advanced nurse practitioners should go hand-in-hand with such developments.
- Certain hospitals have employed nurse managers in community liaison roles. The further development of these roles could bridge the gap between primary care and acute care services.
- This study supports the view that patients use A&E services to avail of hospital facilities, such as diagnostic tests. Better links and easier access to diagnostic equipment for GPs, would improve the primary care services.
- If the GP visit card scheme was expanded, patients may have a financial incentive to visit primary care sources rather than the A&E department.
- The development of a public access nurse-led telephone advice service in Ireland may reduce patient anxiety and reduce A&E overcrowding by re-directing some patients to primary care sources.

Recommendations for Education

- At present, programmes to educate nurses to the advanced nurse practitioner level are located in a single site in Trinity College, Dublin. Consideration should be given to developing these programmes in universities outside of Dublin, to facilitate interest nationwide.
- Education in primary care skills at an in-service education level and university level is important in dealing with the service demands.
- Since the majority of respondents agreed that they attended the A&E department because of worries about their health, further education for nurses and other health professionals in relieving anxiety for patients is recommended.
- Since much of the literature refers to these patients in derogatory terms such as “inappropriate attenders”, an in-service education programme to challenge the culture of inappropriateness would be valuable. Crouch et al. (1997)
described a similar programme used to educate nurses. Nursing does not exist in a vacuum and such in-service education should include other healthcare professions, such as doctors, radiographers and physiotherapists, amongst others.
References


Family’s perception of change for persons with intellectual disability who have left a long stay institution to live in a community based residential programme.

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This study has provided an insight into the views and experiences of family members of this client group. Overall the findings were positive and sit well with Wolfensberger’s (1983) principles of normalisation and social role valorisation.

The general philosophy of care based on respect and individuality of each client was evidenced in individual care plans and practice areas mission statements. Key to expert practice was concern for revealing and responding to clients as persons, respecting their dignity, caring for them in ways that preserve their personhood, protecting them in their vulnerability, helping them feel safe in their environment, comforting their families and so, preserving the integrity of close relationships.

Furthermore, communication and the inclusiveness of families within care planning and delivery were evident and seen to be central aspects of staff interaction with families.

Title of Poster: The Clinical Learning Environment: A Concept Analysis

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Background and context: The author believes that through analysing the concept of the clinical learning environment it will assist in understanding what it means and it is hoped this will support future research in the clinical area.

Aim: The aim of this paper is to provide an in depth analysis of the concept of the clinical learning environment.

Methodology/Analysis: A well established and documented method of concept analysis has been utilised to facilitate the process or analysis. The Walker & Avant (1995) approach is used, as it is logical and systematic approach for the analyst.

Summary of key findings/Results: there is a plethora of literature available on the chosen concept. A definition of the clinical learning environment will be offered and following in depth analysis of the literature the defining attributes have been identified and a model case is offered.

Conclusions: much of the literature examines the ideal clinical learning environment with minimal data available on techniques that may be utilised to remove the many inhibiting factors. Therefore, the author believes this area is ripe for further studies.
"An Investigation to identify what Knowledge exists among Registered Nurses’ working in the Field of Intellectual Disability as to the Risk of Osteoporosis to Women with Downs Syndrome”

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Abstract

Background

Osteoporosis is a major public health problem, causing considerable pain and disability to those affected. It is a silent disease and may not be known to exist until a fracture has occurred. Nurses are in a pivotal role as they have direct contact with women who have Down syndrome and their families. There needs to be a greater awareness of these risks in order to prevent and effectively manage osteoporosis in this population of women.

Literature Review

The World Health Organisation (2003) has identified osteoporosis as the second leading healthcare problem in the world, after cardiovascular disease. Osteoporosis is defined as a disease characterised by low bone mass and micro-architectural deterioration of bone tissue, leading to excess bone fragility and
consequently increases in fracture risk (World Health Organisation, 2003). It is also known as the "silent thief ", robbing the skeleton of its banked resources slowly over a long period of time with the end result of not being able to withstand normal mechanical stress (Glasworth & Wilson, 1996).

As osteoporosis is a silent disease there may be no pain or symptoms until a fracture has occurred (Irish Osteoporosis Society, 2003). The prevention of osteoporosis must begin when bones are forming, not when the disease manifests itself, and preventive behaviours must be maintained throughout one's adult years (Ziccardi et al., 2004). By the age of seventeen, 90% of adult bone mass is laid down. Bone continues to grow in strength until peak bone mass is achieved in the early thirties. From the mid forties onward bone is lost naturally at a rate of 1% per annum (The National Dairy Council, 2002).

Women with Down syndrome have several pre-existing conditions that put them at a greater risk of developing osteoporosis. People with Down syndrome experience delayed and stunted growth resulting in smaller stature and are therefore at risk of developing osteoporosis (MacGillivray, 1995). Muscular and orthopaedic anomalies are well known in Down syndrome. These abnormalities of the skeleton include flat foot, genu valgum, patella instability and atlantoaxial instability which all contribute significantly to walking difficulties (Rasore-Quartino, 1999). These conditions can limit the amount of physical exercise that the individual with Down syndrome may be able to partake in. This can seriously affect an individual reaching peak bone mass. A particular feature of individuals with Down syndrome is the motor clumsiness characterised by hypotonia and joint hyper flexibility which significantly delay the development of gross motor skills and increases the risk for joint dislocation (Angelopoulou et al., 1999). Like muscle and other parts of the body, bone suffers if it is not used. There is need for regular weight bearing exercises, which put force on the bone, stimulate growth and therefore good bone strength. (The Irish Osteoporosis Society, 2003). In addition, individual with Down syndrome frequently has osteoarthritis, which limits their physical activity and puts them at risk of osteoporosis (Cooper, 1998).

Carefully formulated diets to ensure adequate calcium and vitamin D intake, more active lifestyle, and increased physical activity that improve muscular tone and muscle strength should be instituted in an effort to avoid or postpone the development of osteoporosis for women with Down syndrome (Angelopoulou et al., 1999). Women with Downs Syndrome are at a higher risk of developing osteoporosis due to many other conflicting health care factors like
the early onset of the menopause, high prevalence of epilepsy, hypothyroidism, sedentary lifestyle and poor nutrition (Elduff, 2002: Peabody & Stasikelis, 1999). It has repeatedly been reported that women with Down’s syndrome experience the menopause at an earlier age than women in the general population (Carr and Hollins, 1995; Schupf et al., 1997; Cosgrave et al., 1999).

A one year study undertaken by Milberger et al (2002) examined osteoporosis in 23 postmenopausal women with Down syndrome. The participants had their bone mineral density measured in three sites (lumbar, spine and forearm) using dual energy x-ray Absorptiometry (DXA scan). The findings indicated that the women tended to be inactive and they frequently had coexisting conditions (i.e. thyroid disease and seizure disorders) whose treatment may contribute to a reduction in bone mineral density. Eighty–seven per cent of the participants had osteoporosis or osteopenia in at least one of the three sites measured. The results highlight the need for intervention efforts targeted to ageing women with Down syndrome.

Screening for osteoporosis in community dwelling adults with intellectual disability was conducted by Tyler et al., (2000). Dual energy x ray Absorptiometry were obtained of the heel. Valid measurements were obtained by 107 participants (57% male and 43% women), a response rate of 94%. Prior to the study only 1% of the entire sample bore a diagnosis of osteoporosis. Following screening the following diagnosis were made. One fifth of the sample (21%) had osteoporosis and 34% had osteopenia. Down syndrome was identified as the strongest statistical predictor of bone mineral density this is consistent with previous observations that young adults with Down syndrome appear to achieve lower peak bone mineral density than individual with intellectual disability due to other causes or those without an intellectual disability. Such findings highlight osteoporosis as a potentially major health care need for people with Down syndrome, playing an important part in their physical health and quality of life.

No studies were identified that looked specifically at osteoporosis knowledge and nurses working within the field of intellectual disability. From the generic population studies have identified that nurses and senior nursing students have less than adequate knowledge of osteoporosis (Berarducci, 2004: Sedlak et al., 2000; Hunt & Repa-Eschen, 1998).

**Aim**

The aim of this study was to identify what knowledge exists among registered nurses’ working within an organisation, in the field of
intellectual disability as to the risk of osteoporosis to women with Downs Syndrome.

**Methodology**

The questionnaire to identify osteoporosis knowledge was developed from the literature review and leaflet information from The Irish Osteoporosis Society, The National Dairy Council and The National Osteoporosis Society (in The United Kingdom). The questionnaire was then peer reviewed. The questionnaire with an information letter regarding the study and its aim were distributed accompanying each nurses wage slip. The nurses were from a single organisation whose services extend across South Kildare, Laois, Offaly, Westmeath and Longford. An overall response rate of 49% was achieved.

**Results**

The respondents were predominantly female within the 30-49 year old category, qualified as Registered Nurses in Intellectual Disability and working primarily within the adult services. The average period of time qualified was 15 years and the average time with the organisation was 11 Years. There was an overall lack of knowledge regarding osteoporosis and women with Downs Syndrome irrespective of age, nursing education, length of time qualified as a nurse, nursing post held and length of time working within the services. The large majority of the respondents (98.5%) identified that they did not have adequate knowledge in the areas of osteoporosis and women with Down syndrome and all of the respondents (100%) identified a need for education regarding osteoporosis and women with Down syndrome. These finding were similar to Hunt & Repa-Eschen (1998), where there was also strong support 91% (n=121) from the nurses who took part in the study for an educational programme on osteoporosis.

**Mention the similarity with other study findings**

**Conclusion**

This study identified that a lack of knowledge exists among registered nurses’ as to the increased risk of osteoporosis to women with Downs Syndrome. There is a need for ongoing education to inform nurses about osteoporosis prevention, detection and management for women who have Down syndrome.
Reference list


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Initial finding of lesbian women’s experience of Irish health care

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There is a dearth of knowledge about Irish lesbian women’s lives and social experiences. There is a lack of acknowledgement of the existence of lesbian women through the legal system which reinforces the invisibility of lesbian women in Irish society. This invisibility permeates all social institutions in society such as religion, education and the family.

This paper will present the initial findings of the study on lesbian women’s health care. It will focus in particular on the experiences of lesbian women in both primary and hospital health care setting. A hermeneutical phenomenological methodology was used in this research. Individuals give meaning to the situation in which they find themselves in this is informed by both cultural norms and expectations the objectives of the study are

1. to explore the lived experience of health of lesbian women;
2. to investigate the meaning that lesbian women construct of that experience.

International studies point out that lesbian women internalise negative attitudes of the dominant culture towards them; equally heterosexuals internalise the norms, values and belief systems of cultural socialisation whether they be negative or positive (Rust, 1993; Mead, 1934). Nurses and doctors are products of this culture and it may be difficult for them to shed their former socialisation (Mackintosh, 2000; May & Purkis, 1995).

The findings from this study suggest that the more open a lesbian woman is about her sexuality the more positive her experience of health care. However the initial history taking and the nature of the heterosexual language on the forms, which negates their existence, frustrate lesbian women. Equally the use of receptionist/administrators as gatekeepers to health care providers until the form is filled removed the autonomy of lesbian women. In
some cases the previous experience of negative attitudes by health care providers alienates the lesbian woman from seeking further health care.
Ready for discharge? Exploring referrals and documentation in the discharge of older people from the Emergency Department

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**Introduction**
Continuity of care for older people can only be achieved by effective discharge planning (Bull & Roberts, 2001). A seamless transition across organisational boundaries is necessary for providing quality healthcare and to avoid fragmentation of care provision. Regular liaison between the emergency department and others involved in the provision of emergency care, including GPs and community services is necessary (Irish Society for Quality in Healthcare, 2000). Evidence suggests that there is a lack of communication, documentation and continuity of care communication between primary and secondary care (Department of Health & Children, 2001). As the number of older people are steadily increasing, there is a need for further research in the care that is experienced by the older person discharged from the emergency department, as there is little research undertaken in this field.

**Aim**
The aim of this study was to examine aspects of the present levels of referrals to staff in primary care from an emergency department in one health care area in the Republic of Ireland.

**Design**
This study was part of a wider research study which explored dimensions of the management of the older person following care in an emergency department in preparation for discharge home to the primary care sector.
Methods
The method adopted was a survey approach which employed the use of standardized questionnaires comprising both open and closed questioning styles. Raw statistical data was analysed using SPSS for Windows while the qualitative data arising from the open-ended questions were content analysed for themes. The sample (n=222) included: all grades of qualified nurses (n=27) and all grades of medical staff (n=34) in the emergency department; all public health nurses (PHN) (n=59), all practice nurses (n=34) and general practitioners (GP) (n=68) in the primary care area.

Findings

Discharge of patients with complex needs
When questioned how much notice they were given regarding the discharge needs of patients from the emergency department with complex needs, 74.5% (n=41) of all public health nurse respondents reported that they had never been notified of discharges from the emergency department. The majority of comments from GP and practice nurse respondents included: “little if any” to “none”.

Need to increase the level of referral between the emergency department and the primary care sector
When asked if there is a need to increase the level of referral between the emergency department and the primary care sector, 96.3% (n=53) of PHN respondents stated that there was such a need. Many of the hospital doctors said they were “unsure” (33.3%, n=5) while 26.7% (n=4) said that the current level of referral was “good”. Almost half of the hospital nurse respondents (47.4%, n=9) stated that the current level of referral was “satisfactory” while 47.4% (n=9) felt that the referral level was “unsatisfactory”.

Notification after an older patient is discharged from the emergency department
Respondents in the primary care sector were asked, in relation to communications (letters, phone calls, etc.), how long after an older patient is discharged from the emergency department would they receive notification of their discharge. The majority of PHN (70.3%, n=38) respondents stated that they never got notification from the emergency department following discharge of an older patient. Comments from the GP respondents varied from “a day” to “weeks”, and comments from practice nurse respondents were similar with many reporting that they receive notification in “a week, sometimes never” or “one week to 10 days later when A&E letters arrive in the weekly post. Since it is not uncommon to find that patients will have attended their GP during this immediate post
emergency department attendance period there is the possibility that the GP will have no idea of what happened in the emergency department nor have details of treatment and clinical outcome. However this situation can be contrasted with 60% of the hospital doctor respondents (n=9) and the majority of emergency department nurse respondents (78.9%, n=15) reporting that they send out communications on the “same day” as an older patient was discharged.

**Categories for inclusion in the referral criteria for older people in the emergency department**

Participants in both areas were asked to indicate what categories are important to have in the referral criteria for older people. Results were variable between groups of respondents however; particular agreement was found in the categories of “history of falls”, “history of wounds” and “patient living alone”.

**Assessment of the current discharge planning documentation being used**

All respondents were asked to assess the current emergency department discharge planning documentation being used. An overwhelming 76.4% (n=42) of PHN respondents, 59.4% (n=19) of GP respondents and 44.4 % (n=8) of practice nurse respondents said that the current emergency department discharge planning documentation was “Unsatisfactory”. In contrast, the majority of hospital doctor respondents (33.3%, n=5) stated that the current emergency department discharge planning documentation being used was “Good”, while the majority of hospital nurse respondents (63.2%, n=12) stated that the current emergency department discharge planning documentation being used was “Unsatisfactory”.

**How could the discharge planning documentation be improved?**

When asked how the current discharge planning documentation could be improved, many of the public health nurse respondents included the following:

- “have never seen any; as a PHN I don’t get any documentation from A&E so any would be an improvement”;
- “every patient should be given documentation as to what investigations were carried out and why”;
- “need for standard discharge form to be completed and sent to relevant PHN”;
- “automatic discharge letter”.

**Adequacy of the information received relating to discharge of older people from the emergency department**

When asked if the information they received relating to the discharge of older people from the emergency department was
adequate, the majority of public health nurse respondents, 50.9% (n=28) and similarly, 62.5% of the GP respondents (n=20) and 50% (n=9) of practice nurse respondents described the information received “Not adequate”.

**Methods that could be use to improve communication**

Respondents were asked if communication could be improved, and to indicate which method (from a list including the current GP letter, current emergency card, telephone follow-up, e-mail, PHN green letter or “other”) would be of benefit. The respondents were in favour of more than one method of communication with a phone call being deemed to be of benefit by many of the respondents. However, the overriding finding was that communication needs to be significantly enhanced, regardless of which method or methods are being utilised.

**Discussion**

The management of discharge of older people and in particular the quality of liaison and communications is a fundamental aspect of the safe and effective care of this client group. According to Jones (2000), the emergency department has an important role at the interface between primary and secondary care. A key finding in this study refers to difficulties in relation to staff respondents in the community care sector receiving notification regarding the discharge of older patients with complex needs from the emergency department.

In this present study, respondents in the primary care sector identified the need to increase the level of referral between the emergency department and primary care sector along with improving liaison, co-operation and communication between these two care sectors. This is supported by Mion et al. (2001) who state that emergency departments historically have never had well established links to community agencies in respect of the management of older patients. By comparison, many of the hospital doctor respondents in this study reported the current level of referral as either good or very good whilst the majority of nurse respondents in the emergency department reported the current level for referral as satisfactory (47.4%) or unsatisfactory (47.4%). These findings support those of McKenna et al. (2000) in that a lack of synchronization exists in relation to the level of communication between these two care sectors. Important issues arise from the findings of this study which pose the questions as to whether the GP’s are receiving communication from the doctors and nurses in the emergency department but are not communicating it to the PHN’s; staff in the emergency department are claiming that they
send communications while significant numbers of GP’s and PHN’s report that they get little communication.

When transferring an older patient between hospital and primary care, the prompt and comprehensive dissemination of information will help ensure continuity of care (Victor et al. 2000). However, the majority of primary care respondents in this study reported major delays in receiving notification of the patients’ discharges. Previous research identified GP’s dissatisfaction with the written discharge information they received from hospitals (Meara et al., 1992; MacMillan et al., 1993; Worth et al., 1993). These findings are generally supported in the findings of the current study in that the current discharge documentation used was identified by the majority of respondents in this study as being unsatisfactory.

A concern exists for the continued lack of liaison between community and acute care settings and suggestions for improvements include high quality information and technology systems (The Royal College of Nursing, 2000). This current study reports similar findings that would endorse these recommendations with respondents in both locations identifying that communication could be improved by using conventional methods such as telephone and legible discharge reports. When respondents in the current study were asked for their opinion of the information they received relating to the discharge of older people from the emergency department, the majority of primary care staff respondents reported this as being not adequate. In this study when asked to identify what form of communication would be of benefit to improve the level of communication between care sectors, results varied between the different groups of respondents in relation to what form of communication would be best. However, the overriding finding was that communication needs to be enhanced, regardless of which method is used.

Overall there would seem to be apparent contradictions in the perceptions of the range and availability of communications between the primary and secondary sectors as represented by their different responses within the survey. While this is not readily explained within the findings it may however be reasonable to draw the inference that there are disparities between these groups with regards to the perceptions of secondary care professionals as compared with those of the primary care sector staff. This applies in particular to issues of the availability, level and quality of communications that exist and as to whether communications are in fact taking place. This also applies with regard to the quality, timing and standardization of communications in that they do take place between the care sectors as agreed.
Conclusion
This topic of study is highly relevant to clinical practice due to the current bed shortages and financial constraints in health care. There is a need for adequate follow-up for older people between the hospital and community interface in order to prevent reoccurrence of health problems following discharge from the emergency department. Current liaison strategies, documentation of information and efficient means of communication between emergency departments and the primary care sector would appear to be disjointed and is failing to meet the needs of both the secondary and primary sectors. The findings of this study support previous research in that there is a need to increase the level of referrals between sectors, with many staff in the primary care sector reporting dissatisfaction with the level and timing of notification received when older people are discharged from the emergency department.

Recommendations arising from the study include:
- In the context of practice development, the need for a shared vision between care sectors resulting in the development of an effective communication strategy that meets the needs of the older person being treated in the emergency department;
- The need to increase the level of liaison and referral between the emergency department and the primary care sector;
- The need to have referral criteria particularly in relation to older people discharged from the emergency department, and that a workable degree of standardization be employed across the region;
- Improving the documentation between care sectors by providing more information, more legible reports and the use of computerized printouts;
- The use of a standard discharge form;
- The need to have discharge information sent out from the emergency department in a timely manner.
References


Cultural diversity of Pre-registration Nursing Programmes: An Exploration of the Experiences of South Asian Students on Pre-registration Nursing Programmes in a UK University

Draft paper, please do not quote without permission

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Background and Context:
Nurse lecturers involved in recruitment and retention are constantly aware of the need to ensure that pre-registration nursing programmes recruit students from diverse populations, especially those populations that make up the local health care consumers. In spite of this there is increasing evidence that Schools of Nursing and Midwifery struggle to recruit students from minority ethnic groups, with the consequence that these groups are not fully represented in nurse training. This shortfall has obvious implications for the cultural diversity of pre-registration nursing programmes in that students from both minority ethnic groups and white British groups are not able to engage with a culturally rich educational experience. There are numerous reasons why recruitment from minority ethnic groups, especially people with South Asian backgrounds is particularly challenging, including a lack of tradition of entry into nursing and a lack of understanding of the role of the nurse in the UK (Anionwu, 2004).
Study Methodology and Methods

This Health care Workforce Deanery funded study focused on the need to pay attention to the experiences of South Asian nursing students as an integral part of the national concern with recruitment and retention of minority ethnic students into nurse training. The aim of this study was to describe the entry profiles and academic progression of South Asian students studying pre-registration nursing and to compare these with their White British counterparts. This was seen as important in that there is a possibility of an ethnocentric bias at play which assumes that there are indeed differences in entry profiles and subsequent academic progression between ethnic groups that have a significant bearing on the achievement of programme outcomes. Whether or not significant differences exist between South Asian students and White British students it is important, in light of the low numbers entering nurse training, to listen to the experiences of those who do access undergraduate nursing programmes, in order to shed light on, and attempt to improve, recruitment from those ethnic groups. With this in mind the second phase of the study aimed to explore the experiences of South Asian nursing students, which may impact on their achievement of programme outcomes.

A mixed methodological approach to data collection utilised quantitative and qualitative methods. All nursing students on pre-registration programmes commencing September 2001 to September 2004 were entered into a database using the categories of age, gender, ethnicity, entry profiles (academic qualifications), and progression data (assessment grades), n=1102. Of these students 75 identified themselves as having South Asian ethnicity, which amounts to 6.8%. In 2001, the number of people in Leicester identifying themselves as being of Indian origin formed the largest single ethnic community group in the city numbering 72,000 or 25.7% (Leicester City Council, 2006). This figure ranks Leicester as having the largest Indian population of any local authority area in England and Wales. These figures support the premise that under recruitment to nursing from South Asian groups in Leicester is a real issue and one which nurse educators involved in recruitment and retention need to address as a matter of urgency if the future population of qualified practitioners is to reflect the diversity of its health care consumers.
The table below shows the ethnic composition of Leicester using 2001 census data.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Leicester</th>
<th>Percent</th>
<th>England &amp; Wales</th>
</tr>
</thead>
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<tr>
<td>Asian or Asian British: Indian</td>
<td>72033</td>
<td>25.73%</td>
<td>1.99%</td>
</tr>
<tr>
<td>Asian or Asian British: Pakistani</td>
<td>4276</td>
<td>1.53%</td>
<td>1.37%</td>
</tr>
<tr>
<td>Asian or Asian British: Bangladeshi</td>
<td>1926</td>
<td>0.69%</td>
<td>0.54%</td>
</tr>
<tr>
<td>Asian or Asian British: Other Asian</td>
<td>5516</td>
<td>1.97%</td>
<td>0.46%</td>
</tr>
</tbody>
</table>

Statistical analysis of the quantitative data has shown no significant difference in entry profiles, progression and achievement in programme outcomes between South Asian students and White British students. However, qualitative data from interviews with twenty South Asian nursing students has revealed their experiences, both positive and negative, are often, but not exclusively culturally determined. Students reported experiences with accessing personal tutor support, peer group support, issues in clinical practice, academic issues, personal and family issues, and communication issues.

In order to understand the student experience and in an effort to avoid overplaying the notion of culture or indeed ethnicity, a departure from the usual body of `ethnicity` literature has been taken. The intention here is to avoid the pitfalls associated with an essentially ethnocentric position, whereby ethnicity may be used to explain differences in experiences or outcomes between different groups that may or may not exist. The analysis draws, for the most part, on the work of Robert Putnam who in attempting to solve the mystery of the disappearance of social capital and civic engagement in America described the notion of bonding and bridging. Putnam makes a distinction between two kinds of social capital: bonding capital and bridging capital. Bonding occurs when you are socializing with people who are like you: for example the same age, race, and religion. He argues that in order to create peaceful societies in a diverse multi-ethnic country, one needs to have a second kind of social capital, which he calls bridging. Bridging is what you do when you make friends with people who are not like you, for example supporters from another football team. Putman argues that those two kinds of social capital, bonding and bridging, serve to strengthen each other (Putnam, 2000). The concepts of Gemeinschaft (community) and Gesellschaft (society) (Tonnies,
1957) are also examined as a means of understanding aspects of the students’ experience.

References


Leicester City Council http://www.leicester.gov.uk/


UK Census 2001 http://www.statistics.gov.uk/
Background and context: Partnership working with those that use mental health services has become increasingly important to how we provide services and meet users’ needs. If this is to be achieved then it is vital that the views of service users are sought and considered in relation to service improvements and developments.

Aim of the study: The purpose of the study (a small scale [19] user focused monitoring project) was to achieve a clearer understanding on the stated concerns of service users regarding the quality of the service during discharge from hospital.

Methodology: The following six key themes were identified by service users for investigation:

1. The discharge process whilst in hospital
2. First contact after discharge
3. Involvement in care
4. Family involvement
5. Social support
6. Most and least helpful experience during the discharge process

The data collecting method was by questionnaire that was administered in person by other service users. The inclusion criteria for the survey were to target those who had been discharged within a time frame of no longer than 3 months.
**Analysis:** The data has not been subjected to any statistical analysis but charts showing the percentages of the responses to the questions have been calculated. Written verbatim comments are also presented to add richness and meaning to the numerical responses.

**Summary of findings:**

* Discharge planning meetings must be a part of a process that involves the service user and their significant others.
* A care plan should be an agreed course of action between the user and the service providers with specific outcomes/goals that are written down and with users receiving a copy of the plan.
* Written and verbal information to be given to users regarding medication.
* A need to involve family and/or significant others in the care planning/supporting and discharge arrangements.
* Higher profile to the availability of social support/integration opportunities.

**References:**


Title: Expanded practice in community mental health nursing

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Background and context
Although nurse practitioners have been an accepted part of the landscape of health care services in the United States for over 40 years, this is a very new development in Australia. There is considerable anecdotal evidence, however, that many Australian nurses are already engaging in expanded practice roles. In the mental health service setting, community mental health nurses enjoy a high level of autonomy and make daily choices about the engagement of medical practitioners.

Aim of the study
The purpose of this research was to investigate the extent to which community mental health nurses in Victoria are already undertaking expanded practice roles, their attitudes to expanded practice, and whether such practices have the support of key stakeholders.

Methodology including research design and sampling
A two stage research design was employed. Stage 1 involved a series of individual interviews and focus groups with community mental health nurses, consumers of mental health services, carers of persons with a mental illness, general practitioners and psychiatrists. Stage 2 involved the distribution of a questionnaire to a sample of 296 community mental health nurses employed by rural and metropolitan services in Victoria, Australia.

Analysis
The interviews were transcribed and analysed using the ‘framework’ method of Ritchie and Spencer (1994). The questionnaire data were analysed using SPSS.

Summary of key findings
The results indicate that despite the medical profession’s unwillingness to acknowledge the current existence of expanded nursing practices and doctors’ resistance to the perceived threat
posed by nurses trespassing on medicine’s exclusive professional turf, community mental health nurses in Victoria are already overstepping their professional boundaries and service users support these practices.

Conclusions
This paper discusses the implications of these findings for mental health nursing practice and education and also for the delivery of mental health care.
MIGRANT WOMEN’S BIRTH STORIES

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Childbirth is a universal event, but the way societies attach meaning and manage it is not (Priya, 1992). Birth in Britain has been confined to a medical understanding (Kitzinger, 2000) but this does reflect the ideals of all women accessing the maternity services. Many migrant women who make use of the service are from countries who advocate a traditional birthing system, where birth is understood through its social, psychological and spiritual functions (Chalmers, 1996). Women hold their cultural and spiritual beliefs close to them and when maternity care does not reflect these beliefs, women can be left feeling dissatisfied (Schott and Henley, 1996). The quality of maternity care is important, as it shapes women’s wellbeing after birth and the bonding process with her newborn child (Garcia, Kilpatrick and Richards, 1990). Childbirth, therefore, needs to be removed from a medical ideology alone, in order to appreciate its spiritual and social significance (Priya, 1992).

Britain is a multi-ethnic society (Schott and Henley, 1996 and Bharj, 1999) and many of its population have settled in the country through migration. Migrant women mainly come from countries that maintain traditional childbearing practices (Katbamna, 2000) and those of childbearing age will enter the British maternity services. Many migrant women still maintain their traditional beliefs and practices of childbirth and face conflict when faced with a medicalised birthing system that does not reflect their ideologies (Choudhry, 1997; Rice, 2000; Wiklund, Aden, Hogberg, Wikman and Dahlgren, 2000 and Small, Yelland, Lumley, Brown and Liamputtong, 2002). Many women are refugees who come from countries of instability only to face a system that does not acknowledge their individuality or belief systems, increasing their vulnerability (Schott and Henley, 1996 and Bulman and McCourt, 2002). Women are expected to subscribe to a system that focuses on their physical health rather than their physical, social, emotional
and spiritual wellbeing (Priya, 1992). Still, many women who are familiar with traditional birth practices may not have faced the influence of a medicalised system of childbearing care. Many of those who are aware of the medical model of care still choose to experience childbirth within the parameters of traditional beliefs and practices (Davis-Floyd, 2000).

In a multicultural society, health care providers need to ensure that care reflects the needs of a wide range of people (Cheung, 2002). In order to provide midwifery care that is woman centred, midwives should understand the needs of women (Rice, 2000). Health professionals have to review their care practices and assess whether these match the traditional beliefs and values of childbearing women (Kaewsarn, Moyle and Creedy, 2003). Whatever the cultural beliefs of the women, midwives should be providing support to childbearing women at such a vulnerable time in their lives (Davies, 2000). It is the quality of care and support that shapes women’s experience of childbirth and their abilities to take on their new mothering roles (Callister, 1995 and Schott and Henley, 1996).

Zaheera Essat is currently carrying out a PhD investigation which is interested in ethnic minority migrant women’s birth stories. The research aims to establish the cultural and spiritual ideas and meanings associated with birth practices amongst a diverse group of migrant childbearing women. To ascertain how far these ideas and beliefs are met in traditional English maternity services and to what extent their birthing experience takes place within the woman’s cultural context. Looking at the women’s life as a whole and to see how the transition to motherhood fits into the challenges of everyday life.

The researcher will share the experience of listening to the life stories of migrant women and the stories of the women interviewed. The experience of using the biographic narrative interpretive method will be shared in some detail and how it challenged many of the researchers assumptions based on the stories revealed by the women.


How I improved my teaching practice to enhance the learning of Post Registered Sick Children’s Student Nurses

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Stenhouse (1975, 144) stated that “it is not enough that teachers’ work should be studied, they need to study it themselves”.

This paper will address my experience of an action research study I undertook to improve my teaching practice. Three areas that I aimed to improve were identified. These were (a) to increase engagement and participation of all students in class, (b) to improve my time management of classes and (c) to increase the relevance of subjects to students. Whilst the study also investigated the approaches to learning of the student nurses and the influences on their learning, I am going to confine this presentation to my experience of improving my teaching practice through action research.

The teacher as researcher model has been widely discussed in recent years (Whitehead 1989, McNiff 1988, Altricher 1993, Hoban 2002) and is considered to be particularly applicable to improving the practice of teachers. In this study guided by Elliotts (1991) model of action research I am a teacher researcher improving my teaching practice by addressing problems to enhance the quality of student learning in post registered nurse education.

The study took place in a hospital based school of nursing where the author was employed as a tutor teaching on the post-registered sick children’s nursing programme.

Data collection included self observation of my teaching practice over nine classes, evaluation of those classes by the students and observation of two classes by a colleague. This necessitated the development of a self-observation tool which I used in conjunction with field notes and a reflective diary. Evaluation forms were developed for the three areas of my teaching practice that I aimed to improve.
The action research included one cycle of planning the teaching of each class, implementing the plan, observing how well the plan worked, reflecting on the plan and finally re-planning of each class. Qualitative data were analysed using thematic content analysis. This action research process facilitated improving my practice in the areas identified and the research findings of the study confirmed the value of action research in facilitating improving teaching practice.

References


The Primary Family Caregivers Perceptions about Assessing and Meeting the Spiritual Needs of the Terminally Ill Care Receiver

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Abstract

One of the key principles of nursing is providing holistic care for clients and their families; this includes addressing spiritual needs. At this time in America’s health care delivery system the primary family caregivers are assuming an increasingly large role in the nursing of the chronically and terminally ill family members. Nurses may need to guide these caregivers in the spiritual assessment of their terminally ill family members. Patients with terminal illness and their families usually have extensive support systems that consist of family, friends, neighbors, co-workers and professional helpers. This system is the most important source of emotional support for friends and families (Narayanasamy, 1993). Highfield (1992) reported friends and family are also the main source of spiritual support for patients.

The purpose of this qualitative study, utilizing hermeneutical inquiry, was to examine the primary family caregiver’s perception of the spiritual needs of the dying family member and how the primary family caregiver met these needs. The study also examined what nurses did to assist the primary family caregiver to meet the spiritual needs of the terminally ill care receiver and what nurses could do to improve the spiritual care given. An exploratory study with structured interviews was performed. The subjects were selected utilizing a purposeful sampling method. Seven primary family caregivers were interviewed within 3-9 months of their care receivers’ death. Transcribed interviews were analyzed using Creswell’s (1998) data analysis spiral technique. The findings included five broad themes:
1) primary family caregivers’ actions, 2) primary family caregivers’ perception of spirituality, 3) primary family caregivers networking and connecting with others, 4) primary family caregivers’ interpretations of the care receivers dying process, and 5) primary family caregivers’ perceptions of spiritual care as part of professional nursing practice.

References


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First year student nurses views of their first Clinical Learning Environment.

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Background and Context
The requirement to support first year student nurses on clinical placement is becoming more and more necessary due to changes in nursing education. Irish nurse education is presently influenced by many stakeholders. Evaluating the environment in which student nurses learn and the stakeholders’ involvement is an essential component of a quality based nursing education programme.

Aim of the study
The overall aim of this study was to explore first year student nurses’ views of their First Clinical Learning environment.

Methodology
In order to investigate student nurses views a quantitative non-experimental descriptive survey was used which incorporated the use of an attitude rating scale in the form of a questionnaire as a means of data collection consisting of three sections. The sample consisted of n=69 undergraduate students in their first year of the BSc in Nursing programme.

Analysis
The Statistical Package for Social Sciences (SPSS) was used to perform inferential statistical analyses.

Summary of key findings
The main finding from the study concludes that a quality Clinical Learning Environment is in fact present and is conducive to learning. Within this clinical environment all the key staff members (Clinical Nurse Manager, Clinical Placement Co-ordinator, Registered Nurse, Preceptor and Link Lecturer) had an appropriate level of contact with the students.
There appeared to be no significant relationship between the demographic characteristics of the student sample and their opinion of the Clinical Learning Environment.
Conclusions
Student nurses learning on first practice placement is directly correlated with the factors, which influence the Clinical Learning Environment. For this reason it is recommended that the quality system shown to be in place is upheld by the continuing preparation of preceptors and comprehensive student preparation prior to first practice placement. Additionally it is recommended that further longitudinal research be conducted following student nurse transition from first year to fourth year.
“Labour ward Midwives views on Continuous Foetal Monitoring? “

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Background and Context
Continuous fetal monitoring is the most commonly used tool for assessment of the fetus during labour despite the fact that no conclusive research evidence can attribute it to improved perinatal outcomes in women with low risk pregnancies. The current “best practice guidelines” advise that intermittent auscultation should be implemented for low risk pregnancies. In light of these findings it was felt imperative to ascertain the views of labour ward midwives on this issue and the current situation in Irish maternity hospitals.

Aim of the study: to identify midwives perceptions of Continuous foetal monitoring in order to understand how this may impact on their practice.

Methodology
Design: a descriptive survey using self-completion Questionnaires
Setting: a multi centre study; conducted in December 2004 in five maternity hospitals in the republic of Ireland.
Sampling: convenience sampling.
Analysis: spss

Summary of key findings
- A significant majority of respondents (65.7%) reported that CTG monitoring is overused in their unit.
- An overwhelming majority of respondents reported that it is not desirable midwifery practice to have a woman in continuously monitored Labour.
- A significant minority (5.8%) indicated that they had received a “high” level of training in CTG interpretation as student Midwives.
Conclusion
It is evident from the research results that midwives feel that CTG monitoring is overused. This is alarming considering that its widespread application is attributed to increasing obstetric interventions. As it is our duty of care to ensure implementation of the best-evidenced based guidelines this has serious implications for the role of the autonomous midwife in normal midwifery care. The low level of CTG training for student midwives is startling and an area that warrants immediate investigation.
The relationship between child temperament and ADHD: implications for school and pediatric nurses.

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Abstract

The purpose of this study was to examine the theoretical differences and similarities between ADHD and child temperament. The participants were 32 primarily white, middle class children, ages 6 to 11 years, who were referred to a developmental pediatric neurology clinic for symptoms related to ADHD. The sample also included a comparison group of 23 children with the same sociodemographic characteristics from a community sample. All of the children were assessed for ADHD symptoms and child temperament using standardized parent reports and interviews.

Pearson Product Moment Correlations, ranging from .47 to .92 and averaging .73, were found among the symptoms of ADHD: hyperactivity, impulsivity, and inattention and the temperament dimensions of negative reactivity, task persistence, activity, attentional focusing, impulsivity, and inhibitory control. One sample t-tests showed that the children in the ADHD group had significantly higher scores on negative reactivity, activity and impulsivity, and lower scores on task persistence, attentional focusing and inhibitory control than the normative samples.

The proportion of children in the ADHD group was examined to see if they were over represented on the high maintenance temperament profile. A chi-square analysis showed that 66% of children with high maintenance temperaments in the ADHD group was significantly higher than the expected 14%. An independent t-test showed that the families of the children in the ADHD group reported more unhealthy behaviors on the general functioning subscale of the McMaster Family Assessment Device than did the families in the comparison group. The results of this study showed...
that although the constructs of ADHD and temperament have been regarded as two separate bodies of knowledge, they are theoretically and empirically bridged. Tools which pediatric and school nurses can use to easily identify at-risk children are introduced to help with earlier referrals for preventive interventions.
References


Challenges and Opportunities of Undergraduate Inter-professional Education: the students’ perspective.

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Abstract

Since 2003 Allied Health Inter-professional pre-registration education at London South Bank University has comprised undergraduate Occupational Therapy, Physiotherapy, Diagnostic Radiography and Therapeutic Radiography. A common learning theme runs throughout the three levels of these programmes comprising series of units taught inter-professionally.

The first common learning unit introduces a variety of subjects and skills that are fundamental to all the professions and is the first unit the students study. It provides a foundation for ongoing contact with service users and professional colleagues and incorporates a wide range of learning and teaching methods.

The aim of the study was to determine the challenges and opportunities of inter-professional education from the students’ perspective.

The study was undertaken in two parts. Part 1 used the ‘Readiness’ for Inter-professional Learning Scale questionnaire. Questionnaires were distributed to the entire undergraduate student population involved in the Inter-professional Scheme for Allied Health. Part 2 comprised focus group methodology. Four uni-professional focus groups were held followed by a multi-professional group. At the same time as completing the questionnaire students were asked whether they would be willing to participate in the focus groups.
Participants were identified by maximum variety sampling using the characteristics of full-time students, part-time students, gender and age. There were no exclusion criteria. At each uni-professional focus group two self-selecting participants for the multi-professional focus group were identified.

Inferential statistics using non-parametric tests of comparison and correlation were used to analyse quantitative questionnaire data. Transcripts of the focus groups were examined using thematic analysis.

Findings identified a breadth of opinion in respect of how inter-professional education has been received by the students. There were three main themes that emerged from the student focus group interviews; inter-professional awareness, impact on patient care, most enjoyable aspects. The less positive aspects of the delivery tended to be more structural. Results also indicated that different professional groups interact with this unit in different ways because of variations in preferred learning styles. Across the professional groups prior experience in health and social care settings also affected their approach to the unit content, both positively and negatively.

Results of the study have informed decisions on unit development and course delivery thus further developing the skills and attitudes required for practice in an inter-professional work environment.
INCREASING TREND IN THE UPTAKE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE IN IRELAND

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**Background**
The international literature suggests the uptake of complementary and alternative medicine (CAM) is increasing worldwide. National prevalence studies on CAM use have been carried out in many countries. However, to date no such prevalence studies have been performed in Ireland.

**Aim**
The aim of this study was to estimate the prevalence of CAM use among the general population in Ireland and to identify characteristics of typical CAM users.

**Methodology**
A descriptive, quantitative design was used. A secondary data analysis of the SLAN (National Survey of Lifestyles, Attitudes and Nutrition) 1998 (N=6539) and 2002 (N=5992) surveys was undertaken, providing a representative cross-section of the Irish adult population. Use of CAM was determined by whether or not respondents had ever attended a CAM practitioner.

**Analysis**
Data was analysed using $\chi^2$ test for independence of categorical variables and multivariate logistic stepwise regression.

**Summary of key findings**
Twenty-seven percent of participants reported they had attended a CAM provider in 2002, an increase from 20% in 1998. Characteristics primarily associated with CAM use were being female, aged 30-59 years, being separated or divorced, having a third-level education, being from a higher income group, and being self-employed. Other factors associated with CAM use were dissatisfaction with health, work affected by health, medication use,
pain, anxiety, and depression. Additionally, healthy behaviour was associated with CAM uptake; women who have breast feed, individuals who read food labels, take vitamins/ supplements, eat a healthy diet, and exercise regularly were all more likely to use CAM. Of those regularly taking prescription drugs, 51.9% also admitted taking vitamins, minerals, or food supplements.

Conclusions
This study supports international findings in relation to the increasing popularity of CAM use. Further research is warranted to determine patterns of self-prescribed CAM uptake in Ireland.
SELF-CARE IN THE CABG POPULATION: AN EVALUATION OF THE MOST APPROPRIATE TIME FOR DELIVERING INDIVIDUALIZED PATIENT EDUCATION

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ABSTRACT

Background: Due to shortened length of hospital stay and the need for patients following Coronary Artery Bypass Graft (CABG) surgery to manage their condition at home, it is important to provide education at a time which will allow for maximum gain in outcomes. An alternative to in-hospital patient education is individualized teaching that is delivered 1 – 2 days post-discharge, via telephone.

Purpose: 1) To determine the efficacy of an individualized telephone patient education intervention, delivered 1-2 days post discharge, in enhancing the CABG patient’s knowledge of self-care behaviours, their actual performance of self-care behaviours, and symptom experience; and 2) to examine the confounding effects of anxiety on the effectiveness of the individualized telephone education intervention.

Design: A randomized, pre-test-post-test clinical group experimental design.

Sample: The sample included patients who had their first time CABG; were literate in English; cognitively oriented to person, place, and time; and had access to a working phone, in the hospital or at home.

Analyses: Descriptive statistics were used to characterize the sample. Repeated measure analysis of variance was performed to examine differences in the outcomes among the two groups, over
time. The hypothesized relationships between variables were tested using Pearson correlation coefficients.

**Results:** Results indicated no statistically significant differences between the experimental and control groups in their knowledge of self-care behaviours, their actual performance of self-care behaviours, and symptom experience. The nature and method of delivery of the individualized intervention were proposed to have contributed to changes in knowledge, self-care, and symptom over time within both groups. Significant correlations were noted between anxiety and all outcomes of interest; as well between knowledge and self-care; and self-care and symptoms experienced.

**Implications:** Implications for practice, theory, and research were discussed. Specifically, the following were suggested: to consider the use of multi-component interventions as part of usual client care, to design and deliver using one-on-one teaching methods individualized patient education interventions; and to consider the patient’s environment during teaching interactions.
The metabolic syndrome is a multi-dimensional clinical problem that is related to the development of cardiovascular disease. These CVD risk factors include abdominal obesity, insulin resistance, atherogenic dyslipidemia, and hypertension. In addition, insulin resistance is associated with a pro-inflammatory, pro-thrombotic state, which further complicates the picture. With the pathology related to insulin resistance, management should be aimed at the prevention of both type 2 diabetes and heart disease and the control of the component of the syndrome. Clinical practice should be grounded in the scientific knowledge and management plans need to be based on the best current evidence that is available. The aim of this poster is to examine the available evidence for the treatment of metabolic syndrome and to translate that evidence into a plan of care.

Prevalence: The prevalence of metabolic syndrome worldwide is thought to be 20 to 25% with the incidence rising with age. In the United States the prevalence among people 20-29 years of age is 6.7% while it is 43.5% in persons 60-69 years of age. There are ethnic differences that need to be considered in both the diagnosis and management of this syndrome.

Definition: The World Health Organization has defined metabolic syndrome as:

- **Must have one of the following glucose or insulin abnormalities:**
  - Hyperinsulinaemia: upper quartile of population
  - Fasting plasma glucose > 110 mg/dl

- **Any two of the following:**
  - Hypertension > 140/90 or controlled with current treatment
  - BMI > 30 kg/m or waist/hip ratio > 90 men, > 85 women
    (will need to modify by ethnic group)
  - Microalbuminuria
The management of the conditions related to the metabolic syndrome is critical to the prevention of cardiovascular disease. Current available treatment modalities of the five components of the metabolic syndrome that have been shown to reduce CVD are as follows:

**Therapeutic Lifestyle Changes (TLC)**

**Weight Management Goals:** 7-10% reduction in weight over one year should be the goal. The ADA has developed evidence based nutritional guidelines for the dietary management of diabetes. These same principles can be applied to patients with metabolic syndrome. The goal of the diet therapy also known as medical nutrition therapy (MNT) is to attain and maintain an optimal metabolic state. Carbohydrates and monosaturated fats should account for 60 to 70% of the energy intake. When discussing sweeteners, sucrose has been shown to provide better glycemic control. Increasing soluble dietary fiber while decreasing intake of highly refined carbohydrates may provide additional benefit. Four non-nutritional sweeteners have been shown to be safe in both diabetic and pregnant patients. These can be safely used and will help to reduce both glycemic load as well as caloric intake. Low fat diets have been proven to reduce overall cholesterol levels. The use of low fat with moderate carbohydrate diets have been shown to result in modest weight loss, no increase in triglycerides and overall decrease in plasma lipids levels. It is recommended that less than 10% of calories should come from saturated fats. If LDL cholesterol is over 100, the saturated fat intake should be reduced to 7%.

**Increased Physical Activity Goal:** 30 minutes of moderate to intense activity daily is the minimum requirement. The increase in physical activity will help to reduce the resistance to insulin as well as promote weight loss. This benefit of glucose tolerance requires ongoing exercise. Studies have shown in order to maximize the benefit, exercise must be done every 2 to 3 days. The effect on glucose tolerance as measured by fasting glucose levels disappeared after 72 hours, making routine exercise essential to helping control insulin resistance. In addition to improving glucose tolerance, exercise has also been shown to increase HDL as well as reduce blood pressure and improve cardiac function making it an essential part of the management of metabolic syndrome.

**Lipid Management:** Decrease the LDL-c to <100 mg/dL; Increase the HDL-C to >40 mg/dL (men) or > 50mg/dL (women) and decrease Triglycerides to < 150 mg/dL. The use of multiple drugs has been successful in helping patients achieve better lipid control.
High LDL-C is best treated with an HMG-CoA reductase inhibitor (statin). HDL-C is best treated with exercise. If exercise fails, Nicotinic Acid can be added to the drug therapy. If triglycerides are elevated to 200-499 mg/Ld you should consider drug therapy along with dietary changes. Strategies can either be to increase the amount of statin given or use a triglyceride lowering drug such as fibrte or nicotinine acid along with the statin can help to achieve your management goal quicker.

**Hypertension:** The goal for antihypertensive therapy in patients with hypertension is a BP of less than 120/80 mm Hg; however, lowering BP to 130/80 mm Hg has been shown to reduce CVD risk. Treatment should follow the guidelines published by the Seventh Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VII). Drug choices include diuretics, alpha blockers, beta blockers, calcium channel blockers, angiotensin-converting enzyme (ACE) inhibitors, and angiotensin receptor blockers. Choice of a particular drug class and a particular agent within a drug class is dependent on co-morbidities.

**Pro-inflammatory, Pro-thrombotic State:** No currently available drugs target either PAI-I or fibrinogen. Antiplatelet therapy with aspirin 81 mg daily is the most frequently prescribed treatment to reduce clotting risk in patients with the metabolic syndrome. Aspirin has been shown to be effective for both primary and secondary prevention of CVD and therefore should be used in patients with the metabolic syndrome who do not have contraindications to its use. Though no drug is currently available to reduce the pro-inflammatory state, some statins do lower c-reactive protein and have potential for use in this regard.

**Insulin Resistance:** Insulin resistance is first managed with TLC and then with pharmacotherapy (eg, metformin, thiazolidinediones [TZDs]) as needed. A study was conducted on patients with impaired glucose tolerance, many of whom also had the metabolic syndrome, to compare the effects of TLC, metformin, and placebo on the syndrome’s incidence and resolution. By year 3, cumulative incidences of the metabolic syndrome were 51%, 45%, and 34% in the placebo, metformin, and lifestyle groups, respectively, thereby demonstrating that TLC had the most beneficial effect of all. In one study, metformin was seen to reduce the incidence of diabetes up to 43% . TZDs, including rosiglitazone and pioglitazone, are also being investigated as a way to control insulin resistance and prevent the development of diabetes in patients with the metabolic syndrome.
Conclusions:
Metabolic syndrome is a growing problem worldwide. The translation of research into an evidence-based treatment plan is needed to manage the five components of the disorder. By developing evidenced-based plans we may be able to impact the development of cardiovascular disease.
Title: Quality of Life as a Foundation for Person Centred Planning in Social & Vocational Rehabilitation Services for Adults with Intellectual Disabilities

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ABSTRACT
Traditionally factors considered in planning programmes for people with intellectual disabilities have focussed on the individual experience of disability. This has led to fragmented services and interventions, which fail to take account of the individuals’ interrelated quality of life values and needs. This study was undertaken to examine how providers of social and vocational rehabilitation services can move beyond restricted outcome dimensions by adopting a holistic approach that takes account of quality of life circumstances.

Aim of the Study: The aim was to design and pilot a person centred model of service provision that focuses on improving the quality of life of people with intellectual disabilities

Methodology: An action research approach was adopted and the study was conducted over four phases. Phase one involved an examination of approaches to social and vocational assessments for adults with intellectual disabilities. Phase two involved the design and pilot of an Occupational Guidance and Vocational Profiling tool. Phase three involved the design and pre-test of a questionnaire, which measures subjective quality of life circumstances. Phase four involved the design and piloting of a Key Stage Quality of Life Profile that measures objective quality of life circumstances. A purposive sampling strategy was adopted.

Analysis: The findings of each phase were analysed to identify strengths, gaps and key issues emerging that require further research.
**Summary of Key Findings:** The outcome of the study was the development of a standardised set of tools using quality of life indicators that form the basis of a person centred model of service.

**Conclusion:** Further research should be conducted with adults with intellectual disabilities to establish what quality of life means to them. Involving people with intellectual disabilities in determining what constitutes quality of life may result in needs driven and person centred services.
A national study of external breast prosthesis use and quality of life

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Background and context
A good-quality prosthesis and prosthesis-fitting service is an essential part of post-mastectomy care. However, this is an area of care that has minimal information or research available to women. In Ireland, there has been no research in this area at all and a rigorous evidence-base is required to inform practice.

Aim of the study
The overall aim of this research was to gain an insight into women’s experience of the provision, fitting, supply and use of breast prostheses in Ireland. The specific focus of this paper will be on the relationships between external breast prosthesis use and satisfaction, arm and breast symptoms, and quality of life.

Methodology
A comprehensive questionnaire that included the WHOQOL-BREF and the Arm and Breast Symptom subscales of the EORTC Breast Symptom Module was posted to 1242 women with a breast prosthesis.

Analysis / Summary of key findings
527 (46% of those eligible) returned completed questionnaires. A sizeable proportion of women expressed dissatisfaction with various aspects of the prosthesis, in particular its weight (24.4%), comfort (17.3%) and movement with the body (14.3%). Higher levels of satisfaction with aspects of the external breast prosthesis were associated with higher quality of life scores in each of the WHOQOLBREF domains (i.e. physical health, psychological, social relationships and environment) and fewer breast and arm symptoms.
symptoms. The more frequently that the prosthesis was replaced, the higher the quality of life scores on the psychological, social relationships and environment QoL domain subscales and the fewer arm and breast symptoms experienced.

**Conclusions**
Quality of life and external breast prosthesis use is a relatively unexplored area in the literature to date. Consequently, it is imperative that these findings are used by policy-makers and practitioners to advocate for a quality service and to facilitate women’s experiences in relation to external breast prosthesis use.
Exploring ICT as a Learning Tool in Public Health Nursing

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ABSTRACT

The nature of health care today is constantly changing and this means that staff needs to remain updated educationally. “Learning to learn” is now increasingly acknowledged as an ultimate life skill. In community care, nurses are more isolated from centres of education than other strands of nursing, as a result of this; they often experience difficulties in trying to access new knowledge and information. Consequently, the author decided to look at the introduction of learning through ICT for community nursing staff. The idea behind this was to take education to a local level and make it more accessible for all.

This thesis set out to examine if the community nursing teams would use ICT as a learning tool. The author explored if the participants found it an appropriate tool, if they felt that its introduction had aided their learning needs, changed their practice in any way and played a role in the overall plan of forming a learning organisation.

A case study approach was used to carry out the research. The participants in this research project included eighteen staff from three separate health centres who volunteered to participate. These consisted of eleven Public Health Nurses, six Registered General Nurses and one Health Care Assistant. The study was carried out over a five month period. The first two months involved staff training and the ICT package being introduced. The final three months involved data collection and analysis.

The research findings showed that ICT was a valuable asset and can be used quite successfully by nurses as a learning tool. While acknowledging that there were barriers to overcome, overall, ICT offers huge potential for future access to education for community nurses.
Title: Studying Up the Pharmaceutical Industry in Ireland

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Increasingly, the transnational pharmaceutical industry’s influential role in shaping health priorities has come under scrutiny. One important dimension of this influence takes the form of its relationships with health advocacy organisations. As part of a wider research project on health advocacy organisations and their relationships with the pharmaceutical industry in Ireland, an under-researched area within the Irish context, this paper will explore the results of a survey of 104 Irish-based pharmaceutical and healthcare companies and interviews with a range of pharmaceutical company executives around their relations with health advocacy organisations carried out in 2005/06. The analysis will highlight the nature and extent of the difficulties of ‘studying up’ the power structures in society and the role of gatekeeping institutions such as the Irish Pharmaceutical Healthcare Association which represents ‘big pharma’ in Ireland in preventing access. Nevertheless, what the data reveal is that while the most common form of relationship involved the donation of cash or support in kind, there was a diversity and complexity of relationships among a number of pharmaceutical and health care companies and Irish health advocacy organisations which indicate that the situation in Ireland does not fall outside of the overall trends documented in the wider literature. These relationships include the role of companies in establishing health advocacy organisations and assisting them in public relations (e.g. websites), the formation of formal partnerships with them, and the involvement of representatives from health advocacy organisations in disease awareness campaigns, product promotion, and recruitment for clinical trials.
Title: Caring for female patients: male nurses’ experiences.

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Background and Context: It has been suggested that men in nursing enter the profession for the same reason as women (Lodge et al 1997) and evidence suggests that males have historically been competent caregivers in a variety of settings (Poliafico 1998; Macintosh 1997). Although caring is a universal concept attributed to the nursing profession, little is known about the experiences of male nurses who care for patients of the opposite sex.

Aim of the study: The aim of this paper is to present the findings of two research studies that explored the concept of caring for female patients from a male nurses’ perspective.

Methodology: A qualitative descriptive design was used with semi-structured interviews as a method of data collection. Five male registered general nurses (RGN) were purposively selected in the first study and six male registered psychiatric nurses (RPN) were purposively selected in the second study.

Analysis: Burnard’s (1991) framework consisting of a system of coding and categorisation was used to analyse the data. Themes were generated from both studies and the common themes from both studies are presented in this paper.

Summary of key findings: Four common themes emerged from the findings. These themes were deemed to have an impact on the caring interventions that male nurses’ utilise in their daily practice. These themes are: fear of sexual allegations, caring interventions, factors influencing caring interventions and learning about caring interventions for the opposite sex.

Conclusion: It is clear from the findings that barriers exist for male nurses who care for female patients. As nursing strives to readdress the gender balance, learning about caring interventions for the opposite sex needs to be explicitly included in the undergraduate curriculum. Further research to explore and
elaborate on the experiences of male nurses in clinical settings is also advocated. Finally, emphasis needs to be given to facilitating male nurses to explore their fears of sexual allegations and develop strategies for coping in clinical practice. A failure to do this may result in male nurses disengaging from female clients.
Preceptorship: A model of support that facilitates undergraduate student nurse education and learning and promotes effective clinical teaching environments.

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Background and Context

The education and training of nurses in Ireland has undergone radical change over the past ten years. In 1994 the transition from the traditional three year apprenticeship nurse training to the introduction of a three year diploma programme with supernumerary status for students, brought the position of pre-registration nurse education (psychiatry, intellectual disability, general) in this country in line with that of the United Kingdom, Australia and Canada. In 2002 the diploma in nursing programme was replaced in Ireland by a four-year competence – based degree programme. As part of this programme, the Nursing Education Forum Report recommended that each student nurse be assigned to a preceptor (a registered nurse) as registered nurses are considered an essential part of student nurse learning within the clinical learning environment. A number of models of support for nurses exist; the model of support chosen for student nurse learning when on clinical placement in Ireland is that of preceptorship. The role of the preceptor encompasses the teaching, learning and assessing of newly qualified nurses when on clinical placement. However, one of the most difficult responsibilities of a preceptor is the role of assessor. Preceptors appear to have difficulty with the use of questioning as a teaching strategy and the provision of feedback to students. Therefore the content of the training programmes should be specifically targeted to meet the needs of the preceptor. Evaluating the needs of preceptors is an essential part of the training and regular review and evaluation of programmes and of preceptors and preceptees experience of preceptorship are essential priorities, for without such, deficits such as the use of questioning and feedback may remain undetected.
For preceptorship to be successful, it is fundamental that open communication with constant feedback between all the stakeholders (preceptor, the preceptee, clinical nurse manager, clinical placement co-ordinator, the link lecturer and course co-ordinator within the academic institution) involved in student nurse learning occurs on an ongoing basis throughout the student’s training.

**Aim of the Poster:**

The purpose of this poster is to critically discuss how preceptorship as model of support facilitates undergraduate nurse education and learning and promotes effective clinical teaching environments.
Lecturers Perspectives on the Academic Standard of the Written Work of Nursing Students in Ireland

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Abstract:
There have been significant changes in the philosophy, design and delivery of nurse education programmes in Ireland in recent years (Department of Health and Children 1998), reflecting a broader imperative of fostering empowerment and professionalism in nursing (Department of Health and Children. 2004), which have had profound implications for the learning and educational practices of nurse-lecturers and students. Among these is the requirement for nursing students to engage in a higher level of academic activity and articulation of professional knowledge, thereby increasing the necessity for proficiency in academic skills (Hegyvary, 2000). Indeed, there is an increasing expectation that all nurses will engage in scholarly activity as an inherent component of ongoing professional development and lifelong learning (Wildman 1998, Silva et al 1999).

While Rolfe (1997) identifies writing as one of the most important skills that the critical and questioning nurse can develop, concerns have been raised recently in both the nursing literature (Ofori and Charlton 2002, Tordoff 1999, Brennan 1995) and from a localised context in relation to levels of student confidence and competence in literacy and academic writing skills among undergraduate and postgraduate students. Moreover, academic failure remains the most commonly cited reason for attrition among nursing students.
(White et al 1999). It is within this context that a collaborative research study exploring lecturers’ perceptions of student academic performance was situated. The aim of the study was to systematically examine and collate views held by lecturing staff in Schools of Nursing and Midwifery in Ireland in relation to the standard of students’ academic written work across a range of programmes. A mixed methodology was used, adapting a purposeful sampling technique and incorporating both qualitative and quantitative data. The findings of the study identify shared concerns among lecturers and provide some direction for responding to these. Thus, they form a useful research resource for intervention planning and further exploration into other dimensions of this issue.

References:


Silva, M.C. Cary A.H. & Thasis C (1999) when students can’t write: solutions through a writing –intensive nursing course. Nursing and Health Care Perspectives.20, pp.142-145


A Survey of Nurses’ and Midwives’ Knowledge of Risks and Lifestyle Factors Associated with Osteoporosis

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ABSTRACT

The aim of this study was to investigate nurses’ and midwives’ current knowledge of osteoporosis. It also assessed their education and training needs in relation to osteoporosis. This study may be seen as the first step to addressing the lack of education about osteoporosis among health care professionals by establishing knowledge levels and educational needs.

Method
A quantitative, descriptive survey was conducted via questionnaire with 128 nurses and midwives in a rural general hospital in the North West of Ireland.

Sample
A stratified, random sample of 128 nurses and midwives in the North West of Ireland

Results
A generally high level of knowledge about certain risk factors was exhibited. The main deficit of knowledge and lifestyle factors in this study was that of exercise and bone health. A link was, however, established between age and knowledge scores and a more significant link was established between years of qualification and knowledge. Registered Midwives were found to have a high knowledge level. Nurses and midwives received their information from media sources, as opposed to a formal education session. Almost all of the respondents identified a need for further education on the subject of osteoporosis.

Key Words: ‘osteoporosis’, ‘nurses’, ‘knowledge’ and ‘education’.
INTRODUCTION

Osteoporosis is a progressive, potentially crippling disease, which is largely preventable (Report on Osteoporosis in the European Community, 1998). It is no longer confined to the growing older population of Ireland but has implications for all age groups.

Osteoporosis is a skeletal disease characterized by low bone mass and deterioration of the micro architecture of bone tissue, with a consequent increase in bone fragility and susceptibility to low trauma fractures (World Health Organisation (WHO), 1994). In recent years there has been a marked increase in the number of patients hospitalised in Ireland for the typical osteoporotic fractures of hip, vertebrae and wrist. Hospital In-Patient Enquiry (HIPE) data show that hip fractures have doubled in patients over 60 years of age: from 1,509 cases in 1990 to 3,202 cases in 2002 (Irish Osteoporosis Society (IOS), 2004).

In Ireland, osteoporosis fractures are an important public health problem. Fractures are associated with a mortality rate of 25%, with approximately 50% of survivors suffering complete or partial loss of mobility and independence (IOF, 2004; IOS, 2004; Barnville et al., 1994). The first clinical sign of osteoporosis may be a low impact Colles’ fracture in mid-life.

Many patients presenting at Emergency Departments with low impact osteoporotic fractures are not diagnosed with osteoporosis and miss out on interventions that may prevent further fractures at a later date (National Osteoporosis Foundation (NOF), 2003). Feldstein et al. (2003) stated that less that half (46%) of women who sustained suspected osteoporosis related fractures received treatment or education in the six months following a fracture to prevent another fracture occurring, as recommended in clinical guidelines (Scottish Intercollegiate Guidelines Network (SIGN), 2003).

By the year 2031, forecasts predict that the number of citizens who are aged over 65 years will have doubled from 402,000 or 11.5% of the Irish population in 1996 to between 858,000 and 873,000, representing between 18 and 21% of the population (Department of Health and Children, 2001). Many healthcare professionals see osteoporosis as a disease of the elderly; they are wrong. Osteoporosis is a progressive, potentially crippling disease, which is largely preventable (Report on Osteoporosis in the European Community, 1998) and all age groups may be at risk.
Osteoporosis and Risk Factors
There are two main types of osteoporosis:

1. Primary Osteoporosis
   - Postmenopausal osteoporosis (Type I)
   - Age-related or senile osteoporosis (Type II)

2. Secondary osteoporosis

While risks for primary osteoporosis are largely non-modifiable, risks for secondary osteoporosis may be modifiable. It is important that health care providers identify risk factors for the disease and follow up on these. In women over 45 years of age osteoporosis accounts for more days spent in hospital than many other diseases, including myocardial infarction, diabetes and breast cancer (Cummings and Melton, 2002). These authors go on to state that a white woman’s risk of hip fracture is 1 in 6 compared to a 1 in 9 risk of breast cancer, further underlining the importance that osteoporosis should have in the public awareness.

Lifestyle factors such as: a dietary intake low in calcium, especially in childhood/early adulthood, smoking, excessive alcohol intake, low body weight, lack of resistance/weight bearing exercise and over exercising, resulting in periods of amenorrhoea that interfere with the beneficial effects of oestrogen on bone metabolism, also pose risks for the development of osteoporosis (Compston, 2004; Irish Osteoporosis Society (IOS), 2004; SIGN, 2003; National Osteoporosis Society (NOS), 1998).

Osteoporosis Prevention
One Irish Initiative, the Saffron Report (1999), specifically highlights changes needed with regard to the policy on osteoporosis screening and the need for health care professionals to fully exploit their role in prevention. Further, the Report on Osteoporosis in the European Community (1998) recommends:

"Prevention of osteoporosis should be a major priority in the ongoing education and training of health professionals” (p 10).

However, the nurse needs an adequate knowledge base of osteoporosis, its aetiology and risk factors, as well as preventative behaviours to fulfil her teaching role. Berarducci et al. (2002) found that lack of osteoporosis knowledge among nurses can negatively impact nurses participating in preventative behaviours. They suggest that nurses need to have an understanding of factors relating to osteoporosis prevention to be able to promote bone health. This re-enforces a study by Hunt and Repa-Eschen (1998) where nurses rated their own knowledge of osteoporosis as ‘less than adequate’ (p 59).
REVIEW OF THE LITERATURE

Women’s Knowledge of Osteoporosis
The majority of studies indicate that women appear to be ill informed of osteoporosis. Increased knowledge of osteoporosis has been linked to increased age (Williams et al., 2002; Ungan and Tumer, 2001) and education (Ungan and Tumer, 2001; Sedlack et al., 2000). Interestingly, the American and Canadian studies reported women receiving most of their education/information on osteoporosis from their Health care providers (Ribeiro et al., 2000; Ailinger et al., 1998), in contrast to the UK studies where women reported receiving most of their information from the media (Sweirs, 1996; Williams et al., 2002).

Nurses’ Knowledge of Osteoporosis
While the knowledge of women and college students has been assessed (Ungan and Tumer, 2001; Ribeiro et al., 2000; Sedlak et al., 2000; Ailinger and Emerson, 1998; Sedlak et al., 1998; Weiss and Sankaran, 1998) few studies that refer to the knowledge of nurses as a specific group are available, and none including midwives. The paucity of studies within this group indicates that research into nurses’ and midwives’ knowledge of osteoporosis is scant (Hunt and Repar-Eschen, 1998).

Studies with women in general, stated that knowledge increases with age and/or experience (Berraducci et al., 2002; Williams et al., 2002; Ungan and Tumer, 2001). However, these finding were refuted in the nurses’ studies (Li et al., 2001). Two studies suggested that the scores achieved by nurses were similar to the general public (Berraducci et al., 2002; Beraducci, 2004). In addition, the variety of tools utilised have different strengths and are difficult to compare, even if the same questionnaire is utilised, each researcher modifies it to suit their sample (Ziccardi et al., 2004).

There is no consensus that increased knowledge of osteoporosis correlates positively with age or experience in either group, women or nurses. Despite many respondents being within the peri-menopausal age range, many women and nurses’ reported that their primary care provider had not discussed osteoporosis prevention measures with them.
METHODOLOGY
The purpose of this study was to examine the knowledge level of nurses and midwives in relation to the risk and lifestyle factors associated with osteoporosis and also to ascertain any educational needs of this population with regard to osteoporosis. As this study aims to measure nurses’ and midwives’ knowledge of osteoporosis the logical methodology would appear to be quantitative.

In previous studies to assess knowledge of osteoporosis, a questionnaire was the tool of choice (Berraducci, 2004, Berraducci et al., 2002, 2000; Ziccardi et al., 2004; Li et al., 2001). As knowledge can influence practice (Burns and Grove, 2000) it was deemed important to utilise an objective measure of knowledge, with a view to developing an educational programme following this and based on the findings of this study, if appropriate. A self-report questionnaire was chosen, as it allowed efficient and cost effective communication of facts from the sample. A further consideration when opting for this method is that questionnaires are one of the simplest ways of collecting data (Burns and Grove, 2000) and can be analysed quickly and accurately, using computerised statistical packages. The utilisation of such a tool gives results that will be numerical and thus quantifiable. In addition, as the variables to be measured were also known in advance, i.e. risk factors for osteoporosis and lifestyle factors that can affect the disease, a quantitative approach was indicated.

Research Design
The survey is also a useful tool in assessing the needs of a population (Oppenheim, 2000). The method of gathering data for this survey is the self-administered questionnaire. Within this study, the education and training needs of the staff regarding osteoporosis are assessed in part II of the survey.

Questionnaires can be utilised to measure attributes, attitudes, beliefs, knowledge and behaviour (Murray and Beynon, 1998). This questionnaire was handed out directly by the researcher. A questionnaire that is handed out personally has an advantage in that the respondents connect it with an individual or organisation, which may improve the response rate (Sitzia & Wood, 1998). It has, also been suggested that it is pointless to construct a questionnaire when there is an existing questionnaire that has been validated by previous research (Thomas et al., 1997). Therefore the author utilised a previously validated questionnaire.

The original Facts on Osteoporosis Quiz (FOOQ), developed by Ailinger et al., was theoretically informed by Orem's (1995) Self-Care Theory this was published in 1998 and updated in 2001. The
author selected this questionnaire as it was pertinent to the objectives of the study. Permission was sought and granted from Ailinger et al. to utilise their questionnaire, with slight modifications to suit the Irish population. The tool was comprised of two sections. Section I, the Facts on Osteoporosis Quiz (FOOQ) (Ailinger et al., 2003), having twenty questions with ‘true’, ‘false’ or ‘don’t know’. Section II contained 13 demographic questions asking details of age, sex, qualifications and personal and professional knowledge of osteoporosis. This section also contained an opportunity for staff to state if they were interested in attending education sessions and what topics they may like included. One question also asked staff if they personally had taken any steps to prevent osteoporosis, thus eliciting any lifestyle factors that staff themselves might have implemented to prevent osteoporosis.

Sample
Inclusion criteria were:

a) Respondents must be a Registered General Nurse (RGN) and
b) Engaged in patient/client contact, rationale being that this group would be interacting with patients and offering educational/health promotion advice within their role.

As it was not feasible, due to time constraints, to administer the questionnaire to the entire target group in this study, the author utilised a stratified sampling design. This involves dividing the population into homogeneous sub-groups and then taking a simple random sample in each subgroup. Using the same sampling fraction within each strata indicated that the author conducted non-proportional stratified random sampling. However, the size of each strata (n=10) required the utilisation of non-parametric testing during the analysis.

Results
The questionnaire was distributed to the target group (n=140) and 128 nurses/midwives responded, giving a response rate of 91.5% (n=128).

Five questionnaires were received with ‘no specific unit, on relief’ and these were included in the calculations, as they were completed fully. These five questionnaires then formed a new strata ‘General Relief’ comprising of 5 respondents. The formation of this strata did however, impact on all other strata as the numbers within these fell below the 10 assigned to each strata.

Table 1 describes the responses of the nurses and midwives surveyed to the quiz. Almost all the respondents (92.96%) knew that there were many ways to prevent osteoporosis and almost as many knew that physical activity did not increase the risk of osteoporosis. This shows a high knowledge level of these important
risk factors. However, only 6.25% (n= 8) identified the statement that walking had a great effect on bone health as false, and engaging in high impact/weight training improved bone health was identified as correct by only 38.28% (n= 49) of respondents. This means that under half of the respondents were unaware of the current thinking on exercise and osteoporosis. Under half again (33.59%, n=43) identified low weight in women as a risk factor, another risk factor in today’s climate of dieting for young women. Just over half, (53.12%) were able to link alcoholism and osteoporosis (n=68) and a similar number, 54.68% (n=70) either didn’t know (n=30) or were erroneous in stating that replacing hormones after menopause cannot slow bone loss as true (n=28). The results of the FOOQ are shown in table 1.
### Table 1
Responses to The Facts On Osteoporosis Quiz

<table>
<thead>
<tr>
<th>Facts on Osteoporosis Quiz</th>
<th>No: who responded True</th>
<th>No: who responded False</th>
<th>No: who responded Don’t Know</th>
<th>No: of Responses correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions</td>
<td>(n)</td>
<td>(%)</td>
<td>(n)</td>
<td>(%)</td>
</tr>
<tr>
<td>1. Physical activity increases the risk of osteoporosis.</td>
<td>8 (6.3%)</td>
<td>117* (91.4%)</td>
<td>3 (2.3%)</td>
<td>117 (91.4%)</td>
</tr>
<tr>
<td>2. High impact exercise (weight training) improves bone health.</td>
<td>49* (38.3%)</td>
<td>62 (48.4%)</td>
<td>17 (13.3%)</td>
<td>49 (38.3%)</td>
</tr>
<tr>
<td>3. Most people gain bone mass after 30 years of age.</td>
<td>10 (7.8%)</td>
<td>104* (81.3%)</td>
<td>14 (10.9%)</td>
<td>104 (81.2%)</td>
</tr>
<tr>
<td>4. Low weight women have osteoporosis more than heavy women.</td>
<td>43* (33.6%)</td>
<td>67 (52.3%)</td>
<td>18 (14.1%)</td>
<td>43 (33.6%)</td>
</tr>
<tr>
<td>5. Alcoholism is not linked to the occurrence of osteoporosis.</td>
<td>34 (26.6%)</td>
<td>68* (53.1%)</td>
<td>26 (20.3%)</td>
<td>68 (53.1%)</td>
</tr>
<tr>
<td>6. The most important time to build bone strength is between 9 and 17 years.</td>
<td>104* (81.9%)</td>
<td>18 (14.2%)</td>
<td>5 (3.9%)</td>
<td>104 (81.2%)</td>
</tr>
<tr>
<td>7. Normally, bone loss speeds up after menopause.</td>
<td>114* (89.1%)</td>
<td>9 (7%)</td>
<td>5 (3.9%)</td>
<td>114 (89%)</td>
</tr>
<tr>
<td>8. High caffeine combined with low calcium intake increases the risk of osteoporosis.</td>
<td>105* (82%)</td>
<td>13 (10.2%)</td>
<td>10 (7.8%)</td>
<td>105 (82%)</td>
</tr>
<tr>
<td>9. There are many ways to prevent osteoporosis.</td>
<td>119* (93%)</td>
<td>3 (2.3%)</td>
<td>6 (4.7%)</td>
<td>119 (92.9%)</td>
</tr>
<tr>
<td>10. Without preventive measures, 50% of Irish women will have a fracture due to osteoporosis in their lifetime.</td>
<td>98* (76.6%)</td>
<td>8 (6.3%)</td>
<td>22 (17.2%)</td>
<td>98 (76.6%)</td>
</tr>
<tr>
<td>11. There are treatments for osteoporosis after it develops.</td>
<td>96* (75%)</td>
<td>19 (14.8%)</td>
<td>13 (10.2%)</td>
<td>96 (75%)</td>
</tr>
<tr>
<td>12. A lifetime of low intake of calcium and vitamin D does not increase the risk of osteoporosis.</td>
<td>11 (8.6%)</td>
<td>107* (3.6%)</td>
<td>10 (7.8%)</td>
<td>107 (83.6%)</td>
</tr>
<tr>
<td>13. Smoking does not increase the risk of osteoporosis.</td>
<td>16 (12.5%)</td>
<td>100* (78.1%)</td>
<td>12 (9.4%)</td>
<td>100 (78.1%)</td>
</tr>
<tr>
<td>14. Walking has a</td>
<td>109 (85.2%)</td>
<td>8* (6.3%)</td>
<td>11 (8.6%)</td>
<td>8 (6.25%)</td>
</tr>
</tbody>
</table>
15. After menopause, women not on oestrogen need about 1000mg of calcium (example, 4-5 glasses of milk) daily.


17. Early menopause is not a risk factor for osteoporosis.

18. Replacing hormones after menopause cannot slow down bone loss.

19. Children 9 to 17 years of age get enough calcium from one glass of milk each day to prevent osteoporosis.

20. Family history of osteoporosis is not a risk factor for osteoporosis.

(* Indicates the correct answer)

No respondent scored 100% on the quiz. One respondent scored nil, and it was observed that this respondent ticked ‘don’t know’ throughout the quiz. The decision was made to delete this score from the analysis to stop data becoming skewed.

Table 3 shows the frequency scores in the FOOQ. The mean score was 13.86 (median 14).

Table 2

Scores Achieved on the FOOQ

<table>
<thead>
<tr>
<th>Scores Achieved</th>
<th>Frequency (n)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>1</td>
<td>.8</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
<td>3.9</td>
</tr>
<tr>
<td>10</td>
<td>7</td>
<td>5.5</td>
</tr>
<tr>
<td>11</td>
<td>6</td>
<td>4.7</td>
</tr>
<tr>
<td>12</td>
<td>7</td>
<td>5.5</td>
</tr>
<tr>
<td>13</td>
<td>26</td>
<td>20.5</td>
</tr>
<tr>
<td>14</td>
<td>11</td>
<td>8.7</td>
</tr>
<tr>
<td>15</td>
<td>21</td>
<td>16.5</td>
</tr>
</tbody>
</table>
Analysis
The statistical test used to assess whether any difference existed between scores on the FOOQ and age, sex, and other variables, were cross tabulation charts and the Pearson Chi square test.
One third of respondents had a Diploma in nursing (33.6%) and over a quarter had a degree in nursing (25.8%). The largest age group was the 26-30 years (21.1%) however a relatively even spread over age was achieved. The largest group were qualified 1-5 years (26.6%) followed by 6-10 years (21.9%). Almost all respondents were female (95.3%). The non-parametric, Pearson’s Chi-Square test was conducted to ascertain if there was statistically significant differences between scores on the Facts On Osteoporosis Quiz (FOOQ) and age, post graduate qualifications, years of experience, area of work, sex, and lifestyle factors affecting osteoporosis. Analysis indicated that there was a positive correlation between years post-qualification and knowledge; a further link although weaker, was noted between age and knowledge. There was no statistical link between having a postgraduate qualification in orthopaedics and scores on he FOOQ. The only positive correlation in this area was a statistical significance between those respondents who were Registered Midwives and knowledge scores. A positive correlation between knowing someone with osteoporosis and knowledge was indicated and another, weaker correlation between those who had received information on osteoporosis and those who hadn’t.

Knowledge of Lifestyle Factors
Almost three quarters of respondents could correctly identify the calcium intake recommended by the IOS (71%). Of those who stated they were personally taking steps to prevent osteoporosis (Q.7), 15 had increased calcium in their diet, 10 had increased their milk/dairy intake, 6 had taken calcium supplements and 8 had changed their diets to ‘eat healthily’ totalling 39 out of the 54 respondents who had made lifestyle changes. These results signify that the most identifiable change made by respondents in the prevention of osteoporosis was to their diet. The Slán Survey (2003) reported that 33% of the Irish public surveyed do not achieve the recommended daily intake of calcium, so changes to
their diet to increase vitamin D and calcium are in line with the current recommendations (NOS, 2002).

Other changes made by respondents to prevent osteoporosis included the following: 1 had given up smoking, and 2 were taking HRT, both strategies recommended by the NOS (2002). Eight had stated ‘eat healthily’ and 1 had ‘increased vegetable intake’; neither of the latter strategies is specific to osteoporosis prevention, although recommended by the Health Strategy (Government of Ireland, 2001).

The question that almost all respondents answered incorrectly in the FOOQ was Q. 14 where only 6.25% (n=8) scored correctly, in other words almost all respondents (93.75%) erroneously believe that ‘walking has a great effect on bone health’. It is pertinent to note here that Allinger et al. (2003), in their revision of the FOOQ stated that the expert reviewers declared this question “too difficult” i.e. less than 20% of Allinger et al.’s pilot population were correct. Allinger et al.’s (2003) finding has been mirrored in the present study. Although walking has an obvious cardiovascular benefit and is generally recognised as being ‘good for you’ there is little evidence that it has a beneficial effect on bone density (NIH, 2000). Two respondents reported taking up swimming to prevent osteoporosis which is not shown to build up or maintain bone mass, however the NIH state that swimming and cycling maintains body strength and aids balance which help to prevent falls in later life (2000).

The main deficit of knowledge and lifestyle factors in this study was that of exercise and bone health. Less than 7% of the respondents in this study were correct about walking and bone health and only 39% recognised that high impact and/or weight training were beneficial for bone health.

**Osteoporosis Knowledge**

Six questions in the FOOQ addressed knowledge about osteoporosis in general and results indicate a high level of knowledge in some respects.

Despite the fact that the largest group of respondents were in the 26-30 age group (n= 27), higher scores in the quiz were recorded by respondents over 46 years. More than half of the 46-50 year olds scored over 16 (53.3%), and half of the over 50’s achieved the same score (50%), thus indicating a high level of osteoporosis knowledge in this group, especially when compared with the low number of the 26-30 age group who achieved a similar score (7.4%). This was a statistically significant difference and reflects the study by Ungan and Tumer (2001). This finding was replicated in Williams et al.’s (2002) study, they found there was a trend towards
increased knowledge of osteoporosis with increased age, both re-enforcing Berarducci et al.’s findings (2002), which stated that older women had a greater knowledge of osteoporosis.

With regard to general knowledge of osteoporosis, again a high level of knowledge was evident. Over three quarters of respondents (76.6%) were aware that without preventative measures, half the population of Irish women would suffer an osteoporosis-related fracture during their lifetime. Almost half of the respondents (42.2%) reported taking steps to prevent the disease, of these: 2 reported swimming, which has no documented effect on BMD (NOS, 1998), one was taking fish oils supplements commonly taken for osteoarthritis not osteoporosis, and 22 specified exercise, but not which type they participated in. Increasing vegetable intake may have a marginal effect on calcium levels, as may a general vitamin supplement, but neither is specific to osteoporosis (IOF, 2004). The majority of the respondents (85.9%) knew osteoporosis affected men and women and three quarters (75%) were aware that there were treatments for osteoporosis after it developed, showing a high level of knowledge in these areas. This may indicate the respondents’ focus on the treatment of osteoporosis and subsequent fractures i.e. secondary prevention, rather than an emphasis on education to prevent the disease and minimise its effects, i.e. health promotion.

Knowledge Scores on the FOOQ and Effects of Variables
In comparison with Ailinger et al.’s (2001) study, where the mean score of their cohort was 15 on the FOOQ; in this study, the mean was 13.75 (median 14). This is significant, as the cohort in this study were nurses and midwives, and Ailinger et al. utilised a sample of the lay public, thus supporting the suggestion by Berarducci et al., (2002) and Ziccardi et al. (2004) that there is no difference in knowledge of osteoporosis between health care professionals and lay persons. The lack of difference in knowledge between health care professionals and lay people is worrying in light of the role that nurses and midwives play with regard to health education/promotion with their client groups.

Much of the research literature examined in this study reported an increase in knowledge with educational levels (Berarducci et al., 2002; Williams et al., 2002; Ungan and Tumer, 2001). However, there was no correlation noted in this study between postgraduate educational levels and knowledge scores, even though over half (59.4%) of the respondents reported having a postgraduate degree or diploma. These findings correspond with the findings of Li et al. (2001) who also utilised a cohort of nurses with varying educational qualifications in their study. A link was, however, established between age and knowledge scores and a more significant link was
established between years of qualification and knowledge. Nurses or midwives who were qualified for more than 20 years scored higher with over half (53.8%) of this group scoring above 16 in the FOOQ. Those who were qualified for 16-20 years also scored high with 42.9% scoring over 16, establishing a stronger link than age alone e.g. two nurses may be the same age, however the nurse with the longer years of experience scored higher, thus suggesting a link between nursing experience and osteoporosis knowledge. This finding compares to that by Li et al. (2001) who found orthopaedic nurses with longer years of experience scored higher that their peers and contrasts with Beraducci et al, (2002) and Ungan and Tumer, (2001) who both reported that increased age of the respondents was linked to an increase in osteoporosis knowledge.

A surprising result of the study was the statistical significance between one professional cohort over the remainder. Although nurses working in the rheumatology had the highest score on the FOOQ, with 83.3% (n=5) scoring between 16-20 correct, among the Registered Midwives (RM), almost all (96%) scored more than 11 with 48% scoring 11-15 and a further 48% scoring 16-20. This was the only group who showed a statistically significant difference in scores. As this is the first study that included midwives specifically as a group, no comparison with other research can be made. Also of consequence in affecting the knowledge scores was having received information on osteoporosis previously. Where/how information was received was not statistically significant, which would indicate that the knowledge levels of the respondents were unaffected by receiving information from either education programmes or the media.

Reflecting the results of Alilinger and Emerson (1998), this study also noted a positive correlation between knowing someone with osteoporosis and knowledge score. Having a family member with osteoporosis was also slightly significant.

**Sources of Information on Osteoporosis**

One interesting revelation of this study comes from the response to question 11 the sources of information on osteoporosis. In the present study, those who reported receiving information on osteoporosis cited newspapers /magazines as the top source (59.1%), followed by formal education programmes (40.9%) then television (18.2%). If newspaper/magazine and television are combined then 77.3% (n=51) of nurses and midwives received their information from media sources, as opposed to a formal education session. Although it is acknowledged that respondents may have ticked more than one source, this is a worrying finding as the media sources may not be reliable or based on the most recent evidence.
It also means that nurses and midwives as a resource are not being utilised for health education. However, almost all (93%) of the respondents identified a need for further education on the subject of osteoporosis, suggesting recognition of the role they could play in the education of clients.

**Expressed need for osteoporosis education**
As stated earlier, the vast majority of respondents (93%) indicated that they would like to attend an educational session on osteoporosis, thus supporting Ailinger et al. (1998) and Berarducci et al.’s (2002) findings that nurses would refer patients to information sessions on continuing education for osteoporosis, as well as attending such sessions themselves. The necessity of osteoporosis education and clear practice guidelines for nurses and midwives is evident.

**Limitations of the study**
The following limitations have been identified.
- The data collection tool was developed for use with laywomen and may have limitations in terms of measurement of specific knowledge of nurses, midwives and male health care providers.
- The sample was limited to a population accessible to the researcher during a specific two-week period, thus excluding some of the population from the study; this may be regarded as a limitation of the study (Polit and Tatano Beck, 2004).

**CONCLUSION**
Findings from this study endorse the view expressed by other researchers that nurses’ knowledge of osteoporosis is less than adequate (Berarducci et al., 2002; Hunt and Repa Eschen, 1998). The scores of this cohort on the FOOQ when compared to those of Ailinger et al. (2003) are similar, suggesting no difference between this group of Health Care Professionals and the lay public surveyed by Ailinger et al. (2003). Views also purported by Beraducci et al. (2002) and Ziccardi et al. (2004).

In this sample of nurses and midwives the author found a positive correlation between years qualified and knowledge scores on the FOOQ and a weaker relationship between age and knowledge scores. Conflicting with other studies, a link was not identified between level of education and knowledge; however, that the sample consisted of a qualified, professional cohort rather than lay public, must be documented. The more knowledgeable nurses and midwives were the ones who reported having received information previously or who knew someone with the disease. This sample reported that the media was their primary source of information,
leading the author to construe that health professionals, who should be the first point of contact, are not always at the forefront of providing information about osteoporosis.

Research has shown that osteoporosis and fracture rates will continue to rise unless there is a concerted approach to detection and prevention in high-risk groups and indeed, in all groups and age categories (SIGN, 2003). Nurses and midwives in the Republic of Ireland have a comprehensive broad based role, they provide clinical care and general health promotion services to all age groups. Scope exists for developments in research methods, further studies in different settings and with different groups would be beneficial to all Health Care Professionals. To ensure nurses and midwives participate fully in this endeavor, it is essential that they are equipped with the necessary knowledge to meet their educational needs. This study is a beginning effort in assessing their knowledge and educational needs.
Models of care among midwives and their influence on the management of the third stage of labour: results from a grounded theory study

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During a grounded theory study exploring midwifery practice in the third stage of labour, significant practice variation was found among study midwives. This practice variation was in part explained by the identification of an interventionist-non interventionist practice continuum and three models of care: the interventionist, the non interventionist and the reflexive model (see fig 1). The three models were underpinned by beliefs about childbirth, beliefs about the role of the midwife and the woman during childbirth and midwives’ aims for care.

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Midwives adopting a complete interventionist approach to third stage practice sat to the extreme right of the continuum and adopted an interventionist approach to all aspects of third stage care, which was dominated by the use of active management. Midwives adopting a complete non interventionist approach to all aspects of third stage care sat at the extreme left of the continuum and adopted a non interventionist approach to all aspects of third stage care, which was dominated by physiological management. Midwives practising at a mid point on this continuum were identified as flexible/reflexive practitioners, who drew upon both
interventionist and non interventionist strategies when managing care as appropriate.

While the different models reflected different values and beliefs, it was apparent that midwives lying at the extremes of the interventionist-non interventionist practice continuum reflected similar attributes in being rigid in their approach, dominant and directional when advising women about how the third stage of labour should be managed.

Facilitating midwives to explore their personal belief system and their model of practice for third stage care, may assist them in reflecting on the care they give and the implications of their model in relation to informed choice and their personal practice.
Title: The Lived Experience of Re-entry Women in Traditional Baccalaureate Nursing Education

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The critical shortage of nurses has resulted in increased recruitment of nontraditional students who fill multiple roles in addition to their student role. Minimal research has been conducted with this population enrolled in a college environment designed for traditional students.

The purpose of this study was to explore the lived experience and margin-in-life of re-entry women enrolled in two traditional baccalaureate nursing programs in Indiana. The theoretical framework for the study was McClusky’s Power Load Margin Theory and the population consisted of ten re-entry nursing students who volunteered for participation. Demographic data was collected and semi-structured interviews were conducted with each participant. Participants completed Stevenson’s Margin-in-Life Scale and demonstrated an average margin of 0.60492.

Interviews were audio taped, transcribed, and subjected to systematic phenomenological analysis inspired by the work of Max van Manen. Five main themes emerged and were entitled success, support, transitions, challenges, and relationships. Success was comprised of three sub-themes: motivation for returning to school, persistence or determination to complete the program, and time management strategies. Support included two sub-themes: support from family and friends and support from self-care strategies.

The transitions theme included feelings of anxiety upon returning to college and academic difficulties encountered. The challenges theme was comprised of financial challenges and challenges encountered balancing multiple responsibilities. The fifth theme included relationships with university faculty and staff and relationships with fellow students.

Simultaneous triangulation was employed applying quantitative and qualitative methods in order to enhance the understanding of the
lived experience of the participants. To present a visual image of the interaction between the five themes and the margin-in-life, the researcher conceptualized a model entitled the Margin-in-Life Model.

This research provided rich information about the lived experience of re-entry women. Further research is needed to gain a more complete understanding and identify implications for nursing education.
TITLE: HEALTH CARE ASSISTANTS: EXPLORING THE VIEWS OF STUDENT NURSES

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Abstract

Background: While health care assistants (HCAs) form an integral part of the healthcare workforce, the views of student nurses remain unexplored. This is despite the fact that research has shown that students work closer with assistants than they do with qualified staff.

Aim: This paper reports on one phase of a larger project, which investigated the student nurses’ perceptions of the role of HCAs and how this affects the clinical placement experience.

Methodology: Focus groups and one to one interviews were used. All pre-registration nursing students (n=780) were sent details about the study and asked for their voluntary participation to attend. In total, 45 students volunteered to participate.

Analysis: Interviews, focus groups and discussion groups were all recorded and transcribed. The transcripts were subject to content analysis.

Findings: The findings suggest that HCAs influence students learning in the clinical practice area. Students reported that the role of the student nurse and assistant were similar. Although some students had prior care experience no student was provided with any preparation or guidance to work with this member of staff. Overall, students welcomed the support and learning opportunities from assistants, however some raised concerns with regards the blurring of roles in practice and the availability and approachability of HCAs compared to registered nurses.

Conclusion: Findings suggest that the HCA have an active role in teaching student nurses in clinical practice. This brings into question the qualified nurses’ teaching role and current educational approaches to the acquisition of clinical skills. This study has highlighted the role of the HCA in supporting students during their clinical placements. However it has raised some issues worthy of further investigating; in particular the precise nature of this perceived multi-faceted relationship on student learning and their entire clinical experience.
Title: To make visible the contribution of Children’s Nurses to the care of hospitalised children in Ireland

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Background: There is limited empirical data internationally on the contribution of Children’s Nurses at a staff nurse grade in clinical practice. More recent studies tend to focus on nursing competencies, advanced scope of practice for CNS and ANP roles. It remains difficult to define and to understand what it is that matters most in the practice of nursing children particularly in Ireland. A greater understanding of the contribution of Children’s Nurses is required

Aim: To examine how children’s nurses articulate and document nursing practice in caring for children and families.

Methods: A triangulation approach using 4 focus groups, (25 nurses), documentary analysis (24 nursing records) and questionnaires (24 nurses) in 3 hospital sites was completed to gain a picture of children’s nursing in clinical practice. Data was analysed using both SPSS and NVivo.

Results: The ‘dual role’ of caring for children and families emerged as the main theme throughout the study. The work of the Children’s Nurse could be effectively duplicated, as quite often, nursing problems and interventions were clearly distinct from that of the child and its parent/family. The range of interventions was particularly evident throughout the analysis. Three key themes also emerged which roughly reflected the nursing process; assessment,
problems and interventions. The Children’s Nurses role as an orchestrator, assessor and educator were identified from qualitative analysis. Documentary analysis illustrated a more task-orientated approach and less multidimensional approach to care in comparison to the focus groups.

**Conclusion:** The ‘dual role’ of a Children’s Nurse in caring for what is effectively two client groups demonstrates the complexity of children’s nursing. This study enhances understanding about the contribution of children’s nurses to caring for children within the Irish health care setting and as such makes a key contribution to making visible, the unique work of the Children’s nurse.
Title: Community Registered General Nurses: The ‘sandwich’ between the Health Care Assistant and Public Health Nurse-the filling, the dressing or the side dish?

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Background: The contribution of Registered General Nurses (RGN) in community practice in Ireland is not clearly understood. One of the fundamental requirements in achieving a health service with primary care as the central focus for the delivery of care is to reappraise and understand the involvement of nursing groups within the community.

Aim: To make visible the contribution of the RGN to patient care by identifying core elements of community nursing.

Methods: A questionnaire was distributed to the mailing list of the INO community-nursing database (n=430). The 107 nursing elements listed focused on patient problems, nursing interventions, outcomes of care and coordination of care. A qualitative open-ended section was included for respondents to add information on elements of community nursing that were excluded from the questionnaire. Data was analysed using both SPSS and NVivo.

Results: The response rate was 37% with representation from 22/26 counties in the Republic of Ireland. Four distinctive pictures emerged; (1) items that emerged as core elements of community RGN practice, (2) items that were strongly endorsed as core components of community nursing, (3) items that were rated most important and (4) items that lacked consensus agreement. The qualitative data identified items that had not been listed in the questionnaire i.e. elder abuse, isolation, loneliness and also highlighted items on questionnaire that were reinforced by respondents i.e. leg ulcers, difficulty communicating. Within the qualitative data were expressions of frustration within their present role; feeling disempowered, lacking autonomy, not utilizing skills
sufficiently and disappointment of having to work within such tight parameters.

**Conclusion:** A desire for recognition and for RGNs to be viewed as a substantial ‘filling’ not as a ‘side dish’ or a ‘dressing’ to other nursing groups is essential for the sustainable growth and development of community nursing in Ireland.
An evaluative study on the effectiveness of a Teaching and Assessing/ Preceptorship programme offered in the South West of Ireland by a Nurse Education Centre in partnership with a Third Level Institution.

**Presenters / Researchers:**

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**Background and Context:**
The allocation of student nurses to the clinical placement area is an integral part and a major component of the undergraduate Bachelor of Science Degree (BSc.) in nursing curriculum. While on placement each student is assigned a named preceptor. A preceptor is a registered nurse who has been prepared for their role by completing a Teaching, Assessing/ Preceptorship programmes.

**Aim of the Study:**
This research aims to evaluate the effectiveness of a locally facilitated Teaching and Assessing/ Preceptorship programme in preparing preceptors for their role and in achieving seven nationally designed expected learning outcomes.

**Methodology:**
A utilisation focussed evaluation approach was adopted. This approach values the opinions and experiences of stakeholders.

A sequential triangulation approach was implemented:
- Stage 1 examined the end of programme evaluations since September 2002 to develop themes.
- Stage 2 involved 3 focus group interviews purposefully selected, with all major stakeholders.
- Stage 3 formulation, distribution and analysis of questionnaire.
The questionnaire, following a pilot, was adapted and distributed to every student nurse on the undergraduate programme and to every preceptor who had completed the locally provided Teaching and Assessing / Preceptorship programme which is being evaluated.

**Analysis:**
Stage 1 analysis is qualitative and inductive. A thematic analysis approach was adopted. Focus groups were analysed utilising a thematic approach. Stage 3 questionnaires: descriptive and inferential analysis carried out using SPSS version 13.0.

**Summary of Key Findings:**
The preceptorship programme was viewed as beneficial for preceptors. Differences in judgements of the effectiveness of the outcomes are evident between preceptors and students.

**Conclusion:**
It is intended that findings will inform future changes in the current preceptorship programme being offered and to disseminate these within the nursing profession as the results may have wider application to other areas offering similar programmes.
Background: Sexuality is an integral part of the human experience and a basic right of all. In recent years, the emphasis on service users’ rights is forcing health care professionals to reconsider and reconstruct their views around the sexuality of people experiencing mental health problems. However, there is a lack of research in the area of practice. A possible reason for this may be a combination of a belief that this area of practice poses little or not difficulty to mental health/psychiatric nurses or a belief that people with a disability are asexual.

Design:
The focus of this paper is on presenting the findings of a Grounded Theory study that aimed to explore how psychiatric nurse respond to issues of sexuality in practice. Ethical approval was obtained from the Faculty of Health Sciences and the relevant health service provider.

Data collection and analysis: Using an unstructured interview, data were collected from 27 psychiatric nurses working in a mental health service in an urban area. The methodology that informed this study was Glaser’s approach to Grounded Theory.

Findings: The core category to emerge from the data was conceptualised as ‘Veiling Sexualities’. ‘Veiling Sexualities’ describes the participants’ accounts of how they responded to the sexuality dimension of clients’ lives, through their practice of psychiatric nursing. The participants’ main concerns about sexuality were related to their feelings of personal and professional vulnerability, due to a lack of competence, comfort and confidence in this area of
practice. The participants dealt with these feelings by a process conceptualised as 'Veiling Sexualities', which had three subcategories: 'Hanging the Veil', 'Lifting the Veil' and 'Re-veiling'. These formed a 'Veiling-Re-veiling Sexualities Cycle'. This cycle of action was influenced by a pattern of thinking that emerged through a process conceptualised as 'Weaving the Veil', and was maintained, subsequently, by a number of rationalisations, conceptualised as 'Mythical Self talk'. The focus of the presentation will be on presenting the theory.
An investigation into students’ performance of invasive and non-invasive procedures on each other in classroom settings.

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Classroom based clinical skills teaching within pre-registration nursing education has undergone resurgence in the last few years in the United Kingdom (UK). This is mainly due to widely held beliefs that pre-registration nursing programmes were not adequately providing students with training in fundamental clinical skills (UKCC,1999). In response Higher Education Institutions (HEIs) have been encouraged to place more emphasis on developing students’ practical skills in the classroom setting, to complement their placement experiences.

Whilst recent literature offers insight into the operational aspects of developing and running a clinical skills department in HEIs (Hilton & Pollard, 2004; Bradley & Postlethwaite, 2003), there is limited evidence regarding the types of procedures taught or the risks and benefits of students practising these procedures on each other (Reford & Klein,2003). This study therefore sought to identify the current status of peer practiced learning (PPL) in HEIs.

The aims of this study were; to ascertain the extent to which HEIs permitted students to practice invasive and non invasive skills on each other; identify whether consent was obtained prior to participation; and, to elicit alternative tools used for teaching and learning clinical skills.

A survey approach was adopted and questionnaires were sent to all Schools of Nursing in the UK (n=72). Ethical approval was acquired and principles of strict confidentiality were adhered to throughout. Both quantitative and qualitative data were obtained. Quantitative data were analysed using SPSS and qualitative data were systematically scrutinised for emerging themes.
The findings support the notion that PPL in the classroom setting is a desirable method of teaching and learning core clinical skills. However, notable inconsistencies in the range of procedures students are allowed to perform on each other were found. Further, the mechanisms of risk assessment and obtaining consent appear decidedly variable. This is arguably unacceptable in the current litigious climate and therefore warrants further exploration. This presentation will share the broad conclusions drawn from the study and offer recommendations.

References


Global Nursing Shortage: One Solution

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Abstract:

Background:
There is a current and emerging global shortage of nurses. In 2003, an estimated 126,000 Registered Nurse (RN) positions were unfilled in US hospitals. The Department of Health and Human Services projects that the shortage will more than double by 2010. Strategies are needed that will rapidly increase the supply of nurses. To that end, nursing programs need to increase student capacity and attract qualified students who have not traditionally been drawn to the profession.

Aim:
The purpose of this project is to provide an expedited method for graduating increased numbers of baccalaureate prepared nurses within the state of Indiana. The proposed project will facilitate that goal by enrolling students with a proven educational track record in an accelerated baccalaureate nursing program.

Methodology:
Beginning in January of 2005, market analysis and information gathering was begun to decide the feasibility of developing an accelerated second degree program in nursing at a Indiana Christian liberal arts university. Benchmarking was undertaken, budgets constructed, an evaluation plan created, and stakeholder buy in begun. Since that time, policies and procedures have been written, curriculum developed, and approvals sought.

Findings:
A number of schools are offering accelerated nursing programs for college graduates to become nurses. In 2005, approximately 169 accelerated programs existed. This growth in programs exceeds all other types of entry-level nursing programs at four year nursing schools. Benchmark data revealed that a pool of qualified applicants existed and budgets projected a profit in the first year of the program.
Summary:
Accelerated programs in nursing are viable and quality nurses can be graduated in shortened timeframes in order to help meet the nursing shortage. It is reasonable to conclude that like programs can be developed in other locations and thus address the global nursing shortage.
Evolution or Devolution – Nurses’ Performing Endoscopy

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(From a study for MScN entitled: Gastroenterology Nursing Practice in 2006: A Descriptive Study of Nursing and Medical Staff’s Views of the Advanced Nurse Practitioner Role In Gastroenterology Nursing)

Background:
The post of Advanced Nurse Practitioner (ANP) in Gastroenterology is currently under development at an Urban Teaching Hospital. In the United Kingdom this role is more commonly known as the “nurse endoscopist”. The researcher has been appointed to develop this role in accordance with best international practice and hospital needs. The American Society for Gastrointestinal Endoscopy recommends that nurses carry out only sigmoidoscopy and upper endoscopy on unsedated patients. In August 2005 the British Society for Gastroenterology relaxed their restrictions on nurses performing only upper endoscopy on unsedated patients. However the Society for Gastroenterology Nurses and Associates continue to recommend sigmoidoscopy only on unsedated patients. Notwithstanding these recommendations there are multiple reports in the literature of nurses performing colonoscopy, dilations and other advanced procedures on sedated patients and gaining comparable results to medical endoscopists.

Aim:
The aim of the study is to determine healthcare professional’s perceptions on the parameters of practice acceptable in the role of Advanced Nurse Practitioner in Gastroenterology in Ireland.

Methodology:
A quantitative descriptive approach was adopted in this study. A non-experimental quantitative descriptive survey design utilising a questionnaire was chosen.

A non-probability convenience sample of 101 nurses and doctors from six endoscopy units in an urban area was drawn from the defined population.

Analysis:
Data were analysed using SPSS, descriptive statistics and chi-square.

**Summary and findings:**
Although respondents reported good understanding of the role a significant majority requested more information suggesting some uncertainty on this point. It would appear that the majority of staff surveyed are supportive of a wide scope of practice for an ANP in the near future. However there is a core of resistance from junior doctors regarding procedures and prescribing issues contrasting sharply with senior doctors who were very supportive on these issues as were the vast majority of nurses. It is surprising that more nursing staff did not support independent practice by an ANP. Independent practice is a core feature of advanced nursing practice and the lack of support may indicate a failing to understanding the role. Change management emerged as a consideration in the development of this role. Excellent change management will determine the success or otherwise of the role. It is evident that staff surveyed, from all backgrounds, require more information and guidance.
Evaluation of the BSc (Hons) Nursing Clinical Assessment Documentation for the Effectiveness of Students Learning in Clinical Practice.

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Clinical learning and assessment of that learning are integral to the BSc (Hons) Nursing Programme. Named preceptors (registered nurses) are responsible for teaching and assessing students on practice placements. Clinical assessment documentation has been developed collaboratively with 6 Health Care Institutions in North Dublin to assist the student in maximising the integration of theory and practice and to assess the student competence while on practice placements.

This paper was part of a larger study. The aim of this study was to evaluate the clinical assessment documentation currently in use on the BSc (Hons) in Nursing, from a student’s perspective who is involved in completing the documentation. Questionnaires were administered to students (n=600) to evaluate the clinical assessment documentation. Data were analysed using descriptive statistics. The findings in relation to the evaluation of clinical assessment documentation within the BSc (Hons) programme will be presented. Some of the issues identified include whether students felt prepared for using the documentation prior to the placement, user friendliness of the assessment documentation, clarity of the guidelines for completing the assessment documentation for students and relevance of all elements of the assessment documentation to clinical practice.

Assessment is a crucial element of the learning process in nursing (Wallace 2003). The findings of the evaluation will influence the ongoing development of the clinical assessment documentation and will help lecturers and practitioners to meet the students’ needs by; upholding the knowledge that links education, research and clinical practice, promoting high quality learning for students and supporting and assisting students to develop their clinical competence.

Reference
Effectiveness of Approaches to Parenting Education Among Incarcerated Women

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Pregnant and parenting women in U.S. prisons represent a population at risk for ineffective and dysfunctional parenting. In spite of histories of substance abuse, chaotic lifestyle, loss of custody, and instances of neglect, most women desperately desire to maintain parenting roles during their incarceration, and look forward to reunification with their families. In many state penal institutions, parenting programs are offered in order to enhance the abilities of women to care for their children and to assist them in developing a positive self image. While parenting programs appear to have positive impact on women in prison, as measured by self reports of program satisfaction and knowledge of growth, development and positive parent-child interactions, the cost of such programs can often be a problem.

A pretest-posttest quasi-experimental design was used to determine the impact of parenting programs on incarcerated women. Women self selected into one of two parenting programs. One program was six weeks in length and was taught by a child psychologist. The other parenting program was 16 weeks in length and taught by vocational educational staff in the correctional institution. A volunteer group of women who did not attend any parenting group, but were on the waiting list for entry into a parenting class, was used as a control group. Data Collection strategies included the Parenting Stress Index, the Problem Solving Inventory, and focus groups. Quantitative data were analyzed using SPSS. Analysis of variance compared the scores on the Parenting Stress Index and the Problem Solving Inventory. Descriptive statistics were used to summarize demographic characteristics of the sample. Content analysis was used to extract and define the themes and issues emerging from the focus groups.
The results of this study indicate that the length of time in a parenting class and the type of instructor did not have an impact on the outcomes measured in this study. There were significant differences in perceived stress, problem solving ability, and expressed anxiety and anger related to separation from their children, among the women who did not participate in the parenting classes and those who did. Participation in parenting classes had a positive impact on the women in this study.
Parents' and nurses' attitudes to family centred care - an Irish perspective

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Abstract:

Aims and Objectives:
To examine the attitudes of parents and nurses to the model of care delivery on an in-patient children’s unit in a Regional General Hospital.

Background:
A review of the literature uncovered research studies relevant to the area under investigation, as well as many discussion articles.

Method:
This descriptive survey of parent and nurse’s attitudes regarding the implementation and practice of a partnership approach to care was undertaken on a children’s unit in an Irish regional general hospital. The survey consisted of a self-designed questionnaire, which was posted to the sample. The scoring system for the questionnaire format was analysed using Statistical Package for Social Sciences (SPSS 11.0). The sample consisted of parents (n=100) and nursing staff (n=44) from the children’s unit.

Results:
The findings did not suggest major differences between the attitudes of the two groups on the care delivery on the unit.

Conclusions:
Both groups agreed that there was a need for improvements of the facilities for resident parents on the unit.
Relevance to practice:

The findings of the research could act as a catalyst for change and the development of the service and service providers. It is hoped that it will also contribute to the improved satisfaction of the service provided to sick children and their families by parents and by the nurses who provide the care.

- Family Centred Care
- Partnership
- Empowerment
- Facilitation
- Parents
- Nurses
Do it MY Way! Midwifery Students Identify Characteristics and Practices of Ineffective Clinical Preceptors

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Background and Context: At the 2003, American College of Nurse-Midwives (ACNM) Student Meeting concerns were raised about the quality and behavior of clinical preceptors including the topic of “hazing” and negative preceptor behaviors that undermined student learning and self-esteem. Educators were disturbed by the report and asked that a survey be conducted to seek more information. Few studies in health related professions have specifically explored negative characteristics of clinical preceptors.

Aim of the Study: This study learned about the perceptions of midwifery students’ concerning negative clinical experiences and ineffective role modeling received from clinical preceptors.

Methodology: A qualitative descriptive study was conducted via a survey published on a URL website. A voluntary convenience sample of 145 students from midwifery schools in the United States met inclusion criteria of at least one semester of clinical and current enrollment. The responses to open-ended questions provided qualitative data and quasi-statistics about negative clinical preceptor behaviors or traits, student experiences, and clinical settings.

Analysis: Content analysis derived groupings and themes from the data through the open-ended questions. The responses were broken down, sorted, and organized into groups. Frequency counts of common phrases/themes were determined. The patterns of themes were established by relating the grouped data to each other. Quasi-statistics were generated to tabulate insights from the data. Descriptive statistics identified student and clinical setting characteristics.

Summary of Key Findings: Six major areas contributed to negative experiences with preceptors including; the number of preceptors encountered; preceptor teaching style; life stressors of
the preceptor; lack of preceptor knowledge; and a harsh clinical environment. The most difficult aspects of negative preceptors’ were the insistence for the students to “do it MY way”.

**Conclusions:** Without effective preceptors, much of midwifery’s accumulated knowledge will be lost. By identifying negative practices, improvements can be made to assist the preceptor and student in the process of learning. More research on, and interventions for negative practices are needed.
Cultural Competence and Cultural Desire: Intercultural Experiences of Nursing Students Make a Difference

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Nurse educators are challenged to provide experiences for nursing students so they will be competent to work with the growing diverse population. Globalization, cultural competence, and diversity are part of the nursing curriculum. Intercultural experience is a requirement in a private Christian liberal arts university. Nursing students are required to take Transcultural Nursing (2 credits) and a corresponding practicum (1 credit). This study examines cultural competence, intercultural experiences, and nursing students (pre-nursing and senior students).

Cultural competence of nursing students was the subject of a joint research project with a senior nursing student. 56 freshman pre-nursing students and 53 senior nursing students completed the Inventory for Assessing a Biblical Worldview of Cultural Competence Among Healthcare Professionals by J. Campinha-Bacote (2005). While the student’s research focus was cultural competence and the relationship of personal characteristics, the second focus of the research was the examination of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters.

The inventory measured the level of cultural competence and the following constructs: Biblical Cultural Awareness, Biblical Cultural Knowledge, Biblical Cultural Skill, Biblical Cultural Encounters, and Biblical Cultural Desire. Each construct was measured by designated questions within the 25-question inventory. Significant t-test scores between pre-nursing students and senior nursing students were reported for the constructs awareness (p=0.0046), knowledge (p=0.0041), and encounters (p=0.0041).

The relationship between the constructs and intercultural experience (within the United States) of students were significant for cultural knowledge (p=0.0010), and for intercultural experience (outside the United States) for cultural desire (p=0.016). Thus, it appears that
an intercultural experience of nursing students increases their cultural desire.

Reference

Campinha-Bacote, J 2005, A biblically based model of cultural competence in the delivery of healthcare services, Transcultural C.A.R.E., Cincinnati, Ohio, USA.
Women’s Experiences of Urodynamic Studies

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Background
Urodynamic studies (U.D.S.), involving catheterisation of the lower urinary tract, are required in investigations of patients with urinary incontinence or lower urinary tract symptoms (Ku, 2004). Gray, (2000) defines the term U.D.S. as a set of tests that measure bladder, urethral and pelvic floor muscle function. U.D.S. investigations are focused on the lower urinary tract to investigate bladder filling and voiding function, to define bladder storage disorders accurately and to assess objectively the severity of voiding dysfunction (Guo et al., 2004).

U.D.S., therefore, are an important preoperative requisite for many women who present with urinary incontinence; particularly those who have mixed stress and urge urinary incontinence, those with recurrent incontinence following previous surgery and those with evidence of neurological symptoms. (Chapple and MacDiarmid, 2000). Although generally well tolerated, some patients regard U.D.S. as an unpleasant and painful procedure (Ku, 2004). The investigation is however, potentially distressing and embarrassing for the patient (Shaw, 2000). There has been limited research and a lack of empirical studies on the topic of women’s experiences of U.D.S. in the medical, nursing or midwifery literature. Given the paucity of research on women’s experiences of U.D.S., both
internationally and in Ireland, it is clear that investigation on this topic is still emerging.

Aim of Study

- To explore women’s experiences of urodynamic studies.
- To describe women’s experiences of urodynamic studies.

Literature Review

Urodynamic studies are the most reliable & objective way of diagnosing the type of urinary incontinence and the underlying condition. (I.C.S., 1998). It is suggested that continence is a necessity for comfortable social adjustment and conversely, urinary incontinence frequently causes profound psychological and social consequences and restricts social activities (Wyman et al., 1990). Many women suffering from stress urinary incontinence (S.U.I.) after pregnancy and delivery refrain from seeking medical advice for various reasons, one of which is the fact that they believe that their situation is an inevitable part of normal ageing and consequently they believe nothing can be done about it (Peake et al., 1999). Less than half of the affected women with bothersome S.U.I. symptoms, that is, leakage on walking, coughing or sneezing, seek professional help with only 45% of women in U.S.A. consulting a physician regarding these symptoms (Hunskaar, et al., 2002). Incontinence has been associated with impaired quality of life, social isolation and depressive symptoms (Holroyd et al., 2004). According to Viktrup, (2001) pregnancy and delivery may cause urinary incontinence of varying degree. Vaginal delivery induces urinary incontinence, especially the first vaginal birth, as do large babies and difficult deliveries marked by lengthy pushing phases with or without instrumentation. (Chiarelli and Cockburn, 2002). Three studies were identified from the United Kingdom, two quantitative studies and one qualitative study and to date, very limited research has been identified on this topic in an Irish context highlighting the evident gap in existing knowledge.

Methodology

Descriptive qualitative methodology was the theoretical framework underpinning this study. The sampling method was a non-probability sampling strategy using purposive sampling. Data collection was by means of semi-structured interviews. The age profile of the women was from 25 – 64 years of age. Sample size was seven participants. Interviews took place in participants’ homes and venues convenient for the participants and lasted one hour.
Ethical Considerations
Ethical approval was obtained from the hospital’s ethics committee study site and Faculty of Health Sciences, Trinity College, Dublin. A research proposal and the research instrument, information leaflet and consent form for participants were submitted. Women gave written consent immediately prior to interview.

Data Analysis
Colaizzi’s (1978) Framework for Qualitative Data Analysis was used to analyse the collected data. It consists of a systematic framework of steps that provide guidance for researchers (Saunders, 2003). According to Colaizzi (1978), the seven-stage framework for analysing qualitative data is intended to be applied to interview transcripts or descriptions written by people who have experienced the phenomenon being studied. The goal of Colaizzi’s (1978) data analysis process is to find common patterns of experiences shared by participants (Polit et al., 2001). Data analysis began during data collection and consisted of transcribing verbatim each of the seven audio-tapes.

Discussion
The discussion focused mainly on five main themes; the role of the specialist midwife, attitudes towards urinary incontinence, experiences of U.D.S., women’s recommendation for care related to U.D.S. and perceived barriers to understanding urinary incontinence.

The role of the specialist midwife as perceived by the women centred around two fundamental areas, the role of professional support and the role of education. The interpersonal and communication skills of the professional were described by the women as being extremely helpful in reassuring them throughout the procedure.

Several participants described that as a result of attending for the U.D.S. test, they became aware of the number of women who suffered from urinary incontinence. Most of these expressed the fact that they had not realised the extent of the problem. This was a common theme in all of the interviews.

The experiences of urodynamic studies (U.D.S.) provoked both positive and negative feelings as described by the participants. Several women described the U.D.S. investigation as a positive experience while others recalled slightly negative emotions during it. The findings confirm Shaw’s study (2000) that U.D.S. is not normally painful. By the convincing and striking statement of the participants that U.D.S. is not painful, it further validates the role of
U.D.S. as an investigative study of the lower urinary tract. This is an important finding from an Irish perspective. The women’s acceptance of having U.D.S. performed was a notably dominant theme. Despite the fact of being apprehensive before the test, most of the participants were prepared to have it done. Several women described a raised awareness of bladder function as a consequence of attending the U.D.S. investigation. The experiences as described by the participants validate the role of U.D.S. as suggested by Chapple and MacDiarmid, (2000) that U.D.S. are an important requisite for many women who present with urinary incontinence. In addition, these findings are supported in a study by Gorton and Stanton, (1999) where awareness of bladder function was heightened as a result of the test.

Urodynamic studies were viewed by some women in a positive light and were seen as beneficial and effective towards their recovery. U.D.S. were considered to be part of a process towards becoming continent and regaining control of their lives. The findings validate Gorton and Stanton’s (1999) view that women in their study would be quite happy to have the test repeated and would endorse the test as guide for future diagnosis and management of urinary incontinence.

Finally, there appeared to be a diminished level of understanding of urinary incontinence by health care professionals and of the possible treatments available as expressed by the participants. In order to identify the problem of urinary incontinence, health care professionals need education and training to achieve this aim. This was a significant finding that emerged from this study. The importance of increased professional awareness in relation to understanding urinary incontinence was identified.

Recommendations for Professional Practice

- Health care professionals should have a thorough knowledge of continence promotion and continence awareness programmes.
- Identification of the condition of urinary incontinence, appropriate referral for urodynamic studies is necessary to investigate and confirm the diagnosis.
- Increasing the knowledge base of the general public by the professionals regarding continence promotion and prevention of incontinence at specific public information days.

Recommendations for Professional Education

- More midwives to become specialists in urodynamic studies which will assist in the diagnosis of urinary incontinence.
- Clinical midwife/nurse specialists should be enabled to develop their knowledge and expertise to a high academic standard,
and to look towards the future by becoming advanced practitioners

- The development of a recognised structure for advanced practice should enable expert midwives/nurses to advance practice in the interests of patients (Rolfe and Fulbrook, 1998)

**Conclusions**
This study provides innovative information concerning women’s experiences of U.D.S. from an Irish perspective. The role of the professional as perceived by the women centred around two fundamental areas, the role of professional support and the role of education. A recurring theme occurring throughout the study was that urinary incontinence is a hidden condition, which has the potential to lead to shame, despair and grief. Overall, the participants experienced no evidence of pain or ill effects with a notable lack of embarrassment from the U.D.S. investigation. U.D.S. was viewed as a positive step towards the participants’ recovery and as a baseline for future treatment with recommendations for increased professional awareness being made for the management of urinary incontinence.

**Acknowledgements**
- To the participants who took part in the research study.
- I wish to express my thanks to the management and administrative staff of the hospital for giving me the opportunity and supporting me in undertaking the MSc. Midwifery degree.
- Sincere thanks to all my medical colleagues, midwifery and nursing colleagues and line managers for their continued interest and support
- To my supervisor
- To the hospital’s librarian
Knowledge, Experience and Attitudes of nurses towards clients with Borderline Personality Disorder

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The aim of this research was to gauge the knowledge, experience and attitudes of Irish psychiatric nurses towards clients with a diagnosis of Borderline Personality Disorder. It also hoped to elicit the opinions of these nurses concerning the care and service delivered to these clients and how it might be improved. A quantitative survey was employed, using an adapted version of a previously tested questionnaire. All nurses working in a clinical role (n=157) within one psychiatric service in the Republic of Ireland were posted a copy of the questionnaire, of which 65 were returned yielding a response rate 41.4%. The results indicate that attitudes towards working with clients with Borderline Personality Disorder are positive, but practically all staff perceive them as a difficult client population to work with. Staff knowledge is reasonable but community staff appear to have higher knowledge levels than inpatient staff. The majority of respondents believe that the care currently delivered to these clients is inadequate for a variety of reasons and believe that agreed treatment protocols and the establishment of a specialist service for Borderline Personality Disorder are required in order to provide adequate care. The author discusses the findings and concludes that the health services need to rethink the care they offer to clients with Borderline Personality Disorder if best practice is to be achieved. Also, staff working with these clients require appropriate support, supervision and education.
STRESS IN A NURSING SAMPLE: PSYCHOLOGICAL AND HEALTH VARIABLES

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Objective: to explore stress and resilience (sense of coherence-SOC) in a sample of nurses working under pressure during a period of political violence and upheaval.

Sample: A sample of Nurses (n=127) from two hospitals in Johannesburg. Distinctions were made in terms of work load and responsibilities. The role of mediating variables such as perceived social support and positive work perceptions were explored.

Measures: These included Nursing Stress Scale (Grey-Toft & Anderson, 1081),Profile of Mood States (shortened version by Shacham, 1983) Index of Well-Being (Campbell, Converse and Rodgers, 1976), General Health Questionnaire-28 (GHQ-28, Goldberg& Williams, 1988) and the Orientation to life Questionnaire-Sense of Coherence (OLQ-13,Antonovsky,1987).

Results: The most significant contributor to overall stress was workload (NSS). This variable was strongly associated (p<001) with anxiety and insomnia (GHQ-28). OLQ-13 measures were positively related to general well-being (IWB) (p<.0001) but negatively correlated with depression (GHQ-28,p<0001). Multiple regression analyses showed that depression accounted for 26% of the variance. High scores on the OLQ-13 showed lower levels of depression and mood.

Conclusions: The study linked psychological variables to Sense of Coherence which is essentially a health variable. The results show
that depression is a significant predictor of health status (SOC). Individuals with higher SOC scores also show greater psychological well-being, lower tension and overall less stress (NSS) albeit in troubled and uncertain times. Antonovsky’s suggestion regarding general resistance resources (GRR) such as social support (a supportive partner/husband) was not significant. However work support (NSS) was confirmed as a significant GRR.
Nursing, technology and ethics: opportunities for transformation of neonatal intensive care

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Background and context
In 2004, a school of nursing and health studies introduced a five-year program to embed values in education, research, and service. This program responds to a concern that, with increasingly diverse populations, there may be a belief that it is difficult to discern and instill in nursing education and practice values that are both reflective of this diversity and that are generally applicable. It was also seen as fundamental that nursing research have a values-based foundation, and that institutional practices be reflective of these values.

Aim of the study
The aim of the study is to determine mid-term progress of the initiative toward the goal of embedding values in the school’s educational, research and service activities.

Methodology including research design and sampling
The qualitative methods include: interviews with all department chairs, a 20% sample of fulltime and five part-time faculty, 10 undergraduate and graduate students, and 5 administrative staff; review of syllabi for all nursing courses; and observation of 3-5 faculty meetings. The focus of the interviews is on respondent perceptions of the utility of the values-based initiative, its impact on their particular role (e.g., nursing education), and its likely longer-term impact on nursing practice and research.

Analysis
Atlis.ti will be used to analysis the qualitative data.

Summary of key findings
The initiative has thusfar devised a core set of values that have been agreed-upon by the faculty through a participatory process,
reviewed curricula to determine the degree to which these values are embedded, and initiated a process of assessing research and service activities against these core values. The interviews will be completed by August 31, and data analysed by September 30.

**Conclusions**

The values-based initiative has already had impact on the engagement of faculty and staff in the process of determining shared values – itself positive in terms of identifying shared concepts of common good and other values, and their implications for nursing practice.
Pathways to success: The role of language in supporting the academic development of nurses from overseas entering higher education in the UK

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**Abstract:**  
Qualified nurses from overseas wishing to progress their careers in the UK through the Higher Education route need to be UK-registered nurses (NMC 2005 regulations) and to have gained a language qualification equivalent to at least 6.5 IELTS. However, when entering a UK university diploma/degree programme in Nursing Studies they may need to make significant cultural adjustments and deal with the high demands of a complex field of study in addition to coping with having English as a second or third language.

This paper reports on a qualitative investigation into language development within a preparatory 3-month overseas nurses programme (ONP). The programme prepares the students for NMC registration and enables them to embark on diploma/degree study as a part of their continuing professional development. It begins with a 3-day component on language-related issues within nursing studies, particularly concerning written assignments. The content is based on a view of language as an essential tool for learning and for communicating meaning, according to two complementary, theoretical perspectives: socio-cultural theory and systemic functional linguistics (SFL).

The aim of this research is to evaluate the effectiveness of the 3-day language-based component by examining the students’ progress in their English use over the 3-month programme. Five sets of data are being collected.
1 and 2: a set of student essays, at the beginning and end of the ONP, for SFL text analysis and comparison;
3 and 4: student questionnaire responses, also at the beginning and end of the ONP, for comparison using socio-cultural methods and to synthesise with the analysed data from the written work;
5: semi-structured recorded one-to-one interviews with the same students, at then end of the ONP to add to the synthesis drawn from the other data.
The findings are discussed in terms of their implications for helping overseas nurses prepare for UK study.

Subject area of presentation: (1) Education, (2) Clinical Education, (3) Communication in Healthcare

Abbreviations:
IELTS = International English Language Testing Service
NMC = Nursing and Midwifery Council
ONP = Overseas Nurses Programme
SFL = Systemic Functional Linguistics
Statements about Patient Care at Handover: A Quantitative Analysis

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Abstract

Statements about patient care at handover: a quantitative analysis using a case study design

Background
The nursing handover of information about patients is an everyday occurrence on all wards at least twice daily in some format or other. The content of that report should be concise, relevant and enabling continuity of care

The rationale for this study was to gain an understanding of handover statements and to quantify the care statements. The hypothesis was that communications between nurses at shift handover transmit nursing care intervention and care instructions.

Method
This was a quantitative study. Taped handover reports on two surgical wards with different specialities were used for this pilot study. On both wards 4 handover reports [comprising data on 100 patients were audio taped. Analyses involved categorizing the data to specific nursing care, medical care or ‘other’ statements, utilising Georgopoulos and Sana’s (1971) categorisation tool.
The Central Office for Research Ethics Committee, the university and the Hospital Trust Ethics Committees approved the research. All involved with the study were fully informed and consented to the handover being taped, with confidentiality and anonymity being maintained at all times.
Results
The findings show that the nursing and medical care categories are used and reported upon but not for all patients. The reports contained more medical orientated care statements than nursing statements. There appeared to be no consensus on the wards re the use of statements for transmitting nursing care. The reports were delivered at high speed and contained many abbreviations and jargon requiring socialization and previous knowledge to interpret the report.

Conclusion
Handover is a complex phenomenon with many different facets that is dominated by medical care statements.

When using taped handovers, training needs to be given to staff so that normal voice speed is used. The tape recording machine must be correctly set before the reporter commences otherwise data is lost.

Handovers require good communication for accurate interpretation of the care statements by all nurses, but especially student nurses. There needs to be an educational focus so that students can interpret care statements and understand care interventions. Taped handovers may therefore lose more than is gained. The hypothesis that communication between nurses at shift handover transmits nursing care interventions was not supported. Care statements were not transmitted with sufficient clarity of purpose.

Key words
Shift handover, nurse-to-nurse reporting, intershift report, ward handover, and nurse communication
The application of antenatal perineal massage. A review of literature to determine instruction, technique and dosage.

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Aim of review
To determine the instruction, technique and dosage described for antenatal perineal massage in research trials.

Search and review methodology
Using Ovid Online a search of relevant databases for English language articles was performed. The databases searched were British Nursing Index, Ovid Medline, CINAHL, EMBASE and AMED. Primary research articles that used antenatal perineal massage as an intervention were included.
Summary of key findings

Large randomised-controlled trials have identified antenatal perineal massage (APM) can reduce rates of perineal tears during childbirth.

Pamphlets, face to face education (with and without models) and in some cases a training video were used to educate women. The recommended APM techniques are described as stretching or stretching and rubbing techniques of the perineal tissues, using digits. It is a simple technique, mostly self-applied, but it would seem the effectiveness of instruction is rarely checked i.e. review of technique or direct observation of technique. Also there are often no strategies described for facilitating adherence apart from record keeping in the form of a diary or infrequent telephone calls. APM appears to have been considered as a sole approach to preserving perineal tissue structure and function, and no research has considered enhancing its effect by combination with other approaches during pregnancy, other than education.

Generally APM is applied after the 34th week of pregnancy after education from a midwife. The duration of each repetition varies (1-2 minutes) and commonly the overall application was 10 minutes. There is variance in the literature as to the frequency required from daily to 3-4 times weekly.

Conclusions

Antenatal perineal massage techniques are presented as simple digital techniques. However strategies for promoting adherence or for checking that the technique is performed correctly appear to be lacking.
'Conflict and Ambiguity’ in the practice of Restraint in Mental Health of Older people: “it’s hard to find a happy medium”

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Abstract

Aim: To explore the culture of nursing practice, through the nurses’ understanding and explanation of their role in search for shared meaning and beliefs behind their practice in relation to the use of physical/mechanical or chemical restraint in the field of mental health of older people.

Design: A qualitative particularistic ethnographic / ethnonursing method was employed to explore the culture of nursing practice. This was to establish the nurses understanding of the meaning of ‘Restraint’. To examine the reasons they attribute to the use of restraint. To explore the nurses feelings and beliefs in relation to the use of restraint. Also to examine the nurses knowledge and institutional position on the use of restraint.

Setting: The study was undertaken in two hospital units one of which was Psychiatry of Old Age (acute care) and the other was Continuing Care of Older People with Enduring Mental Illness. I currently work in the service, were I conducted this study.
**Data Analysis:** Data collection occurred through semi-structured interviews conducted with eight participants and participatory observation conducted by myself as I had the ability to conduct this observation through my everyday practice within the field. Data analysis was conducted utilizing a qualitative ethnonursing data-analysis method as devised by Madeleine Leininger (1985).

**Findings:** Four major themes emerged from the data: 1) "controlling", "containing", "preventing"; 2) ‘Protection versus Restraint’; 3) “but I see how necessary it is”; 4) “what do we do, What do we do”. This lead to the construal of my central theme ‘Conflict and Ambiguity’ that nurses are faced with in their day to day practice in relation to restraint.

**Conclusions:** Until we resolve the conflict and ambiguity that exists in relation to restraint there is the risk that other procedures to reduce the use of restraint in practice may be short lived or ultimately unsuccessful.
TITLE: Da. DA! DA! Would you listen to me?

Subtitle:

Enhancing Service User Involvement in the ASPR* Process – A critical exploration of the Republic of Ireland’s Disability Act 2005

* The ‘Assessment of need, service statements, service provision and redress’ (Assess, State, Provide and Redress: ASPR) process / approach, Part 2, Sections 7 – 23 of the Disability Act (TO/TAO, 2005) aims to provide an effective process for targeting unmet health and education needs of individuals with intellectual, as well as other, disabilities and ensure public services to meet those needs.

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BACKGROUND:

On 8th July 2005 the framework for a potentially huge cultural shift in the way the needs of people with intellectual disabilities, and other disabilities, are assessed and delivered became the 14th act of legislation from the Houses of the Oireachtas / Tithe An Oireachtais for that year. The Republic of Ireland is still in the infant stages of these changes and their full potential is a long way from being realised. The cause of this ‘positive revolution’ is the Disability Act (TO/TAO, 2005). In spite of heated opposition from many professionals, voluntary agencies and individuals with disabilities over concerns about the robustness of the Disability Bills (TO/TAO, 2001 & 2004) (e.g. Finlay, 2005) and questions over the extent to which it can be said to be ‘rights-based’, following a number of amendments, it is now established on the Irish statute books and is expected to bring changes to intellectual disability service delivery and the quality of life of people with intellectual disabilities. The extent to which people with intellectual disabilities can actively participate in care processes as a result of the Disability Act
AIM:

To critically explore potential ways and means of enhancing active participation by people with Intellectual Disabilities in the implementation of the ‘ASPR’ process of the Republic of Ireland Irish Disability Act (TO / TA), 2005).

OBJECTIVES:

Increase awareness of and generate critical debate on the Disability Act (TO / TA), 2005), in particular the ASPR process and how people with intellectual disabilities may be facilitated in using it most effectively.

The poster does not proclaim to exhaust all issues, but instead sets out to offer ideas and approaches which may generate debate and in turn lead to best practice in care.

METHOD:

The author utilizes Gilbert & Rose (1998) six key headings ‘for ensuring user involvement’ to critically analyse the potential for service user participation in the Disability Act ‘ASPR’ process (TO/TAO 2005).

POSTER CONTENT:

In this presentation the author applies Gilbert & Rose (1998) six headings for ensuring user involvement to analyse the Disability Act (DA) (TO/TAO 2005).

FINDINGS AND DISCUSSION

1. Ensure Assessment Officers (AO) and Providers know and understand the needs of people with intellectual and other disabilities.

This may seem an obvious statement that need not be stated, however, research suggests otherwise. For instance, Lennox et al (1997) found that primary care physicians listed lack of knowledge of conditions and illnesses specific to Intellectual Disability as
among the top five barriers to care. Further more, Greenhalgh (1994 p. 6) found that strategies for health promotion and education were designed for the general population with little account taken of people with additional needs, such as people with disabilities. She stated that ‘the interrelated problems of difficulty in diagnosis, incorrect attitudes and low expectations have contributed to a situation which is little short of scandalous’.

While acknowledging AO’s have expertise, no one AO is likely to have an in-depth understanding of the wide range of disabilities and their individual manifestations, or the full range of expertise and services available. Providers may have responsibility for providing services for people with intellectual and other disabilities across a range of statutory and non-statutory providers and disciplines. The ASPR process needs to inform and encourage providers to understand the distinct care and support needs of people with intellectual disabilities. This may be achieved through detailed and accessible service statements.

2. Make information accessible

Service Statements may appear too lengthy and laborious for some people to read because of the format they are presented in or the language that is used. One only has to look at some individual ‘person-centred’ education or health care plans to see how excluded people can be from easily understanding them. This is particularly so for people with intellectual, and other disabilities and yet they are the people to whom the service statements are for. This issue is clearly acknowledged in Part 3 Section 2, Subsection 3- Access to information of the Disability Act (TO/TAO, 2005) and is the only time that the label ‘intellectual disabilities’ is explicitly used. The section requires the head of a public body to ensure, as far as practicable, that information published by the body, which contains information relevant to persons with intellectual disabilities, is in clear language that is easily understood by those persons. This came into affect six months after the Act became law on the last day of 2005. However, anecdotal evidence suggests that almost one year afterwards limited progress has been made.

According to Moffat (1996), the use of pictures, symbols, signs and tapes can easily be incorporated into a statement; making it more accessible to the people it is about. Exemplars of the use of these mediums are highlighted in Keenan (2006a & b) and may be seen in Hollins & Wilson (2004) & Keenan (2006c).
3. Processes that enable the needs and wishes of service users to be incorporated in the service statement.

This may be achieved partly by the individual service statements. If the statements are based on, for example, the aims of the NSDS (See Box 1) the focus for standards to be achieved will be on the outcomes for the individual and the quality of the service is measured by how frequently these outcomes are achieved and to what standard.

4. Mechanism by which users can understand and participate in monitoring service provision.

According to Gilbert and Rose (1998) service users are rarely consulted in regards to monitoring. However, the NDA are to be commended for recommending that independent monitoring teams for evaluating health care service standards should include people with intellectual and other disabilities (NDA, 2006). While the NSDS has yet to be rejected, amended or fully approved by the minister for Health and Children some service providers are utilising them to measure quality and performance within their own organisation. Anecdotal evidence suggests that service user involvement in the monitoring and evaluating processes, while patchy, is on the increase in the field of Intellectual Disabilities.

5. Clear and explicit process through which users can give feedback and make complaints

According to Gilbert and Rose (1998), the views of service users need not only to be heard but to be sought. People with intellectual disabilities and their cares are known to be generally passive recipients of services and are reluctant to criticize the service they receive for fear of their provision being affected.

The ASPR approach offers applicants a redress process. How accessible the redress system will be in terms of being easily understood and readily available it is too early to say. Until clear detailed guidelines are provided and the complaints system is utilised and evaluated over time we will not have a clear view of its effectiveness. However, the opportunities do exist to seek feedback at each stage of the ASPR approach and if these are nurtured by professionals, cares and significant others then the potential for quality feedback and improvements to processes are enormous.
Box 1. Aims of the National Disability Authority’s National Standards for Disability Services.

The aims of the first ever National Standards for Disability Services are to ensure:

- That the safety, dignity, independence and well being of service users are protected and promoted,
- That person-centred service provision is established and nurtured in these services, and
- That all services are provided to an agreed level of quality and performance and that the level of quality is consistent on a national basis.

(NDA, 2006)

6. Opportunity for involvement of an advocate

Within the redress component of ASPR (TO/TAO, 2005) service users are able to participate fully in the redress process. Service users also have the opportunity to have an advocate to act purely in the interests of their needs when making a complaint.

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Issues in children’s nursing - Fathers of chronically ill children and their interaction with the Irish healthcare system.

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Background and context
To explore the lived experience of fathers of chronically ill children

Aim of the study
To explore in detail fathers’ experiences of dealing with the healthcare system.

Methodology including research design and sampling
A Heideggerian approach within a phenomenological methodology was chosen. A convenience sample of five fathers whose children have chronic epilepsy was selected. Data was collected using five unstructured interviews in which participants described their experiences of caring for their chronically ill child.

Analysis
Thematic data analysis using the constant comparative method within a phenomenological interpretative perspective assisted by Atlas ti a computer software data analysis package was undertaken.

Summary of Key findings
- A fragmented approach was experienced when dealing with the healthcare system.
- The delivery and context of information expressed particularly at the stage of diagnosis was significant.
- The development of short and long term goals in the delivery of care for their child was essential.
- Information gathering was utilized as a coping mechanism.
- The recognition of the father as an equal partner was crucial.
- The role that voluntary organizations played was valued.
- Hope founded on realism was desired.
Conclusions
Interaction with the healthcare system is an important contributing factor to the experience of being a father of a child with a chronic illness. The communication of the initial diagnosis is significant and sets the scene for later interaction with the healthcare system. Measures that demonstrably increase fathers’ ability to cope with their child’s illness were well received. Conversely, the negative aspects related to limited information, the lack of timely assistance, and a failure to reach out towards fathers in their time of need. The importance of good on-going communication was identified as being critical. A continuous assessment process to assist parents’ to meet the needs of their child should include a strand specifically addressed to fathers.
Title: Strengthening the Capacity of Family Nurse Practitioners (FNPs) and Nurse Midwives to Serve Diverse, Vulnerable Populations

Presenters: Jean Kelley, PhD, APRN, BC (FNP) and Irene Jillson, PhD
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Background and Context:
With ethnic diversity increasing significantly in the United States and European countries, training practicing nurses and nursing faculty to serve ethnically diverse populations is critical, as is the need to increase the pool of ethnically diverse students. Over a period of five years the FNP and midwifery faculty implemented a curriculum to prepare culturally competent graduates to meet the primary health care needs of ethnically diverse populations. Students participated in an enhanced academic curriculum that included specific content and experiences/activities related to mastering awareness, knowledge, skills, and values in cultural competence. The program had linkages with a local school and primary care facility serving primarily low-income ethnically diverse populations.

Aim of the Study:
To determine the impact of an enhanced academic program on the graduate’s service to ethnically diverse, low-income populations.

Methodology Including Research Design and Sampling:
The study includes a mailed survey of a 100% sample of program graduates and in-depth interviews with 10 graduates. In the mailed survey, graduates were asked about their practice setting, professional development, and satisfaction with the program in preparing them in areas such as providing culturally competent care, collaboration and resolving ethical conflicts in practice. In the in-depth interviews, students are asked to provide narrative discussion about service to ethnically diverse populations.

Summary of Key Findings:
Preliminary findings available from the survey find that: 80% of the respondents work with vulnerable populations and believe that the program prepared them to so relative to the 12 practice areas included in the survey. Half have been involved in civic engagement and one-third has been involved in research studies.
Conclusions:
The study demonstrates the importance of training nurses specifically to address the needs of ethnically diverse populations and of engaging in partnerships with relevant organizations to do so.
Title of Abstract:
Slow codes: perspectives of nurses and doctors

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Background
Slow codes are cardiopulmonary resuscitative efforts intentionally conducted too slowly for resuscitation to occur. While some authors argue that a slow code is a nonmaleficent and beneficent act towards the hopelessly ill patient, others believe that this practice is harmful and deceptive, that it disregards patient and surrogate autonomy and deprives the patient of a peaceful death.

Aim
The aim of this research study was to ascertain nurses’ and doctors’ perspectives on the practice of slow codes to understand why they take place despite the availability of do-not-resuscitate orders.

Methods
A Heidiggerian phenomenological study, using unstructured interviews with a sample of 3 nurses and 2 doctors was carried out in an acute hospital in Ireland in 2005 to examine the experiences of nurses and doctors practicing a slow code. Data analysis involved the use of Colazzi’s (1978) reductive procedure.

Findings
Health care professionals believed that slow codes were intended as beneficent acts towards the irreversibly ill patient. However, participants indicated that slow codes were undignified and pointless when intrusive measures were used.

Conclusions
This study concluded that clinical guidelines regarding CPR need to be devised for use in Ireland to prevent slow codes. Legislative clarity needs to be addressed, possibly, in the form of advance medical directives, to assist practitioners in decision-making regarding CPR. Training for health care professionals in sensitive communication skills with patients and families and the provision of an explanatory leaflet regarding CPR for patients and families is also recommended.
Full title of paper:
Choice and Decision Making for Adults with a Moderate Intellectual Disability – the impact of person-centred planning

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Abstract
A comprehensive review of the literature pertaining to the concept of choice and decision making reveals that people with intellectual disability (ID) are restricted in terms of the opportunities they have to exercise choice. A number of factors both personal and environmental have been found to be associated with increased choice. Recent government publications both in Ireland and the UK have advocated for greater involvement of the individual in choices which affect their life and to that end person-centred planning (PCP) has been widely endorsed (National Disability Authority & Department of Health & Children, 2004 & Department of Health, UK, 2001). However, there is little in terms of a sound evidence base to suggest that PCP actually increases opportunities to exercise choice. Therefore, this study sought to address this gap in the literature by investigating the impact of a person-centred approach on the perceived opportunities for adults with a moderate intellectual disability (ID) to exercise choice. A comparative survey design was utilized to measure choice availability within two similar service sites under the remit of a single care provider in the Irish republic. One site has a system of planning called person-centred planning in place and the other uses a more traditional approach. A convenience sample of 10 subjects were chosen in each service site (n=20). Choice availability was measured using The Choice Questionnaire, (Stancliffe & Parmenter, 1999) which has demonstrated good psychometric properties. Results indicated that
adults with a moderate intellectual disability have few opportunities to exercise choice. No significant findings were reported when summative scores for the Choice Questionnaire were compared across sites. However, trends were observed whereby those in the PCP site consistently reported greater choice availability than those in the comparable site. The researcher acknowledges the limitations posed by the poor sample size and thus recommends that a larger study be conducted to investigate these trends further. Comparison of summative scores for the Choice Questionnaire for the sub-groups within sites highlighted that those who live at home have greater opportunities to exercise choice when compared with those who live in staffed hostels irrespective of approach to planning.

References:


Representing Professional Practice: What do Electronic Nursing Classification Systems Really Say about Nursing?

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Advocacy for electronic classification systems has accelerated in the face of complex challenges to nursing, such as the absence of nursing data from patient care summaries and national data repositories. Accurate representation of nurses’ contributions to health outcomes impacts fiscal management, health care planning, policy development, workforce recruitment and retention, and nursing participation in decision making. As electronic health records are progressively implemented, the actual content and nature of nursing data contained in electronic classification systems becomes increasingly important, both politically and culturally. The aims of this study included challenging positivist assumptions regarding the role of technological applications, and exploring the impact of using standardized languages as representational tools.

Agger’s (1992) work in cultural studies as critical theory provided both the theoretical and methodological framework for this mixed method research. Data sources included 1) a structural analysis of a selected classification tool; 2) nursing narratives in 100 patient records originating in four practice settings: i) acute medical-surgical care; ii) inpatient mental health; iii) home care; and iv) long term/aged care; 3) the results of coding nurses’ narratives according to the International Classification for Nursing Practice (ICNP®); and 4) focus group interviews with registered nurses from participant institutions.

Analysis of the classification performance indicated that the ICNP® captured most nursing tasks with considerable accuracy, but concurrently revealed that nurses’ records are fragmented, and vary substantially between practice areas in terms of comprehensiveness. Key results included the position of the nurse as both a text and context of nursing, the potential of classification systems to commodify nursing consequent to deconstructivist representation, and how electronic classification systems discipline nursing to conform to a standardized approach to documenting care. This research recommends that nurses recognize their role as active partners in determining how nursing should be represented and how nurses document their professional practices.
Looking Beyond “Culture” in Health Care: Identifying a Culture Industry

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The health care system is progressively dependent upon technology for health information management, clinical decision support systems, health research, and health education. Both practitioners and health care consumers are increasingly desensitized to the hegemony and ideological messages embedded both in the structures and products of health care, and within the system itself. Further, many practitioners face working conditions so demanding that the time and perspective necessary for active participation in critical analyses of the health care system are largely impossible.

This research employed a critical reflexive cultural studies approach to examine electronic health information management as a culture industry. Agger’s (1992) work on cultural studies was used to position health records as cultural artifacts and to explore the extent to which health information management, functioning as a culture industry, positions and protects its hegemony through features such as sign value, academic disciplining, and creating false needs.

This presentation details the application of a critical reflexive cultural studies approach to bring forward written health records as cultural texts and to enable a decentering discourse to consider the ideology embedded in a progressively technological health care system. In this research, electronic health information management as the quotidien, or the everyday accepted ‘norm’ in health care, was challenged within the context of prevailing positivism in health information management. Further, this approach facilitated a critical dialogue about the written health record as a political force, as a representation of popular health care culture, and as reflections of the literary lives of health care practitioners.

The potential for critical reflexive cultural studies, as a recommended research methodology, to contribute to repositioning health information management is explored. The value of this approach to healthcare research is further presented in terms of
political, human resource management, and fiscal implications to healthcare professionals and the health care system.
Ethical Considerations when Conducting Research with Vulnerable Populations with Mental Health Problems – Lessons Learned

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**Abstract:**

**Aim:**
The aim of this presentation is to explore the ethical dilemmas confronted by two researchers who are in the process of conducting research with people with mental health problems.

**Methodology:**
With reference to the ethical principles underpinning the conduct of research, a review of the literature was conducted using the following databases: CINAHL, PUBMED, PsychLit and IngentaConnect. Keywords used to locate pertinent literature included: research, mental health, ethics, consent, vulnerable populations and various combinations of these. This strategy identified a wide range of original research, review and opinion papers representing a varied geographic spread. A paucity of Irish research was found consequently strengthening the need for the current review. The literature reviewed was then considered in light of the researchers experiences and current research projects to formulate this presentation.

**Summary of key findings:**
Conducting research with vulnerable populations, notably those with mental health problems is fraught with ethical dilemmas e.g. gaining ethical approval, access to samples, issues concerning capacity and informed consent. A review of the literature highlights that these dilemmas often present researchers with practical impediments to the completion of research, which results in a tendency to omit service users from the research process. However, there is a growing recognition of the need to include persons with mental health problems, as they are the persons with first hand experience and are therefore in a pivotal position to inform understanding.
**Conclusion:**
It could be suggested that in order to enhance service provision and our understanding of mental health problems, it is necessary to locate the voice of all those affected. However, conducting research with vulnerable populations is difficult. This paper will discuss the experience of two researchers and offers a critical consideration of these experiences in the light of available literature.
Title: Reality Shock: Challenges facing Mental Health Mature Nursing Students

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Background and context
Research that only utilises mental health nursing students is rare. Mental Health Nursing has traditionally attracted a high level of mature applicants and this trend has not altered since the introduction of the Bachelor in Science in Nursing programme. Mature students have diverse portfolios of educational and occupational experience and are an important asset in nursing today. For many mature students, entering into nurse education is seen as ‘fulfilling a lifelong ambition’ in reality they face many challenges not always shared by their younger classmates.

Methodology including research design and sampling: A qualitative descriptive method was utilised to guide the research with focus groups being the method of data collection. Purposive sampling was used to recruit the participants. Current mental health mature nursing students in one urban university were invited to participate.

Analysis of the data: Qualitative data was analysed using content analysis.

Summary of key findings: Findings revealed that the academic realities were largely unanticipated and generally more demanding than students had imagined. The competing academic and practice demands impacted profoundly on their personal lives. Entering nurse education represented a significant change for these students and many had given up secure employment to return to full time education. Students regarded this as their last opportunity to fulfil
their life long ambition which added to their motivation to succeed but also fuelled their fear of failure.

**Conclusion:** The findings of this research highlights that although mature students are committed to their learning, they are faced with a multitude of barriers that traditional students do not have to contend with. These findings have the potential to inform the future development of Bachelor in Science (Nursing) programmes in order to facilitate the participation of mature mental health students.
REGISTERED NURSES’ EXPERIENCES OF CLINICAL SUPERVISION

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Abstract
Title: Registered Nurses’ Experiences of Clinical Supervision.
Background and context: Formal systems of clinical supervision have not been implemented in the Republic of Ireland. There is a growing awareness of their effectiveness in enhancing analytic skills and in helping to retain staff in clinical practice. Clinical supervision was incorporated in the MSc/Graduate Diploma Programme in Renal and Urological Nursing to help to enhance personal and professional development for students.
Aim of the study: To elicit clinical supervisors’ and supervisees’ experiences of Clinical Supervision while undertaking the course in Renal and Urological Nursing.
Methodology: A qualitative descriptive research design was used in this study. A purposive sample of 10 registered nurses participated in the study, five were clinical supervisors and the other five were supervisees. Data were collected by semi-structured interviews. Each interview was of 45 minutes duration and was undertaken by the researcher in the Centre of Nurse Education.
Analysis: Data were analysed by content analysis.
Summary of key findings: Following data analysis six major categories emerged from the data. These categories emphasised positive aspects of clinical supervision, negative aspects of clinical supervision, factors which impacted on the process, support, formal systems of clinical supervision, reflective practice in groups.
Conclusions: There was a general feeling the clinical supervision was a good experience for many members of this study group. However the concept of clinical supervision was perceived as inappropriate to encompass the complex nature of the clinical supervision sessions. This begs the question is clinical supervision a practice with no name or should it be called something else? Naming a practice appropriately may encourage practitioners to implement the practice. The findings of this study has implications for management and for the clinical environment in terms of supporting practitioners to develop analytic skills and in helping them to make sense of the concept of clinical supervision in their clinical setting.
Accountability – what do we mean?
Nurses’ perceptions of professional accountability

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A pilot study set out to explore nurses’ perceptions of professional accountability. There is considerable literature on accountability but little to note of nurses own understanding of this multifaceted abstract concept from their day-to-day experience. Much is written to explain its requirements and to provide definition; a concept that is integral to professional practice although appears infamously when things go wrong in health care. The aim of the study was to garner an understanding of how nurses perceive professional accountability in their everyday interactions and interventions and to go on to generate a theory from nurses’ perceptions through their discourses.

As befits a subject where little is known an exploration of the meanings and social construction of the concept by nurses, from their day-to-day experience, was planned. Method was guided by symbolic interaction theory, Gadamerian Hermeneutics and grounded theory methods; a slurring of methods which accommodates the researcher's ontology and the research subject.

Five nurses attending generic further professional development education at university were individually interviewed. The recorded conversations were transcribed and analysed following a constant comparative process. Scrutiny of data was a search for possible emergence of initial codes and categories. Data collection and analysis goes on with questions of the data and to look for comparisons, differences and diversity as the research continues.

One initial phenomenon has emerged where the individual freedom to nurse accountably was seen to be expanding but then also perceived to be constrained; tentative categories of ‘responsibility and rights’, ‘relationships’, ‘knowledge and autonomy’, and ‘values like goodness, trust, honesty and justice’ have been found. These were seen to be interconnected and interdependent. At this early stage the emerging hypothesis and its related categories have been considered with caution.
Continuing professional development: exploring the influence of enquiry based learning on clinical nursing practice

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Abstract

The purpose of this study was to explore whether qualified nurses who had undertaken a continuing professional development module which utilised enquiry based learning as the educational strategy, believed that their nursing practice had been influenced by this educational approach. The literature indicates that nurses can make a vital contribution to health care by being flexible and innovative practitioners able to adapt to new demands by engaging in a process of life-long learning. The literature reviewed has identified that the design of continuing educational programmes are influential in the evolution of such a practitioner. Enquiry or problem based learning has been proposed as an effective adult style of learning, promoting the development of self-directed, reflective, change management and problem solving skills. Exploring continuing professional education’s influence on practice and patient care is a key factor in monitoring and evaluating CPE initiatives.

This study is underpinned by the assumptions of Gadamerian hermeneutic phenomenology, which is believed to reside within a social constructivist paradigm of inquiry. Semi-structured interviews were conducted with eight nurses who had undertaken a continuing education module underpinned by the enquiry based learning approach.

The responses in this study indicate that participants believe that their practice of nursing has been positively influenced by engaging in enquiry based learning. It was believed that practice was influenced by becoming self-directed critical reflective practitioners, with evidence based practice held up as the benchmark of good
practice. Self reports of practice change attributed to engaging in EBL were provided, with the patient identified as the principal beneficiary, echoing the espoused aims of continuing professional development. EBL was credited with being a motivating, energising and enjoyable way of learning but participants were critical of the lack of preparedness of both the students and facilitators. Consideration needs to given as to whether EBL is viewed as a philosophy of learning or as a facilitative strategy used alongside other educational methods.
Exploring Midwives’ experiences and perceptions on use of the Internet in Midwifery Practice – A Pilot Study

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Exploring Midwives’ Experiences and Perceptions on Use of the Internet in Midwifery Practice – A Pilot Study

**Background:** Midwives are facing new challenges as increasingly women are turning to the Internet for information during pregnancy. This research begins from the premise that Information Communication Technology (ICT) has the potential to revolutionize client-provider power relationships in maternity service.

**Aim:** To test the efficacy of an on-line tool to explore midwives experiences and perceptions of pregnant women using the Internet.

**Methodology:** Following a largely quantitative paradigm a random sample of 40 midwives from two NHS Trusts was invited to participate in a cross-sectional, exploratory, descriptive pilot study to test an email questionnaire. The questionnaire invited midwives to share their experiences and views of using the Internet and working with women who presented them with challenging information from Internet sources during pregnancy.

**Analysis:** Quantitative data was analysed using SPSS software. Supplementary qualitative data was analysed using a content analytic approach.

**Findings:** Of the 35 respondents, 63% (n=22) agreed that the Internet supported critical aspects of their clinical practice. Many reported they did not have the necessary searching or appraisal skills despite almost a third (31%, n=11) having had some form of training in use of the Internet. Sixty nine percent of the respondents (n=24) reported a pregnant woman had discussed with them information they had retrieved from the Internet in the last year. Relevant illustrations were provided, depicting how the Internet has an impact on the changing power relation between pregnant woman and health professionals. Minor changes to enhance the questionnaire completion and validity were identified. Test-retest statistics confirmed the instrument reliability.

**Discussion:** Midwives perceive the Internet as an information source for themselves and pregnant women, with the potential to improve information dissemination and health care delivery. This paper confirms the need for further research in this area that will enable health professionals to critically appraise the evidence available for pregnant women on the Internet.
Comparison of perinatal grief between women that continue or terminate the pregnancy after second trimester diagnosis of fetal anomaly.

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**Background:** Although prenatal diagnosis is presented as providing alternative options regarding pregnancy outcome for women, therapeutic options for fetal anomalies in Ireland are legally limited. Consequently many women when confronted with an adverse diagnosis are placed in a difficult situation that may be associated with psychological morbidity.

**Aim:** This investigation was undertaken to describe grief resolution in women that continue the pregnancy and compare it with women who choose to terminate the pregnancy after second trimester diagnosis of fetal anomaly.

**Method:** A prospective cohort of 41 women choosing to continue or terminate the pregnancy after the adverse diagnosis participated in the study. Depression was evaluated by the Edinburgh Postnatal Depression Scale and bereavement was assessed by the Perinatal Grief Scale. For women that continued the pregnancy measurements were recorded on three occasions, Time 1: within 4-6 weeks of diagnosis, Time 2: 4-6 weeks pre birth, Time 3: 6-12 weeks postnatally. One measurement was recorded 6-12 weeks postnatally in women who terminated the pregnancy. Data were analysed with $\chi^2$ tests, Mann-Whitney $U$ tests, independent $t$ tests and paired sample $t$ tests.
**Results:** Thirty one women continued and 10 women terminated the pregnancy after the diagnosis. The most common indications for termination of pregnancy were CNS and chromosomal abnormalities. When the pregnancy was continued, significant differences were observed in the mean composite EPDS scores between Time 1 and Time 2. No significant differences in composite PGS Scores at Time 1, 2 and 3 were observed. EPDS and PGS scores at time 3 were compared between the groups. No significant differences in the mean composite scores or proportion of positive scores were found.

**Conclusion:** This study suggests that there is no significant difference in grief resolution among women who continue or terminate a desired pregnancy after fetal anomaly diagnosis.
Title: An exploration of women’s expectations for labour and birth in Irish Hospitals.

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Background
Women’s expectations of childbirth are thought to be one of the fundamental determinants of women’s satisfaction with the childbirth experience. Knowledge of women’s expectations of childbirth may be effective in promoting realistic expectations of birth and in helping women achieve a satisfying birth experience. Involving women in determining the important elements of a service requires a thorough assessment of women’s needs. In Ireland women’s expectations for childbirth have not been well documented.

Aim of the study
To explore women’s expectations for labour and birth in Irish Hospitals

Methodology
A qualitative, descriptive study consisting of a series of five focus group interviews was conducted. To obtain a diversity of cultural, socio-economic demographic, and service provision perspectives, a purposeful sample of 22 participants were recruited from four randomly selected maternity hospitals

Analysis
A qualitative analysis, which emphasised the interaction and synergy of the groups, identified three broad themes and ten specific categories.
Key findings

Three key themes encapsulate the findings; Setting goals for labour and birth; Achieving identified goals, and Reconciliation with unachieved goals.

Women’s expectations of labour and birth are informed by a diverse range of influences including family, media and previous experiences. Choice, control and a woman’s relationship with her carers are important to help women achieve their expectations.
Socializing Men into Nursing

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Abstract

Background: As of 2004, there were more than 2.9 million Registered Nurses (RNs) in the United States. More than 2.4 million RNs are employed in nursing. Male nurses account for 5.7% of all nurses, up from 5.4% in 2000.

Aim of the Study: To explore the process that led to the male nurse’s decision to become a nurse and to remain a nurse.

Methodology: Grounded theory methods were used to generate a descriptive theory of socialization of men into nursing. Data were collected by individual, semi-structured, in-depth interviews with 20 male Registered Nurses, residing in Massachusetts, with 1 to 35 years of experience as RNs. The participants were recruited through personal contact with people known to the researcher and through snowball sampling. The researcher did not know any of the men prior to the interview. The audiotaped interviews were transcribed and verified.

Analysis: Analysis was conducted throughout the data collection period using open, axial, and selective coding. A constant comparative approach was used until saturation of the categories appeared. Memos, in the form of code notes, theoretical notes, and operational notes, helped to establish an audit trail. MaxQDA, a qualitative software package, was used to assist with data management and analysis.

Findings: A basic social process, socializing men into nursing, emerged from the data. The basic social process comprises a trajectory of four stages, which encompass the path that men travel to become and remain nurses. These stages occur in a linear manner. The first stage is prior to considering nursing. This is
followed by choosing nursing, becoming a nurse, and ends with being a nurse.

Conclusion: This study extends our knowledge of male nurses by describing the trajectory that men follow in becoming a nurse. It has implications for policy development that will influence the recruitment and retention of men in nursing.
Title: A Comparative analysis of the results of a citation ranking system built within a web based educational tool for understanding the PICO framework in evidence based practice

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Introduction

The concepts of using research/evidence to substantiate and validate clinical practice decisions have been around for a long time. It was not until 1992, however, that these concepts were formally organized under the heading of ‘evidence based medicine’ (EBM) by Gordon Guyatt at McMaster University in Canada (Anonymous, 1992). With the acceptance of EBM as an actual discipline, the idea of using systematic evidence to make clinical decisions expanded to encompass all of healthcare under the title ‘evidence based practice’ (EBP) as well as professional disciplines outside of clinical medicine, such as evidence based librarianship.

The Centre for Evidence-Based Medicine lists the following five steps to practice EBM: (1) ask an answerable question, (2) find the best evidence, (3) critically appraise the evidence, (4) act on the evidence, and (5) evaluate the performance (Centre for Evidence-Based Medicine). The first two steps for practicing EBP are crucial for success in EBP. One must be competent in asking an answerable clinical question and not only familiar with information resources but have proficiency in using the best available resources to answer the clinical question.

To assist students in learning to ask answerable questions, educators at the School of Nursing within the University of Pittsburgh, Pittsburgh, PA created a web-based training tool, Accessing and Assessing the Evidence (AAE) (http://www.nursing.pitt.edu/aae.php). The AAE tool allows students to review clinical scenarios, create questions using the PICO (Patient, Intervention, Comparison, Outcome) acronym format, learn about EBP search tools such as clinical queries, and evaluate journal citation and abstract relevance in answering an expert’s clinical question. This paper reports on the development of the AAE, nursing student’s utilization of the tool in the classroom and evaluation of students learning through comparative analyses of citation ranking in answering the expert’s clinical question.

Background

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients (Sackett, et al., 1996). EBP builds on EBM by adding decision-making based “not only on the available evidence but also on patient characteristics, situations, and preferences” (McKibbon, 1998). The School of Nursing at the University of Pittsburgh is evolving its curriculum to be centered on the fundamentals of EBP.

W.S. Richardson, lists seven benefits to well-formulated questions: (1) they help focus reading time on those items directly relevant to
current patient needs, (2) they keep focused attention on the identified learning needs, (3) they suggest the directions needed so answers can be quickly found, (4) they direct one to the best resource for finding an answer, (5) they alert (or re-alert) one to the curiosity and delight of learning, (6) they help learners to achieve a better understanding of the content taught, and (7) they assist nurses with both patient education and care (Richardson, 1998).

To practice EBP one must be able to ask answerable questions. There are two recognized types of questions in EBP – foreground and background. McKibbon states that, "Framing a background question is relatively easy. The question is usually in the form of one or more of 'the seven Ws: who, what, for whom, why, where, when, and how well?'" (Mckibbon, and Marks, 2001). Foreground questions usually appear as compound sentences, state a defined need and are for a specific patient. Asking EBP questions represents an acquired rather than innate skill (Eldredge, 2000) and a challenge in EBP. Eldredge states that more clearly stated questions tend to yield a better answer (Eldredge, 2000).

The importance of having the ability to ask an answerable clinical question in order to begin practicing EBP was one element for curriculum development and in developing the AAE. Based on the assumption that learning occurs best in the context of solving realistic challenges (Bransford, et al., 1999), clinical scenarios were developed to provide the best resources for students to use for simulating real PICO and foreground question construction. The PICO is a recognized acronym in EBP that stands for Patient Intervention Comparison Outcome (PICO) (Booth, 2005). Using PICO as an anatomical question framework helps assure the research clinician that they have established a foreground question. It also assists when formulating search queries in literature databases.

To assist and guide the user in formulating a PICO and a foreground question, the user can compare their structured PICO and question to an expert’s PICO and question within the AAE through parallel screen display. An example is shown in Figure 1. Each expert PICO and question includes a review of expert literature search strategies as performed by a medical librarian. Within the AAE the literature search demonstration provides screen shots of search strategies within appropriate databases, as well as narrative explaining the search and the use of EBP filters. A link within the search strategy page and on the user/expert question comparison page connects to a page of recognized filters for use in the primary health sciences databases. Filters are pre-existing search strategies that have been
proven over time to quickly and easily adjust a search to find evidence. When searching certain databases the use of filters will attempt to “improve the retrieval of clinically relevant and scientifically sound study reports” (Wilczynski, et al., 2001). To complete the search, the librarian selected appropriate citations believed to answer the expert’s question.

One of the final steps in practicing EBP is critically assessing the literature to answer the question. The AAE provides selected citations and abstracts from the expert librarian’s search for the user to critically appraise and rank, in value of importance, the article’s capability in answering the expert’s clinical question. While the AAE does not provide full article text, it retrieves the abstract from the National Library of Medicine’s, PubMed database (http://www.pubmed.gov). Through the link to PubMed the user has options to continue reading and searching, and if using a computer with the University of Pittsburgh’s computer network, access the full article text as provided by the libraries.

To rank the articles’ citations, the AAE provides radio buttons and point values. The radio buttons are labeled ‘excellent,’ ‘good,’ and ‘okay.’ If one of the three options is not selected then the article does not receive points. Each time a user submits a ranking, a tally system in the AAE shows a popularity score for the citation (see Figure 2). The expert’s opinion is not revealed to the user of the AAE.

Using the AAE in a specific class provides the instructor a tool to measure a student’s performance in writing the PICO and foreground question. Analyzing the student’s collected opinions on the search results can be evaluated from the ranked citations. Individual rankings may also be reviewed. For instance, if an instructor assigns the class to read one specific clinical scenario in the AAE, establish a PICO and formulate a question, the user’s PICO and question are stored under the user’s name in the AAE database. After the question is created the user then reviews the selected articles that potentially answer the expert’s question, and ranks them accordingly. The instructor can analyze the appraisal skill level of the class or an individual by their recorded ranking of articles.

Methods
The system design was constructed for the tool to work with any Internet browser. The programming code for the web pages is php, an open source scripting language. The data for the site is located in the freely available software package, MySQL (Mysql Ab, 2006) database, which is housed on an Apache web server. The php
scripts access the MySQL database to dynamically produce the HTML code that is processed through the web server.

The MySQL database houses data used by the system and also collects data input from user’s entries. By using multiple tables in MySQL, data is sorted according to clinical scenario, type of EBP question, citation and user. By using tables to collect and distribute data within the database, information can be stored at different points in the system. This makes adjustments to the interface, and changing or adding additional content easy.

**Modules**
The AAE divides the concepts of EBP into two modules. This creates a natural division when introducing the concepts of EBP and in assigning student’s tasks within the AAE.

Use of the AAE requires a username and password. Access for anonymous users is provided by a general login and password on the log-in page. For the AAE to be utilized within curricula, students are provided a username and password by the system developer. Registered access provides a tracking system for an instructor when assigning specific scenarios or various EBP assignments as homework.

**Module One**
The first module contains clinical scenarios written by experts. The instructor can assign a specific clinical scenario for the students to use or let the students select a scenario of their interest. When used for one’s own practice any clinical scenario may be selected. Once the clinical scenario has been selected the user then selects the question type they would like to develop. Radio buttons are provided for the user’s and expert’s question. In the current version of the AAE, the user may select any type of question for themselves and any type of question from the expert. Once they have selected two types of questions they are directed to the next stage in question formulation.

To create the question the system presents the selected scenario with a blank PICO and foreground question template. The user completes the template and submits her/his work through the AAE. After submitting their work the AAE presents the expert’s PICO and question for comparison (See Figure 1).

**Module Two**
The second module presents the expert librarians search strategy for the expert’s question and selected citations for students to rank. If viewing the optional expert search strategy the user will see the
search presented in a step by step annotated layout. This facilitates easier understanding of the EBP search strategy developed by the librarian. Links are provided for additional evidence based practice library resources (Health Sciences Library System, University of Pittsburgh, 2005). These links open in new windows so the librarians search strategy, or expert’s PICO and question, can be referenced during the users search.

The final section of module two lists selected citations from the annotated search. The users are asked to rank the selected citations based upon their understanding of the PICO and question. The available rankings are shown in Table 1.

Table 1. AAE citation ranking scale

<table>
<thead>
<tr>
<th>Ranking Scale</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>1</td>
<td>Excellent</td>
</tr>
<tr>
<td>2</td>
<td>Good</td>
</tr>
<tr>
<td>3</td>
<td>OK</td>
</tr>
</tbody>
</table>

The results of the rankings are stored in two separate tables in the MySQL database. One table contains a summary of the rankings for each article and the other table stores the user’s ranking for each citation.

In summary, the AAE is a web-based tool that can be easily integrated into an undergraduate or graduate EBP curriculum. In Module 1, students are given an assignment to select a clinical scenario, select a question type, develop the PICO, and the clinical question. The instructor can view students’ completed PICO and clinical questions in relation to the selected scenario. When the instructor feels the students are ready to progress in their EBP experience, they may then move to the second module of the AAE and rank selected citations to answer the expert’s clinical question. The instructor can compare the students ranked citations to the experts ranking. This establishes a means for a general assessment on how well the class selects articles to answer a given question.

Results
Thirty-three students in an undergraduate nursing research course tested the AAE tool while learning evidence based practice concepts. In the first module the students developed 102 PICOs and questions. Fifty percent of the student’s responses were rated by the instructor as totally correct. The other 50% experienced difficulty formulating the PICO, the question, and/or both. One
student bypassed the AAE tool’s tracking system when selecting a question type, thus causing an error of seven unclassified questions.

Table 2 presents a numerical summary of the student mistakes made within the AAE.

Table 2. Student errors in module I (students, n=33)

<table>
<thead>
<tr>
<th>PICO n=102</th>
<th>Question n=102</th>
<th>Question Type n=96</th>
<th>Total n=102</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Mistakes</td>
<td>25</td>
<td>33</td>
<td>7</td>
</tr>
</tbody>
</table>

The students could select ‘therapy,’ ‘diagnosis,’ ‘etiology,’ ‘harm’ or ‘prognosis,’ as a question type when writing their PICO and question. The predominant question type was ‘therapy.’ ‘Prognosis’ was the second most popular selection as can be seen in Table 3.

Table 3. Question type chosen by students (question type, n=96)

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Diagnosis</th>
<th>Prognosis</th>
<th>Etiology</th>
<th>Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>54 (56%)</td>
<td>1(1%)</td>
<td>30(31%)</td>
<td>0(0%)</td>
<td>11(11%)</td>
</tr>
</tbody>
</table>

The second module contains 40 selected journal article citations from the librarian’s search. The students ranked the citations according to their relevancy in answering the expert’s PICO and question. The students ranked 36 citations, giving a total of 380 rankings. Eight citations were ranked 34 times. Seven other citations were each ranked eight times. The remaining 21 citations were each ranked at least once, but less than five times. As shown in Table 4, almost a third of the citations were ranked by the students as not being relevant.

A panel of four experts (two clinical and two non-clinical) provided 100 rankings of the selected citations in the AAE. Table 4 shows a comparison of the citations that were ranked by both the expert panel and the undergraduate students.

Table 4. Ranking of citation relevance to expert PICO and question.

<table>
<thead>
<tr>
<th>Rankings</th>
<th>Excellent</th>
<th>Good</th>
<th>OK</th>
<th>Not Relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students n=380</td>
<td>72(19%)</td>
<td>102(27%)</td>
<td>97(25%)</td>
<td>109(29%)</td>
</tr>
<tr>
<td>Experts N=100</td>
<td>21(21%)</td>
<td>29(29%)</td>
<td>27(27%)</td>
<td>23(23%)</td>
</tr>
</tbody>
</table>
Discussion
The results of this initial test for learning EBP concepts from the AAE tool were promising. In module I, students focused on only two question types, therapy and prognosis. In reviewing the formulated questions by the students, their performance was adequate for undergraduate students first attempting foreground question development. They showed more competencies in creating a workable PICO than establishing an answerable foreground question. This is not surprising when one examines the student’s level of clinical knowledge and experience in question development. The low number of ‘harm,’ and ‘diagnosis’ questions and the non-existence of ‘etiology’ questions posed by the students may relate the clinical scenarios presented or the instructor commenting that ‘harm’ and ‘etiology’ questions are difficult to formulate. This remark may have guided the students away from ‘harm’ and ‘etiology’ questions.

When measuring student’s expertise in selecting journal article abstracts to answer a question, the second module of the AAE shows overall agreement between the experts’ opinion and the students. However, closer examination of the data showed greater discrepancy in relevancy between the students’ rankings and the experts. In this student population the methodology to critically appraise research literature had not yet been introduced. This may have been a consequence to the discrepancy in journal article ranking between the students and the experts. For future research subject specific experts will be selected to contribute their ranking of selected journal articles in the AAE.

The AAE tool’s ability to guide the students in creating PICO’s and questions from a variety of scenarios, view an expert’s PICO, question and search strategy, appears to lead the user through the steps in evidence based practice while reinforcing the concepts. For an instructor, the AAE can monitor students in their EBP practice, provide guided feedback during the learning process and add an active learning component to the curriculum.

Changing academic curriculum reveals flexibility and systematic thinking. As health sciences professionals’ education migrates towards individual ability to access, evaluate and manage information all through their lives (Caetano, 1996) educators need to make sure students have the necessary skills. The AAE is one tool that will help health sciences professionals learn to access and evaluate information. While built on the concepts of EBP, the AAE extends into the larger and ultimate goal of fostering life long learning through teaching how to ask the ‘right’ questions, where to
find the necessary answers and ultimately, how to apply those answers to solve the problem.

References:


Centre for Evidence-Based Medicine, Learning EBM. Retrieved September 6, from http://www.cebm.net/learning_ebm.asp


Figure 1. Parallel display of user and expert’s PICO with question

**PICO & Question Formulation**

Based upon the Scenario below, your Question and PICO are listed with an expert’s question and PICO. The scenario could generate many different questions, so your PICO and resulting question may be different. The EXPERT answer provides an example.

A 36 month old child presents to the emergency department with an acute asthma episode. The child has been seen often in the ED and the staff has begun to recognize him. The child has been diagnosed with RDS respiratory airway disease and has a history of moderate, persistent wheezing. In the past vital signs show that there is plate out of 80% and wheezing. The new attending ordered an MDI/spacer to deliver Albuterol. You are wondering if there is evidence to support her request over using the standard t-piece nebulizer.

**Patient**

YOUR: 36 month old child with acute asthma episode  
EXPERT: 36 month old child with asthma

**Intervention**

YOUR: albuterol via t-piece nebulizer  
EXPERT: giving albuterol through a MDI/spacer

**Comparison**

YOUR: albuterol via MDI/spacer  
EXPERT: giving albuterol through a t-piece nebulizer

**Outcome**

YOUR: rapid relief from asthma  
EXPERT: Relief of asthma through fastest method of Albuterol delivery

**Foreground Question**

YOUR: (Prognosis) In a 36 month old child, does delivery of albuterol via t-piece nebulizer relieve an acute asthma attack faster than using albuterol via a MDI/spacer  
EXPERT: (prognosis) Would administering albuterol through a MDI/spacer be better than standard t-piece nebulizer in a 36 month old child in diminishing a wheezing attack?

- Review the EXPERT search strategy
- Review the EBP filter

**Journal Articles**

- Rank citations used for EXPERTS question
Figure 2. – User ranking of citations and point values shown from previous rankings

### Evidenced Based Practice Training

**Selected Citations from the EXPERT search for the following question:**

Would administering albuterol through a MDI/spacer be better than standard 1-piece nebulizer in a 36 months old child in diminishing a wheezing attack?

<table>
<thead>
<tr>
<th>Title</th>
<th>Number of rankings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A prospective evaluation of the 1-hour decision point for admission versus discharge in acute asthma.</td>
<td></td>
</tr>
<tr>
<td>Select a rank for the article:</td>
<td>Excellent = 12</td>
</tr>
<tr>
<td>Improvement of asthma control with a breath-activated pressurized metered-dose inhaler (RAI): A prospective claims study of 6558 patients using a traditional pressurized metered-dose inhaler (MDI) or a breath-activated device.</td>
<td>Good = 1</td>
</tr>
<tr>
<td>Select a rank for the article:</td>
<td>OK = 4</td>
</tr>
<tr>
<td>Salbutamol via metered-dose inhaler with spacer versus nebulization for acute treatment of pediatric asthma in the emergency department.</td>
<td></td>
</tr>
<tr>
<td>Select a rank for the article:</td>
<td>Excellent = 6</td>
</tr>
<tr>
<td>Prospective observational cohort safety study to monitor the introduction of a non-CFC formulation of salbutamol with HFA125a in England.</td>
<td>Good = 5</td>
</tr>
<tr>
<td>Select a rank for the article:</td>
<td>OK = 4</td>
</tr>
<tr>
<td>Beta-agonists through metered-dose inhaler with valved holding chamber versus nebulizer for acute exacerbation of wheezing or asthma in children under 5 years of age: A systematic review with meta-analysis.</td>
<td></td>
</tr>
<tr>
<td>Select a rank for the article:</td>
<td>Excellent = 6</td>
</tr>
<tr>
<td></td>
<td>Good = 3</td>
</tr>
<tr>
<td></td>
<td>OK = 1</td>
</tr>
</tbody>
</table>
The Experience of Parenting a Chronically Ill Foster Child with Complex Medical Needs

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A child’s official placement in an approved living situation away from the home of the birth parent at the direction of a state’s department of social services is termed foster care. Currently there are more than 500,000 children in the United States foster care system. Most children entering foster care have chronic behavioral, developmental, medical, or physical problems. Presently, the majority of foster care research has focused on needs of foster children and the way the system can meet those needs. Few studies provide information about the experience from the lens of the foster parent. Nurses need this information to influence the health and well being of chronically ill foster children and their foster parents.

The aim of the study was to explore the experience of parenting a foster child with chronic illness and complex medical needs from a phenomenological perspective.

Phenomenological inquiry using van Manen’s method was utilized as the research design for this qualitative study. Purposive sampling was used to obtain a sample of 13 participants. The number of participants in this study was based upon achieving repetition of discovered information.

Data analysis included the identification of significant statements, sentence structure variation, meaning statement formulation, and key element identification after which meaning units, theme clusters, and essential themes were identified. Literary and artistic resources also were used to further explicate study findings.

The data show five interwoven themes form the structure of the phenomenon. The themes are: Committing to Parenting a Child with Complex Needs, Coming to Know the Needs of a Medically Complex Foster Child, Intervening, Sensing the Loss of a Foster Child, and Becoming.
This study shows parenting a chronically ill foster child with complex medical needs is a multi-faceted experience. It has implications for nursing, medicine, governmental agencies, clergy, foster parents, and the general public.
**Full title of abstract:** Changing lifestyle behaviours - patient perspectives on an information booklet.

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**Abstract**
This poster reports on a pilot study which used qualitative data collection methods to assess patients’ perspectives of an information booklet designed to help patients with coronary heart disease (CHD) make informed choices about their lifestyle and facilitate change.

Four general practices were purposively selected in Northern Ireland and the Republic of Ireland to take part in a pilot study which employed patient focus groups to develop a lifestyle information booklet for CHD patients. Utilizing these groups accessed information which patients considered important and necessary for
inclusion in a secondary prevention booklet. The resultant booklet was then piloted as part of an intervention in the four general practices. A further patient focus group initiated post intervention ascertained if the booklet was judged ‘fit for purpose’ by the CHD patients who used it. The primary questions used related to the content of the information, the perceived usefulness of it and the format of presentation.

Patients emphasised the value of clear and simple information contained in one booklet rather than multiple leaflets; inclusion of information on stress, medication, and community support; use of large font size, colour, charts and pictures; and other positive features. They disliked filling in the self-monitoring forms and expressed the need for more space to record cholesterol/ BP/weight readings.

Evaluating patients’ perspectives on the effectiveness and relevance of resources improves our understanding of the connection between health education literature and its influence on a patient’s ability to make healthier lifestyle choices. Such understanding can, in turn, help identify strategies which may lead to greater patient health gains. This study has implications for nursing practice by assisting in the decision-making process regarding the format of health promotion literature provided for patients.
INTRODUCTION
The number of patients who choose not to wait for treatment or who leave before treatment is completed is one of the most common problems facing Emergency Department (ED) staff. Many individuals choose to attend an ED for treatment instead of seeing their GP. Long waiting time in ED is one of the key complaints from patients (Maitra & Chikhani 1992; Hoffenberg et al 2001). The reasons for the long waiting times are increased presentations; increased admissions from EDs and inappropriate use of the service (Australian Institute of Health & Welfare 1994; Moshin et al 1998, Lambe et al 2003). The problem has been reported across Australia, the UK, Ireland and the US.

The Australasian Triage Scale (ATS) comprises five categories of urgency and is used in Australian EDs. The categories are from high acuity to low acuity: resuscitation (1), emergency (2), urgent (3), semi-urgent (4) and non-urgent (5) (Australian College of Emergency Medicine, 2000).

BACKGROUND
Many studies have explored the problem of waiting times in emergency departments with the majority from US research (Spaite et al., 2002; Lambe et al., 2003). Lambe and colleagues (2003) reported all patients waiting on average 56 minutes before being
seen with 42% waiting longer than one hour and the primary reason for the delay was low ratios of ED doctors and triage nurses.

Context of this study
A provisional examination of routine attendance data from The Alfred ED reveals some interesting trends in the “did not wait” cohort over 2002 and 2003 with a total of 2,627 patients identified as leaving the ED before treatment commenced. This represents 6.8% of all attendances to the ED (total 38,731). The average length of time these patients waited was 1 hour and 55 minutes (Pickersgill 2003).

Attendance by category demonstrates that the majority (90%) of ‘did not waits’ were of low acuity (categories 4 & 5) with the average age of the majority between 20 years to 34 years (47%). Numbers of those who ‘did not wait’ peaked at the weekends (38%).

Waiting time is defined as time from the patient’s arrival at the ED to contact with a doctor or nurse for treatment. The data clearly demonstrated the types of patients who were leaving ED before treatment commenced but did not give any information regarding their reasons for leaving, whether they were registered with a general practitioner and whether they sought alternative treatment elsewhere. Therefore, a further study aiming to answer these questions was undertaken.

RESEARCH DESIGN

Setting
The Alfred is a metropolitan hospital in Melbourne and the ED is also the Victorian state trauma centre. For the financial year 2004-2005, a total of 39,063 patients were seen in the Department (with a capacity to treat 50,000 annually). On average 107 patients are seen per 24 hours, with an admission rate of 25%. Patients are seen by the triage nurse and categorised according to the Australasian Triage System (ACEM 2000). Patients then give their personal details to clerical staff and take a seat in the waiting area until they are called.

Aims
The aims of the study were to:
1. describe the characteristics of those who did not wait for treatment in ED over four one-month periods including triage category and time of the day.
2. explore patients’ perceptions of their ED experience using a telephone questionnaire.
Methods
A two stage design was used. Stage 1 used prospective data collection from triage records to identify the characteristics of patients who did not wait. For Stage 2, a questionnaire was administered by telephone to patients who left the emergency department prior to commencement or completion of treatment. The stage 2 questionnaire used was originally devised by St George’s Hospital, Sydney (unpublished) and was adapted for this study (with permission). The questionnaire was initially piloted with twenty patients.

All patients’ data were entered into a computer system which allowed times of arrival, time treated and time discharged to be recorded. A column for comments was also available for such items as “left against medical advice”. All patients had to pass by the triage desk and clerical area to leave the department.

The questionnaire was administered by a team of experienced ED staff nurses. The researchers introduced themselves and the reason for the call and if the participant agreed to take part, the researcher asked them 15 questions which took approximately 3-5 minutes to complete. If they disagreed, the researcher ended the call.

Sample
Data for all patients who attended the ED and left before treatment during the study period were included in Stage 1. Those who provided a telephone number were contacted by nurses within 72 hours of their presentation. If there was no reply after three attempts, the questionnaire was filed as “unable to contact”. A poster was displayed in the ED waiting area outlining the study. Patients were asked the following: whether they were registered with a GP; had they seen the GP about their presenting problem; did they have pain on arrival in ED; reasons for not waiting; whether treatment was sought elsewhere (and if so, where); was their presenting problem appropriate for ED; their reason for choosing the Alfred ED and any comments regarding their ED visit. Data collection took place over four separate months to reflect the four seasons from February 2004 to January 2005.

RESULTS

Stage 1 data: Patient demographics
A total of 11,866 patients were treated and the number of did not wait in the four one-month periods was 6.7% of the attendances (n=795 patients). The mean age of those who did not wait was 37.06 years (SD 15.7 yrs). The mean time patients spent in the
department following triage was 129.5 minutes (SD 193 mins) and median time 82 minutes. Over 60% of those who did not wait for treatment were male (n= 482, 60.6%). Half of those who did not wait for treatment were ATS 5, 30% were from ATS category 4, 14% were in ATS 3 and 3% were ATS 2.

Data was collected from one month demonstrated some seasonal variation with statistically significant differences between the seasons ($\chi^2 = 792.0$, df = 3, $p=<0.001$).

The majority (40%) of those who did not wait for treatment presented on Sundays (n=83, 20%) and Saturdays (n=79, 19%). Three hundred and seventeen patients (39.9%) arrived between 6pm and midnight, 234 (28.4%) between noon and 6pm, 160 (20.1%) between midnight and 6am and 83 (10%) between 6am and noon when data is examined in 6 hour blocks.

Not enough information was gathered to use the ICD classification, so classification was based on the information at triage. At the triage desk patients were unspecific in their complaint. The most common complaints were classified as psychiatric (n=136, 17%), musculoskeletal complaints (n=129, 16%), 104 (13%) presented with lacerations or wounds and 80 (10%) had a gastro-intestinal complaint.

Stage 2 data: Questionnaire
A total of 243 of the 795 ‘did not waits’ were contacted and answered the telephone survey (30.6% of stage 1 patients). A further 177 (22%) had no phone or incorrect phone numbers recorded/given. The respondents’ mean age was 39 years (SD 16.1 yrs). The majority (n=134, 55%) were male. All the data below is from the 243 patients.

The analysis demonstrated the following points:
- The majority of patients were registered with a General Practitioner (n=189, 77%).
- One fifth (n=54, 22%) did not have a registered GP.
- One quarter had seen their GP with their presenting problem on previous occasions (n=62, 26%).
- Three quarters attended ED as their first consultation with the complaint (n=179, 74%).
- The most common reason for attending The Alfred ED was because the incident (injury/onset of symptoms) occurred within a kilometre of the hospital (n=91, 38.6%).
- Two thirds (n=152, 62.6%) had pain on arrival to ED.
- Seventy percent (n=169) were presenting for their first visit to the ED with this particular problem.
Twenty percent of patients felt they had waited too long to be seen (n=89, 23%) and 12% left because their problem subsided. A total of 51 patients (13%) stated “other reasons” but these were not documented. One third (n=76) thought their problem was inappropriate for the ED. Half of respondents claimed that no-one told them about the waiting time (n= 112, 46.7%) or why there was a delay in being seen (n=126, 52.5%).

Fifty percent (n=127) sought alternative treatment elsewhere following departure from ED. Some returned to their GP (n=91, 42.5%) and others went to private hospitals (n=10, 4.7%) other EDs (n=9, 4.2%) or medical centres (n=3, 1.4%).

When invited to make further comment at the end of the interview, seven patients commented further on their severe pain in ED stating that this was their main concern. A total of 51 patients (21%) made further comment regarding the nursing and/or reception staff at triage with 38 positive and 19 negative comments about reception staff and 41 positive and 18 negative comments about nursing staff.

**DISCUSSION**

The study set out to examine the characteristics of those who did not wait for treatment and to survey those patients via a telephone survey. From the data we ascertained that the majority of those who did not wait for the study period were from ATS 4 and 5, were male and in their 30s. The study also established particular days and times were there were higher numbers of those who did not wait. Compared to the provisional data collected over 2002/3, there was no overall differences except an increase in mean waiting time from 1 hour 55 minutes to 2 hours and nine minutes.

The data also highlighted the need for early psychiatric assessment. The Department of Psychiatry was contacted and they now receive a daily copy of the “did not wait” patient list and follow up by phone all those known to their department. Another issue was the limited communication with patients (no information about waiting times is displayed in ED). This finding has been previously reported in a UK study (Maitra & Chikhani, 1992)

**CONCLUSION**

Telephone follow up was a useful method to investigate this cohort of patients. Our data demonstrate that waiting times remain a key source of discontent for patients attending the ED. A percentage of patients continue to use the ED for their primary healthcare.
These data can be used to inform strategic planning for the ED, providing evidence of local need with regard to peaks of ‘did not wait’ activity. It also highlighted that a significant percentage of those who do not wait seek treatment elsewhere placing a further burden on the healthcare system.

REFERENCES


Evaluating outcomes of the Emergency Nurse Practitioner role in a major urban Emergency Department

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Background:
Emergency Departments (ED) are faced with rapidly increasing healthcare service demands and increasing numbers of emergency patient presentations are seen. The result is longer waiting times and length of stay for patients in the ED. The Nurse Practitioner (NP) role is an alternative model of healthcare service delivery to patients. The literature surrounding the implementation of the NP role has demonstrated decreased waiting times, improved patient and staff satisfaction and cost-effectiveness all leading to improved health outcomes.

The development of the NP role has enabled experienced registered nurses in the ED setting to extend their skills in the development of clinical decision making and incorporation of evidence-based practice. The NPs practice broadens the nursing role outside the current scope of practice for the registered nurse in five extended
practice areas including prescribing medications, initiating diagnostic imaging and laboratory tests, approving absence from work certificates, referral to specialists, and admitting and discharging patients.

In Victoria in 1998, the NP role was introduced. The Department of Human Services (DHS) developed the role with key stakeholders. The DHS funded the Alfred Emergency and Trauma Centre in July 2004 as a pilot site and two Emergency Nurse Practitioner Candidates (ENPC) commenced. The title ‘Nurse Practitioner’ is protected by legislation and prevents unauthorised use. Nurses who are practising within the role and seeking accreditation as a NP are called candidates. Initially, the ENPCs focussed on Australasian Triage Scale (ATS) Categories 3-5 presentations (which reflect lower acuity). The ENPC completed the episode of care for each presentation from initial assessment, intervention, prescribing, diagnosis, treatment and disposition, within a collaborative ED team utilising Clinical Practice Guidelines (CPGs) for each presentation. This new model of care was a change from the traditional ED medical model (TM) employed in the ED. The TM group was defined as medical officer managed care with assistance from nurses.

**Aim:**
The aims of the study were to i) evaluate the impact of the NP role on waiting times and delivery of care to all patients presenting to the ED and ii) evaluate the impact of NP role on waiting times and delivery of care in the common diagnostic groups seen by the ENPC were included to allow meaningful comparisons between the ENPC and TM patients.

**Methods:** In the first part of the study; all patient presentations to the Alfred ED between September 2004 and August 2005 were assessed in a retrospective comparative analysis design. For the second part of the study, patients must have presented between Sept 2004 and August 2005 and between the times of 0700 and 2300 hours (the hours ENPCs were rostered). Patients were selected by common diagnostic subgroup as classified by ICD-10-AM (Statistical classification of Diseases and Related Health Problems, 10th Revision, Australian Modification). Common diagnostic subgroups were defined as more than 15 patients for each diagnostic subgroup. These were:

**Table 1: ICD Description of Presentations:**

- Cellulitis, skin, any site. Excludes cellulitis of finger or toe L03.01 / L03.02
- Open wound of face (excludes eye)
- Bite (non venomous) of head (excludes face)
- Open wound of forearm
- 412 -

- Open wound of wrist, hand, bite to wrist, hand
- Fracture of wrist, hand
- Sprain/strain of hand (includes finger)
- Injury to muscle/tendon of wrist, hand
- Open wound of lower leg, bite
- Sprain/strain of knee
- Fracture of foot (includes toes)
- Sprain/strain of ankle
- Sprain/strain of foot (includes toes)
- Attendance for follow-up (includes injections) / Review following earlier treatment
- Attention to or removal of surgical dressings and sutures

This allowed for the ENPCs most commonly encountered discharge diagnoses to be directly compared with identical diagnostic subgroups of the TM group. All outcome measurement data was entered on the ED Patient Information System (a computerised attendance registry). Identification of the type of practitioner was analysed by the ENPC or TM surnames. Data was collected on time of arrival, time waiting to be seen by the ENPC or TM, length of stay, and disposition. The Alfred Hospital ethics committee approved the research project as a retrospective audit for the purpose of quality improvement.

Statistical analysis
Data analysis was performed using Stata statistical software 8.0. No formal sample size calculation was undertaken. Continuous variables were used as the distribution was not normal with medians and interquartile ranges presented using Wilcoxon rank sum test. A two-sided p-value of less than 0.05 was considered statistically significant.

Results:
Part 1:
When all patients are examined for the first part of the study; the NP treated patients (n=1,988) were compared to the traditionally model of being treated by a physician (n=38,096). Statistical differences were recorded in the time patients were waiting to be seen and length of stay. The median waiting time of NP patients was 17 minutes (range 7-40) compared to 26 minutes (range 9-62) for the traditional physician patients (p<0.0001). The length of stay for NP patients was also significantly less at 111 minutes compared to the physician treated patients 233 minutes (p<0.0001). The NPs treated more patients of lower acuity using the Australian Triage Category (ATS). They treated 61% of patients in ATS 4 compared to the ED physicians 33% and 30% of ATS 5 compared to the doctors treating 10% in that category.
Part 2:
A total of 3156 patient presentations were included in this study. The ENPC group accounted for 18.1% (n= 572) of the sample, whilst the TM group accounted for 81.9% (n=2584)(Table 2).

Table 2: Number of patients seen (by ATS Category).

<table>
<thead>
<tr>
<th>Triage Category</th>
<th>TM n(%)</th>
<th>ENPC n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATS Cat 3</td>
<td>504 (19.5)</td>
<td>35 (6.1)</td>
</tr>
<tr>
<td>ATS Cat 4</td>
<td>1509 (58.4)</td>
<td>364 (63.7)</td>
</tr>
<tr>
<td>ATS Cat 5</td>
<td>571 (22.1)</td>
<td>173 (30.2)</td>
</tr>
<tr>
<td>Total</td>
<td>2584 (100)</td>
<td>572 (100)</td>
</tr>
</tbody>
</table>

Patients in the TM group waited nineteen minutes longer to be seen than those seen by an ENPC. Patients waited a median time of 31 minutes (IQR 11.5-76) as compared to the ENPC group who waited 12 minutes (IQR 5.5-28; Wilcoxon P<0.001). When wait to be seen times were stratified by ATS category, patients were consistently waiting longer to be seen by the TM group. Table 3 describes the waiting times stratified by ATS categories 3 – 5.

Table 3: Patient wait to be seen time (by ATS Category).

<table>
<thead>
<tr>
<th>Wait to be seen time</th>
<th>TM Median min (IQR)</th>
<th>ENPC Median min (IQR)</th>
<th>Wilcoxon rank-sum P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATS Cat 3</td>
<td>22 (10-43.5)</td>
<td>6 (4-15)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ATS Cat 4</td>
<td>37 (13-87)</td>
<td>14 (6-30)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ATS Cat 5</td>
<td>27 (9-82)</td>
<td>11 (5-25)</td>
<td>&lt;0.001</td>
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</table>

The overall length of stay (LOS) also differed significantly between the two groups. ENPC LOS was 76 minutes less than the TM group. ENPC LOS was 94 minutes (IQR 53.5-163.5) compared to the TM group 170 minutes (IQR 100-274; Wilcoxon P<0.001).

Discussion
This study has shown that the implementation of the ENPC had a significant association with reduced waiting times and LOS for ATS category 3-5 patients in the ED setting. These findings suggest that the ENPC role may be a useful strategy in managing the increasing service demands on EDs.
There has been limited research on the emerging ENPC role. Extrapolations of results from international studies to the Australian context are made difficult because of different funding and service models. A recently published case control study conducted by Considine et al. examined waiting times, treatment times and ED LOS between ENPC managed patients and patients managed via traditional ED processes. Their results are due to the study being conducted from Monday to Friday between 0800 and 2230hrs whilst the Alfred model covers all shifts. The ENPC appears to have greatest impact on waiting time and LOS when the ED is busiest. Australian and international studies appear to have findings more consistent with ours.

Stratifying patients into each of their ATS categories displayed significant differences in waiting times between the ENPC and TM groups. The greatest reduction in waiting time was 23 minutes for patients within ATS category 4. A study conducted in the United Kingdom demonstrated a reduction in the mean waiting time for care by an ENP from 86 minutes to 22 minutes when compared with the TM group. This result is consistent with our study with an overall reduction in waiting times measured.

A national study examining the role of NPs in many specialities is planned and has been funded by the Australian Research Council which will allow further investigation into the role and its effectiveness on patient outcomes.

This study has some limitations. There is a small likelihood that some of the data collection was incomplete and inaccurate. Nevertheless, it is unlikely that patients were not entered into the ED computer log. The efficiency and knowledge of the ENPC no doubt increased over the study period and this would impact upon the efficiency of their care and the key performance indicators measured in this study.

**Conclusion:**
The study demonstrated the successful implementation of the nurse practitioner role at the Alfred ED with reduction in waiting times and length of stay. The NPs tended to treat the lower acuity patients and this allowed the ED physicians more time with higher acuity patients. This model is beneficial to manage the increased service demands in ED.

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A Clinical Internship Model for the Nurse Practitioner Programme:

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Introduction:
Nurse practitioners have been working in US and UK hospitals for a considerable length of time. The role of the Nurse Practitioner in Victoria, Australia is relatively new and to date only seven nurses have been endorsed by the Nurses Board of Victoria (NBV website, 2006). In Victoria a nurse practitioner is defined as “…a registered nurse educated for advanced practice who is an essential member of an interdependent health care team and whose role is determined by the context in which s/he practices.”

Background:
Nurse practitioners (NPs) were introduced as health care providers to meet the healthcare delivery needs and to provide a cost effective manner to maintain quality of care (McMullen et al., 2001). Most of the literature reports that NPs are highly skilled, cost-effective and are able to provide a high level of care with better documentation (Hylka & Beschle 1995; Spisso et al., 1990). A Cochrane Review (Laurant et al 2005) reported that nurses can provide a high quality of care and achieve good health outcomes for patients but their findings were limited to primary care.

Gardner et al. (2004) outlined three board areas of study related to NP curricula: clinical practice, clinical sciences and nursing studies which highlighted the importance of the clinical environment and the essential role of a clinical mentor. NP competency standards have been formulated by the Australian Nursing and Midwifery Council (ANMC) (Gardner et al., 2006).

Clinical internship is usually associated with medicine but the concept of internships for nursing is growing as research has shown benefits in staff recruitment and retention (Hall and Marshall, 2006; Murphy et al., 2004; Alvarado et al., 2003). One paper has
examined the use of internship for NPs and clinical nurse specialists in a Canadian hospital (Alvarado et al., 2003). Overall, the authors report its usefulness but acknowledge the necessity of a supportive infrastructure. Murphy et al. (2004) describe a four month internship for NPs to enhance clinical practice.

The mentorship model is well established in nursing programmes (Lloyd and Bristol, 2006). The emphasis on the mentorship experience being successful and productive depends on collaboration and a multidisciplinary approach. The complexity of mentorship cannot be overlooked and problems such as poor communication and poor objective identification for NPs are highlighted by Barker (2006).

Those who wish to become nurse practitioners must fulfil certain criteria in order to become an NP; be enrolled in a Masters programme and also seek employment as a NP candidate. A nurse cannot use the NP title without formal endorsement with the relevant Nurses Board in Australia.

The focus of the NP role is on health promotion, education, and the complementary nature of the advanced nursing role with five extended practice areas: limited prescribing, initiation and interpretation of diagnostics, referral to medical specialists, admitting and discharging privileges and approval of absence of work certificates. When applying for Nurses Board endorsement, nurses need to complete clinical practice guidelines (CPGs) relating to their specialty. These guidelines outline different presentations and seek to provide a high level of evidence for the relevant treatment. The guidelines are signed off by the relevant personnel: radiologist, director of nursing and relevant specialist consultant (orthopaedics for example). A formulary of all the drugs the NP prescribes must also be submitted. The nurse needs to demonstrate advanced clinical practice skills, leadership and research skills to gain NP endorsement.

**Aim of the paper**

The aim of this paper is to outline the clinical internship model developed by La Trobe University School of Nursing & Midwifery for the Masters NP programme.

**The internship model:**

Consultation via a curriculum development committee with industry partners and academics revealed the need for a clinically focused Masters NP programme. The University NP Masters was developed and consists of three core units and the clinical internship in the student’s specialty area such as community or emergency for
example. Prior to undertaking the clinical internship, students need to complete three core units: health assessment and diagnostics, therapeutic medication management and evidence-based guideline development for clinical practice guidelines (CPGs). The internship aims to develop a detailed understanding of related physiology, pharmacology, psychological impact and contemporary interventions for NPs and their patient cohort. The clinical internship enables the student to gain the knowledge and skills necessary to manage patients within their clinical practice. The internship integrates theory and practice using the Australian Nursing and Midwifery Council (ANMC) competencies (Table 1). These competencies have been incorporated into an assessment tool. Students need to complete written assignments for the internship as well as presenting case studies to their mentor in the clinical environment (and demonstrating their knowledge and assessment skills).

Table 1: ANMC Competencies for Nurse practitioner competency framework:

<table>
<thead>
<tr>
<th>Standard 1: Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations</th>
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<tbody>
<tr>
<td>Competency 1.1: Conducts advanced, comprehensive &amp; holistic health assessment relevant to a specialist field of nursing practice</td>
</tr>
<tr>
<td>Competency 1.2: Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidenced based and informed by specialist knowledge.</td>
</tr>
<tr>
<td>Competency 1.3: Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments.</td>
</tr>
<tr>
<td>Competency 1.4: Demonstrates skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and the education of others.</td>
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<tr>
<th>Standard 2: Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability</th>
</tr>
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<tbody>
<tr>
<td>Competency 2.1: Applies extended practice competencies within a nursing model of practice.</td>
</tr>
<tr>
<td>Competency 2.2: Establishes therapeutic links with the patient/client/community that recognise and respect cultural identity and lifestyle choices.</td>
</tr>
<tr>
<td>Competency 2.3: Is proactive in conducting clinical service that is enhanced and extended by autonomous and accountable practice</td>
</tr>
</tbody>
</table>
Standard 3: Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service.

Competency 3.1: Engages in and leads clinical collaboration that optimize outcomes for patients/clients/communities

Competency 3.2: Engages in and leads informed critique and influence at the systems level of health care.

The mentor:

The student should identify a suitable mentor within their work environment and the mentorship process must be approved by the co-director/director of nursing and the consultant physician before the internship commences. The rationale for this is that hospital or clinical agency need to be supportive of their staff members who are engaging in the Nurse Practitioner course given the impact on health care resources. While it is important that the student chooses their mentor, the hospital or health care agency and also the course co-ordinator must input and will have final approval. Once a health professional has agreed to be a mentor a formal written agreement between the student, mentor and University will be signed.

It was felt that there were certain characteristics a mentor should possess and these are detailed below. The mentor should be:

- Up-to-date and have clinical expertise in your specialty
- Available during clinical placement and commit to being a mentor for the duration of the internship
- Accessible within the clinical environment for teaching and reviewing patients seen by the student
- Have a good understanding of the Nurse Practitioner model and the extended scope of practice of the role
- Able to provide clinical supervision
- Able to observe the student working clinically and provide thorough critical feedback on their performance in the role

The mentor will assist the student to develop and apply advanced assessment, diagnostic and pharmacological skills to become a NP. The student and mentor need to meet weekly during the semester and these meetings are aimed at providing a structured approach to clinical learning. The mentor and student need to develop and maintain a clinical learning plan and keep a log of the meetings that shows how the objectives have been achieved that includes the content of all self-directed learning activities. The patient log records all patients seen along with their assessment findings, tests ordered, diagnosis, mentor review and plan of care. This tool can be incorporated into the daily clinical work and also used specifically for the six case presentations required as part of the academic
assessment. For the case presentations, as well as using the patient log, there is a clinical case presentation assessment tool, which incorporates the ANMC competencies and also uses the Bondy scale. This scale allows students and mentors to identify the areas of independent practice and those of a supervised, assisted and dependent level of practice. This information can also be used in framing the ongoing learning objectives during the weekly meetings.

The student, mentor and unit coordinator from the University are to meet twice per semester. The purpose of this meeting is to ensure that the unit objectives that are specific to the student’s area of specialty clinical practice are being achieved and provide a forum for the student and mentor to raise clinical or theoretical issues.

**Clinical objectives:**
In order to formalise the internship, clinical objectives have been developed for the student and these are divided into three main areas: clinical, leadership and research. Students can add other specific objectives if they wish to. There are 225 clinical hours per semester (450 hours for the two semesters) which allows the students to complete their clinical objectives.

The objectives are outlined in Table 2.

**Table 2: Clinical objectives for the clinical internship:**

**Clinical:**

1. Interdependently practice advanced health assessment and diagnostic skills in the specialty area
2. Develop and apply advanced clinical knowledge and decision making skills related to patient/client group
3. Select, perform and interpret appropriate diagnostic and other laboratory tests
4. Individualise the use of the clinical decision making process as the framework for gathering and organising medication information, planning, prescribing, administering, documenting and evaluation to suit their practice needs.
5. Apply pharmacological interventions appropriately including therapeutic effects and adverse events
6. Compile and complete clinical practice portfolio
7. Integrate data from existing standardised screening tests into care management
Evidence Based:
1. Trial and further develop clinical guidelines for advanced nursing practice for a range of conditions in a specialty area of clinical practice

Leadership:
1. Demonstrate clinical leadership in practice development and clinical care whilst working as part of a multidisciplinary team.
2. Develop professional relationships within the multidisciplinary team
3. Undertake continuous quality evaluation of the care given (including patient/client satisfaction and auditing of role)
4. Identify and utilize the appropriate hospital and community resources and support groups
5. Provide clinical and educational support to nursing staff for patients/clients
6. Provide the relevant health education and health promotion to the patient/client group
7. Provide clinical audit of workload of patient/client group

Discussion:
The importance of the NP clinical internship cannot be underestimated and previous studies have highlighted its importance (Gardner et al., 2004). Also from a managerial perspective, the written support and approval of the NP’s manager is essential as issues can arise with relocation of tasks and changes to the working relationships with the new NP role (Reay et al., 2003). This perspective is also highlighted by Marsden et al. (2003) who examined NP deployment and in particular organisational and cultural issues.

Although the assessment tool incorporating the ANMC NP competencies and Bondy scale have not been formally assessed for validity and reliability, the feedback from mentors and students has been positive. A formal study will examine the tool in the next 12 months. From previous work on piloting competencies, the benefits are substantial to the NPs and the process works well (Mason et al., 2005).

Conclusion:
The clinical internship model allows students and mentors to identify the level of practice and can be used in framing the ongoing learning objectives ensuring a clinically focused programme is delivered. The incorporation of the ANMC NP competencies and the Bondy scale into the clinical assessment allows the NP to develop their clinical skills and knowledge in their specialty.
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Testing case studies for use in nurse education and research on clinical judgement and decision-making


Professor P. Anne Scott (Principal Investigator)
Professor P. Treacy (UCD)
Dr. P. McNeela
Dr. A. Hyde
Dr. K. Irving
J. O’Brien
F. Sheerin

Presenters:

case study approach which set out to (i) identify the nursing knowledge that is involved in making judgements and decisions, (ii) to examine how this knowledge base varies according to different areas of mental health practice, while taking into account the influence of the type of decision task involved and any
environmental restrictions that may be present. This information can be useful in both educational and research contexts. In both these contexts we believe that a case study approach can be used to (iii) provide insight into how organisational and interpersonal factors contribute to the nursing decision making process and (iv) identify how effective clinical decision making can be promoted. The number of 7 nurses from acute and community mental health settings and with varied levels of clinical experience took part in the testing of our case study approach. Our approach had three different stages. Firstly, each participant was asked to work individually through a computer-based case and relevant patient notes by ‘thinking aloud’, a process that took between 7 and 18 minutes. This was followed by the completion of a rating scale on the case, and by a post-scenario interview of approximately 10 minutes which related to the sources of information used in making judgements and decision. While the data was filmed and audio-taped, think aloud protocols were analysed using the process tracing methodology for verbal protocols. The post-scenario interviews were qualitatively analysed using content analysis. The most apparent conclusion from the piloting data is the necessity of audiovisual data for interpreting what participants are referring to or looking at as they think aloud. The post-scenario interview was particularly effective in uncovering participants’ approaches to clinical judgment and decision-making which were mainly intuitive in nature. A nurse’s observation, experience and prior knowledge were consistently cited as important in judgment and decision-making across interviews. We believe that this illustrates that this approach can be very useful in nurse education around clinical judgement and decision-making as well as in research on this topic.

Educational Standards & the Baby Friendly University Award: Gaining the certificate of commitment for King’s College, London

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Background and Context:
The Baby Friendly Initiative (BFI) has developed a new award for universities. This award is given to educational institutions that can demonstrate that their midwifery (or health visitor) pre-registration students have met a set of 19 infant feeding learning outcomes on completion of their training.

Conflicting advice and poor standards have continually been reported in the area of midwives facilitating mothers’ breastfeeding. It has long been argued that if student midwives (or health visitors) were trained to a defined standard during their basic training, then maternity units would find it easier to achieve the Baby Friendly Award themselves. The BFI Educational Standards award was launched at the end of 2002 and to date only one university has gained the certificate of commitment – Paisley in Scotland.

Aim of project:
The aim of this educational project is to show how the Florence Nightingale School of Nursing & Midwifery at King’s college, London University has integrated the 19 learning outcomes into pre-registration midwifery training.

Methodology:
The project to achieve this was started two years ago and went through the process of incorporating the 19 learning outcomes in the midwifery curriculum for all students. The educational content was then taught throughout the relevant cohorts of students and application was made to the BFI to gain a certificate of commitment.
Analysis:
The certificate of commitment was gained during the autumn of 2006 making the Florence Nightingale School of Nursing & Midwifery the first university in England to achieve it. Full assessment will be occurring during June 2007 and it is hoped that King’s College will be successful in gaining this prestigious status.

Conclusion:
Introducing the BFI Educational Standards in university seek to train midwives to a defined ‘gold standard’ in infant feeding, during pre-registration training thereby resulting in newly qualified midwives having the skills necessary to be more effective in supporting breastfeeding women thereby transforming care.
Lessons from Cuba

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This paper has emanated from a doctorate in Governance thesis entitled – Public Health: why are the Cubans so successful? For the purpose of the conference, the main focus of the paper will be primary health care and maternal and child health in Cuba and lessons are relevant to health care policy in the Republic of Ireland have been distilled.

Health outcomes: infant mortality and life expectancy are closely correlated with GDP. Countries with higher GDP generally have better health outcomes. Cuba is the classic outlier in this regard. Economically a third world country, life expectancy in Cuba is equivalent to the Republic of Ireland, and infant mortality rates are comparable with all of the high income countries. A case study research design was used to examine the reasons behind these conspicuously good health outcomes. Twenty weeks of fieldwork, divided into two phases, was carried out in Cuba.

The paper sets the context and rationale for the study. It highlights critical junctures in modern Cuban history and analyses public health in Cuba. The case study design is described. A variety of methods: participant and non-participant observation, reflective diary, focus group interviews and semi structured interviews, were used. Ten explanatory themes emerged and are combined in a theoretical model to explain Cuba’s success.

The study concludes that Cuba is successful in public health because health has become emblematic of the revolution and that political will is central to this achievement. Recommendations distilled from
the study include: development of health policy based on systematic needs assessment; placing Primary Care at the centre of health service provision and changing the title of the Department of Health and Children to Department of Public Health.
Using simulation to prepare nursing students for their roles as staff nurses.

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Background
The BSc (Hons.) in Nursing is a four year full-time course that includes theoretical and practical elements. Students learn a wide range of skills to enable them fulfil their professional duties. The Nursing Skills Centre in the School of Nursing at Dublin City University has a state of the art simulated learning centre that replicates the health care setting. It provides students with a safe, supportive and realistic environment to practice nursing skills before entering the clinical setting.

Simulation accommodates diverse learning styles and teaching methods (Jeffries 2005). Previous research has shown overwhelming positive evaluation of simulation exercises mirroring the real world by students and lecturers (Wildman & Reeves 1996).
There is also evidence to support its value as a teaching strategy to improve student’s clinical performance (Alinier et al. 2004).

A simulation exercise was undertaken to prepare fourth year student nurses for their role as staff nurses by exposing them to experiences such as caseload management, clinical decision making and prioritising care. This project was conducted collaboratively with clinical colleagues from two general hospitals to ensure it emulated the real world.

**Aim of Study**
The purpose of this study was to evaluate the simulation exercise designed to prepare nursing students for their roles as staff nurses, and explore its value as a teaching and learning exercise from student, school of nursing staff, clinical staff and actor perspectives.

**Methodology including research design and sampling**
Student participants were recruited on a voluntary basis from the current cohort of fourth year BSc students. Three student nurses, one male and two female, from the general pathway took part in the initial exercise. Seven actors from the local community were recruited to play patients roles. The School of Nursing staff and clinical colleagues co-ordinated and observed the exercise. The exercise itself consisted of an orientation to the facilities and equipment, a verbal handover report of the patients, the actual simulation exercise, group and individual debriefing and feedback, and finally the evaluation. Actors were given scripts to follow and sufficient information regarding their condition to enable them to play the role required.

Learning opportunities were identified based on the curriculum outcomes of the management modules in year 4. They were then categorised under the headings of

1) Organisation / management,
2) Clinical Practice,
3) Legal/ethical/professional issues,
4) Communication.

**Data Analysis**
The evaluation incorporated both quantitative and qualitative methodologies. Data analysis was conducted using SPSS and ENVIVO software.

**Summary of Key Findings**
The results of this evaluation support the positive findings of previous research.
Students found the exercise realistic, enjoyable and beneficial. They felt that valuable learning had occurred and reported an increase in their own perceived proficiency in each of the learning categories. They stated that they were able to identify their own strengths and weaknesses and that they felt more confident following the exercise. They also identified the debriefing and feedback session as particularly helpful. All of the student participants said they would repeat the exercise if the opportunity was available and that they would recommend it to their friends.

School of nursing staff and clinical colleagues felt that the simulation was a valuable teaching method that benefited student learning. Actors felt it was realistic and that their instructions were easy to read and understand.

**Conclusion**

This simulation exercise indicates that simulation is a valuable teaching and learning strategy that is viewed positively by students, lecturers and clinical staff.

**References**


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