# Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes

December 2012

An Roinn Sláinte
DEPARTMENT OF HEALTH

Patient Safety First
Working together for quality services

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# Abbreviations

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| **ABA** | An Bord Altranais |
| **AMP** | Advanced Midwife Practitioner |
| **ANP** | Advanced Nurse Practitioner |
| **CAO** | Central Applications Office |
| **CMM** | Clinical Midwife Manager |
| **CNM** | Clinical Nurse Manager |
| **CMS** | Clinical Midwife Specialist |
| **CNS** | Clinical Nurse Specialist |
| **CPC** | Clinical Placement Co-ordinator |
| **DoH** | Department of Health |
| **DoHC** | Department of Health and Children |
| **DOMINO** | Domiciliary Care In and Out of Hospital |
| **HEA** | Higher Education Authority |
| **HEI** | Higher Education Institute |
| **HIQA** | Health Information and Quality Authority |
| **HRB** | Health Research Board |
| **HSE** | Health Service Executive |
| **ID** | Intellectual Disability |
| **IV** | Intravenous |
| **MHC** | Mental Health Commission |
| **MLU** | Midwifery-Led Unit |
| **NCCP** | National Cancer Control Programme |
| **NMPDU** | Nursing and Midwifery Planning and Development Unit |
| **NQAI** | National Qualifications Authority of Ireland |
| **ONMSD** | Office of Nursing and Midwifery Services Director |
| **RM** | Registered Midwife |
| **RGN** | Registered General Nurse |
| **RNID** | Registered Nurse Intellectual Disability |
| **RPN** | Registered Psychiatric Nurse |
| **RCN** | Registered Children's Nurse |
| **The Nursing and Midwifery Board** | An Bord Altranais agus Cnáimhseachais na hEireann |
| **WHO** | World Health Organisation |

# Review Group Membership

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|---|---|
| Prof Martin Bradley | Chair |
| Mr Eddie Byrne | Health Service Executive |
| Ms Anne Cody | Public Interest Representative |
| Mr Liam Doran | Irish Congress of Trade Unions |
| Ms Mary Duff | Irish Association of Directors of Nursing and Midwifery |
| Prof Josephine Hegarty | Irish University Association - Heads of Nursing and Midwifery |
| Ms Michelle Hoey | Graduate Nurse |
| Mr Des Kavanagh | Psychiatric Nurses Association |
| Mr Leo Kearns | Forum of Irish Postgraduate Medical Training Bodies |
| Ms Geraldine Keohane | Midwifery Representative |
| Ms Mary Kerr | Higher Education Authority |
| Ms Bernadette Kerry | Irish Nursing and Midwifery Practice Development Association |
| Ms Aisling Maher | Student Representative |
| Prof Mary McCarron | Irish University Association - Registrars |
| Ms Mary McTague | Clinical Placement Co-ordinators Association |
| Dr Derek O'Byrne | Institutes of Technology - Registrars |
| Mr Frank O'Leary | Health Service Executive |
| Ms Sheila O'Malley | Department of Health (retired February 2012) |
| Dr Maura Pidgeon | The Nursing and Midwifery Board |
| Mr Kevin Plunkett | Mental Health Nurse Managers Ireland |
| Ms Geraldine Regan | Irish Association of Directors of Nursing and Midwifery |
| Dr Michael Shannon | Health Service Executive |
| Ms Frances Spillane | Department of Health |
| Ms Catherine Timoney | Nurse Managers - Intellectual Disability National Group |
| Mr Michael Troy | Department of Education and Skills |
| Prof John Wells | Heads of Institutes of Technology - Nursing Department Forum |

**Chair Workforce Planning Subgroup:** Dr Michael Shannon
**Chair Curriculum Subgroup:** Dr Maura Pidgeon

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| **Project Lead:** | Dr Kathleen Mac Lellan, Nurse Advisor, Department of Health |
| **Secretariat:** | Mr Patrick Clifford, Assistant Principal Officer, Department of Health<br>Ms Joan McKenna, Higher Executive Officer, Department of Health<br>Ms Paula Monks, Higher Executive Officer, Department of Health<br>Ms Alison Geraghty, Executive Officer, Department of Health<br>Ms Marion Lawrence, Clerical Officer, Department of Health |

# Foreword

It has been my privilege to chair this Review of Nursing and Midwifery Undergraduate Education. This is the first national review to be undertaken since the introduction of the undergraduate programmes in 2002, programmes which are now delivered within the higher education sector.

We have engaged in a wide and comprehensive consultation with the professions, the Nursing and Midwifery Board, students, patient groups, educationalists, health service managers, policy makers, and the trade unions.

Almost without exception the undergraduate programmes are seen as successful. There is a wide appreciation and acknowledgement of the benefits of degree level education and of the student experience within higher education. Patient groups noted that students appeared to be more confident and thoughtful in their approach to planning care, explaining the rationale for procedures and treatment regimes; and were willing to invite and answer questions from patients and relatives.

Service managers and students valued the support of the Clinical Placement Co-ordinators and the period of internship prior to qualification. This was seen as a period of consolidation of learning and experience with the opportunity to take on more responsibilities, to adapt more fully to the challenges of the clinical environment and to develop some personal resilience.

There was strong support for maintaining the current points of entry into the four disciplines of nursing whilst acknowledging the value of interdisciplinary and shared learning provided it was well planned and had clear relevance for the discipline.

Those areas that required further consideration centred more on the governance arrangements for the programmes. It was acknowledged that while all of the current programmes had standards in place, it was desirable to have a more consistent approach to student assessment, with clear expectations as to the level of clinical practice to be achieved at set points in the programme. In addition the standards should also address the number of attempts a student might have to undertake assessments, and the total amount of time allowed for completing the degree. For the sake of consistency these standards should be applied nationally. While higher education institutions have their own governance arrangements, the clinical and public protection issues within nursing and midwifery programmes are of paramount importance, and consistent practice in this area is essential in retaining public confidence.

This Review has taken place at a time of significant developments in the delivery of healthcare. These developments reflect advances in treatment and care, the greater use of technology and diagnostics and our increasing understanding of how services can be organised to achieve better outcomes for the public's health. Nurses and midwives will be at the centre of these reforms. They make up the largest component of the professional workforce, delivering care 24/7 across hospital and community boundaries. Their skills, expertise and flexibility will be required to develop and expand new and more autonomous nurse- and midwife-led roles, in areas such as nurse-led patient discharge, chronic disease management, palliative care, nurse/midwife prescribing and nurse-/midwife-led care.

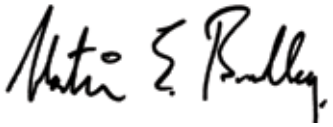
Nothing stands still which requires all of us to have a more open and engaged approach with patients and clients. An approach and a way of working that empowers and motivates others to maximise their health potential for as long as possible, whether it be the new mother and child, the person with a disability or chronic condition, or the frail older person is desirable.

In one of our patient group consultations, a young man said that he expected nurses to know about him, to know about his condition and how to treat and care for him. He wasn't going to ask what qualifications they had. What he would remember was how they had made him feel. We must continue to ensure that the patient and client remains at the centre of all that we do.

In conclusion I want to thank the Review Group who gave so generously of their time, and willingly shared their expertise and knowledge. Over the past year we have participated in frank, constructive and open debate and we have a consensus on the way forward. This is reflected in the recommendations.

We have been ably assisted by our Project Lead, Dr. Kathleen Mac Lellan, and our Secretariat, Patrick Clifford and his support team. They have had the task of analysing the numerous written submissions, organising the consultation events, and drafting the final report. We are indebted to them.

I trust this Review will contribute to the further strengthening of the nursing and midwifery degree programmes.



Professor Martin Bradley
Chair

# Terms of Reference

**Review of the Undergraduate Nursing and Midwifery Degree programmes**

The Review will be conducted on a modular basis consisting of the following elements:

1) An examination of:
   - the content of the undergraduate programmes
   - the structure of the current degree programmes including the separate points of entry, clinical placement requirements and governance arrangements.

2) An analysis of the number of student places required to ensure sufficient numbers of nurse and midwife graduates for new patterns of service delivery within the public health system.

The Review Group will consider the findings of both exercises and report to the Minister for Health by September 2012. Following the completion of these exercises the Department of Education and Skills and the Higher Education Authority in consultation with the higher education institutions will lead on the development of any changes required in relation to the organisation and delivery of nursing and midwifery degree programmes within the higher education system. This will take into account the broader education policy considerations in relation to demand for such programmes nationally and internationally and the overall funding implications involved and take full consideration of the findings of the report to the Minister for Health on workforce planning and curricula changes.

# Executive Summary

Ireland has a strong reputation for delivering excellence in nursing and midwifery education and for providing highly qualified, competent and motivated nurses and midwives. Over the last ten years the educational system has undergone significant change, particularly with the move of undergraduate nursing and midwifery education into the universities and higher education sector.

The undergraduate programmes have been in place since 2002 for nursing (general, psychiatric, intellectual disability) and since 2006 for midwifery and the integrated children and general nursing programme. Upon successful completion of these programmes students may register their qualification with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board, Ireland).

Given the changing profile of the population, the changing patterns of treatment, care and service delivery, it was considered timely to undertake a review of the undergraduate programmes.

The Review commissioned by the Minister for Health was to examine the efficiency and effectiveness of the programmes in preparing nurses and midwives to practice in the healthcare system now and into the future. The Review chaired by Professor Martin Bradley started its work in November 2011; and committed itself to a wide consultation process with a broad range of professional groups, across education, service delivery, management, students and patient/client interest groups.

Two subgroups were established, one to undertake an examination of the content and structure of the undergraduate programmes and the other to carry out an analysis of the number of student places required to ensure sufficient numbers of nurse and midwife graduates for new patterns of service delivery within the public health system. The Health Research Board compiled an evidence synthesis of the international literature to ascertain best practice in curriculum design and delivery in terms of the factors and variables that influence the outcomes of nursing and midwifery undergraduate education programmes.

### Introduction to the Recommendations

Throughout the consultation there was widespread support for the move to degree level education and integration into the higher education sector, and positive comments on the quality of the newly qualified nurses and midwives. Their readiness to undertake clinical practice and their ability to use evidence to underpin that practice was noted. The period of internship was seen as a key factor in developing preparedness for practice and is a unique feature of the programmes in the Republic of Ireland.

The role of the Clinical Placement Co-ordinators who provide support to the students and the clinical staff who teach the students was also highly valued and there was particular concern that the clinical placement co-ordinator role needed to be strengthened and protected.

Those areas that needed further development were focused on more explicit standards for the measurement of student progress and the achievement of competencies at particular points in the programmes.

The integration of theory and clinical practice could be strengthened by the stronger engagement of academic staff in teaching and support within the clinical area. It was also suggested that this would reinforce and facilitate the clinical contribution of lecturers.

There was much debate on how the curriculum should reflect the ongoing developments in care and treatment, and the changing nature of nursing and midwifery practice. It was acknowledged that there would always be cycles of change driven by research and development and the needs of patients, clients and their families. There was a limit however as to the amount of content that could be captured in an undergraduate curriculum. The emphasis should reflect the theory and principles which underpin

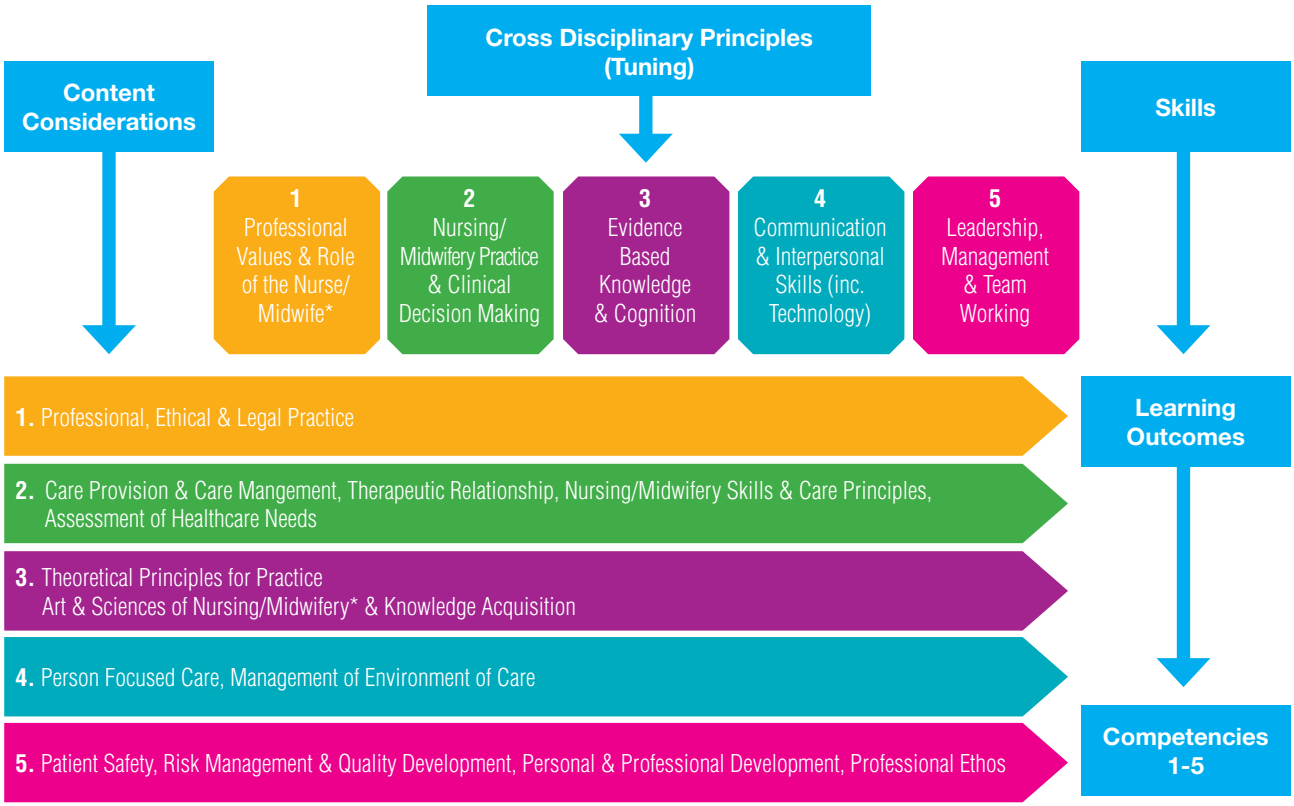
practice and the competencies to be achieved. These should reflect current best practice and be refreshed over time. This needs to be a dynamic process with engagement between the Nursing and Midwifery Board, service, the practitioners and education providers.

The Review Group recommended that the Nursing and Midwifery Board build on the strengths of the current programmes aligning these with future patterns of healthcare delivery which will see strengthening of the primary and community care sector. This should reflect the refocusing of services to meet the needs of the older person, those children and adults with chronic diseases, and the well established community models for the support of those with mental health issues and those with intellectual disability. In addition it should support the further expansion of nurse- and midwife-led care. The delivery of care will also be driven by the evidence-based clinical programmes being developed by the Health Service Executive (HSE), the patient safety and quality agenda and the pending Department of Health, Health and Wellbeing Framework.

## Content and Structure of the Undergraduate Programmes

The Review Group gave consideration to the duration of programmes, entry requirements, views concerning governance issues and international models of undergraduate education. It was agreed that curriculum changes to include advances in treatment and changing care models should not add excess content to existing curricula. Changes should occur through changing the emphasis within existing modules and clinical learning, and the subsequent clinical assessments of the student, reflecting an outcome and competency[1] based curriculum. Five broad domains from the Tuning Project[2] were identified as a guide to curricula content development (Figure 1).

**Figure 1: Curriculum Content and Principles for the Undergraduate Programmes (adapted from Tuning)**




* *The curriculum should respect the unique requirements for the nursing or midwifery education programme as provided for in Directive 2005/36/EC*

1 A competency describes what is observed when a nurse or midwife combines knowledge, skills, attitudes and judgement to perform role-relevant tasks.
2 Further information available: http://www.cbie-bcei.ca/wp-content/uploads/2012/04/tuningnursingfinal.pdf

From the consultation a number of themes emerged which would enhance the programmes; these included nationally agreed competencies with standard assessment processes for each discipline for each stage of the programme. Such competencies were considered important in terms of patient safety and ensuring appropriate progression through the programmes. Service users supported a person centred approach to care with increased service user involvement in programme design and delivery. The concepts of patient empowerment, self care and a recovery based approach were identified by service users as critical.

The clinical practice opportunities within the education programmes were identified as essential in preparing graduates to practice, and a number of recommendations to enhance the clinical learning opportunities are made including consideration of increasing the length of the internship to support consolidation of learning and workforce planning.

Curricular themes of professionalism, leadership, culture, the role of the nurse and midwife, programme structure, curriculum content and clinical assessment were explored. The immersing of students in professional scholarship and establishing a clear understanding of what it means to belong to the professions of nursing and midwifery were seen as the foundation to establishing the values, attitudes and behaviours that underpin good professional practice. The development of a sound knowledge base with a commitment to evidence-based practice, and lifelong learning were seen as essential, along with the desire to be accountable for maintaining high quality care, and developing partnership working with patients and carers.

Following considerable debate and taking into account international experiences and expert opinion the Review Group were of the view that in order to maintain the academic and clinical practice integrity of midwifery and the four disciplines of nursing and to reflect the HSE workforce plan, students should continue to choose the relevant point of entry on application to the CAO[3] for undergraduate nursing or midwifery education courses. The benefits of the separate points of entry for nursing and midwifery are identified as:

- preparing graduates to practice confidently from day one of employment in their chosen discipline
- ensuring a sufficient supply of graduates with the required competencies and experience for specific population groups. In countries where there is an absence of students qualifying in psychiatry, intellectual disability and children's nursing, the nursing contribution to the care of these client groups is diluted
- acknowledging the distinct scopes of practice for each nursing discipline but building on the opportunities for shared learning
- recognising midwifery as a discipline and profession in its own right as identified through the Nurses and Midwives Act 2011.

## Workforce Planning

The number of nurses and midwives required is for determination by the HSE based on a needs assessment and priorities established through the service planning processes. Workforce planning must reflect the impact of health reform, the economic challenges and the quality and patient safety agenda.

The delivery of a sufficient number of effectively prepared nurses and midwives from the undergraduate programmes is essential to ensure that an appropriate supply of nurses and midwives are available to meet the needs of the health service. The Workforce Planning Subgroup examined possible scenarios for establishing the number of student places required to ensure sufficient numbers of nurse and midwife graduates up to 2022. All scenarios were examined at a high level. Effective service delivery requires

3 The higher education institutions in the Republic of Ireland have delegated to the Central Applications Office (CAO) the task of processing centrally applications to their first year undergraduate courses.

processes to ensure that there will be sufficient staff available at the right time, with the right skills, diversity and flexibility to deliver high quality care i.e. appropriate skill mix.

It was agreed that in order to maintain stability within the health and higher education system the current number of undergraduate student nurses and midwives (1570) should continue to be commissioned until the economic and service reform agenda becomes clearer. This recommendation takes into account the 2009 Employment Control Framework for the Health Service and the workforce planning scenario which indicated that the overall numbers of students currently being prepared at undergraduate level just met the demand.

It is recommended that a regular workforce planning exercise is undertaken and that in the medium to long term a national framework should be developed to assist with the determination of nursing and midwifery staffing levels and skill mix aligned to patient acuity/dependency and service developments.

## Review Recommendations

The Review Group agreed 16 recommendations. The recommendations provide strategic direction for reconfiguration and a refocus of the undergraduate education programmes to prepare nurses and midwives to practice now and in the future in line with the health reform agenda.

The Nursing and Midwifery Board will lead on the development of the new standards for the curriculum and course design. The Department of Education and Skills and the Higher Education Authority in consultation with the Department of Health and higher education institutions will lead on the development of any changes required in relation to the organisation and delivery of nursing and midwifery degree programmes within the higher education system. This will take into account the broader education policy considerations in relation to demand for such programmes nationally and internationally and the overall funding implications involved; and take full consideration of the findings of the report to the Minister for Health on workforce planning and curricula. The HSE will support the workforce planning recommendations. Responsible bodies should work with experts from the professions of nursing and midwifery as required to progress the implementation of the recommendations.

The Department of Health has agreed to establish a monitoring group to meet six monthly for two years to monitor and support the implementation of the recommendations. An interim report will issue after year one. This monitoring group will be chaired by the Department of Health and will include representation from the Department of Education and Skills, health services, higher education institutions, the Nursing and Midwifery Board and the trade unions.

# List of Recommendations

## Curriculum Recommendations (C1-C12)

### Recommendation C1

The 4 year, BSc honours degree (NQAI level 8) programme for nursing and midwifery; and the 4 points of entry to the disciplines of nursing should be retained by An Bord Altranais agus Cnáimhseachais na hEireann (the Nursing and Midwifery Board, Ireland).

C1.1 In order to maintain the academic and clinical practice integrity of midwifery and the four disciplines of nursing; and to reflect the HSE workforce plan the Nursing and Midwifery Board and HEIs will continue to require students to choose the relevant point of entry on application to the CAO[4] for undergraduate nursing or midwifery education courses.

C1.2 The Nursing and Midwifery Board in consultation with the HEIs will standardise the maximum time normally allowable for students to repeat academic and clinical assessments and to complete BSc nursing/BSc midwifery programmes.

C1.3 HEIs will develop a nationally agreed mechanism by which students can exit the nursing and midwifery programmes with the accumulation of credits and/or with an accredited/academic award aligned to the National Framework of Qualifications where appropriate. The student will not be eligible to register as a nurse or midwife with the Nursing and Midwifery Board with this exit award.

### Recommendation C2

HEIs will enhance shared learning across the nursing and midwifery programmes; and with multi-disciplinary undergraduate programmes.

C2.1 HEIs should continue to develop shared learning across the disciplines of nursing and midwifery, particularly in year 1 and should integrate as appropriate module content across the entirety of the programme.

C2.2 HEIs should also continue to develop, as appropriate, shared learning between nursing and midwifery programmes, and other relevant undergraduate programmes.

### Recommendation C3

The Nursing and Midwifery Board and the HEIs will give further consideration to flexible modes of entry, enabling wider access to the undergraduate programmes such as:

C3.1 Recognition of prior learning (RPL).

C3.2 The use of specialist schemes e.g. FETAC, Higher Education Access Route (HEAR)[5] schemes.

C3.3 Graduate entry programmes for those who have already attained degree level education in a relevant area.

### Recommendation C4

The Nursing and Midwifery Board in consultation with the Department of Health and relevant stakeholders will establish a post-registration education framework based on service need and workforce demand.

4 The higher education institutions in the Republic of Ireland have delegated to the Central Applications Office (CAO) the task of processing centrally applications to their first year undergraduate courses.

5 The Higher Education Access Route (HEAR) is a college and university admissions scheme which offers places on reduced points and extra college support to school leavers from socio-economically disadvantaged backgrounds.

### Recommendation C5

In consultation with the Nursing and Midwifery Board, national and local governance arrangements should be enhanced by HEIs and the HSE/health service providers.

C5.1 Local Joint Working Groups should operate within an agreed memorandum of understanding between the HEIs and the HSE/health service providers. The memoranda should be based on a framework of nationally agreed governance principles, which supports national policies and the health reform agenda with locally agreed addendums if required. Composition of Local Joint Working Groups should reflect health system changes and be reviewed accordingly.

C5.2 HEIs and the HSE/health service providers will enhance their clinical engagement to facilitate the promotion of theory, practice and research. This will include dedicated HEI staff time to teaching and facilitation of learning in the clinical area and may include joint appointments.

C5.3 The HSE/health service providers and HEIs will ensure dedicated staff are available to support clinical placements within primary, secondary and tertiary care including community care placements. The minimum ratio for CPCs[6] is 1:30 for nurses and 1:15 for midwives and should be maintained. As community placements increase HEIs, the HSE/health service providers and the Nursing and Midwifery Board will be required to consider the necessary additional support for students on community placements.

## Curriculum Content[7] Recommendations (C6-C7)

### Recommendation C6

The Nursing and Midwifery Board will identify the competency goals for the four nursing programmes and the midwifery programme.

C6.1 The five specific domains from the Nursing Subject Area Group (SAG) of the Tuning Project[8], should inform the competency goals at bachelor degree level:

- Professional values and the role of the nurse/midwife
- Nursing/midwifery practice and clinical decision making
- Evidence-based scholarship, knowledge and cognition
- Communication and interpersonal skills
- Leadership, management and team working.

The Nursing and Midwifery Board should engage with HEIs, the HSE/health service providers and the Department of Health in ongoing collaboration to review and update learning outcomes taking account of the dynamic nature of practice development and the role of the nurse and midwife. The curriculum will be underpinned by a population focus reflecting developments in health policy and delivery of services thus providing for nurses and midwives to attain the knowledge and skills to provide optimum safe quality care in a modern health service.

C6.2 The Nursing and Midwifery Board, HEIs and HSE/health service providers will agree national practice competencies[9] aligned to learning outcomes for each stage of the programme for each division of the register supporting the patient safety agenda.

C6.3 The Nursing and Midwifery Board, in providing for the protection of the public, will require that safety of the public is at the core of all assessment decisions and that patient safety overrules all other considerations with regard to student performance in the clinical area.

6 Clinical Placement Co-ordinators (CPCs) are qualified nurses or midwifes who support preceptors and clinical nurse/midwife managers in the teaching and assessment of student nurses and midwives on clinical placement.

7 The curriculum is the collective education plan that encompasses the education philosophy, education programme content, processes of teaching and learning and assessment strategies.

8 Further information available: http://www.cbie-bcei.ca/wp-content/uploads/2012/04/tuningnursingfinal.pdf

9 A competency describes what is observed when a nurse or midwife combines knowledge, skills, attitudes and judgement to perform role-relevant tasks.

### Recommendation C7

HEIs and their healthcare partners will ensure a person centred philosophy of care underpins all curricula.

C7.1 HEIs and their healthcare partners must ensure that the values of treating people with care and compassion, with dignity and respect and with impartiality remain at the core of the student experience. The values and the principles that underpin the curriculum will shape and guide the choices and daily practice of the students and those who teach them.

C7.2 HEIs should increase the involvement of patients/clients and carers in curriculum planning, teaching and in the evaluation of the programme. A modern healthcare system will require more of the population to have the knowledge and skill to take care of their own health, to live independently for as long as possible and for nurses and midwives to work in partnership with patients, clients and carers in the interests of providing high quality care, tackling health inequalities and building resilience and promoting health and wellbeing.

C7.3 HEIs in partnership with their healthcare partners must ensure that students and those who work with them are familiar with the local systems and processes for ensuring patient safety, including the governance arrangements for the effective identification and management of risk, escalating concerns, professional accountability and procedures for addressing standards. Students should also be familiar with the theory and practice of risk management, concepts of clinical governance and the theory of human factors.

## Clinical Placement and Assessment Recommendations (C8-C12)

### Recommendation C8 - Clinical Placement

The Nursing and Midwifery Board and the HEIs will review student clinical placement requirements to take account of changing health service delivery models.

C8.1 HEIs and their health and social care partners will further develop community and primary care placements to enhance the development of community related skills, in particular the care of patients/clients in their own homes or local communities.

C8.2 The Nursing and Midwifery Board along with the HEIs will investigate innovative ways in which students can access placements where they have clinical exposure alongside professions drawn from allied health and social care fields in order to develop specific clinical skills that will prepare them on qualifying to work effectively within the multidisciplinary team. The overall learning experience and final clinical assessment including community placements should be supervised by a nurse or midwife.

C8.3 The Nursing and Midwifery Board and the HEIs will seek to reduce the number of specialist placements informed by a clear rationale as to how such placements contribute to the development of the core competences; accompanied by an emphasis on significantly longer core placements taking place in each of the first three years of the programme leading up to the internship.

C8.4 In acknowledgement of the changing age profile of the population the Nursing and Midwifery Board and the HEIs will establish a substantial and mandatory older person clinical placement for relevant nursing programmes.

C8.5 The Nursing and Midwifery Board and HEIs should detail opportunities for students to engage in reflective clinical practice for each stage of the programme which would be reflected in the curriculum model.

C8.6 The Nursing and Midwifery Board will establish a mechanism in conjunction with specific HEIs to recognise and approve placements that may take place outside the EU.

### Recommendation C9 - Internship[10]

The internship component of the programme is critical in terms of preparing the graduate for clinical practice. The internship must be retained within the framework of the undergraduate programmes.

C9.1 The Department of Health, the Nursing and Midwifery Board, HEIs and the HSE/health service providers should give consideration to increasing the internship from 36 weeks to 52 weeks to meet the clinical, academic and service requirements in terms of continuity for workforce planning and consolidation of learning.

C9.2 The Nursing and Midwifery Board, HEIs and the HSE/health service providers should explore the most effective means of assessing the student throughout the internship period.

C9.3 The Nursing and Midwifery Board, HEIs and the HSE/health service providers should identify appropriate community placements for internship in line with health service reconfiguration and in keeping with the pending national framework for health and wellbeing.

### Recommendation C10 - Clinical Assessment

The Nursing and Midwifery Board, HEIs and the HSE/health service providers will review student clinical assessment processes including documentation to promote standarisation of clinical assessments in line with competency goals for the four nursing programmes and the midwifery programme.

C10.1 HEIs and the HSE/health service providers should implement shared governance processes (operationalised through the framework of nationally agreed governance principles) for clinical assessment including joint assessment and early intervention for student competence issues.

### Recommendation C11 - Preceptorship[11]

C11.1 The Nursing and Midwifery Board should provide national guidance and standards for preceptors.

C11.2 The HSE/health service providers should ensure that identified preceptors are available to support students in clinical placements within primary, secondary and tertiary care.

C11.3 HEIs and the HSE/health service providers should develop, implement and facilitate a national mandatory preceptorship programme with protected time facilitated by the employer in line with the Nursing and Midwifery Board guidance and standards.

C11.4 HEIs and the HSE/health service providers should recognise the value of the role of the preceptor through honorary access to certain facilities such as online library access and representation on Local Joint Working Groups.

### Recommendation C12

The Nursing and Midwifery Board should detail the clinical expectations of supernumerary students[12] for each stage of the programme (Year 1 – Year 3) maximising student learning and student integration; and linked to competency goals.

10 Internship means the 36 week rostered clinical placement undertaken in year 4 of undergraduate programmes. During this period the student is a paid employee of the health service. There is a student-staff replacement ratio of 2:1.

11 A preceptor is a registered nurse or midwife who supports student learning in clinical settings and assumes the role of supervisor and assessor.

12 Supernumerary means students are surplus to rostered staff nurses and midwives (i.e. funded establishment) and participate in care under the guidance and supervision of registered nurses and midwives.

## Education Programme Evaluation Recommendations (E1)

### Recommendation E1

Education programme evaluation in terms of design, content and programme delivery should occur through a continuous improvement approach by the Nursing and Midwifery Board, HEIs and the HSE/ health service providers.

E1.1 HEIs and the HSE/health service providers should put in place systems to capture feedback from student nurses and midwives, employers and the public and use this feedback to inform the design, content and delivery of education programmes as well as national policy.

## Workforce Planning Recommendations (WP1-WP2)

### Recommendation WP1

In order to maintain stability within the health and higher education systems it is recommended that the current number of undergraduate student nurses and midwives (1570) continue to be commissioned by the Department of Health until the economic and service reform agenda becomes clearer.

### Recommendation WP2

The HSE in co-operation with the Department of Health should undertake a five year workforce plan to be reviewed regularly in light of the extent of change planned under the reform agenda taking account of economic considerations; and in line with policy developments. The plan should have the active involvement and input of local healthcare and senior nurse/midwife managers. It should include an examination of staffing levels and skill mix in all relevant service areas aligned to patient acuity/patient dependency to ensure the most effective use of the nursing and midwifery resource. Requirements should be collated nationally to ensure a system wide and strategic approach.

## Research Recommendation (R1)

### Recommendation R1

Research to advance education innovation and to evaluate education programme design, content and delivery should be conducted by the Nursing and Midwifery Board, HEIs and health service providers in order to enhance and promote education effectiveness and excellence.

R1.1 The Nursing and Midwifery Board, HEIs and the HSE/health service providers should engage in research to evaluate the effect of different approaches for the delivery of nursing and midwifery curricula. Appropriate research methodologies preferably using comparative groups of sufficient sample sizes to show differences in the effect of differing approaches to teaching and learning should be utilised and national and/or international cross-institutional prospective research should be considered.

# Section 1
# Introduction

The Department of Health has undertaken a review of the undergraduate nursing and midwifery degree programmes in order to establish their efficiency and effectiveness in preparing nurses and midwives to practice in the Irish healthcare system now and into the future. The undergraduate degree programmes have been in place since 2002 for nursing (general, psychiatric and intellectual disability nursing) and 2006 for midwifery and integrated children and general programmes.[13] Undergraduate nursing and midwifery programmes must be of a high standard and quality for those students who are educated to provide safe and effective care to patients and clients in a modern health service. The Review Group in taking forward its work had regard to the objectives of the current health reform programme, the future workforce needs of the health system and the need to maintain value for money. The Review, chaired by Professor Martin Bradley was conducted on a modular basis consisting of the following elements:

(1) An examination of:
- the content of the undergraduate programmes
- the structure of the current degree programmes including the separate points of entry, clinical placement requirements and governance arrangements.

(2) An analysis of the number of student places required to ensure sufficient numbers of nurse and midwife graduates for new patterns of service delivery within the public health system.

Following extensive consultation, an examination of international undergraduate nursing and midwifery education and the findings of both exercises referred to in (1) and (2) above the Review Group prepared this report for the Minister for Health, along with an implementation plan. The Review Group held 8 meetings from November 2011 to October 2012 and a total of 16 recommendations were agreed.

The Nursing and Midwifery Board will lead on the development of the new standards for the curriculum, and programme content. The Department of Education and Skills and the Higher Education Authority in consultation with the Department of Health and higher education institutions will lead on the development of any changes required in relation to the organisation and delivery of nursing and midwifery degree programmes within the higher education system. This will take into account the broader education policy considerations in relation to demand for such programmes nationally and internationally and the overall funding implications involved; and take full consideration of the findings of the report to the Minister for Health on workforce planning and curricula changes. The HSE will support the workforce planning recommendations.

The Review Group agreed an inclusive consultative approach to the Review. A dedicated webpage on the Department of Health website was utilised to provide on-going information on the Review. A Briefing Paper (DoH 2012a) provided background information and the context of the Review. An information brief was distributed widely and made available on the website after each Review Group meeting in order to provide information on the Review progress.

A broad consultation process involving a call for submissions, focus groups and stakeholder meetings was completed early 2012. A summary of the consultation exercise is presented in Section 7. The complete Consultation Report was published on the Department of Health website in March 2012 (DoH 2012b).

13 Referred to as the Review for the remainder of the Report.

Two subgroups were identified and worked to the following terms of reference:

- **Workforce Planning Subgroup:**
  An analysis of the number of student places required to ensure sufficient numbers of nurse and midwife graduates for new patterns of service delivery within the health system. Dr M. Shannon, Director, Nursing and Midwifery Services, HSE chaired the Workforce Planning Subgroup. Key issues identified by the Workforce Planning Subgroup are presented in Section 8.

- **Curriculum Subgroup:**
  An examination of the content of the undergraduate programmes, the structure of the current degree programmes including the separate points of entry, clinical placement requirements and governance arrangements. Dr M. Pidgeon, CEO, the Nursing and Midwifery Board chaired the Curriculum Subgroup. Key issues identified by the Curriculum Subgroup are presented in Section 9.

The Health Research Board undertook an evidence review of undergraduate nursing and midwifery curricula. A summary of this evidence review is presented in Section 6.

Draft recommendations were agreed June 2012 by the Review Group based on health policy, the health reform programme, the consultation exercise, the report of the Curriculum Subgroup, the report of the Workforce Planning Subgroup, the evidence review and meetings with stakeholders. These draft recommendations were reviewed and amended accordingly following a consultation process with key stakeholders July 2012.

In summary the Review Group was of the view that the current undergraduate degree programmes are successful in terms of delivering competent fit for purpose graduates. The review process provided the opportunity to build on the strengths of the programmes in order to provide for efficient and effective education delivery going into the future. The education process including both the regulation and delivery of education should be robust enough to embrace evolving healthcare delivery models. Strong education preparation will prepare Irish nurses and midwives to continue to provide safe and high quality care meeting the needs of a modern healthcare system.

The Review Group agreed 16 recommendations relating to the curriculum, education programme evaluation, research and workforce planning. The Department of Health has agreed to establish a monitoring group to meet six monthly for two years to monitor and support the implementation of the recommendations. An interim report will issue after year one. This monitoring group will be chaired by the Department of Health and will include representation from the Department of Education and Skills, health services, higher education institutions, the Nursing and Midwifery Board and the trade unions.

# Section 2
# Context of Healthcare Delivery in Ireland

## 2.1 Irish Healthcare Background

The Programme for Government (2011-2016) sets out a fundamental reform and restructuring agenda to ensure equal access to healthcare based on need. This includes significant strengthening of the primary care sectors and radical reform of the acute hospital system and the introduction of a 'money follows the patient' funding model.

In parallel is the important delivery of policy outlined through various Department of Health documents and frameworks such as Quality and Fairness: *A Health System for You* (2001a), *Primary Care: A New Direction* (2001b), *A Strategy for Cancer Control in Ireland* (2006a), *A Vision for Change - Report of the Expert Group on Mental Health Policy* (2006b), *Tackling Chronic Disease - A Policy Framework for the Management of Chronic Diseases* (2008a), *Report of the Commission on Patient Safety and Quality Assurance* (2008b), *Changing Cardiovascular Health: National Cardiovascular Strategy 2012-2019* (2010a), *Strategic Framework for Role Expansion for Nursing and Midwifery* (2011a) and the pending Framework for Health and Wellbeing.

The Department of Health Statement of Strategy 2011-2014 provides high level aims and objectives for a three-year period (DoH 2012c), underpinned by a performance framework.

### Health Sector Objectives

- Keep people healthy
- Provide the healthcare people need
- Deliver high quality services
- Get the best value from health system resources

### Strategic Programme areas

***Programme 1: Fair Access and Sustainability***

To work towards the ultimate achievement of a universal, single-tier health service, supported by Universal Health Insurance, where access is based on need, not income.

***Programme 2: Patient Safety and Quality***

To provide leadership and stewardship of patient safety and quality for the entire health system in line with the vision and recommendations set out by the Commission on Patient Safety and Quality Assurance.

***Programme 3: Health and Wellbeing***

To help people live healthier and more fulfilling lives and to promote cross-sectoral policy development so as to create social, economic and environmental conditions that support good health, including good mental health, on equal terms, for the entire population.

***Programme 4: Primary Care***

To deliver significantly strengthened primary care services with expanded access to GP care free at the point of use and with an enhanced focus on structured care and chronic disease management.

***Programme 5: Acute Hospitals***
To reform the acute hospital system in order to provide faster access for patients to high quality services and to prepare for the introduction of a single tier system of hospital care supported by Universal Health Insurance.

***Programme 6: Specialised Care Services***
To provide a wide range of long-term supports and services aimed at ensuring that people who need long-term services and care can achieve their full potential and enjoy a high quality of life in the workplace, and within their own homes and communities.

Healthcare requirements will be driven by population demographics and epidemiology. While the general health of the population is improving, and more people are enjoying a healthier old age the reality is that Ireland has an aging population. Over the past decade, Ireland has achieved a rapid and unprecedented improvement in life expectancy (DoH 2011b). Those with chronic diseases now have the potential for an improved quality of life, through proactive monitoring of their condition and early intervention. However chronic diseases comprise 77% of the overall disease burden and 70% of health resources. Hospital stays are shorter with increased use of technology and non-invasive treatments, including day case work which now accounts for 60% of hospital activity. These changes have led to greater in-patient acuity, with hospital beds increasingly being utilised for those with co-morbidities and multiple pathologies, and the acutely ill who cannot be cared for at home or in the community. This has led to an increase in patient turnover and a health system making more effective use of its scarce resources.

Patient safety and the awareness of risk controls has grown over recent years and has resulted in a series of risk reduction initiatives, clinical audit programmes, utilisation of evidence-based practice, adherence to clinical guidelines, introduction of care pathways, early detection of patient deterioration through the use of early warning scores and peer review. It is predicted that the increase in the volume of care delivered in the community will increase as identified in the *Programme for Government 2011-2016, Time to Move on from Congregated Settings. A Strategy for Community Inclusion* (HSE 2011a) and *A Vision for Change - Report of the Expert Group on Mental Health Policy* (DoHC 2006b). The following details Irish Health Data as outlined by the OECD (2012):

- Total health spending accounted for 9.2% of GDP in 2010, slightly less than the OECD average of 9.5% (Ireland: 7.8% in 2007, 9.9% in 2009).
- Number of acute care hospital beds in Ireland in 2010 was 2.3 per 1,000 population (OECD average 3.4 beds).
- In 2009, life expectancy in Ireland stood at 81 years, more than a year above the OECD average (79.8).

However for any health system to be successful it requires a more sustained focus on preventative health and health promotion. The Department of Health is developing a Framework for Health and Wellbeing, which aims to improve the health of the nation from 2012 to 2020 and reduce health inequalities by addressing the causes of preventable illnesses. The policy framework will be Ireland's vision for a healthier population that is protected from threats to public health living in a healthier and more sustainable environment, with increased social and economic productivity and greater social inclusion. It proposes a whole-of-government approach where considerations of health and wellbeing and equity are addressed in the development, implementation and evaluation of policies and services. Addressing the determinants of health across the life course will allow consideration of each life stage as a specific phase and also as a continuous journey.

- The proportion of adult smokers fell from 45.6% in the early 1970s to 29.0% by 2007 (latest year available) (OECD average 21.1% in 2010).
- Alcohol consumption in Ireland is among the highest in OECD countries, with a consumption of 11.9 litres of alcohol per adult in 2010 (OECD average 9.5 litres).

- Obesity rate among adults - based on actual measures of height and weight - 23% in 2007 (latest year available) is higher than in other European countries (Less than United States - 36% in 2010, less than United Kingdom - 26% in 2010). Obesity's growing prevalence foreshadows increases in the occurrence of health problems (such as diabetes and cardiovascular diseases), and higher healthcare costs in the future (OECD 2012)

A number of goals are emerging from the framework:

**Goal 1:** Increase the proportion of Irish people who are healthy at all stages of life
**Goal 2:** Enable every sector of society to play its part in improving health
**Goal 3:** Reduce health inequalities
**Goal 4:** Protect the public from threats to public health.

National clinical programmes are defining how health services are clinically delivered, measured and resourced. Over 30 programmes, led by multi-disciplinary frontline teams of clinicians, have been established since 2010 to improve and standardise patient care. The areas targeted for improvements include: primary care, out patients, emergency services, surgery and chronic diseases. Since the establishment of the Special Delivery Unit in the Department of Health the national clinical programmes are also aligned under scheduled and unscheduled care. The programmes are based on three main objectives which are key pillars of any healthcare system – to improve the quality of care, to improve access to all services and improve cost effectiveness (HSE 2012a).

The *HSE National Service Plan 2012* identifies the need as outlined in the HSE National Clinical Programmes, to move to models of care across all services/care groups which treat patients at the lowest level of complexity and provide services at the least possible unit cost. This means, for example, that patients need to be treated, as far as possible, in primary care rather than hospital settings and that older people need, where appropriate, to receive community supports such as home help, home care packages and intermediate care rather than long-term residential care (HSE 2012b).

The delivery of the health service priorities through a quality driven agenda is supported by the Health Information and Quality Authority (HIQA), the Mental Health Commission (MHC) and implementation of the recommendations of the *Report of the Commission on Patient Safety and Quality Assurance* (DoHC 2008b).

The *Report of the Commission on Patient Safety and Quality Assurance* (DoHC 2008b) provides for a model of healthcare for the future that will have a quality and standards driven agenda. A key component of the Patient Safety First initiative is the National Framework for Clinical Effectiveness. Clinical effectiveness involves a number of processes, but primary among these are (i) the development or adaptation and use of clinical guidelines to support evidence-based practice and (ii) the use of clinical audit to improve patient care and outcomes. A 'quality and safety culture' ensures that quality and safety is seen as fundamental to every person working within that service including clinical and non-clinical staff, healthcare managers and the board or equivalent of an organisation. HIQA has published *National Standards for Safer Better Healthcare* (2012) for all healthcare services excluding mental health services provided or funded by the HSE. Eight themes describe how a service should provide high quality, safe and deliver care centred on the service user (Figure 2).

**Figure 2: Themes for Quality and Safety (HIQA 2012)[14]**




Themes in the *National Standards for Safer Better Healthcare.*

## 2.2 Meeting Future Healthcare Demand

In order to meet the future healthcare needs of the population the Government is embarking on a major reform programme for the health system, the aim of which is to deliver a single-tier health system, supported by universal health insurance, where access is based on need, not on income and appropriate care is delivered in the appropriate setting.

The Health Service Executive (Governance) Bill 2012, published 18th July 2012, paves the way for major changes in the design of the health services. The legislation provides for the abolition of the board of the HSE and a new governance structure based on a number of directorates, each with their own identified stream of funding. The board will be replaced by a Directorate, headed by a Director General. There will be Directors for areas such as primary care, mental health etc. The HSE will eventually be dissolved as the health reform programme advances. It is intended that the HSE will be replaced by a different body under a new model of Universal Health Insurance.

## 2.3 Clinical Governance

Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver (HSE 2011b). It is built on the model of the Chief Executive Officer or equivalent working in partnership with the clinical director, director of nursing/ midwifery and service/professional leads. Over recent years the health service has placed an important emphasis on quality and patient safety by developing an infrastructure for integrated quality, safety and risk management with the aim of achieving excellence in clinical governance. Clinical governance guiding principles have been developed by the HSE for utilisation as a guide for clinical governance

14 Reproduced with permission from HIQA.

development, across the continuum of care, in each of the national clinical programmes. The principles are as follows:

- Patient first
- Safety
- Personal responsibility
- Defined authority
- Clear accountability
- Leadership
- Inter-disciplinary working
- Supporting performance
- Open culture
- Continuous quality improvement

The models of care developed by the national clinical programmes are central to the further development of clinical governance.

## 2.4 The Nurses and Midwives Act 2011

The purpose of the Nurses and Midwives Act 2011 is to enhance the protection of the public in its dealings with nurses and midwives, to recognise midwifery as a separate profession, to provide for the registration, regulation and control of nurses and midwives, to enhance the high standards of professional education, training and competence of nurses and midwives, to investigate complaints against nurses and midwives and to increase the public accountability of the new Nursing and Midwifery Board of Ireland (Bord Altranais agus Cnáimhseachais na hÉireann). Among the key provisions are:

- provision for a regulatory body to be known as Bord Altranais agus Cnáimhseachais na hÉireann (the Nursing and Midwifery Board of Ireland)
- recognition of midwifery as a separate and distinct profession and provision for midwives attending a woman in childbirth to have adequate indemnity insurance
- the provision of a non-nursing/midwifery majority on the Board and on its Fitness to Practise Committee
- the provision of a stronger governance and accountability structure for the Board
- an improved investigation mechanism for complaints about nurses and midwives including the establishment of an assessment committee prior to Fitness to Practise investigations and the appointment of investigators to facilitate such preliminary investigations
- competence assurance.

Competence assurance is provided for in the Act and competency scheme(s) for the maintenance of professional competence of registered nurses and midwives will be devised by the new Nursing and Midwifery Board. There is an obligation on employers to facilitate the maintenance of professional competence of nurses and midwives in particular by providing learning opportunities in the workplace. Competence assurance provides great opportunity for nurses and midwives to engage in meaningful continuing professional development processes related to clinical practice.

# Section 3
# Nursing and Midwifery Education in Ireland

## 3.1 Role of An Bord Altranais agus Cnáimhseachais na hEireann (Nursing and Midwifery Board, Ireland)

The Nursing and Midwifery Board is the statutory regulatory body for the nursing and midwifery professions in Ireland. Its main functions relate to the promotion of high standards of professional education and training and professional conduct among nurses and midwives including the maintenance of the Register of Nurses.

The Nursing and Midwifery Board as outlined in the *Nurses and Midwives Act 2011- Part 10, 85 Education and Training* has the statutory responsibility to set and publish in the prescribed manner the standards of nursing and midwifery education and training for first time registration and prepare guidelines on curriculum issues and content to be included in programmes approved in compliance with the EU Council Directive 2005/36/EC (European Commission 2005a). The Nursing and Midwifery Board approves bodies which may deliver such programmes.

## 3.2 Nursing and Midwifery Undergraduate Degree Programmes

### *3.2.1 Programme Delivery*

The undergraduate nursing and midwifery degree programmes have been in place since 2002 for nursing (general, psychiatric and intellectual disability nursing) and 2006 for midwifery and integrated children and general programmes. Thirteen higher education institutes (HEIs) deliver 44 undergraduate degree programmes in partnership with 57 main healthcare agencies. This accounts for 1570 places in nursing and midwifery at pre-registration level (ABA 2011). The National Qualifications Authority of Ireland (NQAI) has placed the nursing and midwifery undergraduate programmes at Level 8, Honours Bachelor Degree with Bachelor of Science (BSc) as the academic award. Five programmes are delivered at undergraduate degree level (Table 1).

**Table 1: Summary of Nursing and Midwifery Undergraduate Degree Programmes**

| Programme Title | Years | Registration | Number of Programmes | Number of Places | Number of HEIs | Number of Healthcare Agencies |
|---|---|---|---|---|---|---|
| Children's and General Nursing | 4.5 | RCN, RGN | 4 | 100 | 4 | 4 |
| General Nursing | 4 | RGN | 14 | 860 | 13 | 22 |
| Intellectual Disability Nursing | 4 | RNID | 8 | 180 | 8 | 10 |
| Midwifery | 4 | RM | 6 | 140 | 6 | 7 |
| Psychiatric Nursing | 4 | RPN | 12 | 290 | 12 | 14 |

The student receives a combination of theoretical and clinical instruction and this period generally includes normal third-level college holidays. The usual entitlements/conditions regarding a means-tested third-level grant applies to student nurses and midwives. The first clinical placement occurs early in the programme, usually within three months of commencement. A continual 36 week rostered clinical placement (internship) takes place during the fourth year. During this period the student is a paid employee of the health service. Table 2 outlines the Nursing and Midwifery Board requirements (ABA 2005a,b, 2011).

**Table 2: The Nursing and Midwifery Board Requirements: Nurse and Midwife Registration Programmes**

| Aspect | General, Intellectual Disability & Psychiatric Nursing | Children's & General Integrated Programme | Midwifery Programme |
|---|---|---|---|
| Theoretical Instruction (to include self-directed study, exams) | 58 weeks | 70 weeks | 58 weeks |
| Clinical Instruction (supernumerary clinical placement) | 40 weeks | 54 weeks | 40 weeks |
| Internship (inclusive of annual leave) | 36 weeks | 36 weeks | 36 weeks |
| Other/Discretionary Component (at least half should comprise supernumerary clinical placement) | 10 weeks | 10 weeks | 10 weeks |
| **Total Minimum** | **144 weeks** | **170 weeks** | **144 weeks** |

### *3.2.2 Progression of Education Programmes*

There are a number of key reports which have informed the progression of nursing and midwifery undergraduate education programmes in Ireland. Table 3 refers to these reports and outlines key recommendations of interest to this review of undergraduate nursing and midwifery education.

**Table 3: Summary of Key Reports**

| | |
|---|---|
| **1998** | ***Report of the Commission on Nursing (Government of Ireland)*** |
| The *Report of the Commission on Nursing* considered alternative models of nurse education and training. It concluded that distinct pre-registration education programmes for general, psychiatric and intellectual disability nursing should be retained in order to ensure nursing competence and to attract recruits.<br><br>*Recommendations Nursing:*<br>- Pre-registration nursing education in Ireland should be a third-level four-year degree-based programme<br>- The transition to a degree-based programme should be nationwide and should start in the academic year of 2002<br>- The four year degree programme, which could lead to the awarding of an honours degree should encompass theory and clinical practice in three nursing divisions: general, psychiatric and intellectual disability. This would encompass clinical placements including 12 months continuous placement as a paid employee of the health service. The academic year should be based around the existing academic calendars for third-level institutes<br>- The CAO[15] would administer the application system for pre-registration education.<br><br>The Commission on Nursing recommended the establishment of the Nursing Education Forum to agree a strategy for the implementation of degree level pre-registration education.<br><br>*Recommendations Midwifery:*<br>- An Bord Altranais review the duration and theoretical content of the current midwifery education programme<br>- Piloting of a direct entry midwifery education programme should be conducted. | |
| **1998** | ***Nurse Education and Training Evaluation in Ireland. Independent External Evaluation. Final Report (Simons et al)*** |
| A number of key findings and implications detailed. Some key findings:<br>- Partnership at strategic, as well as local level, between the stakeholders in nursing education in Ireland is critical<br>- Common agreements concerning which philosophy of nursing and nurse education should underpin and guide the development of curricula should be achieved<br>- Earlier timetabling of clinical experience and the relevance of practice emphasised more in theoretical instruction confer benefit<br>- importance of preceptorship programmes at point of entry to the workforce. | |

15 The higher education institutions in the Republic of Ireland have delegated to the Central Applications Office (CAO) the task of processing centrally applications to their first year undergraduate courses.

## Table 3: Summary of Key Reports – *continued*

**1999** ***Nursing Education Forum established***

Terms of Reference:

- To prepare a strategy for the implementation of a four year pre-registration nursing education degree programme
- To estimate the additional costs arising from the introduction of such a four year degree programme as a replacement for the present three year diploma programme
- To consider the respective weighting that should be given to academic achievement and general suitability in the context of the transfer of the application system for entry to pre-registration nursing education to the CAO, and to furnish recommendations to the Minister for Health and Children in relation to this matter as a matter of urgency
- To consult extensively with nurse teachers involved in the development and delivery of the registration diploma programmes.

**2000** ***Report of the Paediatric Nurse Education Review Group*** **(DoHC 2000a)**

The *Report* recommended that:

- There should be various educational options for those wishing to obtain registration as a Registered Sick Children's Nurse
- Paediatric nurse education should be offered at both pre-registration and post-registration levels
- The option of an integrated programme leading to a dual qualification be explored within the context of a direct entry programme
- Paediatric nurse education should be available outside the Dublin region and that the Cork hospitals and University College Cork be considered as potential providers
- All three paediatric hospitals in Dublin should utilise a collaborative approach for clinical placements.

**2000 Report of the Nursing Education Forum (Government of Ireland)**

- Series of recommendations to ensure delivery of the degree programme.
- Establishment of a national implementation committee.
- It was recommended that An Bord Altranais undertake research to examine the rationale for and impact of maintaining three points of access to pre-registration nursing.

**2002 Pre-registration 4-year degree programme commenced with multiple divisions of the register - specifically general, psychiatric and intellectual disability.**

**2003 A pilot programme of direct entry midwifery registration education commenced in June 2000 and was completed in May 2003. This was a three-year registration diploma programme.**

**2004** ***Report of the Expert Group on Midwifery and Children's Nursing Education*** **(DoHC)**

Recommendations:

- A 4-year pre-registration midwifery honours degree programme be introduced in time for the academic year commencing autumn 2005
- A 4.5 year pre-registration integrated children's/general nursing honours degree programme be introduced in time for the academic year commencing autumn 2005.

**2004** ***Rostered Year Replacement Ratio Project for BSc*** **(Deloitte Report)**

When first introduced the 4th year clinical placement was for 52 weeks and involved a student-staff nurse replacement ratio of 3.5:1. In 2004 Deloitte recommended that a 2:1 ratio should be implemented. They also recommended a review of the whole programme including the length of the rostered year. This resulted in fourth year nursing students on the undergraduate nursing degree programme undertaking a 36 week clinical rostered placement.

**2005** ***Review of Specialist Model of Initial Training in Ireland*** **(Carney et al on behalf of An Bord Altranais)**

The study findings recommended that distinct registration education programmes should be retained in each of the five divisions of the register. Methodology involved documentary analysis and public consultation focus group interviews, individual interviews and national postal survey of nurses and midwives on the active register.

**2006**

- **Direct-entry 4-year midwifery programme leading to registration as an RM commenced in Ireland.**
- **4.5 year Integrated Children/General undergraduate degree programme leading to the registration as a RCN and RGN commenced.**

# Section 4
# Nursing and Midwifery Education – International Trends

## 4.1 Midwifery

Midwifery registration education is delivered world-wide either through direct entry midwifery education programmes or in the form of a shortened second registration qualification. A growing number of countries are now offering direct entry midwifery programmes (Belgium, Denmark, Ireland, Italy, New Zealand, United Kingdom and some Canadian provinces). Direct entry midwifery education programmes tend to be three or four year diploma or degree programmes. Midwives in the United States are either certified nurse-midwives or certified midwives. Those undertaking the education in order to become a certified midwife are required to have a Bachelors Degree and specific health and science courses prior to entry to midwifery education.

## 4.2 Nursing

Two models of nurse registration education exist internationally, that is the generic and the specialist model. The generic model prepares nursing graduates for generic practice for multiple client groups in varied settings. The specialist model makes a distinction between branches of nursing and prepares for a graduate nurse with competencies for a specific client group e.g. children's nursing, psychiatric, intellectual disability, adult nursing. A review of models of initial training and pathways to registration identifies that globally the specialist model is the exception (Fealy et al 2009). Ireland provides for direct entry programmes for general, psychiatric, intellectual disability and integrated children's and general nursing. Germany offers direct entry to general, paediatric or geriatric nursing. The United Kingdom offers a three year degree programme with 4 registrations - adult, children, mental health and learning disability. Generic and field specific competencies must be achieved during this programme.

Pre-registration nursing education programmes tend to be either three or four year diploma or degree programmes. For example Australia, Italy and New Zealand offer three year degree programmes, Denmark and Finland offer three and a half year degree programmes, Canada, Ireland and the Netherlands offer four year degree programmes. Some countries offer both diploma and degree programmes for example the United States offers a three year diploma, two or three year associate degree and a four year degree. A number of countries including Denmark, Germany, New Zealand, Australia and the United States offer accelerated programmes for graduates of non-nursing disciplines. These programmes generally take 11-18 months to complete and are offered to graduates of education programmes relevant to nursing such as graduates with science degrees (Raines & Taglaireni 2008).

## 4.3 World Health Organisation (WHO)

The WHO Regional Office for Europe in 2005 undertook a review of basic nursing and midwifery education programmes in Europe (Fleming & Holmes 2005). The report documents the status of entry level education for nurses at the time. It was acknowledged that there was a move to higher (university) level education but that many European countries had diverse entry level ages, qualifications and curriculum. It should be noted that generally education programmes for registration of nurses and midwives are at diploma or degree level.

There has been a general move worldwide towards degree level education which is supported by the WHO (WHO 2001a, WHO 2009), the UK Nursing and Midwifery Council and the review of education in Australia (Heath 2002). The *WHO European Strategy for Nursing and Midwifery Education* identified that the academic level of baccalaureate degree is a prerequisite for professional practice (WHO 2001a).

The WHO published *Global Standards for the Initial Education of Professional Nurses and Midwives* in 2009 (WHO 2009). The WHO estimates that 35 million nurses and midwives make up the greater part of the global healthcare workforce and that the global standards for the initial education of professional nurses and midwives are intended to serve as a benchmark for moving education and learning systems forward to produce a common competency-based outcome in an age of increasing globalisation. The goal of the global standards is to establish educational criteria and assure outcomes that:

- are based on evidence and competency
- promote the progressive nature of education and lifelong learning
- ensure the employment of practitioners who are competent and who, by providing quality care, promote positive health outcomes in the populations they serve.

This has resulted in standards relating to outcomes, governance, accreditation, faculty and programme admission. The standards state that:

- graduates demonstrate established competencies in nursing and midwifery practice
- graduates demonstrate sound understanding of the determinants of health
- graduates of an initial programme in nursing or midwifery meet regulatory body standards leading to professional licensure/registration as a nurse or a midwife
- graduates are awarded a professional degree
- graduates are eligible for entry into advanced education programmes
- nursing or midwifery schools employ methods to track the professional success and progression of education of each graduate.

Nursing or midwifery school graduates will be knowledgeable practitioners who adhere to the code of ethics and standards of the profession. Nursing or midwifery schools should prepare graduates who demonstrate:

- use of evidence in practice
- cultural competence
- the ability to practise in the healthcare systems of their respective countries and meet population needs
- critical and analytical thinking
- the ability to manage resources and practise safely and effectively
- the ability to be effective client advocates and professional partners with other disciplines in healthcare delivery
- community service orientation
- leadership ability and continual professional development.

## 4.4 European Union

Europe has a key influence on how Ireland delivers its education for nurses and midwives. Specifically of relevance is the Bologna Declaration. The Bologna Declaration's aim has been to create a coherent, compatible and competitive European Health Education Area by 2010. The main objectives of the Bologna Declaration include: creation of comparable, uniform and easily readable degrees through a European Credit Transfer System (ECTS), promotion of EU-wide quality assurance based on comparable criteria and methodologies, promotion of lifelong learning and removal of obstacles to mobility in the EU (CRE 2000). The European Union Directive 2005/36/EC was transposed into Irish law in 2008 and repealed previous directives.  It has implications for recognition of qualifications of nurses and midwives

who were educated and trained in other Member States who wish to travel and work as registered nurses or midwives in Ireland (ABA 2009a). The European Commission (2011) published a *Green Paper on Modernising the Professional Qualifications Directive (Directive 2005/36/EC)* which includes arrangements for recognition of nursing, midwifery and other health professional qualifications across Europe and common minimum standards for nurse and midwife education. The Green Paper was aimed at gathering stakeholders' views on modernisation of the Directive.

### *4.4.1 Tuning Educational Structures in Europe*

Tuning Educational Structures in Europe Programme emanated from the Bologna Process. The 47 countries that have signed the Bologna Declaration have agreed to implement student centred, outcome based and transparent higher educational programmes on the basis of three sequential cycles: the Bachelor, the Master and the Doctorate. The aim of the Tuning project was to contribute to the main objectives of the Bologna process by the transformation of traditional degrees into bachelor and master degrees and the reconstruction of the logic of their underlying study programmes. Tuning aimed to implement the Bologna process at a university level and concentrated on transparency and the development of a common language in the description of higher education programmes, not least to enhance comparability and to foster their international recognition (Lokhoff et al 2010). A guide to defining key programme competences and writing good degree programme learning outcomes is provided. Nursing is outlined as an example (see Table 4).

**Table 4: Sample Learning Outcomes – Nursing**

| Level | Programme Learning Outcome |
|---|---|
| **First cycle/ Bachelors** | The nurse can work closely with individuals, groups and carers, using a range of skills to carry out comprehensive, systematic and holistic assessments. The assessments must take into account current and previous physical, social, cultural, psychological, spiritual, genetic and environmental factors that may be relevant to the individual and their families. |
| **Second cycle/ Masters** | In his/her designated speciality, the nurse must demonstrate his/her mastery of advanced nursing skills (including diagnostic and therapeutic techniques) to assess and manage patients with complex health/illness states. |
| **Clinical Doctorate** | The nurse can demonstrate leadership in his/her chosen clinical area, ability to influence and set strategic practice development and research agendas. |
| **Doctorate/ PhD** | Can demonstrate a systematic acquisition and understanding of a substantial body of knowledge which is at the fore-front of the discipline of nursing, or an area of professional nursing practice. |

# Section 5
## Nursing and Midwifery in Ireland

The Nursing and Midwifery Board identifies that in 2011 Ireland had 67,130 nurses and midwives on the active file of the register. Nurses and midwives can hold more than one registration and there were 89,723 qualifications registered with the Nursing and Midwifery Board as outlined in Table 5.

**Table 5: Qualifications Registered (Active File): The Nursing and Midwifery Board 2011**

| | |
|---|---|
| Advanced Midwife Practitioner | 4 |
| Advanced Nurse Practitioner | 97 |
| Children's | 4,157 |
| General | 55,819 |
| Intellectual Disability | 4,615 |
| Midwives | 12,065 |
| Nurse Prescriber | 386 |
| Psychiatric | 9,384 |
| Public Health | 2,414 |
| Tutors' | 600 |
| Other | 182 |
| **Total** | **89,723** |

The Health Service Executive census indicates that there are 35,030.76 whole time equivalents for nursing and midwifery posts May 2012.

The scope of nursing and midwifery practice in Ireland is defined by the Nursing and Midwifery Board as the range of roles, functions, responsibilities and activities, which a registered nurse or midwife is educated, competent, and has authority to perform (ABA 2000a). Accountability is the cornerstone of professional nursing and midwifery practice. The Nursing and Midwifery Board regulatory framework is comprised of the professional guidance and support on issues relating to clinical practice and professional conduct together with the requirements and standards for education and the processes for determining a registrant's fitness/competency to practice. This guidance is contained in the *Scope of Practice Framework* (ABA 2000a), the *Code of Professional Conduct* (ABA 2000b) and practice guidelines.

The past decade has witnessed much evolution and expansion of the role of the nurse and midwife in response to service demands. Specifically, new initiatives such as implementing the clinical career pathway, expanding scope of practice, nurse- and midwife-led services, the introduction of medication and ionising radiation prescribing and expanded clinical decision making have been introduced. It is envisaged that nurses and midwives will continue to provide high quality, responsive care with enhanced roles reflecting their education, continuing professional development and expertise into the future. This care will be provided in and across hospitals and the community, for acute and chronic illness, palliative care and across the lifespan.

## 5.1 Nursing and Midwifery Career Pathways

The undergraduate degree programmes should provide the appropriate foundation for nurses and midwives to practice following registration. They should be the basis of a career trajectory and prepare nurses and midwives for on-going continuing professional development and attainment of further competencies as appropriate from novice to expert practice. Career pathways can be considered in terms of clinical, management, education and research pathways. Table 6 outlines the roles of nurses and midwives on the clinical career pathway.

**Table 6: Clinical Career Pathway**

| |
|---|
| *Staff Nurses/Staff Midwives*<br>Staff nurses and staff midwives are integral members of the multi-disciplinary team providing significant clinical care for individuals and families in a wide range of settings including acute, community, residential and extended care settings and homes. They provide comprehensive patient assessments to develop, implement and evaluate an integrated plan of healthcare, and provide evidence-based nursing and midwifery interventions. The staff nurse or midwife engages in monitoring and evaluating the patient's response to interventions and treatment. A number of staff nurses and staff midwives have undertaken additional education in order to become registered nurse prescribers or prescribers of ionising radiation. |
| *Clinical Nurse/Midwife Specialists (CNS/CMS)*<br>CNSs/CMSs work with the multi-disciplinary team to provide specialised assessment, planning, delivery and evaluation of care using protocol driven guidelines. Care delivery and caseload management is delivered in line with core concepts (clinical focus, patient/client advocacy, education and training, audit and research, consultancy) (NCNM 2008a). |
| *Advanced Nurse/Midwife Practitioners (ANP/AMP)*<br>ANPs/AMPs caseload involves holistic assessment, diagnosis, autonomous decision making regarding treatment, provision of interventions and discharge from a full episode of care. Care delivery and caseload management is provided by advanced practitioners in line with core concepts (autonomy in clinical practice, expert practice, professional and clinical leadership, research) (NCNM 2008b,c). |

There are three front-line nursing and midwifery management roles; clinical nurse/midwife manager I, II and III. The clinical nurse/midwife manager II is generally in charge of a ward or unit. The clinical nurse/midwife manager I reports to the clinical nurse/midwife manager II and acts up in his/her absence. The clinical nurse/midwife manager III is more likely to be in complex services e.g. larger acute general hospitals in charge of a department. Additionally there are assistant director of nursing/midwifery and director of nursing/midwifery roles. These roles are organisational and strategic and are generally part of corporate management and stewardship of organisations (Table 7).

**Table 7: Nurse and Midwife Manager Competencies (OHM 2004)**

| | |
|---|---|
| **Generic nursing and midwifery management competencies** | 1. Promotion of evidence-based decision-making<br>2. Building and maintaining relationships<br>3. Communication and influencing skills<br>4. Service initiation and innovation<br>5. Resilience and composure<br>6. Integrity and ethical stance<br>7. Sustained personal commitment<br>8. Practitioner competence and professional credibility |
| **Additional Competencies** | |
| **Front-line nursing management level** | • Leading on clinical practice and service quality<br>• Planning and organisation of activities and resources<br>• Building and leading a team |

**Table 7: Nurse and Midwife Manager Competencies (OHM 2004)** – *continued*

| | |
|---|---|
| **Mid-level nursing management** | • Empowering and enabling leadership style<br>• Proactive approach to planning<br>• Effective co-ordination of resources<br>• Setting and monitoring performance standards<br>• Negotiation skills |
| **Top level nursing management** | • Leading on vision, values and processes<br>• Strategic and systems thinking<br>• Working at corporate level<br>• Establishing policy, systems and structures<br>• Developmental approach to staff |

The *National Clinical Leadership Development Framework* was developed to assist and support nurses and midwives, whatever their role, from staff nurse or staff midwife to director of nursing or director of midwifery to identify and develop the competencies they need to perform as a clinical leader. It provides a national approach and structure for competency achievement for clinical leaders and their development (HSE 2012c). The framework articulates seven core competencies which provide the foundations for the clinical leader development pathway (Table 8).

**Table 8: Clinical Leadership Competencies (HSE 2012c)**

| Competency | Competency Statement |
|---|---|
| Competency 1:<br>Self Awareness | Develops self-awareness for professional practice, relationships and clinical leadership. |
| Competency 2:<br>Advocacy and Empowerment | Acts as an advocate for patients, staff and professional standards and enabling self empowerment. |
| Competency 3:<br>Decision Making | Makes clinical decisions informed by up to date knowledge and skills, intelligence, insight and understanding about the needs of patients and service users. |
| Competency 4:<br>Communication | Communicates effectively as a clinical leader using a range of communication approaches. |
| Competency 5:<br>Quality and Safety | Provides care that is safe and effective, participating in continuous improvement and practice development. |
| Competency 6:<br>Team Work | Contributing to and developing team effectiveness as a clinical leader. |
| Competency 7:<br>Clinical Excellence | Developing and shaping a culture of clinical excellence in everyday practice. |

An education career pathway tends to be either in the third level institutions or in the centres of nursing and midwifery education. The third-level institutions provide undergraduate and postgraduate education programmes for nurses and midwives. There are opportunities for nurse/midwife lecturers with progression to senior lectureships or professorships within the school of nursing and midwifery. The centres of nursing and midwifery education provide a broad range of continuing professional development and education to nurses, midwives and members of the healthcare team.

While all nursing and midwifery roles require a research and evidence-based approach, a number of particular roles have clear and explicit responsibilities in this area. Ireland has seen the development of a number of clinical research facilities. Nurses and midwives support the management and operations of these facilities. The construction of a career pathway for nurses and midwives involved in medical-led research is recommended (NCNM 2008d). The ANP/AMP and CNS/CMS are examples of specific roles in clinical practice that incorporate research. Nurses and midwives in the third level institutions have pursued specific research roles and are engaged in research at doctoral and post doctoral level.

## 5.2 Role Expansion of Nurses and Midwives

The Department of Health has provided policy direction outlining the process for successful consideration of expansion of nursing and midwifery practice. The *Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Care* (DoHC 2011a) through a six step process provides a framework for nursing and midwifery role expansion in line with service need and national policy direction. It promotes clinical care that is delivered in a timely and evidence-based manner that reflects patients' needs. The *Strategic Framework* was developed within the context of clinical and regulatory standards. Each of the six steps of the framework outlines the necessary considerations for nursing and midwifery role expansion. The steps encompass service needs analysis, skill mix considerations, impact on service delivery, supports required and evaluation of clinical outcomes.

Enhanced nursing and midwifery roles are of critical importance to support the implementation of the national clinical programmes and the National Cancer Control Programme. Development of nursing and midwifery practice should be in the context of multi-disciplinary, multi-skilled teams. National, regional and local guidelines and frameworks should provide the process and clinical standards required for best practice by all members of the multi-disciplinary team.

## 5.3 Summary

The healthcare environment has changed significantly over the last decade driven by changing demographics and epidemiology and the health reform programme. Nursing and midwifery are responding to the requirements of healthcare priorities and service developments and have developed their role and function significantly in the last decade in order to enhance the quality of the patient journey. An overview of the relevant policies which will drive changes in service delivery for midwifery, general, psychiatric, intellectual disability and children's nursing is provided in Appendix 1. These drivers and new models of care delivery provide the context for the content of future nursing and midwifery undergraduate degree programmes.

# Section 6
# Evidence Review Undergraduate Nursing and Midwifery Curricula – Summary

An Evidence Review to inform the Department of Health of the best available evidence on the effectiveness of undergraduate nursing and midwifery curricula was undertaken by the Health Research Board (HRB) (Mongan & Farragher 2012). The curriculum is the collective education plan that encompasses the education philosophy, education programme content, processes of teaching and learning and assessment strategies. Two research questions were developed:

(1) What is the evidence from international literature, on the positive and negative outcomes of nursing and midwifery undergraduate education programmes (curricula)?

(2) What is the evidence from international literature, on the factors/variables that influence positive and negative outcomes of nursing and midwifery undergraduate education programmes (curricula)?

For this review, only intervention studies (randomised control trials, non-randomised control trials, and before and after studies) published in English since 1996 and from the following countries were included – USA, Canada, Australia, New Zealand, Norway, Switzerland, EU countries. The following is a summary of the search undertaken:

| | Number of full-text obtained | Number included in review |
|---|---|---|
| *Database searching:*<br>Pubmed, CINAHL and Medline | 124 | 104 |
| *Hand searching:*<br>Journal of Nursing Education<br>Journal of Continuing Education in Nursing<br>Nurse Education Today<br>Nurse Education in Practice<br>Nurse Educator | 81 | 51 |
| Review of reference lists | 16 | 8 |
| **Total** | **221** | **163** |

In total, 163 papers from 11 countries that evaluated some aspect of the nursing curriculum or compared different types of nursing curricula and that could be described as being either before and after (pre/post) or comparison studies were identified and reviewed. These papers were themed under the following headings:

- Teaching approaches
- Comparison of different curricula types
- Impact of change in curriculum approach
- Medication calculation/administration
- Use of information technology/information literacy
- Clinical skills
- Clinical placement
- Impact of a change in program/syllabus content.

There were no papers that met the inclusion criteria that evaluated the direct entry midwifery curriculum. No studies have been undertaken in any country that evaluated the entire curriculum in relation to graduate competencies and readiness to practice. The studies that have been completed concentrated on specific individual aspects of the curriculum and were undertaken with small sample sizes with the result that it cannot be concluded that any current curriculum has an evidence base supporting its effectiveness in educating nursing students to the required or pre-defined standard. Methodologically, the studies tended to be of low quality with many limitations. This does not necessarily mean that curricula are not of high quality; it simply means that no curriculum has been evaluated sufficiently to prove its effectiveness.

The retrieved studies may be described as small-scale, single-centre studies that are based on a wide variety of topics and provide a wide range of conclusions. Given the quality of the papers on nursing curricula the HRB could not recommend using these papers as a better basis for designing or modifying the existing nursing curriculum in Ireland. A better approach to evaluation of any redesign or modification of the Irish nursing or midwifery curriculum may be to develop a national, cross-institutional prospective programme of research.

# Section 7
# Consultation Report – Summary of Key Issues

## 7.1 Introduction

The Review committed to a wide and inclusive consultation to inform the work of the two subgroups and the development of recommendations. A variety of consultation processes were utilised in order to encourage active participation from all relevant stakeholders. Submissions were sought in December 2011, focus groups were held January to March 2012 and stakeholders were invited to meetings in February and March 2012. The following details the response to the consultation.

| | |
|---|---|
| **Submissions** | 227 |
| **Focus Groups** | 18 (Nursing, Midwifery and Public Interest) |
| **Stakeholder Meetings** | 22 Stakeholder Groups |

The attendance at the focus groups and the number of submissions indicated a huge interest and enthusiasm to contribute to the Review. Many participated through collective responses and representations. There was a general welcome for the Review and the opportunity to contribute to its deliberations through attending focus groups and providing written submissions. There was strong support for the provision of the undergraduate programmes at degree level with a general sense that students on graduation were 'fit for purpose'. The education programmes were seen to have facilitated the students to engage in a broad range of subjects such as research methodologies, ethical and legal considerations, risk assessment and management. The complete consultation report was published on the Department of Health website in March 2012 (DoH 2012b). A number of themes emerged in the consultation which centred on the following:

- Public Interest Considerations
- Programme Structure
- Programme Content
- Clinical Placements
- Governance Arrangements.

## 7.2 Public Interest Considerations

The public interest groups welcomed the opportunity to provide their opinions on the education and preparation of nurses and midwives. The concepts of patient empowerment, self care and a recovery approach were identified as very important to service users. Service users considered the development of a therapeutic relationship, having confidence in the knowledge and skills of the nurse or midwife and excellent communication between the nurse or midwife and the service user as essential to the therapeutic relationship. A greater emphasis on equality, diversity and inclusion was called for.

A number of recommendations were made for consideration in the development of the recommendations for the future education of nurses and midwives:

- Inclusion of service users in the development of curriculum content and programme delivery, and opportunities for service users to participate in student teaching through for example sharing their experiences and providing 'patient stories'

- Incorporation of self-awareness and a greater understanding of 'transference'[16] in the nurse-patient relationship. Reflective journaling was identified as a tool that could be promoted to support this
- Communication skills as an assessed subject
- An increase in interdisciplinary training to appreciate more clearly the need for a 'joined up' approach to patient care
- Provision of examples of real-life healthcare-related events and situations
- The principles of dignity, respect, equality and diversity as central to the curriculum thus promoting inclusive practice
- More focus on care in the home and community, with a greater understanding of the partnership between the health professional and family/carers in maintaining patient recovery and ongoing health
- A continuous improvement approach to training including educators spending time in the clinical or learning environment.

## 7.3 Programme Structure

There was support for maintaining the current separate points of entry to the nursing and midwifery professions. This was valued and seen to best prepare students to develop a strong focus with the scope of professional and clinical practice associated with the specific discipline and care setting. Graduates prepared in this way were considered to be more confident in their clinical practice, more secure in their leadership roles and more prepared to engage with other disciplines; and confident in their own practice base.

It was anticipated that as healthcare and service delivery became more diverse it would be essential for all nurses and midwives to be able to articulate more clearly the unique contribution that they bring to each field of care as well as being confident in utilising other models and interventions from the wider health and social care field in the interests of their patients and clients.

There was therefore general support for and acceptance of relevant shared learning and common foundation subjects particularly for the first year of the programme. Some suggested that there were common foundation opportunities which could also apply over the four years. This it was felt was different from a generic programme.

There was call to increase the internship to 12 months in order to support the services in workforce planning around the student to staff nurse (2:1) replacement ratio. The feasibility of the 2:1 ratio in the community was raised as a potential barrier to providing community placements for interns.

There is no accelerated pathway for graduates to attain a postgraduate registration qualification in a second discipline, with the exception of children's nursing and midwifery. This was seen to impact on nursing and midwifery workforce mobility and flexibility and limited career pathways and options for graduates. A graduate entry programme or an accelerated programme was proposed.

## 7.4 Programme Content

It was generally accepted in the consultation that the curriculum should be more outcome and competency based rather than content driven. It was noted that incremental learning is happening over the four years and that the identification of outcomes and competencies appropriate for each year was important. It was suggested that this approach would be useful in the development of academic content and to identify the level at which students have attained for each year.

16 Transference is a phenomenon characterised by unconscious redirection of feelings from one person to another (in this care nurse to patient or patient to nurse).

A population health approach to care delivery with health promotion/prevention skills would enable graduates to function equally well in hospital and community settings. Hospital, acute care and an illness model were identified as dominating the curriculum and it was felt an increased community focus and a health focus was required. The curricula needs to continually adapt to emerging healthcare policy and the changing models of delivery of healthcare ensuring the dynamic nature of knowledge and skills required for practice. This requires flexible curricula to allow for significant healthcare changes in Irish society to be incorporated in a timely manner. The following suggestions were made in terms of inclusion in the curricula:

- A renewed emphasis on the philosophy of person centred care, and the core values of compassion, empathy and caring
- The promotion of health and wellbeing, both at the preventative level but also in the context of chronic disease management
- A focus on the quality and safety agenda, including more in depth health assessment skills and the use of early warning scores
- Alignment of curricula with models of care associated with the clinical care programmes
- In line with population demography and epidemiology a stronger emphasis on gerontology and dementia care for mental health, intellectual disability and general nurse programmes.
- Chronic disease management, in particular models of community support
- End of life care, both within the home and institutional setting
- Greater integration of pharmacology and medication management throughout the programmes rather than being provided as a distinct module
- Inclusion of leadership, general management and teamworking skills
- Inclusion of clinical judgement, physical and psychosocial assessment, and decision making skills which would prepare nurses and midwives to work more autonomously in the community within the team structure. This approach would also provide the foundation for progressing to medication and ionising radiation prescribing; and expanded, specialist and advanced practice
- Good communication and interpersonal skills
- Opportunities for interdisciplinary education
- Greater curriculum content on equality, diversity and inclusion with an emphasis on preparing nurses and midwives to be aware of the specific healthcare issues and needs of diverse, multi-cultural, minority and ethnic groups as well as an emphasis on inclusive practice.

A principles based approach to the curriculum was advocated which would support national consistency where graduates attain specific competencies at the end of their programmes of education.

## 7.5 Clinical Placements

Clinical placements were universally valued by students, health service providers and HEIs. Early exposure to clinical placements was seen as a positive. A stronger emphasis on older person care was advocated for mental health, intellectual disability and general nurse programmes. Core and fundamental skills for nursing it was considered could be gained from older person placements.

The specialist placements as currently structured in years two and three were seen to fragment the programme and its delivery. Students described themselves as ‘tourists’ when on many of these placements. The current structure means that students in the main do not have general placements after year one and enter their internship year (4th year) having that large gap in their attainment of core skills which can impact on their performance. A significant challenge is the retention and development of skills and knowledge attained in first year as years two and three are predominantly focused on multiple short specialist placements the value of which were questioned. The extent of short specialist placements was seen as a luxury and it was considered that students would benefit more from a smaller

number of major placements. Students described the logistics of travel for multiple specialist clinical placements in terms of distance, travel arrangements, requirements to move accommodation and cost as onerous.

Clinical placements it was proposed should be integrated more effectively with theoretical components to allow students to more easily apply theory to practice. For example students might do a specific clinical placement but may not have had the theoretical/academic content.

With the move to community care students require more time in community placements including community intervention team placements which should be facilitated at the beginning of the programmes. It was considered that a broader range of community placements should be utilised. Following the patient journey from the home with primary care at the lowest level of complexity through to the acute hospital services was advocated. Midwives in particular considered that more community placements were necessary in order to have more focus on the normal aspects of midwifery both in hospital and in the community.

The internship was seen as essential for consolidation of learning and development of critical thinking skills. It was felt that there are gaps in attaining key clinical skills/competencies in the internship year for example intravenous drug administration and blood transfusions. Development of core competencies for the internship it was felt would be useful but would require a structured framework at national level.

Preceptors[17] were seen to be integral to the programmes and their input was highly valued. Initial education preparation for preceptors was identified as varied throughout the country. It was suggested that preceptorship training could be mandatory and potentially be defined at a national level. On-going support for and evaluation of preceptors was identified as important going forward. Preceptors were seen as a diminishing resource and at times they could have up to five students to precept. It would appear that the understanding and interpretation of supernumerary status and reflective practice is varied which impacts negatively on student experiences. Further guidance from the Nursing and Midwifery Board was requested.

It was considered that broader interpretation in what defined a clinical placement would be useful. It was suggested that this should allow for placements where there is no nurse or midwife for example a student psychiatric nurse or a student intellectual disability nurse could have a valid learning opportunity with a psychologist. The clinical placement learning outcomes and assessment should however be overseen by a nurse or midwife. While there was no consensus it was considered that it would be useful to explore the potential for a national framework for curriculum content and assessment processes or a national curriculum.

There was a strong call for consistent national assessment processes and documentation. This would minimise variation in assessment across the country. This would support consistency of outcomes and competencies attained on registration as a nurse or midwife.

## 7.6 Governance Arrangements

The current arrangements between HEIs and health service providers are managed through Local Joint Working Groups. These were highly valued however they appeared to work better in some areas than others. It was considered that the joint working groups should stay strategic, be inclusive and work with formalised memorandums of understanding. The joint working groups it was emphasised should have inclusive representation from both clinical and academic staff with a high level of commitment and responsiveness to issues.

17 A preceptor is a registered nurse or midwife who supports student learning in clinical settings and assumes the role of supervisor and assessor.

Clinical Placement Co-ordinators (CPCs)[18] are generally attached to hospital services and do not provide cover in the community. There are some exceptions in mental health and intellectual disability. The employment location of CPCs was raised in terms of creating flexibility in supporting more diverse clinical placements.

It was suggested that there are a number of competing priorities for academics including the need to undertake research and to publish. However the importance of lecturers being clinically credible and maintaining clinical competence in their area of interest was raised. Consideration should be given to other types of appointments e.g. lecturer practitioners. The 'link lecturers' were not seen to work in reality. The importance of clinical staff teaching on programmes was valued and it was considered that more such teaching should occur. There was call for more visibility of academic staff when students are on clinical placements to augment assessment and support of students. The role of allocations officers was acknowledged.

## 7.7 Summary

There was strong support for the degree programme in the consultation process. Suggestions were made to improve programme oversight, programme delivery and programme evaluation. It was considered that consideration should be given to a standard curriculum, assessment process and documentation. Greater guidance was called for from the Nursing and Midwifery Board and suggestions were made in relation to the Nursing and Midwifery Board education requirements and standards. General support for the five points of entry remained however the concepts of shared learning, common foundation subjects and interdisciplinary education were advocated.

Learning outcomes and specific competencies for each year of the programmes were seen to be essential. A philosophy of patient empowerment, population health improvement and life-long learning was advocated. A principles based approach to the curriculum driven by emerging models of healthcare delivery in Ireland was advocated which would support national consistency where graduates attain specific competencies at the end of their programmes of education. On-going transparent evaluation of the programmes was recommended.

18 Clinical Placement Co-ordinators (CPCs) are qualified nurses or midwifes who support preceptors and clinical nurse/midwife managers in the teaching and assessment of student nurses and midwives on clinical placement.

# Section 8
# Workforce Planning Subgroup – Summary of Key Issues

## 8.1 Introduction

A Workforce Planning Subgroup chaired by Dr Michael Shannon, Director Nursing and Midwifery Services, HSE was established to ascertain a projection of the number of student places required up to 2022. The subgroup completed its work through an advisory group and a working group with Ms Liz Roche, Area Director, ONMSD as Project Lead. The subgroup included representatives from nursing and health management, various health and education staff representative groups, human resources, FÁS, education, nurses and midwives with experience in planning services from nursing (general, mental health, intellectual disability, children's) and midwifery services.

## 8.2 Context

The requirement to deliver a sufficient number of effectively prepared nurses and midwives from the undergraduate programmes is important to ensure that an appropriate supply of nurses and midwives are available to meet the needs of the health service and within resources available. However, the context of these projections is complex and dynamic as per PESTLE analysis (Table 9).

**Table 9: PESTLE analysis of environmental issues impacting on student places for nursing and midwifery undergraduate education**

| | |
|---|---|
| **Political Issues**<br>Health sector reform<br>Reform of higher education<br>Programme for Government 2011-2016<br>- Strengthening Primary Care<br>- Universal Health Insurance<br>- Croke Park Agreement<br>Statutory reports *(Report of the Commission on Patient Safety and Quality Assurance* (DoHC 2008b)*; HIQA investigation reports)*<br>DoH undergraduate nursing and midwifery education review 2011-2012<br>*Vision for Change* (DoHC 2006b) | **Economic Issues**<br>Decrease in funding for the health service by 8.15% since 2008/ contingency retrenchment<br>Continuing changes in global and national economic climate and job market<br>Public service and health sector agreements to fulfil *National Recovery Plan* 2011-2014 e.g. employment control framework, incentivised retirement, moratorium on recruitment<br>Planned reduction in health budget of €1.5 billion in 2013 and 2014<br>Reduction of staffing to 95,500 by 2014<br>Skill demand and supply<br>Reduction in undergraduate student nurse numbers in Ireland by the DoH in 2009 by 310 (↓16.5%) |
| **Social issues**<br>Ongoing demographic and epidemiological changes<br>Older age profile<br>Increase in chronic diseases<br>Increasing levels of service user expectations and advocacy<br>Demand for nursing and midwifery education<br>Demand and availability of flexible working opportunities<br>Move to treatment at the lowest point of complexity | **Technological changes**<br>Developing evidence base for healthcare<br>Innovation in practice and healthcare interventions<br>*Strategic Framework for Role Expansion of Nurses and Midwives* (DoHC 2011a)<br>*A Vision for Psychiatric Mental Health Nursing* (HSE 2012d)<br>*Review of the Role of Public Health Nursing* (HSE 2012e)<br>*A Strategy and Educational Framework for Nurses Caring for People with Cancer in Ireland* (HSE & NCCP 2012)<br>Suite of education programmes relating to Dementia ONMSD 2012<br>Expansion of day procedures/surgery<br>Reduced lengths of hospital stay |

**Table 9: PESTLE analysis of environmental issues impacting on student places for nursing and midwifery undergraduate education –** *continued*

| **Legislation** | **Environmental issues** |
|---|---|
| Nurses and Midwives Act 2011<br>Nurse and Midwife prescribing (medicinal & ionising radiation)<br>European directives (professional and/or employee)<br>National employment legislation<br>Health Acts | Public Service Agreement Action Plan – nursing and midwifery implications<br>Health service structural change<br>- Abolition of Health Service Executive<br>- Establishment of Patient Safety Authority<br>- Maintenance of the Special Delivery Unit<br>Changing skill mix across healthcare professions including nursing and midwifery<br>Student nurse/midwife attrition<br>Rationalisation/reconfiguration of services |

## 8.3 Scenarios

The Workforce Planning Subgroup examined four possible scenarios in its deliberations for undertaking an analysis of the number of student places required to ensure sufficient numbers of nurse and midwife graduates up to 2022. All scenarios are examined at a high level and are non-discipline specific.

***Scenario 1: Forecasting future staffing requirements based on maintaining the current density of nurses/midwives per 1000 population.***

The tool developed by the Labour Market Research and Skills Unit in FÁS applied to the health service[19] for the Department of Health was used to assess the demand and supply of nurses and midwives for the total health sector up to 2022. This produces a workforce model based on population growth as a proxy for assessing demand for registered nurses and midwives. One of the assumptions is the supply of nurses and midwives to the workforce from the undergraduate programmes. The project methods included desk research and secondary analysis of existing data and in its absence health service surveys. Data was sourced from the HSE, the Nursing and Midwifery Board, Independent Hospitals Association, Federation of Voluntary Agencies, Enable Ireland, Nursing Homes Ireland, Central Statistics Office and Higher Education Institutes. For modelling purposes a number of assumptions were made.

This scenario projected an undersupply of nurses throughout the projection period however the FÁS modelling tool used in this scenario does not make any claim as to the adequacy of the existing density nor is it based on any decision to maintain this over time or to increase the proportion of the nursing and midwifery workforce that will be directly employed. Additionally, such quantitative modelling is at national level only and is based on the overall assumption of being self sufficient, to maintain existing numbers of staff.

Given the current economic climate, and the substantial policy changes affecting healthcare, the output from this scenario may be perceived to be of limited value. The reality for the foreseeable future will be to provide a quality and safe service in new and innovative ways, but with decreased resources. The challenge will be to do more with less particularly in the context of a planned reduction in overall health service numbers from the current level of 102,000 approximately to 95,500 by 2014.

***Scenario 2: Forecasting future staffing requirements taking into account the 2009 Employment Control Framework in the Health Service.***

The Employment Control Framework was introduced in 2009 as a result of government policy to facilitate a permanent, structural reduction in staff numbers and to contribute significant and ongoing savings to the Exchequer[20]. This scenario uses the FÁS modelling tool used in Scenario 1 with adaptations to accommodate the following assumptions:

19 FÁS *A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations* (Behan et al 2009).
20 (HSE 2010) HSE HR Circular 001/2010 Revised Employment Control Framework for the Health Services - 2010

- Overall HSE staff reductions reduced by 15.5% from their highest in September 2007. This is applied at a national level to nurses and midwives by 2015.
- Public sector staffing levels to remain at 2015 level for the remainder of the projection period.
- Use of agency nurses/midwives was maintained static for the duration of the projection period. These were based on the estimate of usage – and the required 50% reduction as outlined in the 2012 National Service Plan.
- In this scenario it is assumed that as the public sector numbers are reduced the non public sector will expand to meet the demand. Non public sector (private hospitals/nursing homes/ non-directly funded voluntary organisations) staffing levels were projected based on population changes – to maintain the density per 1000 population.
- Reductions in the public sector numbers are not likely to provide additional supply to the overall health economy as reductions are targeted at those who are eligible to retire.
- Healthcare assistants are not included therefore skill mix is not taken into account directly.

Scenario 2 took into account a reduction of 15.5% of nurses and midwives in the public sector as that was calculated as an equal pro-rata reduction for all staff categories in the health service. This actually projected the numbers to be reduced to 32,988 - a reduction of over 6000 nurses and midwives since September 2007. This reduction was applied following consultation and verification with HSE HR function. The output of this scenario noted that overall the numbers of students being prepared at undergraduate level and postgraduate level just met the demand (given additional leavers/reducing of hours etc). This scenario acknowledged the economic and employment control context but also projected a small undersupply of nurses throughout the health economy for most of the projection period. This gap can be met, using alternative internal and external sources of supply.

This scenario indicates that in order to maintain stability within the health system it is reasonable to continue with the intake of the current number of undergraduate student nurses and midwives for the foreseeable future or until the economic and service reform agenda becomes clearer.

***Scenario 3: Examining the skill mix of nurse and midwife to support staff.***

The output from this scenario highlights the current skill mix in the Irish public health sector is similar to the four other countries (Northern Ireland, England, Scotland, Wales) that were benchmarked who have similar health/nursing structures to Ireland. In the context of the Public Service Agreement 2010-2014, the Health Sector Action Plan 2012 has identified the requirement to further explore skill mix. A national group has commenced this exercise and the output of this work may have an impact on determining student numbers in the future. A number of skill mix initiatives are under urgent examination in the context of achieving further efficiencies under the Public Service Agreement.

***Scenario 4: Examining the impact of the National Clinical Programmes on the requirement for nurses and midwives.***

The examination of this scenario, given its limitations in being able to aggregate the total number of nurses/midwives required in the health service, has highlighted the extent of the health service change in Ireland. It also demonstrates the potential cost and staffing efficiencies that may be made in the future when services are redesigned.

Initial evidence from the outputs of the programmes indicates that additional nurses are required – specifically at specialist and advanced practice level for programmes relating to chronic diseases. This suggests that additional staff nurses may be required to be prepared in order to release staff to be developed in specialist and advanced practice. However, other programmes such as the National Acute Medicine Programme (HSE 2010) have suggested that bed days could be saved by implementing their model of care. As such this would create cost and staffing efficiencies and therefore increase the capacity for staff to be redeployed to meet the needs of patients with chronic diseases or to work in other care settings such as primary care/community. From a policy perspective, cognisance of the Employment Control Framework will also have to be considered in this context.

Using data from the national clinical programmes, it is not possible to project with any accuracy at a macro level the number of nurses and midwives required to meet the needs of the health service for the following reasons:

- The current national clinical programmes do not when aggregated account for the total health services delivered
- Some programmes identify specific staffing requirements whereas others do not
- Many of the programmes will overlap when models of care and staffing requirements are identified.

## 8.4 Nurse/Midwife Staffing Levels and Skill Mix

Effective service delivery requires processes to ensure that there will be sufficient staff available at the right time, with the right skills, diversity and flexibility to deliver high quality care i.e. appropriate skill mix. The *Integrated Workforce Planning Strategy for the Health Services* (DoHC & HSE 2009) identifies as its overall goal to ensure that strategic and operational workforce planning processes are established as key activities in the health service. The strategy states that it provides the framework for future workforce planning decisions that will lead to better outcomes. It highlights that workforce planning must be integrated with service and financial planning and outlines the principles for guiding better workforce planning decisions. It also supports initiatives on reconfiguration of the health service human resource including those already underway such as improved Consultant/Non Consultant Hospital Doctor ratios, nurse prescribing and SKILL (Securing Knowledge into Lifelong Learning) development for support staff. It also provides service planners with the tools to assess other sources of supply for service improvement through redeployment, retraining or changed skill mix.

The term 'skill mix' is usually used to describe the mix of positions, grades or occupations in an organisation. It may also refer to the combinations of activities or skills needed for each job within the organisation.

Skill mix is generally embedded in the workforce planning agenda; the overall aim being to have appropriate numbers of nurses and midwives and other skill mix in place with the right skills and competencies to serve population health needs (DoHC 2011a). Healthcare Assistants support the delivery of patient care under the supervision and direction of qualified nursing personnel (DoHC 2001c). A level 5 FETAC approved programme for Healthcare Assistants has been developed and is provided by the Centres of Nursing and Midwifery Education throughout the country. The programmes have been seen to make a positive contribution to the delivery of patient care in clinical settings in Ireland (HSE 2008). In the context of the Public Service Agreement 2010-2014, the Health Sector Action Plan 2012 has identified the requirement to further explore skill mix. A national group has commenced this exercise and the output of this work may have an impact on determining student numbers in the future.

## 8.5 Summary

The requirement for nurses and midwives is for determination by the health system based on a needs assessment and established priorities through the service planning and workforce planning processes. Workforce planning needs to be developed further using a bottom up approach taking cognisance of health reform, economic challenges and the quality and patient safety agenda. The projected supply of nurses and midwives reported in some of the scenarios needs to be seen in the wider context of health reform and economic constraints that must take into account alternative solutions – particularly in the short term. These solutions include the requirement to reconfigure services and the workforce; and to examine alternative internal and external nursing and midwifery workforce supply options.

The Workforce Planning Subgroup made two recommendations to the Review Group. The Subgroup considered that in order to maintain stability within the health and higher education systems that the current number of undergraduate student nurses and midwives (1570) continue to be commissioned

for the foreseeable future or until the economic and service reform agenda becomes clearer. This is based on the outcome of scenario 2 which forecast future staffing requirements taking into account the 2009 Employment Control Framework in the Health Service and indicated that the overall numbers of students being prepared at undergraduate level just met the demand.

The FÁS study identified oversupply in some programmes with the exception of general nursing (Behan et al 2009). It also highlighted that the current divisions of nursing do not allow for inter-divisional flows or transferability of skills across divisions. It is important that consideration of the breakdown of the numbers required for intake to each of the undergraduate programmes continues to be monitored in order to meet workforce demand. It is noted that *Vision for Change* (DoH 2006b) sets out in detail the strategic direction for Irish mental health services and the functions of the overall structure. It recommended a reduction of approximately 1,727 RPNs based on 2007 levels. The Workforce Planning Subgroup identified that the uptake of incentivised schemes in the mental health area has seen a reduction of staff. The HSE August census indicates that RPNs are down 897 from 2009 staffing levels (↓15.67%). However the impact of the further implementation of all elements of *Vision for Change* (DoH 2006b) will need to be incorporated into future workforce planning.

In light of the above scenarios and the changing demands of the health service a five year workforce planning exercise to examine the nursing and midwifery workforce requirements is recommended. This should have the active involvement of local healthcare managers and include an examination of skill mix in all service areas to ensure the most effective use of nursing and midwifery skills. Requirements should be collated nationally to ensure a system wide and strategic approach.

# Section 9
# Curriculum Subgroup – Summary of Key Issues

## 9.1 Introduction

A Curriculum Subgroup chaired by Dr Maura Pidgeon, Chief Executive Officer, the Nursing and Midwifery Board was established and four themes were examined - professional scholarship, programme structure, curriculum content and clinical assessment. The Curriculum Subgroup included representatives from HEIs, health service providers, representative organisations, patient representatives, the Nursing and Midwifery Board and the Royal College of Physicians of Ireland; and was supported by a Research Assistant, Ms Dawn O'Sullivan. An international webinar/seminar was conducted to consult with a panel of experts on the following themes: clinical assessment, curriculum content, professionalism/culture/leadership and structure of the programme. Consideration was given to the themes that emerged from the Consultation Report (DoH 2012b).

The recommendations of the Curriculum Subgroup to the Review Group are principle based with strategic intent underpinned by professional scholarship. Professional scholarship incorporates disciplinary knowledge, behaviours, values and attitudes; and a commitment to lifelong learning, evidence-based practice, leadership, high quality care, compassion and caring. Clear understanding of what it means to belong to the professions of nursing and midwifery involves incorporation of professional parameters (legal and ethical issues), professional behaviours (discipline specific knowledge and skills, appropriate relationships with clients and colleagues, attitude and appearance); and professional responsibilities and accountability.

## 9.2 Programme Structure

The duration of programmes, exploration of various international models of undergraduate education, entry requirements, including a preliminary examination of graduate entry to nursing and midwifery and views concerning governance issues were considered by the Curriculum Subgroup. A variety of terms are used for different models of education provision in nursing and midwifery:

- ***Direct Entry Model:*** Students choose the relevant point of entry on application to the CAO[21] for undergraduate nursing or midwifery education courses[22].
- ***Generic/Generalist Model:*** A single basic preparatory training where all nursing students undertake a comprehensive training/education programme in nursing and exit with a generalist nursing qualification.
- ***Common foundation programme:*** A programme which encompasses a common foundation (all core modules) for year one or longer for all disciplines followed by specialist theory and practice.

The 'direct entry' model reflects the philosophy that there are fundamental differences between the divisions of nursing and between nursing and midwifery in terms of required knowledge, skills and competencies. The following Irish reports are summarised in section 3 and all provide recommendations supporting the 'direct entry' model:

21 The higher education institutions in the Republic of Ireland have delegated to the Central Applications Office (CAO) the task of processing centrally applications to their first year undergraduate courses.

22 In Ireland there are direct entry education programmes at degree level (4 years) in general nursing, psychiatric nursing, intellectual disability nursing, combined children's and general nursing. The combined children's general and nursing programme is a 4.5 year programme.

*Report of the Commission on Nursing* (Government of Ireland 1998)
*Report of the Paediatric Nurse Education Review Group* (DoHC 2000a)
*Report of the Nursing Education Forum* (Government of Ireland 2000)
*Report of the Expert Group on Midwifery and Children's Nursing Education* (DoHC 2004)
*Review of Specialist Model of Initial Training in Ireland* (Carney et al on behalf of An Bord Altranais 2005).

The Curriculum Subgroup noted that the proponents of the generic approach to registration education indicate that having a single registration qualification permits ease of movement across specialties, enhances mobility and provides a united family of nurses. Assumptions inherent in this model are that it prepares graduates to be competent to practice across a variety of settings and client groups upon graduation and to have the capacity to differentiate the care and interventions required by very different client groups i.e. psychiatric, intellectual disability, midwifery etc. The Curriculum Subgroup identified that a generic model had deficiencies in terms of:

- a minimal focus on the clinical and theoretical aspects of the particular specialist discipline which leads graduates to be inadequately prepared to function as discipline specialists (e.g. a mental health nurse not being adequately prepared to work in community and in-patient settings)
- a requirement for post-registration programmes to develop basic competencies for population groups
- difficulties with recruitment, retention and workforce planning
- loss of specialist nursing knowledge and skills in the care of clients with intellectual disabilities
- developing a professional identity.

Direct entry midwifery is provided in a number of European countries, New Zealand and Canada. A common foundation programme is not suited to midwifery education programmes because it does not support midwifery as a distinct profession as provided for in the Nurses and Midwives Act 2011.

The Curriculum Subgroup concluded that evidence and expert opinion supports the need to retain direct entry to midwifery; and the four points of entry to nursing from the perspective of the competencies required by the graduate to meet the complexity of care, optimum treatment and interventions for different client groups and to ensure appropriate workforce supply.

### *9.2.1 Shared Learning Models*

Many Irish HEIs in their current programmes espouse this concept through the sharing (across the four divisions of nursing and midwifery) of certain core materials across the four year programme[23] but most especially in year one. Modularisation provides an opportunity for inter-professional education that, when used correctly, can support rich learning. However as identified in the MINT project (Nursing and Midwifery Council (UK) 2010) the challenge of sharing lectures for example midwifery students sharing modules with nursing students requires that due regard is given to student requirements. The Curriculum Subgroup agreed the merits of sharing modules across the entirety of the programmes particularly in year one. Further consideration could be given to flexible modes of entry and enabling wider access to the undergraduate programmes.

## 9.3 Curriculum Content

The Curriculum Subgroup considered the context of curriculum content with specific reference to health reform including *A Vision for Change - Report of the Expert Group on Mental Health Policy* (DoHC 2006b), *Time to Move on from Congregated Settings. A Strategy for Community Inclusion* (HSE 2011a), *Tackling Chronic Disease - A Policy Framework for the Management of Chronic Diseases* (2008a) and *Children First, National Guidance for the Protection and Welfare of Children* (DCYA 2011).

23 4.5 year programme for the dual qualification children's and general nursing

The Curriculum Subgroup reviewed EU requirements, the national policy initiatives of Ireland, the report of the TUNING (Europe) (Nursing) project[24], the International Council of Nurses competencies framework (ICN 2008), the report of the Institute Of Medicine (US) (2010) *The Future of Nursing: Leading Change, Advancing Health,* the American Associations of Colleges of Nursing (AACN 2008) report regarding curriculum content for future nursing education programmes, the recommendations of the World Health Organisation (WHO 2011) related to patient safety and *Building a Culture of Patient Safety* (DoHC 2008b). In addition cognisance was taken of the education requirements and standards of the Nursing and Midwifery Board and of the learning points from the operationalisation experiences of conducting site visits, reviewing curricula and a review of the conditions and recommendations of approval for programmes over the last number of years by the Nursing and Midwifery Board.

The curriculum content needs to reflect the national health reform programmes including community and integrated care; and older person care. Education should prepare nurses and midwives to deliver patient focused, equitable, safe, high quality nursing and midwifery care for the Irish healthcare services promoting health and wellbeing. Nurses and midwives should engage with all healthcare professionals to deliver efficient and effective care and assume leadership roles in the evolving healthcare system as partners on the healthcare team. Advances in the education of nurses and midwives reflect continual developments in the practice of nursing and midwifery across the continuum of care. Curriculum content development should occur without adding excess content to existing curricula but by exploring ways of incorporating key aspects into modules or by changing the emphasis of existing content and through clinical learning. This also supports the shift from input based content to outcome and competency[25] based curricula.

The Curriculum Subgroup identified principles which will guide the nursing/midwifery curriculum to ensure the student has the required competencies at point of registration and also that he/she is an active participant in lifelong learning. They also provide a focus for reflection to promote the integration of theory and practice. The principles are intended to support the dynamic healthcare environment in which the graduate is expected to provide safe competent care into the future. The following is the list of principles:

- Practice in primary, secondary and tertiary settings
- Care for the patient across the health/illness continuum
- Care for the patient across the lifespan from birth to older years
- Practice from a holistic, caring framework
- Practice from an evidence base
- Promote safe, quality patient care
- Utilise assessment, diagnosis, planning, implementation and evaluation skills
- Manage the healthcare environment for the patient/client
- Use clinical critical reasoning to address simple to complex situations
- Assume accountability for one's own and delegated nursing and midwifery care
- Improve the quality of life of patients and their families facing life-limiting and life-threatening illness
- Actively promote older person care with particular reference to multiple pathologies including physical/psychological/social health problems to integrate care and support the inter-professional care needs of the older adult
- Support the patient and their family at end-of-life
- Care for diverse populations
- Adapt to changing work environments

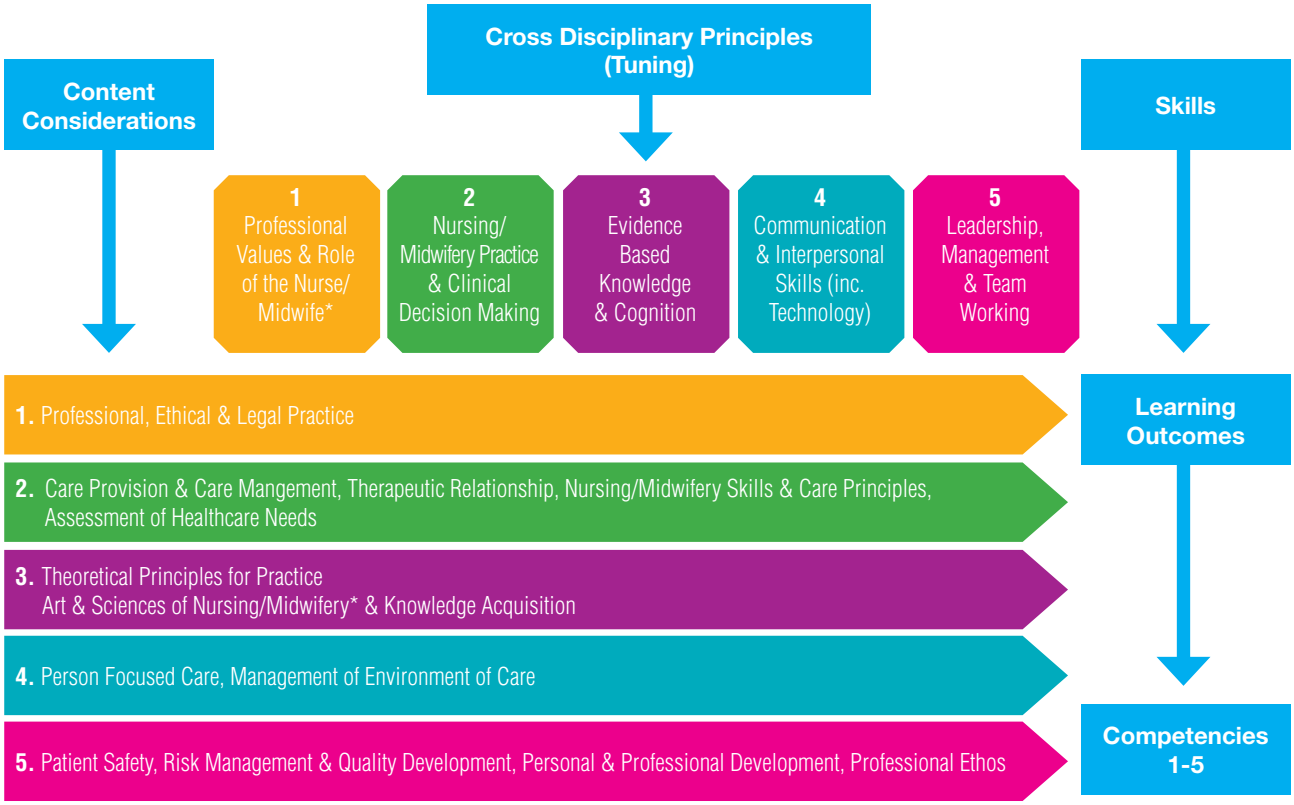
24 http://www.cbie-bcei.ca/wp-content/uploads/2012/04/tuningnursingfinal.pdf

25 A competency describes what is observed when a nurse or midwife combines knowledge, skills, attitudes and judgement to perform role-relevant tasks.

- Participate in and contribute to the inter-professional team and the inter-professional learning environment
- Build on existing good practice placing the patient at the centre of care and decision making
- Work in an empowering partnership with patients, families and communities
- Work with and respect the expert patient
- Engage in care of self in order to care for others
- Engage in continuous professional development
- Participate in education and training in conflict resolution, the management of lone working and work related aggression and violence.

Five broad domains from the Tuning Project[26] have been identified by the Curriculum Subgroup as a guide to curricula content development (Figure 3).

**Figure 3: Curriculum Content and Principles for the Undergraduate Programmes (adapted from Tuning)**




* *Respects the unique requirements for the nursing or midwifery education programme as provided for in Directive 2005/36/EC*

The content of the education programme should respect the structure of the programme as a 4-year honours degree level 8 National Qualifications Framework (NQF) award that leads to registration in one of four disciplines of nursing or midwifery on the register as maintained by the Nursing and Midwifery Board[27]. Each division of the register has an identified unique philosophy associated with

26 Further information available: http://www.cbie-bcei.ca/wp-content/uploads/2012/04/tuningnursingfinal.pdf
27 Four and half years for combined general and children's programme.

the patient/client as the focus of care. All content should respect the provisions of the Directive of the EU 2005/36/EC (European Commission 2005a). The Framework outlines the skills, learning outcomes and competencies to be achieved within the overall Tuning (adapted) Framework of cross-disciplinary principles and content considerations.

## 9.4 Clinical Placement and Assessment

Students undertake a number of clinical placements during their undergraduate programme. The Curriculum Subgroup gave specific consideration to the requirement to clarify supernumerary status particularly with regard to a shared understanding and operationalisation in the clinical area by both HEIs and health service providers to ensure maximum learning and the effective facilitation of student integration into their clinical experience.

Students are supported in clinical practice by a number of key personnel including nursing and midwifery practice development co-ordinators, link lecturers, clinical placement co-ordinators (CPCs), allocation liaison officers (ALOs) and preceptors. There is no national standard for preceptorship training which is currently provided locally between health service providers and HEIs. A national preceptorship programme with opportunity for refresher programmes was advocated. The Curriculum Subgroup recommended that different models of student support within the clinical learning environment should be explored which would provide greater clarity in relation to the clinical and theoretical elements of the programme.

Clinical assessment occurs during each clinical placement by a preceptor. Ensuring consistency in the assessment process will help avoid variations in preceptor assessment procedures. Hence it was considered that there may be merit in developing a common assessment tool reflecting the Nursing and Midwifery Board education requirements and standards. Undergraduate nursing and midwifery students are required to complete a number of short duration clinical placements before their final year of internship. These short placements can challenge competence attainment and identification of weak students. The Curriculum Subgroup agreed that a reduction in the number of specialist placements informed by a clear rationale as to how such placements contribute to the development of the core competences, accompanied by emphasis on significantly longer core placements taking place in each of the first three years of the programme leading up to the internship would be helpful. In addition the establishment of a substantial and mandatory older person clinical placement for relevant programmes and the further development of community placements to enhance the development of community related skills were considered important.

## 9.5 Summary

The Curriculum Subgroup made 17 recommendations to the Review Group. The recommendations were principle based with strategic intent underpinned by professional scholarship. Programme governance was agreed as critical to successful implementation of the education programmes and the Curriculum Subgroup recommended that Local Joint Working Groups should operate within a memorandum of understanding between third levels and health service providers. The memoranda should be based on a framework of nationally agreed governance principles which supports national policies and the health reform agenda with locally agreed addendums if required. Enhanced clinical engagement between HEIs and healthcare organisations would facilitate the promotion of theory, practice and research.

# Section 10
# Discussion and Recommendations

## 10.1 Introduction

The review of the undergraduate degree programmes was conducted in the context of a changing economic environment and reform of healthcare delivery and structure. This healthcare reform involves significant strengthening of the primary and community care sector and radical reform of the acute hospital sector, reflecting the significant refocusing of services to meet the needs of the older person, those children and adults with chronic disease, and the well established community models for the support of those with mental health issues and those with intellectual disability. The introduction of a 'money follows the patient' funding model is planned. Department of Health policy such as *A Vision for Change - Report of the Expert Group on Mental Health Policy* (2006b), *Tackling Chronic Disease - A Policy Framework for the Management of Chronic Diseases* (2008a), *Report of the Commission on Patient Safety and Quality Assurance* (2008b), the patient safety and quality agenda and the pending national Framework for Health and Wellbeing provide strategic direction for future healthcare delivery.

The Government reform programme provides opportunity to ensure that promotion and prevention become integral parts of a whole government approach to improve not only the delivery of health services but in the treatment and management of all patients.

This Review provides valuable information to inform the delivery of education for nurses and midwives at undergraduate level taking into account current and future service needs. There are now seven years of nursing graduates and three years of graduates from the midwifery and the integrated children's and general nursing programmes. It was timely therefore to conduct the first comprehensive review of the undergraduate nursing and midwifery degree programmes in order to establish their efficiency and effectiveness in preparing nurses and midwives to practice in the Irish healthcare system now and into the future, and to make recommendations for any changes required.

Recommendations were agreed by the multi-disciplinary Review Group taking the following into account:

- Health policy
- The Health Reform Programme
- The *Programme for Government* (2011-2016)
- *Context of Healthcare Delivery in Ireland* (Review Briefing Paper 23rd February DoH 2012a)
- National and international education models for nursing and midwifery (Review Briefing Paper 23rd February DoH 2012a)
- *Consultation Report* (DoH 28th March DoH 2012b)
- *National Strategy for Higher Education to 2030* (Department of Education and Skills 2011)
- Examination of the content of the undergraduate programmes and the structure of the current degree programmes by the Curriculum Review Subgroup chaired by Dr Maura Pidgeon
- Analysis of the number of student places required to ensure sufficient numbers of nurse and midwife graduates for new patterns of service delivery within the public health system by the Workforce Planning Subgroup chaired by Dr Michael Shannon
- The Health Research Board Evidence Review which examined the effectiveness of undergraduate nursing and midwifery curricula (Mongan & Farragher July 2012).

The Review Group was mindful of the role of the Nursing and Midwifery Board as outlined in the *Nurses and Midwives Act 2011- Part 10, 85 Education and Training*. The Nursing and Midwifery Board has the statutory responsibility to set the standards of nursing and midwifery education and training for first time registration and prepare guidelines on curriculum issues and content to be included in approved

programmes in line with the EU Council Directive 2005/36/EC (European Commission 2005a). It is noted that there is a possibility that as part of the modernising agenda of the Commission related to the Qualifications Directive 2005/36/EC articles within this directive may be amended. The Review Group took cognisance of the recommendations of the *National Strategy for Higher Education to 2030* (Department of Education and Skills 2011).

At the outset the Review aimed to "build on excellence" adopting an inclusive consultative approach acknowledging the quality of existing education programmes. The Review Group agreed on the need to ensure that nurses and midwives attain the knowledge and skills required to provide optimum care to patients in a modern health service and that education programme content should reflect developments in health policy and delivery of services.

The recommendations were developed in line with global nurse and midwife education standards in order that Irish nursing and midwifery graduates will be competent to provide safe, quality care and promote positive health outcomes for the populations they serve. Nurses and midwives hold a professional qualification which ensures they are competent to deliver the required standard of care meeting the standard set by the regulator. The recommendations are underpinned by professional scholarship which incorporates disciplinary knowledge, behaviours, values and attitudes; and a commitment to lifelong learning, evidence-based practice, leadership, high quality care, compassion and caring for others.

An increasing participation of students with disabilities in higher education requires systems which are open and flexible to ensure that placements are accessible to all students. The *National Guidelines for Working with Nursing and Midwifery Students with a Disability or Specific Learning Disability in Clinical Practice* (McKernan C. & Quirke M. 2012) provides guidance for educators to support an inclusive education environment for student nurses and midwives. These guidelines are underpinned by the Employment Equality Acts (1998-2011) which prohibit discrimination on the grounds of a disability; and the Disability Act (2005) which provides a legislative basis for improving access to a wide range of public services and facilities for people with disabilities.

## 10.2 Curriculum Considerations

Curriculum considerations centred on the structure of the programmes, the curriculum content and the clinical placements. The curriculum is the plan that encompasses the education philosophy, education programme content, processes of teaching and learning and assessment strategies.

### *10.2.1 Structure of the Current Degree Programmes*

There are direct entry education programmes at degree level (4 years) in midwifery, general nursing, psychiatric nursing, intellectual disability nursing and combined children's and general nursing. The combined children's general and nursing programme is a 4.5 year programme. Significant support for the provision of the undergraduate nursing and midwifery programmes at degree level (level 8 National Framework of Qualifications) emerged from the consultation and the Curriculum Subgroup.

The benefits of the current education programme structure including the internship period were identified during the consultation process as preparing graduates for practice from day one of employment as a nurse or midwife for specific population groups. This means that nurses are not required to undertake additional post registration education in order to be prepared to practice for example in psychiatry or paediatrics. Students must however choose their discipline at leaving certificate stage and there are limited opportunities to gain registration qualifications in other disciplines without re-doing a second four-year registration education programme.

A number of countries offer accelerated programmes for graduates of non-nursing disciplines. Ireland offers a graduate entry programme to medicine which is perceived as a successful route to medicine. The Review Group supported the concept of flexible modes of entry enabling wider access to the

undergraduate nursing and midwifery programmes. Exploration of opportunities for graduate entry programmes for nursing and midwifery should be considered in line with service need and workforce demand. This should encompass recognition for prior learning and flexible progression opportunities as identified in the *National Strategy for Higher Education to 2030* (Department of Education and Skills 2011). This strategy recommends that routes of progression should be flexible into; within and across HEIs and that a national framework for the recognition of prior learning must be developed and recognised by all HEIs.

Reform of selection and entry to university in the context of national educational policy is the subject of debate and review. In terms of future direction the Irish Universities Council identify that the 'white heat' of the points race is most keenly felt in first year entry routes which are inherently specialised with little or no overlap with other courses (IUA 2012). Nursing is not identified in this cohort of courses. Nursing is within the 30% of undergraduate programmes where students enter the university sector through specialised entry routes but students share a substantial amount of lecture/lab time with students on a common entry programme in a cognate area.

Following considerable debate taking into account international experiences and expert opinion the Review Group were of the view that in order to maintain the academic and clinical practice integrity of midwifery and the four disciplines of nursing and to reflect the HSE workforce plan, students will continue to be required to choose the relevant point of entry on application to the CAO[28] for undergraduate nursing or midwifery education courses. The benefits of the separate points of entry for nursing and midwifery are identified as:

- preparing graduates to practice confidently from day one of employment in their chosen discipline
- ensuring a sufficient supply of graduates with the required competencies and experience for specific population groups. In countries where there is an absence of students qualifying in psychiatry, intellectual disability and children's nursing, the nursing contribution to the care of these client groups is diluted
- whilst acknowledging the distinct scopes of practice for each nursing discipline there are opportunities for shared learning
- recognising midwifery as a discipline and profession in its own right as identified through the Nurses and Midwives Act 2011.

#### *10.2.1.1 Shared Learning*

Shared learning both across the disciplines of nursing and midwifery and interdisciplinary was supported throughout the consultation process and by the Curriculum Subgroup. The stakeholders (Irish Medical Council, Pharmaceutical Society Ireland, Pre Hospital Emergency Care Council) identified a 'learning together' concept as a useful process of education. Further opportunities for meaningful interdisciplinary learning over the entire education programmes and specifically in year one should be explored. This concept is supported by the *National Strategy for Higher Education to 2030* (Department of Education and Skills 2011) which recommends that HEIs should offer broad-based courses and more interdisciplinary learning opportunities for students in the first year of their undergraduate studies.

#### *10.2.1.2 Internship*

The internship was highly valued and seen as essential for consolidation of learning and development of critical thinking skills. Nationally agreed competencies with standard assessment processes for each discipline for each stage of the programme were considered important in terms of patient safety and ensuring appropriate progression through the programmes. The consultation process identified that

28 The higher education institutions in the Republic of Ireland have delegated to the Central Applications Office (CAO) the task of processing centrally applications to their first year undergraduate courses.

an increase of the internship period from 36 weeks to 52 weeks would be useful in terms of learning opportunities, consolidation of clinical practice and minimising workforce planning issues that emerge for health service providers when trying to manage the workforce gap between the 36 and 52 weeks[29]. The Review Group on consideration of the length of the internship period recommend that consideration be given to an increase in the internship to 52 weeks in order to support consolidation of learning and manage workforce considerations.

#### *10.2.1.3 Programme Governance*

Governance arrangements are the policies, procedures and quality assurance processes in place to ensure the integrity of the undergraduate education programme. These include arrangements to support clinical placements and the work of the Local Joint Working Groups set up between HEIs and healthcare providers.

Robust governance structures should be formally in place between academic institutions and health service providers in order to ensure the integrity of the programmes. HEIs and health service providers are complex entities, each with their own specific needs and priorities. It is important to ensure that there is clarity and understanding in relation to their respective roles and responsibilities.

The success of the Local Joint Working Groups was identified as varied in the consultation process but their role is essential in maintaining the formal links between health service providers and HEIs. Key success factors that emerged were the need for the joint working groups to be strategic, inclusive and work together in a consistent and responsive manner with formalised memorandums of understanding. The Review Group recommend that this memorandum of understanding is based on a framework of nationally agreed governance principles.

The Clinical Placement Co-ordinators (CPCs) are an important support for students and should be in a position to support students in an equitable manner regardless of location. The current ratio for CPCs is 1:30 nurses and 1:15 midwives and the Review Group considered that this minimum ratio must be maintained. As community placements increase consideration will be required by health services and HEIs of the support for students. The Review Group considered that dedicated staff should be available to support clinical placements within primary, secondary and tertiary care. Exploration of different models of student support within the clinical learning environment would be useful.

Nursing and Midwifery Practice Development Co-ordinators provide support and monitor the implementation of standards at senior management level. The HEI staff, preceptors, allocations officers and lecturers are critical elements of the teaching and learning for students both in college and on clinical placements. Nursing and midwifery are clinical practice based professions which requires HEIs to provide both theoretical and clinical practice teaching, learning and assessment by competent staff who undertake ongoing development of academic and clinical skills. This reflects considerations in the *National Strategy for Higher Education to 2030* (Department of Education and Skills 2011) which recommends that all HEIs must ensure that all teaching staff are both qualified and competent in teaching and learning and should support ongoing development of their skills. Lecturers being clinically credible and maintaining clinical competence in their area of interest was highly valued in the consultation. The Review Group considered that enhanced clinical engagement between HEIs and healthcare organisations would facilitate the promotion of theory, practice and research.

29 During the internship the student is a paid employee of the health service. There is a student-staff replacement ratio of 2:1.

## Recommendation C1

**The 4 year, BSc honours degree (NQAI level 8) programme for nursing and midwifery; and the 4 points of entry to the disciplines of nursing should be retained by An Bord Altranais agus Cnáimhseachais na hÉireann (the Nursing and Midwifery Board).**

C1.1 In order to maintain the academic and clinical practice integrity of midwifery and the four disciplines of nursing; and to reflect the HSE workforce plan the Nursing and Midwifery Board and HEIs will continue to require students to choose the relevant point of entry on application to the CAO[30] for undergraduate nursing or midwifery education courses.

C1.2 The Nursing and Midwifery Board in consultation with the HEIs will standardise the maximum time normally allowable for students to repeat academic and clinical assessments and to complete BSc nursing/BSc midwifery programmes.

C1.3 HEIs will develop a nationally agreed mechanism by which students can exit the nursing and midwifery programmes with the accumulation of credits and/or with an accredited/academic award aligned to the National Framework of Qualifications where appropriate. The student will not be eligible to register as a nurse or midwife with the Nursing and Midwifery Board with this exit award.

## Recommendation C2

**HEIs will enhance shared learning across the nursing and midwifery programmes; and with multi-disciplinary undergraduate programmes.**

C2.1 HEIs should continue to develop shared learning across the disciplines of nursing and midwifery, particularly in year 1 and should integrate as appropriate module content across the entirety of the programme.

C2.2 HEIs should also continue to develop, as appropriate, shared learning between nursing and midwifery programmes, and other relevant undergraduate programmes.

## Recommendation C3

**The Nursing and Midwifery Board and the HEIs will give further consideration to flexible modes of entry, enabling wider access to the undergraduate programmes such as:**

C3.1 Recognition of prior learning (RPL).

C3.2 The use of specialist schemes e.g. FETAC, Higher Education Access Route (HEAR)[31] schemes.

C3.3 Graduate entry programmes for those who have already attained degree level education in a relevant area.

30 The higher education institutions in the Republic of Ireland have delegated to the Central Applications Office (CAO) the task of processing centrally applications to their first year undergraduate courses.

31 The Higher Education Access Route (HEAR) is a college and university admissions scheme which offers places on reduced points and extra college support to school leavers from socio-economically disadvantaged backgrounds.

## Recommendation C4

**The Nursing and Midwifery Board in consultation with the Department of Health and relevant stakeholders will establish a post-registration education framework based on service need and workforce demand.**

## Recommendation C5

**In consultation with the Nursing and Midwifery Board, national and local governance arrangements should be enhanced by HEIs and the HSE/health service providers.**

C5.1 Local Joint Working Groups should operate within an agreed memorandum of understanding between the HEIs and the HSE/health service providers. The memoranda should be based on a framework of nationally agreed governance principles, which supports national policies and the health reform agenda with locally agreed addendums if required. Composition of Local Joint Working Groups should reflect health system changes and be reviewed accordingly.

C5.2 HEIs and the HSE/health service providers will enhance their clinical engagement to facilitate the promotion of theory, practice and research. This will include dedicated HEI staff time to teaching and facilitation of learning in the clinical area and may include joint appointments.

C5.3 The HSE/health service providers and HEIs will ensure dedicated staff are available to support clinical placements within primary, secondary and tertiary care including community care placements. The minimum ratio for CPCs[32] of 1:30 nurses and 1:15 midwives and should be maintained. As community placements increase HEIs, the HSE/health service providers and the Nursing and Midwifery Board will be required to consider the necessary additional support for students on community placements.

### *10.2.2 Content of the Undergraduate Programmes*

The content of the undergraduate programmes should prepare nurses and midwives with the appropriate skills and competencies to practice safely and effectively in a reformed healthcare system. It is reasonable to expect that the content of the programmes is reviewed and updated regularly to reflect new and changing models of care delivery. The consultation highlighted that it was generally accepted that the curriculum should be more outcome and competency based rather than content driven. It was felt that the curriculum was overloaded with content i.e. the list of subjects being taught had been continually expanded over the years rather than being refocused in line with healthcare developments. Programme learning outcomes should be future proofed regarding the dynamic nature of practice development and the future role of the nurse and midwife.

Patient safety and the management of risk emerged as key concepts that should be threaded through the delivery of the undergraduate programmes in line with the *Report of the Commission on Patient Safety and Quality Assurance* (DoHC 2008b). A number of additions to programme content which support the patient safety agenda emerged in the consultation phase including a better understanding of the 'human factors' in patient safety such as early warning scores and increased knowledge in relation to medication management.

32 Clinical Placement Co-ordinators (CPCs) are qualified nurses or midwifes who support preceptors and clinical nurse/midwife managers in the teaching and assessment of student nurses and midwives on clinical placement.

Nurses and midwives will be required to adapt work practices to support the delivery of the pending Department of Health Framework for Health and Wellbeing. With a population perspective, this policy framework takes into account the wider determinants of health such as poverty, unemployment, social exclusion etc. The health services as driven by the Programme for Government 2011-2016 will provide more care in the community with a population health focus.

The consultation identified that nurses and midwives were seen to graduate with the ability to provide evidence-based care to defined population groups. The requirement for clinical reasoning and the ability to conduct comprehensive psychological, cognitive and physical/clinical assessments including increased pharmacology content was strongly endorsed by the Review Group. This approach would directly benefit clinical care providing early access to assessment and clinical decision making promoting timely provision of interventions and detection of patient deterioration.

The educational preparation for nurses and midwives should support a philosophy of care and the development of a therapeutic relationship between the nurse or midwife and the patient. This encompasses the core values of nursing and midwifery in terms of compassion, empathy and caring. This was particularly emphasised by the public interest focus group and submissions.

### *10.2.3 The Public Interest*

The consultation provided information directly from public interest groups in terms of their views on the undergraduate nursing and midwifery education programmes. A number of key issues emerged. The public interest groups expressed the importance of including patient empowerment and the concept of the expert patient engaged in self care with a recovery approach in the education programmes.

Service users considered the development of a therapeutic relationship between the nurse and patient as important to the overall experience of the service user with the health service. Confidence in the knowledge and skills of the nurse or midwife and excellent communication between the nurse or midwife and the service user were seen as essential to the therapeutic relationship. The importance of creating a culture of nurse and midwife empowerment in order that they develop as 'questioning practitioners' was identified. It was considered that there should be greater emphasis on equality, diversity and inclusion with an emphasis on preparing nurses and midwives to be aware of the specific healthcare issues and needs of diverse, minority and ethnic groups. An increase in interdisciplinary education and placements in the community were proposed.

Opportunities for service users to contribute to the curriculum and participate in student teaching providing 'patient stories' were strongly recommended by the public interest participants in the consultation process. A person centred philosophy of care with associated national policy initiatives underpinning all curricula was recommended. This is in line with the *National Standards for Safer Better Healthcare* (HIQA 2012).

## Recommendation C6

**The Nursing and Midwifery Board will identify the competency goals for the four nursing programmes and the midwifery programme.**

C6.1 The five specific domains from the Nursing Subject Area Group (SAG) of the Tuning Project[33], should inform the competency goals at bachelor degree level:
- Professional values and the role of the nurse/midwife
- Nursing/midwifery practice and clinical decision making
- Evidence-based scholarship, knowledge and cognition
- Communication and interpersonal skills
- Leadership, management and team working.

The Nursing and Midwifery Board should engage with HEIs, the HSE/health service providers and the Department of Health in ongoing collaboration to review and update learning outcomes taking account of the dynamic nature of practice development and the role of the nurse and midwife. The curriculum will be underpinned by a population focus reflecting developments in health policy and delivery of services thus providing for nurses and midwives to attain the knowledge and skills to provide optimum safe quality care in a modern health service.

C6.2 The Nursing and Midwifery Board, HEIs and HSE/health service providers will agree national practice competencies[34] aligned to learning outcomes for each stage of the programme for each division of the register supporting the patient safety agenda.

C6.3 The Nursing and Midwifery Board, in providing for the protection of the public, will require that safety of the public is at the core of all assessment decisions and that patient safety overrules all other considerations with regard to student performance in the clinical area.

## Recommendation C7

**HEIs and their healthcare partners will ensure a person centred philosophy of care underpins all curricula.**

C7.1 HEIs and their healthcare partners must ensure that the values of treating people with care and compassion, with dignity and respect and with impartiality remain at the core of the student experience. The values and the principles that underpin the curriculum will shape and guide the choices and daily practice of the students and those who teach them.

C7.2 HEIs should increase the involvement of patients/clients and carers in curriculum planning, teaching and in the evaluation of the programme. A modern healthcare system will require more of the population to have the knowledge and skill to take care of their own health, to live independently for as long as possible and for nurses and midwives to work in partnership with patients, clients and carers in the interests of providing high quality care, tackling health inequalities and building resilience and promoting health and wellbeing.

C7.3 HEIs in partnership with their healthcare partners must ensure that students and those who work with them are familiar with the local systems and processes for ensuring patient safety, including the governance arrangements for the effective identification and management of risk, escalating concerns, professional accountability and procedures for addressing standards. Students should also be familiar with the theory and practice of risk management, concepts of clinical governance and the theory of human factors.

33 Further information available: http://www.cbie-bcei.ca/wp-content/uploads/2012/04/tuningnursingfinal.pdf
34 A competency describes what is observed when a nurse or midwife combines knowledge, skills, attitudes and judgement to perform role-relevant tasks.

### *10.2.4 Clinical Placements Requirements*

Clinical placements provide structured supernumerary and internship experience in a wide variety of clinical settings to ensure attainment of established competencies in nursing and midwifery meeting regulatory standards leading to registration as a nurse or midwife. The clinical placements contribute significantly to the 'fit for practice' graduate. Supernumerary placements occur from first to third year. Students are surplus to rostered staff nurses and midwives (i.e. funded establishment) and participate in care under the guidance and supervision of registered nurses and midwives. Internship is the 36 week rostered clinical placement undertaken in year four of the undergraduate programmes. During this period the student is a paid employee of the health service. There is a student-staff replacement ratio of 2:1.

The clinical placement opportunities in first to third year and internship were highly valued in the consultation process and potential adjustments to improve clinical placements were detailed. It was considered that restructuring would provide more cohesive programme delivery. The current structure means that students in the main do not have general placements after year one and enter their internship year having spent the majority of the previous two years on specialist placements. This can create a large gap in competence attainment which may impact on performance. The extent of short specialist placements was seen as a luxury and students would likely benefit more from a smaller number of major placements. This may ease some the logistics of travel for specialist clinical placements in terms of distance, travel arrangements, requirements to move accommodation and cost as described by students. The establishment of a substantial and mandatory older person clinical placement for relevant programmes was recommended both in the consultation process and by the Curriculum Subgroup.

Preceptors were highly valued as detailed in the consultation and seen as essential to clinical learning. The preparation and on-going support of preceptors was identified as important. It was evident from the consultation and the Curriculum Subgroup that there are differing assessment processes utilised in the clinical areas. The requirement for competencies with standard assessments identified for each year was considered important in the consultation process. This would support students to gain clear outcomes for each programme stage and on graduation. Such an approach is in line with international nursing education provision. The Curriculum Subgroup supported this approach. This would minimise variation in assessment across the country and would support consistency of outcomes and competencies attained on registration as a nurse or midwife. The role of HEIs and the potential for joint assessments between preceptors and lecturers could support consistent student assessment of competencies and would also provide support for preceptors.

It was considered by both students and staff that preparation for the internship would be useful in terms of optimising the learning opportunities in the internship. This could encompass detail of specified competencies to be obtained during the internship and the provision of opportunities to recap and refresh on information and clinical skills obtained from years one to three. Students become paid employees of the health service provider for internship and this changes their role in terms of responsibility and accountability. Support for this transition for students was identified in the consultation and by the Curriculum Subgroup as important.

The further development of community placements to enhance the development of community related skills was recommended by the Curriculum Subgroup and emerged very strongly in the consultation. The Review Group considered that the investigation of the use of appropriate community placements for internship cognisant of health service reconfiguration and in keeping with the pending national Framework for Health and Wellbeing should occur. Exploration of innovative ways in which students can access placements where they have clinical exposure alongside professions drawn from allied health and social care fields in order to develop further specific clinical skills that will prepare them on qualifying to work effectively within the multidisciplinary team should occur.

## Recommendation C8 - Clinical Placement

**The Nursing and Midwifery Board and the HEIs will review student clinical placement requirements to take account of changing health service delivery models.**

C8.1 HEIs and their health and social care partners will further develop community and primary care placements to enhance the development of community related skills, in particular the care of patients/clients in their own homes or local communities.

C8.2 The Nursing and Midwifery Board along with the HEIs will investigate innovative ways in which students can access placements where they have clinical exposure alongside professions drawn from allied health and social care fields in order to develop specific clinical skills that will prepare them on qualifying to work effectively within the multidisciplinary team. The overall learning experience and final clinical assessment including community placements should be supervised by a nurse or midwife.

C8.3 The Nursing and Midwifery Board and the HEIs will seek to reduce the number of specialist placements informed by a clear rationale as to how such placements contribute to the development of the core competences; accompanied by an emphasis on significantly longer core placements taking place in each of the first three years of the programme leading up to the internship.

C8.4 In acknowledgement of the changing age profile of the population the Nursing and Midwifery Board and the HEIs will establish a substantial and mandatory older person clinical placement for relevant nursing programmes.

C8.5 The Nursing and Midwifery Board and HEIs should detail opportunities for students to engage in reflective clinical practice for each stage of the programme which would be reflected in the curriculum model.

C8.6 The Nursing and Midwifery Board will establish a mechanism in conjunction with specific HEIs to recognise and approve placements that may take place outside the EU.

## Recommendation C9- Internship[35]

**The internship component of the programme is critical in terms of preparing the graduate for clinical practice. The internship must be retained within the framework of the undergraduate programmes.**

C9.1 The Department of Health, the Nursing and Midwifery Board, HEIs and the HSE/health service providers should give consideration to increasing the internship from 36 weeks to 52 weeks to meet the clinical, academic and service requirements in terms of continuity for workforce planning and consolidation of learning.

C9.2 The Nursing and Midwifery Board, HEIs and the HSE/health service providers should explore the most effective means of assessing the student throughout the internship period.

C9.3 The Nursing and Midwifery Board, HEIs and the HSE/health service providers should identify appropriate community placements for internship in line with health service reconfiguration and in keeping with the pending national framework for health and wellbeing.

35 Internship means the 36 week rostered clinical placement undertaken in year 4 of undergraduate programmes. During this period the student is a paid employee of the health service. There is a student-staff replacement ratio of 2:1.

### Recommendation C10 - Clinical Assessment

**The Nursing and Midwifery Board, HEIs and the HSE/health service providers will review student clinical assessment processes including documentation to promote standardisation of clinical assessments in line with competency goals for the four nursing programmes and the midwifery programme.**

C10.1 HEIs and the HSE/health service providers should implement shared governance processes (operationalised through the framework of nationally agreed governance principles) for clinical assessment including joint assessment and early intervention for student competence issues.

### Recommendation C11 - Preceptorship[36]

C11.1 The Nursing and Midwifery Board should provide national guidance and standards for preceptors.

C11.2 The HSE/health service providers should ensure that identified preceptors are available to support students in clinical placements within primary, secondary and tertiary care.

C11.3 HEIs and the HSE/health service providers should develop, implement and facilitate a national mandatory preceptorship programme with protected time facilitated by the employer in line with the Nursing and Midwifery Board guidance and standards.

C11.4 HEIs and the HSE/health service providers should recognise the value of the role of the preceptor through honorary access to certain facilities such as online library access and representation on Local Joint Working Groups.

### Recommendation C12

**The Nursing and Midwifery Board should detail the clinical expectations of supernumerary students[37] for each stage of the programme (Year 1 – Year 3) maximising student learning and student integration; and linked to competency goals.**

## 10.3 Education Programme Evaluation

Nursing and midwifery education programmes are being delivered in a changing healthcare environment. The health system as a whole is undergoing significant reform. Education programme learning outcomes within this context should be regularly evaluated in terms of the dynamic nature of practice development and the enhanced role of the nurse and midwife. A continuous improvement approach to education programme delivery should be utilised. Education programme evaluation should occur frequently in terms of design, content and programme delivery. HEIs should put in place systems to capture feedback from student nurses and midwives, and use this feedback to inform institutional and programme management as well as national policy. HEIs should conduct a national survey of health service employers on a regular basis which should be used as part of an assessment of quality outcomes for the system. This is in line with *The National Strategy for Higher Education to 2030* (Department of Education and Skills 2011).

36 A preceptor is a registered nurse or midwife who supports student learning in clinical settings and assumes the role of supervisor and assessor.

37 Supernumerary *means* students are surplus to rostered staff nurses and midwives (i.e. funded establishment) and participate in care under the guidance and supervision of registered nurses and midwives.

## Recommendation E1

**Education programme evaluation in terms of design, content and programme delivery should occur through a continuous improvement approach by the Nursing and Midwifery Board, HEIs and the HSE/health service providers.**

E1.1 HEIs and the HSE/health service providers should put in place systems to capture feedback from student nurses and midwives, employers and the public and use this feedback to inform the design, content and delivery of education programmes as well as national policy.

## 10.4 Workforce Planning Considerations

The determination of the numbers of students required to ensure sufficient numbers of nurse and midwife graduates for new patterns of service delivery within the public health system requires engagement in formal workforce planning processes. Workforce planning must be integrated with service and financial planning and encompasses principles for guiding better workforce planning decisions. *An Integrated Workforce Planning Strategy for the Health Services* (DoHC & HSE 2009) provided recommendations for workforce planning around four strategic goals as outlined below:

***Strategic Goal 1*** - Ensure a health workforce that is based on four principles of patient/client focussed, sustainable, available and flexible

***Strategic Goal 2*** - Support and build an integrated and evidence-based workforce planning process

***Strategic Goal 3*** - Develop excellent capacity and resources for effective integrated workforce planning

***Strategic Goal 4*** - Provide the tools and data systems to support the workforce planning function.

The workforce planning implications of the implementation of the clinical care programmes and reconfiguration of the health services provide the future scenarios for planning for analysis of the number of student places required. This should give due consideration to the appropriate skill mix (nursing, midwifery and other) based on future service need aligned to patient acuity/dependency.

Best practice indicates that workforce decisions should be made with good quality data on:

- patient mix (acuity/dependency) and service demands
- current staffing (establishment, staff in post)
- factors that impinge on daily staffing levels (absence, vacancies, turnover, ward size and layout etc)
- evidence of the effectiveness of staffing – quality patient outcomes/nurse-/midwife-sensitive indicators.

The Review Group recommend that a regular workforce planning exercise is undertaken and that in the medium to long term a national framework should be developed that would assist with the determination of nursing and midwifery staffing levels and skill mix encompassing patient acuity/dependency and service developments. This framework would also take into account the requirement to provide cost-effective and efficient services leading to safe quality care across all services.

In order to maintain stability within the health and higher education systems the Workforce Planning Subgroup recommended that the current number of undergraduate student nurses and midwives (1570) continue to be commissioned for the foreseeable future or until the economic and service reform agenda becomes clearer. This recommendation follows the Workforce Planning Subgroup scenario which forecast future staffing requirements taking into account the 2009 Employment Control Framework

in the Health Service. This scenario indicated that the overall numbers of students being prepared at undergraduate level just met the demand.

### Recommendation WP1

**In order to maintain stability within the health and higher education systems it is recommended that the current number of undergraduate student nurses and midwives (1570) continue to be commissioned by the Department of Health until the economic and service reform agenda becomes clearer.**

### Recommendation WP2

**The HSE in co-operation with the Department of Health should undertake a five year workforce plan to be reviewed regularly in light of the extent of change planned under the reform agenda taking account of economic considerations; and in line with policy developments. The plan should have the active involvement and input of local healthcare and senior nurse/midwife managers. It should include an examination of staffing levels and skill mix in all relevant service areas aligned to patient acuity/patient dependency to ensure the most effective use of the nursing and midwifery resource. Requirements should be collated nationally to ensure a system wide and strategic approach.**

## 10.5 Future Research

The Health Research Board (HRB) completed an evidence review of nursing and midwifery curricula internationally. The retrieved studies were described as small-scale, single-centre studies that are based on a wide variety of topics and provide a wide range of conclusions. There were no papers that evaluated the direct entry midwifery curriculum. Given the quality of the papers on nursing curricula the HRB could not recommend using these papers as a better basis for designing or modifying the existing nursing curriculum in Ireland. A better approach suggested by the HRB to evaluation of any redesign or modification of the Irish nursing or midwifery curriculum may be to develop a national, cross-institutional prospective programme of research.

### Recommendation R1

**Research to advance education innovation and to evaluate education programme design, content and delivery should be conducted by the Nursing and Midwifery Board, HEIs and health service providers in order to enhance and promote education effectiveness and excellence.**

R1.1 The Nursing and Midwifery Board, HEIs and the HSE/health service providers should engage in research to evaluate the effect of different approaches for the delivery of nursing and midwifery curricula. Appropriate research methodologies preferably using comparative groups of sufficient sample sizes to show differences in the effect of differing approaches to teaching and learning should be utilised and national and/or international cross-institutional prospective research should be considered.

## 10.6 Summary

The Review has engaged in a broad range of activities including extensive consultation to ascertain the important drivers and requirements for future delivery of undergraduate nursing and midwifery education. The Review which was conducted against the background of a healthcare system undergoing significant reform is both timely and strategic with its emphasis on health and wellbeing, more care delivery in people's homes and in the community, and a new more dynamic engagement between patients, their carers and health professionals. This is alongside a proactive approach to chronic disease management, and a renewed focus on patient safety and quality of outcomes.

Throughout the consultation process the success of the current education programmes was acknowledged and the Review was seen as an opportunity to build on the strengths of the current programmes. The consultation and the Curriculum Subgroup endorsed an outcomes focused curriculum with consistent national assessment processes to support consistency of outcomes and competencies throughout the programme and on registration as a nurse or midwife.

Nurses and midwives on completion of pre-registration education programmes should be competent to practice safely and effectively. Graduates should demonstrate established competencies in nursing and midwifery meeting regulatory standards leading to registration as a nurse or midwife. Graduates should be prepared to embrace lifelong learning and engage in competence development and maintenance leading to development of expertise in their defined roles which will expand and evolve in line with healthcare developments. Graduates will be integral members of the multi-disciplinary team providing significant clinical care for individuals and families in a wide range of settings.

The recommendations provide strategic direction for reconfiguration and a refocus of the undergraduate education programmes to prepare nurses and midwives to practice now and in the future in line with the health reform agenda. Each recommendation has been given significant consideration in the context that it will make a sustainable difference to the quality of the delivery of the education programmes. The Review Group considers that it is very important that the recommendations are implemented by the identified responsible bodies in a reasonable timeframe (Table 10). Responsible bodies should work with experts from the professions of nursing and midwifery as required to progress the implementation of the recommendations.

The Department of Health has agreed to establish a monitoring group to meet six monthly for two years to monitor and support the implementation of the recommendations. An interim report will issue after year one. This monitoring group will be chaired by the Department of Health and will include representation from the Department of Education and Skills, health services, higher education authorities, the Nursing and Midwifery Board and the trade unions.

## Table 10: Recommendations - Implementation Plan

| Curriculum Recommendations | | Responsible Body | Timeframe |
|---|---|---|---|
| **Programme Structure (C1-C5)** | | | |
| **C1** | C1 | The Nursing and Midwifery Board, | Immediate and on-going |
| | C1.1 | The Nursing and Midwifery Board, HEIs | 2 Years |
| | C1.2 | The Nursing and Midwifery Board, HEIs | 2 Years |
| | C1.3 | HEIs | 2 Years |
| **C2** | C2, C2.1, C2.2 | HEIs | Immediate and on-going |
| **C3** | C3, C3.1, C3.2, C3.3 | The Nursing and Midwifery Board, HEIs | 2 Years |
| **C4** | C4 | The Nursing and Midwifery Board, DoH | 2 Years |
| **C5** | C5, C5.1 | HEIs, HSE/Health Service Providers | 1 Year |
| | C5.2 | HEIs, HSE/Health Service Providers | Immediate and on-going |
| | C5.3 | HSE/Health Service Providers, HEIs | Immediate and on-going |
| **Curriculum Content (C6-C7)** | | | |
| **C6** | C6 | The Nursing and Midwifery Board | 1 Year |
| | C6.1 | The Nursing and Midwifery Board, DoH, HEIs, HSE/Health Service Providers | 1 Year |
| | C6.2 | The Nursing and Midwifery Board, HEIs, HSE/Health Service Providers | 2 Years |
| | C6.3 | The Nursing and Midwifery Board | Immediate and on-going |
| **C7** | C7, C7.1, C7.2, C7.3 | HEIs | Immediate and on-going |
| **Clinical Placement and Assessment (C8-C12)** | | | |
| **C8** | C8, C8.1, C8.2, C8.3, C8.4, C8.5, C8.6 | The Nursing and Midwifery Board, HEIs | 2 Years |
| **C9** | C9, C9.1 | The Nursing and Midwifery Board, DoH, HEIs, HSE/Health Service Providers | Immediate and on-going |
| | C9.2, C9.3 | The Nursing and Midwifery Board, HEIs, HSE/Health Service Providers | 1 Year |
| **C10** | C10 | The Nursing and Midwifery Board, HEIs, HSE/Health Service Providers | 2 Years |
| | C10.1 | HEIs, HSE/Health Service Providers | 2 Years |
| **C11** | C11, C11.1 | The Nursing and Midwifery Board | 1 Year |
| | C11.2, C11.3, C11.4 | HEIs, HSE/Health Service Providers | 1-2 Years |
| **C12** | C12, C12.1 | The Nursing and Midwifery Board | 1 Year |

| Education Programme Evaluation Recommendations | Responsible Body | Timeframe |
|---|---|---|
| E1 | The Nursing and Midwifery Board, HEIs, HSE/Health Service Providers | 1 Year |
| E1.1 | HEIs, HSE/Health Service Providers | 1 Year |

| Workforce Planning Recommendations | Responsible Body | Timeframe |
|---|---|---|
| WP1, WP2 | HSE, DoH | Immediate and on-going |

| Research Recommendations | Responsible Body | Timeframe |
|---|---|---|
| R1, R1.1 | The Nursing and Midwifery Board, HEIs, HSE/Health Service Providers | Immediate and on-going |

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# Appendix 1
## Midwifery

The Nursing and Midwifery Board endorses the definition of a midwife as adopted and amended by the International Confederation of Midwives in 2005[38]. The definition of a midwife states that:

> "A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for the parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife may practise in any setting including home, community, hospitals, clinics or health units." (ABA 2005b)

The International Confederation of Midwives (ICM 2010) identifies a number of key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families. These include:

- partnership with women to promote self-care and the health of mothers, infants, and families
- respect for human dignity and for women as persons with full human rights
- advocacy for women so that their voices are heard
- cultural sensitivity, including working with women and healthcare providers to overcome those cultural practices that harm women and babies, and
- a focus on health promotion and disease prevention that views pregnancy as a normal life event.

The Nursing and Midwifery Board outlines five domains of competence which represent the level the midwifery student must reach on completion of the education programme for entry to the midwives division of the register maintained by the Nursing and Midwifery Board. The aim is to ensure that students acquire the skills of critical analysis, problem-solving, decision-making and reflective skills and abilities essential to the art and science of midwifery. Safe and effective midwifery practice requires a sound underpinning of theoretical knowledge that informs practice and is, in turn, informed by that practice. Within complex and changing healthcare environments, it is essential that practice is based on the best available evidence.

The competencies encompass five domains:

1. Professional/ethical midwifery practice
2. Holistic midwifery care
3. Interpersonal relationships
4. Organisation and co-ordination of midwifery care
5. Personal and professional development.

38 Definition was revised and adopted by ICM Council June 15, 2011

## Context of Midwifery Care

Ireland has the highest fertility rate in the EU at 2.07[39] in 2008 compared with EU average of 1.56 (CSO 2011a,b, DoH 2011a). The average age at which women give birth to their first child has risen from 25 years in 1980 to 29 years in 2009. There were 73,724 births registered in 2010, a decrease of 554 on 2009. The overall trend is however an increasing birth rate year on year and it should be noted that the 2010 total is 27.4 % higher than in 2001. Increasing births has led to an increase in demand for maternity services. Pregnant women want a wide range of choices when it comes to models of maternity care. A recent survey indicated that 46% would prefer to have their baby delivered in a doctor-led unit and 43% in a midwifery-led unit with choice strongly influenced by safety considerations (Byrne et al 2011).

The *Report to Chief Executive Officers of the Health Board – Domiciliary Births Group* (Domiciliary Birth Expert Group 2004) recommended that women should have greater choice of maternity services through the effective utilisation of midwifery skills. The *Maternity Services in the Eastern Region – A Strategy for the Future 2005-2011* stated that services need to be provided through a range of service initiatives and a variety of models of care, in order to enhance the quality of care and provide women with choice (HSE 2005). Key recommendations within the report concern:

- an interdisciplinary team approach to the maternity services across all levels of care
- continued development of community-based maternity services for women with low risk pregnancies
- services to continue to be responsive to the needs of vulnerable and disadvantaged women
- development and implementation of models of care within and between primary and secondary care to increase choice and continuity of care for women.

The *Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area* identifies that the current maternity service model, by international standards is relatively hospital-focused, with a strong emphasis on medically led services (KPMG 2008). The Mother and Infant Scheme is described as having defined this model, assuming that antenatal care is to be delivered by GPs and Obstetricians. This *Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area* identified the requirement for structures that facilitate the enhancement of team working and allow for the seamless coordinated movement of women and/or their babies regardless of the level of care required. Recommendations emphasise the strengthening of community care, and that the current Domiciliary Care In and Out of Hospital (DOMINO), Outreach and Early Transfer Home schemes be significantly expanded to provide antenatal care in the community for all women who are assessed as low risk. The review also proposed that all women should have access to efficient and effective community based, midwife provided postnatal care.

Irish research supports midwifery-led care for low risk women. The MidU study was a pragmatic two group randomised controlled trial comparing midwifery-led care provided for low risk women in an integrated midwifery led unit (MLU) using evidence-based policies and procedural guidelines, with consultant-led care, in the HSE North-Eastern region. The results show that midwifery-led care, as practised in this study, is as safe as consultant-led care, results in less intervention, is viewed by women with greater satisfaction in some aspects of care and is more cost-effective (Begley et al 2009). These results compare favourably to Cochrane and international systematic reviews of midwife-led care (Hatem & Gates 2008, Devane et al 2010). Hollowell et al 2011 also present evidence supporting the policy of offering low risk women a choice of birth setting.

39 Total Fertility Rate (TFR) is a measure of the average number of children a woman could expect to have if the fertility rates for a given year pertained throughout her fertile years.

The Institute of Obstetrics and Gynaecology in their report *The Future of Maternity & Gynaecology Services in Ireland 2006-2016* address the need for the integration of primary and secondary care within the maternity services. The report recognises the crucial role that midwives play in pregnancy and particularly in relation to 'normal' pregnancies and supports the expansion of the DOMINO service nationally and the development of new career paths for midwifery, including further development of clinical midwife specialists and advanced midwife practitioners (Institute of Obstetricians and Gynaecologists 2006).

The *Strategic Framework for Role Expansion of Nurses and Midwives* (DoHC 2011a) notes many expanded and enhanced roles for midwives (Table 11). In addition to care of low-risk women midwives are managing the complex health needs of women and babies.

**Table 11: Examples of Expanded Roles – Midwives (DoHC 2011a)**

- Midwife-led discharges
- Midwife-led pre-booking clinic at 12-weeks gestation
- Midwives' clinics for low-risk women throughout pregnancy
- Midwife-led diabetic clinic
- Bereavement and miscarriage clinic
- Clinical Midwife Specialists (CMSs) (Examples include diabetes, drugs liaison, bereavement and loss)
- Counselling and psychological care
- Domestic abuse screening
- Drop-in clinics
- Examination of the newborn
- Helpline service for mothers and professionals
- Increased community services and outreach clinics
- Ultrasonography services, fetal assessment, antenatal diagnosis, fetal therapy and associated counselling and management
- Advanced Midwife Practitioner (AMP) (Diabetes): Continuity of care for women with Type 1, Type 2 and gestational diabetes
- Advanced Nurse Practitioner (ANP) (Neonatal): Admission, newborn assessment, ordering investigations, interpretation of results, central catheter placement, IV cannulation, referrals, prescribing, resuscitation, intubation and transport
- AMP (Urodynamics): Comprehensive health assessment, planning and initiation of care and treatment modalities to achieve patient centred outcomes and evaluate their effectiveness, initiating and terminating a care episode within the agreed scope of AMP practice guidelines
- AMP (Midwifery): Caseload management, provision of clinical supervision, leadership

The *Report of the Lourdes Hospital Inquiry* (Harding Clark 2006) made a number of recommendations that have implications for midwifery care. It found that support systems must be in place to conduct regular and obligatory audit and that there must be mandatory continuing professional development and skills assessment at all levels of healthcare. Staff also need to attend programmes updating skills and competencies; and should be able to recognise that procedures change in accordance with research.

The HSE national obstetrics and gynaecological programme identifies its aims and objectives as follows:

**Table 12: HSE National Obstetrics and Gynaecological Programme (HSE 2012b)**

**Improving choice in women's healthcare**

*Access*

- Increase number of patients attending for antenatal care in early pregnancy from 55% of total births in 2007 to 70% in 2012.
- To improve choice by developing and delivering new models of maternity care.

*Quality*

- To maintain the low national maternal and perinatal mortality rates.
- Stop the rate of caesarean sections in first time mothers increasing.
- To develop and implement national guidelines.

*Cost*

- To reduce the number and cost of medical negligence cases in obstetrics.
- To reduce incidence of multiple births after infertility treatment.

## Summary

The policy direction for maternity care will define the environment in which midwives will practise now and into the future. It is important to acknowledge the significant developments that have taken place in midwifery care in Ireland. These developments and new models of care provide greater choice for women in Ireland including DOMINO schemes, midwife examination of the newborn, increased community services and midwifery-led units. Whilst the main focus of the midwives role as outlined in the EEC Council Directive of 1980 (80155/EEC) and WHO/ICM/FIGO (1992) is promoting 'normal midwifery' it is important to note that the role of the midwife in providing holistic support, specialised midwifery care and ensuring that issues such as emotional support and breastfeeding for more complex pregnancies are adequately provided when there is a need for medical interventions. This is the environment in which student midwives will complete their education and progress to practising as registered midwives.

# General Nursing

In relation to general nursing the Nursing and Midwifery Board (2005a) identifies that:

> "the general nursing programme contains the essential elements that facilitate the development of professional knowledge, skills and attitudes necessary to meet the nursing needs of patients who are acutely or chronically ill. General nurses also have an important role in the promotion of health. The healthcare services and the work trends of general nurses are changing continuously and the general nurse must be able to respond to the health needs and demands of the Irish population. Nursing practice also involves working with other professions and the general nursing programme aims to develop nurses who will act as effective members of a healthcare team at various levels of the healthcare system" p.16.

A general nurse provides care across hospital and community, for patients with acute and chronic illness, those requiring palliative care and care for older people. In-patient care can vary in its complexity from care in a long-term setting to care in a critical care environment. Care is also provided in the patient's home and increasingly outreach and in-reach integrated care programmes are being developed. The traditional segmentation of service from hospital to community is no longer appropriate. The *Programme for Government 2011-2016* provides for healthcare reform aiming to reduce reliance on acute hospitals in order that more care can be delivered in the community.

**The Nursing and Midwifery Board outlines five competencies for general nursing practice (ABA 2005a):**

1. Professional/ethical nursing practice
2. Holistic nursing care
3. Interpersonal relationships
4. Organisation and co-ordination of nursing care
5. Personal and professional development.

The Nursing and Midwifery Board has provided specific guidance for nurses working with older people. Standards are outlined which are supported by specific competency indictors for older person care:

Standard 1: Person-centred holistic care
Standard 2: Therapeutic relationships
Standard 3: Care environment
Standard 4: End of life care
Standard 5: Quality of care
Standard 6: Professional development (ABA 2009b).

## Context of General Nursing

The national demographic and epidemiological profile indicates that general nurses will require skills to care for an increasing number of people with chronic diseases and cancer, and for an older population. The World Health Organisation has attributed 86% of deaths and 77% of the overall disease burden in Europe to chronic diseases. Ireland's disease trends are similar with cardiovascular disease and cancer being responsible for more than two thirds of all deaths and the leading cause of premature mortality. Age-standardised mortality rates for major causes of death such as heart disease and cancer continue to decline in Ireland. However in the area of health determinants, lifestyle factors such as smoking, drinking, and obesity continue to be issues of concern which have the potential to jeopardise many of the health gains achieved in recent years (DoH 2011a).

*A Strategy for Cancer Control* (DoHC 2006a) and the *National Cancer Control Programme Fact Sheet* (DoH 2011b) outline prevention diagnosis and treatment processes and challenges for cancer care in Ireland. On average approximately 24,800 new cases of invasive cancer (including non-melanoma skin cancer) are diagnosed each year. The number of newly diagnosed cases is rising by 6-7% annually and is projected to reach nearly 55,000 in 2030. Survival rates have improved significantly over recent years. Five year survival rates have increased to 55% in 2004-2007 from 40% in 1994. More than 30% of cancer could be prevented, mainly by not using tobacco, having a healthy diet and being physically active.

The National Cancer Control Programme goals are better cancer prevention, detection and survival through a national service based on evidence and best practice. All breast cancer diagnostic and surgical services have been re-organised into the eight cancer centres, rapid access diagnostic clinics for prostate cancer (six cancer centres to date) and for lung cancer in all eight cancer centres have been established. A community oncology nurse programme, an initiative to integrate medical oncology care between the acute hospital and community settings has been initiated. A training programme for nurses who work in primary care, with a particular focus on public health nurses and practice nurses has been developed and implemented. This programme covers cancer prevention, referral and patient assessment, treatment and post-acute care. *A Strategy and Educational Framework for Nurses Caring for People with Cancer in Ireland* (HSE & NCCP 2012) provides priorities for cancer nursing in Ireland.

A number of the national clinical programmes will establish the care pathways and clinical guidelines which provide the evolving environment for delivery of general nursing care (Table 13). Implementation of the standardised national clinical programmes is identified in the *HSE National Service Plan 2012* as one of its priorities. A number of key performance indicators have been developed to support the implementation of the programmes.

**Table 13: National Clinical Programmes (HSE 2012b)**

| | |
|---|---|
| Acute Coronary Syndrome | Epilepsy |
| Diabetes | Rheumatology |
| Primary Care | COPD |
| Acute Medicine | Heart Failure |
| Elective Surgery | Stroke |
| Rehabilitation Medicine | Critical Care |
| Asthma | Orthopaedics |
| Emergency Medicine | Dermatology |
| Renal | Palliative Care |
| Care of the Elderly | |

The *Report of the National Acute Medicine Programme* is published and provides a framework for acute medical care and identifies the implementation of four general models of hospital (HSE 2010). The programme aim is the standardisation of access to and delivery of, high quality, safe acute medicine services nationally.

The future growth in healthcare will be in the areas of ambulatory care (including chronic disease management and day surgery), diagnostics and rehabilitation which will be based in local (model 2) hospitals. The objectives are:

- Navigation hubs to support the streaming of patients to the most appropriate available care setting and enhance communication between primary care, community services and hospital-based services
- Management of acute medical patients in dedicated Acute Medical Units, Acute Medical Assessment Units and Medical Assessment Units

- Timely care from a senior medical doctor
- National implementation of a national 'Early Warning Score' to help in the early detection of patients who are likely to deteriorate
- Access to same day diagnostics
- Expedited discharges (including integrated discharge planning 7 days per week)
- Rapid access to OPD.

The *National Emergency Medicine Programme* is a strategy to improve safety, quality, access and value in emergency medicine in Ireland (HSE 2012f). The programme recommends new models of care to be delivered through a National Emergency Care System and networks of emergency departments. The new models of care are identified as being more effective if they involve close collaboration between pre-hospital and emergency department-based care within networks. Emergency Medicine is a relatively new and rapidly evolving specialty.There are specific implications for nursing including an emergency nursing competency framework.

The *Programme for Government 2011-2016* commits to reforming the model of delivering healthcare, so that more care is delivered in the community. The aim of primary and community care services is to support and promote the health and wellbeing of the population by making people's first point of contact with the health services easily accessible, integrated and locally based.

As services move to community settings acute in-patient care has intensified with shorter hospital stays, increased use of technology and non-invasive treatments creating a higher mix of patient acuity. There has been a rapid rise in day cases over the last number of years with 60% of all hospital admissions now for day case treatment. The average length of stay for the remaining inpatients shows a gradual decline, and, for the first time in 2009, has dropped to under 6 days. There has also been an increase of 74% in the number of outpatient attendances since 2001. The need for acute inpatient care both in terms of admission rates and average length of stay increases steeply with age. Persons over the age of 65 account for almost 50% of all bed usage although they represent just 12% of the population (DoH 2011a).

An aging population will provide challenges for care delivery. Barrett et al (2011) identify that cardiovascular diseases are common in older adults with the prevalence of chronic conditions increasing with age. Three quarters of older adults are overweight or obese and depression is common among older adults. The *National Quality Standards for Residential Care Settings for Older People in Ireland* (HIQA 2009) provide a baseline for those with the responsibility for providing care to assess the quality of care planning, strategically develop appropriate and sustainable resources; and provide continuity and stability to the lives of those in their care.

## Enhanced Roles

The extent of expanded and enhanced care provision being provided by general nurses is detailed in the case studies provided in the *Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Care* (DoHC 2011a). A summary of examples of role expansion relevant to general nursing is provided in Table 14.

## Table 14: Examples – Role Expansion (DoHC 2011a)

- Advanced Nurse Practitioners (Examples include emergency, diabetes, cardiology)
- Application and care of Continuous Positive Airway Pressure (CPAP), Bilevel Positive Airway Pressure (BiPAP) and non-invasive ventilation (NIV)
- Clinical Nurse Specialists (Examples include diabetes, Chronic Obstructive Pulmonary Disease, heart failure)
- Electrocardiogram (ECG) analysis
- Follow-up clinics older person services (e.g. dementia, parkinson's disease)
- Ionising radiation prescribing
- Intravenous cannulation and venepuncture
- Male catheterisation
- Medication prescribing
- Nurse-led clinics (e.g. leg ulcer clinics)
- Nurse-led discharge utilising agreed protocols
- Pre-operative assessment

The use of medication management protocols and nurse prescribing of medications and ionising radiation have provided mechanisms to support expanded nursing roles.

### Summary

It is evident that service delivery will be more oriented to community based services with those in acute setting requiring more complex care provision. The last decade has seen significant changes in role and subsequent supporting competencies for general nurses and many new expanded roles being developed. Changes in service delivery including new care models provide the context for the education required for undergraduate general nurses.

# Psychiatric Nursing

The Nursing and Midwifery Board (2005a) defines psychiatric nursing:

> "as a specialist nursing discipline with the primary objectives to facilitate the maximum development of the mental health of the individual who has psychiatric problems and to promote psychiatric nursing. The basis of the work of the psychiatric nurse is the relationship the nurse has with the person and their families who use the mental health services. The manner in which the psychiatric nurse develops this relationship, in partnership with those who use the services and their carers, and the skills the nurse uses within these relationships is the focus of psychiatric nursing" p.20.

The Nursing and Midwifery Board outlines five competencies for psychiatric nursing practice (ABA 2005a):

1. Professional/ethical nursing practice
2. Holistic nursing care
3. Interpersonal relationships
4. Organisation and co-ordination of nursing care
5. Personal and professional development.

Three main models are utilised to define, describe and understand mental health problems. These are the biological, psychological and social models; and increasingly mental health problems are viewed as a complex interaction of bio-psycho-social factors (Farrelly 2008). One in four people will experience a significant episode of mental illness in their lifetime (DoHC 2011b, WHO 2001b). Suicide is one of the top ten leading causes of premature death in Europe and is the principle cause of mortality among 15-35 year old males in this region (WHO 2005) and mental health problems account for approximately 20% of the total disability burden of ill health across Europe (WHO 2004). The WHO places high value on countries having national policy on mental health and legislative provisions that protect the human rights and dignity of people with a mental disorder (WHO 2001b, WHO 2003a, WHO 2003b, WHO 2006). The European Commission (2005b) issued a Green Paper on developing strategies to improve mental health in the European Union in 2005 which Ireland has signed up to.

### *5.5.1 Context of Mental Healthcare*

The Mental Health Act (2001) provides the legislative framework for the admission, detention and treatment of persons with a mental disorder and it established the Mental Health Commission in 2002. In 2006 the DoHC published *A Vision for Change* (DoHC 2006b), and later that year, the Mental Health Act (2001) was commenced in full. *A Vision for Change* sets the policy for the future development of mental health services in Ireland (DoHC 2006b). It aims to migrate services from traditional institutional based model to a patient centred, flexible and community based mental health service, where need for hospital admission is greatly reduced.

Mental health services are provided in many settings including acute inpatient facilities, day hospitals, day care centres, low support and high support community accommodation. There are 66 centres registered as approved centres for the admission and treatment of acutely ill patients under the Mental Health Act and approximately 800 other centres providing community based services. Psychiatric hospital admissions have gradually declined over the decade, and are 20% lower than in 2001 (DoH 2011a). It is noteworthy that in 2007, 49% of discharges occurred within two weeks of admission, 20% within 2-4 weeks and 94% within 3 months. Suicidal behaviour represents a global public health

problem and its prevention continues to challenge health and social services at all levels of Irish society. In recognition of this, in 2005 the DoHC published *Reach Out, the National Strategy for Action on Suicide Prevention* (DoHC 2005). The strategy sets out an action plan that is practical, based on evidence and international best practice. The National Office for Suicide Prevention is responsible for overseeing the implementation of the strategy and co-ordinating suicide prevention efforts around the country.

Significant progress has occurred in relation to moving towards community care since the publication of *Planning for the Future* (DoH 1984). *A Vision for Change* recommends fundamental change in the way services are delivered and development of infrastructure to support this. Key recommendations are:

- Involvement of service users and their carers should be a feature of every aspect of service development and delivery
- Mental health promotion should be available for all agegroups, to enhance protective factors and decrease risk factors for developing mental health problems
- Well-trained, fully staffed, community-based, multidisciplinary CMHTs (Community Mental Health Teams) should be put in place for all mental health services. These teams should provide mental health services across the individual's lifespan
- To provide an effective community-based service, CMHTs should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families
- A recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Care plans should reflect the service user's particular needs, goals and potential and should address community factors that may impede or support recovery
- Links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalised
- Services should be evaluated with meaningful performance indicators annually to assess the added value the service is contributing to the mental health of the local catchment area population
- A plan to bring about the closure of all mental hospitals should be drawn up and implemented.
- Mental health information systems should be developed locally. These systems should provide the national minimum mental health data set to a central mental health information system.
- Broadly-based mental health service research should be undertaken and funded
- Planning and funding of education and training for mental health professionals should be centralised in the new structures to be established by the Health Services Executive
- A multi-professional manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this policy. This plan should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the DoHC and service providers.

The *Programme for Government 2011-2016* commits to a comprehensive range of mental health services as part of the standard insurance package offered under Universal Health Insurance. This includes development of community mental health teams and services as outlined in *A Vision for Change* (2006b) to ensure early access to more appropriate services for adults and children and improved integration with primary care services. The Mental Health Act 2001 will be reviewed in consultation with service users, carers and other stakeholders, informed by human rights standards. A Mental Capacity Bill that is in line with the UN Convention on the Rights of Persons with Disabilities will be introduced.

A National Clinical Programme Director for Mental Health was appointed in 2010. The aim of this role is to introduce evidence-based and standardised clinical pathways for specific mental health issues. Multidisciplinary working groups have been established to design the care pathway with service users. Initial Priority Programme design has commenced in:

- Early Identification of Psychosis
- Self Harm & Suicide
- Eating Disorder
- Physical Health Needs of People with enduring Mental Illness
- Delirium
- Recovery (DoH 2011c).

Promotion of positive mental health and prioritisation of suicide prevention are identified as priorities in the *HSE National Service Plan 2012*. A number of key performance indicators have been developed to support the implementation of the programmes.

The HSE has published a series of guidance papers to advance community mental health services to support the following targets for change:

- Establishment of professionally complete community mental health teams
- Rapid access to emergency assessment in the community and prompt access to routine assessment
- Availability of day hospital care and treatment on a seven day week basis
- Improved effectiveness and efficiency of care and treatment through the implementation of the clinical programmes in mental health
- Significant reduction in acute inpatient admissions
- Significant reduction in length of stay for acute inpatient admissions (HSE 2012g).

The Office of the Nursing Services Director (HSE) completed a project to *'Develop and Strengthen Psychiatric Nursing Capacity to Support the Implementation of Vision for Change'* in order to strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change* (DoHC 2006b). Four key themes emerged:

1. Adopting a recovery approach
2. Improving outcomes and service quality
3. Developing clinical capacity
4. Enhancing organisational effectiveness (HSE 2012d).

### Mental Health Commission

The Mental Health Commission was established in 2002 to promote high standards in the delivery of mental health services. The annual reports of the Inspector of Mental Health Services are important indicators of the quality of the mental health services and provide recommendations for service development (MHC 2010). The Mental Health Commission in 2005 commissioned the National University of Ireland, Galway to conduct research on the economics of mental healthcare in Ireland. The 2008 report *The Economics of Mental Healthcare in Ireland* recommends accurate and comprehensive mental health information systems and the further application of economic analysis to mental healthcare in Ireland (O'Shea & Kennelly 2008).

The Mental Health Commission (2007) published a *Quality Framework Mental Health Services in Ireland* which is applicable to all mental health services in Ireland. Eight themes are underpinned by 24 standards and 163 criteria. A toolkit has been developed to accompany the framework. The themes are:

- Provision of a holistic seamless service and the full continuum of care provided by a multidisciplinary team
- Respectful, empathetic relationships are required between people using the mental health service and those providing them
- An empowering approach to service delivery is beneficial to both people using the service and those providing it

- A quality physical environment that promotes good health and upholds the security and safety of service users
- Access to services
- Family/chosen advocate involvement and support
- Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service
- Systematic evaluation and review of mental health services underpinned by best practice, will enable providers to deliver quality services.

## Summary

Mental health policy will be a key driver in determining the environment for psychiatric nursing practice. A significant volume of care will be delivered in community settings and many of the traditional mental health institutions will close. Psychiatric nurse graduates will be practising in line with these trends in care delivery.

# Intellectual Disability Nursing

The Nursing and Midwifery Board (2005a) states that

> "the philosophy of care of a person with an intellectual disability contains a number of implicit principles, which embrace the concept that all persons with all levels of ability have the same rights and, in so far as possible, the same responsibilities as other members of society. They have a right and a need to live within the community like other people and they have a right to receive those services necessary to meet their specialised and changing needs. They should receive, if and when necessary, professional assistance and services which will allow recognition, development and expression of the individuality of each person. Nurses who work with persons with an intellectual disability have a diversity of roles, from intensive physical nursing of individuals with profound handicap to supportive guidance in the management and habilitation of children, adolescents and adults. The care of persons with an intellectual disability forms part of the nursing profession as a whole, yet it is specialised and very different from other disciplines of nursing" p. 24.

The Nursing and Midwifery Board outlines five competencies for intellectual disability nursing practice (ABA 2005a):

1. Professional/ethical nursing practice
2. Holistic nursing care
3. Interpersonal relationships
4. Organisation and co-ordination of nursing care
5. Personal and professional development.

Since the 1970s, there has been a concentrated effort to move people with an intellectual disability (ID) from segregated institutional type settings into community-based accommodation. Central to this is the belief that this would promote community integration and enable people with an ID to live as equal and valued members of their communities. Ireland has made considerable progress in moving services in this direction, although there are individuals who continue to live in large segregated settings (McCarron et al 2011). A person-centred approach is identified as an important model of care for those with an intellectual disability.

People with ID are identified as a cohort that experience inequalities in relation to access to and treatment within health services (Council of Europe 2003). In 2006 the Council of Europe published an Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015. The plan promotes the rights and full participation of people with disabilities in society (Council of Europe 2006).

The Scottish Government (2012) identify central roles of learning disabilities nurses as:

- effectively identifying and meeting health needs
- reducing health inequalities through the promotion and implementation of reasonable adjustments, and
- promoting improved health outcomes and increasing access to (and understanding of) general health services, consequently enabling social inclusion.

The Department of Health (DoH 2012d) recently published *Value for Money and Policy Review of Disability Services in Ireland* proposes a fundamental change in approach to the governance, funding and focus of the Disability Services Programme, with the migration from an approach that is predominantly centred on group-based service delivery towards a model of person centred and individually chosen supports.

The recommended model of supports should be underpinned by a more effective method of assessing need, allocating resources and monitoring resource use.

## Context of Intellectual Disability Care

The National Intellectual Disability Database (NIDD) is maintained by the Health Research Board (Kelly & Kelly 2011). In December 2010 there were 26,484 people registered on the NIDD, representing a prevalence rate of 6.25 per 1,000 population. The prevalence rate for mild intellectual disability was 2.09 per 1,000 and the prevalence rate for moderate, severe and profound intellectual disability was 3.69 per 1,000. The prevalence rate among the under fours continues to decline however there has been an overall increase in prevalence in the 55-years-and-over age group. The total number with moderate, severe or profound intellectual disability has increased by 39% since the first census of Mental Handicap in the Republic of Ireland was carried out in 1974. This reflects an increase in the lifespan of people with intellectual disability. This changing age profile observed in the data over the past three decades has implications for service planning and service delivery.

The National Disability Strategy was launched in September 2004 (Department of Justice and Law Reform 2004). It provides for a framework of new supports for people with disabilities. The Strategy builds on a strong equality framework. It puts the policy of mainstreaming of public services for people with disability, which was adopted by Government in 2000 on a legal footing.

The Disability Act 2005 defines disability as *"a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment"*. Part 2 of the Act provides a statute based right for people with disabilities to an assessment of disability related health, personal social service and education needs.

The *National Disability Strategy Towards 2016 - Strategic Document* (DoHC 2009a) describes high-level, long-terms objectives for people with disabilities as follows:

- Every person with a disability would have access to an income which is sufficient to sustain an acceptable standard of living
- Every person with a disability would, consistent with their needs and abilities have access to appropriate health, education, employment and training and personal social services
- Every person with a disability would have access to public spaces, buildings, transport, information, advocacy and other public services and appropriate housing
- Every person with a disability would be supported to enable them, as far as possible, to lead full and independent lives, to participate in work and society and to maximise their potential
- Carers would be acknowledged and supported in their caring role.

The majority of intellectual disability service provision occurs in settings that cater for groups of people and which are separate from the rest of the community. Most day services occur in segregated, group settings (approximately 90%) and most residential services are provided in segregated group settings (approximately 90%). Many of the individuals in disability services receive what are sometimes described as 'wraparound' services from a single provider. This means the person receives a residential service (i.e. a place to live and daily supports), a day service (i.e. occupation of varying types up to five days a week) and also a variety of health services and other personal social services depending on their needs. These are all currently funded by the Disability Services Programme Budget through the health vote. Lack of individualised service provision, and a standardised needs assessment has been highlighted (Expert Reference Group on Disability Policy 2011).

*Time to Move on from Congregated Settings – A Strategy for Community Inclusion* (HSE 2011a) stated that various agencies were providing accommodation in "congregated settings" across twenty counties with just over 4,000 people living in these settings. A new model of support in the community is proposed

which envisages that people living in congregated settings will move to dispersed forms of housing in ordinary communities, provided mainly by housing authorities. People will have the same entitlement to mainstream community health and social services as any other citizen, such as GP services, home help and public health nursing services, and access to primary care teams. They will also have access to specialised services and hospital services based on an individual assessment. People will get the supports they need to help them to live independently and to be part of their local community. A core value underpinning the proposal is that people should make their own life choices, neither the HSE nor Service Providers own a client but have a responsibility to maximise their independence.

*Time to Move on from Congregated Settings – A Strategy for Community Inclusion* (HSE 2011a) identifies that the supports provided for people with disabilities are driven by values of equality, the right of individuals to be part of their community, to plan for their own lives and make their own choices and to get the personal supports they need for their independence. Such expectations are underpinned by legislation and policy. Person-centred planning tailored to individual needs, wishes and choices is advocated.

### Health Needs of People with an ID

In terms of the health of people with an ID, it is recognised that their health needs are greater and more complex and often present differently from those of the general population (NHS Quality Improvement Scotland 2006). Specific conditions are associated with people with an ID and require additional consideration by service providers (Atherton 2006, Royal College of Nursing 2006).

The National Health Service's (NHS) *2009 Health Needs, Annual Evidence Update* has focused on five key themes relating to the health needs of people with learning/intellectual disabilities i.e. cancer, coronary heart disease, challenging behaviour, epilepsy and respiratory illness. The healthcare needs of people with learning disabilities are well documented in the literature (van Schrojenstein Lantman-de Valk & Noonan Walsh 2008). Health needs might be related to disabilities, e.g. epilepsy, sensory deficits, syndrome-related (e.g. hypothyroidism in people with Down syndrome) or secondary to them, e.g. obesity and reflux disease. People with ID also visit primary care professionals less often than would be expected, they receive fewer screening tests and fewer health investigations despite evidence that regular and repeated health checking in primary care can identify previously unrecognised healthcare needs (Felce et al 2008).

Furthermore, people with an ID are more likely to have communication impairments which affect their own and others' ability to recognise any deterioration in health status and contribute to inequalities in their healthcare (Atherton 2006). In tandem with the increasing evidence emerging internationally around the health needs of people with an intellectual disability, many intellectual disability services are aiming to provide a social model of service for their clients.

The report: *Growing Older with an Intellectual Disability: The First Results of The Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing (IDS-TILDA)* (McCarron et al 2011) is a national representative study of 753 people with an intellectual disability aged 40 and over. Table 15 details findings from the study.

## Table 15: Findings Growing Older with an Intellectual Disability (Mc Carron et al 2011)

- People with ID enjoy life as they get older. Most had a hobby, went on holidays or day trips, engaged in regular leisure pursuits and had social contacts with others. But they seldom engaged in social activities with friends outside their home and families had limited roles in their lives.
- Over three quarters of adults with an ID reported that they never wrote, texted, emailed or used social media tools such as Facebook to contact their family or friends. Moreover, less than 60% used the telephone to make such contacts. Adults with an ID were less likely to own a mobile phone than other adults in the Irish population.
- Adults with an ID in Ireland were not actively engaged with their communities and community 'presence' was not actually equated with 'living' in the community.
- Many in the IDS-TILDA sample, particularly those in the younger age cohorts, reported experiencing good health but there were significant concerns in terms of cardiac issues (including risk factors), epilepsy, constipation, arthritis, osteoporosis, urinary incontinence, falls, cancer and thyroid disease. Younger adults with an ID had a much higher incidence of disease and identifiable risk factors for conditions such as coronary artery disease and stroke, than same age and older cohorts in the general population. Women with ID had higher risks for many diseases.
- The prevalence of diabetics in those age 50-64 years was double that found for the general population. Women within the mild to moderate range of ID were at the greatest risk.
- Sixty-one percent of Irish adults with ID are overweight or obese.
- Prevalence of depressive symptomatology was higher among women. It also increased with age, level of ID, sensory loss, reported experience of loneliness and living in a residential centre. But of those who reported a mental health diagnosis, over 90% were in receipt of psychiatric support.
- The prevalence of mental health and emotional problems is greater among persons with an ID than in the general population.
- Almost one fifth (18.5%) of Irish adults with an ID reported that they had previously received a diagnosis of depression; this was considerably higher than the 5% reported in the general population.
- Persons with ID are at least at the same risk of dementia symptoms as they grow older as the general population with the risk higher for people with Down syndrome.

### Summary

The age, health needs and location of those with an intellectual disability provide the context of care delivery for intellectual disability nurses. As those with ID are living longer their health needs are increasing. ID policy is promoting the importance of community integration and enabling people with an ID to live as equal and valued members of their communities. The profile of skills and competencies required for intellectual disability nurses into the future are drivers for the requirements for undergraduate education.

# Children's Nursing

The Nursing and Midwifery Board states that the children's/general nursing programme contains the essential elements that facilitate the development of professional knowledge, skills and attitudes necessary to meet the nursing needs of clients along the life span continuum. Nursing the child with healthcare needs requires the adoption of a child and family centred philosophy within which each child and his/her family are valued. The aim of children's nursing is to facilitate child and family empowerment, and to enable maintenance/restoration of optimal wellbeing for the child in a needs led culturally sensitive and high quality manner (ABA 2005a).

The Nursing and Midwifery Board outlines five competencies for children's nursing practice (ABA 2005a):

1. Professional/ethical nursing practice
2. Holistic nursing care
3. Interpersonal relationships
4. Organisation and co-ordination of nursing care
5. Personal and professional development.

Children's nurses care for children and young people from birth to adolescence. They care for children with acute or chronic illness and also children with life limiting conditions. Children have unique needs, one of which is the involvement of their family in their care. Central to children's nursing is the concept of family centred care which recognises that, in most cases, children and young people are best cared for by their parents, or by other people they know well. Children's nurses therefore work in partnership with the child and the family to promote, maintain or restore optimum health and wellbeing.

Internationally, models of children's healthcare include a greater focus on the delivery of daycare, short-stay or community based care which is underpinned by the assumption that where possible, children and young people should be cared for in, or as close as possible to, their own homes. Currently in Ireland however, children's healthcare services remain predominantly hospital based with the majority of children's nurses practising in the acute hospital sector. Due to advances in technology and enhanced survival rates, the last number of years has seen increasing numbers of children with complex care needs being cared for in their own home. In many of these situations, the children's hospitals continue to provide a significant amount of support to the child and family.

It is likely that children's nursing will evolve in light of proposed developments in the delivery of children's healthcare services in Ireland. These include the development of a new model of care in paediatrics, the planned Children's Hospital of Ireland and future configuration of children's healthcare services.

## Context of Children's Nursing

The National Children's Strategy (DoHC 2000b) is a 10-year plan with a vision of an Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own, where all children are cherished and supported by family and the wider society, where they enjoy a fulfilling childhood and realise their potential. It identifies three national goals:

- Children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity
- Children's lives will be better understood; their lives will benefit from evaluation, research and information on their needs, rights and the effectiveness of services
- Children will receive quality supports and services to promote all aspects of their development.

In 2009, there were 1,107,034 children aged under 18 living in Ireland. This accounted for almost one-quarter (24.8%) of the total population of Ireland (DoHC 2010b). Table 16 presents some key findings form the *State of the Nation's Children* (DoHC 2010b).

**Table 16: Extracts of Key Findings – State of the Nation's Children (DoHC 2010b)**

- Ireland continues to have the highest proportion of children in the European Union (Population Estimates, Central Statistics Office, 2009).
- The majority of child deaths occur in the period of infancy (less than one year of age) (Vital Statistics, Central Statistics Office, 2009).
- More than half of the total hospital discharges among children were children under 5 years of age (Hospital In-Patient Enquiry, Department of Health and Children, 2009).
- In 2009, there was a total of 145,749 hospital discharges among children. The most common reported principal diagnosis recorded was 'diseases of the respiratory system' (13.0%), followed by 'injury, poisoning and certain other consequences of external causes' (9.7%). Other diagnosis included diseases of the digestive system, congenital malformations, chromosomal abnormalities and neoplasms.
- The numbers of hospital discharges among children with a diagnosis of 'transport accidents', 'intentional self-harm' and 'accidental poisoning' continue to fall (Hospital In-Patient Enquiry, Department of Health and Children, 2009).
- Almost one-quarter of 7-year-old children are either overweight or obese (WHO European Childhood Obesity Surveillance Initiative, National Nutrition Surveillance Centre, 2008).
- Approximately 6 in 10 children registered as having an intellectual disability are boys (National Intellectual Disability Database, Health Research Board, 2009).
- Approximately one in 4 children on the National Physical and Sensory Disability Database are registered as having multiple disabilities (National Physical and Sensory Disability Database, Health Research Board, 2009).
- The number of cases of confirmed child abuse has increased (Child Care Interim Data Set, Health Service Executive, 2008).
- There has been an increase in the number of children admitted to psychiatric hospitals (National Psychiatric In-Patient Reporting System, Health Research Board, 2008).

The *National Policy - Palliative Care for Children with Life-Limiting Conditions in Ireland* (DoHC 2009b) identifies that in Ireland there are approximately 1,400 children living with a life-limiting condition and in the region of 490 childhood deaths per year. Of childhood deaths due to life-limiting conditions, the majority occur in the first year of life, with approximately 350 deaths per year from life-limiting conditions. An integrated care pathway is proposed which outlines the key stages in delivery of care in hospital and community settings to children and young people with palliative care needs. This pathway is divided in to 3 stages:

- Diagnosis or recognition of a life-limiting condition
- Ongoing care that may last weeks, months, years
- End of the child's life, including bereavement care.

The *Agenda for Children's Services: A Policy Handbook* (DoHC 2007) identifies seven national service outcomes for children in Ireland:

- healthy, both physically and mentally
- supported in active learning
- safe from accidental and intentional harm
- economically secure
- secure in the immediate and wider physical environment
- part of positive networks of family, friends, neighbours and the community
- included and participating in society.

Through ensuring the policy, organisational support and practice methods that promote a whole child/whole system approach, better outcomes for children can be achieved. Children and families should be able to expect that whatever the focus of the service they are receiving (e.g. prevention, early intervention, community services, hospital services, protection or out-of-home care), they will experience it as:

- whole child/whole system focused
- accessible and engaging

- coherent and connected to other services and community resources
- responsive to their needs
- staffed by interested and effective staff
- culturally sensitive and anti-discriminatory.

The Department of Children and Youth Affairs was established on 2nd June 2011 and will focus on harmonising policy issues that affect children in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people, youth work and cross-cutting initiatives for children. It mission is to lead the effort to improve the outcomes for children and young people in Ireland. The responsibilities of the Department encompass a wide range of policy and service activity, both direct and indirect, for children and young people in Ireland. Its mandates include:

- the direct provision of a range of universal and targeted services
- ensuring high-quality arrangements are in place for focused interventions dealing with child welfare and protection, family support, adoption, school attendance and reducing youth crime, and
- the harmonisation of policy and provision across Government and with a wide range of stakeholders to improve outcomes for children, young people and families.

The *Programme for Government 2011-2016* places priority on children through committing to:

- a referendum to amend the Constitution to ensure that children's rights are strengthened
- the National Children's Hospital
- a new area based approach to child poverty.

### Dependency and Acuity in the Children's Hospitals

The acuity and dependency of children in the acute healthcare services has risen significantly over the last number of years. Children's nurses are challenged to adapt their nursing practice to meet the needs of these children. Children once cared for exclusively in an intensive care/high dependency setting may now be nursed in a ward environment, for example children with an epidural in situ, children receiving inotropes (medication to support cardiac function) or other infusions. The increasing complexity of children's healthcare needs coupled with advances in medical interventions and treatment results in additional demands for paediatric intensive care. For example, in one children's hospital due to its specialist nature and complexity of care 80% of children admitted to the paediatric intensive care unit in 2010 were generated by its inpatient population (OLCHC 2011).

In 2008, the HSE commissioned a review of current paediatric critical care facilities and services in Ireland with a view to developing paediatric intensive care services at that time and in the lead up to the opening of the new National Paediatric Hospital (Det Norske Veritas (DNV) 2008). The review recommended increased paediatric intensive care/high dependency capacity to meet service demand. In addition, the review explored the needs of children requiring long-term care. International best practice recommends that the most appropriate setting for children requiring longer term care is the community or at home. At present these children are primarily located in hospital-based transitional care units. It was recognised that it will take time to develop the infrastructure to provide home based care for these children and recommended that a review should therefore be undertaken to assess the balance of services which should be available in the new Children's Hospital of Ireland and those in a setting more local to, or at, the child's home (DNV 2008).

## National Model of Care for Paediatric Healthcare in Ireland

The National Paediatric Hospital Development Board (2010) has published a *National Model of Care for Paediatric Healthcare in Ireland*. As part of this model, the new Children's Hospital of Ireland will be a central component of an integrated healthcare system for Ireland's children, young people and their families. This system will be based on a national network of interconnected elements from GPs and local health centres, through local and regional hospitals, right up to one national tertiary hospital. The network will require standardised processes and protocols that apply at all levels of the network so that children and young people receive the highest standard of care relative to their clinical needs irrespective of where they enter the network.

This *National Model of Care for Paediatric Healthcare Services in Ireland* is built on a number of fundamental principles, including:

- Care will be provided as close to the child's or young person's home as possible, depending on their clinical needs
- Care will be provided within the network at the appropriate level, in order to use resources efficiently
- Where clinically appropriate, short-stay or ambulatory day care will be provided in preference to inpatient care
- Parents and family will be supported to engage with and contribute to the care, treatment and healing process.

## Summary

Policy direction and the new model of paediatric care will drive the context of practice for children's nurses into the future. Children's nurses will provide for more complex acute care within the national tertiary centre. The changing model of care delivery will require children's nurses to be prepared to work outside of hospital settings to a greater extent. Skills and competencies for delivery of community care will be important.


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