School of Nursing and Midwifery
Trinity College Dublin

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Transforming Healthcare Through Research, Education & Technology

November 8th – 10th November 2006

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A Study of Transition: Challenges facing newly qualified sick children’s nurses communicating with parents of hospitalised children.

Siobhan MacDermott  MSc, RGN, RSCN
Lecturer
Dublin City University
Glasnevin
Dublin 9

Introduction
The nurse-parent relationship is considered to be the cornerstone of quality children’s nursing care (Espezel and Canam 2003). Although this long-standing view is incorporated in the philosophy of family-centred care and widely promoted by most children’s organisations, it is unclear as to how successfully it is practiced. In fact, studies suggest that nurses in hospitals continue to concentrate on the physical nursing care aspect of their job (Fenwick 2001, McCabe’s 2004).

The extent to which nurses are able to communicate effectively with parents of sick children has not been well documented. While several studies in recent years have explored parental involvement in the care of their child (Casey 1995, Fenwick et al. 1999, Kirk 2001), few exam communication as an essential element underpinning such interaction. In addition few studies highlight the experiences of newly qualified nurses in relation to nurse-parent communication. This study explores newly qualified nurses’ perceptions of their nurse-parent communication skills and describes a strategy introduced to improve practice.

Methods
Action research was the selected methodology of choice for this study. In an attempt to not only answer the research question but also to overcome the problems of dissemination of findings, action research was found to be the most appropriate methodology. A convenience sample of 10 newly qualified sick children’s nurses were recruited for the study and semi-structured interviews were used to collect data. The constant comparative method was employed as a tool for analysing the data.

Findings
The findings of this study reveal that newly qualified nurses learn their communications skills from observing more experienced nurses in their interaction with parents. However evidence shows
that more experienced nurses tended to adopt a more authoritarian approach to communication (Burnard and Morrison 1991). In addition the participants identified the need for communication skills training. Several suggestions were offered to develop an in-service education workshop involving role-play. The theory aspect of communication skills was viewed as important by participants in underpinning the practice. However learning the theory alone was considered inadequate.

Conclusions
As with action research a strategy for improved practice was initiated and re-evaluated by the participants. A workshop was introduced to the in-service programme for newly qualified nurses, designed to improve the effectiveness of nurse-parent communication. Overall this study highlighted many weaknesses in the training and education provided for newly qualified nurses in nurse-parent communication currently. In addition a strategy for improved practice was introduced successfully within the hospital.

References


Staff nurses’ lived experience of power and powerlessness

Author: Ann Maher, RGN, RSCN, RNT,BNS,MSc(Nursing).
Lecturer, Department of Nursing and Health Science, GMIT, Castlebar.
Contact; 094-9043254, Ann.Maher@gmit.ie

Abstract

Power is considered to be present in every nursing situation. Indeed, power is said to be necessary to ensure excellence in nursing practice. Yet, nurses are frequently portrayed by both themselves and those outside the profession as powerless. If, as Benner (1984) suggests, power is necessary for excellence in nursing, what then are the consequences of nurses experiencing powerlessness? If nurses experience powerlessness, does this limit their ability to empower others? Does the centrality of the concept of caring in nursing influence nurses’ experience of power and powerlessness.

Methodology

Using a phenomenological approach, this study sought to describe the meaning of power and powerlessness as experienced by staff nurses in their practice in surgical units within a general hospital setting in the Republic of Ireland. Husserlian phenomenology was the particular methodology used. 10 staff nurses participated in unstructured interviews and the data analysis method used was guided by Collaizzi’s (1978) framework.

Findings

The findings indicate that staff nurses’ experiences of power and powerlessness related to four main areas:

- Team membership (both nursing and multidisciplinary teams),
- Nurse-patient relationships
- Having control
- Being controlled

The essential structure of power and powerlessness was constructed using these themes. The implications of the findings were outlined, as were recommendations for staff nurses, nurse managers and nurse educators.

References

This research was submitted in part fulfilment of the degree of Masters of Science in Nursing, The Royal College of Nursing Institute, London in 2003.
A Report on student involvement in the planning, development and delivery of their educational programmes

Geraldine Main and Alun Jones

School of Nursing, Midwifery and Social Work
University of Manchester
Oxford Road
Manchester
M13 9PL

Geraldine.Main@manchester.ac.uk; E-mail
Alun.Charles.Jones@manchester.ac.uk

Telephone 0161 275 5333

ABSTRACT

Background - In the United Kingdom, student health professionals finding satisfaction with educational experiences is considered important to producing effective practitioners. The ways in which students contribute to the development of their educational programmes is also thought to reflect organizational effectiveness. This paper describes the setting up and progress to date of a project concerning mixed group of students, including nurses of different specialities, midwives and social work students, and their participation in organising a Student Council which is a representative committee with decision-making responsibilities.

Aims - The aims of the paper are to report on the process and preparation for setting up the Student Council and benefits gained by students and university teachers through participating in curricular related committee work. The paper describes situations that encouraged a sense of student-centeredness and ownership of students’ educational experience overall, because of the project. However, group work can be challenging as well as helpful to participants and some important group tensions are explored in context.

Findings - Information gained to date from student and staff self-reports, suggests that students feel a greater sense of self-confidence, engage more meaningfully with their educational tasks and gain a better understanding of difficulties encountered when planning and delivering an educational programme, through participation in this type of representative project. Reciprocal
empathy between university lecturers and students is also enhanced. Although limited in scope, the project work suggests that more effective delivery of educational programmes for health professionals seems subsequently possible because of collaborative work.

**Conclusion** – This project may help inform education and training agendas for students and teachers alike within the *School of Nursing, Midwifery and Social Work* within the *University of Manchester*. An awareness of the complexities in relation to ways group work effectively and enhance the esteem of its members could contribute to improving the quality of education programmes for health professionals but as well care provided to health care service users.

**Key Words:** Student Council, Partners in Education, Student Centeredness
Informed Consent During the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour involving Consent to Procedures.

Author and Presenter:
Dr Jayne E Marshall: PhD, MA, PGCEA, ADM, RM, RN
Midwife Lecturer / Assistant Director for LBR Programmes

Academic Division of Midwifery, School of Human Development
University of Nottingham
Post Graduate Education Centre
Nottingham University NHS Trust (City Hospital Campus)
Hucknall Road
Nottingham NG5 1PB
United Kingdom

Tel: 0115 82 31925
Fax: 0115 82 31930

Background and Rationale:
In recent years, government reports have recommended that maternity care should be based on a partnership between the midwife, the obstetrician, the general practitioner (GP) and the woman, in which the woman has choice, control and continuity of care (Department of Health [DoH] 1993, DH 2000, DH 2003a, House of Commons Health Committee 2003). Health professionals are therefore expected to supply women with sufficient unbiased information in order for them to be in a position to make informed choices about their care throughout the whole childbirth process. Furthermore, emphasis has developed that not only endorses the importance of all health professionals having competence in communication skills (DH 2003b, DH 2000, Universities United Kingdom [UK] 2003) but also encourages health professionals to learn and work together in collaboration and so acquire a better appreciation of each other’s roles (Symonds et al 2003, DH 2001, Marshall and Kirkwood 2000).

In practice, it has not only been personally observed, but also documented in studies, that during intrapartum care women accept what is done to them without challenging midwives and doctors, and in turn, the health professional accept this as consent to proceed. This has been highlighted by Patterson’s (1994) study that explored informed consent in labour and in studies into vaginal examinations undertaken by Bergstrom et al (1992), Menage (1993) and Coldicott et al (2003), artificial rupture of the
membranes conducted by Henderson (1991, 1984) and the National Childbirth Trust [NCT] (1989) and by Kirkham (1987), who examined communication and interactions between health professionals and women during intrapartum care. However, although a literature search into the subject revealed a substantial amount of research data revolving around communication and the concept of choice in maternity care, there was generally a lack of data specific to the area of intrapartum informed consent, thus supporting the rationale to undertake a study in this area. Nevertheless, as Ralston (1994) asserts, one of the fundamental issues surrounding intrapartum informed consent is the effectiveness of communication between health professionals and the woman.

**Aim of the Study:**
To explore the issue of informed consent to procedures undertaken during the intrapartum period.

**Methodology:**
The study was undertaken using an ethnographic approach that involved participant observation. 100 healthy women, who went into labour spontaneously at term, were recruited. The data collection took place in a large teaching hospital in an East Midlands city from April 1997 until December 1999. The subjects (health professionals and women) were observed throughout the labour until the woman and baby were transferred to the postnatal area. Follow-up semi-structured interviews, based on the observations, were conducted with the women and midwives, within 24 hours.

**Analysis:**
A CAQDAS package (NUD*IST) was used to assist with the data analysis and using principles of grounded theory (Glaser and Strauss 1967, Strauss and Corbin 1998).

**Summary of Key Findings:**
The key findings from the study were:

♦ Obtaining informed consent during labour is difficult.

♦ Not all women wanted to be fully informed about intrapartum care and procedures.

♦ The midwives’ knowledge of legal and ethical issues concerning consent was variable and limited.
Attempts to empower women to make intrapartum choices were constrained by the culture of the labour ward environment and the adherence to policies and procedures.

The obstetricians and paediatricians were less effective communicators than anaesthetists.

**Conclusions:**
These findings could be used in partnership between maternity service and education providers to ensure that health professionals not only have effective communication and interpersonal skills, but also are more conversant with the legal and ethical implications of consent.

**References:**


Traveller Women's Cervical Health: Evaluation of A Cervical Screening Project in Laois and Offaly

Authors:
Patricia Marteinsson, RGN, RM, PHN, MSc. Nursing, Dip. Medical Ethics, Dip. Health Education, IBCLC, Des. PHN for Travellers Laois/Offaly

Mary O’Neill, RGN, RM, PHN, Dip. Counselling & Women’s Health, Project Manager Sexual Health, HSE Dublin Mid-Leinster, Tullamore.

Deirdre Kavanagh, RGN, RM, RPN, PHN, Dip. Counselling, Addiction Studies, & Health Care Management, Co-ordinator Primary Health Care Programme for Travellers, HSE Dublin Mid-Leinster, Tullamore.

Petra Daly, B.A, Higher Diploma Youth & Community Development, Community Development Health Worker, Tullamore Travellers Movement.

Mary Hegarty, B.A., M.A. Health Promotion, Lead Qualitative Researcher, Department of Public Health, HSE Dublin Mid-Leinster, Tullamore.

Background
A cervical screening project for Traveller women has been implemented in Laois/Offaly because

- Life expectancy for Traveller women is 12 years less than for the general population and the indicators of health status for Travellers are below average (Taskforce Report, 1995).
- On average, 73 women die from cervical cancer in Ireland each year and the average age at death is 56 years. Average age at diagnosis with carcinoma in situ is 32 years (NCRI & WHC, 2006).
- Early detection and treatment of cervical cancer can minimise the risk of advancing disease (Department of Health, 1996).
- Cervical cancer screening is effective in substantially reducing the incidence of and mortality from cervical cancer in the population (IARC Working Group, 2005).
- Uptake of screening and other health care initiatives among Travellers is historically low and there may be cultural factors which act as barriers. Specific supports may be required in order to overcome any barriers.

The project was implemented by a multidisciplinary partnership which included the Traveller Health Unit, local Traveller
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organisations, General Practitioners (GP) and Practice Nurses, The Public Health Nursing Service, and The Primary Health Care Programme for Travellers (PHCP), Community Health Workers from the Traveller Community, The Primary Care Unit and the Department of Public Health. The population consisted of Traveller women aged 25-60 who had never had a smear or had not had a smear for over five years. Exclusion criteria included women who were pregnant or who had a hysterectomy. Traveller women were invited to avail of free cervical screening at GP practices following information sessions and promotional work. The project team supported Travellers to avail of free screening.

The aim of this study is to evaluate this Cervical Screening Project.

**Evaluation Methodology:**
The evaluation is running concurrently with implementation of the programme and employs both quantitative and qualitative methods including:

- Collation of statistics in relation to the target group facilitated by Designated PHN records on the Integrated Care One Network (I.C.O.N) Project; statistics on uptake from the Primary Care Unit, HSE (2006)
- Documentary analysis of Project records (PHCP Co-ordinator)
- Focus groups with Traveller women will explore their understanding of cervical screening and the experiences in relation to it. Two focus group involving 21 participants were held in training centres. There were two facilitators for each group and a vignette was used to facilitate discussion. A further three focus groups are planned.
- Perspectives of the Community Health Workers and the members of the project team will also be documented through focus groups (two held and further two planned)
- Perspectives from General Practice have been elicited using questionnaires.

The findings will specify:
- Number of Traveller women eligible to take part in the programme and numbers of invitations issued and followed up
- Numbers of information sessions provided to Traveller women
- Numbers of women screened under the programme
- Numbers of General Practices involved in the programme

Preliminary indicators suggest that fear of cancer itself and fear of perceived loss of virginity may be important influences on uptake. It is evident from findings to date that that the strength of the communication process involved, rapport with clients and support
provided can influence uptake. The availability of female smear-takers and the fact that the service is free is also important. The need for awareness raising and education of Traveller women in relation to cervical screening is immense there are many barriers to be overcome in even getting Travellers to discuss the topic.

Evidence of added value from this programme in terms of health promotion work with Traveller women will also be presented.

References


Patricia Marteinsson RGN, RM, PHN, MSc. Nursing, Dip. Medical Ethics, Dip. Health Education, IBCLC, Des. PHN for Travellers Laois/Offaly

Anne Harte, PHN for Travellers Longford/Westmeath, 6 Church Street, Longford

Background and Context
Traveller Health Strategy identified that a need existed to develop an adequate system to gather data on an ongoing basis on Traveller health. This data will provide the baseline from which progress can be measured and by which services can be planned and monitored.

Aim: (ICON Measurement Tool) provides a means of producing a demographic profile of a nomadic population.

Methodology: Survey

Analysis: A community profile has been compiled from the Designated PHN for Traveller records showing the breakdown of the Traveller Community in Laois/Offaly/Longford/Westmeath.

Key Findings: ICON facilitated integrated care for the population. The measurement tool provided a database to profile the community. This process was facilitated by documentation developed by the team.

Conclusion: ICON facilitated the delivery of integrated care while providing a method of accurate tracking in a nomadic population, sharing information for services and providing the community demographic details in an anonym’s way which is essential for service planning.
The development and psychometric evaluation of an instrument to measure midwives’ perceptions of the conditions important for empowerment.

Authors:
Dr Anne Matthews PhD MSc (Econ) BSocSc RGN RM
Lecturer in Nursing, School of Nursing, Dublin City University
Phone: (00 353 1) 7008957 email: anne.matthews@dcu.ie

Professor P. Anne Scott PhD MSc BA (Mod) RGN
Deputy President, Dublin City University

Dr Pamela Gallagher PhD DipStat BA (Mod)
Lecturer in Psychology, School of Nursing, Dublin City University

Background and context
This is an exciting time for midwifery in Ireland, with many unique practice and education opportunities on offer. These include the development of evidence-based midwifery-led services and the integration of midwifery education into the third level sector. Within this context, it is critical to articulate and measure the conditions which facilitate empowerment in midwifery.

Aim of the study
The aim of the research reported in this study was to develop and psychometrically evaluate a scale to measure midwives’ perceptions of the conditions important for empowerment.

Methodology (design and sampling)
A cross-sectional survey of practising midwives (n=244) was carried out in May 2005.

Analysis
Exploratory factor analysis (using Principal Axis Factoring and an oblique (Oblimin) rotation) was carried out in the development of this instrument and this is reported in this paper.

Summary of key findings
The Perceptions of Conditions for Empowerment in Midwifery Scale (PCEMS), developed in this study was found to be a valid and reliable instrument. It has three internally reliable sub-scales: Autonomous practice; Effective management and Women-centred practice.
Conclusions
The PCEMS is an appropriate tool to measure midwives’ perceptions of their workplace conditions, within a changing midwifery and maternity care landscape.
Teaching and Learning about Research in the Context of the Nursing Curriculum in Scotland: Perceptions and Experiences of Lecturers and Students

Dr Gerri Matthews-Smith, Senior lecturer research/ Teaching Fellow, Napier University, School of Community Health, Canaan Lane Campus, 74 Canaan Lane Edinburgh EH9 2TB g.matthews-smith@napier.ac.uk Tel 0044 131 455 5615

Background and context
This paper centres on an analysis of the contrasting perceptions of lecturers and students of the place of research in the nursing curriculum. An investigation into the conceptions held by both teachers and students requires the research to be conducted from a ‘second order’ perspective. The way teachers think about teaching and the way students think about learning cannot be observed. Aim of the study

Methodology including research design and sampling
A second-order qualitative approach known as phenomenography (Marton 1981; 1986), which has been used extensively in research on student learning has been adapted for this study. Data collection techniques included in-depth interviews and focus group discussions. The qualitative data package - NUD-IST was used to assist management of the data during analysis

Summary of key findings
It has become clear through this project that there needs to be more evidence-based support for the rhetoric on evidence-based nursing, and its place in teaching and learning. The study has provided a basis for developing research in nursing education in this direction by describing a fully developed methodology especially suitable for this research purpose. In addition, it has offered a conceptual framework that provides a stronger theoretical underpinning for nurse education, derived directly from the experiences of students, as well as staff, in nurse education. In so doing, it also contributes to the wider research into student learning which is currently paying more attention than in the past to teaching and learning within the differing subject areas.
EXPLORATION OF GENERAL WARD NURSES PERCEIVED COMPETENCE LEVEL IN THEIR CRITICAL CARE SKILLS.

Presenter Details
Caron Mc Mahon RGN, RM, RNT, MSc (Ed), H. Dip. Critical Care Clinical Skills Nurse School of Nursing Dublin City University Dublin 9

Phone 01 7007934
Fax 01 7007919
Email caron.mcmahon@dcu.ie

Abstract

The aim of this research study was to explore medical and surgical ward nurses perceived competence level in the critical care skills required to care for acutely ill patients outside Intensive Care Units (ICU) and High Dependency Units (HDU) as 80% of these patients are receiving 'suboptimal care'. The importance of providing optimal care for these critically ill was identified as a national priority in the UK as early as 1999.

A quantitative approach utilising a descriptive, cross-sectional survey design was employed. Convenience sampling invited 428 participants to participate. A response rate of 46.72% (n=186) was achieved utilising a study specific semi-structured questionnaire, which evaluated 68 distinct critical care skills. Data analysis was achieved using Statistics Package for Social Sciences (SPSS) Version 11.

Findings indicated ward nurses have varied levels of competence in relation to critical care skills. The areas of perceived low competence were identified as 'interpretation of twelve lead electrocardiographs', 'venupuncture', 'cannulation', 'recognition of cardiac rhythms', 'removal of central lines', 'lung auscultation', 'reading a chest x ray', 'removal of respiratory underwater seal chest drains', 'assembly and maintenance of Gomco suction', assessment of Tracheotomy cuff pressure and knowledge of time to deflate cuff, all aspects of 'non invasive respiratory support', 'male catheterisation', and the 'care of epidurals'.

The main implication for practice are that patients are receiving suboptimal care in all the skills identified above thus supporting the necessity for clinical based education programmes and
educationalists who will identify and support post registration staff in their continued professional development.

References


Positive Attitudes to Schizophrenia and Their Impact on Practice

Ms. Patricia McBride,
Lecturer,
University of Paisley,
High Street,
Paisley PA1 2BE
Scotland
Tel: 00441418494292
Mob: 07958631216
E-mail: mcbr-rn0@wpmail.paisley.ac.uk

Abstract

Psychosocial Interventions are clearly evidenced as Best Practice for those patients diagnosed as having schizophrenia. However following a review of the literature into the failure of mental health nurses to use these skills despite being trained in their use a number of issues were highlighted as areas of concern. It was decided that further exploration of the attitudes of mental health nurses towards those with psychosis and current working practices was required.

A pilot survey was carried out with three different groups of nursing staff in the local area selected as convenience samples from different venues, a conference, a group of mental health nurses and a generic group. A questionnaire was used to identify 3 main areas, biographical and professional background, attitudes towards working with schizophrenia and practice related behaviour. The data was analysed using SPSS, comparing results from the different groups for attitudes and practice behaviours and exploring links between attitudes and behaviours both overall and within the individual groups.

The main findings are that attitudes varied between the groups depending on their clinical background but that behaviours did not. This appears to suggest no link between attitudes and behaviours in working with schizophrenia. This initial study however does not provide an explanation for this phenomenon and the need for further exploration of the clinical behaviours of nurses has been identified as a result.
Introduction

There is a large body of evidence supporting the use of Psychosocial Interventions in mental health practice, particularly in the treatment of schizophrenia with the result the SIGN guidelines (1998) regard it as best practice for this patient group. Psychosocial Interventions. However alongside this is evidence that, despite training in the required skills, these are often not put into practice by mental health nurses, particularly in in-patient areas where they are indicated as being most effective (Brooker et al.2003, McCann & Bowers 2005).

Psychosocial Interventions are primarily an eclectic approach to care that make use of a number of different interventions depending on the needs of the client and their family. These interventions have all been shown to have an impact when used individually however there is evidence suggesting that combining some of these in PSI can have a greater impact on outcome (Razali et al 2000).

While individual work is a part of the intervention there is a greater focus on the family within this way of working. This ties in with the work of Leff et al (1982) and Falloon et al (1992) who argued that family dynamics could be a major influencing factor on the development and maintenance of the illness. Much of the work with families centres around education about the illness, how it affects the individual and treatment and future outcomes.

However working with the individual can also be integral to this approach to care in that it allows the client to focus on specific aspects of their symptoms which are problematic. CBT features greatly in this and indeed much of the research into PSI and psychosis focuses on this approach (Tarrier et al 1998, Hall & Tarrier 2004). The research suggests that CBT is of particular value in assisting the client to deal effectively with hallucinations, particularly auditory, and disturbing thoughts. The focus is not always about removing these but about developing more effective coping strategies (Norman et al 2002).

In most cases while there is some initial use of the skills learned there is evidence to suggest that these skills are not maintained over a period of time (Freiheit & Overholser 1997, Milne et al 1999). Lack of appropriate supervision is featured as having a major impact on development and maintenance of clinical skills (Sloan et al 2000), however there would appear to be a number of other causes including a lack of management support for a change in the current way of working, possibly due to a lack of understanding of the intervention (Milne et al 2003).
In most clinical areas the number of nurses trained in these skills tends to be fewer than not and many of the untrained nurses often do not see the value of training and using PSI with this client group. This lack of peer support can lead to a reduction in the use of these skills in those who are trained in them (Brooker et al 2003) suggesting that colleagues have a great influence on practice and behaviour. Some of this pressure is linked to a fear of change and a belief that the traditional ways of doing things are best because it’s always been done that way (Daiski 2004). However, it is also possible that nurses’ attitudes to treatment approaches reflect the reliance on the medical model as the mainstay of treatment for schizophrenia (Nolan 1993). This is often tied in with the view that schizophrenia is incurable and can only be managed by medication causing barriers to other potentially useful interventions.

To this end a pilot study was carried out among nurses in the local area in an attempt to more clearly identify the attitudes and behaviours of nurses in a variety of clinical environments.

**Study Population**

The study comprised three groups of nurses from different backgrounds with a range of clinical expertise.

1) **Conference group** - 29 mental health nurses who attended a conference exploring the issues around the delivery of PSI. These were experienced staff with a specific interest in this field and a high level of knowledge and skill, 76% having more than 10 years experience and 30% more than 20 years. Of these more than half (56%) worked in specialist community practice.

2) **Psychosocial Interventions students** – 26 registered mental health nurses completing extra modules to obtain their degree. There were varying levels of knowledge and expertise in this group but some level of interest in the subject having chosen to study these modules, with 77% having less than 15 years clinical experience. In this group 65% worked in specialist community practice.

3) **Generic group** – 22 nurses from a variety of backgrounds, not mental health with little knowledge of or interest in PSI. There was an even spread in terms of length of experience although most of the group (70%) had less than 20 years. This group also had a wider range of clinical background with only 34% working in community and was the only group which had nurses from elderly care (10%).
There were a higher number of females overall in the study although the numbers in the PSI group were evenly balanced, 46% male to 54% female. The higher number of females in the generic group (92%) was not unexpected as nursing is still a mainly female dominated profession. However a higher number of males would have been anticipated in the conference group, only 23%, due to both the fact that mental health nursing attracts more males and they often occupy higher positions.

**Results**

The questionnaire consists of 3 parts, biographical data including work and training history, an attitude toward psychosis scale and a behaviour scale exploring activities specific to PSI. The total scores for both attitudes and behaviours were compared for the different groups in the survey and the results are illustrated in Tables 1 and 2 respectively.

The total score possible in the attitude scale was 80 and as can be seen in Table 1 the maximum score in individual groups and overall, although positive, was less than this. The total mean also indicates a positive attitude although this did vary within the groups, most noticeably in the generic group which had a substantially lower mean score than the other two groups (see Table 1). However this score was as expected given that, of the 3 groups, the members of generic group do not work within the field of mental health and would not necessarily have the knowledge or experience of working with schizophrenia which would impact on attitude.

**Table 1  Attitude Scores Between Groups**

<table>
<thead>
<tr>
<th>Categories</th>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference Group</td>
<td>29</td>
<td>37</td>
<td>69</td>
<td>59.28</td>
</tr>
<tr>
<td>PSI Group</td>
<td>26</td>
<td>12</td>
<td>68</td>
<td>54.65</td>
</tr>
<tr>
<td>Generic Group</td>
<td>22</td>
<td>5</td>
<td>68</td>
<td>38.36</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>5</td>
<td>69</td>
<td>51.74</td>
</tr>
</tbody>
</table>

Analysis of variance indicted a significant difference between the scores of the groups with the result F(2,78)=16.33 and a probability score of p< .05 indicating that membership of the conference group or PSI group resulted in a positive score for attitude. The post hoc tests confirm that the significant difference in attitude is due to the fact that the generic group differ in clinical background from the other two groups there being no significant difference between the attitude scores of the conference group or the PSI group all of
whom work within the field of mental health, mainly nursing. The reliability of the attitude scale was tested using Cronbach’s Alpha which produced a score of .893 for the scale in total and an inter-item result of .896 both of which indicate that the scale is reliable in terms of measuring attitude.

The behaviour scores, which had a possible total of 40, did not match the positive attitudes identified despite the fact that the highest score possible was recorded within the conference group (see Table 2). However the low mean of total scores may have been affected by the fact that only 55 out of 79 actually completed this part of the questionnaire. Between the different groups there were no significant differences in the scores and analysis of variance confirmed this with $F(2,55) = 1.83$ and a probability score $p > .05$ indicating no relationship between group membership and the behaviours being measured. Although the mean for the generic group was higher when compared to those of the PSI group and the conference group this may be reflective of the fact that only 8 people out of a possible 22 completed this section. This in itself was not unexpected as the behaviours being measured were specific to skills for PSI and therefore this group would be unlikely to exhibit them. Of the three groups the PSI students recorded the lowest score on this scale (Table 2), which could be regarded as reflecting the fact that they are still learning the skills and would therefore be assumed not to be using them on a regular basis. However it is also more difficult to test reliability for this scale as a number of different issues were being measured some of which were not inter-related.

Table 2  Behaviour Scores Between Groups

<table>
<thead>
<tr>
<th>Categories</th>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference Group</td>
<td>25</td>
<td>9</td>
<td>40</td>
<td>20.24</td>
</tr>
<tr>
<td>PSI Group</td>
<td>22</td>
<td>9</td>
<td>30</td>
<td>17.91</td>
</tr>
<tr>
<td>Generic Group</td>
<td>8</td>
<td>13</td>
<td>37</td>
<td>23.75</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>9</td>
<td>40</td>
<td>19.82</td>
</tr>
</tbody>
</table>

There was also found to be no significant relationship between overall attitudes and behaviours, $r = -.042$, $p$ (one-tailed) > .05.

**Discussion**

Taking into account the different clinical backgrounds of the population surveyed it is clear that the results of the attitude scale correspond with the area in which the nurses work. It may be that there are issues around autonomous practice, which is a feature of community working, and the need to be more proactive in care.
delivery may have a positive influence on attitude. However the other possibility is that those working in community areas already have these attributes and this is their reason for choosing to work in this setting. There is also the fact that attendance at the conference and the class on PSI is voluntary which raises the issue of self-selection due to previous or existing interest in the subject and therefore a more positive attitude. However the questionnaire did not allow this to be explored in detail as very few staff from in-patient areas attended either the conference or the PSI classes, so at present their attitudes are unclear.

It is also apparent that these positive attitudes do not translate into the specific behaviours in practice that are appropriate for this client group. There may be several reasons for this, including lack of awareness of the specific skills required, although given that the conference group have experience and knowledge in this field that does not fully explain the results. The scale itself could have been part of the problem as it was asking people to measure their activity in units of time per day and it is possible that while people carry out some of the activities regularly they may not do others, for a variety of, as yet unclear, reasons.

The need for further exploration of the clinical behaviours of nurses has been identified from this pilot. It is planned to make use of structured activity diaries, using the behaviours from the questionnaire as the basis for the issues being explored to allow people to more clearly and specifically describe their behaviours with this client group. Within the diary there will also be an opportunity for the respondents to explain their reason for the use, or not, of the identified interventions. It is envisaged that this will facilitate a greater depth of understanding of which activities are most common and the reasons for skills not being used, even if they have been learned.
References


Research Awareness: The Route To Evidence Based Nursing. Findings From A Randomised Descriptive Survey Of Registered Nurses In Ireland.

Catherine McCabe  MSC BNS, RGN, RNT Research fellow, School of Nursing and Midwifery, Trinity College Dublin.

Fiona Timmins  MSC FFNRCSl NFESC BNS BSc Health & Soc (Open) RNT RGN
Senior Lecturer, Director BSc (Cur), School of Nursing and Midwifery, Trinity College Dublin.

& Robert McSherry  RGN, DipN (Lon), B.Sc. (Hon’s), MSc, PGCE, RT, ITLM,
Principal Lecturer Practice Development, University of Teesside, Practice Development Team, UK.

Background & Context: Achieving evidence-based practice remains problematic. This is the first study to explore this area within an Irish context.

Aim: This study aimed to establish levels of research awareness.

Methodology: A randomised sample of 2,000 registered nurses were provided with a self-administered Research Awareness Questionnaire (RAQ) directed towards measuring healthcare professionals: attitudes towards research, their understanding of research and the research process and associations with practising using an evidence base.

Findings: Response rate was 12%. There was overwhelming agreement (92%) with the principles that evidence based practice has a large part to play in improving patient care. 93% of respondents agreed that evidence based practice is the way forward to change clinical practice. Furthermore, most nurses perceived evidence based practice as integral to their role and recognised the personal gains of engaging in evidence based practice activities. There was significant association between levels of confidence to undertake a piece of research and whether the individual had received adequate information about the research process, had basic knowledge and understanding of the research process or had research awareness education or training. A large percentage (57.9%) didn’t feel confident with research activity. 71% of the nurses within the study indicated that they had insufficient support
and encouragement from peers and professionals to engage in research activities. Similarly, 69.2% indicated insufficient support from the management.

**Conclusions:** The study demonstrates that nurses have a positive attitude to research but face many obstacles. The key obstacles centre on a lack of time, support, knowledge and confidence. This study argues for corporate and strategic action to devise, implement and support the introduction of a robust framework to achieve evidence based practice within the organisation.
Nurses’ experiences and knowledge of urinary catheterisation, management and care: A Descriptive Study.

Presenter Contact Details

Margaret McCann
Address: Lecturer, School of Nursing and Midwifery, Trinity College Dublin, 24 D’Olier Street, Dublin 2
Qualifications: RGN, RNT, Cert (Dialysis, Nephrology and Transplantation), BNS (Hons), MSc, FFNMRCISI
Contact No: 8968542
Email Address: mccannm1@tcd.ie

Marie Hennigan
Address: Clinical Practice Development Nurse, St Josephs Hospital, Raheny.
Qualifications: RGN, SCM, BSc, MSc
Contact No: 8478433
Email Address: mariehennigan@beaumont.ie

Susan Hawkshaw
Qualification: RGN, RSCN, Dip in Health, Safety and Welfare at Work, BNS, HDip in Quality in Healthcare
Institution: Beaumont Hospital

Marie Kelly
Qualification: RGN, RM, Post Grad diploma in Urology, Diploma in management
Institution: Beaumont Hospital

Bernie Burke
Qualification: RGN, RM, Diploma in Management
Institution: Beaumont Hospital
Background and Context
The purpose to this study was to explore nurses’ experiences and knowledge of urinary catheterisation, management and care. This collaborative project was between a Third Level Education Institute and Two General Teaching Hospitals in Ireland.

As widely acknowledged in the literature urinary catheterisation insertion and management is primarily a nursing responsibility. The management of such patients requires nursing decision making which is based on best nursing practice. It is expected that this study will identify the opportunities for continuing professional development in this specific area of practice.

Aim of Study
To explore nurses experiences and knowledge of urinary catheterisation, management, and care and the opportunities for continuing professional development in this specific area of practice.

Methodology
A descriptive survey methodology was employed. Following a pilot study the sample for the main study was 553 registered general nurses excluding Divisional Nurse Managers and Director of Nursing. Data was collected via a postal questionnaire which had a total of 34 questions with both closed and open ended questions utilised. This questionnaire was adapted from a survey used in an Australian study. A total of 207 questionnaires were returned (37%). Data analysis was carried out using the Statistical Package for the Social Science

Summary of Key Findings
Key findings suggest that a majority of respondents indicate that their level of current knowledge is adequate yet an evaluation of their knowledge indicates gaps in their knowledge on the insertion, management and care of patients with urinary indwelling catheters.

Conclusions
As nurses play such a pivotal role in the decision making process relating to the insertion and care of urinary catheters it is important that they have the most up to date knowledge on urinary catheter care. It is expected that this research will identify the opportunities for continuing professional development in this specific area of practice.
A systematic review of the literature on the symptoms experienced by women with acute myocardial infarction (AMI).

Gillian McCorkell  R.N. R.M. BSC (HONS)
Clinical Trials Nurse, Cardiology
Altnagelvin Hospital Health and Social Services Trust
Glenshane Road
Londonderry
BT47 6SB

TELE/FAX 0044 2871611445.
E MAIL. gmccorkell@alt.n-i.nhs.uk

Abstract:

Background: Although recent studies have provided some background into the management of women with myocardial infarction (MI), there is controversy over the difference in symptoms experienced by men and women. Even with Acute Myocardial Infarction (AMI), where anticipated symptoms are more clear-cut, women can have vague or non-classical symptoms.

Aim of the review: The purpose of this systematic review is to focus on the symptoms associated with AMI in women. The specific questions are: 1) do women’s symptoms associated with AMI differ from that of men and as a result, 2) do women delay longer than men in reporting their symptoms of AMI and seeking medical assistance?

Methodology: A systematic literature review of research studies published from 1995 to 2005 identified by a search of the MEDLINE and CINAHAL databases. A search strategy was employed using the keywords myocardial infarction; symptoms; gender differences and women, singly and in combination.

Key findings: 26 studies met the criteria for inclusion methodology. They comprised twelve quantitative, nine qualitative and five mixed method studies. The primary symptom of AMI has often been associated with chest pain, which is the symptom focused on by women and health care professionals (HCPs). Consequently, when women present with other symptoms such as fatigue or shoulder pain, HCPs do not readily associate these symptoms with AMI.
**Conclusions:** HCPs must develop a new awareness of additional symptoms and recognise those associated with AMI in women, besides chest pain. The adoption of new strategies is required for the management of women at high risk of coronary heart disease and HCPs need to search for clues beyond an isolated presenting symptom by completing a thorough health history.

These results should be combined to formulate clinical guidelines, to facilitate earlier diagnosis and treatment of this costly and often elusive disease in women.
Public Health Nursing Case Management:  
A cost effective intervention for high-risk pregnancy

Jo-Ellen M. McDonough, PhD, RN, BC  
Assistant Professor  
Department of Health Environments & Systems  
School of Nursing, Medical College of Georgia  
Augusta, Georgia 30912, USA  
Telephone (706) 721-4768 FAX (706) 721-0655  
jemcdonough@mcg.edu

Background and Context: Professional registered nurses know from experience that they influence patient outcomes, but scientific evidence of this influence is scanty (Burns & Grove 2001). Outcomes studies by nurses examining nursing practice are at a preliminary stage. There is little research on comprehensive, outpatient case management of high-risk prenatal clients by nurses in community settings (Issel 1996). Nursing case management (NCM), a component of the South Carolina (SC) High Risk Channeling Project (HRCP) was never evaluated to determine the impact of NCM on pregnancy or birth outcomes or the cost of perinatal care.

Aim of the study: The purpose of this study was to evaluate the impact of public health prenatal NCM on pregnancy, birth, and cost outcomes for a sample of high-risk women enrolled in the HRCP.

Methodology: This was a retrospective study of secondary data from a naturally occurring cohort of pregnant Medicaid women living in six SC counties who had live births between January 1 and December 31, 1995, and who could be matched with their infants (n = 1,928 mother-baby pairs). The cohort consisted of three naturally occurring groups: nurse case managed (NCM, n = 205), other case managed (OCM, n = 831), and not case managed (NoCM, n = 892).

Analysis: Descriptive, correlation, and multivariate methods were used to analyze linked Medicaid, Vital Statistics, and HRCP data for mother-baby pairs.

Summary of Key Findings: There were significant differences between the three groups in demographic, risk, and outcome variables. The OCM (Other Case Managed) group, which was case managed primarily for “social” not medical risks, had the best birth and cost outcomes of the three groups. Given that the demographic and risk profiles of the OCM group were nearly identical to the group that was not case managed (NoCM), the major difference between the two groups was the addition of a case management...
intervention for the OCM group. The effect of this additional prenatal intervention was to increase the cost of prenatal care for the OCM group by 48% compared to the NoCM group. However, the average birth cost of an OCM infant was 33% less that of a NoCM infant, resulting in net perinatal cost savings of $446 (4.8%) per mother-baby pair.

The NCM group had the most medical and pregnancy-related medical risk factors, earliest entry to prenatal care (PNC), most PNC visits, and highest percent of women with adequate PNC. The NCM group also had the lowest mean gestational weight gain, lowest infant birth weight, and shortest gestation of the three groups, although all group means fell within normal ranges. Birth diagnosis distributions for "prematurity" and "died/transferred" improved substantially for the NCM group during the years of the project. Improvements in birth diagnoses for infants of nurse case managed women in this study may be attributed, in part, to the impact of the NCM intervention. These improved birth outcomes were estimated to save SC Medicaid more than $438,000 for a 6-county area of the state in one year.

**Conclusions:** Findings suggest that a prenatal case management intervention impacts positively on birth and cost outcomes. Extrapolating from that finding, prenatal nursing case management (NCM) of pregnant medically high-risk women by public health nurses appears to be an effective intervention that improves pregnancy and birth outcomes for these women and reduces the cost of perinatal care. Public health NCM may get high-risk women to care early, keep them in care, and ameliorate the effects of selected medical risk factors, thereby reducing the incidence and costs of preterm birth and low birth weight infants. It was estimated that every dollar invested in providing medically high-risk women with public health NCM yielded $3.97 in overall perinatal cost savings, making public health NCM a cost effective intervention for high-risk pregnancy.

**References**


Multi-tasking - a fact of life for nurses

Sean Duffy, MSc, RNT, RGN, DipN, H/Dip B-Studies
Lecturer in Nursing, School of Nursing, Dublin City University,

Evelyn McElwain, MSc, RNT, BSc(Hons), RGN, H/Dip
Lecturer in Nursing, School of Nursing, Dublin City University,

Professor P. Anne Scott, PhD, MSc BA(Mod), RGN
Deputy President, Dublin City University,

Dr. Anne Matthews, PhD, MSc(Econ), BSocSc, RGN, RM.
Lecturer in Nursing, School of Nursing, Dublin City University,

Abstract

As clinical nurses, we sometimes find it difficult to articulate what it is we do. This may be due in part to the fact that we are often engaged in doing a number of ‘things’ at once i.e. ‘multi-tasking’. Observing nurses in clinical practice and recording their activities, should provide a visible record of the extent of this phenomenon. The overall aim of this pilot study was to investigate the activities and decision making of registered general nurses in the Irish healthcare setting. The objectives were; to identify the scope of activities that nurses undertake, to ascertain what nurses perceive as their role and to examine nurses’ interactions with patients and interdisciplinary colleagues.

Two general hospitals were the sites for the study. An acute medical ward and an acute surgical ward were included from each of the hospitals. Five nurses from each ward were observed and their activities recorded. This was carried out over 3 observation periods, each observation lasting two hours (6 hours in total for each participant). Participants also had one semi-structured interview carried out, this took place after the observation period was completed and lasted approximately one hour. Quantitative data has been analysed using SPSS. The semi structured interviews have been transcribed, coded and analysed using NVIVO.

While the overall aim of this study concentrated broadly on the activities and decision making of registered general nurses in the acute healthcare setting, one of the main findings concerns the area of multi-tasking. This presentation will highlight the degree to which nurse’s multi-task, it will also discuss examples of when the nurse was observed multi-tasking, and the breadth of activities nurses engage in.
What are the barriers to and facilitating factors for writing nursing careplans among Registered Psychiatric Nurses: a descriptive study.

Contact Details of Presenter

Mary McHale, RPN, BNS, MHSc
Nurse Practice Development Co-ordinator, Mayo Mental Health Services, St Marys Hospital, Castlebar, Co Mayo
086 1722703,
mary.mchale@mailn.hse.ie

Abstract

This study focused on discovering what are the barriers to and facilitating factors for writing nursing careplans among registered psychiatric nurses. A descriptive survey using a convenience sample at an urban psychiatric hospital in Ireland was conducted. A structured questionnaire, translated and adapted from a previous study by Bjorvell et al. (2003a) was used to collect data. A response rate of 65% (n=96) was obtained. The findings of this study included barriers and facilitating factors. Barriers are identified as lack of time for writing, lack of interest by the multidisciplinary team in nursing careplans and poor format of documents used. Lack of power to change practices with regard to nurses careplans and lack of recognition of nurses writing efforts by other multidisciplinary team members was also found to be significant. The facilitating factors were found to be nurses perceptions of their knowledge levels and positive attitudes towards their nursing careplans. The study concluded that considerable barriers exist in psychiatric nursing for writing nursing careplans which has the potential to adversely affect patient care. Ownership of nursing careplans should be promoted at an organisational level and supported by leadership to promote confidence and esteem of nurses.
Postnatal Care: Realigning the needs of new mothers with service provision.

Ms Meredith McIntyre  
B.App Sc (Adv Nursing), M.Ed.St, RN, RM  
Senior Lecturer Nursing and Midwifery  
School of Nursing & Midwifery  
Monash University  
Peninsula Campus  
McMahons Road  
Frankston 3199  
Australia  
+ 61 3 99044354  
Meredith.McIntyre@med.monash.edu.au

This review aims to establish a body of evidence to support the need for radical change in the provision of postnatal care and support services for new mothers.

New mothers in Victoria remain dissatisfied with their in-hospital postnatal care despite wide ranging changes implemented within maternity services in the past thirteen (13) years. Postnatal care continues to be provided within a medical model primarily concerned with physical recovery, incapable of addressing the psychosocial context in which women become mothers. New mothers report that their ordinary needs for support and adjustment after birth are overlooked. The provision of postnatal services that support new mothers requires reorientation to reflect psychosocial constructs that take into consideration, family structure, intra-family and inter-personal relationships, sources of social capital, the influences of neighbourhood characteristics and community connectedness.

A systematic review of papers published in English 1995 – 2006 pertaining to models of postnatal care, client satisfaction with postnatal services, influence of neighbourhood, community connectedness and sources of social capital in Australia, United Kingdom, Europe and USA was undertaken.

Key findings indicate that the provision of in-hospital postnatal care does not provide the ideal environment for women to rest and recover following birth, is not efficient in meeting the identified needs of women in the early postnatal period, is expensive and is not valued equally to that of antenatal & intrapartum care by health professionals, policy makers & service providers. Evidence exists to support the benefits associated with moves towards a social model
of postnatal service provision, enlisting the potential supports of neighbourhood facilitated through enhanced community connectedness.

This review presents a body of evidence to support the need for radical change in the provision of postnatal care and support services in order to realign the psychosocial needs of new mothers with service provision.
Do patients maintain their exercise participation and physical wellbeing subsequent to participating in Phase III cardiac rehabilitation?

Gabrielle McKee,  
Trinity College Dublin,  
Faculty of Health Sciences  
School of Nursing and Midwifery,  
24 D’Olier St,  
Dublin 2,  
Ireland

Introduction

Aims and objectives
The aim of this study was to ascertain the level of exercise patients were participating in and their perceived physical wellbeing before entering Phase III cardiac rehabilitation, post Phase III cardiac rehabilitation and 6 months later.

Methodology
For this study we used three sets of information, level of fitness at entry to programme, Stages of Change tool and the physical dimension of the Short Form 36 (SF 36). A total of 75 patients are used in this analysis with not all data available at all time points.

Results and discussion

Level of Fitness: Exercise stress tests (Bruce protocol) were carried out of the patients at the beginning of Phase III cardiac rehabilitation. In this study 54% of the patients had exercise capacity only equivalent to sedentary lifestyle (METS ≤ 10).

Stages of Change: The stage a patient was at was recorded at interview and given a numerical value of 1-5. The patients came into cardiac rehabilitation with a good awareness of exercise as a risk factor or were just beginning to plan changes relating to this risk factor (mean value =3.64 ± 1.05). There was a significant improvement in this parameter over the whole period of the study as seen using repeated measures analysis of variance.

Short Form 36: Physical dimension: Patients entering cardiac rehabilitation had a below normal score for the physical dimension of the SF 36 quality of life tool (mean value =67.46 ±23.14). Over the whole time period of the study the changes were highly significant.
Conclusion
At the end of phase III cardiac rehabilitation the patients had improved their engagement in exercise (stages of change) and also felt physically better (Short form 36: physical dimension). Detailed analysis showed that these changes were mainly maintained but not further built on post programme.
AN ANALYSIS OF WAITING TIME FROM PHASE I TO PHASE III CARDIAC REHABILITATION:

Kerins M, Cardiac Rehabilitation Unit, St. James’s Hospital, Dublin

McKee, Gabrielle
Trinity College Dublin,
Faculty of Health Sciences
School of Nursing and Midwifery,
24 D’Olier St,
Dublin 2,
Ireland

Introduction
Cardiac Rehabilitation is generally categorized into four phases. Phase I, the inpatient period, Phase II, the immediate post discharge time (2-4 weeks), Phase III, the intermediate post discharge time (2-6 months) and Phase IV, is long term, maintenance for life (Building Healthier Hearts 1999). Coats et al (1995) recommend that the optimal time scale for phase three cardiac rehabilitation is 6-12 weeks post event depending on local policy and individual progress. It is our goal to achieve this time frame for our patients. The delivery of the service takes the form of an individual interview with the patient by the Cardiac Rehabilitation Co-ordinator during phase II, where he/she is assessed and recruited for the Phase III programme. Following an exercise stress test they enter the programme.

This study aims to ascertain some of the factors that contribute to delays in participation in Phase III cardiac rehabilitation.

Objectives
• To determine the length of time from discharge post cardiac event to Phase II and Phase III cardiac rehabilitation
• To analyse the reasons for delay of uptake of Phase III.

Methodology:
The data used in this study are part of the normal audit and evaluation data of the department.

The analysis covered a twelve-month period from July 2004 to June 2005. During this period two hundred and thirty eight patients agreed to enrol on a phase three cardiac rehabilitation programme. Two hundred and twenty seven of these records were complete and therefore suitable for analysis. At the end of each phase III cardiac rehabilitation programme the patients were asked to complete an evaluation form in which they were asked “After your cardiac event
was the timing of the course: a) too soon, b) too late c) just right”. There were 146 responses. These included all participants on the last day who completed the questionnaire.

**Results**

Time from Discharge to Phase II: 52% of patients had their Phase II cardiac rehabilitation complete within 4 weeks post discharge.

The majority of patients (55%) commenced participation in phase III cardiac rehabilitation by 9 weeks post discharge (see Table 1).

<table>
<thead>
<tr>
<th>Time of Discharge to Phase III commencement</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;9 weeks</td>
<td>55%</td>
</tr>
<tr>
<td>10-12 weeks</td>
<td>22%</td>
</tr>
<tr>
<td>13-15 weeks</td>
<td>14%</td>
</tr>
<tr>
<td>16-18 weeks</td>
<td>4%</td>
</tr>
<tr>
<td>19-21 weeks</td>
<td>4%</td>
</tr>
<tr>
<td>&gt; 21 weeks</td>
<td>5%</td>
</tr>
</tbody>
</table>

The range of time from post discharge to getting on the Phase III Cardiac rehabilitation programme was 1 week – 34 weeks. We analysed in depth the reason for the delay in those who were on the waiting list for 12 weeks or greater.

- 37% were on the waiting list.
- 27% were patient deferred.
- 18% were late referral.
- 9% were readmitted.
- 5% were unwell and 4% missed their appointment.

When patients were asked about their viewpoint in their programme evaluation questionnaire, on the subject of waiting times, 96% stated that the timing of the programme was “just right”, 3% said it was “too late” and less than 1% said it was too soon.

**Discussion**

Seventy-seven percent of patients commenced cardiac rehabilitation within the recommended time frame 6-12 weeks post hospital discharge. This was a very good result. We then analysed the reason for delay in the remaining 33%. It would be expected that there would be some delays that cannot be altered i.e. unwell, readmitted. But some of the other causes of delayed may be confronted to reduce waiting times.
Patient deferral: again within this subgroup the patient have some genuine reasons. A lot of the patient deferral may also do with motivation and the patient’s view of cardiac rehabilitation and it’s importance to recovery. The main group to look at would be those still on the waiting list. It is interesting to note that while we set ourselves a standard of a waiting time of twelve weeks or less, 14% of patients were only waiting a further three weeks to start their programme and this falls well within the time frame set by the Cardiovascular Strategy (2-6 months)

References


Midwives perceptions and experiences of caring for women whom they know or suspect have been sexually abused in the past.

Miriam McKenna
Trinity Centre for Health Services
St James’s Hospital
Dublin 8
01 896 3921
mckennmi@tcd.ie

ABSTRACT

Background
The high incidence of female sexual abuse and rape infers that at some stage in their lives, there is a strong possibility that survivors will experience childbirth. This may result in long term sequelae for the survivor and present as post traumatic stress disorder. Flashbacks, commonly associated with the disorder may be triggered during pregnancy and childbirth owing to the intrusive nature of midwifery and obstetric practice. This may add to the violated and depressed feelings of the survivor, whose trauma of the event has continued. The experience of birth may therefore become an added trauma.
While it may be impossible to anticipate all of the effects of sexual abuse related issues, increased awareness of the severity of the implications and ramifications of these issues in midwifery practice may help to reduce their severity during antenatal, labour and postnatal care. Midwives knowledge, perceptions, and understanding of these issues is therefore of extreme importance.

Aim
To explore midwives perceptions and experiences of caring for women whom they knew, or suspected, were survivors of sexual abuse.

Methodology
Following purposive sampling of five participants, Hermeneutic phenomenology was used to guide this study in eliciting, interpreting and analysing the lived experience of these participants.

Analysis
Thematic analysis was guided by Van Maan 1994
**Key Findings**

Overall findings suggest that midwives were ill prepared to support these women due to an identified deficit in their educational background and training. Possibly due to lack of knowledge and awareness, midwives felt they were poorly supported by colleagues in this area.

**Conclusion**

There is urgent need to address this issue in terms of education and support in clinical practice. The overall incidence and accompanying ramifications for care also needs to be addressed nationally in terms of raising awareness. Recommendations for future practice and research development are included.
The Introduction of Case Based Learning in the Applied Biomedical Science Curriculum within the Undergraduate Nursing Sciences Programme.

Presenter – Mr Niall Mc Kenna BSc, RN
Contact Details - School of Nursing and Midwifery
Queens University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast BT9 7BL
Northern Ireland

Tel 02890972391 n.mckenna@qub.ac.uk

Background
It is widely documented that the teaching of the biosciences within the nursing curriculum has been long identified as a source of anxiety for undergraduate nursing students. The purpose of this study was to pilot the introduction of case based learning in the delivery of applied biomedical sciences in the nursing programme.

Aim and Objectives of the study
The aim of the study was to evaluate the inclusion of case based learning as an effective teaching strategy within applied biomedical sciences module to a cohort of third year nursing students. The objectives were to establish whether this approach promoted the development of an interactive group learning environment, providing the student with a greater understanding of complex pathophysiological processes and their application to practice.

Methodology
The study was evaluative in nature selecting a convenience sample (n=150) of third year Adult Branch nursing students. Three case based tutorials were incorporated concurrently with the existing traditional tutorial format within a seven week applied biomedical science module. A 24 item questionnaire was issued in completion of the case based scenarios. A response rate of 88% was recorded (n=132).

Analysis
Data from the questionnaires was analysed using SPSS and written feedback was coded to identify common respondent themes.

Summary of Key Findings
Results concluded that the introduction of case based learning promoted greater interactive learning within tutorial groups,
encouraged the adoption of deeper learning strategies with students suggesting greater understanding of the complex multi faceted pathophysiological concepts involved in specific disease processes in comparison to the existing tutorial formats.

**Conclusion**
Results indicate that students strongly support the view that the adoption of case based learning ought to be an essential component in the delivery of applied biomedical science in the undergraduate nursing sciences programme.
Developing, implementing and evaluating individual care plans in Intellectual Disability services

Elizabeth Mc Keon
R.N.I.D. MSc Education & Training Management, BNS, Diploma in Management, Post graduate Certificate in Third Level Learning and Teaching.

Lecturer in Nursing (Intellectual Disabilities)
School of Nursing
Dublin City University
Telephone: 01-7006582
Liz.mckeon@dcu.ie

Background:
Within intellectual disability services, the use of individual care plans has still to be widely adopted. While individual care plans may be implemented into intellectual disability services, numerous issues and concerns are encountered in relation to their development and implementation. This study is presented in two parts. First it identified an action research approach that was used to develop and implement individual care plans in a service for people with intellectual disabilities. Secondly, it evaluated the approach to investigate concerns, and issues that may have arisen as a result of this approach. The aim of this paper is to provide an overview on the impact of developing and implementing individual care plans for people with intellectual disabilities in a newly developed service.

Methods:
An action research approach that was collaborative, participative and included the intention of evaluating the process was adopted for this study (Cohen, Manion and Morrison 2003). A small purposeful sampling was used n=5. Access was granted by the Director of Nursing to the site and consent of the participants was sought under the guidance of Wellington’s eight clear guidelines (2000). Data was collected using taped transcribed semi structured interviews. Data analysis employed seven steps as outlined by Cohen, Manion and Morrison (2003).

Results:
Four main themes that emerged were:
1. Exclusion in the development, implementation and evaluation of individual care plans (client, family and staff)
2. Staff not being valued
3. Lack of commitment (to education and training, resources)
4. Attitudes of staff about the purpose of individual care plans
Conclusions:
A need for more collaboration between the client, staff and family in any developments that influence client care was identified. Further education, training and support for staff needs to be provided to all staff in order to ensure a consistent and transparent approach to care is adopted. Clarification of roles is paramount to ensure that all relevant personnel are involved in all aspects related to the development and implementation of individual care plans.

Keywords:
Intellectual disabilities, individualised care plans, action research, client involvement, practice development, education, training.

References


Teleform: A medium to embrace the evolving world of information technology within health care research

Are we evolving or revolving with the introduction of new technology?

Mary T. Mc Menamin, Research Associate, Institute of Nursing Research, University of Ulster

Dr Vivien Coates, Professor of Nursing Research, Institute of Nursing Research, University of Ulster, Altnagelvin Health and Social Care Trust

Dr Adrian J. Moore, Managing Director, Causeway Data Communications Ltd, Innovation Centre University of Ulster

Dr Maurice J. O’ Kane, The Laboratories, Altnagelvin Health and Social Care Trust

Professor Brendan P. Bunting, School of Psychology, University of Ulster

Correspondence to: m.mcmenamin@ulster.ac.uk

Abstract

Introduction
Nursing has witnessed an enormous and revolutionary advancement in the introduction and integration of information technologies within the past few decades. This can result in bewilderment and frustration with the escalating introduction of dynamic and challenging software. The Royal College of Nursing has recently published a position statement on promoting excellence in care through research and development (Royal College of Nursing, 2004). Therefore to achieve this ideal it is imperative that nurses attempt to challenge and integrate new and innovative technologies to enhance their practice.

The aim of this poster is to explore the issues and challenges encountered and reflect upon the lessons learnt when using Teleform® software as part of a substantial research project.

Teleform
The successful integration and implementation of Teleform® is a significant advancement within the field of nursing research. Cardiff’s Teleform® automates the process of collecting, evaluating, validating, and storing data via forms (Cardiff Teleform, 2002). This
important software application enables researchers to create data collection forms, facilitates electronic distribution to participants, supports a quality control check for data gathered and automatically exports this information to a database so it can immediately be used by other applications for example S.P.S.S. (Cardiff Teleform, 2002).

Teleform® is a very powerful tool that is capable of capturing and processing thousands of paper and electronic forms each day with accuracy, speed and efficiency. However, using this software can be difficult. For example, modest changes to the questionnaire can have an impact upon the underlying statistical database. Appropriate and continued technical support is essential. The absence of an appropriately trained technician can cause delays and mean stipulated milestones cannot be achieved. This in turn can have a major financial ramification for the proposed research project.

The study
This poster reports on the use of Teleform® within a large research project capturing an extensive volume of research material generated from a total of 457 patient interviews. Teleform® afforded an ideal medium to capture the data generated from the structured interviews onto the researcher’s laptop. Thereby considerably reducing the time spent upon transferring this data unto S.P.S.S. These structured interviews are gathering data on an extensive array of variables. These include social integration and support, perceived mastery, economic status, perceived powerlessness, general health status and knowledge of diabetes management. This psychosocial data will then be merged with a clinical database for final analysis.

Conclusion
The experience gained when using this software has been a valuable part of the learning process of being involved with a large research study. Through explaining some of the issues that have been encountered during the last two years it is intended to enable other researchers to consider the potential value of this software within their own work.

References

Abstract

Working within a contraception clinic the researcher became aware that women's sexual behaviour changed after consuming alcohol. Using both qualitative and quantitative methods of data collection this research explores the hypothesis that alcohol has an impact on women’s sexual behaviour putting them at risk of a sexually transmitted infection, namely Chlamydia Trachomatis.

The use of questionnaires and focus groups enabled evidence to be collected that showed the age of the first drink was significant to the amount they drank both on a typical night and a heavy night. Young women were consuming large quantities of alcohol both in one intake (binge drinking) and over time. The women who initiated alcohol consumption earliest were the ones who drank the most on a heavy night, had the most sexual partners and were the ones who were more likely to be Chlamydia positive.

These findings suggest that women should be encouraged to commence drinking at an older age and that the age of first drink, the number of sexual partners, and the amount of alcohol consumed on a heavy night should be recognised as risk factors for Chlamydia infection. This evidence will be used to inform staff who work in the field of contraception as to the risks women take in relation to alcohol consumption.

Conclusion

This detailed research has given evidence to support the hypothesis that alcohol does impact on the sexual behaviour of young women aged 16-24 in relation to Chlamydia infection. The findings from this research suggest that women should be encouraged to commence drinking at an older age. The age of first
drink, the number of sexual partners, and the amount of alcohol consumed on a heavy night should be recognised as risk factors for Chlamydia infection.

The evidence from this research will be used to inform staff who work in the field of contraception as to the risks women take in relation to alcohol consumption encouraging them to discuss drinking behaviour with the woman as a way of reducing risk.

It is recognised, as by Newburn and Shiner (2001) that more research is required in relationship to young people’s ‘risky drinking’. Research is particularly necessary given the evidence that young people are drinking more and drinking more often (Coleman & Carter 2003) and the impact the new licensing laws may have on young people’s alcohol consumption.

This was a unique piece of research as there was no other literature found in relation to alcohol consumption and Chlamydia infections related to women. However one women in the research was aware of the impact, as she commented;-

Group 2 woman 1

“They try to teach you about STI’s more than any thing else but it’s the drink that causes it, well, it doesn’t cause it, but obviously it doesn’t help on the way either”

Heading – alcohol consumption in girls under 25 in relation to Chlamydia infection.

Bottles/glasses

Age of first drink-

- by the age of 15 years 80% of women had consumed alcohol
- 19.2% of women started to consume alcohol at age 14
- age of first drink ranged from 3 ½ to 18 years.
- The younger women in the study started drinking at the youngest age.

Choice of drink-

- the first drink of choice for 31% of the women was alco-pops
- the second drink of choice for 27% of the women was shorts/shorts
- the third drink of choice for 20% of the women was wine.
Amount drunk on a typical night out-
- 75% (155) of women drank 5 or more units (binge drink)
- 12 women consumed over the recommended intake for a week, in a night.
- 1 woman consumed 49 units on a typical night.

Amount drunk on a heavy night out –
- 94% of women drink more than 5 units of alcohol (binge drink) on a heavy night.
- women who commenced drinking at the youngest age consumed the most units on a heavy night.
- 27 women drank 21 or more units on a heavy night.
- 1 woman consumed 50 units on a heavy night.
- Only 12 women drank less than 5 units on a heavy night.

Number of day’s alcohol was consumed in the previous week.
- 68 (29.1%) had had 3 nights of drinking
- 3 (1.3%) had drunk daily.
- 59 (25.2%) had had one night of drinking.
- 51 (21.6%) had had 2 nights of drinking

condom use-
- Only 98 (43.6%) women used condoms regularly
- 147 women said they were less likely to use them after drinking alcohol
- 187(80%) women thought that condoms reduced sexually transmitted diseases.

Number of sexual partners
- range of number of sexual partners was 1 to 30.
- 42 women had been seeing more than one sexual partner at a time.
- The more alcohol consumed both on a typical night and a heavy night the more sexual partners the women had had.
- The more sexual partners the more likely they were to have been treated for Chlamydia.

Regrets about having sex after drinking alcohol
- 86 (36.8%) women said they regretted having sex after having drunk alcohol.
Alcohol and first sex-

- 60 (25.6%) women had drunk alcohol the first time they had sex.

Key findings-

Chlamydia infection was associated with

- young age of first drink
- number of life time partners
- women who binge drink both on a typical and heavy night out.
- Age of onset of drinking is important to the amount of alcohol consumed.
The Development and Psychometric Testing of the Abuse Assessment Tool to Identify Intimate Partner Violence in Jamaican Women

Leila McWhinney-Dehaney  
BSN MPH PhD  
Ministry of Health  
Jamaica  
Lot 31 Readers Pen  
Box 57  
Morant Bay  
St. Thomas  
Jamaica WI  
Tel. 876-743-0629  
leilamcd@yahoo.com

Ora Lea Strickland RN PhD FAAN  
Emory University, Atlanta GA

Background: Intimate partner violence (IPV) is a worldwide problem. While there are instruments available for use in the developed world no such instruments are available in Jamaica to identify women at risk for IPV or women who experience IPV either in a clinical setting or in population-based research.

AIM: This study developed and validated the Abuse Assessment Tool (AAT) for the identification of IPV in Jamaican women.

Methods: A cross sectional design was used to test the psychometric properties of the AAT in a convenience sample of 205 women in Primary Health Care clinics and Crisis Centers. The scale was developed based on findings from a qualitative study conducted in Jamaica and the literature on IPV. Content and face validity of the instrument were confirmed through expert panel reviews, and subject feedback. Reliability estimates were conducted. Hypothesis testing and exploratory factor analysis (EFA) were used to assess construct validity. The EFA included principal components analysis with oblique rotation. Sixty-seven items were included in the initial scale which included a non-pregnant (AATNP) and a pregnant (AATP) component.

Results: EFA resulted in the extraction of two latent factors on the AATNP and three on the AATP. The final scale consisted of 37 items. A short form of 12 items was developed from the AATNP and the AATP, each had an alpha of .93 and .95 respectively. Construct validity assessment showed significant correlations between all versions of the AAT and the Center for Epidemiologic Studies
Depression Scale, Spielberger Anxiety State–Trait Inventory Scale, the Modified Post Traumatic Stress Disorder Scale, the Miller Physical Symptoms and Injury Survey Scale and the Pregnancy Outcomes Checklist. 

**Conclusion**: This measure provides a culturally reliable and valid tool, which can be used for identifying Jamaican women who are exposed to intimate partner violence.

Key words: Intimate Partner Violence, Jamaican Women, Screening Instrument
Adolescents coping with mood disorder: a grounded theory study

Robert J. Meadus, PhD, RN
Memorial University
School of Nursing
St. John’s, NL
Canada A1B 3V6
meadusr@mun.ca
(709) 777-6716

Introduction
Melancholy or sadness is a common phenomenon that occurs in all age groups. Feeling a certain amount of sadness and emotional pain is a part of life. But there is a point where the feeling of sadness becomes chronic, disabling, and insufferable; it is not a passing mood, but a serious illness, defined as a mood disorder (Gelman, 2000). These disorders, referred to as brain disorders, completely disrupt a person’s emotional and physical health. The World Health Organization (WHO, 2001) predicts that within the next 20 years mood disorders will become “the second cause of the global disease burden” (p. 10).

Mood disorder in children and teenagers are a significant problem in North America. These disorders are associated with disturbances in psychosocial, physiological, academic, and social functioning (Frydenberg, 1997). These disorders are leading causes of disability worldwide and impose substantial health and economic burdens on individuals and families, as well as society (Costello et al., 2005). In children and adolescents, the most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder (De Santis & Ekegren, 2003). According to the WHO (2001), mental disorders are becoming more common worldwide, often beginning in the adolescent years. These disorders among children and adolescents are more persistent than previously thought and have numerous negative associated features, including further episodes of depression, impaired social and academic relationships, nicotine dependence, abuse of alcohol and other substances, risky sexual behaviour, teenage childbearing, early marriage, and an increased risk of suicide (Fergusson & Woodward, 2002).

Prevalence
Interpretation of the epidemiology of child and adolescent mental health disorders is difficult. The annual prevalence of mood disorders in children and adolescents is not as well documented as that for adults (United States Department of Health & Human...
Resources, 1999). Although no national epidemiological studies have been undertaken concerning adolescent mood disorder, an estimated 7.5 million children in the United States are reported to have been plagued with mental disorder, nearly half of which lead to serious disability. About 1/3 of these children and adolescents receive care (Scahill, 2001). Researchers have reported that approximately 18% to 20% of, or 1.5 million children and youth in Canada, were at specific risk for mental health problems (Health Canada, Childhood & Youth Division, 1998).

**Purpose**
Empirical studies have been conducted which identified the factors that contribute to child and adolescent vulnerability for mood disorder. However, there is an absence of literature concerned with how these young people cope with mood disorder. Nursing as a humanistic discipline is concerned with the understanding of human experience. The purpose of this study was to explore the phenomenon of coping as experienced by adolescents with a mood disorder and to generate a grounded theory of the processes involved as they cope with a psychiatric illness. Given the lack of information on the coping experience of youth with mood disorder, research illuminating how adolescents cope with mental illness is needed. Ultimately, exploring how adolescents cope with the stress of a mood disorder may provide a theory which will aid in the development of a nursing model for caring for adolescents with mood disorders.

**Research Questions**
How do adolescents experiencing a mood disorder cope?
What other persons and things influence coping?

**Methodology**
The proposed method for this study was a qualitative, inductive strategy using grounded theory to explore the phenomenon of adolescent coping with a mood disorder. This method is most appropriate for studying nursing phenomena because it explores the richness and diversity of human experience, considered the essence of nursing. The phenomenon of adolescents coping with a mood disorder is an unresearched area and as such grounded theory is a useful method in this situation. Strauss and Corbin (1998) defined grounded theory as an approach and a method that uses a systematic set of procedures and techniques, with the goal to build an inductively, derived grounded theory. I followed the guidelines suggested by Strauss and Corbin with data collection and analysis occurring simultaneously and generated the theory following data analysis using the various coding procedures, open, axial, and selective.
Data Collection
Unstructured interviews that were taped recorded, and a review of some of the participants’ health records constituted data collection for this study. During the sampling process, 14 adolescents agreed to participate in the study, the final sample consisted of nine participants. One male and eight females shared their experience of coping with a mood disorder.

Data Analysis
Data were collected and analyzed simultaneously according to the approach of Strauss and Corbin. Each interview was transcribed verbatim and analyzed before the next scheduled interview. The interviews were analyzed concurrently using the constant comparative method. This approach of open, axial, and selective coding allowed a structured process in analysis of data that lead to development of the core category. The phases describing the phenomenon of coping were Feeling Different, Cutting off Connections, Facing the Challenge/Reconnecting, and Learning from the Experience. The core category An Unplanned Journey Coping through Connections was identified.

Implications
This study has contributed to the knowledge base of nursing science by providing an increased focus on the coping needs of adolescents. The Meadus’ theory of adolescent coping with mood disorders can serve as a guide for initiation of particular interventions during the stages of the coping experience. This study provided evidence of the development of a substantive theory for adolescents who are coping with a mood disorder. This theory contributed to the area on evidence-based mental health care for ill adolescents. The next step would be to test this theory in the practice setting. This study may also have some implications for policy development related to promotion of community mental health strategies for adolescents. Advanced practice nurses who work at the community level have the expertise in developing policy around prevention of mental health disorders. Also, nurses need to work with school personnel to develop an effective policy around mental health prevention and intervention within the school system. Better links between the school system and the hospital based mental health system are needed so adolescents requiring service are able to access the system in a timely manner. This initiative would help in early detection, treatment and tertiary prevention.
The needs of midwives caring for the breastfeeding mother as identified by midwives in clinical practice.

**Teresa Meaney** Msc (Nursing), BNS, DNS ,RGN, RM,RNT, RMT  
College Lecturer (Nursing)  
Centre for Nursing Studies,  
National University of Ireland Galway,  
Aras Moyola,  
Galway.

Tel (091)492927 teresa.meaney@nuigalway.ie

**ABSTRACT**

The aim of this study was to explore the experience of midwives caring for the breastfeeding mother. A review of the literature indicates a dearth of material relating to this issue, despite the fact that the midwife has been identified as the key person responsible for this aspect of maternity care (Department of Health ,1994). It appears that the issues relating to the personal experience of breastfeeding have been lost in the accounts of the health advantages of breastfeeding. Health professionals have tended to focus on the biomedical model of breastfeeding exposing its benefits for mother and baby (Cunningham et al .;1991; Schmied et al.2001).

A purposive sample of ten registered Midwives was chosen for this study. The midwives worked in a large teaching hospital in the Republic of Ireland. A qualitative research approach, using Heideggerian phenomenology was chosen for this study. Data was collected using unstructured interviews. The interpretation of the text for this study was guided by a phenomenological hermeneutic analysis method. Analysis of the interview data revealed the following needs of Midwives caring for the breastfeeding mother as identified by midwives in clinical practice. Midwives need to understand breastfeeding no just as a biophysical or nutritional process but also as a personal and intimate experience. The importance of midwives having an interest in and liking for breastfeeding was identified, Midwives positive attitude towards breastfeeding was identified as having a positive impact on facilitating the breastfeeding mother, Midwives negative attitude towards breastfeeding appeared to have a negative impact on facilitating the breastfeeding mother. Midwives need to give consistent advice on breastfeeding in order to facilitate the breastfeeding mother, The need for more time to facilitate the breastfeeding mother was identified, The need to understand the physical and psychological demands of caring for a breastfeeding mother from a midwives perspective was identified, The need for
midwives to give mothers a realistic expectation of what breastfeeding involves was identified. The study findings suggested that midwives need to address the psychosocial aspects of breastfeeding in order to facilitate the breastfeeding mother. Breastfeeding is not simply the physical process of feeding a baby, but rather successful breastfeeding involves an emotional and intimate engagement between mother and baby that is mutually satisfying. The findings from this study challenge the focus of maternity care to shift and include the psychosocial aspects of breastfeeding for mother and baby. Health professionals cannot afford to ignore the deep psychological intimacy shared between mother and baby in successful breastfeeding.

Recommendations arising from this study are made in an attempt to acknowledge the importance of the psychosocial and intimate aspects of breastfeeding and its contribution to successful breastfeeding.


Department of Health (1994) A National Breastfeeding Policy For Ireland Dublin:

To Have and to Hold
Recruitment and Retention
of Middle Grade Paediatric Nurses in the NHS Scotland

Research Undertaken May - September 2004

Caroline Mearns MBA, PgCTLHE, RSCN, RGN
Napier University
School of Nursing, Midwifery & Social Care
Comely Bank Campus
Edinburgh EH4 2LDTel: 0131 667 5523
Email;c.mearns@napier.ac.uk

Abstract

Title: ‘To Have and To Hold; Recruitment and Retention of Middle Grade Paediatric Nurses’.

Background and Context

There is evidence to suggest that specialist nursing areas are experiencing particular recruitment and retention problems. With D and E grades representing the largest proportion of the nursing workforce, they pose the biggest recruitment and retention challenge for the NHS. Nurses account for 48% of total staff costs, the impact on the NHS is substantial.

Aim of the Study

The aim of this research was to explore the factors contributing to the growing problem of recruitment and retention of D and E grade Paediatric nurses in the NHS Scotland. The research considers the balance of pay and non-pay factors and considers the hypothesis that non-pay factors are of increasing importance.

Methodology, Research Design and Sampling
Drawing on primary and secondary sources, the study used a qualitative and quantitative methodology, based on a review of existing literature, focus groups with key stakeholders, a survey of D and E grade nurses and analysis of recruitment and retention data. The research focussed on the two largest Paediatric hospitals in Scotland.

Based on a total population of 560 staff the survey secured an overall response rate of 33%. Qualitative data was analysed and categorised into themes.

Summary of Key Findings

The key recurring factors were: praise and recognition, high care standards, pay, career progression, staffing levels, skill mix, workload, flexible working, leadership, and patient outcomes. Significantly, non-pay factors were highly influential.

Conclusion

The findings support current literature, but offer evidence not previously reported. Given the scale of the survey, this allows generalisations to be made throughout the nursing sector. Urgent measures are required to address some of the issues identified within this study. Strategies recommended include; new emphasis on valuing staff, leadership training, improved workforce planning, increase pay, new opportunities for career progression and conducting exit interviews. Further research is required to identify the effectiveness of current and future initiatives.
INTRODUCTION

The key issues associated with recruitment and retention of nurses within the NHS, in particular of paediatric nurses within Scotland will be explored. In order to gain a comprehensive overview, an extensive literature review will be undertaken, covering a wide range of articles, books, previous research studies, conference proceedings, government reports and publications.

THE PROBLEM OF RECRUITMENT AND RETENTION

Most businesses and organisations face difficulties in recruiting and retaining staff. However, this is a greater problem within public sector organisations, with these usually suffering from a distinctive image problem, particularly amongst young people starting on their careers. Public sector pay packages are also usually less competitive, with little or no real pay progression and this may therefore be viewed as a significant contributing factor to recruitment and retention, particularly within the NHS (IRS Employment Review 2002).

The number of unfilled nursing posts in Scotland is rising. According to the latest health service statistics, there has been a 46% increase in the turnover of nurses in Scotland. Vacancies also rose by 193 to 1,869 over a 6-month period, between October 2001 and March 2002 (IRS Employment review 2002, No 751).

Furthermore, there is evidence to suggest that specialist areas are also experiencing particular recruitment and retention problems. In 2002 the Royal College of Nursing (RCN) reported that there is a chronic shortage of paediatric nurses within the NHS, with a shortfall of approximately 20%. Their studies identified 1,328 vacant paediatric posts, with a further 1,441 posts needed just to meet the demand. Astonishingly, almost two-thirds of NHS trusts said that they did not have enough paediatric nurses.

Information obtained from ISD Scotland identifies that the largest vacancy factor within the NHS is of middle grade nurses. Middle grade nurses are classified as grades D and E\(^1\). These grades account for 74.% of the total population of all trained nurses at

\(^1\) Newly qualified staff nurses commence on grade D and depending on experience, competence and local policy, apply for an E grade within 1-2 years, F grade 3-5 years and G grade after 5 years, all dependant on a position becoming available. Appendix 1.1 illustrates the differing pay scales by grade, therefore highlighting the pay incentives for promotion and career progression within the NHS.
RHSC, with this being somewhat higher than the national average at 65% of all nursing staff (*ISD Workforce Statistics 2002*). Due to current restructuring within human resource services at Yorkhill Hospital, specific data was not available to the researcher on the proportion of D and E grade nurses, relative to the total. However, it is anticipated that Yorkhill Hospital will have a broadly comparable number of D and E grades to RHSC Edinburgh.

D and E grades therefore represent the largest proportion of the nursing workforce. These grades also pose the biggest recruitment and retention challenge for the Health Boards, with exceptionally high staff turnover and an estimated direct cost of £5,000 - £25,000 being incurred by the Boards per staff member. With nurses accounting for 48% of total staff costs the impact on the NHS is substantial (McCafferty 2004). This was significant in providing focus for the research.

**Aims and Objectives**

The aim of this research is to explore the factors contributing to the growing problem of recruitment and retention of D and E grade paediatric nurses in the NHS Scotland. The research will consider the balance of pay and non-pay factors and consider the hypothesis that non-pay factors are of increasing importance. The specific objectives of the research are:

- To identify the most influential factors in recruitment and retention of D and E grade paediatric nurses within the NHS Scotland;
- To highlight any recurring themes associated with these factors;
- To recommend specific human resource (HR) tools and strategies that might be adopted to improve recruitment and retention practices.

**Setting the Context for the Research**

The Royal Hospital for Sick Children Edinburgh (RHSC), Lothian Health Board and The Royal Hospital for Sick Children Glasgow (Yorkhill Hospital), Greater Glasgow Health Board are both recognised as paediatric centres of excellence and provide care for children aged 0-14 years. Both hospitals serve as national referral centres, with Glasgow providing services for the west of Scotland and Edinburgh services for the Lothian, Fife and the Borders.

Their objectives are to provide for the delivery of high quality modern health care, ensuring that the needs of the children and their families are met. Specialist services in both hospitals include;
general medicine/surgery, specialist medicine/surgery, day care, accident and emergency (A&E), out patient services (OPD), burns & plastics, intensive care (ITU), high dependency (HDU), oncology and theatre. Although both hospitals provide primary (community care), this was not included within the remit of this research.

The RHSC Edinburgh is a 150 bedded hospital, treating approximately 5,000 in-patients per year, employing approximately 454 (head count) trained nurses. This represents 314 whole time equivalent (WTE) staff, including full and part-time, permanent and temporary workers.

Yorkhill Hospital Glasgow, is Scotland’s largest children’s hospital, and has 266 in-patient beds, treating 15,000 in-patients per year, employing a total of 825 (head count) trained nurses, the WTE was not available.

In 2004, the vacancy factor\(^2\) of trained nurses at RHSC is estimated at 6%, and 7.8% at Yorkhill. Unfortunately it was not possible to determine the percentage of vacancies within grades D and E, at either hospital. It was also the intention of the researcher to obtain figures relating to the turnover of nurses at both hospitals, as an indication of job motility, however this data was also not available at either hospital.

This is relatively high, with Scotland’s average vacancy of qualified nurses (over a three month period) reported as 1.1%, Wales 3.35% and England 4.7%. Whilst this allows comparisons to be made, QMUC & RCN (2002), suggest that these figures be treated with caution due to the use of different data collection methods.

**Literature Review**

Research conducted by the Office of Manpower Economics (1999), highlighted the recruitment and retention issues facing nurses, midwives, health visitors and other professionals allied to medicine. They identified career progression, as a key factor affecting retention, but a major issue affecting both recruitment and retention was the lack of career development. The report also highlighted the problem of obtaining the necessary data on vacancies due to lack of computerised data, lack of central data and lack of resources and time to carry out in depth analysis of recruitment and retention data. (*IRS Research Brief 1999*).

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\(^2\) The number of vacant trained nursing posts measured against the number of staff on the staff establishment
Research specifically focusing on the NHS was conducted by Southamton University Hospitals NHS Trust (2001). They identified that they had a major problem, with a vacancy factor of 8.2% of middle grade nurses (grades D&E). They undertook a literature review to understand the national picture, performed a benchmarking exercise with 9 trust of similar size, to identify areas for change and conducted one-on-one exit interviews. These methods produced both qualitative and quantitative research evidence, which enabled them to identified the key factors affecting recruitment and retention, within their Trust as:

- Workload, staffing and skill mix
- Education and training
- Career opportunities
- Leadership and Culture
- Working conditions

As a direct result of this research the Trust decided to invest over £1m to resource infrastructure changes i.e. education and training, leadership, research & development. It is too early to evaluate the outcomes, but it is hoped that it will have had a positive effect on recruitment and retention, job satisfaction and improved patient care (Shobbrook 2002).

Further research performed by the Kings Fund (2002), The Last Straw, identified a range of factors affecting recruitment and retention of nurses, both positive and negative. Issues that they identified as significant included:

- Personal satisfaction
- Loyalty
- Pay and budgetary constraints
- Staffing levels
- Stress at work
- How people are treated at work
- Support
- Family- friendly working
- Education and Training
- Leadership development

Particularly significant from their findings, were examples of nurses who ‘stay in the NHS because of loyalty and commitment rather than for reasons of personal satisfaction’. Managers of the future would be very foolish to rely on this loyalty and as the title of the King’s Fund research allures to, who knows what the last straw will be, especially in an already diminishing workforce.
There has been extensive research on the issue of recruitment and retention, the most current and relevant literature with Scottish, UK and international dimensions, has been reviewed above and all have been instrumental in influencing the approach taken in this study. It is evident however, that the majority of literature relating to the NHS has a general focus with very little research specifically on recruitment and retention of paediatric nurses. Although we are able to generalise from studies already undertaken, there will be regional variations and problems particular to the paediatric environment, therefore there was an obvious need to perform detailed research within paediatric nursing, Scotland.

**Recruitment and Retention Strategies**

The government and the NHS have introduced measures to address some of the issues identified within the literature review. The Scottish Executive is developing a more strategic and systematic approach to workforce issues in the health sector. *Facing the Future (2001)* is a co-ordinated programme of recruitment and retention for nurses and midwives within the NHS Scotland.

Considerable funding was made available to enable a range of initiatives to be implemented under the banner of Facing the Future. The key themes that emerged from this and other conventions included; skill mix, career packages and pathways, leadership, flexibility, education and training, new roles and working conditions. From this key initiatives that were implemented including; leadership-training programmes, return to practice courses and improved professional development for all nurses. Whilst it could be argued that it is too early to evaluate the effectiveness of such measures, this research will provide evidence which will strongly suggest, that the initiatives thus far, have been less than effective.

Central to the government’s modernisation plan is *Agenda for Change*. This is another ambitious strategy, which is expected to revolutionise the current pay system and career structure for nurses. As well as improving pay and career pathways it is also expected to result in changes to work patterns, nursing roles and enhance career development (*QMUC, RCN 2002*).

This new system is due to be rolled out in December 2004 and whist is expected to have a positive impact on recruitment and retention of nurses, this research will highlight that there is much apprehension amongst nurses. Most are anxious to see the impact of the changes before they decide whether to stay within the NHS.
METHODOLOGY

RESEARCH DESIGN

Within the limitations and time-frame of this study, the researcher decided to concentrate the main focus on the staff who were currently in post. Therefore, consultations with and surveys of nurses who had left the health boards were not undertaken. The table below illustrates the research design:

- Tasks not undertaken are shown in white

RESEARCH METHODS

Literature Review

An extensive literature review was undertaken, together with a review ISD data. The literature review revealed that although there had been a number of studies of recruitment and retention in the NHS, there had been few studies based on primary research and none specifically in paediatric nursing. The findings of previous studies, however, identified a number of recurring themes within the research topic including, workload, staffing, and skill mix, education and training, career progression, leadership and motivation. Building on these, this allowed further and in-depth exploration of the subject topic through the use of both quantitative and qualitative research methods.
Consultations

Consultations with HR managers and clinical managers in each Trust would have provided a more in depth understanding of the current problem within the clinical setting. Discussion with the Scottish Executive and NHS Scotland would also have given greater understanding of recruitment and retention policies and priorities. Within the time frame and limitations of the study an extensive consultative programme of research was not possible.

However, in addressing this the researcher attended a one day Conference 'Reflections and Future: Developing the NHS Lothian Plan for Recruitment and Retention' on the 16th July 2004 and this offered opportunities to here, first hand, what senior mangers were saying about this topic and to contribute to seminar sessions. The conference also offered the researcher the opportunity to discuss a number of particular issues with the HR Director for Lothians and elicit his view on key issues and problems. There was also an opportunity to discuss the Facing the Future agenda, with personnel from the Scottish Executive and gain valuable information on the methodology used in their research.

Analysis of ISD Data

ISD provide annual data on vacancy rates by grade, by trust and by speciality. This data was analysed to establish the overall scale and pattern of recruitment and retention problems and key trends. This was briefly discussed in the opening Chapter.

Focus Groups and Research Review

A focus group was used to ensure that the opinions and experiences of a small representative group, from the health board was obtained. Specifically, the researcher approached the Recruitment and Retention Steering Group, based at the RHSC Edinburgh and was invited to present at the next meeting. This allowed the research proposal, research questions and proposed methodology to be discussed. The main focus of the discussion centred on the current factors affecting recruitment and retention and whilst most factors had been identified from the literature, two new themes emerged as important; clinical speciality and hospital location. These were subsequently included in the questionnaire. The Group consists of ten people and included representation from HR, managers and middle grade nurses from within the Trusts. Interviewing the different staff disciplines gave an in-depth insight of the research issues, prior to moving into the main survey research stage.
Analysis of Exit Interview Data

It is policy within hospital trusts to conduct exit interviews with all employees on termination of employment. This information should be recorded and kept on record within the HR department. It had been the intention of the researcher to obtain ethical approval to access this information for the purpose of this research and to guarantee anonymity. However, major problems arose from lack of data input and failure of HR or managers to conduct exit interviews. It was therefore not possible to obtain data for analysis.

Surveys and Sampling

It was the researchers initial intention to use a stratified approach to sampling, using the three largest health boards in Scotland (Lothian, Greater Glasgow and Grampian). However, having identified the total population of middle grade nurses in the two largest (RHSC Edinburgh and Glasgow) accounted for over 80% of all D and E Grade nurses, it was decided to focus the surveys on the latter. Also since the researcher could feasibly and manageably undertake a census of all D and E grades at these locations (560), it was decided to that this was the best option. Given the scale of the survey and census approach, this would also allow generalisations to be made throughout other locations. The survey secured a response rate of 33%.

The overall details of the survey are presented in the table below. Both hospitals had similar response rates, RHSC, Edinburgh 37.1% and Yorkhill, Glasgow slightly lower at 30.6%.

Survey of Employed D&E Grade Nurses

<table>
<thead>
<tr>
<th></th>
<th>Population (Responses) &amp; (Responses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHSC Edinburgh (Total population) Responses</td>
<td>210 (78 responses – 37.1%)</td>
</tr>
<tr>
<td>Yorkhill (Total population) Responses</td>
<td>350 (107 responses – 30.6%)</td>
</tr>
<tr>
<td>Total population in both hospitals</td>
<td>560</td>
</tr>
<tr>
<td>Completed surveys</td>
<td>(185 responses 33.0%)</td>
</tr>
</tbody>
</table>

Pilot Survey

Prior to launching the survey the questionnaire was piloted to identify design problems, highlight workability and manageability.
This allowed evaluation of the adequacy of the questionnaire in measuring the variables, isolate any bias, vagueness or inadequate questions. Oppenheim (1992) has written much about the design of questionnaires and stresses the importance of revising and refining the questions before the researcher undertakes the research study.

Postal Questionnaires

Because of the sheer numbers involved in this large-scale study, the use of a postal questionnaire was thought to be the best technique to use. One of the main advantages of using this approach is that it offers precision and specific measured responses and allows a great deal of data to be collected quickly and objectively. Questionnaires are also less costly in terms of time and money than interviewing and some respondents may be geographically inaccessible. The internal mailing system was used within the two hospitals to save on costs.

There are also disadvantages associated with this method, including poor response rates. Kelley et al (2003) suggests that response rates to postal questionnaires are usually low, around 20% and therefore a large sample is required to ensure that the demographic profile is representative of the survey population, allowing generalisations to be made. This was overcome by conducting a census survey, to secure a larger number of participants.

The open-ended questions were used to encourage the respondent to answer in their own words and express their own views, overcoming any bias. Careful consideration was given to the construction of the questions, ensuring a logical order, layout designed to gather specific data. The wording used was carefully constructed to avoid subjectivity and which was open to interpretation by the respondents. This was tested through piloting the questionnaire.

Closed questions were used to collect demographic data and a rating scale was used to rank factors of motivation and satisfaction, recruitment and retention, in order of importance. To determine the strength of opinion over the four categories, a weighting was applied on a sliding scale from 4 to 1, 4 being the most important. Whilst this is a reliable method to measure the strength of opinion and which factor the respondent thought the most important, it will not tell how much more important (Oppenheim 1992.).

The questionnaire was thus designed to provide both quantitative (frequency) and qualitative data (meaning). This method of
triangulation allowed the same issues to be explored from different perspectives, increasing the validity of the results.

In conclusion, the questionnaire was designed and piloted to ensure that it would answer the specific research questions and a method of triangulation was used to increase reliability and validity. The survey sample was chosen to be representative of the wider NHS Scotland middle grade survey population and large enough to ensure adequate number of responses. The postal questionnaire was thought to be the most appropriate tool to collect large numbers of data, within the time frame available and at the lowest time and financial cost to the researcher.

**Data Analysis**

The qualitative data from the surveys was analysed to allow the richness of the data to be examined. It was then categorised into themes, with these constructed from the key concepts from the open question responses and the comment section, for each question. These were highlighted using different colours and further thematic analysis undertaken to make the data more manageable - identifying key categories and emerging themes. Finally the emerging themes were categorised into a smaller number of final themes prior to the survey responses being analysed.

SPSS and Excel were both considered as appropriate software for analysis, but the latter was the preferred option and proved to be efficient in analysing the data and undertaking cross-tabulation. As advanced analysis was not required, a statistician was not consulted.

**Evaluation and Limitations of the Research**

The research design has adopted a robust approach that offers achievable outcomes. The research sample was large enough to enable some generalisations to be made about recruitment and retention issues within the NHS Scotland, especially paediatric nurses. There was a high response rate and overall it provided a very rich source of data. However, it is important to appreciate that circumstances will vary according to the type of trust, location and specialities within different clinical environments. Such variations could be analysed through further analysis of the data.

The research focus is on the two largest health boards in Scotland and therefore will not examine variations that may be prevalent within the smaller health boards, or in rural areas. These aspects could not be explored within the limitations of this research.
RESULTS & DISCUSSIONS

INTRODUCTION

Given the wealth and richness of data generated from the survey, it is not possible to present or analyse all the findings in this research. Therefore, after undertaking initial analysis of all respondents’ opinions on recruitment and retention, the researcher focused on analysing the reasons given as to why nurses want to stay with or leave the NHS.

Five hundred and sixty questionnaires (560) were sent out and one hundred and eighty five (185) participants responded (33%). The response rate at Yorkhill was 30.6% and Edinburgh (37.1%).

SATISFACTION AND MOTIVATION

The survey sought to establish how satisfied and how motivated paediatric nurses were at their work. It also sought to differentiate between satisfaction and motivation in their jobs. For example, did they equate in equal measure the same factors to satisfaction and motivation?

The main results are summarised in the table below and this highlights that nurses are generally satisfied and motivated, most of the time. It also shows that nurses are slightly more satisfied than they are motivated.

<table>
<thead>
<tr>
<th>Satisfaction and Motivation</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
| Satisfaction                | 5      | 2.7%        | 151      | 81.6%| 28    | 15.1%| 0    | 0%
| Motivation                  | 4      | 2.1%        | 134      | 72.4%| 39    | 21.0%| 3    | 1.6%

Within the demographic profile of the survey the most interesting differences to have emerged through the cross tabulation of responses relating to satisfaction were that younger nurses (20-35 years old) and those who have been qualified the shortest time appeared more satisfied than especially the 36 to 50 year old group (30% of the survey population). Within the demographic profile of the survey the cross tabulation of responses relating to motivation showed a broadly similar pattern.
The results (weighted) are summarised in the table below and show that overwhelmingly that nurses regard *high care standards* as crucial to their satisfaction and motivation. *Patient outcomes* are also seen important for both. However, nurses distinguished between satisfaction and motivation, placing high priority on *Praise and Recognition* as a critical factor in motivating staff. In particular, the intrinsic motivators emerged as key factors contributing to meaningful, worthwhile and rewarding work.

<table>
<thead>
<tr>
<th>Job Satisfaction &amp; Motivation Factors</th>
<th>Satisfaction</th>
<th>Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Career progression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial reward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manageable workload</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill mix</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong leadership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship - line manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship - colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education/training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Praise/reognition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Care Standards (29.5%)</td>
<td>High Care Standards (16.6%)</td>
</tr>
<tr>
<td>Patient Outcomes (13.2%)</td>
<td>Praise &amp; Recognition (14.6%)</td>
</tr>
<tr>
<td>Staffing Levels (9.7%)</td>
<td>Patient Outcomes (12.1%)</td>
</tr>
</tbody>
</table>

When respondents were asked to rank the top 3 factors in order of importance further analysis revealed a similar picture as shown overleaf.
PRAISE AND RECOGNITION

Having identified praise and recognition as especially important for motivating staff, the survey then explored how often staff received either from the NHS, the hospital or their line manager. The results shown in the following table demonstrate that less than 70% received praise and recognition from either the NHS or the hospital and only 25% from their line manager. This finding is significant, as the research will demonstrate that this has a negative affect on retention of nurses.

How Often do Nurses Receive Praise and Recognition?

Cross tabulation of these results by hospital location showed that RHSC nurses received more praise and recognition from their line managers, than at Yorkhill. This is particularly significant given the fact that nurses at RHSC were more satisfied and motivated than their colleagues in Glasgow.

RECRUITMENT AND RETENTION FACTORS

The respondents were asked to rank the same factors used in satisfaction and motivation, but with two additional factors – hospital location and hospital speciality. They were also asked to identify the top three factors in order of importance and again a
weighted and non-weighted analysis was conducted to inform and test the results.

The table below shows that respondents differentiate between recruitment and retention and also place different emphasis on most of the factors. It also shows that career progression and pay were the most important factors, relating to both. An interesting finding was that pay became the most important factor for retaining nurses, although it has already been identified as a factor of low importance in their motivation. Whilst the latter finding is entirely consistent with established theories of motivation, these findings offered insights, not previously reported in the literature on recruitment and retention. Specifically, pay has become a crucial factor in retaining nurses.

![Recruitment & Retention Factors](chart.png)

To test this hypothesis, the survey design enabled further analysis to be conducted on the top three factors in order of importance (see table below). The results confirmed that pay again emerged as the top factor in retaining staff and this challenges one of the researchers key aims –namely that non-pay factors are of increasing importance.
Recruitment & Retention: Top Three Factors in Order of Importance

<table>
<thead>
<tr>
<th>Recruitment</th>
<th>Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career progression (18.8%)</td>
<td>Financial reward (17.3%)</td>
</tr>
<tr>
<td>Financial reward (17.2%)</td>
<td>Career progression (14.6%)</td>
</tr>
<tr>
<td>Flexible working (10.2%)</td>
<td>Staffing levels (11.3%)</td>
</tr>
</tbody>
</table>

Analysis of from the demographic variables showed few differences, although among retention factors E Grades thought pay to be more important (19%) compared with D Grades (14%).

**DO NURSES THINK THERE IS A RECRUITMENT & RETENTION PROBLEM?**

A rich source of qualitative data was obtained by asking nurses whether they thought there was a recruitment and retention problem of paediatric nurses within their area. The following table shows that a significant number of nurses thought there was a recruitment and retention problem. However, more thought that the problem was particularly acute in relation to retention.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>84 (45.4%)</td>
<td>68 (36.7 %)</td>
<td>33 (17.8%)</td>
</tr>
<tr>
<td>Retention</td>
<td>121 (65.4%)</td>
<td>43 (23.2%)</td>
<td>21 (11.3%)</td>
</tr>
</tbody>
</table>

**ANALYSIS OF RECURRING THEMES: NEGATIVE FACTORS**

Based on the analysis and specifically the frequency of opinions made by Nurses 5 key themes were identified as a recurring problem. Among Nurses who believed recruitment was a problem thought pay and resources were the most important, followed by working practices with extrinsic factors identified as third most important. The belief of nurses who thought retention was a problem (often the same nurses, described working practices, leadership and intrinsic motivation as the most important. The following table summarises these recurring themes and also highlights the specific factors within each theme (in brackets).

---

3. Extrinsic motivation is defined as motivation which comes form within; through feelings of self-worth, challenging meaningful work, recognition, praise and feeling valued.

Extrinsic motivation

4. Intrinsic motivation is defined as motivation that comes from outwith, ie promotion, financial rewards, job security, pension schemes etc.
Main Reasons Cited for Recruitment and Retention Problems

<table>
<thead>
<tr>
<th>Recruitment is a Problem</th>
<th>Retention is a Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay/resources (Pay)</td>
<td>Working Practices</td>
</tr>
<tr>
<td></td>
<td>(Staffing levels, Skills Mix and Workload)</td>
</tr>
<tr>
<td>Working Practices</td>
<td>Leadership</td>
</tr>
<tr>
<td>(Staffing levels, Skills Mix &amp; Workload)</td>
<td>(Support)</td>
</tr>
<tr>
<td>Extrinsic motivation</td>
<td>Intrinsic motivation</td>
</tr>
<tr>
<td>(Career progression)</td>
<td>(Praise and Recognition)</td>
</tr>
</tbody>
</table>

**Praise and Recognition**

The analysis showed that lack of praise and recognition was by far the most cited reason, with nurses placing considerable importance on feeling valued. This aspect of the research also highlights a fundamentally important recurring theme, which is not only reflected in the literature by many other authors, but also by the findings identified from the quantitative analysis from the survey. The following comments from nurses indicate their strength of feeling and its impact:

"There is no praise or recognition. Staff are treated very poorly, their views/opinions are not valued. People become fed up with lack of recognition”.

"Lack of praise and recognition for years of working and experience. Feel like just a number most of the time”.

"I feel undervalued by manager, disillusioned with nursing. Nurses need to be valued more. A simple thank you at the end of a shift from your line manager would make a world of difference”.

"The trust treats staff very poorly. In previous trust in England I felt valued and my opinions were taken into account”. "No recognition of care provided, feel taken for granted”.

These findings prompt two important questions. First, if so much is known about the importance of praising, recognising and valuing staff and appears time and time again, have the NHS understood this? Second, if the importance of these issues is understood, why have the lessons not been learned?

**Pay**

A substantial number of nurses cited poor pay as a key issue pertaining to recruitment and retention of nurses, Common
terminology used by nurses included; “underpaid”, “poor pay”, “lack of money”, “little financial recognition” and “low wages”. There was a broad consensus that the NHS needs to address the issues of nurse’s pay if they are to improve recruitment and retention. It should also be noted however, that many believe that nurses are no longer prepared to tolerate poor pay and conditions. Comments that support this theme include:

“Nursing pay and conditions continue to be insulting. Radical change is required to recruit and retain nurses”.

“I believe that self-worth is highly related to salary. I enjoy my job as a paediatric nurse, but most of the time morale is low, due to low pay of nurses in general. I’m not sure if people will put up with it for much longer”

“Job satisfaction and financial reward mean as much to us as to anyone else. The public and NHS need to realise that we do not live on dedication alone”.

The researcher was also able to conclude that whilst pay was viewed as a significant issue, it becomes more significant coupled with other unresolved concerns, especially when they felt understaffed and overworked. One nurse who wrote supported this statement:

**Leadership and Support**

Lack of support was highlighted as the biggest problem facing many nurses, closely followed by relationship with line manager. Many felt unsupported within their clinical area and unable to approach them for advice. Frequently used phrases included; “ineffectual management” and “poor leadership”. The real concerns felt by nurses are evident from the following quotes:

“In my area, communication/relationships with senior managers is a real issue. I feel intimidated by some senior members and find them unapproachable and unsympathetic”.

“Managers are too far away from the clinical areas to understand what the staff on the shop floor feel. They do not listen enough. Patient care is compromised because staff are under pressure to ‘get the job done’. There is growing concern that managers now only carry out crisis management”.

This recurring theme - lack of support, is characteristic for both grades of nurses studied, therefore may suggest that there is a
general lack of support for nurses of all grades in the NHS, but this would require further research. Statements to support this opinion include:

“There is often no support and lack of guidance, especially for newly qualified staff”.

“There is a lack of support for higher grades and lack of support for managers”.

Effective leadership is essential in the NHS, given the complexity and demands of the service and as such will have an enormous impact and influence on the issues of recruitment and retention identified within this study.

**Career progression**

Having identified the importance of career progression as a motivator for nurses (see chapter one), it is significant that career progression however, is cited as a main problem for many paediatric nurses. The following quotes from nurses reflecting their concerns:

“There is a lack of career prospects above ‘E’ grade level, with the higher grades not leaving. People feel stuck”

“ITU is such a specialist area, very few senior positions become available. if you enjoy working in this area, there is nowhere for you to go in career progression”

“Lack of career progression becomes very frustrating and demotivating when you know that places are limited, particularly senior posts and competition high”

“Due to limited posts within paediatrics, I feel that many ‘E’ grades with qualifications and experience are cheated out of management posts due to the lack of movement and lack of available posts. Once people get to ‘F’ grade or above, they rarely move”

This research confirms the findings from previous studies that have identified career progression as a significant problem. However, it also raises the question of whether career progression is more of a problem within paediatrics and other clinical specialities. With the NHS become more specialist this, has greater significance and would benefit from further comparative research.
Staffing levels, Skill Mix and Workload

Low staffing levels, poor skill mix, and heavy workloads was frequently given as factors which negatively impact on recruitment, but particularly retention. Many spoke about “unacceptable staffing levels”, “inexperienced staff” and “unmanageable workloads”. Whilst this in itself was seen as damaging, there was also a general recognition that this increase pressure at work, in turn leads to higher levels of stress. The negative effect that this has on nurses is highlighted by the following quotes:

“Poor working conditions due to shortage of staff and inappropriate skill mix, means that you are unable to give the patient care that you want to”

“Staff are overworked (not enough nurses on ward for workload), sometimes to an unsafe level”.

“One of my main concerns is that there is consistently an inadequate number of staff or an inappropriate skill mix on the wards within my hospital. This leads to staff having to cope with workloads on shifts which are unmanageable. This leads to staff becoming disheartened and often unmotivated”.

ANALYSIS OF RECURRING THEMES: POSITIVE FACTORS

The recruitment and retention problems most frequently cited has been discussed above. There was a minority of nurses (18%), however, who viewed the NHS in a more positive light. The three most cited reasons are given in the table below.

Main Positive Reasons Cited for Recruitment and Retention

<table>
<thead>
<tr>
<th>Positive Factor for Recruitment Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extrinsic Motivation (Job security)</td>
</tr>
<tr>
<td>Intrinsic Motivation (Job satisfaction)</td>
</tr>
<tr>
<td>Flexible Working</td>
</tr>
</tbody>
</table>

Many of the nurses who wanted to stay spoke about ‘love of the job’, ‘happy at work’ and ‘job satisfaction’. The main reasons given for not wanting to leave the NHS was related to job satisfaction in being able to deliver a high standard of nursing care. This supports theories of motivation, discussed previously, where great importance was placed on employees feeling that their work was meaningful and rewarding.

"I really feel that I can make a difference and deliver good quality care".
"Because ideally the NHS can provide valuable treatment".
"I really feel that I can make a difference and deliver good quality care".

"I would like to contribute to the NHS providing excellent standards of care".

Other Recurring Themes

Stress and Low Morale

Stress and low morale emerged as critical factors relating to nurses who would consider leaving the NHS. The following views highlighted the current mood within the profession:

"I frequently find my work very stressful. There is more day to day work pressure than ever before, often related to low staffing levels".

"At times I feel very depressed".

"Stress in the NHS is constant. It is difficult to maintain a happy healthy lifestyle".

"Lack of nurses and busy wards eventually lead to low morale. Marks & Spencers begins to look inviting! What a waste of good nurses".

Although the issue of stress and low morale did not appear as one of the top five most important, it did emerged however, as particularly important in combination with other factors.

Agenda for Change

The implications of Agenda for Change have emerged as one of the crucial factors influencing the future decisions of many nurses. Whilst it is expected to improve pay and conditions for nurses, this research has highlighted that many nurses are sceptical, apprehensive and anxious to see the impact of the changes before they decide whether to stay within the NHS. For example:

"If circumstances are worse with agenda for Change, I would seriously consider leaving".

"Unsure about agenda for Change- feel it may cause more problems with morale amongst nurses".
“If Agenda for Change is good financially, I can see no reason to leave”.

“Agenda for change and other changes within the NHS making long term future with the NHS questionable”.

There is clearly much anxiety in relation to future changes within the NHS and this study has demonstrated that Agenda for Change in particular, will have a substantial impact on future recruitment and retention of nurses.

**THE FUTURE INTENTIONS OF NURSES**

Having identified the current issues of recruitment and retention, the researcher believed it important to establish the intentions of nurses over the next 5 years and in particular whether they might stay in or leave the NHS. The following results suggest that a significant number (14.5%) are already planning on leaving the NHS, whilst a further 44.8% are uncertain. This conveys that there is a serious retention problem, which given the ageing of the workforce is likely to worsen.

**Intentions for the Next 5 years**

<table>
<thead>
<tr>
<th>Intentions</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying with the NHS</td>
<td>75</td>
<td>40.5%</td>
</tr>
<tr>
<td>Leaving the NHS</td>
<td>27</td>
<td>14.5%</td>
</tr>
<tr>
<td>Uncertain</td>
<td>83</td>
<td>44.8%</td>
</tr>
<tr>
<td>Total;</td>
<td>185</td>
<td>100%</td>
</tr>
</tbody>
</table>

**CONCLUSIONS**

This research has gathered a very rich source of data on the factors affecting the recruitment and retention of middle grade paediatric nurses. The analysis of the literature and the results of survey have also enabled the specific aims and objectives of the study to be met. Whilst some research on these issues has been conducted previously within mainstream nursing (adult), the focus on paediatric nurses is novel. The size of the survey, the richness and very recent nature of the data also makes this research likely to be of wider interest to researchers, policy makers and health care management.

The research has identified that retention of nurses is paramount, recruiting nurses will merely replace the nurses that are leaving the NHS or retiring. However, this research has shown that issues of
recruitment and retention are interwoven and this is demonstrated from analysis of both the quantitative and qualitative data.

Moreover, the research has concluded that there is serious recruitment and retention problem of middle grade paediatric nurses within Scotland and also that the problem of retention is likely to worsen, especially as the age profile of nurses increases. Less than half of the nurses surveyed thought that they would stay in the NHS. Out of the remainder, 45% were uncertain and 14.5% stated that they considering leaving, the implications of which are huge. The crisis facing the NHS is widely reported and local and national initiatives are being put in place to try to address the problem. Findings contained within this and other studies confirm the urgency of such measures.

Paediatric nurses identified many factors (positive and negative) influencing recruitment and retention, but the key recurring themes included:

- Pay
- Praise and recognition
- Staffing levels
- Skill mix
- Workload
- Leadership/Support
- Stress
- High care standards
- Flexible working
- Career progression

The research also established that the themes identified were multifactorial, with nurses never citing them as single issues. These themes were also, not surprisingly, regarded as both positive and negative and appeared on both sides of the equation. The overwhelming interpretation given in respect of these factors was in the main negative, with more nurses discontented than contented. This was reflected in both the volume and strength of comments made.

Of particular significance, this research has demonstrated that pay has become very important for recruiting and retaining nurses and this challenges the research hypothesis (drawn from the current literature), that non-pay factors are of increasing importance. Whilst pay was not identified as the most important for satisfaction or motivation, it did become the most important factor in retaining nurses and the second most important for recruitment. These findings offer new insights, not previously reported in literature,
specifically, pay has now become a crucial factor in retaining nurses.

Another key conclusion is that praise and recognition emerged as very influential and significantly, the factor that is least valued by the NHS. This conclusion emerged, not only from the theories of motivation, but powerfully through the quantitative analysis where less than 70% received praise and recognition from the NHS or from the hospital and only 25% from their line manager. The theme also emerged as the most frequently cited in the qualitative analysis. Thus far, this key finding has not been reflected in literature, nor adequately recognised by the NHS.

A number of other key factors were identified as having a negative impact on recruitment and retention. First, low staffing levels, inappropriate skill mix and unmanageable workloads were frequently given as reasons why nurses leave. Indeed, many believed that the combination of these factors made their working environment unsafe. These issues appeared to have a cumulative effect. For example, people may have been prepared to tolerate low staffing levels, but if their workload was heavy, their tolerance was reduced.

Second, poor leadership and lack of support was also identified throughout the survey as a big problem facing many nurses. The majority of the criticism was directed at line manager and above. Many nurses felt totally unsupported and found their managers unapproachable. The research has shown that this is likely to aggravate the stress felt by many nurses as highlighted within this study.

Third, occupational stress is inherent in all professions, however, in view of the nature of the work and from the evidence presented within this study, nursing appears to be becoming even more stressful. It is not surprising therefore, that low morale and high stress levels were reported by many nurses as negatively impacting on their enjoyment of the job.
Finally, but of equally importance, limited opportunities for career progression and promotion were highlighted by a significant number of nurses and identified as a major problem affecting recruitment and retention of paediatric nurses. The feeling amongst nurses was that opportunities for progression are less within a specialist area of nursing (paediatrics), in comparison to that offered within main stream nursing (adult). Further research would be necessary to clarify this by comparing actual and perceived differences between paediatrics and main stream nursing.

The conclusions thus far have been predominantly negative. However, there were a minority of nurses (around 18%) who identified positive aspects of working in the NHS. In general nurses saw the NHS as providing job security and attractive fringe benefits, in particular a good pension. This was given as the top reason for either returning to or staying in the NHS.

The majority of nurses, who wanted to stay in the NHS also, found their jobs very satisfying and rewarding. Most attributed this to personal satisfaction, derived from being able to deliver high standards of patient care.

Another positive factor identified, particularly from those nurses with children, was the flexible working arrangements, within the hospital environment. Many believed that the flexibility of shifts and working hours was beneficial in facilitating childcare. On the other side of the equation however, some nurses thought that the long hours and unsocial nature of the shifts, were inflexible and therefore viewed them negatively.

The population studied was representative of paediatric nurses within NHS Scotland and large enough to allow some generalisations to be made within the NHS, UK wide.

The research findings within this study also offer additional insight into current issues affecting recruitment and retention of paediatric nurses and has obvious implications for future initiatives that should be undertaken to address the problem. Fundamentally, the NHS needs to develop and implement a much more effective strategy, supported by new HR practices which will allow it to not only grow its own nurses, but to hold on to them. As the title of this research suggests the NHS needs 'to have and to hold'.

**RECOMMENDATIONS**

The issues raised within this research are complex. As such there are no single answers. Strategies adopted to address the problems
of recruitment and retention must therefore be multifaceted, appreciative of the influence that all factors have on each another. The key recommendations are discussed below.

**New emphasis on Valuing Staff:** A key recommendation is that the NHS places greater emphasis on valuing staff and it is vital to promote a culture whereby staff are praised and recognised for their contribution to health care. This philosophy should flow not only through day to day working practices, but through all education & training programmes, particularly for those within a supervisory role. Regular appraisal reviews must be undertaken, whereby achievements can be recognised and rewarded. Achievements should also be publicised in newsletters, at team meetings etc and staff encouraged and supported to present their work at conferences and seminars.

**Leadership Training for all Supervisory Staff:** The NHS needs to ensure that supervisors and managers are equipped with the necessary skills to enable them to effectively manage and support their staff. Good nurse leaders are fundamental to the success of the NHS. The researcher would therefore recommend that leadership/management training becomes mandatory for all staff in a supervisory role. Whilst this will have initial cost implication, this will be outweighed by the long term benefits gained from successfully retaining staff, of all grades.

**Promote Sharing of Good Practice:** The Sharing of Good Practice is another recommendation that all NHS managers should adopt. Examples of good recruitment and retention practice must be identified. This should be achieved through the development of recruitment and retention forums, where the sharing of good practice can take place locally, nationally and internationally. Organisations should also benchmark with best practice elsewhere to assess and improve current performance.

**Localised Workforce Planning:** Workforce planning needs to be given a higher priority within Scotland, with the focus on retention rather than an over emphasis on recruitment. Otherwise, there will be a danger of merely replacing nurses as they leave. Evaluation of nursing establishments will be essential to ensure that the number of nurses and skill mix within each ward area reflect the workload (realistic establishments). This will not only improve delivery of patient care, but will also have a positive impact on reducing stress in the workplace.

**Increasing Pay:** Nurses must be given more pay. Current research indicates that nurses will not put up with poor pay for
much longer, particularly when other issues remain unresolved and other job alternatives for nurses improve. With the implementation of “Agenda for Change”, later this year, it is expected that 90% of nurses will earn more, however careful evaluation will be required to monitor its success. The NHS Scotland should also consider introducing an Edinburgh weighting allowance, similar to that offered for nurses working in London. The cost of living in Edinburgh, in particular housing has rocketed over the last few years.

**New Opportunities for Career Progression:** It is imperative that effective appraisal reviews are performed twice a year to identify and support professional development and career progression. This is particularly important in light of advancements in technology, increased demand for services and the need to expand the role of the nurse. These future developments should offer new career pathways and provide more opportunities for promotion.

**Exit Interviews:** - The NHS must put systems in place, so that they can find out why staff are leaving and use the information to inform retention strategies. Someone other than their immediate line-manager should perform the exit interview, in an attempt to discover the true motives for leaving. Exit interviews should be conducted for all nurses leaving, even if they are staying within the hospital, but moving to another area. Valuable information will still be gained. It is essential that Management Information Systems (MIS) are in place to ensure coded data obtained from both exit interviews and termination/change forms is inputted and analysed.

**Further Research:** - The final recommendation is that it would be useful to conduct a similar study within three years, thereby tracking a longitudinal profile on how responses and views have changed and whether current or new initiatives have been effective and to what extent. Further comparative research may also be beneficial to identify if career progression is more of a problem for paediatric nurses compared to that offered within main stream nursing (adult).

Implementing these recommendations will go a long way toward addressing the recruitment and retention crisis facing the NHS.
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Lived Experience of Equine Facilitated Psychotherapy in Adult Female Survivors of Abuse

Krista M. Meinersmann, PhD, APRN-BC
Byrdine F. Lewis School of Nursing
Georgia State University
P. O. Box 4019
Atlanta, GA, 30302-4019 USA
kmeinersmann@gsu.edu
Work Number: 404-651-4552
Home Number: 770-390-9204
Fax Number: 404-651-3096

Judy Bradberry, PhD
Department of Nursing
Brenau University

Florence Roberts, PhD
Department of Nursing
Brenau University
Gainesville, GA
Lived Experience of Equine Facilitated Psychotherapy in Adult Female Survivors of Abuse

Childhood abuse and intimate partner abuse are major public health problems. It is essential to develop interventions that increase the health and safety of women while respecting their autonomy. This research examined one such intervention, Equine Facilitated Psychotherapy (EFP). EFP is a form of psychotherapy that includes equines and provides clients with opportunities to enhance self-awareness and re-pattern maladaptive behaviours. Research on the effectiveness of EFP with children and adolescents with emotional or behaviour problems supports its effectiveness. Anecdotal accounts of the effectiveness of EFP with adult women appear in the literature but there is little research to support these accounts.

The purpose of this study was to explore the experience of EFP. A qualitative design was used to explore the lived experience of women who have experienced abuse and participated in EFP. Sample recruitment was done by sending letters to therapists who provide EFP and asking them to share the information with potential participants. Selection criteria included: age, experience of abuse at some point in their life; participation in EFP, and ability to read and speak English. Interested participants contacted the principle investigator. Interviews were conducted and audiotaped and transcribed. Five women met the criteria and were interviewed.

Data analysis involved the research team reading interviews, writing summaries and identifying common patterns and themes. The team met to compare their findings and refine the patterns and themes. To assure authenticity the transcribed interviews and the preliminary findings were shared with participants. In general the participants who read the findings concurred with the interpretations. One participant asked that we add some of her comments under one of the patterns that reflected her thoughts on the notion of power. This information was added to the discussion of the identified pattern.

Four patterns were identified: I Can Have Power; Doing it Hands-On, Horses as Co-therapists, and Turned my Life Around. The pattern I Can Have Power emerged from the women’s comments about learning that they were no longer powerless or helpless and that they could have control of their lives. The participants comments about Doing it Hands-On represent ways that EFP allowed them to be actively involved in the therapy sessions beyond talking and processing their experiences. The women’s comments about the horses’ contribution to therapy are found in the pattern
Horses as Co-therapists. The participants’ stories of overcoming emotional roadblocks in their lives are represented in the pattern Turned by Life Around. Overall the participants’ stories spoke of EFP as a powerful experience that changed their lives. As one said “It’s changed my life just ultimately to the max.”

Conducting this study has reinforced our belief that EFP is an effective and powerful intervention for women who have experienced abuse. Therefore, the next step will be to plan an intervention study that will examine some of the consequences of abuse such as depression, anxiety and lowered self-esteem prior to, during and after participation in EFP. It is our belief that the results will demonstrate that EFP is an effective intervention for women who have experienced abuse.
The experience of rural midwives supporting intellectually disabled women during pregnancy and childbirth.

Maureen Miles, Coordinator and Lecturer of Post Grad Midwifery program. RN, HV cert, RM, PG Soc Sci, MClinNur(MCHN), MACMI.

Dr Ysanne Chapman, Senior Research Fellow, RN, PhD, MSc(Hons), BEd(Nursing), GDE, DNE, DRM, MRCNA.

Prof Karen Francis, RN, DipHlthSc, Armidale CAE, BHIthSc, UWS, MHlthSc (Primary Health Care), UWS Hawkesbury, GradCert in UniTeaching&Learning, CSU, MEd (Distance and Rural Ed), CSU, PhD, (Uni Adelaide).

ADDRESS: Monash University, Gippsland Campus, Northways Road, Churchill, Victoria, Australia.

ABSTRACT

Mothers with intellectual disabilities encounter particular difficulties navigating a path toward parenthood. The literature identifies a sense of loss of control through the medicalisation of childbirth. The impact on women is intensified when physical or intellectual disability is an additional factor. This group of vulnerable mothers are denied their pregnancy and birthing choices afforded to other mothers because of their disability, are often regarded as high risk, more susceptible to increased intervention, with the reality of being transferred to give birth in hospitals that are geographically distant from their homes.

A new parent needs support; a new parent with an intellectual disability faces additional attention on the assessment of parenting abilities, their ability to learn parenting skills. Little is known about the support that intellectually disabled mothers may (or may not) receive from partners, family, friends and the service system before and during childbirth. When midwifery support is available the sparse research findings suggest that this is not always helpful (unhelpful help) and is often a constraint rather than a resource.

The aim of this study is to provide insight into rural midwives experiences caring for women who are intellectually disabled.

Four rural midwives who have given pregnancy and birthing care to women with intellectual disabilities were interviewed. A systematic thematic analysis was undertaken and emerging themes grouped and clustered using a phenomenological process of analysis.
Core findings included the identification of both the positive and negative experiences of midwives who are facing the challenges of assisting women of this genre. In describing the tensions experienced whilst giving care to women with intellectual disabilities the midwives identified a continuum. They suggested they went from allowing the mothers to do things for themselves to exercising control over all aspects of mothering. This continuum was encapsulated within an ambience of the midwives ‘making sure’ that their identified key characteristics of ‘good’ mothering were being met.
Title of Study: An Ethnographic Study of a Stroke (Support) Group.

Authors: Una Moffatt, RGN, ENB 249, BNS(Hons), MSc. Stroke Unit, Sligo General Hospital, Sligo. 071 9171111 Bleep 214. una.moffatt@mailb.hse.ie

Sinead Hahessy, R.G.N., B.A.(Hons), M.A.(Soc. Sc.), Pg Cert in Education. Department of Nursing and Midwifery Studies, NUI Galway, Galway.

Introduction:
From international studies it is estimated that in Ireland there are 30,000 people with residual disability from stroke (1). Clinical experience and literature review reveal that stroke survivors and their families are at risk of loneliness and isolation in addition to other psychosocial problems including depression. A Stroke Support Group was set up to provide mutual support and social integration.

Aims & objectives:

Aims:
• To complete an ethnographic study of the stroke support group.
• To explore the experiences of people attending such a group.
• To develop nursing knowledge of the problems encountered by people following stroke.

Objectives:
• To describe the culture of the group.
• To understand gender differences in stroke.
• To determine health beliefs and values of the group.
• To explore post-stroke psychosocial difficulties.

Methodology:
This qualitative study utilised ethnography as its methodology. Data collection included participant observation of the group’s meetings and outings over 1 year and recording of field notes. Unstructured interviews based on the analysis of observation data were held with a purposive sample of 13 participants, including stroke survivors and carers. Interviews were recorded by audio-tape and transcribed verbatim. Analysis revealed 6 themes.

Results:
The findings of this research included: benefits of group participation; psychological effects including suicidal intent; life
changes for women; life changes for men; health beliefs and values of the group; and gendered dominance – effects on the group. The ‘benefits of group participation’ was sub-divided into comparing, similarity and identity, social interaction, helping others and group moods.

Although presented separately, men and women were affected equally by the loss of valued roles and identities, such as ‘housewife’ or ‘man of the house’. All participants benefited from being part of the group. Participants were very reluctant to take antidepressants even when prescribed or dispensed, including those who had considered suicide. Although aware of risk factors for stroke, many (particularly men) held a fatalistic view and did not heed advice regarding smoking and diet.

**Conclusion:**
Further research is needed in the area of stroke in the Republic of Ireland. It is recommended that Health Promotion strategies for stroke prevention consider the fatalistic view held by this group and explore whether it is representative of the population in general.

**References**

**Acknowledgements:**
Research and Education Foundation, Sligo General Hospital who supported the study through a research seed grant.
Developing spiritual awareness through art – a visit to the art gallery as a teaching-learning strategy with undergraduate nursing students

Bróna Mooney, MSc; BNS (Hons.); R.G.N; R.N.T; Cert. in Critical Care. Lecturer in Nursing Studies, National University of Ireland, Galway.
E-mail: brona.mooney@nuigalway.ie Phone: 00 353 91 495395

Fiona Timmins MSc BNS BSc Health & Soc (Open) FFNRCSI NFESC RNT RGN,
Senior Lecturer, Director BSc (Cur),
School of Nursing & Midwifery,
Trinity College Dublin

In recent years, nursing educationists have displayed interest in the use of arts as a teaching methodology. However, teaching through this medium is underdeveloped. Works of art can communicate a broad spectrum of human experiences and can be used to enhance student learning. One example is art gallery visits, which offers opportunities for critical and creative exploration of knowledge through experience. A need also exists to foster more innovative teaching strategies in helping students developing an understanding in the more abstract subject topics incorporated in nursing curricula. One such subject area is spirituality. Providing spiritual care is very much part of the ‘art’ of nursing.

This paper describes an innovative teaching-learning strategy employed to facilitate the exploration of spirituality through the medium of art with second year nursing students. Following a visit to the National Gallery of Ireland, students were invited to take part in focus group interviews to explore their views on art as a medium to explore spirituality and the art gallery visit as a teaching methodology (n=18). Results indicate that art can be a powerful tool that stimulates thought and discussion amongst students. Learning is both individualised and enjoyable. Themes emerged from the interviews pertaining to the universal and individual nature of spirituality. This teaching methodology offered students the opportunity to reflect upon their own understanding and develop a deeper awareness of the meaning of spirituality. Recommendations from this study include the need for greater integration of arts into undergraduate nursing curricula and further empirical exploration of this topic.

Keywords: Spirituality, Nursing, Art, Students
Title of Research Project:  Teaching Neurological Observations: A Novel ICT Approach

Author/s:
**Ms. Bróna Mooney**, MSc; BNS (Hons.); R.G.N; R.N.T; Cert. in Critical Care. Lecturer in Nursing Studies, National University of Ireland, Galway.
E-mail: brona.mooney@nuigalway.ie Phone: 00 353 91 495395

**Ms. Eimear Burke**, BNS (Hons.); HDip OH&S (Hons.); R.G.N. Applied Teacher, National University of Ireland, Galway.
E-mail: e.burke@nuigalway.ie Phone: 00 353 91 495352

**Background and Context:**
Neurological observation is the collection of information on a patient’s central nervous system. Nurses carry out neurological assessments in a variety of clinical settings to aid with diagnosis of a neurological disorder; as a baseline observation; following a neurosurgical procedure and post-trauma. Student nurses may experience a degree of anxiety in undertaking neurological assessment. The utilisation of ICT software as a teaching strategy is one way in which to expose students to high-tech education and allow them to develop clinical skills in a safe and non-threatening environment.

**Aims/Objectives:**
- To integrate ICT based teaching strategies in undergraduate nurse education;
- To develop appropriate clinical skills to undertake a neurological assessment;
- To evaluate students impressions of the session using the ICT software and case study approach.

**Methodology & Data Analysis**
An interactive teaching-learning seminar was devised at the Department of Nursing & Midwifery Studies, NUIG to facilitate student learning in this area. Two nurse educators facilitated the seminar which included an interactive Neurological Observations CD-ROM and a Simulated Case Study approach. Case studies were devised based on the CD-ROM Neurological Observation software. Second year student nurses worked independently through the CD-ROM exercise. Following this, students applied knowledge gained from the CD-ROM to solve patient case scenarios. Evaluation of the neurological observation seminar was conducted and data was analysed following the session.
Study Findings
A 100% response rate (n=78) was achieved. Results indicated that students favoured interactive learning. In particular students highlighted the integration of the CD-ROM and patient case scenarios as positive aspects of the session.

Conclusions
Accurate and consistent assessment of neurological observations is essential to establish a patient’s neurological status and illustrate any clinical changes. Student nurses require appropriate learning opportunities to undertake clinical skills for neurological assessment. This interactive seminar achieved its objectives through a variety of teaching methodologies namely ICT, role play, group work and patient simulation exercises.
Temporality and the experience of being a patient on haemodialysis therapy

Authors

Aoife Moran, Professor P Anne Scott,
School of Nursing,
Dublin City University,
Glasnevin,
Dublin 9

Professor Philip Darbyshire,
School of Nursing & Midwifery,
Flinders University, Australia.

Background
End stage renal disease (ESRD) occurs when renal functions are severely impaired resulting in an inability to maintain homeostasis. The kidneys are permanently damaged, and the patient can no longer survive independently without renal replacement therapy. Haemodialysis is one modality of renal replacement therapy, which involves the person adhering to a strict regime of dialysis, medications, and dietary and fluid restrictions. These patients must also accept dependency on the haemodialysis machine and healthcare staff for survival.

Aim
The aim of the study was to provide a detailed description of the experience of being a patient with end stage renal disease (ESRD) on haemodialysis therapy.

Methodology
The methodology employed was interpretive phenomenology. The setting for the study was a haemodialysis unit based in a large city hospital in the Republic of Ireland. A purposive sample of sixteen participants aged from 20-70 years was recruited. Semi-structured interviews were conducted with each participant. An interpretive approach to data analysis was performed.

Findings
The narratives of the participants suggested that their present experience of haemodialysis therapy was shaped by their past life experience, and their possibilities for the future. These findings highlighted that lived time or temporality was significant within the participants’ experience of haemodialysis therapy. Temporality is subjective time, as opposed to linear or objective time, and is
influenced by the person’s current life events, past life experience, and possibilities for the future.

**Conclusion**
The study highlighted that temporality, or lived time, was significant within the participants’ experience of haemodialysis therapy. These findings suggest that the person’s life plan may be an important starting point in the provision of care to the patient on haemodialysis therapy. It is anticipated that these findings would assist in making the care of the patient on haemodialysis more patient-centred and effective.
Highlighting the Nursing Contribution to Health Care. 

Developing an Irish Nursing Minimum Data Set for Mental Health Nursing

AUTHORS:

Ms Roisin Morris, MSc, Research Fellow, School of Nursing, Dublin City University
Dr Padraig MacNeela, Psychology Lecturer, National University of Ireland, Galway
Professor Anne Scott, Principal Investigator, Head of the School of Nursing, Dublin City University
Professor Pearl Treacy, School of Nursing and Midwifery, University College Dublin
Dr Abbey Hyde, Senior Lecturer, School of Nursing and Midwifery, University College Dublin
Mr Jonathan Drennan, MSc, RPN, Lecturer, School of Nursing and Midwifery, University College Dublin.
Ms Anne Byrne, MSC, RGN, Research Fellow, School of Nursing and Midwifery, University College Dublin.
Mr Gerard Clinton, MSc, RGN, Lecturer, Research Assistant, School of Nursing, Dublin City University.
Dr Michelle Butler, Lecturer, School of Nursing and Midwifery, University College Dublin.
Ms Pamela Henry, MSc, RGN, Lecturer, School of Nursing, Dublin City University.

In Ireland today there is a very definite need to strengthen the voice of nursing in order to highlight the contribution that nurses make to the Irish health care system. The dearth of quality data on nursing activities must be addressed if we are to be able to effectively manage, teach, research and resource nursing in Ireland. This aim of this study is to develop and validate an Irish Nursing Minimum Data Set (I-NMDS) to assist in the systematic collection of standardised information on client problems, nursing interventions and coordination and organisation of care activities in mental health nursing. Eleven hospitals across the four HSE areas took part in the study to nationally validate the Irish Nursing Minimum Data Set, resulting in the collection of 370 I-NMDS instruments representing 1600 days of mental health client and nursing data. Quantitative analysis of the data indicates that the I-NMDS is a valid and reliable tool for the collection of information on client problems and nursing interventions in both acute and community mental health nursing settings in Ireland. A valid and reliable Irish Nursing Minimum Data
Set tool can be used in the future to provide data and information about nursing care to influence practice, administrative and health policy decision-making. This research was conducted as part of a larger research programme to develop an Irish Nursing Minimum Data Set and to investigate the nature of clinical judgement and decision-making among nurses in Ireland.
Title: Final year mental health student nurses’ experiences of caring for clients with suicidal behaviour

Jean Morrissey, RGN, RMN, DipN, BEd, MSc (Couns Psy), Dip Superv, MBACP (Accred)  
Lecturer, School of Nursing & Midwifery, Trinity College Dublin,  
Email: morrisje@tcd.ie

Louise Doyle: RPN, BNS, MSc, RNT, Lecturer, School of Nursing & Midwifery, Trinity College Dublin, Email: doylel1@tcd.ie

Brian Keogh: RPN; BNS; PGDip (Education); PGD PGDip (Stats); MSc (Adv Nursing) Lecturer, School of Nursing & Midwifery, Trinity College Dublin, Email: keoghbj@tcd.ie

Background and context: Research on student mental health nurses’ responses to suicidal clients is sparse. Published nursing research has made little contribution to our understanding about nurses’ experiences of caring for clients engaging in suicidal behaviour. Clients presenting with suicidal behaviour form a considerable number of the overall presentations to both inpatient and community outpatient facilities in Ireland. Caring for suicidal clients poses a challenge to mental health nurses. Consequently, the recent National Strategy for Action on Suicide Prevention (2005) suggests that health professionals working with clients who present with suicidal behaviour should be adequately equipped with skills to appropriately respond to this group of individuals. The aim of this is research is to explore final year student nurses’ experiences of caring for clients with suicidal behaviour in order to inform curriculum development for subsequent mental health student nurses.

Methodology including research design and sampling: A descriptive qualitative method will guide the research using focus groups to collect the data. Purposive sampling will be utilised to recruit the potential participants. All current final year mental health student nurses (n=25) will be invited to participate in two to three focus groups (depending on response) of about 6 -8 participants each.

Analysis of the data: Qualitative data will be analysed using content analysis.

Summary of key findings: Key findings are not available at present, however, data collection, analysis and results will be completed for the conference.
ABSTRACT

Background
Traditionally, measuring appropriateness of attendance at Accident and Emergency (A&E) involved using implicit criteria and subjective judgement which lacks reliability and generalisation. Presently, any method which attempts to measure appropriateness of A&E attendance must have reliability and validity. Any such method would be the “gold standard” or “criterion standard”. The Hospital Urgencies Appropriateness Protocol (HUAP Tool) contains a range of objective, explicit criteria which may enhance reliability and validity compared to previous research studies. Examination of appropriateness of A&E attendance is essential as it may identify barriers to care and whether cost-effective patient care and significant health gain is being achieved.

Aim
Establish the reliability and validity of the HUAP Tool and using this, evaluate the appropriateness of visits to an A&E department.

Methodology
Quantitative descriptive design. A pilot study established the reliability and validity of the HUAP tool. The study itself involved the retrospective review of a convenience sample of 213 patient case notes who attended A&E using the HUAP tool.

Analysis
Intrareviewer reliability test was K 1.00 and interreviewer reliability K 1.00 and validity of K .50. Of the 213 case notes reviewed, n=46 (21.6%) were evaluated as inappropriate.

Key Findings
The HUAP tool is a highly reliable instrument with moderate degree of validity. Inappropriate use was associated with being younger, being male and attending at the weekend.
Conclusions
Strategies to reduce inappropriate attendances to A&E involve improving access to primary care, restricting A&E access, education and finally modifying present A&E services. One or more of these strategies could be targeted at individual groups. The increased reliability and validity of the HUAP tool in measuring appropriateness of A&E attendances means that it could be used to measure the success or failure of the strategies used to deal with inappropriate attendance at A&E.

Geraldine Murphy  R.G.N, R.M, P.H.N, BSc, MSc,  
Newcastle, Tyrrellspass, Co.Westmeath, Ph. No. 044 9221967,  
E mail geraldine,arthur@gmail.com  

Lorraine Swords, Psychologist, University College Dublin  

Dr. Eilis Hennessy, Psychologist, University College Dublin  

Dr B. McClean  Snr Clinical Psychologist with the Brothers of Charity Roscommon, E Mail bmcclean@indigo.ie  

Abstract  

Background:  There is a growing body of evidence in the literature to suggest that behaviour difficulties in preschool children with developmental delay can impact on child development and cause additional stress to the family. Evidence on the most appropriate method of providing support to families to develop their own competencies in managing behaviour difficulties is limited.  

Aims:  To assess the impact of the Positive Behaviour Support programme on four preschool children with developmental delay and behaviour difficulties, and their families.  

Method:  A series of four case studies were undertaken. Both qualitative and quantitative research methods are used to assess the impact of Positive Behaviour Support (i) on the child’s behaviour (ii) on parental perceptions of the child’s behaviour (iii) parental perceptions of the impact of the child on the family and (iv) the social validity of the intervention.  

Results:  Results of the case studied are mixed. Two of the children showed a decrease in the defined behaviour over the intervention period. The programme positively influenced parental perception of their own ability to manage their child’s behaviour in three of the four cases studied. The results also suggest that the Positive Behaviour Support programme is an acceptable method of supporting these families. Results are discussed in relation to implication for practice, contribution to existing knowledge and recommendation for future research.
**Conclusion:** Positive Behaviour Support is a practical, cost-effective, alternative method of supporting families of preschool children with developmental delay and behavioural difficulties. However, further longitudinal research is needed into the long-term benefits for the child and the family.
Title: The Challenge of Nurses to maintain Dignity in Long Stay Older Adult Units

Ms Jill Murphy, RGN, MSc Gerontological Nursing (TCD), PGCT&LHE (UCC).
Dpt of Nursing and Midwifery
Health Science Building
University of Limerick
Limerick
061-233655
jill.murphy@ul.ie

Background and Context
Dignity is the central phenomenon of nursing. However nursing has not operationally defined dignity and there appears to be only one tool claiming to measure dignity (Chocinov, H. Hack, T. McClement, S. Kristjanson, L. & Harlos, M. 2002). Evidence suggests (Sholton, I. & Seedhouse, D. 1998) that the health care system has failed in certain nursing care interventions to maintain dignity in long stay units for the older adult, a factor attributed to the abstract concept of dignity and precise definition. If nurses are to maintain patient’s dignity, then nurses must have knowledge of the concept, and an awareness of how to deliver care whilst maintaining older adults dignity.

Aim of the Study: To describe how Dignity is evidenced by nurses in Older Adult Units.

Methodology
The study is a quantitative descriptive study of registered general nurses perceptions of dignity working in long stay units for the older adult in Ireland. Sixty nurses working in eight long stay units for the older adult, returned a postal questionnaire, describing how nurses perceive dignity whilst delivering care to the older adult. The author completed a preliminary concept analysis resulting in three attributes of dignity being used to develop the questionnaire. The study was analysed using the spss package.

Summary of key findings
Nurses maintained patients dignity on long stay units for the older adult. However areas where nurses compromised older patient’s dignity were highlighted in this study, which included dignity being compromised when administering medication, feeding, and toileting and maintaining hygiene.
Conclusions
Recommendations include further research on developing a tool to measure the concept of dignity. This study has been conducted at an early stage of development of research in Ireland, before the concept of dignity has been defined. By conducting further studies in long stay older adult units and testing the effects of nursing interventions a higher awareness of dignity may occur.

References:
ABSTRACT

Background: Compliance therapy, an intervention based on motivational interviewing and cognitive behaviour therapy has been shown to be effective in reducing levels of non-compliance with medication in those with serious mental illness. It was initiated by mental health nurses as a therapeutic intervention in the research site but failed to become fully established as an integral part of ward routine.

Aims of the study: The aims of this evaluation were to establish those factors that militated against and those that facilitated mental health nurses in changing their practice, by facilitating the implementation of compliance therapy.

Methodology: This evaluation takes an utilisation-focused approach involving collaboration with stakeholders and commitment to use of findings. The underpinning research paradigm was qualitative. Purposive samples involved four mental health nurses and a practice development co-ordinator in semi-structured interviews.

Analysis: This was undertaken using Burnard’s 14 stage thematic analysis.

Findings: A number of themes emerged strongly as militating against nurse’s ability to change in the context of the delivery of compliance therapy. These included, lack of effective leadership skills, an innate resistance to change among staff, lack of requisite training and support and insufficient support from management. Improved autonomy of nurses, the appointment of clinical nurse specialists and the enthusiasm for change generated by a strategic organisational refocusing mental health project were the more positive aspects facilitating change.

Conclusion: It is important that negative factors are addressed in the interest of the initiation and sustenance of future change efforts. Positive factors need to acknowledged as such and their effect maximised.
A descriptive study of the practices and perceptions of family-centered care amongst children’s nurses in Ireland

Maryanne Murphy,
RGN, RCN, RNT, Higher Diploma (Children’s Nursing), BSc.Nursing, MSc. Nursing (Education) (Hons)
Lecturer in Children’s Nursing,
Trinity College Dublin,
Ph. +353(1)8962619
Email:Maryanne.murphy@amnch.ie

Abstract

Family-centered care has become the cornerstone of children’s nursing practice in the 21st century. It is conceptualised as a philosophy that supports the integrity of the family unit and respects the family’s expertise in caring for their child both in and out of the hospital (Daneman et al. 2002). The challenge of including parents as partners in care as one of the most rewarding privileges and responsibilities of children's nurses (Moynihan et al 1995). Family-centered care embraces the child and family as a unit and encourages the inclusion of the family in both the planning and provision of the child’s care in the healthcare setting. It is underpinned by professionals recognising the central role of the family in the care of their sick child. Children's nurses have signified their acceptance and knowledge of family-centered care and they have also indicated that they do not always incorporate this knowledge into their practice. The literature suggests that children's nurses find it easier to offer descriptions of family-centered care rather than implement it in practice.

Descriptive quantitative methodology was employed to guide this study on the practices and perceptions of family-centered care amongst children’s nurses in Ireland. Data was collected using the Family-Centered Care Questionnaire on a systematic sample of (N=300) children's nurses. The Family-Centered Care Questionnaire assessed the practices and perceptions of family-centered care amongst the respondents. SPSS was employed to analyse the data.

The respondents indicated that they had a good understanding of the complexities in caring for children and their families. The
findings of this study also indicated that the respondents had some difficulties with the application of family-centered care in practice.

The findings of this study highlighted that respondents had an understanding and knowledge of family-centered care. However, it also highlighted that significant differences existed between the respondents' practice and perception of it in practice. The findings will be presented and a number of recommendations for practice and further research are proposed as a result of this study.

The curriculum in children's nursing programmes needs to continue to develop in order to keep pace with the evolving emphasis of family-centered care in children's nursing practices. The findings of this study also suggest an examination of organisational and managerial issues in children's hospitals are required to support family-centered care practices.
Title: Informing questionnaire development with cognitive interviewing: reflections from practice.

Kathleen Neenan: RGN; RSCN; RNT; BNS; MSc, Research student, School of Nursing & Midwifery, Trinity College Dublin, Email: kaneenan@tcd.ie
Frances O’Brien: RGN; BNS; RNT; MA, Lecturer, School of Nursing & Midwifery, Trinity College Dublin, Email: obrienfr@tcd.ie
Brian Keogh: RPN; BNS; PGDip (Education); PGDip (Stats); MSc (Adv Nursing) Lecturer, School of Nursing & Midwifery, Trinity College Dublin, Email: keoghbj@tcd.ie

Background and context: Questionnaires are a reasonably inexpensive means of collecting data. They require little time and energy to administer and they offer the possibility complete anonymity which is crucial in obtaining information about opinions, perceptions and experiences. However designing a questionnaire that collects objective, reliable and valid information is a time consuming and difficult task. This paper examines the role of cognitive interviewing in the development of a questionnaire used to measure mature students experiences of undergraduate nursing education.

Methodology: Following a review of the literature on cognitive interviewing, a group of 10 mature nursing students were invited to assist in reviewing the questionnaire. This was to be the final stage in the development of the questionnaire prior to the pilot study. The participants were asked to go through the survey question by question and to verbalise their feelings on what the question meant to them and if the question was clear and appropriate. They were also invited to comment on the design and layout of the questionnaire and to suggest alterations to the letters of invite and information sheet.

Summary of key findings: The cognitive interviews were audio recorded and the results were used to inform the further development of the data collection instrument.

Conclusion: Although the cognitive interviewing technique is a time consuming process and an extra step in the development of questionnaires, it is an invaluable strategy for ensuring that the contents of the data collection tool have content and face validity prior to the data collection phase of the research process. It also offers the researchers an opportunity to ask respondents about...
their feelings towards the questionnaire and gives the researchers an opportunity to alter the design and layout of the questionnaire consequently maximising the likelihood of a high response rate.
Introduction
Interdisciplinary learning is an ‘educational approach in which two or more disciplines collaborate in the learning process with the goal of fostering inter-professional interactions that enhance the practice of each discipline. Such interdisciplinary education is based on mutual understanding and respect for the actual and potential contributions of the disciplines.’(AACN, 1995:1). The past three decades have seen a global increase in the use of interdisciplinary learning in health professional education (Lavin et al 2001). Reports from the health sciences literature provide evidence of interdisciplinary learning in undergraduate, postgraduate and continuing education programmes (Fealy, 2005). The main driver for this educational approach is generally agreed to be the increasing complexity of patient care and the resultant need for collaboration between health professionals (Larson et al 1995, Lavin et al 2001, Hall et al 2001, Fealy, 2005).

Background to the Study
In 2004, the six Schools of the Faculty of Health Sciences at Trinity College Dublin articulated a set of common graduate attributes. These attributes included: the ability to participate effectively in inter-professional approaches to health care delivery; the ability to cooperate with other health care professionals and to understand the roles of other health professions.

In defining these shared attributes one of the aims was to facilitate educational collaboration across the Faculty’s undergraduate
programs. This paper reports on the initial collaboration between
the School of Nursing and Midwifery and the School of Clinical
Speech and Language Studies to design and deliver a pilot module
focussing on communication skills for students enrolled in the first
year of the BSc (Intellectual Disability Nursing) and the BSc (Clinical
Speech and Language Studies).

Two lecturers from each of the participating Schools designed and
delivered the module in collaboration. The design process
commenced with the identification of interpersonal communication
as a core clinical competency for both disciplines. Some previous
clinical experience was agreed as the only pre-requisite for student
enrolment. The module aims were threefold: firstly, to assist
students to analyse their own interpersonal communications skills;
secondly to assist them to develop their understanding of the role
and boundaries another healthcare profession and finally to gain
some knowledge of the course of study leading to the award of a
degree in another healthcare discipline.

The module consisted of an introductory workshop attended by all
students followed by student-led group interviews and a second
workshop. At the first workshop the Faculty graduate attributes
were introduced and the relationship between interdisciplinary
learning and interdisciplinary practice was discussed. Interview
schedules and video assessment sheets were distributed and
students reviewed them in interdisciplinary groups of 2-3. Each
group was given videotape and the first workshop concluded with a
demonstration of the equipment available to students for recording
their interviews.

The groups had three weeks to develop their questions and arrange
and conduct their interviews. Subsequently, each group member
individually reviewed his or her own performance using the
communication skills assessment sheet.

At the second workshop students shared their individual reflections
on their interview skills and on the process in general. They also
discussed points of commonality and difference between their
programmes of study and their disciplines. Several communication
frameworks were introduced and the module concluded with a
review and discussion of communication skills evidenced in video-
recordings of televised interviews.

The Study Aims
1. To explore the extent to which the pilot module assisted
   students to develop their understanding of another healthcare
discipline
2. To explore the extent to which the module assisted students to analyse their own interpersonal communication skills
3. To consider whether the module may provide a model for the further development and implementation of interdisciplinary learning across the Faculty.

Research Methodology

Design and Method
The study was conducted using an exploratory evaluative, descriptive survey design. This was deemed to be the most appropriate design, as it would allow the researchers to explore and describe the opinions of the student population. The researchers developed a questionnaire comprising of 16 likert-scale items with subsections relating to:

1. Student enrolment
2. Module management
3. Development of students’ interpersonal communication skills and knowledge
4. The interview process
5. Students’ understanding of another healthcare discipline

The questionnaire also included a qualitative section in which students were invited to comment in their own words on the least and most useful aspects of the module and to make suggestions for improvement.

Interviews were considered as a data-gathering method however factors such as limited staff and student availability outside of class and possible student reluctance to give feedback directly to their lecturers meant that a questionnaire was the most efficient and effective method available.

Data Collection and Analysis
Questionnaires were completed by 38 students from Clinical Speech and Language Studies (CSLS) students and 17 intellectual disability nursing students at the conclusion of the second workshop. The questionnaires were administered by the University’s centralised student feedback service. Data was analysed by the service to produce frequency distributions in the form of percentages for each item. In addition to the statistical report for all students taking the module, separate reports were produced for each disciplinary group.

Main Findings
Most respondents were satisfied with most aspects of the module’s management
- clarity of objectives, information about activities and assessment requirements - however nursing students were less satisfied than their CSLS counterparts. This disparity appears to be strongly linked to two factors. Firstly, the nursing students’ work on this module did not contribute to their final grade whereas the work produced by CSLS students did and second, most nursing students found it very difficult to schedule the interview around their class timetables.

Most respondents felt that the module provided a useful framework for exploring the area of interpersonal communication skills. By the end of the module most of them were able to identify the key steps in effective interpersonal communication and analyse the effectiveness of their own communication skills. Interestingly, only 62% of respondents rated their communication skills as effective before doing the module while 92% gave themselves an effective rating at the conclusion. It is unclear whether this finding indicates an actual improvement in the communication skills of 30% of respondents or whether in fact the video interview and reflective tools enabled them to make a more informed judgement of their existing skills or they simply gained in confidence.

The interview process itself was viewed by 80% of respondents as a useful way of developing their understanding of their counterparts’ healthcare discipline although fewer respondents perceived the interview to be successful in assisting them to understand the scope of practice of their counterparts’ discipline (68% agreement) or to feel more confident in discussing professional issues with intellectual disability nurses or clinical speech and language therapists (60% agreement).

The students’ written comments and suggestions confirmed the key findings from the quantitative data. In addition however, the comments and suggestions illuminated other issues broadly related to the module design and logistics. As noted earlier assessment was an issue which divided the respondents along professional lines. The group who were not assessed found the process less useful and more onerous while a significant number of CSLS students felt that their nursing counterparts were less motivated to make time for the video interviews. This finding reinforces the view that students tend to put effort into those parts of a course which are assessed (Biggs, 1999).

The use of video cameras for the interviews also posed a number of problems. The limited number made access difficult, a fact which was compounded by timetable clashes between the groups. Secondly there was insufficient time for the students to become accustomed to the equipment and a number of them felt inhibited
by the camera during their interviews. However, this finding in itself can be viewed as a positive outcome of the learning experience for the students, in that it provided students with insights into the real experience of clients, who are often asked to allow interviews to be video-recorded. In addition some students also reported difficulties in operating the cameras - again a necessary skill for CSLS students for their clinical practice.

Conclusions
From the students’ perspective the module appears to have been a worthwhile interdisciplinary educational experience and it may therefore provide a useful model for further collaboration. The success of future collaborations, however, depends just as much on logistical considerations such as timetabling and the provision of adequate resources as on traditional curriculum issues. Finally, it is clear that the work of all students engaged in such modules should be assessed. Whether the assessment task needs to be uniform across the whole class remains to be seen.

References


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AN EXPLORATION OF THE LEARNING STYLES OF UNDERGRADAUTE BSc NURSING STUDENTS

Mary Nevin RGN, BNS (Hons), MSc, RNT
Clinical Nurse Tutor,
School of Nursing and Midwifery,
Trinity College Dublin
Contact Details: Ph: 01-8963975  Email: nevinm@tcd.ie

Background and Context
There is an increasing emphasis in nursing education to identify ways of ensuring that students utilize fully their opportunities for learning and achieve their fullest potential. An individual’s learning style is identified as a significant factor affecting how that person learns, yet very little is known about the learning styles of student nurses in Ireland.

Aim of Study
To explore the learning styles of nursing students, and to examine whether there was a relationship between learning styles and factors such as students’ age, gender, and academic performance within the undergraduate BSc in nursing programme.

Methodology
A quantitative descriptive survey was utilised. Questionnaires were posted to a convenience sample of 186 undergraduate first year BSc nursing students.

Analysis
Data was analysed using SPSS version 12. Relationships between learning style, mature/non-mature status and overall expected performance in first year were undertaken using non-parametric analysis (Mann-Whitney U, Kruskal Wallis). For the learning competency scales, where distribution was normal, parametric data analysis was undertaken (Independent t tests, one way ANOVA).

Summary of key findings
The Converger learning style was the most frequently occurring learning style in the sample (35.3%). The students in this sample indicated an overall preference for Abstract learning styles (54.1%). No significant differences were found between males and females. Significant differences were found in ages across the four learning styles. Mature students had significantly higher scores in the learning competency of Abstract Conceptualisation. Finally, no significant differences were found between learning styles and
students overall expected performance in the first year of the BSc in nursing programme.

Conclusions
Use of a variety of teaching strategies is essential given the wide distribution of learning styles in this sample. It important for nurse educators to identify students preferred learning styles, not only to utilise teaching strategies which enhance students preferred learning styles but also to employ strategies that will develop non-dominant styles.
"Aiken reconsidered: The production economics of nursing and its workforce implications"

Dr David Newbold RN, BSc (Econ), MSc (Econ), PGDE, PhD
Lecturer in Nursing
James Clerk Maxwell Building
Florence Nightingale School of Nursing and Midwifery
King's College London
57 Waterloo Road London
SE1 8WA
England
+ 44 20 7848 3636
david.newbold@kcl.ac.uk

ABSTRACT

Background and context
Health systems worldwide face a common problem: cost containment. As a consequence, in the UK and elsewhere, nurses (and other health professionals) face pressures from both the requirements to maintain safe levels of staffing and skill-mix, and the introduction of cost-reducing, case mix management systems such as "Payment by Results”

Aim of the study
The study aims to produce a systematic framework to link staffing levels with clinical survival data and costs, in a way that will assist nurse managers in the efficient allocation of clinical resources

Methodology including research design and sampling
Previously published data, from the research programme led by Professor Linda Aiken, Univ of Pennsylvania, will be used to generate an “isoquant” map of survival rates associated with different levels of patient-to-nurse ratios AND the percentages of graduate nurses in the workforce.

Analysis
Secondary analysis to:
1. Transform the published data from mortality values to survival rates per 1000 patients.
2. Cost the various permutations of patient to nurse ratio and percentage graduate nurses, using reliable local data

Summary of key findings
Preliminary analysis suggests that, There are two principal ‘modes’ of production, each capable of generating similar survival figures. These are the ‘education intensive’ mode, and the ‘labour intensive’
mode. At any given level of survival, the provisional findings are that the education intensive mode of production has lower costs to the provider. It is possible that this effect is reduced by hidden costs, or other costs not borne directly by the provider.

Conclusions
This approach provides nurse managers with a useful framework to assist them in making transparent choices about the local production of outcomes, and – consistent with other major research programmes, -highlights the positive impact of graduate-level nurses on survival and clinical resource use.
Insulin Initiation within the Diabetes Structured Care Programme

**Siobhan Meehan**
HSE Dublin Mid Leinster
Primary Care Unit
Longford/Westmeath Health Office
Springfield
Mullingar
Co. Westmeath

RGN, RPaedN, H. Dip Diabetes,

044 -93 84444
siobhan.meehan@mailq.hse.ie

**Mairead Mannion**
HSE Dublin Mid Leinster
Primary Care Office
Laois/Offaly Health Office
William St
Tullamore
Co. Offaly

RGN, Msc Nursing Studies, H. Dip Diabetes

057 93 26048
mairead.mannion@mailq.hse.ie

**Grainne Nic Gabhann**
HSE Dublin Mid Leinster
Primary Care Project Manager
William St
Tullamore
Co. Offaly

RGN, Diploma in Project Management

057 93 26048
grainne.nicgabhann@mailq.hse.ie
Background

Diabetes Mellitus is a group of metabolic diseases characterised by hyperglycaemia, resulting from defects in insulin secretion, insulin action or both (Pickup and Williams 2003).

The prevalence of diabetes is increasing worldwide. It is predicted that by the year 2025, there will be almost 333 million people with diabetes worldwide. Type 2 diabetes accounts for approximately 85%–90% of all cases of diabetes in European countries (Wass et al 2002). It is estimated that 129,052 persons in the Republic of Ireland have adult Type 2 diabetes (4.3% of the adult population). This corresponds to 3.5% (51,719) of adult males and 5.1% (77,333) of adult females (Institute of Public Health in Ireland Report 2006).

The number of people requiring care is increasing due to increasing incidence and prevalence (Rodgers 2004). Campbell et al (2002) outlines that this increase is due to the following factors:

- Increasing aging population (10% of people over 65 years have Type 2 diabetes).
- Increasing obesity rates.
- Increasing sedentary lifestyle.

Patient Context

Several studies highlight that meticulous glycemic control can prevent/delay the onset of diabetes complications. (DCCT 1993, Holman et al 1998 and Gaede et al 2003). Chronic hyperglycaemia in type 2 diabetes is responsible for a collection of micro vascular and macro vascular complications that lead to significant morbidity and mortality.

The United Kingdom Progressive diabetes study (UKPDS) Holman et al (1998) reported the findings of a 15 year study involving over 5,000 newly diagnosed patients with Type 2 diabetes. Among the findings it was shown that reducing HbA1c by 1% can effectively reduce the relative risk of micro vascular complications by 37% in those patients with Type 2 diabetes.

The patient with Type 2 diabetes requires insulin therapy when lifestyle modifications such as diet and exercise and oral hypoglycaemic agents are ineffective in achieving optimal glyceimic control and to alleviate symptoms that affect their quality of life. This step wise, progressive, combination therapy is essential if the target glycemic goal of HbA1c < 7.0% is to be achieved and maintained (Lebovitz 1999). However, insulin regimes are often only started after a prolonged period of poor glycemic control and
known beta cell failure. As highlighted in the UKPDS study only 33% of patients on maximum oral agent therapy had an HbA1c < 7.0% after 3 years of treatment. Consequently, to achieve a target HbA1c of < 7% it is estimated that 50% of people with diabetes will require insulin therapy (Wincour 2002).

**Insulin Initiation In A Primary Care Setting**

Several authors report that insulin is required in the management of Type 2 diabetes because it is a progressive illness. It leads to a relentless deterioration in beta cell function which cannot be slowed down by diet and tablet (Campbell et al 2002, Wincour 2002 and Rodgers 2004). The positive aspects of commencing insulin therapy in a general practice setting is that care is delivered in the patient's own local environment. The time the patient spends travelling and waiting for care is reduced. It offers a more timely transfer to an insulin regime at times suitable to the patient.

Insulin initiation in primary care is a patient centred approach. Patients are more relaxed in a familiar environment. In this setting time is available to allow patients express their concerns and discuss options of treatment with them and their family. These factors are fundamental to their understanding and self care adherence (Dromgoogle 2004).

The essential players in the insulin initiation process in a general practice setting are the patient with/without a family member, the G.P, practice nurse, dietician and the primary care diabetes nurse specialist.

There has been a cautious approach to the use of insulin therapy in general practice. The reluctance to start insulin therapy is often patient mediated secondary to “psychological insulin resistance” but may also be due to physician reluctance. Deals are often negotiated and excuses made to explain poor blood glucose control (Smith 2006).

Patient education plays a pivotal role in insulin initiation, maintaining good glycemic control and improved quality of life for the individual with diabetes (Paterson 2004).

By increasing a person's involvement in the decision making process, they are more likely to take an active part in the management of their condition. Rodgers (2004) also recommends that people with diabetes be made aware of insulin therapy as a treatment option at an early stage of their education. It is crucial that patients are aware of the progressive nature of diabetes and that starting insulin therapy is viewed as a possible part of
treatment rather than a consequence of non-compliance or failure of present treatment regimes. 
Campbell et al (2002) Outlines some of the factors affecting delayed initiation of insulin therapy in Type 2 diabetes: 

- The perception that individuals with Type 2 diabetes requiring insulin need referral to a specialist secondary care centre. 
- In the past all diabetes nurse specialist were based in secondary care 
- Concerns about the individual’s willingness to inject, fear of hypoglycaemia or weight gain from insulin therapy. 
- Patient maybe resistant to self monitoring of blood glucose. 
- Many patients are taking an array of medications already for concomitant illness and are reluctant to start yet another new treatment. 

Nevertheless the move to insulin therapy should not be delayed. Patients with poor glycemic control have a high mortality, a high morbidity, a low quality of life and increased healthcare costs (Dunn 2004).

HSE Midland Diabetes Structured Care Programme
The HSE Midland Diabetes Structured Care Programme is a primary care based programme dedicated to improving the quality of care for patients with diabetes. It is one of the longest established primary care based diabetes programmes in Ireland. Established in 1997/98 through a partnership between a number of general practitioners with an interest in diabetes, and the Midland Health Board Department of Public Health and Planning. Since 2001 the programme has been linked to the cardiovascular health strategy through the Midland HSE Primary Care Working group and in 2002 the programme was integrated into the national cardiovascular strategy secondary prevention programme: Heartwatch

This programme is developed within the context of all the relevant national policies, including the new Department of Health and Children document Diabetes Prevention and Model for Patient Care (2006). In addition, the operation of the Midlands HSE diabetes Structured Care programme is consistent with core goals in the National Health Strategy “Quality and Fairness A Health System For You” (2001), in particular the goals addressing responsive and appropriate care delivery, high performance and rigorous quality assurance: in essence the provision of “the right care in the right place at the right time”.

The programme is also in line with the Primary Care Strategy(2001), which highlights the need to develop multidisciplinary teams in primary care with the capacity to deliver care for patients with chronic illness such as diabetes in the
community. The programme also encompasses all the essential elements of a chronic disease care model (Tsai et al 2005).

There are approximately 2,500 patients with Type 2 diabetes enrolled in the programme and services are delivered to the patients through a network of 36 GP Practices. Primary care provides the only realistic setting for the care of the majority of patients with diabetes given the burden of diabetes in the community, a prevalence of 7,500 people diagnosed with diabetes in the midland region (Brennan et al 2005) and the fact that the Midland HSE area has no consultant provided endocrinology service.

A holistic team approach forms the basis for diabetes care delivery within the programme. This programme is delivered by the GP, practice nurse and diabetes nurse specialist providing regular patient follow up. In addition, at local level there is regular referral, follow up and recall of patients to members of the dietetic team, ophthalmic and chiropody services. This follow up care involves individual patient goal setting and active patient participation. All diabetes care is guided by clinical guidelines and supported by continued education and research. Quality assurance for the programme is achieved by frequent auditing.

The most recent audit findings were benchmarked against the National Diabetes Audit Report for England 2003/2004 and the results compare very favourably (Brennan 2005). The National Diabetes Audit Report For England included data from a quarter of a million people with diabetes. It involved 20% of primary care trusts in England and 1700 GP practices.

For almost all the process of care indicators the performance of the Midland Diabetes Structured Care Programme was significantly better. In a comparison of the outcomes of care, approximately 56% of patients registered in the English audit achieved the primary Hba1c target of 7.5%. In the Midland Diabetes Structured Care Programme the findings were similar with 54%. The data on B/P control and hypercholesteremia were also very similar in the two audits. These findings indicate that the Diabetes Structured Care Programme is committed to the provision of high quality care based on objective criteria that is benchmarked against national and international guidelines.

**Insulin Initiation in the Diabetes Structured Care Programme**

The Diabetes Structured Care programme facilitates the patients progression to insulin therapy by keeping regimens simple, having ongoing diabetes nurse specialist support, while still addressing all
aspects of metabolic control. In order to assess the quality of care and audit of outcomes of care for patients initiated onto insulin therapy was undertaken.

The Aim of This Study:

➢ To demonstrate that insulin initiation for patients with Type2 Diabetes can be managed in the General Practice Setting.

Objective:
➢ To evaluate process and outcomes of Insulin Initiation Programme for patients with Type 2 Diabetes in a general practice setting.
➢ To identify the benefits of insulin therapy for patients with Type 2 diabetes managed in general practice.

Research Design:
A quantitative design using an evaluative case study was chosen. Data were collected over a sustained period of time to assist in the evaluation of the insulin initiation process.

Sampling:
The sampling method was purposive. All patients with Type 2 diabetes who were started on insulin therapy in 2005 are included in the study. This includes 5 G.P practices with 14 general practitioners. A total of 15 Patients (7 female patients and 8 male patients) with Type 2 diabetes were referred to the diabetes nurse specialist for insulin therapy over a one-year period. The average age of the patients was 56 years. The oldest patient was 74 years and the youngest 33 years of age.

Ethical Considerations:
Ethical issues were considered for this study. All patients involved have given written consent to be part of the Diabetes Structured Care Programme and are aware that their data maybe used for research purposes. HbA1c blood results for data analysis are collated as part of routine care, thus no ethical issues needed to be addressed.

Data Collection and Analysis:
The clinical indicator of the Glycosalated Haemoglobin blood test (HbA1c) pre insulin therapy and 6 months post insulin therapy were used for data analysis. Data analysis involved SPSS version 12
Summary of Findings to date:

- Pre insulin initiation, participants' average HbA1c was 9.7% (range 8.1-12.2, SD 1.11.)
- 6 months post insulin initiation participants' average HbA1C was 7.7%. (Range of 6.0 -9.0 and a SD 0.86.)
- Prior to insulin initiation 80% of participants had an HbA1C of > 8%
- 6 months post insulin initiation insulin 20% had achieved the gold standard of 7%
- Another 50% had achieved an HbA1C of < 8%.

Conclusion

This study outlines that insulin initiation in patients with Type 2 diabetes can be successfully managed in a General Practice setting provided the necessary support mechanisms are in place for patients and staff.

The quantitative data indicate improved outcomes of care for the majority of patients initiated onto insulin therapy. The health gains are obvious in the context of recent evidence which shows reduced risk of up to 37% from microvascular complications with a HbA1c reduction of 1% (Holman et al 1998).

To date there has been no formal qualitative evaluation of the programme. However, anecdotal evidence in the form of observations and comments from the G.Ps and practice nurses has been very positive. Patients are very happy to have insulin therapy commencing in a primary care setting. They do not have to travel long distances or endure long waiting times in the hospital for a doctor /nurse they may not have previously met.

GPs have highlighted the benefit of starting patients on insulin therapy when patient need is identified, rather than having to give patients a hospital referral and wait for an appointment date.

Even though this study's results involves a small sample group, it represents a full years positive results of insulin initiation in the structured care project. This work involved one diabetes nurse specialist in the 4 LHO areas. As far as is known to the authors these are the only published results of insulin initiation in primary care health care setting in the republic of Ireland.

Insulin initiation in primary care is possible with the supportive team work from patient, GP, practice nurse, dietician and diabetes nurse specialist.

However the diabetes nurse specialist also faces challenges in her role of insulin initiation in primary care. If the GP,s are without the
support of the diabetes nurse specialist the GPs and practice nurses would have insufficient time to perform insulin therapy and provide necessary education and ongoing professional support. Some practice nurses may have insufficient skills or knowledge in the speciality of diabetes care and insulin.

Insulin initiation with the Diabetes Structured Care Programme is also a success because the patient is fully involved in the process and their success with insulin therapy is not just a reflection of the HbA1c blood result improving but how the patient actually feels is also taken into account. The diabetes nurse specialist has the time, knowledge and skill to guide and support the patient and his/her family.

Finally, insulin initiation within the Diabetes Structured Care Programme offers patients a positive choice in the development of their treatment and in doing so can make a significant difference to their quality of life.
References:


Nursing children with “life-limiting conditions”- results and discussion of the findings of a nursing research study in Ireland.

Ms Honor Nicholl RGN, RSCN, RCNT, RNT. BSc., MEd.
Lecturer
School of Nursing and Midwifery,
Trinity College, University of Dublin,
24 D'Olier Street,
Dublin 2.
Ph: 6083702
Email: nichollh@tcd.ie

Background and context.
The terminology for children with life-limiting conditions is complex. Sutherland et al (1994) suggest that caring for these children may be impacted upon by the lack of an agreed set of working definitions for such basic terms as child, life-limited and palliative care. In 1997 The Royal College of Paediatrics and Child Health and ACT (ACT1997) established a classification system and defined four groups of life-limiting conditions. The aim of this research study was to identify the specific terminology used by nurses caring for these children in Ireland.

Methodology including research design and sampling.
This descriptive exploratory study used a quantitative approach. The objectives were to identify the terms used by nurses caring for life-limited children; to clarify the use of terms reported in the literature and to identify other terms specific to the Irish context. Data was collected using a structured questionnaire administered by telephone interview. Convenience sampling was used. Initial “snowballing” created a total sample of 152 nurses, of whom forty-six provided data for the study.

Analysis
Quantitative data was analysed using MS Excel. Simple descriptive statistics were used to categorize the terminology and the frequency with which the terms were reported.

Summary of key findings
The results indicate that a range of terms (including those found in the literature) are used when referring to children in the four groups described by The RCP&CH and ACT (1997). The terminology reported by nurses in this study includes terms used in the literature. Terms used include the “child’s diagnostic label” (or derivations of it) and chronic illness.
Conclusions
This study suggests that no standardised terminology is used by nurses for life-limited children in Ireland and a range of terms is reported. This confusion in terminology may impact on the delivery of care, communication, and the provision of services, funding and equipment (Watson, Townsley and Abbott 2002).
Challenges, dilemmas and insights emerging from nursing research studies involving mothers - “the researcher experience”.

Ms Honor Nicholl  RGN, RSCN, RCNT, RNT. BSc., MEd.
Lecturer
School of Nursing and Midwifery,
Trinity College, University of Dublin,
24 D'Olier Street,
Dublin 2.
Ph: 6083702
Email: nichollh@tcd.ie

This paper has arisen out of the experiences of a nurse researcher undertaking a Doctoral study focused on exploring the experiences of mothers in caring for children in Ireland. Interviews have been undertaken with a group of seventeen mothers of children with complex needs who require significant technical and personal care at home. The aim of the paper is to outline some of the key issues that emerge in undertaking research studies where the respondents, as mothers, lead lives that are focussed on care giving for children with complex needs including rare metabolic and genetic disorders.

The researcher in this study was faced with the dilemmas of researching a group who, while telling their stories in research interviews, simultaneously had to meet the demands of care giving and family life.

The challenges this presents to the interviewer (both as a researcher and Children’s nurse) at the pre-interview, interview and post-interview phases will be reported and discussed. These include the issues of recruitment, gaining consent, developing trust, managing the interview situation and professional issues that expectedly and unexpectedly surface during data collection.

In this presentation the subsequent dilemmas, challenges and insights which emerge when consent has been obtained, trust has been developed and the data is being collected will be explored.

Researchers undertaking similar research studies will be invited to discuss their experiences as part of the presentation in order to assist others who may be involved in this type of project.
Interviewing peers and colleagues in nursing research studies—“experiences from the field”

Ms Honor Nicholl  RGN, RSCN, RCNT, RNT. BSc., MEd.
Lecturer
School of Nursing and Midwifery,
Trinity College, University of Dublin,
24 D'Olier Street,
Dublin 2.
Ph: 6083702
Email: nichollh@tcd.ie

Dr Catherine Tracey  PhD, MSc, MBA,RGN,RPN
Freelance Nurse

Gubrium and Holstein (2002) suggest that the “interview is simple and self-evident where the interviewer coordinates a conversation aimed at obtaining desired information” (p3). However, Brannen (1988) outlines a range of issues which arise when interviewing is used to research topics that are highly personal, threatening or confidential.

Little is reported in the research literature, however about the potential issues that may emerge in research studies when professional colleagues are the subjects of data collection and potentially “symmetrical relationships exist” between the researcher and the researched. It is suggested that there are some specific considerations of which interviewers need to be aware with respect to interviewing colleagues or peers in nursing research studies.

In this paper the presenters will outline their experiences in completed and ongoing Doctoral studies of using three different interviewing approaches (namely elite, structured and unstructured interviewing). Based on this the presenters will discuss their experiences of professional, ethical and pragmatic issues that have emerged when using this method of data collection in nursing research studies.

The unique issues and dilemmas in undertaking research with these groups include professional conflicts and tensions in data collection, power and dealing with, the operation of power and conditions under which interviewing took place control in the interview, the use or abuse of self-disclosure and ethical issues in data dissemination.
The researchers’ experiences in interviewing professional nursing colleagues, elites and vulnerable respondents will be used to create a problem-solving discussion forum for others planning similar studies.

This discussion will include some of the practical implications that need to be addressed when planning and undertaking interviews with these groups.
Critical thinking in nursing education and practice– A literature review.

Mr Tom Noone RGN(Hons) RPN(Hons) RNT/BNS(Hons) M Med Sc(NUI)(Hons) MA(DUBL)
Lecture School of Nursing & Midwifery
Trinity College Dublin 24 D’Olier St Dublin 2
Contact 896 3535 Noonet@tcd.ie

ABSTRACT

Aim of Review
This literature review explores critical thinking in the humanities arts and education. While providing a perspective on critical thinking in these areas moreover it aims to provide a perspective on the status of critical thinking in a nursing context.

Search & Review Methodology
Literature spanning the last decade in humanities, arts, education and nursing was searched. A review of the literature sourced provided a perspective on critical thinking in these domains and allowed a comparison between the position of critical thinking in nursing and other human sciences.

Summary of key findings
It is evident in the literature that critical thinking is of concern in the disciplines of psychology, sociology, education, health education and nursing. Definitions of critical thinking which are many and pervasive are given in the literature. Attempts to demystify critical thinking suggest the cloudiness surrounding it (Halonen, 1995). Attempts to differentiate between lower and higher order thinking as well as problem solving aim to provide clarity when critical thinking is considered (Lewis & Smith, 1993). Further insight into critical thinking is reflected in Paul’s conception of reasoning related to critical thinking (Broadbear and Keyser, 2000). There is emphasis on critical thinking in the area of teaching and learning and the challenge for students (McKendree et al., 2002). In the context of nursing critical thinking is evident in educational approaches (Ironside, 2005). This review of the literature reveals that critical thinking is of concern to many disciplines with emphasis of its importance in education coming to the fore.

In nursing the challenges of and the need for nurses to challenge nursing practice is important for The advancement of nursing practice and the nursing profession requires nurses to be critical
thinkers. Nurses can be enabled to become critical thinkers through nurse education and this is a challenge for nurse educators. This literature review acknowledges critical thinking in context of nurse education which ultimately informs nursing practice.

References


Ironside, P. M. (2005) Teaching thinking and reaching the limits of memorization: Enacting new pedagogies Journal of Nursing Education. October No. 44 Vol, 10 pp 441 -


How Adult Are Our Learners?

**Dr Peter Norrie**  
Senior Lecturer  
Charles Frears Campus  
De Montfort University  
266 London Road  
Leicester LE2 1RQ  
England  
+ 44 116 201 2914  
pnorrie@dmu.ac.uk

**Background and context:** Authors such as Knowles (1998) and Daines et al (2002) have proposed the characteristics of adult learners. What is less certain, is the progression undergraduate nursing students make as they move along their academic journeys, from being reliant upon teacher centred learning, through to the ability to be autonomous learners. This may be exemplified by a move away from highly structured teaching methods, to more explorative and less formal ones.

**Aim of the study:** This presentation will explore whether this progression occurs across an undergraduate nursing programme.

**Methodology:** Two phases of research have been employed. Focus groups within an HEI have been used to identify the characteristics of adult learners, based upon Knowles’ model. These themes were incorporated into a Likert scale questionnaire. In addition, space was left for open ended questions and demographic data. The sample was inclusive across three cohorts of an undergraduate nursing programme (n=555, return rate= 57%).

**Summary of key findings:** Using non parametric data analysis, there were no significant differences within the sample with reference to gender or branch. This primary result was largely supported by the qualitative data.

Some significant differences were present with reference to age and year of study, but these suggest that students regress from the characteristics of the adult learners within these parameters. Some significant differences were present with reference to ethnicity, some ethnic minority students were more willing to add to learning with independent study.
Conclusion:
The research findings do not conform to predictions based upon Knowles’ model. There is no evidence that students gain more of the characteristics of andragogy as they progress through their studies. Instead there is some evidence that students become less willing to take responsibility for their learning. This is of concern to all involved in health education.
Title: Highly skilled Jugglers: Mature women in nurse education programmes.

Frances O’Brien: RGN; DNS; BNS; RNT; MA (Adult & Community Ed), Lecturer, School of Nursing & Midwifery, Trinity College Dublin, Email: obrienfr@tcd.ie

Brian Keogh: RPN; BNS; PGDip (Education); PGDip (Stats); MSc (Adv Nursing) Lecturer, School of Nursing & Midwifery, Trinity College Dublin, Email: keoghbj@tcd.ie

Kathleen Neenan: RGN; RSCN; RNT; BNS; MSc, Research student, School of Nursing & Midwifery, Trinity College Dublin, Email: kaneenan@tcd.ie

Background and context: The literature suggests that there are gender differences in the types and extent of problems experienced by mature nursing students. These gender differences present as barriers to female mature students consequently making them more vulnerable to poor academic performance and high attrition rates.

The Aim of the study: The aim of the study was to gain an understanding of mature women’s experiences on a pre-registration nursing degree course.

Methodology including research design and sampling: A qualitative descriptive method was utilised to guide the research with focus groups being the method of data collection. A total of three discipline specific focus groups were completed. Purposive sampling was used to recruit the participants. Current mature students registered on the General, Psychiatric and Intellectual Disability strands of the programme, in one large university were invited to participate.

Analysis of the data: Data was analysed using content analysis.

Summary of key findings: Findings revealed that most female students encountered problems related to relationships with partners, domestic duties, time for social activities and issues surrounding childcare. These themes were consistent across the disciplines.

Conclusion: The findings of this research highlights that although all mature students are faced with a multitude of barriers, female mature students have to cope with multiple role demands that stem from their gender. Considering the majority of mature students on the course are women, the findings of this research would suggest
that a more student centered, flexible programme is required if more mature women are to be encouraged to undertake nurse education programmes in Ireland.
Title: Evaluation of the Acute Paediatric Link Nurse (APLN) Service in a Regional Hospital of the Health Service Executive.

Authors:
Petrina Duff, M. Sc., Research Officer, Clinical Audit & Research, HSE-Dublin Mid Leinster, William Street, Tullamore, Co. Offaly (Tel. 057 9327924; Email: petrina.duff@mailq.hse.ie).

Elaine O’Brien-Doyle, RGN, RCN, H. Dip. Paediatric Oncology, Acute Paediatric Link Nurse, Paediatric Unit, Midland Regional Hospital Portlaoise, Co. Laois (057 8621364; Email: elaine.obriendoyle@mailq.hse.ie)

Background: The APLN service was established within the HSE in 2004 on a pilot basis. The background to the development of the post was based on two objectives as follows:
• to reduce hospital stays for chronically ill children and children with oncology needs, and
• to minimise the number of visits by these children to services, which heretofore would be classified as chronic users of the services.

Aim of the Study: To evaluate the role of the APLN for chronically ill children and children with high dependency needs on the health services within a local area of the HSE.

Methodology: To ensure a comprehensive evaluation, the target population was not sampled but was divided into two distinct groups, i.e., parents of children using the service and healthcare professionals working and liaising with the APLN. Quantitative structured questionnaires were sent to both groups. The questionnaire was developed from five different scales identified in the literature. Both questionnaires focussed on the perceptions of, attitudes to and experiences of users of the APLN service. In addition, data from the Patient Admission System was used to determine any reduction in bed occupancy.

Analysis: All data was analysed using SPSS.

Summary of key findings: The results demonstrated very high levels of satisfaction from both the parents and professional’s perspective with the APLN service as it currently operates. Almost 92% of parents agreed that they were totally satisfied with the care they had received from the APLN service since leaving hospital. All parents agreed that they would recommend the service to other parents. Just over half (54.8%) of professionals agreed they had...
observed a reduction in hospital stays and 54% agreed they had observed a reduction in visits. Almost 92% of professionals agreed they would recommend the service to other hospitals. Areas for improvement were suggested, e.g., the need to communicate the function and role of the APLN with ward staff. The results from the current research compare very favourably with previous research in this area.

**Conclusions:** The main conclusion coming from the research is that the APLN service be continued, expanded and re-evaluated in two years.
What are the meaning and experiences of bullying for nurses registered with A Bord Altranais in Ireland?

Teresa O Callaghan
Clinical Nurse Tutor
School of Nursing and Midwifery
Trinity College Dublin
Trinity Centre for Health Sciences
St James's Hospital
Dublin 8
Ireland
EMAIL ocallat@tcd.ie OR 01-8964020

Introduction
The aim of this study was to establish, what the meaning and experiences of bullying behaviour for nurses in Ireland who are registered with An Bord from both academic and hospital setting perspectives including all grades. Bullying in the workplace has being recognized as an important issue by trade unions in recent years. Several qualitative reports have graphically illustrated the pain, mental distress, and career damage suffered by victims of bullying, however academic study only began recently. Bullying presents considerable methodological problems for researchers. A central difficulty is that of definition, as no clear consensus exists on what constitutes adult bullying. There have been three main approaches to researching workplace bullying. The first has being qualitative and individual in perspective, secondly a descriptive and epidemiological approach has been used and the third approach is influenced by theories and constructs in organizational psychology. This study proposed to use a quantitative survey approach to elicit what are the meaning and experiences of bullying for Irish nurses.

Purpose of the study
- to examine nurses perceptions of bullying behaviour
- to explore eth meaning of this behaviour in terms of job satisfaction, propensity to leave and the reporting of this behaviour
- to examine the effects of bullying on the nurse
- to examine the effects of bullying on the environment
- to explore what issues surround reporting bullying behaviour

Methodology
The design of this study was guided by a cross sectional comparative descriptive survey methodology. The instrument
employed to carry out this study was a quantitative questionnaire devised by Quinn (1999) for a similar study in the United Kingdom. The questionnaire comprised of three main sections with closed ended questions, scales and an optional comments page.

**Sample and response rate**

The sample chosen for this study aimed at reflecting all divisions of the nursing profession. They included registered general nurses, midwives, sick children’s nurses, nurse tutors, college lectures and public health nurses. An Bord Altranais agreed to provide a sample of 250 nurses from the 2003-2004 active register.

The sampling technique used in this study was a simple random sampling technique of which only An Bord Atrainis personnel could have access to. A total of 151 (76%) nurses responded to the questionnaire.

The data illustrated that 91.1% (141) of the respondents were females and 10.1% (11) were males. The respondents comprised of 90 (72%) staff nurses, 14 (13%) clinical nurse managers, 12 (9%) clinical nurse specialists, 2 (1%) nurse lecture, 4 (2%) directors of nursing, 1 (1%) school nurse, 1 (1%) nurse administrator and finally 2(1%) community nurses. The analysis for this study employed the use of SPSS version 10. Independent reliability and validity tests were carried out to justify the tool for this study. (I will elaborate on this further on poster, or send it to you full draft if you wish in the near future)

**Findings**

The finding from this study revealed that 48% (n=72) of the respondents reported experiencing bullying by peer, senior staff or managers in the past twelve months. 72% said that they had being singled out and bullied while 28% said they were bullied as part of a group. In this study respondents indicated that a colleague was the most common perpetrator in the workplace, with a senior manager coming next in line. Relationships between bullying and occupational outcomes were examined by correlational analyses, using cross tabulation t tests and independent t test. Staff who experienced bullying by peers, senior staff and managers in the last year, reported significantly lower levels of job satisfaction compared with those who reported having never being subjected to bullying. Pearson’s Chi Square value at 0.001 illustrates the strength of these variables. Additionally 83% of those who reported experiencing bullying had significantly higher levels of job induced stress ( p<0.040).also there was a significant correlation between those who experienced bullying and who were extremely likely to think about leaving their jobs (p<0.001, 57%). From those who
reported being subjected to this behaviour 69.1% felt like not going to work, 69.5% were thinking about leaving their jobs, and 58% reported feeling miserable and symptoms of clinical depression.

**Bullying and Stress**

Respondents who were bullied in the last year were cross tabulated with changes in levels of stress related to their jobs. Chi Square Tests reported a significance of 0.040 between these two variables. Therefore, nurses who have experienced bullying at work in the last year also reported significantly higher levels of stress in their jobs.
Job Satisfaction and Experiencing Bullying By Peers And Seniors.

Cross tabulating job satisfaction and being subjected to bullying by seniors over the last twelve months indicated a significant relationship existed. Pearson’s Chi Square test produced a p value of .001 between these two variables. Of the total number who responded to this question (n=145, 95.4%), 68% (n=17) who are
bullied a few times and frequently are dissatisfied in their jobs, while 82\% (n=98) who are satisfied in their jobs are rarely or never bullied.

**Bullying and Job Satisfaction**

![Bar chart showing the relationship between bullying and job satisfaction.]

**Job Satisfaction**

**Bullying and Work Environment**

![Bar chart showing the relationship between bullying and work environment.]

I feel that I work in a supportive environment.
Bullying and Stress Levels

Actively Looking For a Job in the Next Year and Experiencing Bullying By Peers, Senior Staff and Managers.

Cross tabulation and chi square tests were undertaken to see if any correlation existed between those who will actively look for a different job in the next year and those who are subjected to bullying from peers and seniors in the last year. There was a significant relationship found between these two variables (p=0.003). This demonstrated that 79% (n=74) of respondents who rarely or never experience bullying in the last year are unlikely to look for a job in the next year, compared with 50% (n=18) of respondents who have experienced bullying a few times and frequently in the last year are more likely to actively look for a job in the next year.
Bullying and Thinking of Leaving Current Job

![Bar chart showing the relationship between bullying and thoughts of leaving the job. The chart indicates that a higher percentage of those who are bullied often/all the time think about leaving their job frequently.]

**Thinking About Leaving Their Jobs And Experiencing Bullying From Peers And Seniors.**

Bullying and Thoughts of Leaving your Job

![Bar chart showing the relationship between bullying and thoughts of leaving the job. The chart indicates that a higher percentage of those who are bullied frequently think about leaving their job often/all the time.]

**Think about leaving your job**
Being Bullied and the Likelihood of Looking for a New Job

Chi square tests were undertaken to see if there was a significant relationship between these two variables. Pearson’s test produced a p value of .001 illustrating a significant relationship between those who experience bullying and who are currently thinking about leaving their jobs. The majority of nurses who think about leaving their jobs frequently and all of the time have experienced bullying a few times and frequently over the last year (57%, n=20), in
comparision to those who have rarely or never experienced bullying and rarely or never think about leaving their jobs (87%, n=54).

**Currently Experiencing Bullying And Did It Affect Health**

Cross tabulation of nurses who are currently experiencing bullying and did it affect their health were undertaken. Pearson’s Chi Square test reported a highly significant relationship (p=0.001) between these two variables. 78% of nurses who experience bullying frequently report a significant impact on their health. 41% of nurses who rarely experience bullying also report that it has an impact on their health also. The data also revealed that 76% of those who witness bullying a few times and frequently are dissatisfied in their jobs (p=0.019).

The Effect of Bullying on a Persons Health

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<th>Frequency of Bullying over the last year</th>
<th>Health Effects</th>
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<td>A few times</td>
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<th>Frequency</th>
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<td>Rarely</td>
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<td></td>
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<tr>
<td>A few times</td>
<td>38</td>
<td></td>
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<tr>
<td>Frequently</td>
<td>22</td>
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- 594 -
Who Bullies In The Workplace
The data showed that the majority of respondents indicate that the most common person to bully in the workplace is a colleague.
accounting for 42% of the bullies, with senior staff and management next in line (37%).

Who Bullies in the Workplace?

Most Frequently Reported Bullying Behaviours
The most frequently reported bullying behaviours reported in Ireland were (!) undue pressure to produce work (38.0% n=58), shifting of goal posts without telling you (32.9% n=49), with holding necessary information from you (32.2 % n=48) and constantly undervaluing your efforts (26.7% n=39).
REPORTING BULLYING BEHAVIOUR

This study identifies that 95% (n=37) of nurses reported the experience of bullying to a friend or colleague. 67% (n=33) of the respondents confronted the bully, and 53% (n=31) spoke with managers. The data also shows that the majority of cases were not reported formally either to a union representative or by making a formal complaint.
Conclusion
To conclude, this study supports national and international research findings that bullying at work affects the physical and psychological well being of victims and can threaten to destroy their careers. Furthermore, workplace bullying impacts negatively on organisations. There is inconvenience and inevitable cost of staff turnover and litigation costs. The effects of bullying at work seem to have high implications for staff retention in nursing. While awareness of this problem is apparent in this profession, there have been some provisions made to deal with in Ireland by the production of the Dignity at Work Policy (2004).
Scoping the availability and state of readiness of cardiac care equipment in General Practice premises.

AUTHORS

Mrs. Carol Oldroyd  BSc.(Hons), RGN, PGCE, RNT
Senior Lecturer in Cardiac Nursing

Mrs. Alison Day (nee Middleton)  MSc., BSc.(Hons), RGN, RN, PGCE
Senior Lecturer in Emergency Nursing

Professor Tom Quinn  MPhil, RN, FESC, FRCN
Professor of Cardiac Nursing and Director, Applied Research Group in Emergency Cardiovascular Care

Mrs. Sonia Godfrey  MSc., BSc.(Hons) Nursing, SRN, OND, NDN, Cert. Ed., PWT
Associate Head of Nursing, Midwifery and Health care

School of Health and Life Sciences
Richard Crossman Building
Coventry University
Priory Street
Coventry
CV1 5FB

Background and Context
Cardiovascular diseases are the most common cause of premature death in developed countries. Much of the initial assessment and longer term management is undertaken in the primary care setting but little is known about the availability and state of readiness of cardiovascular diagnostic and monitoring equipment in general practice premises. The local Cardiac Network commissioned a study to scope the availability and state of readiness of cardiac equipment in 170 general practices across four local Primary Care Trusts.

Aim of the study
To assess the availability and state of readiness of electrocardiogram (ECG) machines, Holter monitors (24hr tapes), blood pressure machines – both static and ambulatory - and defibrillators in general practice premises in one managed clinical network in England, resulting in recommendations for the future provision of equipment, maintenance and training within the Network.
**Methodology**
Practices were surveyed using a structured questionnaire, which was mailed to all practice managers identified by the Network. A generic reminder was issued to all practices two weeks after initial distribution, a further final reminder to individual non-responding practices was issued two weeks thereafter.

**Analysis**
Data was analysed using SPSS version 12.0 under supervision of a qualified statistician.

**Summary of key findings**
The project yielded a response rate of 75 (44%). Results indicated that both provision and training of the identified cardiac equipment is variable resulting in the recommendation that standardised guidelines would be beneficial in relation to population characteristics, list size and availability of resources. The need for provision of AEDs requires further risk assessment to determine the appropriateness. Practice nurses/managers should be the initial point of contact in relation to the provision, maintenance and training of the equipment. Training needs analysis and auditing of diagnostic interpretation should occur given the issues around skill retention in resuscitation and 12-lead ECG interpretation.
The Buffalo Jump: Rurality, masculinity, and gender negotiation

Author: Chad E. O’Lynn, PhD, RN

Abstract

Considering the realities of an aging American population, the anticipated growing need for informal caregivers, the substantial numbers of men caring for loved ones at home, and the challenges of health and human service delivery in rural areas, nurses should be concerned that virtually nothing is known about how rural men implement caregiving. The paucity of knowledge regarding this group of caregivers may mask a looming men’s health issue, which if not explored, will affect these men and their care recipients. This qualitative study used constructivist grounded theory methods to explore the experiences and process of caregiving for rural men. Twelve male caregivers residing in frontier areas of Montana and Oregon, recruited from newspaper advertisements, provided interviews lasting from 45-120 minutes in total. The participants had provided care to female family members for between 1-28 years. From the data, a theoretical model was constructed proposing how rurality and rural masculinity influence caregiving. For these participants, challenges attributed to caregiving, rural masculinity, and rurality increased stress and pushed caregivers toward crisis. Specifically, stress increasing attributes associated with rural masculinity include an overly-independent self-reliance characterized by a resistance to relinquish control and an unwillingness to ask for help; a neglecting of personal emotional needs; and a neglecting of personal health needs. Stress increasing attributes associated with rurality include isolation and, for some, an outsider status. Resources attributed to financial sources, rural masculinity, and rurality reduced stress. Specifically, resource attributes associated with rural masculinity include a self-reliance characterized by a work-action orientation; a value placed on hobbies and the outdoors; a value placed on common sense; and a
self-perception of a provider role. Resource attributes associated with rurality include a self-reliance characterized by a willingness to engage in hard work, pervasive community support, faith, and a belief that one should take care of one’s own family members. Increased caregiver demands required participants to adopt perspectives and behaviors inconsistent with personally-constructed gender. With increased levels of stress, participants negotiated conflicts with constructed gender in one of three ways: gender conflict preservation, which facilitated movement toward caregiver crisis; gender compromise, which facilitated an adaptive state in which men tolerated gender conflicts in order to achieve completion of caregiver tasks; or gender reconstruction, which facilitated a change in individual constructed gender and led to a state of resiliency. This latter process instilled a realization of the importance of the affective quality of the caregiving experience. Participants did not negotiate rurality attributes in a similar fashion. A generic model was proposed for transferability to other caregiver populations. Uniquely, this study considers gender and culture as holistic contexts and offers a theoretical explanation to the behaviors and perspectives involved with male caregiving over time. In addition, this study uniquely provides self-reported attributes of rural masculinity. The findings are supported by the extant literature of gender ideology theory. Health and human service providers should examine attributes of constructed gender and culture for the appropriateness of fit of caregiver support services.
An Advance Practice Nurse Led Interdisciplinary Palliative Care and Case Management Model for Chronically Ill Elderly Patients in an Emergency Department at Montefiore Medical Centre (MMC), Bronx, New York:

Sean O’Mahony, MB BCh BAO

Marlene E. McHugh MS, RN, FNP, DrNP©

Palliative Care Service
Montefiore Medical Center
Palliative Care Service
3335 Steuben Ave
Bronx, NY 10467
USA

Background and context
MMC is a 1062-bed academic medical centre in a low-income minority community.

Aim of Study
1. To improve the quality of care for elderly patients visiting the ED.
2. To enhance access to home care and hospice for elderly patients.
3. To impact on the use of the acute care setting for elderly patients admitted from the ED.

Methods
1. Retrospective review of the clinical information systems for 125 patients who visited the ED in 2003.
2. Analysis of charge data for 3297 patients who visited the ED in 2002 and 519 patients served by the project in 2005-06.
3. Prospective quality-of-life interviews of patients and satisfaction surveys of patients and families.

Results
519 patients have been served by the project’s nurse practitioner and 214 referred for Home Care and 233 referred to Hospice. Thirty four percent had family member living with them and 70% were unable to take oral medication on own. More than half rated their overall quality- of-life as poor. Only 2% had hospice at home at baseline. 30% of patients died within 12 months of the index ED visit.
59% had their presenting problem for more than 24 hours prior to their ED visit. One third of patients with pain had analgesic
medication in use. Median time to discharge from MMC has decreased by one day for patients served by the project.

**Conclusion**
1. Elderly patients visiting the ED have significantly unmet homecare and palliative care needs.
2. Hospice is underutilized by this population
3. Thirty percent of elderly patients visiting the ED in 2002 died within one year.
4. There have been reductions in hospital length of stay for patients served by the project.
5. This project has been successful in linking patients to home care and hospice services.
A Partnership Initiative in the Primary Health Care Setting
- Exploring the involvement process.

Ms Ann O'Neill, Dip in PH Nursing, MSc in Primary Health Care
Public Health Nurse
HSE South Western Area, Community Health Services
Rowlagh Health Centre
Clondalkin
Dublin 22
Ireland
+ 353 86 8535026
anng.oneill@mailm.hse.ie

Abstract
The purpose of this study was to explore the involvement process of a partnership initiative in the Primary Health Care setting. The Clondalkin Travellers Primary Health Care Initiative is a partnership between Health Service Executive-Dublin West Area and a community development group.

Rationale:
Current health care policy in Ireland promotes Partnerships as the preferred way to plan and deliver health care services. Despite the increased policy shift in recent years towards working in partnerships, translating the theory of the partnership approach into practice is proving a considerable challenge. This research provides some lessons learned from the practical experiences of those involved in a working partnership.

Methods:
In the study I utilised a qualitative methodology, using a combination of semi-structured interviews and a focus group discussion. Interviews and group discussion were transcribed and analysed using a framework analysis.

Key Findings:
This study found that the involvement process was effective, and the partnership, a model of good practice that could be built on. Positive outcomes of the process include improved attitudes and working relationships among the partners, greater awareness of Travellers issues by Health Board members as well as the tangible outcome of Travellers trained and working as Community Health Workers.
The involvement process became less dynamic over time because of a number of issues such as the lack of joint training, frequent changes in Health Board membership and the lack of support and value given to Health Board staff to participate.

There was a shift of power towards the community group in relation to the planning and decision making aspects of the initiative. While this shift in power could be seen as a positive outcome if planned, it appears to have happened by default rather than design.

**Conclusions:**
This study shows that despite its weaknesses, difficulties with participation and lack of real understanding on some issues the involvement process has been effective and that translating policy into practice can happen.

Advice to future partnerships includes the need for senior people who can make decisions, and to clarity aims and roles. Recommendations for the Health Service Executive include providing staff training in community development, and adopting a culture of empowerment and partnership within the organisation.
1. Introduction & Significance of the Study

A partnership initiative in the Primary Health Care setting - Exploring the involvement process.

Community participation in health is stated in the Alma-Ata declaration of 1978 as
‘The people have the right and duty to participate individually and collectively in the planning and implementation of their health care’. Some 27 years on, the amount of community participation and partnerships in health care that has been achieved is limited, why?
Since the Alma-Ata Declaration, community participation and partnerships have slowly gained momentum throughout the health care services both at national level and internationally, assisted in part by the development, growth and success of economic and social partnerships within and among countries.
In Ireland, partnership with the European Union has been a major feature of economic and political success and the social partnerships have ensured stability and the Celtic Tiger phenomenon.

1.1 Partnership in Health Care.

Partnerships have slowly developed and become key aspects within the Irish health care system, and will play an even greater role with the implementation of the National Health Strategy and Primary Care Strategy. Community participation is one of the key principles of the Health Strategy Quality and Fairness: A Health System for You in the provision of a people-centred health service, and provides a challenge to health services.
The term community participation can be defined as a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.

There are different methods of partnership structures in existence within the Irish health service and many levels of engagement. One such level is that of community involvement in using a community development approach to health that involves local people coming together to identify their own health concerns and needs, to support and facilitate them to find solutions and take action in tackling health issues that concern them.
Clondalkin Travellers Primary Health Care Initiative, in which Travellers have developed and are delivering a programme of primary health care to their own community, is an example of such an approach.
1.2 Introduction to author and background to the study.

My initial interest in community participation began when I trained as a Public Health Nurse in 1989, prior to which I quite happily worked in the hospital hierarchal setting where ‘the doctor and nurse knew best’ idea went unquestioned by all. As a new Public Health Nurse full of enthusiasm to work with the community I couldn’t wait to conduct a ‘community health assessment with the community’. However the reality of a reactive service soon set in; increasing clinical and child health demands and reducing staffing levels left little time for community health assessments, I put my head down and got on with the job.

After a few years in Public Health, working in a variety of caseloads including Travellers, I asked to work as the designated Public Health Nurse for Travellers. During this time I became acutely aware that I alone did not have the ability to address the health needs of the Travelling community, and that there was quite a gap between my perception of their needs and their perception of their health needs. This realisation opened my mind to the idea of a community development approach of involving Travellers in their own health care.

At the same time the National Health Strategy 1994, highlighted the need for innovative ways of addressing Traveller health issues through partnership and participation of Travellers themselves. Pavee Point (a community development project) and the then Health Board, set up the first Primary Health Care Initiative for Travellers in 1994.

In 1996 following initial meetings with the Director of Public Health Nursing, the local Traveller support group and myself, a steering committee was set up to develop a Primary Health Care initiative for Travellers in the Clondalkin area of Dublin.

1.3 Clondalkin Travellers Primary Health Care Initiative.

Clondalkin Travellers Primary Health Care Initiative is a partnership between the Health Service Executive (HSE)-Dublin West Area and Clondalkin Travellers Development Group and is managed by a joint steering committee with representation from both partners.

Who are the representatives?

Health Service Executive- Dublin West Area.
When the partnership began Dublin West Area was know as Community Care Area 5, and while the name and some of the staff
have changed, the representatives involved in this initiative are the local Managers of the Community Health Services. These include the Area Administrator, Director of Public Health Nursing, Area Medical Officer and the overall General Manager for the Area who is not presently involved directly, but whose predecessor was in the early stages.

During the period of gathering the data for this study the ‘Health Boards’ were disbanded and the Health Service Executive (HSE) was established. For clarification purposes I have decided that the words ‘Health Board’ will be used throughout this study, to describe the then Health Board and the present HSE, Dublin West Area.

Clondalkin Travellers Development Group
Clondalkin Traveller Development Group (CTDG) is a community project with workers from both the settled and Traveller communities employed. CTDG aims to promote the social, economic, educational, health and cultural interests of Travellers as a nomadic, ethnic group within Irish society. The organisation is involved in a range of activities including development of programmes and activities for Traveller men, women and young Travellers, development of links at local and national level, delivery of training programmes and campaigning and lobbying activities in relation to accommodation issues, education and health, legislation and access to services and facilities.

The partnership process of the initiative began in early 1996 with the two partners coming together to draw up a proposal and set up the training initiative. The Steering committee was set up to be responsible for the overall management, co-ordination and implementation of the Primary Health Care Initiative.

The aims of the Clondalkin Travellers Primary Health Care Initiative which were developed and agreed within the partnership are:

1. To contribute to the improvement of Travellers health through informed health care, self-care and mutual aid.
2. To develop an outreach and localised service where primary health care workers are of the same culture as the recipients of care.
3. To work towards the elimination of the barriers of access to health services that exists.
4. To liaise and assist in creating dialogue between Travellers and health service providers in the area.
5. To develop the skills of Traveller women in providing community based health services
6. To impact on health policy development at local and national level
In November 1997 after nearly a two year process, the Health Board approved the project and training began in January 1998 for a period of 3yrs. In June 2001 six Traveller women qualified as Community Health Workers, and are presently employed by the Health Board providing a peer-led health service to Traveller families in the area. The initiative is still managed and supported by the steering committee, a partnership of the key stakeholders from the Health Board and the community development group.

I have been the Health Board co-ordinator for the initiative since it started in 1996, have experienced the pros and cons of the partnership over the last 8yrs and would be an advocate of community participation and partnerships within all aspects of health care.

Consequently, with the increased policy and cultural shift towards working in partnerships, health professionals are required more and more to use a philosophy of partnership and participation in their practice, however there is still a resistance by health service providers to engaging effectively with communities. Many health professionals have not been educated in participation. Traditional health education has focused on 'doing for' rather than 'working and being with' people.

The Office of Health Management commissioned a discussion paper on ‘Public and Patient Participation in Healthcare’ in response to the proposals for people-centered care outlined in Quality and Fairness to assist health managers to contextualise the proposals set out in the health strategy, to provide examples of good practice and identify principles of partnership to guide developments in this area.

Although the theoretical, philosophical, and practical components of community participation are well articulated, there are few examples that illustrate the experience of initiating and working within a participative project. Clondalkin Travellers Primary Health Care Initiative is one of the few examples of such a partnership in health service delivery in Ireland today, it is therefore important to look at this partnership and see if it is an example of good practice and if there are lessons to be learned for future partnerships.

1.4 Aim of the study

The purpose of this study is to explore the involvement process within the partnership responsible for Clondalkin Travellers Primary Health Care Initiative. To review the experiences of the individuals
from the Health Board and the Clondalkin Travellers Development Group (CTDG), and those lessons learned can guide, support and encourage other health service providers to become more active in community health partnerships.

**Research Question**

How effective has the involvement process been within the Clondalkin Travellers Primary Health Care Partnership?

### 2. Literature Review.

Within my literature review I will clarify the following:

- An understanding of community participation and partnership
- Evidence of Partnerships in Primary health care, International and Irish setting.
- The involvement process of Partnerships
- Current Guidelines on developing Partnerships
- Methodological aspects of literature reviewed

#### 2.1 Understanding Partnership, and community participation.

When setting about this research proposal I found myself interchanging the terms “community participation” and “partnerships”, so it is important to clarify them.

#### 2.1.1 Community Participation in Health.

Community participation was recently defined as: ‘A process through which the community will gain greater control over social, political, economic and environmental factors that determine their health status’

As early as 1948 the WHO’s Constitution states, “Informed opinion and active co-operation on the part of the public are of the utmost importance” in improving health. However it was not until the 1960s and early 1970s that the practical benefits of community participation in and ownership of health projects began to attract increasing attention.

The Alma Ata declaration and concept of community participation is, ‘Primary health care requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of primary health care, making fullest use of local, national and other available resources, and to this end develops through appropriate education the ability of communities to participate’ this was initially taken up by the developing world providing local health care to rural and under
serviced areas, later this concept was applied to developed countries in areas either geographical or socio-economically deprived.

In Ireland there is an increasing acknowledgement of the role of ‘community participation’ in health. At policy level community participation in primary health care was highlighted in ‘Health – the Wider Dimensions and The Years Ahead’. However, translating the policy into action is taking longer. Community participation is beginning to happen now, supported by stronger policy commitments as in the present Health Strategy ‘Quality and Fairness’ where people-centeredness is a key principle.

2.1.2 Partnerships.
Participation can occur at different levels and there is numerous literature available on the different models of participation, mainly from the community development perspective as participation is a key pillar in community development. While there are a number of published models of participation in healthcare the two most commonly used in the Irish health service documentation are ‘The Wheel of Participation’ and ‘The Ladder of Participation’.

My personal preference is for the ‘the Ladder of Participation’ (Appendix 1) because it has clear and practical steps that are as relevant now as in the 60’s, and, note where partnership is placed on the ladder – identified as the starting point of true community participation with two steps to go to achieve full community participation and citizen control.

So partnerships are about people coming together and participating, to make decisions and work together on what is best for them. Partnerships have been around a long time with marriage being one of the best-known kinds of partnership; over the last few years partnerships are common in most areas of business and political life. For partnerships to develop and work you need participation. A partnership is a formal alliance of organisations, groups and agencies that have come together for a common goal.

2.1.3 Methods / level of participation
Although not all forms of involvement have to be directly representative, research has shown that the choice of method and approach must be linked to the particular aims of specific initiatives. Without this link, public participation is unlikely to be translated into a decision that is representative of the public view or indeed meaningful. Also, as shown by Arnstein, genuine participation requires a transfer of power.
There are two broad levels of participation, individual level and group level. The individual level includes one to one interaction in self-care and consumer satisfaction. Group level is where the consumer as part of a community, interest group, participates in commenting on and improving health service delivery.

Methods of participation at both these levels can include postal questionnaires, focus groups and meetings, health panels, Citizen Juries, community representatives on committees and community development approach.

The community development approach is where the community, supported by the health services, is involved from the beginning. The community decides needs and priorities, and empowers participants to solve problems. Community development looks at the collective change in the health status and empowerment of the group as well as addressing the problems of individuals, the principles of community development include participation, empowerment, equity and a belief in the individual’s capacity to make rational informed decisions.

Community Development aims to empower those living in poverty and or experiencing disadvantage, to bring about change. This ‘bottom-up’ approach acknowledges that those affected by poverty are often powerless or excluded from participation in society – either because they as individuals have lost confidence, or because prejudice, discrimination, lack of resources or power prevents them. Empowering people is, therefore, not just about saying that in principle people have a right to a say in how things are run or decisions that are made. It has to be about transferring power by providing the appropriate resources, support, training and access to information that enable people experiencing disadvantage or poverty to act effectively.

2.2 Evidence of Partnerships in Primary Health Care, International and Irish.

Why do we need partnerships in health care delivery? If we accept the determinants of health to include the social, economic, environmental and cultural factors then achieving full health potential and providing an effective health care system is not solely dependent on the health services, ‘the evidence suggests that real gains in health are only likely to be achieved by extending our thinking beyond the boundaries of the health services and generating coherent responses to fundamental problems in society such as poverty, unemployment, housing and adequate education’
As with participation there are also different levels and types of partnerships within the health services. For the purpose of this research I have tried to keep my focus on partnerships in health service delivery. In particular, the focus is where the health service providers are in partnerships with community/special interest groups using the community development approach.

Community participation within a primary health care setting has been more effectively demonstrated in developing countries in terms of improved coverage of service delivery to remote areas. Genuine participation has been seen in the role of the village health worker in India and the barefoot doctor in China. Community participation in health in Europe has until recently remained firmly anchored in tokenism, the last rung in Arnstein’s ladder ‘because there is no political will to power sharing in health decision making by governments, managers and professionals’.

It was only in the early 90s that western governments acknowledged the wider determinants of health and the strength of community involvement with other sectors both within health services and outside. New European health policies have resulted from International health policy based on the experiences of many developing countries over the last 30yrs.

2.2.1 International evidence.

My literature searches provided me with an abundance of examples of different kinds of partnerships but confining it to partnerships in primary health care reduced my findings quite significantly, to approximately 90 hits in Pubmed.

Sources also included Medline, Cochrane and CINAL, as well as WHO sites, Dept of Health in UK and Ireland, Combat Poverty and a general search in Google.

The vast majority of the initial health partnerships were set up to bring about behaviour changes in the physical health of service users, or specific illness/disease control, health promotion and mental health being the two key areas.

The recent international shift, positioning the patient as an ‘insider’ in the health service, connecting health with social gains, along with the quality in health care movement is pushing necessary policy changes to promote increased patient participation and empowerment.

However, even where policy support is strong the practical application is limited, especially at community development approach level.

A) Australia /New Zealand

In Australia, policy support for public participation can be identified in the health strategy of 1993, with evidence of its practical
application later on in the 1990s with a proportion (74%) of the mental health service organizations having some type of formal mechanism in place for consumer participation in 1997-98.

A Community development approach to participation has occurred in the development of community controlled health services to facilitate access to culturally appropriate services to indigenous people. This has, in effect, delegated control to communities themselves to shape and deliver health services to meet their needs.

In New Zealand in 1991, asthma clinics were established within a partnership framework, which involved significant Maori management. Initial studies showed that there was a reduction in asthma morbidity amongst Maori people. A further study was conducted to assess whether the long-term benefits of the partnership program extended beyond reduced asthma morbidity and the extent to which any additional benefits may be related to the partnership approach employed by the program. The program was found to have four key benefits: cultural affirmation; improved access to other health services; a greater sense of control for participants; and positive impacts on the extended family. In response to Māori health policy guidelines developed in 1995/6, North Health developed its first three-year strategy to improve Māori health.

This Māori Co-Purchasing Organizations (MAPO) strategy is driven by one imperative; that is, greater Māori participation at every level of the public health sector.

The MAPO relationships were formalised with North Health through two key legal documents: a Partnership Deed (or Agreement for Co-Purchasing) and a ‘Memorandum of Understanding’. The Memorandum outlined the Treaty-based partnership principles and ensuing relationship.

In September 2002, a review by the Dept of Health agreed that this independent leverage role has provided positive results for Māori health in the past and will continue to do so in the foreseeable future.

**B) Canada.**

Policy translated into practice of community health partnerships in Canada has been effective. A case study by the National Aboriginal Health Organisation reports that key factors of the success were the transfer of control over health services to Aboriginal ownership, focus on primary care, and integration of traditional approaches with mainstream care. The ‘transfer of control and ownership’ indicates that a high level of participation has been achieved and effective.
But from my literature review this is more of an exception than the rule unfortunately.

**C) England /Northern Ireland.**
From early 1990’s Northern Ireland health policies have explicitly stated their desire to see partnerships through community development encouraged and developed. The DHSS in 1999 stressed the need for a ‘reorientation in senior management away from a process of providing for towards a process of working with local communities. Given this strong policy commitment a strong community development and health network has developed to work with health and social care groups.

Heenans case study in Health promotion reveals that local communities can be empowered by community-based health promotion projects. At policy level a similar shift towards Partnership has evolved in England with the most recent document ‘Shifting the balance of power’ 2002 being a ten-year plan. The findings from the Dept of Health’s research programme in England about patient and public involvement showing universal positive outcomes for all stakeholders, showed little evidence of true participation. Reviews of public involvement in the Primary Care Groups reinforce this with only 14% of community health councils rating the consultation process as effective.

**2.2.2. Evidence in Ireland.**
At policy level the National Health Strategy ‘Shaping a Healthier Future 1994’ clearly recognised the significance of the broader determinants of health while looking to achieve health and social gains. But Quality and Fairness 2001 was the first policy document to have a people-centred service as a key objective. The Primary Care Strategy 2001 also emphasises the need for community involvement, but in its action plan recommends only medium levels of participation such as consumer panels. The Health Board Executive 2002 identify that community participation in health can result in better decisions, more effective and efficient services and improved health outcomes.

In practice there are numerous examples of partnerships such as the social partnerships and local area development partnerships where the health sectors are represented. At service delivery level it was difficult to find examples.

The Primary Care Teams in the implementation project have begun to explore different mechanisms for community involvement,
ranging from low to medium level participation including information evenings, consumer panel, and local consultative meetings.
The 2004 progress report from the National Primary Care Steering Group showed that while the majority of the Implementation Projects have set up community consultative groups as their method of community involvement, only two projects had community groups advising and identifying local health priorities.

Evidence of primary health care partnerships using a community development approach was difficult to identify, one of the earliest examples was in North-West Connemara - a successful pilot not replicated despite its limited success. The development of Primary Health Care Initiatives for Travellers provides active partnership and participation of Travellers in the planning and provision of health services to their own community. The National Traveller Health Strategy identified them as an example of best practice.

2.3 The Involvement process of Partnerships

2.3.1 What is the involvement process?
The involvement process sometimes known as the partnership process is the internal working or functions of a partnership, such as the level of participation, what is happening in the group and how it is developing. Combat poverty describes the process as promoting confidence, skill, knowledge and consciousness in those who take part in group action. Effective partnerships do not just happen, they need a lot of work, trust and commitment and it is an incremental process. Partnerships have a high failure rate in the early stages as many struggle with the involvement process. There is an ongoing debate as to whether process is more important than outcome or vice versa especially when it comes to evaluating the effectiveness of partnerships. This is exacerbated by the fact that there is usually a delay between developing and building the process and achieving visible population-level health outcomes I see the involvement process as being primarily about developing relationships, which then form the foundations of an effective and sustainable partnership.

Evaluating the involvement process – literature review

The majority of literature I reviewed conceptualised the success of partnerships in two main ways:
• Process issues, such as how well the partners work together in addressing joint aims and the long-term sustainability of the partnership;
• Outcome issues, including changes in service delivery, and subsequent effects on the health or well-being of service users.

This highlights the complexity of evaluating and measuring the effects of partnerships. Evidence of quality, efficiency and process are fundamental to enhancing outcomes according to Ansari et al. The study stresses the importance of evidence based practice the difficulty of measuring evidence on the impact of collaboration as it is influenced by such diversity of perspective and conceptual facets. Their evaluation of five collaborative health projects in South Africa, are relevant to this research as they were community-based partnerships with isolated and marginalized groups and their findings identified conditions which facilitate effective partnerships. Being larger studies, they looked at process and outcomes. A gap in their study was that it focused on the Health team’s viewpoint only and did not explore that of the community.

There is too much emphasis on process and too little hard evidence that partnerships deliver outcomes, according to Dowling. However he concludes that ‘if process factors relate to the health and sustainability of the partnership it might be the basis of and forerunner to outcome success’. On his peer review of 70 papers on partnership only 36 linked partnership with success, the majority of which were qualitative and focused on the process rather than outcomes and cost benefits. Dowling’s reviews, while extensive in number; are unclear in relation to timescales and validity of studies used. The study is relevant to my research in that the review suggested the following possible dimensions of process success and possible indicators of those successes. This has guided my methodology.

Successful partnerships are believed to depend on the level of engagement and commitment of the partners. Indicators used in the literature to measure levels of engagement and commitment includes the enthusiasm of partners for the partnership, as reflected in the behaviours and/or beliefs of the partners. Successful partnerships are also considered to require agreement about the purpose of and need for the partnership. A fundamental indicator of this concept in the literature reviewed was the degree to which aims and vision are shared, and the existence of interdependency between partners. Successful partnerships are also believed to involve high levels of trust, reciprocity and respect between partners. Therefore, the
literature commonly aims to identify the extent to which partners have confidence in each other.

The environments within which partnerships operate also affect their success. Favourable environmental features include the financial climate, suitable institutional and legal structures, and wider interagency activities. Therefore studies have assessed whether the wider environment is characterised by a political and social climate conducive to partnership working. Satisfactory accountability arrangements, plus appropriate audit, assessment and monitoring of the partnership are also regarded as essential for successful partnerships. Measures of this dimension that have been used include the lines of responsibility and the appraisal arrangements for the partnership.

Adequate leadership and management of the partnership are also necessary attempts to measure this factor have been made by assessing the quality of the partnership's executive authority over the strategic direction of the partnership and the management of activities designed to achieve that broad direction.

The diverse factors of the involvement process are not easy to measure, randomized controlled trials and meta-analysis do not lend themselves to testing the effectiveness of partnerships, and a holistic method of evaluation is required. In my literature search it was mainly case studies that included evaluation of the involvement/partnership process. There were a limited number which focused mainly on the involvement process. Contrary to what Dowling claimed about too much emphasis on process, all of the studies indicated the need for a stronger commitment to process by all partners involved. The studies all stressed the difficulties of translating it into practice.

In Canada Lindsay carried out a small study to evaluate the process of a community development project providing respite care to HIV clients. This highlighted the need for a shared vision, exploring vulnerabilities, valuing the expertise and limitations of others, creating win/win situations, and breaking down traditional barriers as part of the process. As a result social action and effective change were the outcome of the process.

In addition, the community became empowered to move forward with the respite care program and to add additional services such as volunteer training and eventually HIV/AIDS home care training for nurses and social service personnel. Although the health authority had limited involvement in the project initially they became interested as the project developed and commissioned the research to determine the usefulness of such a model for other communities in Canada. Although a small piece of research, the detailed
methodological use of participatory action research and qualitative approach gives the results credibility. The findings are transferable especially to any marginalized grouping.

Heenan looked at the involvement process of a partnership approach to health promotion; this study is very relevant and similar to my own approach – exploratory in nature, ascertaining the views and perceptions of key partners of the partnership. Heenan focused on a wider community, voluntary and statutory partnership of approximately 150 core members, the sample size and mix was appropriate and representative; giving validity to the three main themes that arose on what affected the process:

- **The need for strategic planning to facilitate partnerships** - that commitment to the process by management was not enough - it needs to be supported by a strategic plan, a clear vision, with clarity of the respective roles, looking at different approaches, resources, long term commitment and training for those involved.

- **Contested nature of partnerships** - that many of the difficulties encountered by the project related to different expectations, different perceptions of participation and levels of involvement.

- **Sustainability** - stakeholders found it difficult to sustain momentum because of the perceived lack of involvement by some parties and others felt they were doing the work, resulting in burn out.

But, despite the difficulties, the partnership works. There is a continuing involvement, a sense of ownership, and a taking control of their health by the community.

Key challenges of the process identified by Heenan and by other studies discussed included the following: Different communication approaches resulting in different perceptions, approaches and expectations, the importance of clarifying the role and inputs of organizations/agencies involved in partnership.

The need to develop trust was highlighted in all of the studies, with community/voluntary groups expressing fear that they were being used and health professionals afraid of sharing both information and power. Trust needs time to develop, communication and a willingness to share are important but without trust the process will not develop.
Variations in the meaning of community and participation among partners resulting in a lack of agreement about the level of participation within the partnership. A knock on effect is not allowing/having time to devote to the process and different expectations among partners.

Cultural change is needed to break down the hierarchical and bureaucratic mindsets for health professionals to move away from a process of providing for towards a process of working with communities. There is resistance to give up control and power share.

A similar finding by a case study looking at tackling smoking through health promotion in Scotland voiced a stronger opinion that statutory agencies and community groups are ‘fundamentally incompatible’ that statutory agency members were uncomfortable with community development approaches and high levels of participation.

Many of the studies concluded that none of the projects evaluated were fully engaged in genuine people-centred participation. Michener’s small study of participation in a non formal education project echoed a hard hitting sceptical but realistic view that staff do not want to relinquish control of projects and that unequal power relationships between partners are subject to manipulation and dependency. While this study was based in a developing country, is an educational project and is 6yrs old, I think this issue is still relevant today in the Irish health care system and has been identified as a key challenge to having a more participative healthcare service in the Office of Health Management report. Michener achieves his objective of exposing and encouraging debate about the complexities that challenge partnerships, his negativity and lack of recommendations would pose questions over his objectivity.

But despite the difficulties the partnerships are working on some levels. With continued involvement, a sense of ownership and taking control of their health by communities is happening. By drawing together lessons learned from the practical experiences of participation and partnerships we can strive to improve the level of participation, and the effectiveness of the partnerships.

2.4 Current Guidelines for developing Partnerships.

Several authoritative guides on different ways to involve patients in the planning and development of services have been published.
Involving patients is becoming less discretionary and more compulsory for the providers of services, but engaging patients is not an easy task, and no consensus exists on which methods are most effective under different circumstances. Guidelines may vary according to the level at which a partnership approach will be implemented. At community development level, principles underpinning the process of participation are essential for effectiveness and long term sustainability of partnerships.

Throughout the literature reviewed common key factors have been suggested for effective partnerships, these have also been identified as guiding principles in policy documents for developing partnerships.

Best practice approaches that enable partnerships between communities and statutory agencies involve the following:

1. Senior involvement to lend status and power to partnerships
2. Training for staff engaging with communities
3. Clear aims and objectives with relevant methods of evaluation
4. Performance management of statutory organisation responsiveness to communities.
5. Structures that allow community participation in strategic planning.

In 2002 the Health Board Executive produced ‘Community Participation Guidelines’ to ensure that the principle of ‘people-centeredness’ at the heart of the National Health Strategy remains an important feature of planning and delivery of services. The guidelines recognise the principles of community participation, but when it comes to specific deliverables by health service providers within the health strategy the guidelines talk about advisory panels, committees and consumer panels all of which have limited degrees of participation with no mention of empowerment or sharing of power. However in the appendices the Health Board Executive recommend the use of the ladder of participation model and a community development approach.

Lifford is the first of the primary care implementation projects to have put forward proposed criteria for effective community representation. Within the project it includes criteria for both community representation and health members and recognises the need for capacity building for both.

The Community involvement sub committee of the National Primary Care Steering Group has recently published a position paper ‘Community Involvement in Health’ outlining principles, models of good practice and recommendations for community involvement in the new health structures. The position paper from its research on
models of good practice in Ireland identified that ‘unless community involvement was championed at senior level and actively embedded within corporate strategy, it would remain an add-on and receive neither the commitment nor resources needed’ (Unfortunately access to this research was not available for this study). The document identifies key enablers to support community involvement:

Strategic enablers – corporate strategic level of commitment, high level sponsor appointed to oversee progress and involvement of senior level staff.

Task and Process Enablers – covering the terms of references, accountability, training and details of how the process can be supported.

The key enablers in the position paper are similar and a more detailed version of principles identified by the Office of Health Management.

For the purpose of this research I have focused on the proposed set of principles put together by the Office of Health Management (Appendix 2). The NHS policy documents Signposts and Working Partnership by the Health Development Agency reflect similar core principles.

These principles are a starting structure and are recommended as a guide to developing a partnership, allowing flexibility for the partners to develop the process together. If true partnership is to be achieved then there needs to be an understanding of the power balance between community and statutory organizations and an eventual devolution of power for long term success. This required change in values, perceptions and methods of working necessitates capacity and team building of all partners, both individually and jointly to support the process.

2.5 Methodological aspects of literature reviewed.

The majority of the studies I reviewed for this research use some qualitative approaches in their methodology. Evaluating the complexities of the involvement process of partnerships such as levels of engagement, the commitment of partners, purpose and vision, trust and respect requires a variety of qualitative methodologies.

Process studies, are a method used to evaluate complex social programmes, with the aim of clarifying aims and assessing internal structure and functioning. This was used in the New Zealand study using such tools as participant observation and in-depth interviews.
with members of the partnership. What was good about their approach was that it was carried out by an employee whose purpose was to do ongoing evaluation over a 2 year period as the project developed. Because the evaluation was ongoing it provided space for reflection on the implementation and development of the process. The disadvantage of course was loss of autonomy and independence.

Crawshaw also used this methodology over a 15 month period, focusing on in-depth interviews only. Data was analysed using the conventions of qualitative inquiry, involving a close reading and re-reading of the transcripts, coding, development of analytical categories, and use of constant comparative methods. This allowed key themes to be extracted and data organised within them.

Aspects of participatory action research were used by Lindsey which involved engaging with the community in all stages of the research. Michener, did not state how involved the community/schools were in his research but tools such as participant observation at meetings and training sessions were used as well as in-depth interviews and focus groups were used by both. Ansari and Truman whose research focused on the involvement process of partnerships used the more common qualitative tools, semi-structured interviews and focus group discussions, Heenans research on the involvement process in health promotion only used semi-structured interviews a limitation of the research, as focus groups can help to add further depth and validity to findings.

From this review I have concluded that semi-structured interviews supported by a focus group discussion are appropriate for this research.

2.6 Summary of literature review.

Partnerships in health care are here to stay. From the late 1990s all health policy document and strategies worldwide are promoting community participation and partnerships. Strengthening partnerships in primary health care is a key strategy to improving health and combating poverty.

The literature review has highlighted the inconsistencies and gap between the many theoretical and technical details of partnerships and the practical experiences of working in partnerships. Despite the many policies promoting partnerships in primary health care my review found limited evidence of effective partnerships in the primary health care setting, especially partnerships with a community development approach.
Looking at the evidence, Canada appears to be more advanced in translating policy into practice promoting empowerment and partnership effectively with the Aboriginal community. In Ireland while there are local area partnerships that have Health Board representation, I found no current partnerships involving community development approaches in health service delivery, other than the Travellers Primary Health Care initiatives. The recently implemented Primary Care Teams are only beginning to look at participation at consultation level /consumer panels. So why are we so slow to develop partnerships? The literature review of the involvement process within some of the research has given some interesting aspects to that question. The partnership process suffers from many ambiguities. It is a complex and fragile process requiring commitment and sense of ownership, leadership, effective and regular communication, strategic planning and attention to power issues.

Rationale for research proposal
In Ireland we have the policy documents and the guidelines; however we have limited practical experience about how to develop effective partnerships in the primary health care setting. My research could be a starting point, by reflecting on one of the few partnerships in place within the primary health care setting.

Aim of the study
To carry out an exploratory review of the involvement process within the Clondalkin Traveller Primary Health Care partnership. To review the experiences from the view point of the partners and that lessons learned will support and encourage other health service providers to participate and develop community health partnerships.

Research Question:
How effective has the involvement process been within the Clondalkin Travellers Primary Health Care Partnership?

3. Research methodology
The purpose of this study is to explore the involvement process within the partnership responsible for Clondalkin Travellers Primary Health Care Initiative, focusing on the steering committee members who were responsible for the initial setting up of the initiative and its ongoing management. From the point of view of all the stakeholders both from the Health Board and Clondalkin Travellers Development Group (CTDG) exploring such issues as, how the process was set up, how it
developed, roles, and impact on the working relationships between partners and to assess how it could inform future initiatives.

In this chapter I have outlined the methodology chosen for this research covering:
Research design
Data collection
Data Analysis

3.1 Research design.

Traditionally in health care research a distinction has been placed between two paradigms, the naturalistic paradigm with its emphasis on qualitative data collection and the positivist paradigm with its emphasis on quantitative data. The naturalistic paradigm recognises the individual and emphasises the dynamic and individual aspect of the experience. It allows for a more holistic view of the ‘what, how and why’ of an experience from the participants perspective.

As my study is largely exploratory in nature, I considered a qualitative research method to be most appropriate, as it would enable me to ascertain the views and perceptions of those who had been directly involved with the project.

From my review on methods used in the key studies covered in my literature review, I concluded that the exploration into the experiences of the partners could be best facilitated through in-depth discussion with individual participants.

The two qualitative techniques that I shall be using are semi-structured interviews and a focus group discussion.

3.1.1 Semi-structured interviews

Qualitative in-depth interviews are recognized as an effective method for answering process evaluation questions. Semi-structured interviews allow the participant to convey his or her experience of a specific issue. The interview is not entirely open ended but guided by an agenda. It is important that the interview is sufficiently flexible to allow the participant to elaborate on issues or raise other issues he or she considers most pertinent.

The interviewer also has the freedom to probe an issue in more detail or to follow a line of inquiry introduced by the participant. Semi-structured interviews are useful when collecting attitudinal information and when the research is exploratory in nature as is this piece of research.

3.1.2 Focus group discussions

Focus groups are informal ad hoc groups of people, brought together in discussion sessions to give in-depth responses to a
particular issue, providing opportunities to explore the background to different views. A facilitator, usually neutral or third party takes the groups through a series of themes or topics. The group then develops its own ideas and shares experiences and understanding. In this study I carried out a focus group discussion following the interviews to verify my findings, to complement and put in a group context.

3.1.3 Study setting

This study focused on one partnership initiative, Clondalkin Travellers Primary Health Care Initiative, which is based in the Dublin West area of the Health Service Executive.

Access was sought through the relevant management of both the Health Board workers and the Community Development Project as well as from individual participants.

A preliminary letter was sent to all participants of the study, including an outline of the research proposal, and a consent form (Appendix.3).

Within two weeks of the letter being sent I followed up with a phone call to clarify any issues and arranged a date and venue for the interviews.

As most of the participants still worked in the area I carried out the interviews within the area and I facilitated the choice of venue for those who had moved to other areas.

3.1.4 Study population and sample

Given that the study is an exploratory study of one partnership initiative it was important to include all those that were involved in the original setting up of the partnership and the present steering committee. I approached all the relevant partners/stakeholders that have been involved in the initiative this includes the following:

Members of the original steering committee that set up the initiative in 1996 – this include from the Health Board, the then Director of Community Care, Director of Public Health Nursing, Area Administrator and from the CTDG group, the then Project Co-ordinator, Health co-ordinator, in total five people.

The present steering committee – consisting of Area Medical Officer, Assistant Director of Public Health Nursing, Area Administrator and from the community group the project co-ordinator and health co-ordinator - five in total.

Key informants – I identified two key informants that have been closely involved in the initiative especially in the early stages, one is the Public Health Nurse working with Travellers who worked closely with the partnership initiative, and the second is the external
advisor to the project from 1998 – 2000 who is currently on the National Primary Care Steering Group looking at community involvement in Health.

In total twelve interviewees were approached and ten interviews were carried out, I was unable to locate one participant due to early retirement and being out of the country and one participant refused to participate.

3.2 Data Collection.

The semi-structured interview has been identified as an effective way to explore process issues, guiding the interview with questions focused on the strengths of the partnership and challenges it has faced, relationships and communication among partners, the project's adherence to norms of operation, the level of participation of Steering Committee members, and suggestions for the improvement of the process and operations. My interviews were guided by key questions (Appendix 4) adopted from recommendation of evaluation of partnership projects by the Welsh NHS.

3.2.1. Pilot Interview.

Due to the small sample group my first interview was used as a pilot interview. This allowed me to test my interview technique and to gain confidence in the process as it had been some time since I last carried out interviews. The pilot also highlighted the importance of reliability and validity tests in instruments, using a mini-cassette player it was important to be in close proximity to interviewee and to keep watch to change tape after 30-40min. Some questions were tweaked following the pilot to ensure further clarification.

I carried out semi-structured interviews with ten people that have been involved with the initiative, five of whom were from the community setting, either present or past members of Clondalkin Travellers Development group and five past and present Health Board members in keeping with the partnership ethos of equal representation. The interviews were carried out in pre-set venue lasting on average 30 minutes each. The tapes were transcribed within 24 hours of the interviews, initially fully transcribed by pen then typed up in note format for analysis.
3.2.2 Focus group discussion.

After the transcribing of all the interviews, I read and re-read the transcriptions to familiarize myself with the issues then I began to identify the main themes that were emerging in each transcript in preparation for my focus group discussion. Originally I had intended to invite all those who had participated in the semi-structured interviews to the focus group; however those that moved on from the project declined and generally felt that their interviews were sufficient. I then decided that the focus group would be with the present steering committee. The focus group discussion took place after a pre-arranged meeting of the committee. The objective of the focus group was to maximize the validity of the findings from the interviews, to gain further insight into issues and themes arising and to explore if the findings or lessons learned could impact on the ongoing development of the present steering committee.

3.3 Data Analysis.

There are a number of theoretical approaches for analyzing qualitative data, qualitative research is an interpretative and subjective exercise and the researcher is intimately involved in the process. My decision to use the framework analysis approach was dependant on my research question and the time and resources I had to carry out the analysis. Framework analysis which is similar to thematic analysis allows for a more in-dept review of data, and is useful where there are specific questions to be answered and where timescales are short. Also the framework appealed to me because of its logical progression and use of a matrix to organise information.

Framework Analysis has five key stages. These can be undertaken in a linear fashion and therefore all data can be collected before analysis begins, although framework analysis can equally be used when data collection and analysis occur concurrently.

- **Familiarisation:** In order to become as familiar as possible with the data collected I did all the transcribing myself, first listening to the tape, then transcribed the tapes fully by hand and then typed up each transcription in note format on to the computer. To ensure that I had carried out the transcribing correctly I compared the original tapes with the final typed up note format.

- **Identifying a thematic framework:** This is the initial theme framework which can be from prior issues or emerging issues. My framework was guided by the key headings used in the semi-structured interviews.
• **Indexing /coding:** This is the process of applying the framework to the data, by hand I colour coded specific pieces of data that corresponded to the different themes.

• **Charting:** I created a matrix of themes so that I could easily read across all respondents to that theme. (Appendix 5)

• **Mapping and Interpretation:** This is the searching for patterns, associations and explanations in the data; I found this part initially a blur of data difficult to interpret, but the visual display of themes with codes from all respondents together assisted in the interpretation process.

My findings have been reported through summaries of themes illustrated by direct quotations where appropriate.

**Reliability and validity**

The trustworthiness and rigour of any qualitative research is difficult to promote and ensure. Qualitative research is about the individual’s perception and viewpoint. Given my close working relationship with the project and the participants, mutual trust between each regarding information, process and findings was paramount.

Rigour can be measured through ensuring reliability and validity and reducing error and bias as far as it is possible.

Because of the personal nature of interviewing, the scope for error and bias is quite large, and as I am one of the co-ordinators on the initiative a poor outcome to this study could be interpreted as a reflection on my work and role within the project. In an effort to reduce this bias I clarified with each participant that this study is looking at the pros and cons of the involvement process and that in order to identify lessons learned we must acknowledge our mistakes and weakness.

While carrying out the semi-structured interviews I avoided deviation from the key questions unless the participant did and refrained from bringing my personal perspective into the discussion. In qualitative research the reliability and validity can be addressed by incorporating intellectual honesty, depth of description, accuracy and reflexivity, into the analysis. The research must be open to search for alternate hypotheses and interpretations. Reliability of methodology in this study was ensured by reducing error and bias as much as possible, by carrying out an open and transparent process including a pilot interview and a self review of the final transcripts with original tapes.

Validity of interpretation was supported by carrying out a focus group discussion to support and validate findings from the semi-structured interviews, and a variety of quotes from different participant supporting key themes.
3.3.2 Self – reflexive approach
I was acutely aware of my close involvement in the partnership initiative and how it could influence this piece of research. While my involvement and role developed my interest to carry out this research an important concern for me was how to make sure I did not consciously or unconsciously influence the findings. While I acknowledge that my very presence in the research and as the researcher creates an amount of bias already, I decided to take a reflexive approach in my research to try and reduce this as much as possible.
My reflexive approach consisted of recording my feelings, hunches, assumptions and known bias during the process of carrying out the interviews and focus group discussion and during analysis. In practice this consisted of side notes of my observations and reflections arising from the interviews and interactions with the participants on pages of transcripts and writing in a note to self notebook that I use to keep me focused.
I have been so conscious of the bias effect of close involvement that my supervisor identified the lack of self in the study which I have attempted to rectify in the findings and discussion.

3.3.3 Ethical issues
Ethical approval was sought and received from the research ethics committee of the Royal College of Surgeons in Ireland (Appendix 6) As with any ethical issue the four fundamental ethical principles apply, beneficence, non-malfeasance, respect for autonomy and justice. As this study is qualitative with no procedures/treatments involved and given that there are no clients or consumers involved in the study beneficence and non-malfeasance do not really apply. Autonomy – to respect the right to self determinant was protected by ensuring all the participants had the right to refuse to participate, on agreement to participate, they understood that they could withdraw at any time, consent was in writing.
Justice- being fair and equal: An equal number of participants from the community setting and Health Board setting were interviewed. During the study confidentiality was adhered to at all times, tapes and transcripts were coded and stored securely with the names of participants and related codes saved separately. Given that the participants are working closely together and some met at the focus group, anonymity of quotations and feedback was essential to ensure an open and trustworthy response from all concerned. This was confirmed and adhered to in the focus group discussion also which supported an open and non inhibited flow of discussion among the group.
4. Findings

In this chapter I have described how I collected the data, the subjects I have interviewed and the settings in which the interviews were conducted. I have also presented all my main findings.

4.1. Outline of data collection

As previously stated in my methodology the two methods of collecting data for this piece of research was by semi-structured interviews, followed by a focus group discussion.

I identified twelve people who I wanted to interview, five from the original steering committee of the project, five from the present committee and two key informants.

Of the original steering committee I was unable to contact one person as she had retired and gone travelling, two others had moved to other jobs but I was able to locate them and they both willingly agreed to be interviewed. I interviewed four of the five original members.

The present steering committee has six members one of whom was on the original committee; two Health Board members had just changed in January 2005 so I decided to ask the members who had just left the committee to participate, as it would have been inappropriate to interview the new members as the interviews were carried out in February 2005. Of the two Health Board members that left one was willing to be interviewed, the other declined but allowed me to use comments she made in the phone conversation we had. So again of the five identified I carried out four interviews. The key informants were both agreeable to be interviewed. In total I interviewed ten out of the twelve invited to participate.

For the focus group discussion I invited the present committee members and the two who had recently left. Unfortunately on the day only five were able to attend.

4.2 Conduct of the interviews

The settings for the semi-structured interviews were mainly in the work place of the participants, a private office away from disturbances; on average the interviews took 30 minutes. One interview took place in a quite area of a hotel foyer in the city centre. While not the ideal situation it was what suited the participant at the time and it worked satisfactorily except for some occasional background noises.

Conduct of the interviews was informal given my relationship with all the participants, a brief chat and explanation of the study prior to commencing the interview using the questions to guide and to
keep me focused. I conducted the first interview as a pilot. This helped me to improve my interviewing technique and identified some questions that needed to be added to the subsequent interviews.
All interviews were taped using a micro cassette; quality of the taping overall was good except on one occasion paper was placed over the recorder for a short period muffling the voice sound momentarily.

4.3 Conduct of the Focus group discussion.

For the focus group discussion I used a standard flat tape recorder. Because the group had just come from a meeting it took some moments for the group to adapt to the change of tack as it were, and the flow of the conversation was slow at first. I also felt it was important at this stage to clarify to the group my own awareness of being both the researcher and part of the process. I think my openness encouraged the group to relax, be more open and responsive.
When people settled into the discussion it became quite lively, perhaps too lively as at time it was difficult to keep them from talking all together. Overall the discussion was very open and honest, and closed on a positive agreement to address some of the issues within the committee.

4.4 Findings

I carried out the framework analysis on all the data collected. In identifying the key categories I was guided by the focus of the questions and issues emerging. Within each category I have compared the views of the community group members with those of the Health Board members.
The findings are discussed under the following categories:
  1. Setting up of the Partnership
  2. The Involvement Process
  3. Overview of present Partnership
  5. Partnerships and Health Board
  6. Unequal power
  7. Understanding

4.4.1 Setting up of the Partnership.
It was important to get a clear picture of the participants’ views and recollection of how the partnership was set up 8 years ago. What the participants said was subcategorised under the following headings:
  • Clarity of aims & objectives
• Roles & responsibilities
• Right people involved.

Clarity of aims & objectives
Of the people that were involved in this stage of the partnership there was some agreement about their own clarity of the aims and objectives; but there was a perception that others were not as clear.

Community group members:
‘Yes people involved in the beginning at the setting up stage were clear about their roles and aims’
‘initial aims & objectives unclear, had to be negotiated and through that process they became clearer, we understood it better because of previous projects- there was a common vision present’

Health Board members:
‘some people were aware because of experience...but others would not have been as informed or aware of the issues, yes clear for me and also developed over time’
‘entirely clear to me ...based on my own knowledge of the specific needs of Travellers not met and a need for the project’, managers in Health Board needed to be convinced of the need’

Roles and responsibility
Regarding clarity of roles and responsibilities at the setting up stage of the project the community group were clear about their role and that of the Health Board members. The Health Board members interpreted the roles as more evolving and changing with the process.

Health Board members:
‘responsibilities evolved over time with CTDG as advocates for Travellers and we as the service providers’
‘it was normal for people going into a partnership to be clear about their roles only to find that as the process develops roles change and intermix’

Right people involved
There was a perception that at the initial setting up stage generally the right people were involved, and both community and Health Board members identified the right people to be those that had decision making powers. One or two on reflection identified other people that could have been included.

Community group members:
‘ yes senior Health Board people involved in the beginning it was crucial at this stage they understood and supported implementation’.
‘the chairperson very pro-active-but others not sure, not totally convinced’
Health Board members:
‘generally yes some more appropriate than others, chosen by Health Board management who followed criteria from Pavee Point and adapted to suit local area’
‘as Chair I had to make the case to the program manager....perhaps if he was involved in the committee he would have had a better understanding’
‘later on we could have done with more senior people who could make decisions ...and it would have been better if it were people who have an interest in it’

4.4.2 The Involvement Process
The participants expressed a variety of opinions in relation to the involvement process within the partnership. During the discussions on the involvement process a number of aspects of the process were discussed which I used to code transcripts. These included training, timescales, participation, trust/commitment, dealing with conflict and communication.

Training:
There was overall agreement that there was not enough training about group dynamics and understanding of and working in partnership for the members of the committee. In the initial stages there was one training day, which was considered ineffective by some.
Health Board members:
‘there was little training and while some had experience of partnership on reflection it would have been a good idea’

Community group members:
‘we did a session on what the Primary Health Care and Partnership was about - but it didn’t work very well Health Board felt it was just another meeting’
The focus group strongly supported these views throughout their discussion also with comments such as;
‘well the training is a big thing not just once off but ongoing’
‘Health Board need training on culture, community development...then there would be a broader understanding between both sides’

Timescales:
The majority of those interviewed agreed that the timescales set out for the training of community health workers and development of the project were realistic. At the setting up stages the timescales were part of the negotiations and one of the issues that the Health Board managers ‘had to be convinced about’. This took time but
once agreed there was pressure to start immediately. One Health Board member had difficulty in accepting the amount of time needed to train the Traveller women as community health workers which was close to 3yrs in total.

'I know these things take time, but there seems to be a lot of training (of the Travellers to become community workers) even now.... the process was very long difficult to justify to the Health Board'

Community group members:
'timescales were realistic yes, again they had to be negotiated and phases of the training agreed'

**Participation: level and support:**
The questions on whether there was equal participation and if people were supported to participate, provided a wide range of answers among all the participants, especially among the Health Board members who made some interesting comments indicating that there was little or no support given to them from management and this affected their ability to participate fully;

Community group members:
'yes there was equal participation, ....there was ownership of the project..... but later the Health Board stepped back leaving it to the community group'
‘we were more pro-active and pushed the actions, made more recommendation on how to proceed etc. the Health Board took the lead and guidance from us - an unbalanced dynamic, we were supported to participate and prepared for meetings'

Health Board members
Those who were not involved in the beginning had different responses than those who were involved at the setting up stage. Those members involved in the setting up phase were more positive about the participation levels:
'I felt there was equal participation, we worked well together making representation together to the Health Board management'
‘yes participation levels were good, involvement at all levels gave it strength and a sense of ownership...later the Health Board didn’t need to participate as much once the project was up and running'

Comments from Health Board members who joined the committee later were very different:
' I didn’t participate as much as CTDG did, because I had other work also and I didn’t think it was needed, I didn’t get much support really...I was just landed into it, no handover, just told it was part of my role'
'I got an introduction but it was difficult, could not find previous notes or terms of reference- difficult to participate….felt we never had a say in the decisions and planning- lack of ownership on the Health Board side, CTDG held the control a bit - maybe not intentionally but because the Health Board stepped back’

I was told to go on the committee about 2 yrs ago, wasn’t given any details or told my role, didn’t understand the project and it took me a long time to get to grips with it- still not sure of my role so I don’t participate much really'

The key informant in her interview spoke of similar comments made to her when she spoke with Health Board workers involved in partnerships;

' that there was frustration by Health Board workers, that they got no support from the board- no acknowledgement that they were doing something valuable’

The focus group members all agreed that Health Board members are not as active as community group members. This was justified as ‘this is only a small part of my workload’

Commitment and Trust:
All participants spoke about the commitments of members and trust in a positive way but there was a difference in the strength of opinion between the community and Health Board members and between those involved in the earlier stages and those involved in the present partnership.

Community group members:
'yes there was commitment from all partners....it took two years of a process to develop the trust and commitment – vision, openness and commitment was present’
‘commitment was strong in the beginning....people changed on the committee and those that came on were unclear about their role ...not as committed to partnership...were told to come onto the committee, not by choice .........unfortunately as a result the strength of the committee lessened then’
‘some members of Health Board were very committed to it while others were not sure or as convinced......there was mistrust over funding and budgets by the Health Board and also by us if we heard the Health Board were doing anything that affected us, took time to build up relationship, it happened but it was based upon personalities – it was dependant on personalities to make impact’

Health Board members:
Those involved in the setting up stage felt that trust and commitment was strong and gave example of the rotation of chairperson as proof of trust being developed:
‘yes there was commitment to equality, mutual respect we had ground rules for working in partnership- clear to all’

‘CTDG were very committed and strong...I don’t think there was a them & us situation, there was trust and commitment reflected in the rotation of chairperson...when it came to rotate the chair the CTDG voted me in again I was gratified that there was this level of trust’

However perceptions of the present Health Board members are quite different

‘there was trust to a point but we were economical with the truth sometimes e.g. if there was a problem with service delivery or a cancellation of services we would avoid telling them because we would be inundated with accusations and demands – but really we don’t make these decisions’

‘I admire the CTDG for their work and commitment....I just couldn’t give the same commitment’

**Communication and decision-making:**

Feedback from the participants suggested there was little difficulty with communication methods, there were regular meetings, reports and all members were kept up to date on progress and issues.

How the decision making process worked was harder to extract from the findings, those members involved in the early stages of the partnership agreed that decisions were made by consensus with wide consultation. However the members who joined later and in the present partnership all agree that while the decisions are agreed at the meetings, CTDG have already decided.

**Community group members:**

‘yes communication was good, regular meetings, reports, sharing of information time at meetings....decision making process was possibly not the most democratic as CTDG were more pro-active and pushed the actions....there was planning and decision making discussions but we were better prepared than the Health Board’

**Health Board members:**

‘communication was good but there was still a lack of understanding from CTDG about how the Health Board works and how slow things are in the Health Board’

‘we were kept informed and all decisions were made at the meetings but CTDG were more prepared than we were, their whole focus was the project while this was only one of a number of committees for me’
'meetings clear, well organised kept up to speed about the project ....I felt we never had much say in the decisions and planning – lack of ownership on the Health Boards side’

**Dealing with conflict:**
Conflict did not come across as a major issue with most of the members, many of the members from both community and Health Board saw conflict as a healthy part of the process which was managed through negotiation and facilitation. Community group members felt they had to fight for everything and to push for broader issues while one Health Board member felt she had to anticipate difficulties and defuse them.

**Health Board members,**
Those who were involved in the initial stages were able to deal with conflict and accepted it as part of the ‘power struggle between voluntary and statutory’, But for a few of the Health Board members the conflicts and ‘pushing of agenda’ was a constant stress which they were unable to deal with it and as one members said

‘feeling powerless and unable to contribute’.
This was the reason why one member refused to be interviewed she did not want to revisit the stress experienced.

**Community group members:**
‘obviously bargaining, negotiations and disagreements happened but because of the way we dealt with them through negotiations, allowing time to read, discuss and challenge things it was done in a positive way.........tension between statutory and community was obviously there but that’s healthy people on the committee open to this’

‘conflict possibly around budgets and funding, not really conflict but issues ...it was managed by a sub-group, no major conflicts, challenging the Health Board to take on issues was difficult...they agreed with the community development approach but it was not always possible to carry out at the Health Board level’

**Health Board member:**
The Health Board member who declined to be interviewed gave me permission to use her comments and reason for not participating, ‘I just couldn’t go there again, I’ve moved on completely both in my job and personally, please don’t ask me – it was so stressful being part of that committee’
Other Health Board members:
‘conflict at Health Board level mainly ... for me trying to persuade the department to support the project long-term’

‘conflict was normal and part of the process there was understanding and tolerance which was difficult because of the changes in personnel on the Health Board side. There were difficulties but we worked them out all accepted that we would not all agree on everything. The history of Health Board and voluntary groups there is always a bit of power struggle there’.

4.4.3 Overview of the Present Partnership
In this section the research findings show how the process developed over the years to the present partnership. Findings here support the findings from the previous section on the involvement process and confirm that the process changed once the project was set up and training in place about two years in total. While there is full agreement that the process and partnership was strong and effective in setting up the project, over time the partnership has become less dynamic because of the many issues presented above. Opinions on how the partnership process has developed over the years are quite similar from both the community and Health Board members, with stronger opinions from those that have been on the committee longest.

Community group members:
‘Once the funding was secured and project up and running its like the Health Board stepped back and they are now in a role of overseer –which is fair enough....in terms of influencing decisions and policy it doesn’t happen’

‘to some extent it has lulled...routine meetings, personnel not pro-active or participative the Health Board are limited- it has lost its effectiveness.’

Health Board members:
‘it was always hard work, demanding, never got to grips with it .....at some stage I backed off and became passive’

‘ the Health Board took a back seat apart from the funding....everything was organised and done by CTDG – we were not included in the planning – but that was probably our own fault we stepped back and didn’t say anything......and probably didn’t have time to give anyway’
The role of the Health Board members has changed from being pro-active to being passive and the shift of power in decision making has moved to CTDG.

**Key successes of the process:**
There was general agreement that the partnership had achieved its goal to set up Clondalkin Travellers Primary Health Care Initiative, train Traveller women as Community Health Workers and to have Travellers employed as health workers by the Health Board. It was difficult for the participants to focus on the successes of the actual partnership process; the following are the responses:

**Community group member responses:**
- project up and running well
- project running now for 8yrs, ongoing budgets secured, Travellers employed as community health workers, a second training project started.
- Committee have a broader knowledge about Traveller issues
- Good communication, open and honest relationship
- Helped CTDG to be seen in a different role - improved image
- Improved attitudes of people involved and had a good impact on Travellers especially Traveller women.
- Challenged both sides, built relationships and trust – some outcomes but slow.

**Health Board members responses:**
- project working and Travellers employed as health workers with Health Board
- worked well – achieved objectives and beginning to make an impact
- project started, women trained and employed
- its strength was the commitment of the people involved
- having Travellers involved at all stages

**Weakness of the partnership:**
When asked about the barriers and weaknesses of the partnership most of the participants automatically focused on the issues affecting the involvement process, such as changes in members, participation, decision making issues. It was the community group members who highlighted the lack of outcomes such as Travellers involved in policy and service planning to tackle health inequalities.

**Community group responses:**
- not getting Travellers higher on the agenda in terms of service provision.
- No say in service planning
Strength of committee lessened because of changes in membership, new members didn’t have any decision making powers
Not addressing health inequalities
Challenges understood at partnership level but not brought to or extended to other disciplines.
One of the weakness of the committees are – people with no decision making capacity- only there to listen, must report back and ask, that doesn’t work.

Health Board members responses:
lack of understanding, CTDG always looking to access service planning, that we couldn’t deliver on – they knew this but still kept pushing.
Changes in members all from the Health Board side, made it difficult to keep momentum, as a result we had lack of ownership
Lack of training for the committee members, could have done with some team building.
Vision became unclear once the project was up and running, could have been reviewed.
The focus group members all reiterated the above responses and came up with similar strengths and weaknesses.

Attitudes and working relationships:
Members were asked how attitudes and relationships had developed between the partners over the years. Overall opinion was positive. Attitudes towards one another and relationships have improved with greater understanding of each others roles and limitations within the group.

Community group members:
‘we’re still together, aims and role still relevant, overall running and monitoring of project is ok – trying to push the Health Board to look at broader issues never happened really so we now look to other forums/partnerships’

‘attitudes of the people involved have improved in that they now understand Traveller issues’
‘the project needed the partnership, it challenged both sides, it helped CTDG to be less isolated and marginalized...we needed Health Board for profile and funding, Health Board need our experience and us to deliver the work. Improve attitudes with people involved and with other community groups and Travellers’
Health Board members:
‘I had no experience of Travellers before, so I learned a lot about the difficulties Travellers have with accommodation and health, my attitude changed and as a group I think we came together and worked well to make sure the project worked’

‘attitudes and working relationships improved ...there were strong people involved initially that kept the focus and developed good relationships with CTDG, while we had different ideas and expectations at times – there was good work done. Generally dealing with voluntary groups they don’t see your professional advice and support as valuable unless there is money – but this was not the case with this partnership.’

Overall effectiveness of the process.
While this was not an actual question some of the interviewees went on to talk about the overall effectiveness of the process in a positive light but with some realistic cautions;

Community group members:
‘yes it is overall effective, but implementation is difficult – dependant on people and personalities – limited by institutions who want to hold the power’

‘working in partnership was still good, overall objective reached, successful’

‘very positive impact at some levels, change is slow’

Health Board members:
‘it was effective but the CTDG looking for more that we can not deliver on’

‘yes it worked 90% effective, achieved goals, always issues – part of the process’

4.4.4 Model of good practice / lessons learned
The National Traveller Health Strategy highlights Traveller Primary Health Care Initiatives such as this one as models of best practice of a community development approach to partnership. I asked members to reflect on their involvement within the partnership and whether they would consider it a model of good practice. I also asked them to identify lessons learned for future projects and partnerships. I coded the findings as
• models of best practice
• lessons learned
• advice for future partnerships

Model of best practice:
There was some hesitation in answering this, and while overall the members were positive they all added some words of caution or realism. This sentiment is best illustrated by a member of the focus group as:
‘yes it is a model...its not perfect and best practice implies perfection but that’s not realistic it’s a model we could build on’

Community group members:
‘a good model in its vision, time commitment and that it was a small group, but its implementation is difficult...change happened in small health initiatives but not at policy and service plan level’

‘yes idea and model is great....proved that we could do it, partnership always a struggle – it was the nearest thing to a true partnership we had. Could have been more dynamic, limited by some people and Health Boards response to issues but outcomes were good and a very positive experience’

‘one model of good practice is the PHC projects, elements that make them successful are the partnership with community groups’

Health Board members:
‘it is a model of good practice but tough and hard going, you need great patience and time to commit’

‘yes I think it could be a model, there was commitment to equality, mutual respect....we achieved our goal, addressing issues and beginning to impact – a sense of achievement’

‘could be a model of best practice –yes’

‘yes could be developed as a model of best practice, a very good mix, Health Board would need to be more proactive’

Lessons learned:
Lessons learned varied between the community group members and the Health Board members.

Community group members: The community group members identified two areas of learning
(i) Understanding of Health Board limitations,
‘learned about the restrictions and restraints of Health Board functioning.... took 2 yrs of a process to gain trust and commitment’
showed limitations of what can and cannot be done within Health Board, interesting experience of partnership process, its difficulties, time consuming but can work’

(ii) the energy and commitment involved in the partnership approach

‘it required a lot of energy and work, we always had to prove ourselves but they didn’t’

Health Board members:
The Health Board members however identified lessons learned in relation to their own requirements, such as the need for training and development of staff on working in partnership and one highlighted the issue of broader involvement.

‘need to feedback to key stakeholders and management to promote health and influence services’.

‘community groups demand a lot from us and don’t understand our role and limitations. I learned from my experience not to repeat it …I’m no good at conflict – I just want to do my job as best I can’

‘broader involvement of other stakeholders such as accommodation and social welfare could have helped, need for training and team building, feedback to key stakeholders and managers to promote the partnership and influence service planning’

‘a learning experience for me, never actually worked on such a partnership before, it took me six months to understand what the vision was,

Advice for future partnerships:
There was quite a consensus and commonality about the advice offered by both the community and Health Board members to future partnerships. The key areas of advice were focused on:

The need for senior management on board who have decision making powers
Equal participation / commitment
Specific and clear aims and objectives
Training and ongoing team building
Staff commitment and long term funding.

Community group members:
‘the need to have senior managers on board who can make decisions and influence policy’
‘equal participation and commitment from all partners’
‘specific aims and objectives, training to build capacity on both sides, flexibility to address needs of that community, respect boundaries, exchange information, solidarity built up, diversity, and members to choose to be on board where possible’

‘agreement that you will have high level officials, record minutes, appropriate decision making, look at representation to address any imbalance and that people are resourced’

‘joint training to develop mutual understanding, need to understand social determinants of health and its relevant in service delivery’

Health Board members:
‘for future partnerships there needs to be a lot of training, and you should have a choice or choose to be on the partnership- it makes a difference. It important to understand and clarify aims and roles and what we can and can’t do’

‘it’s the way forward, partnerships needed at all levels, training in what partnership and participation means is essential, clear ground rules, aims and objectives’

‘partnership is talked about a lot as the way forward ….there is a need for time and staff commitment and for long term funding’

‘support of senior managers and reduced workloads to allow time for process, and training’

‘need to know and define why you are on the committee, spell it out for all, clearly define role, aim and vision. Timescales agreed and a regular review of what works and is not working. Senior managers who can make decisions – we spent a lot of time on budgets that could have been dealt with quicker with the right person involved directly’

The members of the focus group discussion agreed on the following advice;

‘the need for training, need to understand each other’s roles and vision and what both sides expect from it, clear and realistic aims and objectives.’

4.4.5 Partnerships and Health Board.
I included the following question after doing the pilot interview as it arose in conversation with the key informant ‘There are very few practical experiences of partnership at health service delivery level, why is this?’ This is a question I have also asked myself during the
process of this study, it leads to the question ‘is true partnership possible?’

This question provoked a lot of discussion and opinions from most of the participants especially the community members who gave their perceptions of the Health Board’s view of partnership at present as:

Community group members:
‘not enough people in Health Board with vision, even then they are not sure about how to go about it…..institutions don’t work that way, partnership from an institutional perspective is having bums on seats. Health Board attitude is about representing my section and how it will affect my work’

‘Health Board people feel powerless to bring about change, difficult for people within to move a vision forward’

‘its never going to be perfect, years of institutional systems to change, embedded ideas …we still need to remind them to consult……….taking on board the broader determinants of health such as accommodation and discrimination – not really seen as their role’

‘Health Board people are being sent to committees and not knowing their role there, not being resourced…. They felt they were taken out of the board to do something else and lost to the board and colleagues- resented this – seen as doing something different, seen as you’re wasting your time and not doing you regular job – as result many Health Board workers stopped taking on new initiatives because of the isolation’

‘middle management the problem where the pressure is on the delivery of services, haven’t learned that by doing such initiatives – long term it would be more beneficial, from experience they have learned that such initiatives often get cut when funding is tight and they revert back to their routine jobs’

‘health strategy talks about health service providers being advocates – if health service providers saw that role they might engage more but they see themselves as health service deliverers…. Strategy identifies the wide gap and highlights the taking on of this role but does not follow through on training or how to – resulting in tokenism rather than real commitment’

‘community groups still outsiders in health – still the ‘how to keep the community happy’ attitude’
Health Board members:
Health Board members in some ways expressed similar views but tried to explain and give reasons as to why there are few partnerships:

‘there are few examples because it is so hard and demands a lot of time and energy with very little thanks…community group just want more and more and don’t understand the system’

‘Health Board reluctant because it is a big institution – we have a statutory responsibility but it is how you do it and work with others that count. A cultural change as well as a change in policy and frameworks is needed, there is a gradual change but reform has distracted people’

‘there is a reluctance because of staffing levels being low, the time commitment and need for long term funding….there is a need to share more such as more involvement with service planning if we are really committed to partnership…this is a good example’

‘The community feel they should be involved in everything….for example the service plans they are plans for the board and staff, what we have to deliver on – you can’t dictate to the community to deliver the same, I have no problem with them accessing once the plans are signed off on and work with us to get the service delivered – but to do up the plans –I don’t think so…service plans are for employees of the board- maybe consult more but they won’t fit in with our plans they have their own ideas on how to work and spend money’

‘not supported by management- they want you to be involved but when there is staff shortages you’re called back …and colleagues get tired of covering for you, as they see your off to yet another meeting- its difficult to marry the two’

Within the focus group discussion there were more optimistic responses to this;

Health Board members:
‘I think its improving as you say …the Traveller Health Unit is working well and over the last few years any new initiative taken on by the Health Board must be done in consultation with the community…..and the community is getting quite vocal –believe you me’

‘yes Health Board don’t get involved in these things (broader issues of health) we accept it affects health but we don’t get involved at
local level, but they are beginning to get together higher up the ladder at policy level over specific issues’

**Community group members:**
‘consultation isn’t partnership and it’s only happening because the community is getting vocal’

**True partnership:**
There were mixed views among members as to whether true partnership was possible with community members being sceptical but willing to work towards it and Health Board members being sceptical.

**Community group members:**
‘people in Health Board don’t understand true partnership, it takes time – it is possible’

‘yes real partnership is possible it happens in some countries – but with the Health Board at present it is not possible…..they still want partnership but on their own terms- I am sceptical but still willing to work towards it’

**Health Board members:**
‘yes it is possible but very difficult’
‘is true partnership possible – yes but down the way a bit’
‘true partnership – is it possible? I don’t think so’
‘I don’t really understand partnership – I don’t think it’s possible’

**4.4.6 Unequal power.**
The community group identified the inequality of power in relation to funding, especially in the early stages of the project; their perception was that the Health Board had more power because they held the money,

**Community group members:**
‘Health Board had more power as they funded...it was necessary to ensure their position was protected by protocols’
‘it varied at first we both had pressure to develop the project, we always had to prove ourselves to them, we did the work while they monitored it’

This perception was identified by a Health Board member also stating that the Health Board (at that time) worked on the model of ‘he who pays the piper calls the tune’.
However despite being the funders other Health Board members seemed to perceive themselves to be less empowered than the community group;
'I was powerless and felt I didn’t contribute anything to the committee'

'well there was a lot of ‘pushing agendas’ by the community group they saw us as having power – but we didn’t at least I didn’t.

The key informant had identified this as a barrier

‘Health Board can’t work in partnership with community if it is not happening within the board’

4.4.7 Understanding.
While at one level throughout the findings there was an agreement that there was understanding among the partners, it was even seen as a successful aspect that there was increased understanding among the members. On a more in-depth analysis there was some evidence of confusion and lack of understanding of each other on specific issues.

Aims and objective:
There was a perception that the aims and objectives were relatively clear to all. However CTDG highlighted the failure to impact broader issues such as addressing health inequalities, pushing boundaries on access to policy and service plans. This demonstrated their apparent understanding of the Primary Health Care Initiative’s stated aim.

To impact on health policy development at local and national level
However the Health Board members either did not share the understanding that they should support that aim, or felt they did not have the power to address this aim.

Health Board members:
‘we had no say in service plans – committee could have pushed but didn’t, Health Board resisted’

‘we would be inundated with accusations and demands – but really we don’t make these decisions’

Partnership:
While there were members who thought that true partnership is possible, it was clear from the comments that some of the Health Board members did not understand that partnership was about process and outcomes, that it meant, trust, sharing of information and working things out together12.

Health Board members:
‘we (Health Board) don’t understand the process of empowerment’

‘there is always a them and us situation’

There was mixed understanding of process verses outcomes, with one Health Board member expressing her lack of understanding at the length of time it took to train the Travellers as community
health workers even though timescales were agreed at the onset of the project. Interestingly from my reflective notes I noticed that the same person when discussing her own learning experiences stated ‘it took me 6mts to understand what the vision was’. Health Board members were on more than one occasion concerned about outcomes being slow, ‘difficulty in justifying process to Health Board’ There was a fear of sharing information expressed by one Health Board member who spoke of being ‘economical with the truth’ if there was a problem with service delivery rather than sharing the problem and trying to solve it together. There was mixed opinions about the idea of community groups participating in the planning of health services with one Health Board member quite adamantly against it in her comment Health Board members ‘no problem with them accessing once the plans are signed off on and work with us to get the services delivered – but to do up the service plans – I don’t think so’. While another Health Board member was more open to the idea ‘there is a need to share more such as more involvement with service planning if we are really committed to partnership’

4.4.8 Reflective notes:
From my reflective notes I have observed the following key changes and learning in my pre research assumptions and knowledge of the partnership process.

In the field notes from my interview with the Chairperson of the original committee (who was the Director of Community Care at that time) I had assumed that this position has decision making powers. This assumption I have discovered was wrong and that she was awaiting decisions from a higher level of management. This raises a couple of questions:
  i) Are roles and responsibilities with the Health Board clear within the Health Board?
  ii) Where does decision making responsibility ultimately lie within the Health Board?

Throughout the interviews Health Board members spoke of the Health Board as a third party with such comments as ‘difficult to justify to the Health Board’ which were repeated again and again. This only became apparent to me after it was pointed out by my supervisor. On reflection I have also referred to the Health Board as the third party on occasions. This may be reflective of Health Board workers own lack of power, sense of ownership and belonging. It may also reflect a strategy or desire not to take responsibility or make a decision and therefore identifies the institution which has
the decision making power as a separate entity. While the existence of this behaviour among Health Board workers may have a bearing on the process of involvement, it is beyond the scope of this study to explore this further.

While I was aware that some of the Health Board members of the steering group were uncomfortable about dealing with some of the conflict and disagreements that arose from time to time, I did not realise the stress and affect it had on one member in particular – so much so that she refused to participate in this research as she ‘didn’t want to go there’ this highlights for me the huge need for training and support of Health Board workers in how to work in partnerships, group dynamics and strategies to deal with conflict.

My reflective notes, after interviews with the Health Board members demonstrated to me that I felt there was confusion about what partnership means. Some people were talking about the committee as being the partnership others referred to the wider partnership between the Health Board and Clondalkin Travellers Development group and the steering committee as the management group with representation from both partners. It was evident from some of my notes and discussions with participants that I too sometimes used the words ‘committee’ and ‘partnership’ interchangeably.

5. Discussion and Conclusion.

How effective has the involvement process been within the Clondalkin Travellers Primary Health Care partnership?

In this chapter I have summarised the main findings of my research, followed by discussion of the key findings. I have compared these findings to the research I critiqued in my literature review for commonalities and differences and have attempted to be as objective as possible in discussing the strengths and weaknesses of my own research. I have highlighted the implications for further research and policy and drawn together the main conclusions of my work.

5.1 Summary of main findings

I have summarised using the different categories within my findings:

5.1.1 Setting up of the partnership.

There was an overall agreement that the partnership at the setting up phase was very effective and successful. Its effectiveness was attributed to clarity of aims and objectives, understanding of roles,
vision and commitment of the members and having senior managers involved who could make decisions.

5.1.2 The Involvement Process
The effectiveness of the involvement process was looked at through a number of themes, and the general perception from the findings was that the involvement process has been effective. The involvement process was most effective within the two years setting up phase. Over time however the involvement process changed and the perception of the members was that it was less dynamic because of a number of issues such as changes in Health Board members who were less senior with no decision making powers which lead to a reduction in participation and commitment. This lead to a transfer of the decision making power to the community group.

Training: The lack of joint training for all members in community participation and on how to work in partnership was highlighted as a major weakness of the process by both groups. This was a contributing factor to the lack of understanding between the partners, and to the shift in ownership and power that occurred.

5.1.3 Overview of present partnership
Members were positive about the partnership but stressed that implementation is difficult. Despite the present lull in the involvement process, agreed successes and outcomes by both partners included:

- Project set up
- Travellers trained and employed as community health workers,
- Achieved objectives and beginning to impact at local level
- Improved image for the community group
- Built relationships and improved attitudes of people involved.

5.1.4 Model of good practice / lessons learned:
This was best summed up in the focus group where the consensus view expressed was that ‘yes this partnership is a model of best practice – its not perfect and best practice implies perfection but that’s not realistic it’s a model we can build on’
Lessons learned were reflected in the advice offered by both the community and the Health Board members to future partnerships
1. The need for senior management on board who have decision making powers
2. Equal participation / commitment
3. Specific and clear aims and objectives
4. Training and ongoing team building
5. Staff commitment and long term funding.
5.1.5 Partnerships and Health Board
The findings from this section highlighted clearly that the community group and the Health Board members feel that the reasons there are still very few practical examples of partnerships at health service delivery level are multi-fold. Reasons include lack of staff and lack of support and value given to those who attempt to work in partnerships.

The study also highlights that the Health Board members cannot be expected to work in partnership if there is no experience of a partnership process within the Board (i.e. if there is no consultation or experience of partnership between different levels of staff and power is not devolved so that all decisions do not have to go right to the top). The Health Board is still a large institution and while there are individuals within the board with the vision, change must happen at systems and framework level to support partnerships.

5.1.6 Unequal power
The theme of unequal power arose throughout the findings. Over time both partners agreed that the power shifted to the community group regarding the planning and decision making process of the initiative. This happened by default rather than design as the Health Board members became less active. While both partners seem to have accepted this shift of power, some Health Board members felt disempowered as a result.

5.1.7 Understanding
Despite the overall effectiveness of the involvement process and success of the partnership, the findings also highlighted that there is still a lack of understanding between the members regarding some of the objectives. Some of the responses from the Health Board members showed that there is confusion and misunderstanding regarding partnership and what working in partnership means and requires.

5.2 Discussion of key findings
While I have presented all of my findings using the above categories I have found that the following themes have emerged strongly throughout the categories and require further discussion.

**Effectiveness of the involvement process**

**Unequal power**

**Understanding**

**Training**

**Health Board and Partnership**
5.2.1. Effectiveness of the involvement process:
The overall perception from the research is that the involvement process was effective. All agreed that the involvement process worked best and most effectively in the setting up phase of the project because it had clear aims and objectives. Roles were clear to most members and were seen as being successful because of the commitment and vision of all the members. As one Health Board member said ‘its strength was the people involved’.

This suggests to me that the effectiveness of the process was dependant on the personalities involved and their level of decision making power, which was confirmed later in that when people did change the level of effectiveness and strength of committee lessened.

There was equal participation and commitment at the setting up stage but over time participation and commitment from the Health Board members became significantly less. Reasons given were; the changes in committee members, lack of support and not seen as a key area of their workload. The constant change of Health Board committee members was a significant issue that was highlighted throughout the research and runs through all the themes to some degree.

The effectiveness of the involvement process was seen by the participants in terms of:

1. **Impact both within and outside the partnership.** The community group members identified that the process not only improved attitudes among the people involved but it improved the image of CTDG within the community and other groups. The Health Board members identified more individual gains of increased understanding of the time commitment to the process, Traveller issues and an increased awareness among some health service providers of Traveller culture and health needs.

2. **Working relationships.** Both groups acknowledge that the working relationship was good at the partnership/committee level. Unfortunately this did not extend to higher Health Board level to influence policy or to look at broader issues, as the community group commented ‘struggled to encourage people to be more active – a waste of time as they had no decision making powers – so we looked to other forums’.

3. **Outcomes.** As I expected the Health Board members looked at outcomes more than the process when asked about the success of the partnership, and the outcomes are valid when looking at the effectiveness of any partnership. The tangible outcomes were that the project was set up and is running for 8 yrs, has trained Traveller Women to be Community Health
Workers, employed by the Health Board and are providing a peer-led health promotion service to the Travelling Community.

While the perception of the participants was that the process was effective and is a model of best practice, only one spoke of the key elements that constituted best practice. This was one of the key informants, who is not part of this partnership initiative but was an external advisor.

The key elements for best practice identified from her experience were:

1. Partnership with community group essential.
2. People who have the capacity to operate at steering committee level on both sides, building capacity levels, supported to attend- childcare etc.
3. Joint training – to understand the partnership,
4. Understand social determinants of health.
5. Joint training to develop mutual understanding, clarity of terms, clear on the decision making process to reduce conflicts, a good reporting system time to prepare.
6. People who have decision making capacity – come to the table.

When judged against these key elements the involvement process could be measured as partially successful and as one participant said can be built on:

1. The partnership is with a community group
2. People who have the capacity to operate at steering committee level on both sides: this was only partially true of this committee, clearly some Health Board members felt they did not have the capacity and were not supported to attend or participate. The community group had the capacity.
3. There was only one day of joint training in 8 yrs.
4. While there was some understanding of the social determinant of health by the Health Board members there was a resistance/ inability to act on them and to address such issues as accommodation.
5. While the training did not happen there was a level of understanding, clarity of terms, reduced conflict and a good reporting system in the initial stages of the process but less so in the present partnership.
6. People with decision making capacity were present around the table from both partners at the initial stages but decreased as members from the Health Board side changed
5.2.2. Unequal power.
Throughout the interviews and in the focus group discussion I was very aware that the imbalance of power was an emerging theme. In the initial setting up phase both partners acknowledged that the Health Board had more of the power as they were providing the funding and that the community group worked hard and negotiated structures and protocol to ensure an equal position. Over time although the Health Board remained the funding agency, the power shifted to the community group regarding the planning and decision making process of the initiative.

As the partnership evolved, both partners identified this transfer of power from the Health Board to the community group. This happened for a number of reasons, the main ones being:

• The changes in Health Board membership. Having only one constant member over the 8yrs affected the dynamics of the partnership because those that replaced the original members were not senior management and had no decision making powers. They also had no choice – but were told to participate. This had a negative effect on their motivation and over time this resulted in the Health Board members being less active, more passive and losing ownership of the process.
• Lack of joint training and support for member to participate fully.
• The community group continued to be pro-active both in managing the project and in pushing their agendas, taking ownership of the project and partnership. Again this process and change in power balance was recognised by both groups, as one Health Board member said ‘CTDG held the control a bit- maybe not intentionally but because the health board stepped back’.

There was a general acceptance of this shift of control and ownership by both groups, the community group were happy to be making the decisions, while the Health Board members recognised their lack of commitment and time to participate more, and that being on the committee was not a key area of their workload, it was more an add-on.

This study shows that there was a transfer of power to the community group, a requirement of true partnership12, however it did appear to happen through lack of participation from the Health Board rather than an agreed part of the process.

5.2.3. Understanding
When asked about aims and objectives most were satisfied that these were clear, implying that there was a common understanding.
There were also indications that understanding on specific issues such as Health Board structure and functioning as well as on community and Traveller issues improved. However through a closer examination of what participants said it became apparent that a common understanding of specific objectives and partnership processes was lacking

While the community group understood that the partnership should endeavour to impact Traveller health policy at local and national level the Health Board did not appear to support this objective. This may be the result of a lack of common understanding between partners or because the Health Board members felt they neither had the support or remit to support this objective.

From my in-depth analysis of the findings I realise that there is still a lack of understanding among some Health Board members on what partnership is about and what it entails. There were ongoing concerns from some Health Board members on how to justify the processes in terms of outcomes. There is still some lack of openness and trust on both sides, especially by the Health Board members who admitted to being economical with the truth to avoid blame and pressure from the community group, which in reality would have happened. The level of partnership where problems and responsibilities can be discussed and shared together requires a higher level of openness and understanding. The mixed opinions of Health Board members on whether to allow the community group access to the planning of health service does indicate a shift towards the concept of community involvement at that level and is supported by health policy.

5.2.4 Training
The need for training for the members of the partnership was echoed throughout the findings in all the interviews and especially at the focus group discussion. It was identified as a weakness within the partnership by all members. The lack of training and its effects on the process have been highlighted by both the community and the Health Board but especially the Health Board members who acknowledged their limited experience of working in partnerships and the need for clearer understanding on both sides regarding roles and limitations of workloads.

Conflict was accepted as part of the process by most, but some of the Health Board members found it difficult to deal with conflict and one in particular was very stressed by this issue. This finding highlights a need for training of Health Board staff on strategies to deal with conflict, and team building as well as working in partnership.
The participants of the study identified the following areas of training as necessary.

1. Joint training for the committee members to cover team building, how to work in partnership and how to dealing with conflict.
2. Training for the Health Board members on community development/team building and strategies to deal with conflict.
3. Training on the broader determinants of health and community development at university level to all health service trainees.

5.2.5. Partnership and Health Board

The majority of participants identified that the ethos of partnership in health care is here to stay. However this study questions how committed in practice the Health Board is to the partnership approach, a number of issues were highlighted for this:

- Health Board perception of partnership at the moment as a ‘chore’ and that ‘partnership from an institutional perspective is having bums on seats’ (indicating that numbers present are more important than the level of participation) This is echoed by feedback from the Health Board members also, who clearly experience the lack of support, understanding and value given to those who attempt to work in partnership. The key informant supported their comments from her experience of talking to Health Board personnel active in partnerships and highlights the need for a ‘how-to guide’ to facilitate involvement along with training for Health Board staff.

- There are a limited number of personnel with vision within the Health Board, but are powerless to change such a structure, it is still a hierarchical institution in need of cultural change ‘years of institutional system to change- embedded ideas to change’. This supports my previous conclusion that at the moment Health Board partnerships such as this one are still reliant on personalities and the vision of the individual.

- The Health Board while recognising the broader determinant of health at policy level are only beginning to see it as part of their responsibility, this issue has been discussed in the research by the community group members as ‘broader issues not being taken on board such as accommodation’ and one of the key informants who highlighted the fact that the Health Strategy recognises the ‘advocacy’ role of health service providers but that they do not see that role themselves. This suggests that it is beginning to happen at policy level but it is like a step too far at the moment at primary care level to go from being a service provider with the power and
responsibility to an advocacy role of empowering others to be active and to share power and responsibility.

- Health Board members state that the Health Board is still a big institution ‘in need of cultural change’ and that while partnership is talked about there is a reluctance because of staffing levels ‘when staff are short you get called back to do extra work ‘Colleagues get tired of covering and don’t understand – it’s difficult to marry the two’. Highlighting the lack of commitment and the lack of vision and understanding that partnerships can provide a long term sustainable health service.

- Another area highlighted by the Health Board members throughout the research is their own lack of power within the Health Board regarding access to influencing service plans and policies, that they ‘can’t deliver on’ on issues they cannot influence. One of the key informants identified this issue also by concluding that, ‘Health Board can’t work in partnership with community if it is not happening within the board’

This comment suggests a key barrier to achieving successful partnerships with the Health Boards. Health Board workers have to experience what it is like to work in partnership within their organisation before they can be expected to work in partnership with the community and other groups. This is a huge challenge that must be addressed within all levels of the Health Board in tandem.

5.3. Comparison with other literature

In my literature review section partnership was defined as a formal alliance of organisations, groups and agencies that have come together for a common goal. This partnership between the Health Board and the Community development group adheres to this definition.

I compared the partnership to Arnstein’s ‘Ladder of Participation’ (Appendix 1) which states:

‘Partnership: From this point on the ladder of citizen power there is increasing degrees of influence on decision making. When citizens enter into a partnership there is the possibility of negotiation and engagement with trade-offs with traditional powerholders. Power is redistributed as planning and decision-making responsibilities are shared. This can happen in situation such as joint committees’

Findings from this research suggest that within this partnership the power has been redistributed to the community group regarding the planning and decision making responsibilities of the initiative. This
occurred through pro-active engagement by the community group and partly by the Health Board taking a back seat with less participation. This partnership has a firm foothold on the partnership step of the ladder of participation.

Partnerships are seen as an effective way to tackle the health inequality gaps of ethnic minorities. I found it interesting to note that most of the international evidence in which there were effective partnerships, have all involved ethnic minority groups, and bodes well for this partnership with the Travellers ethnic group. One participant of the study noted that ‘Partnerships work well with marginalised and excluded groups ...as it is more appropriate, need is greater’. This need was highlighted through the Dept of Health policy documents and supported by the Health Board members in the initial setting up of the partnership who identified 'that there were specific needs of Travellers not met and a need for this project'.

From my literature review the only other evaluated evidence of primary health care partnerships at service delivery level using a community development approach in Ireland was the Connemara project and as it happened one of the co-ordinators of that project is a key informant for this research. In my interview with the key informant the two main issues for the project being discontinued was due to:

1. Different understandings of success and outcomes.
2. No long term commitment or sharing of power by Health Board.

These two issues have also been identified in this research; however unlike the Connemara project there was joint understanding of the success and outcomes of the partnership among the members. While in principle this partnership is considered to be a long term commitment, the research findings highlighted that this does not always translate into practice with the reduced participation of Health Board members to the partnership over the last few years. Health Board members are not being supported by management and when there is a shortage of staff elsewhere they are called on to do extra work and the partnership process is not seen as ‘an important job in itself’. The sharing of power was identified as an issue by the community group who kept pushing the boundaries to try and influence policy and planning while the Health Board members resisted, however there has been a redistribution of the planning and decision making powers to the community group in relation to the health care initiative. Although this has happened more by default than by agreement, it has happened and accepted by the members.
Thirteen years on, it is encouraging to see progress has been made, that within this partnership there is more understanding and common ground between the partners on these two issues and is less of a barrier within this partnership process. This is probably attributed to the shift in attitudes within the Health Boards towards participation over the last few years.

5.3.1 Evaluating the effectiveness of the involvement process
The focus of my research was to explore the effectiveness of the involvement process within the partnership. It is clear from the findings that the involvement process worked best and most effectively at the initial setting up phase of the partnership, a period of two years in total. The factors that contributed to this, according to the participants were similar to what Dowling mentions as dimensions of process success, commitment and vision of the participants, clear aims and need for the partnership, trust and confidence between partners which was highlighted in this partnership by the ‘confidence in the chairperson’ and the presence of senior management.

Dowling and Ansari mentions the need for a favourable environment such as financial, political and institutional, while this research did not directly refer to this issue one participant did mention that a needs assessment had been carried out and that the then Health Strategy supported such initiatives. Also the first Primary health care project for Travellers had been set up 3yrs previously and was seen as successful. On reflection I would say that there was a favourable policy environment, apart from the financial aspect.

As with many of the previous studies, in this study both partners referred to the difficulty of putting partnership into practice, referring to the process as hard work, time consuming and driven by commitment and personalities at times.

Lessons learned from the experiences of both partners were reflected in their common advice to future partnerships;
- The need for senior management on board who have decision making powers
- Equal participation / commitment
- Specific and clear aims and objectives
- Training and ongoing team building
- Staff commitment and long term funding.

These were similar to those identified by Heenan and Dowling as well as in the guidelines from policy documents.
5.3.2 Model of good practice

My research shows that the involvement process with its vision, commitment and transfer of power to the community group has the potential of being a model of good practice with partial success when compared to key elements outlined by the key informant. In my literature review I mentioned guidelines and principles from a number of policy documents such as the NHS 52 the Health Development Agency 53 and the recently published Position Paper on Community Involvement 51 all with similar content.

In commencing this research I focused on the proposed principles put together by the Office of Health Management (Appendix 2). By comparing the effectiveness of the involvement process of this partnership to those principles, the majority of the principles are in place, to a lesser or greater degree. The rights-based approach, mutual co-operation and support, a concern for process and financial support are still reasonably strong. The trust, commitment, communication, evaluation and delegation of power equally, aspects while stronger in the early stages are still present but have been weakened. The one principle which was perceived as lacking in this study was the ‘commitment to embedding partnership within the structure of the health system’. This was identified by the community as ‘not enough people in Health Board with vision’, by Health Board members as ‘not supported by management to participate’ and by the key informant as ‘no institutional learning partnership is ad-hoc’.

These two comparisons suggest that this involvement process is a model of good practice that could be built upon. The process was most effective in the initial setting up phase, but because of the lack of training, changes in Health Board membership and no review of the process over time the involvement process has became stale or ‘lulled’ as one participant said. This would suggest that while time for process is important it is equally important to review, evaluate and set timescales.

Best practice implies perfection and like the other studies 38, 39, 40 that reviewed the involvement process within partnerships none were fully engaged in genuine participation, but despite the difficulties and weaknesses this partnership is working at most levels.

5.3.3 Unequal power.

In my research the participation of the Health Board members lessened over time and as one member said ‘we took a back seat’ in the partnership. This was contrary to the findings of the study on
respite care of HIV clients by Lindsey where the health authority had limited involvement initially but became interested as the project developed, and went on to research the usefulness of such a model to other communities.

This lack of involvement by health workers was also a theme that arose in Heenans study of a community health promotion project that was difficult to sustain momentum because of the lack of involvement of some parties and resulting in burn out of others. While burn out was not a factor in this research it could be a possibility in the future among the community group.

The constant changes of Health Board committee members was a significant issue throughout my research but this issue did not feature directly in the literature I reviewed, however the issue of unequal power was common to a number, if not all, of the studies I reviewed. It was clearly highlighted in Michener’s study suggesting that the unequal power relationships are subject to manipulation and dependency with the community seeing it as an opportunity to extract resources and the statutory agencies holding on to the funds and decision making thus supporting the dependency. What is different in my research is that it is the community group who have more of the power now in relation to the planning and decision making process of the initiative, this imbalance of power has been acceptable to both partners for some time now.

In my research the transfer of power happened as a result of the frequent changes in Health Board membership which had a knock on effect of the ownership being shifted to the community group. The lack of decision making powers among the new Health Board members allowed this shift in power. Ritchie’s study of the process in a health promotion setting concurs with the perspective of unequal representation and involvement resulting in disempowerment, but it was the community members that were disempowered. Crawshaw also highlights the effects and difficulties of engaging and sustaining community involvement.

In my research the community group are a well established community development project, which was not the case in either Ritchie’s or Crawshaw’s research. That may account for the shift in power towards the community group. This research is at odds with the findings of the literature reviewed where the power was perceived to be with the Health services.

5.3.4 Understanding.

Consistent with other studies this research found some lack of understandings between the Health Board and the community group
regarding aspects of the objectives and what partnership entails. Heenan\textsuperscript{40} in her results highlighted similar differences ‘different understanding of partnerships’ different expectations and unrealistic expectations’ and referred to them as key challenges of the process. Naylor \textsuperscript{41} referred to the lack of understanding of partnership and roles as critical issues that affects the level of participation and commitment to the process. The lack of understanding of and commitment to the concept of public involvement was also a consistent finding in the review of public involvement in health\textsuperscript{28} by the Dept of Health in England, and seen as tensions where health service providers see public involvement as beneficial in terms of compliance, management and control of patient health behaviour.

The recent position paper on \textit{Guidelines for Community Involvement in Health}\textsuperscript{51} also highlights the lack of understanding of structures and roles can lead to suspicion and reluctants to participate fully.

\textbf{5.3.5 Training.}

The lack of training for the participants of the partnership was seen as a significant weakness of the process in the research. It was highlighted by both partners but especially by the Health Board members who identified their own lack of knowledge on community development and partnership issues ‘can’t expect people to take on roles without training’. Most of the literature \textsuperscript{34, 40, 48} referred to training as an essential component both at the setting up phase and as an ongoing support to participants of partnerships.

Looking at the Irish context, Lifford Primary Care Project\textsuperscript{50} in their criteria for effective representation, clearly identify similar training needs for Health Board staff on ‘how the community sector works, how to work in partnership, and how to listen and accept different views, negotiate and reach consensus’ as well as support and capacity building for all representatives. The recently publicised \textit{Guidelines for Community Involvement in Health}\textsuperscript{51} in their analysis of projects where Health Boards have engaged with communities found that the need for training was a common theme. Of vital importance is the issue of high quality training, such as capacity building for both community and Health Boards, training on the social model of health, racism, ethos of community development for Health Board staff and how Health Boards operate, their systems protocols and structures for community representatives.

The report also identifies the need for what they call tacit facets of partnership work, which looks at; ‘the key issues of power and knowledge differentials, various education levels, perspectives and experience. Successful outcomes for this type of training would be a willingness to agree common
goals, vision, structures and processes for mediating differences and getting the job done.’

5.3.6 Partnership and Health Board.
A question I had throughout my research was why there are so few examples of partnerships with the Health Board. This was answered quite strongly through the different themes and issues. While a number of reasons were given, the study indicates that the partnership process may not enjoy a priority position of commitment by the Health Board in practice as it does in the policy documents. Findings indicate a lack of understanding of what partnership is, limited number of personnel with the vision of partnership, not taking on the broader determinant of health, an institution in need of cultural changes and above all as identified by a key informant:

‘Health Boards can’t work in partnership with community if it is not happening within the board’

Some of these issues were also identified in other research. Heenan highlighted the need for ‘Cultural change to break down the hierarchical and bureaucratic mindsets’ as well as a resistance to give up control and power share which was strongly supported by Michener. However in my research the Health Board members did not see themselves as having power, it was higher up in the Health Board.

Within the Irish context a Primary Care Conference, in looking at community involvement, acknowledged the ‘sense of the enormity of what needs to be done’ within the Health Board to be committed to community involvement such as commitment of time and resources, acceptance of process and addressing the broader determinants of health.

The recent research done as part of the position paper on community involvement also identified a number of issues indicating the Health Boards capacity for partnership, the low response from Health Boards to submit examples of what they considered to be successful initiatives involving communities indicating ‘that community involvement issues do not enjoy a priority position in each Health Board as yet’. From consultation with service providers involved in the process, behavioral and attitudinal changes were required on the part of the professional involved, change in individuals style, mindset and use of language and a challenge to move outside their comfort zone to enable the process to be successful.

While the research found a range of effective models they existed in isolation as ‘pilots’ or ‘add-ons’ rather than central to the
mainstream health system, again reflecting, as in this research, the lack of institutional learning and strategic commitment to partnerships. This extends into its recommendations of key enablers being sub-divided into strategic, task and process, the strategic enablers focusing on ensuring commitment at corporate strategic level and sustained in all strategic plans, high level sponsor for the committee and senior level staff to ensure a high profile.

My research supported by the literature has identified some of the challenges that exist in the Irish context by looking at one example of partnership between the Health Board and a community group and provides some lessons learned from the practical experience of a working partnership.

5.4 Strengths and limitations of the study

This is a small study focusing on one partnership initiative only. As a consequence the findings cannot be used to generalize. The fact that I am one of the co-ordinators of the project was both an asset and a limitation, an asset in that I have an in-depth understanding of the initiative, the commitment and interest in the process to carry out the study. This could be seen as a limitation in that it has been difficult to reduce and minimise bias, on reflection I think it was more of a strength than a limitation in that my acknowledgement of my own involvement and bias did encourage openness especially in the focus group discussion and the learning from my reflexive notes have added to the story of the research.

The qualitative methodology used was appropriate for this study given the research question and the time restriction for the thesis. The focus group, on reflection would have been more effective if I had been able to engage all the participants that were interviewed. The questions for my semi-structured interviews were based on policy and previous studies on involvement process. Qualitative research has the potential to be difficult to set limits on in terms of level of depth. When doing the analysis I discovered there were still more unanswered questions which, perhaps, I could have focused more on or developed more. However I was very aware of my time frame and took a pragmatic approach in focus so that if interviewees digressed off the point I didn’t include their digression in the analysis. This strict focus may have limited dept of understanding on issues not foreseen when designing the questions. However the focus group session did provide the opportunity for areas missed to be brought up.

Time permitting it would have been better if I could have used a third method such as analysis of records /meetings and reports of
the partnership which would have added stronger validation through triangulation.

Ideally this type of research should have been done using participant observation over a period of years supported by interviews and focus group discussions as was done in the New Zealand study and by Crawshaw, and to broaden out the study to include analysis of outcomes. As the research was exploratory in nature, data saturation was not reached and again a comparison of two or more Primary health care partnerships would have strengthened the research.

Another strength or result of me as coordinator and researcher is that the present committee of the project have actually started to implement some of the recommendations of this study e.g. incorporate training into the steering committee meetings. The first session was on community development –overview and principles, it was agreed that the training would be rotated between each partner on agreed topics.

On a personal note the benefit for me is the total experience of carrying out the research. As a health service provider, prior to this I would have been the type to shy away from the words ‘let’s do research’ the process has demystified and reduced my own bias towards research. I now see the benefits to service provision of systematic investigation into what we are doing and why.

Taking the reflexive approach; keeping a diary and notes was a learning experience for me. I did not believe that my presence in the research was an asset but rather a bias, until I started to do the diary and notes and more importantly analyse them in the context of my findings- it was a bit like stepping out of a situation and looking in at it through other peoples eyes.

5.5 Implications for further research and policy

This study is important because though recommended in health strategies and policies partnership approaches are still rare and evaluation and learning from them even more rare. If this approach to health service provision is to be recommended it must be on the basis of learning through experiences such as this.

This partnership initiative has been running now for over 8 years, it is one of the few partnerships at health service delivery level in the primary health care setting in Ireland today.

This study even with its limitations gives us an insight into the partnership experience. It provides the Health Board and community groups with a small but realistic and practical
experience of a partnership at work, its difficulties, limitation, barriers and more importantly lessons to learn.

While this study alone could not be used to inform policy, the findings reflect those of other larger studies outside Ireland and supports the most recent position paper on community participation in the Irish health service, and together could inform and add a seriously lacking practical dimension and a ‘how to’ guide to the health policy documents that promote partnerships and support the development of future partnerships in health service delivery.

This research highlights the need for more in depth research into similar and different partnerships in health care throughout Ireland and mechanisms which would help health services work together with groups and public to provide services to meet the needs. There is also scope to do comparative studies into how effective partnerships are within different settings and communities such as different ethnic/minority groups, rural and urban communities, different primary and secondary health care settings.

5.6 Conclusions and Recommendations.

The Irish Health Care Services are currently going through a reform and change process, especially the Primary Health Care services. Partnerships in health care will play a key part in this change and while there are guidelines available, this study can support these guidelines by providing an insight into the practical experience of people working in partnerships.

This study can contribute through the sharing of these experiences, both positive and negative, what is needed to maximize the potential within partnerships, a much valued strategy for the promotion of health.

The main conclusions from this research are that within the partnership of Clondalkin Travellers Primary Health Care Initiative, the involvement process has been effective especially in the initial stages of the partnership. However it is less dynamic now because of a number of issues including, lack of training and capacity building for all partners and frequent changes in Health Board members, resulting in a lack of participation and commitment. There has been a shift of power to the community group regarding the planning and decision making process of the initiative. The study questions how committed in practice the Health Board has been to the partnership process to date and identifies this as a key challenge that needs to be addressed before it can commit to working long-term in partnerships.
This study shows that despite its weaknesses, difficulties with participation and lack of real understanding on some issues the involvement process has been effective and that translating policy into practice can happen. This working partnership is an example that others can build on and learn from.

Recommendations

**Clondalkin Travellers Primary Health Care Partnership**

- As a result of carrying out this research on the Clondalkin Travellers Primary Health Care Partnership the members of the committee have agreed to carry out joint training.
- I would recommend that this training should include team building, understanding of community development, working in partnership and conflict resolution.
- Another recommendation for this partnership would be to carry out a full review and evaluation of the partnership’s aims & objectives, the role of the committee and outcomes of the initiative.

**Future partnerships in Health Care**

- All Health Board staff that are working in partnerships or planning to work in partnerships needs to be trained and supported to be committed members of those partnerships, partnership work should be acknowledged and priorities as part of their workload.
- As this initiative is the second of its kind in Ireland and has now been replicated throughout the HSE, the findings from this research could be used to inform the learning of those partnerships.
- Present and new partnerships in the Primary Care setting to develop codes of practice and written agreements that will include and clarify definitions, values, principles and process issues for all members of the partnership.

**Health Service Executive**

- Broader recommendations to promote the partnership process within the Health Service Executive would include:
- Commitment to resource and support present and new partnerships in health care by actively using the guidelines provided by the Health Board Executive \(^{49}\) and the more recent position paper `Community Involvement in Health`\(^{51}\).
- Training of students entering the health care professions, as part of their curriculum to be trained in community development and the ethos of working in partnership.
• Strengthening of inter-departmental co-operation between Department of Health / HSE and all relevant departments to accept and address the broader determinants of health. This is happening regarding specific issues and within some areas but needs to be across the board. The smoking ban was a positive example of this in action.

• Ongoing in-service training of health service staff on how to work in partnership, and the tacit facets of partnership. There was a ‘Partnership within and between’ multidisciplinary development programme facilitated by the social development network which addressed this issue, but it was ad-hoc and got lost in the break up of the Eastern Health Board.

• Within the health service reform that a culture of empowerment, responsibility, authority and accountability is promoted among all staffing levels, to identify clear decision making steps for relevant levels of authority and to reduce this concept of the Health Board being a third person.
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Title: Evaluation of the Impact of the S.T.A.B.L.E. Program on the Pre-transport Care of the Neonate

Authors:
Nancy O’Neill, RN, MN, Neonatal Nurse Practitioner, IWK Health Centre, Halifax, Nova Scotia, Canada Tel: (902)470-8895  nancy.oneill@iwk.nshealth.ca
Alexandra Howlett, MD FRCPC, FAAP Dalhousie University, Halifax, Nova Scotia (902)470-6466  ahowlett@dal.ca

Background and context: Neonates requiring urgent transport are critically ill, and require skilled stabilization prior to transport. When an unexpectedly ill neonate is delivered in a community hospital there is a need for the staff at these sites to be reasonably confident and proficient in pre-transport stabilization. The S.T.A.B.L.E. Program focuses on the stabilization and pre-transport care the referral centre will need to provide while awaiting the transport team.

Aim of the study: To assess if the STABLE Education Program increases regional healthcare provider perceived confidence and clinical abilities in pre-transport stabilization; and to assess the care of transported neonates.

Methodology: A retrospective chart review of all neonates transported in two time periods. A one-page questionnaire utilizing a Likert scale was sent to all participants in the STABLE Program during the initial 13 months

Sample: 124 questionnaires were sent to the participants of the STABLE Program during the study period. 127 charts were reviewed.

Analysis: Mean scores were obtained for each item on the questionnaire as well as calculated responses in percentage. Clinical features of infants were compared using independent t-tests. Comparisons of proportions were made using chi squared tests. Continuous variables were compared using independent t-tests.

Main Outcome Variable: regional health care providers perceived confidence and increased clinical abilities in pre-transport stabilization and pre-transport management of neonates.
Results: 64/124 questionnaires were completed. 96% of participants indicated the course was relevant and useful. 90% indicated that they felt more confident in neonatal pre-transport stabilization, and 86.5% indicated that they had adopted principles of the STABLE Program into their practice. 127 charts were reviewed. There were no differences in birth weight or gestation in the two groups. Analysis of interventions based on the STABLE guidelines in the two time periods was performed and no significant differences were detected.
The Effects of Pre-Oxygenation on Oxygen Saturations after Saline Instillation and Suctioning in Mechanically Ventilated Patients – A Pilot Study

Emily Orme  BSc (Hons) Physiotherapy, MSc
Physiotherapy Lecturer Practitioner
Department of Health and Social Sciences
London South Bank University
Borough Road, London SE1 0AA
England
Tel. (00 44) 020 7815 6151
Email: woodhoue@lsbu.ac.uk

Background
The instillation of saline into the endotracheal tube, prior to suctioning in order to facilitate the clearance of secretions remains controversial. While some research studies have shown that saline helps loosen secretions and is advantageous, other studies have shown that saline may lead to a drop in blood oxygen levels which could be detrimental to the patient (Bostick and Wendelgass, 1987, Gray et al, 1990, Ackerman et al, 1996, Kinloch, 1999).

Aim
The aim of this study was to investigate whether pre-oxygenating ventilated patients, prior to the instillation of saline and suctioning, prevents a drop in oxygen saturation levels.

Methodology
Ethical approval was obtained. 4 ventilated (ITU) patients (2 male) with a mean age 51 years took part. All patients in this pilot study, a randomised controlled cross over design, had thick, tenacious secretions. Subjects were allocated to either (i) the pre-oxygenation group where 100% oxygen was delivered for one minute before the instillation of 5mls saline and one suction or (ii) a standard intervention group who did not undergo pre-oxygenation before saline instillation and suctioning as above. Saturation levels were measured on a Siemens pulse oximeter pre and post suction.

Analysis
The student’s t test was used to determine the significance of the difference in oxygen saturations between the 2 groups for each of the specific time periods. A p-value of >0.05 was considered statistically significant.
Summary
Pre-oxygenation caused a statistically and clinically significant rise in saturation levels from baseline (p=0.02). Both groups experienced oxygen desaturation and the rate of fall was greater in the standard intervention participants compared to the pre-oxygenation group, however these differences did not reach significant levels.

Conclusion
This small pilot study provides preliminary evidence that pre-oxygenation is beneficial when using saline and suctioning mechanically ventilated patients. This could have important implications in the clinical setting and necessitates the need for a much larger clinical trial.

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PARENTS' PERSPECTIVES: CHALLENGES TO EARLY INTERVENTION SERVICE PLANNING AND DELIVERY

Mary Hegarty (1), Clare O’Shaughnessy (2), Hannah Richards (3).

1) Mary Hegarty, Lead Qualitative Researcher, Health Service Executive Dublin Mid Leinster area.

2) Clare O’Shaughnessy, MSc, Lecturer Speech and Language Therapy Department, National University of Ireland Galway, Aras Moyola, Galway. Phone: 091 492957. Email: clare.oshaughnessy@nuigalway.ie

3) Hannah Richards, Specialist Speech and Language Therapist, Wales NHS

A partnership approach to planning is essential with the family involved in the process of collecting information, evaluating it, and making decisions. The need to empower families to be involved in services is crucial. There is a need to organise services so as to promote optimum child outcome and greater parental well-being. In 2004, Health Service Executive Dublin Mid Leinster area, disability services identified a need for parental involvement in the assessment planning and review of Early Intervention Services (EIS) for children with disabilities from birth to six years of age.

This research aimed to identify the needs of these children from the parents’ perspective and to recommend a communication process that is most appropriate for ongoing communication regarding these needs. The approach used was qualitative: five focus groups were held with parents of children who avail of EIS. The selection process aimed to randomly include type of disability and gender and two age groups (0-3 years and 3-6 years) within each group. 19 parents out of 60 families contacted attended.

The outcome of this study highlights the necessity for ongoing regular consultation with parents to facilitate articulation of their needs. Although the sample size is small, the depth of information provided by the parents in this study offers valuable insight into their perceptions of time of referral, disclosure of diagnosis, information and support. It is important to use other methods of consultation for example interviews at venues used by the parents e.g. waiting rooms or through telephone or postal contact.
Consultation can also take place through parent support groups locally and nationally. Parents need to feel they are equals and feel empowered in their dealings with professionals. A partnership approach within which parents are recognised as the expert on their child will help in achieving successful collaboration.
ENHANCING COMMUNICATION FOR ADULTS WITH LEARNING DISABILITIES: NURSING STAFF TRAINING PROJECT 2005

Clare O’Shaughnessy MSc (1) and Finnuala Goulding BSc (2)

1) Lecturer
Speech and Language Therapy Department,
National University of Ireland Galway,
Aras Moyola,
Galway.
Phone: 091 492957.
Email: clare.oshaughnessy@nuigalway.ie

2) Specialist Speech and Language Therapist – Additional Needs.
Birleywood Health Centre,
Digmoor,
Skelmersdale,
Lancashire WN8 9BW
England.
Phone Number: 00441695 724301.
E-Mail: Finnuala.Goulding@westlancspct.nhs.uk

Acknowledgements to all staff and clients who were involved from the Health Service Executive Dublin Mid Leinster area.

A difficulty with communication significantly impairs the ability to achieve independence. The responsibility for promoting effective communication is a shared responsibility amongst all of those who live or work with adults with learning disabilities (ALD) (Royal College of Speech and Language Therapists, 2003). A speech and language therapy (SLT) service to ALD clients within the community was piloted in the Health Service Executive Dublin Mid Leinster area and through consultation it was agreed that the intervention should be in the context of a social model of disability.

This project aimed to:
- Help staff to recognise and adapt their communication style to facilitate the communication needs of their clients.
- Inform SLT practice for this client group
- Provide recommendations for future SLT service provision to ALD clients

The research design was a combination of qualitative and quantitative methods. Following a consultation process 11 staff
members and 11 clients within 6 community houses participated fully in the project.

Each staff member:
- Selected a communication partner
- Attended 2 days training based on the “Take Two!” training package (Purcell, M., McConkey, R. and Morris, I., 2000)
- Completed video interactions pre and post training
- Completed a communication profile with the SLT

The findings were analysed and comparisons were made between the staff’s interaction skills pre and post the project. The majority of staff members improved in their use of communication strategies, allowing the client to lead communication and responding more appropriately. They were more aware of the communication needs of their communication partner and had an increased awareness of their own communication and its effects on others. The information and knowledge learned and obtained during the project supports linking communication goals to the goals set in the person centred planning process.

The project was carried out with limited resources and time allocation. It acknowledges that facilitating staff training and developing communication profiles for ALD clients will benefit the clients to achieve their communicative competence potential.

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Clinical Skills fair at a University Hospital. Innovation for Practice

Author/s:

Helena Hanrahan, Clinical Facilitator A&E, Mary McLoughlin, Clinical Facilitator Oncology, Grainne O’ Shea, International Nurse Facilitator, Christine Sheehan, Clinical Facilitator ICU.

Galway Regional Hospitals, HSE Western Area.
University College Hospital, Newcastle Road, Galway.
Telephone: (091) 524222

GrainneB.OShea@mailn.hse.ie; Helena.Hanrahan@mailn.hse.ie; Christine.Sheehan@mailn.hse.ie; Mary.Mcloughlin@mailn.hse.ie

The idea for the clinical nursing skills fair arose out of a discussion on how to promote best practice through the guidance of available clinical policies procedures and guidelines at our hospital. A venue and date was set.

It was agreed to prioritise skills common to many areas of practice and to invite skilled practitioners to contribute. The event provided an occasion for staff to receive up to date evidence based information on all aspects of clinical care, update their knowledge and information on practical skills, to become familiar with supporting literature, to ask questions, problem solve and share knowledge and expertise. Fliers were sent to all clinical areas and the sessions ran all day. An evaluation questionnaire was formulated and given to all staff that attended the day.

The fair brought together experts in clinical nursing practice who were then recognisable to all attendees. The visual aids, demonstrations, awareness of new equipment for use in the clinical areas, availability of up to date information and handouts were well presented and informative.

Topics included: Continuous Positive Airway Pressure, enteral feeding, stoma care, haemovigilance, urinary catheter care, pain management, syringe drivers, chest tubes, hand washing, nebuliser & oxygen therapy, trachesostomy care, Flexiseal bowel management system and blood glucose management.

160 nurses/midwives had an opportunity to visit the different workstations on the day.
55% of attendees completed evaluations, (65% staff nurses 23% Student nurses 11% CNM’s and 2% others.) 100% evaluated the day as very beneficial and all the attendees agreed that they would recommend such an event to colleagues.

Based on the success of this pilot day it is planned to run this event quarterly.
Using Internet Technology to Teach Graduate Nursing Students: Student and Faculty Evaluation

C. Lynne Ostrow Ed D, RN
Chair Dept. Health Restoration
West Virginia University School of Nursing
Morgantown, WV 26506 USA
lostrow@hsc.wvu.edu

Rose Ann DiMaria-Ghalili Ph D, RN
Associate Professor
West Virginia University School of Nursing
Charleston Division
Charleston WV 25304 USA
rdimaria@hsc.wvu.edu
The purpose of this paper is to share the technology system we use in the state of West Virginia, USA, to meet the needs of nurses returning to school for graduate preparation. This system is the latest in many efforts we have made in distance education for our nurses in order that they might return to school and work on advanced degrees. Student and faculty evaluation of this technology will also be presented.

Need for Distance Learning Technologies

West Virginia is the second most rural state in the US. Since two thirds of its citizens live in communities of less than 2,500, most are living distant from institutions of higher learning. Because West Virginia University is a land-grant University, it has a special obligation to improve access to its offerings to all the state’s residents. The School of Nursing has embraced this commitment and challenge for over 25 years. The School has experimented with many delivery systems from taking the program “on the road” to where students were, to satellite and MDTV course delivery to the present system of web casting (Ostrow & DiMaria-Ghalili 2005).

Graduate nursing education is a challenge for most students who contemplate it. The vast majority of our students are women with competing responsibilities of work and family in addition to schooling. Time is thus, a very precious commodity and often money is as well. Long driving distances to institutions of higher learning that offer masters programs in nursing is an additional challenge for WV nurses. Our efforts in distance education have positively impacted the time/travel factor of these potential graduate students.

Webcasting

Webcasting is a new educational technology used to deliver audio and video presentations via the World Wide Web. This technology enables the learner to participate in a live class via a personal computer. A web cast delivers synchronous web-broadcasting to students in their home, place of employment or local library utilizing web-based streaming video and synchronized multimedia presentation (http://www.sonicfoundry.com). To our knowledge, the West Virginia University School of Nursing was the first school in the North America to put Sonic Foundry®’s Mediasite Live system into production, followed shortly by a university in Canada (DiMaria-Ghalili, Ostrow & Rodney 2005).

In order to produce a web cast, a room is needed that has a camera, microphone, presenter’s computer, a Mediasite Live
Capture Workstation, and Internet access. In addition, designated video and web servers must be allocated. Figure 1 provides a visual representation of the workflow involved with producing a web cast. Audio from the microphone is sent into the Capture Station via the inputs on the sound card, and video from the rear-wall mounted camera, is sent into the video capture card. The presentation images from the presenter's computer are also sent to the capture station by way of a VGA capture card. The Capture Station application sends the video and audio to the Video Server. The presentation images are sent to the Web/FTP server. The MediaSite Live software combines these components into the MediaSite Live Navigator, which is what the student/viewer will see in their web browser on their personal computer.

Figure 1

The MediaSite Live Navigator has two unique ways to communicate in real time with viewers of the presentation: Poll questions and the Q & A Forum. Poll questions are created by the presenter and entered into the presentation configuration prior to giving the presentation. Poll questions are then made active by the presenter at the appropriate time during the lecture and are posted to everyone viewing the web cast. The viewer can choose from multiple answers for the question and they will instantly see the results of the 'voting'. The presenter can monitor the results of the poll also from the MediaSite Live Tools web page where the poll questions were entered. This is a good way to present practice test
questions to students and as a review of material to assess student understanding of concepts presented in the class.

The Q & A Forum is how the viewers present questions to the instructor. There is an "Ask" button in the MediaSite Live Navigator that brings up a window in which the student can enter their first and last names the subject of the question, the question and, optionally, their e-mail address if they would like to have their question answered privately. This feature has been used extensively and is used at the start of every 'class' as an attendance record. We have now added to this feature by incorporating a chat room into the web casting so students can see each other questions and comments. This is an optional feature that the instructor enables before class starts and is useful if the class is not too large. It our experience that 20 students is about the maximum number that a chat room can hold in order that the instructor can keep up with questions and comments that are “coming in” simultaneously. A larger class may function more smoothly for the instructor by only using the Q & A Forum. Questions come in one at a time and the instructor can answer as few or many questions at his/her own pace.

Successful implementation of web casting, or any new instructional technology, requires a delicate weaving of the skills of information technology specialists and faculty to positively influence student success and deliver the curriculum in a manner that emphasizes the curriculum to the student, and not the technology. The technological infrastructure, faculty development, student support and curricular impact must all be addressed during the planning phase of any new technology.

Technology Infrastructure

Support from information technology specialists is the backbone to achieving a positive faculty and student outcome. A considerable amount of time and energy must first be spent developing the necessary technological infrastructure to produce a web cast. At the West Virginia University Health Sciences Center the goal of the Information Systems Operations (ISO) department is to provide state-of-the-art network infrastructure, computing services, user training and Help-desk support in academic and clinical environments. ISO embraced the web casting project early on and worked diligently to test, develop, and refine the technological infrastructure in order to produce web casts. Separate audio and video servers were purchased and set up to transmit the rich streaming audio and video. Conference rooms to house the capture stations needed to be outfitted with the appropriate media
equipment, such as cameras, lights, work station computers, consoles and microphones and document cameras. The web cast system was tested to ascertain that it could deliver the courses as intended. Bandwidth issues were addressed to ensure that the new servers didn’t overtax the University’s information network.

The preparation needed to teach a class via web casting is similar to teaching in any multi-media classroom using standard teaching aids such as: Power-Point, hand-written notes or diagrams, videotapes, web pages, statistical software programs and spreadsheets etc. With this type of web casting system, the instructor does not need to convert these teaching aids to another medium to teach. The capture station “captures” whatever tool the instructor is using and transmits the image via the Internet to the student with only a ten second delay.

Curricular Impact

Implementing distance education instructional modalities as an alternative to the traditional classroom setting impacts the curriculum by building a community of learning (Palloff & Pratt 2003). The ability to simulate a live traditional classroom environment where students can ask questions at any time and get feedback and do group work is ideal. Webcasting offers many of these features because classes are live. First, students can ask for immediate clarification, of any concept. Second, the instructor can solicit student feedback and participation. Third, web cast classes can be linked through the web platform WebCT. During a live web cast students can do “group” work in a bulletin board of WebCT and then the instructor can comment on their work live, thus providing immediate feedback. Fourth, the web casting system automatically archives classes. If students cannot attend the live class, they can watch it at their convenience for as long as it is stored on the server. Also, if they want to study for a test and watch a session again, they can go back and view at their own pace. This saves faculty and support personnel time in taping and mailing the interactive television classes to the nontraditional students who can not attend.

Student Evaluation of Webcasting

We have evaluated this new system mid semester in the first year of implementation and now yearly. I will now present student evaluation data from the years 2005 and 06. The instrument used was an adaptation of Atack’s Online Learner Support Survey (Atack 2002).
Question | 2005 N= 23 | 2006 N=113
--- | --- | ---
I felt I was part of a learning group | 83% A or SA | 79%
Information I received in online course was helpful in completing my coursework | 87% | 72%
I was able to participate in online discussion with my peers | 75% | 79%
Course content was presenting in a way that was easy to understand | 67% | 79%
Directions were clear | 79% | 72%
I was able to obtain technical support I needed quickly | 60% | 61%
I would participate in another course using Webcast again | 83% | 93%
I found online learning was helpful in meeting my learning needs | 79% | 68%
I would prefer classroom learning in the future | 21% |
Overall learning (good or excellent) |  | 68%

A= agree SA= strongly agree

Faculty Evaluation

Ten faculty who teach one or more courses using web casting were surveyed for the first time this year to see how their evaluation of teaching classes via Webcasting compares to that of students. The instrument used again was Atack’s Online Learner Support Survey with questions changed from student to faculty member’s perspective on same issues. There was a 70% response rate. The teaching experience of the faculty was great with 86% having more that 11 years of teaching experience.

Faculty assessment of their computer expertise was:

<table>
<thead>
<tr>
<th>Self Assessment of Skills</th>
<th>Novice</th>
<th>Beginner</th>
<th>Intermediate</th>
<th>Advanced</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic computer Skills</td>
<td></td>
<td>1</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>WebCT Skills</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Web casting</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Responses to specific questions about webcasting were:

<table>
<thead>
<tr>
<th>Web casting Items</th>
<th>SD</th>
<th>D</th>
<th>N</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to communicate effectively with students</td>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning groups can be designed and directed</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to facilitate online discussion</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to obtain technical support quickly for web casting</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Able to respond easily to discussions on Bulletin Board</td>
<td></td>
<td>1</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Plenty of technical help for course development</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Would teach another course using web casting</td>
<td></td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online learning convenient for students to participate in graduate education</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support I received during course has improved my skills teaching online</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>I miss talking face to face to students</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online contact with students was important in my course</td>
<td></td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online teaching increased my instructional design and teaching skills</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prefer traditional teaching in future</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SD = strongly disagree D = disagree N = neutral A = agree SA = strongly agree

Finally, items that asked about the same issue were compared between student and faculty response.

**Comparison of Faculty and Student Responses**

<table>
<thead>
<tr>
<th>Item</th>
<th>Student (A &amp; SA)</th>
<th>Faculty (A and SA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning groups (part of or able to direct)</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td>Online Discussion (able to participate or to facilitate)</td>
<td>77%</td>
<td>100%</td>
</tr>
<tr>
<td>Technical support quickly</td>
<td>61%</td>
<td>57%</td>
</tr>
<tr>
<td>Another web cast course (would take or would teach)</td>
<td>88%</td>
<td>100%</td>
</tr>
<tr>
<td>Prefer traditional classroom</td>
<td>21%</td>
<td>0</td>
</tr>
<tr>
<td>Overall learning/increased my instructional design and teaching skills</td>
<td>68%</td>
<td>86%</td>
</tr>
</tbody>
</table>
Summary

This instructional technology that we use at West Virginia University has enabled the University to extend its graduate programs to all areas of our state, enabling nurses to attend school who might not otherwise have done so. Student evaluation of this technology has been very positive and initial faculty evaluation has mirrored that of students. We believe that this method of teaching meets the need of the virtual learner (Palloff & Pratt 2003) by: focusing on the student, not the teacher; cost effective; uses a reliable technology that is easy to navigate and is transparent to student; enables appropriate amounts of information to be transmitted; and accommodates and encourages human interaction. The authors try to build a “community of learners” as encouraged by Palloff and Pratt and believe that we are being increasingly effective in this goal while using this instructional technology.

References


The Impact of Working in a Non-aversive Environment on Staff Attributions and Burnout in a Service for People with Intellectual Disability and Challenging Behaviour

Austin T O’Sullivan BSc(Hons), HDip, MSc.
Walkinstown Association for People with an Intellectual Disability Ltd.
1 Long Mile Road,
Walkinstown,
Dublin 12.

Tel: 00353-1-4290053
Email: austin@walk.ie

Abstract

This study was designed to look at the relevance of attribution theory in the context of a non-aversive environment. The study also investigated the impact of working in a non-aversive environment on staff stress levels and burnout. 27 care staff working in a non-aversive environment in an Irish agency providing day and residential services to adults with an intellectual disability participated in the study. A cross-sectional 2x3 repeated measures design was used to examine the effects of different types of challenging behaviour in adults with different levels of intellectual disability on staff ratings of attribution dimensions, affects, optimism, helping behaviour and evaluations of the person and their behaviour. The link between staff stress and burnout and challenging behaviour was measured using a demographic questionnaire and a standard measure for burnout.

This study found little support for Attribution Theory (Heider,1958, Kelley ,1971, Weiner 1985, 1986) or for Weiner’s (1979, 1980) Helping Behaviour Theory and Achievement Motivation Theory. However the attribution of 'Control' did vary depending on level of intellectual ability. No differences in emotional responses were found depending on levels of training or experience. No link was found between length of exposure to challenging behaviour and burnout. The incidence of burnout was found to be less than the mean for staff working in the Social Service (MBI-HSS,1996) and was in the low range.

This study uniquely questions the relevance of Attribution Theory and the cognitive-emotion-model in a non-aversive environment, as a framework for examining staffs’ attributions and emotions.
regarding people with an intellectual disability who engage in challenging behaviour. It also questions the manner in which the impact of training is measured. Finally it reports that contrary to existing research no link was found between staff exposure to challenging behaviour and burnout.
A review of the literature on person-centred care: what is it and what are the characteristics?

Claire O’Tuathail, Lecturer, Department of Nursing and Midwifery Studies, national University of Ireland, Galway
RN, MSc., Dip.Gerontology, P.G.Cert. Teaching & Learning in Higher Education
Phone: 00353 (0) 91 495314 claire.otuathail@nuigalway.ie

The aim of this study was to undertake a literature review on person-centred care and provide clarity on a definition and to identify the characteristics of person centred care.

The database Cumulative Index for Nursing and Allied Health Professions (CINAHL) was searched using a number of combinations of person-centred care, patient-centred care, relationship centred nursing/care and combined with key words such as elderly care, caring for older people, and gerontological nursing. All abstracts were read and papers selected for analysis were based on explorations of the notion of person-centeredness and were published between 1995-2006. The literature was critically analysed to identify important dimensions and definitions of person centred care.

Person-centred care has been shown to be a central concept to delivering quality nursing care. Quality of care and person-centred care are terms that are often used interchangeably, moreover there is lack of clarity regarding a definition of what person centred care actually means. The literature suggests the relationship between the nurse and the patient is important, patients have a need to be socially integrated while at the same time perceived as individuals and respect, trust and recognition are central to the notion. Characteristics of person-centred nursing include: having the ability to get to know and understand the patient and thus develop a meaningful relationship and having the ability to promote patient autonomy and choice and involvement in decision-making.

The analysis of the literature provided a clearer understanding of the meaning of person-centred care and the characteristics of this approach to nursing care. There is an urgent need for further research to examine the benefits of person-centred nursing for the patient, nurses and the wider organisation.
The Lived Experience of Daughters Who Care for Frail, Elderly Parents in the Parents’ Home

Margaret N. Owens RN, PhD
Associate Professor of Nursing
Thomas More College
333 Thomas More Parkway
Crestview Hills, Kentucky, 41017 USA.
Phone: 859-344-3410
Fax: 859-344-3537
E-mail: Margaret.Owens@thomasmore.edu

Abstract: The care of frail, elderly parents is a rising concern as the number of aged people in the population increases. It is estimated that over 22 million people currently provide support to elderly family and friends in the United States. Caregivers, the majority of whom are daughters, often provide services at great physical and emotional cost to themselves. Abundant research is available on family caregiving, however, the greatest focus has been on the concepts of caregiver burden and strain. Little investigation into the needs of daughters as a specific group has been conducted. The purpose of this study was to examine the lived experience of daughters who care for their frail, elderly parents in the parents’ home. Using van Manen’s design, data were collected from interviews with seven daughters who were currently in the caregiving role. Support for the themes was gleaned from artistic sources. Ten essential themes were elicited. These themes were that caring for frail, elderly parents in the parents’ home is: (1) being torn between worlds; (2) embracing the wholeness of commitment; (3) a crucible of individual human effort; (4) a means of self-discovery; (5) a thread that can weave a family together or cause it to pull apart; (6) an experience of reciprocity; (7) a doorway to intimacy; (8) the attempt to maintain the autonomy of the parent; (9) grieving the decline of the parent; and (10) making the best use of the time left with a parent. The findings were examined in light of Bowlby’s Attachment Theory and Kristen Swanson’s Theory of Caring. Congruence of the findings with Attachment Theory and partial congruence with the Theory of Caring were found. Implications for research, practice, and education were discussed.
Towards Stress Relief for Minority Hypertensives

Anne Griswold Peirce, RN, PhD
Associate Dean for Academic Affairs
Columbia University School of Nursing
New York, NY USA
212-305-3459 agp1@columbia.edu

Background: Cardiovascular disease (CVD) is the leading cause of death in the US. The highest rates of morbidity and mortality are found in African-Americans. There are many risk factors involved in the high CVD rate including stress. Yet little is known about the relative rates of stress in African-Americans as most stress/coping studies have been done on other racial/ethnic groups.

Aim of Study: The aim of this study was to ascertain the psychometric properties of the Ways of Coping Checklist (WOCC) and Perceived Stress Scale (PSS) when used with African American volunteers.

Methodology: A convenience sample of 200 volunteers was obtained through advertisement and community organizations. Each was given a packet that included the instruments and a demographic survey. Upon completion of the self-administered questionnaires all subjects were interviewed about the relevance of the questionnaire items, plus any items the subjects felt was not covered in the instruments. The study was approved by the Columbia University IRB.

Analysis: The instruments demonstrated adequate reliability using Cronbach’s alpha with the WOCC at .96 and the PSS at .77. Construct validity for each instrument was assessed with factor analysis. The interviews results showed no critical comments or deficiencies perceived in the instrumentation.

The participant’s average age was 41 with 48% male and 52% female representation. Overall the subjects were well educated with 50% having attended college. However, 54% earned less than $30,000 (USD) per year. The subjects reported a number of chronic diseases including CVD, hypertension, diabetes and asthma.

Summary of Key Findings: The psychometric analysis of the stress and coping instrumentation found that the WOCC and PSS both had adequate reliability and validity with a community cohort of African American subjects.
Conclusions: The instruments are psychometrically adequate for inclusion of a larger study targeted specifically at reducing stress in African-Americans with hypertension.
Chronic Obstructive Pulmonary Disease (COPD), Anxiety, and Depression: The State of the Science

Abstract

Heidi Putman-Casdorph, RN, DNSc, Assistant Professor*
hputman@hsc.wvu.edu
phone: 304-293-1775

Susan McCrone, RN, PhD, Professor and Department Chairperson*
smccrone@hsc.wvu.edu
phone: 304-293-5446

*West Virginia University School of Nursing
PO Box 9630, Health Sciences South
Morgantown, WV 26508
USA

Introduction: Chronic obstructive pulmonary disease (COPD) affects 10.7 million people in the United States and millions across the world (NIH, 2003). It is a major cause of disability and death worldwide (Borson et al., 1992). Globally, COPD is the 4th leading cause of death and is projected to be the 3rd by the year 2020 (Murray & Lopez, 1997). The Global Initiative for Chronic Obstructive Lung Disease (GOLD) report estimated that the economic burden of COPD in the United States is $23.9 billion dollars per year in direct and indirect costs (NIH, 2001, p. 13). The worldwide prevalence of COPD for males is 9.3 per every 1,000 and for females 7.3 per every 1,000 (Yohannes & Connolly, 2004, p. 419). These estimates only focus on the physical effects of COPD and do not consider the psychological toll of this chronic illness. Borson et al. (1992) reviewed literature related to COPD and depression and found that COPD prevalence is disproportionate in specific segments of society including the elderly, African Americans, those with a lower socioeconomic status, and in developing countries where tobacco is aggressively marketed without regulation. The scope and prevalence of this chronic disease warrants a review of current research focusing on patients with COPD and psychiatric co-morbidities such as anxiety and depression.

Aim of review: The aim of this review is to examine the prevalence and impact of co-morbid anxiety and depression on COPD and to identify implications for practice derived from these findings.

Search and review methodology: A literature search was conducted using the PubMed database targeting research studies...
and reviews focusing on COPD, anxiety, and depression from 1985 to the present. Seventy-one studies were reviewed.

**Summary of key findings:** Most studies were cross sectional with sample sizes ranging from 26 to 3056 subjects with mild to severe COPD. Prevalence of anxiety or depression ranged from 16% to 50%, which was significantly higher than in the general population. In many studies, anxiety predicted frequency of admission to the hospital for acute COPD exacerbations. Several studies documented a strong correlation between anxiety and depression, while other studies identified a high prevalence of both psychiatric disorders (Light et al., 1985; Anderson, 1995; Kim et al, 2000). Depression and/or anxiety predicted quality of life, functional status, greater use of health services, and in some studies, mortality. Depression and anxiety both significantly contributed to the variance in functional status in patients with COPD (Kim et al., 2000)

**Treatment options included behavioral interventions and pharmacotherapy.**

**Conclusions:** Disturbingly, while treatment for other chronic illnesses such as cancer and cardiovascular disease is advancing to improve the health status of patients, little progress has been made in improving the morbidity and mortality associated with COPD. COPD is the only major chronic disease with a rising mortality rate, doubling in the past 30 years (O’Neill, 2002, p. 195). Depression and anxiety are significantly under diagnosed and under treated in patients with COPD. Implications for practice include the need to assess and screen for anxiety and depression in COPD patients, and to refer these individuals for appropriate treatment.

**References**


The Need for Structured Nursing Care in Clinical Trials

Authors:

Houry Puzantian RN, MSc in Pharmacology and Therapeutics
Clinical Research Unit
Department of Internal Medicine
American University of Beirut Medical Center
P.O. Box 11-0236 Beirut, Lebanon
Tel. 961-3-815448
961-1-350000 ext. 5414
Fax 961-1-365189
e-mail: hp00@aub.edu.lb

and

Samar Noureddine PhD, RN
School of Nursing
American University of Beirut

Aim of review:
The aim of this review is twofold,
• To identify the need for holistic nursing care of clinical trial participants
• To investigate the utilization of the Nursing Process in caring for participants in clinical trials

Review Methodology:
Literature search was performed using CINAHL and Pubmed Databases with various combinations of the following keywords: Nursing Process, nurse, research, trial, investigation, randomized controlled trial, care, patient care and adverse event.

Summary of Key Findings:
Clinical Research Nurse Coordinators (CRNCs) often function in medical teams, independently of Nursing Departments. Randomized Clinical Trials (RCTs) usually entail research activities where the application of nursing care is not clearly addressed. Many CRNCs attempt to develop their own job descriptions and realize that there are “additional dimensions” to Nursing over and above those identified in study protocols. The missing link central to the concerns of all CRNCs appears to be the “culture of caring” for research participants, which is understated in the procedure-oriented RCT culture. CRNCs are nurses who are primarily prepared
to identify patients’ needs and act to meet them; subsequently, they routinely perform unstructured nursing duties to preserve the health and promote the wellness of RCT participants.

Assessment, planning, implementation and evaluation make up the Nursing Process, which is a framework for the provision of holistic nursing care. The nursing process is scarcely reported in the care of clinical trial participants.

Conclusions:
There is an immense need to integrate nursing care in the management of RCT participants. The Nursing Process, providing the standardized structure of care, can promote comprehensive participant management in clinical trials. Further studies are required to elaborate on the development of care plans that attend to both disease states and study-related manifestations of clinical trial participants.
Abstract

Health promotion is an area that is automatically seen and accepted as an important part of the nursing remit. What seems to be somewhat less easy to outline is how well nurses fulfil their responsibility as health promoters. Following on from the Bologna Process (1999), nurse education across Europe is set to undergo significant changes. This mirrors recent UK government initiatives that have moved primary care and health promotion to the heart of the NHS. Yet, there are serious questions over whether nurse educators across the sector are offering courses that meet the need of future practitioners. As a result, it is crucial that educators assess the status of health promotion in their programmes and adapt them accordingly.

This research seeks to question how the current pre-registration diploma course, offered by Liverpool John Moores University, prepares students to undertake their health promotion role. The study used a survey method. Questionnaires were distributed to students from two cohorts, one at the beginning and one end of their training. The total sample was 163, with 79 taken from students at the beginning of their training and 84 at the finish of their training. Analysis of the data suggests that the current
diploma in nursing curriculum has little impact on student nurses’ perceptions of health promotion. The findings highlight inadequacies in how the current curriculum equips students to fulfil a health promotion role in practice. Results demonstrate the lack of coherent health promotion strategy across the curriculum and this is mirrored in practice placements. The results represent a major challenge for nurse education. The researchers recommend a reassessment of the current curriculum to include a specific, ongoing theme of health promotion over the three-year course. This restructuring will provide students with the knowledge and practice to become critically aware practitioners of health promotion in line with current government guidelines. The paper also explores future research possibilities and the implications this will have for understanding how health promotion relates to the nursing curriculum.
Vulnerability Among the Strong: Women Veterans Define Sexual Abuse.

Abstract submitted by:

Nancy Redfern-Vance, Ph.D., M.N., C.N.M.
Valdosta State University, College of Nursing
S. Walter Martin Hall, Room 272
1300 No. Patterson St.
Valdosta, GA 31698-0130
Office: 229-293-6270
nredferrnvance@valdosta.edu

Literature documents the high incidence of sexual abuse of women in the military as well as the long-lasting and costly impact on women’s health. We are in an era where sexual violence has leaped out from closets onto family room television screens, yet definitions of the term “sexual abuse” remain ambiguous and contested. Missing from our dialogue is a definition of sexual abuse directly from women who have experienced it. The research aim was to discover how military women themselves define sexual abuse as it occurs within the context of their lives and how their individual biographies intersected with organizational culture of the military. The goal was to contribute to policy and program aspects for dealing with this complex problem.

Harding’s feminist standpoint theory was used that emphasizes women’s lives as the starting point for knowledge. Personal, contextual definitions of sexual abuse were elicited from life histories of nineteen women veterans who experienced sexual abuse in the military. Sixty-five hours of interview data from 19 women veterans were collected and analyzed using four separate narrative analysis treatments. Life narratives were analyzed for: 1) interviewee-narrator interactions; 2) dramatic presentation and performance; 3) narrative structure; and 4) metaphors and themes.

Findings from women’s narratives revealed that “metaphors of self” influence the nature and quality of the life disruption that results from sexual violence. Women veterans also suffered discrimination and stereotyping. Women soldiers worked hard, to the detriment of their own health, to offset gender perceptions of themselves as “wimps” or weaklings. Women were also bothered by inappropriate medicalization of their experience which they felt was blaming. Labeling the individual as having a disorder draws attention away from the societal context in which sexual violence occurs. Recommendations include advocacy for more culturally appropriate health care for women who have experienced sexual abuse.
A feminist exploration of Traveller women’s experiences of maternity care in the Republic of Ireland

Presenter: Bernadette Reid, MSc. BSc.(Hons) RGN RM RPHN
Position: Lecturer in Midwifery
Address: School of Nursing & Midwifery
University of Dundee
Tayside Campus
Ninewells
Dundee DD1 9SY
Telephone: 01382 632304 ext. 33615
e-mail: b.b.reid@dundee.ac.uk

Background: Traveller women belong to a distinct minority group of Irish people with their own cultural values, language and nomadic tradition. The health status of Traveller women during pregnancy and childbirth remains very poor. This study explored Traveller women’s experiences of maternity care in order that their needs might be identified and perceptions of helpful responses elicited.

Methods: A feminist research methodology was adopted to ‘give voice’ to Traveller women’s experiences of maternity care. A snowball sample of thirteen women aged 19 – 42 years with each having experienced 2 – 8 pregnancies participated. Data was collected using unstructured non-directive interviews and analysed inductively using an established framework. Traveller women reviewed results and conclusions.

Results and Discussion: A fluid concept of culture impacted upon Traveller women’s expectations and negotiation of maternity care. The essential nature of familism, socialisation and religious beliefs, and the particular emphasis placed upon peer support reflected cohesive and supportive aspects of culture. The concept of ‘possessive individualism’ was portrayed as conflictual to contraceptive use, the uptake of preventive care and the reporting of mental health problems and domestic violence. There was cultural unacceptability of majority norm expectations of breastfeeding, husband participation and ‘rooming in’. Political and structural factors such as the direct discriminatory barriers created by general practitioner services; indirect discrimination arising from dysfunctional communication and control of information; poor housing and lack of public transport were the basic causes of inequity of access to care.

Conclusions: Midwives and other health professionals are challenged to respond sensitively to cultural preferences, meet...
informational needs and act as political advocates in efforts improving maternity care experiences for Traveller women.

**References**


A STUDY OF THE EXPERIENCE OF CACHEXIA IN PATIENTS WITH CANCER AND THEIR SIGNIFICANT OTHERS.

Joanne Reid, Professor Hugh McKenna, Dr Donna Fitzsimons and Dr Tanya McCance. Institute of Nursing Research, University of Ulster.

Presenting author: Joanne Reid, RGN, Dip, BSc, MSc. PhD Research Fellow, Institute of Nursing Research, University of Ulster, Shore Road, Newtownabbey, Northern Ireland. Telephone: 0044 2890368255. E-mail: j.reid1@ulster.ac.uk.

Background and context.
Cancer cachexia has received scant research attention. It is reported to occur in up to 80% of patients with advanced cancer, and is associated with poor quality of life, reduced performance status and shorter survival periods. At present there is a dearth of evidence into its nature, impact on patients and effects on their families.

Aim of the study.
The aim of this study is to explore the lived experience of cachexia in patients with cancer and their significant others.

Methodology.
Cancer cachexia has been defined within this study as: the involuntary weight loss of more than 10% of pre-morbid body weight within the last six months resulting from tumour induced metabolic alterations. A purposive sample of 15 patients / 12 significant others has been recruited from a large teaching hospital in Northern Ireland. Each participant has been interviewed once, using an unstructured interview about their / their significant other’s experience of cancer cachexia. All interviews have been digitally recorded and transcribed verbatim for the purposes of analysis. Data analysis using an interpretative phenomenological approach is currently underway. All ethical requirements for this study were met prior to the study commencing.

Summary of Key Findings.
Preliminary results of the twenty-seven completed interviews generated important themes, which reflect the holistic dimensions of the experience of cancer cachexia. These will be explained in turn with quotations to support the relevance of each theme.
Conclusions.
Despite the plethora of studies conducted into the medical management of cancer cachexia, very little work has been undertaken to increase understanding into its impact on patients and their families. This study has the potential to contribute to the present knowledge base that exists in relation to cancer cachexia, thus providing evidence to improve service delivery for this client group.
Title: Health literacy among persons living with HIV/AIDS enrolled in primary health care.

Presenting: Michael V. Reif, PhD, APRN, BC, AACRN, CCRN  
Chair, Department of Nursing  
Georgetown University  
School of Nursing & Health Studies  
3700 Reservoir Road NW  
Washington, DC 20057  
Office: +1 (202) 687.4647  
Email: mrelf01@georgetown.edu  

Co-Author: R. Kevin Mallinson, PhD, RN, AACRN  
Assistant Professor, Department of Nursing  
Georgetown University  
School of Nursing & Health Studies  
3700 Reservoir Road NW  
Washington, DC 20057  
Office: +1 (202) 687.4289  
Email: km293@georgetown.edu  

Background/Context: HIV/AIDS is significant health crisis around the globe, particularly among the poor and in communities of color. One-third of all medical patients possess low health literacy which is associated with lower rates of medication adherence, poorer clinical outcomes, and increased costs associated with service delivery.

Aim of the Study: The aim of this study was to examine the issue of health literacy among persons living with HIV/AIDS at an urban HIV using a mixed-methods approach.

Methodology: This concurrent, mixed-methods study was designed to develop a comprehensive understanding of health literacy among HIV-positive persons seeking primary health care at an urban HIV clinic in the USA. Use of the Test of Functional Health Literacy (TOFHLA) allowed collective prevalence and descriptive data about health literacy while in-depth grounded theory interviews facilitated an understanding of the influential factors, conditions, and consequences of limited health literacy.

Analysis: Nearly 29% of the quantitative sample (n=133) were identified to have limited health literacy. Limited health literacy was associated with educational attainment and sexual orientation. Qualitatively, accessing and understanding HIV information, partnering with the provider, and navigating the health systems were concepts explored among the persons interviewed (n=44).
Conclusions: Building health literacy skills in the context of HIV challenges nurses to critique assumptions about health education and expectations of current systems of health care. Innovative, patient-focused approaches are needed if persons with HIV are to develop effective health literacy skills.
Perceptions of stigma among persons living with HIV/AIDS enrolled in primary health care.

Presenting: Michael V. Relf, PhD, APRN, BC, AACRN, CCRN  
Chair, Department of Nursing  
Georgetown University  
School of Nursing & Health Studies  
3700 Reservoir Road NW  
Washington, DC 20057  
Office: +1 (202) 687.4647  
Email: mrelf01@georgetown.edu

Co-Author: R. Kevin Mallinson, PhD, RN, AACRN  
Assistant Professor, Department of Nursing  
Georgetown University  
School of Nursing & Health Studies  
3700 Reservoir Road NW  
Washington, DC 20057  
Office: +1 (202) 687.4289  
Email: km293@georgetown.edu

Background/Context: Since the early 1980’s, the interactions of social, cultural and biological forces have shaped the global HIV epidemic. Throughout history, persons at risk for or living with a communicable disease have been stigmatized, labeled as deviants, and shunned by society. Rooted in history of other infectious diseases, stigma is frequently experienced by persons living with HIV/AIDS.

Aim of the Study: The aim of this study was to explore the concept of HIV-related stigma among persons enrolled in primary health care at an urban HIV clinic in the USA.

Methodology: Combining quantitative (n=87) and qualitative (n=27) methods, the experience of HIV-related stigma (HRS) was examined. Relationships between HRS, depressive symptoms, quality of life and retention in medical care were examined. Grounded theory interviews, utilizing theoretical sampling, identified sources and processes utilized to manage HRS.

Analysis: HRS is a serious problem for persons living with HIV/AIDS. As a result of higher levels of HRS, persons were more likely to experience depressive symptomatology and a lower quality of life. Time since diagnosis with HIV and race/ethnicity were the two variables predicting high levels of HRS quantitatively. However, HRS was not associated with non-retention in HIV-oriented primary medical care. Qualitatively, the processes and meaning of HRS...
were examined in four domains: personalized, disclosure-related, negative self-image, and public attitudes.

Conclusions: Experiencing various forms of stigma in meeting family, societal and cultural expectations has a significant impact on the lives of persons living with HIV/AIDS. Nursing interventions can reduce HRS and promote coping and connectedness to family, community and the health care delivery system.
Title: ‘Good Faith Reporting’ (Whistleblowing) systematic review

Contact Details:
Majella Robinson, MA, Hdip, BRad.
Clinical Audit Manager,
Clinical Audit and Research Service,
HSE Dublin mid-Leinster,
William St.
Tullamore,
Co.Offaly
Tel no: (057) 9327924
Majella.robinson@mailq.hse.ie

Abstract:

Aim of the review: The aim was to review the evidence about Good faith reporting or whistleblowing in healthcare.

Search and Review methodology: The research question was established using the PICOT methodology – Population, Intervention, Control, Outcome and Timelines. The key words used in the search were: whistleblowing, good faith reporting, policy, healthcare, and improvement. The following databases were searched: Ebscohost research databases consisting of medline, cinahl and biomedical reference collection comprehensive. Other databases searched were Google Scholar, Swetwise, and the Cochrane Collaboration. All the articles that form part of this review were from Ebscohost research databases.

Summary of Key Findings: In summary while there was a considerable amount of evidence about whether a whistleblowing policy should be in place and the framework that this would follow, there was very little evidence in fact of the benefits of having a whistleblowing policy. Whistleblowing is essentially incident reporting under another guise. There is legislation in the UK and Australia to protect the ‘whistleblower’ and none in Ireland. There is no evidence that this makes whistleblowing/incident reporting any more effective.

Conclusions: It would appear that the culture for quality and safety is improving. In reality staff ‘blow the whistle’ all the time they just give it a different name. The focus should be on the development and management of effective quality and risk management structures and systems so that any potential for harm to anyone in healthcare services in managed in a timely and appropriate fashion.
The impact of clinical supervision on staff development

**Mrs Joanne Rouse** RGN, RSCN, MSc  
Senior Lecturer - Child Health  
University of Worcester  
Henwick Grove  
Worcester WR6 2AJ  
England  
+ 44 1905 855565  
j.rouse@worc.ac.uk

There is an increasing awareness of the value of the supervisory relationship in nursing; however there is a lack of evidence to support improvements in professional development result directly from the clinical supervision process. The aim of the study was to focus on the experiences of clinical supervision and its impact on staff development across two acute child health wards at two hospitals within one United Kingdom National Health Service Trust.

The overarching research paradigm was that of interpretivism. The principles of action research and the process of triangulation required a mixed-method approach.

Initially, quantitative methods were employed in the form of a questionnaire, enabling all 63 participants in clinical supervision to be invited to participate. A response rate of 38.09% was achieved. A key finding was that the participants identified clinical supervision as having positive benefits although the process itself is perceived as having a negative image.

Qualitative methods, informed by phenomenology, in the form of semi-structured interviews, provided a detailed account of the experiences of a selection of the participants. Sampling was purposeful and to ensure saturation of data, six staff were interviewed. The taped interviews were transcribed and after topic coding, the data was reduced and analysed according to identified themes. Themes included the experience of clinical supervision, relationships, image, supervisor’s role, personal and professional development, format and impact of clinical supervision.

A model of clinical supervision was recommended incorporating a definition and purpose of clinical supervision and identifying perceived roles and responsibilities of supervisor, supervisees and managers in the process of clinical supervision.
Whilst the image of clinical supervision continues to require embedding within nursing culture, positive effects of clinical supervision on staff development are experienced; however these effects may be implicit. This development occurs on a personal professional level and within the team.
Rehabilitation in Care Homes (RICH-T): a cluster randomised controlled trial

**Professor Cath Sackley**
Primary Care and General Practice
University of Birmingham
Edgbaston
Birmingham
B15 2TT
England
c.m.sackley@bham.ac.uk

Other authors
**Chris Wright** BSc (Hons), School of Health Sciences, **Smitta Mistry** MSc, Primary Care and General Practice, University of Birmingham

**Background & context:** in a care-home population loss of independence in mobility and self-care is strongly associated with poor quality of life, secondary complications and mortality.

**Aim of the study:** To assess the effects of a targeted occupational therapy (OT) and physiotherapy (PT) intervention on mobility and self-care independence of people living in care homes.

**Methodology:**
Design: A cluster-randomised controlled trial using an immediate-intervention group and a delayed-intervention control group (receiving intervention after 6 months).
Participants and Setting: 24 registered care homes in Birmingham, UK were independently randomised to the immediate-intervention group (12 homes, 128 residents) or to the control group (12 homes, 121 residents). Residents with self-care disability who were not receiving end of life care were included.
Intervention: Occupational therapy and physiotherapy targeted to mobility and self-care independence, delivered to individual residents, including the provision of equipment and carer education.

Primary and secondary measures: Assessments were made by staff masked to the allocation at 0 and 3 months (pre- and post-intervention) and at 6-month follow-up. The primary outcome, the Barthel Activity of Daily Living Index (BI) and secondary outcome, the Rivermead Mobility Index (RMI) were assessed at each time point.
Analysis: Data were analysed using SAS (version 9.1) and all statistical hypothesis tests were performed at a 5% level of significance. Intention-to-treat analyses were conducted on BI and RMI using methods that accounted for clustering. Sensitivity analyses were also conducted.

Results: Seventy percent of participants were female; ages ranged from 48 to 108 years, and cognitive function scores ranged between 0 and 30. Other characteristics are given in Table 1.

Table 1: Baseline characteristics by group

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Intervention Group</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Delayed (n=121)</td>
<td>Immediate (n=128)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td>Female</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 (69)</td>
<td>101 (79)</td>
<td></td>
</tr>
<tr>
<td>At least 1 confirmed stroke:</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>26 (21)</td>
<td>28 (22)</td>
<td></td>
</tr>
<tr>
<td>MMSE Score:</td>
<td>&lt; 21</td>
<td>&lt; 21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>77 (64)</td>
<td>91 (71)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>21 – 23</td>
<td>16 (13)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 24</td>
<td>28 (23)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>32 (25)</td>
<td></td>
</tr>
<tr>
<td>MMSE Score</td>
<td>12 (11.6)</td>
<td>10 (12.0)</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>84 (10)</td>
<td>86 (7)</td>
<td></td>
</tr>
</tbody>
</table>

Footnote: SD = standard deviation

Mean BI scores at baseline were 11.1 (SD 4.1) and 12.5 (SD 4.1) in the immediate and delayed intervention groups, respectively. Corresponding values for RMI were 5.8 (SD 4.1) and 6.9 (SD 3.8). Summaries post-intervention and at 6-month follow-up are given in Table 2. There were no statistically significant differences in mean scores between groups across the 6-month period on either BI or RMI.
Table 2: Summary scores for Barthel Index and Rivermead Mobility Index

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Intervention Group</th>
<th>Pre-intervention</th>
<th>Assessment</th>
<th>Post-intervention</th>
<th>6-month follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean (SD)</td>
<td>n</td>
<td>Mean (SD)</td>
<td>n</td>
</tr>
<tr>
<td>Barthel Index (scores 0-20)</td>
<td>Immediate</td>
<td>127 (11.1 (4.1))</td>
<td>108 (10.6 (4.2))</td>
<td>99 (10.7 (4.6))</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delayed</td>
<td>116 (12.5 (4.1))</td>
<td>106 (11.8 (4.3))</td>
<td>88 (11.9 (4.7))</td>
<td></td>
</tr>
<tr>
<td>Rivermead Mobility Index (scores 0-15)</td>
<td>Immediate</td>
<td>127 (5.8 (4.1))</td>
<td>107 (5.1 (3.5))</td>
<td>98 (5.2 (3.8))</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delayed</td>
<td>113 (6.9 (3.8))</td>
<td>106 (6.7 (3.7))</td>
<td>88 (6.5 (3.8))</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion:
The intervention was well tolerated but no between group differences were seen. Future studies should allow for the variability in the participants and homes in the sample size estimate.
Cluster randomised pilot controlled trial of a group exercise and staff training intervention to promote urinary continence in UK care homes.

**Professor Cath Sackley**
Primary Care and General Practice  
University of Birmingham  
Edgbaston  
Birmingham  
B15 2TT  
England  
c.m.sackley@bham.ac.uk

Other authors  
**Chris Wright** PhD, **Fran Badger** RGN, **Natalie Rodriguez** BSc  
School of Health Sciences, University of Birmingham  
**Jelske Besemer** BSc, **Katarina T Van Reeuwijk** BSc, **Leontine T Van Wely** BSc  
Department of Physiotherapy, University of Professional Education Leiden, The Netherlands

**Background & context:**

Aim of the study: To assess the feasibility, acceptability and potential efficacy of a public health intervention consisting of group exercise and staff training to promote continence for elderly care home residents.

**Methodology:**
Design: Phase II pilot exploratory cluster randomised pilot controlled trial.
Setting: Six purposively selected care homes (two with nursing) in the West Midlands, UK.
Participants: Thirty-four elderly care home residents with self-care limitations and including those with cognitive impairment. Care staff employed in the 6 homes.
Intervention: A group exercise class targeted at maintaining/improving functional mobility (one hour, twice weekly for four weeks) delivered by physiotherapists. The control group received usual care.
Staff continence training, two events of one hour each, delivered by nurse specialists.
Measurements: The primary outcome measure was the Rivermead Mobility Index (RMI). Other measures included the urinary symptoms questionnaire and the Incontinence Quality of Life Scale. All were collected by masked assessment at 0, 3 and 6 months.
Analysis: Feasibility of the components of the intervention was assessed by uptake and compliance and acceptability by verbal feedback. An intention-to-treat analysis was performed on the RMI. Comparisons of mean scores on the RMI across Trial Groups at baseline, 6-weeks and 6-month follow-up were conducted using t-tests with standard errors adjusted for clusters.

RESULTS: Six care homes and 34 residents took part. 33 provided data at baseline (17 in the Intervention Group and 16 in the Control Group) and were included in the analysis. Cluster sizes varied from 3 to 7. Twenty-nine participants (88%) were female. The mean age was 86 years (SD=9 years), 11 (30%) were cognitively unimpaired, (12%) were incontinent of urine, and 13 (26%) were mobile with the help of one person or an aid.

A small between-group difference was observed in the trend of RMI scores across the three assessments. After adjusting for clustering, no statistically significant differences were found on mean RMI scores across Groups at baseline (mean effect = 0.24; \( P = .92;\) 95% CI = -6.23 to 6.72), 6 weeks (mean effect = 1.71; \( P = .52;\) 95% CI = -4.14 to 7.56) or 6-month follow-up (mean effect = .77; \( P = .61;\) 95% CI = -3.16 to 4.71).

Both strands of the intervention were feasible and well received with good compliance and positive feedback. Mobility was maintained for the treatment group post-intervention, controls declined. Reported symptom severity decreased for treatment, controls remained stable. Staff training was well received with mainly positive feedback. Questionnaires exposed a lack of basic knowledge on continence.

Conclusions: A group exercise and education public health intervention to maintain functional mobility and promote continence is feasible and acceptable for use with dependent care home residents including those with cognitive impairment. A further trial is required to fully assess the impact on incontinence symptom severity, mobility and prevention.
Research Access to Young People with Cystic fibrosis: Issues for Consideration

Authors: Dr. Eileen Savage, PhD MEd BNS, RCN, RGN. Principal Investigator & Senior Lecturer. School of Nursing & Midwifery, University College Cork. Tel. 021-4901552 Email e.savage@ucc.ie & Ms. Sinead McCarron, MSc, HDip(Sick Children’s Nursing),RCN, RPN. Research Assistant. School of Nursing & Midwifery, University College Cork.

Background and Context: In the past 15 years, a shift towards involving young people as research participants has taken place. This shift mainly stems from recognition that children have a right to have their views heard. The need to seek young people’s views about matters concerning their lives and to have these views acted on is now a policy initiative in Ireland (Government of Ireland, 2000). However, gaining research access to young people is not straightforward and involves layers of negotiation and administration. Experiences of accessing young people with cystic fibrosis aged 13 to 21 years are described in this paper.

Aim of the Study: The aim of the study is to explore health and illness beliefs of young people with CF and of their parents.

Methodology: 15 young people with CF (13-21 years) and their parents are being recruited for the study involving 2 CF centres. Attempts to attend a third CF centre were made but abandoned because of administrative delays associated with a requirement of its ethics committee. Interviews are the method of data collection. Analysis is by constant comparative method and theoretical sampling.

Summary of Key Findings: Findings for this paper focus on experiences of gaining access to young people. Gaining access has been a complex process because multiple CF centres and ethics committees were involved. From a total of 20 young people and parents approached to date, only 7 have agreed to partake. Issues raised for consideration are: identifying clinical gatekeepers; seeking ethical approval including Garda clearance for research with ‘minors’; dealing with parents as gatekeepers; and making direct contact with young people themselves. Attention is drawn to these areas that can make access more or less difficult.
Conclusions: Accessing young people presents challenges to researchers and is an area that has received little attention in methodological literature. The issues raised provide practical insights that may be helpful to other researchers aiming to access young people for their studies.
Violence & Aggression in Nephrology Practice  
– A cause for concern

John Sedgewick,  
MSc (Nurs), MSc (Research), BSc (Hons), RN, RMN, Dip.Nurs,  
Renal Cert, CertED/RNT  
Director Multi Professional Programmes  
School of Health & Social Care,  
University of Teesside, Tees Valley, Middlesbrough. UK

Background and context
The extent of violence and aggression (V&A) within the National Health Service - NHS (UK) continues to be problematic for staff delivering care. Increasing patients numbers with increasing public expectations, often within limited human resources only add further to the burden and stress encountered by staff. The 2000 British Crime reported nurses being up to 4 times more likely to experience work related violence and aggression (V&A).

Aim of the study
1. To establish the nature of violence and aggression experienced by nurses in renal care settings
2. To identify the possible reasons and determine the extent to which hospital policies and procedures were in place to support staff

Methodology
An anonymised survey of delegates attending the annual RCN Nephrology conference was conducted to establish the nature of violence and aggression experienced by delegates –

Results
- 79% of nurses reported violence and aggression in the workplace with the majority (64%) having had an experience during the last year. The severity of attacks ranged from fractured sternum to knife stabbing!
- The impact of such experiences resulted in increased levels of stress (65%) and reduced levels of confidence (23%).
- 77% of respondents reported that renal patients were involved; nearly all respondents reported verbal abuse. Asked to identify causative factors in order of priority, respondents stated that it seemed that the major cause was patients’ expectations of service and staff.
Summary & conclusions
The need for effective staff education in helping staff cope and respond to violence and aggression remains an important goal. The need to establish clear boundaries with both patients and their relatives remains an important goal as indicated by 72% of respondent in this study. This remains a challenge where service users are increasingly more demanding on what they expect to receive from those delivering care.
Loneliness among elderly people living at home alone in rural Australia.

**Dr Ken Sellick**  PhD, MPsych, B.BSc. RN, FRCNA  
Senior Research Fellow, School of Nursing & Midwifery  
Monash University Australia

**Dr Janice Chesters**, PhD, BA (Hons).  
Senior Lecturer, School of Rural Health  
Monash University, Australia

**Professor Karen Francis**, PhD, MHSc, BHSc, RN, MRCNA  
Professor of Rural Nursing, School of Nursing & Midwifery  
Monash University, Australia

**Correspondence to:**  
Dr Ken Sellick, Senior Research Fellow, School of Nursing & Midwifery, Monash University, Gippsland Campus, Northways Road, Churchill, Victoria 3842, Australia  
Email: ken.sellick@med.monash.edu.au  
Tel: 61 3 5122 6681

Loneliness in the elderly is a major health concern effecting some 12-40% of people aged 65 years and older (Creecy, Bery & Wright, 1985). In addition to being a distressing experience, loneliness has been identified as a precursor to poor nutrition (Walker & Beauchene, 1991), physical ailments (Evans & Dingus, 1989), psychosomatic complaints (Bradley, 1967), depression and risk of suicide (Hraba, Lorenz & Pechacova, 1997), greater likelihood of admission to a nursing home (Russell, Peplau & Cutrona, 1980) and poor quality of life (Felton & Berry, 1992). The prevalence and adverse health consequences of loneliness are of particular concern for elderly people living at home alone in rural communities due to geographic isolation and limited access to health and support services.

We are currently undertaking a major study to determine the prevalence of loneliness, depression and associated health problems among older persons living at home alone in rural communities; to identify those at risk for loneliness, depression and other health concerns; and to obtain an in-depth understanding of the experiences and needs of lonely older persons. Our primary aim is to use this information to design, implement and evaluate a community-based support program to meet the needs of this population.
This paper reports on the initial survey of older persons (aged 65 and over) living alone in rural communities in Victoria, Australia. A preliminary sample of 60 participants were recruited through local advertisements and with the assistance of key community agencies (e.g. aged care assessment teams, community health centres, district nursing services, general practitioners, home care services). Participants were asked to complete a self-report questionnaire designed to obtain socio-demographic information and measures of health status, chronic health conditions, use of health services, social contacts, social activities, loneliness and depression. Standardised assessment tools included subscales of the OARS Multidimensional Functional Assessment Questionnaire (McDowell and Newell, 1996), the UCLA Loneliness Scale (Russell, 1996) and the Geriatric Depression Scale (Yesavage et al, 1983).

Data were entered on to SPSS for Windows (Version 14) and analysed using frequency and summary statistics to describe sample characteristics, and prevalence of health problems, loneliness and depression. Inferential statistics were also used to identify the extent to which socio-demographic, health status and social factors were related to loneliness and depression. Findings are discussed in relation to health needs, prevalence of loneliness and the early identification of at-risk elderly. Practical problems we experienced in conducting the survey are also described. Results from this study are not only relevant to Australian elderly, but to other countries which have large rural elderly populations.

References:


HOLISTIC NURSES’ EXPERIENCE WITH MODALITIES: PERCEIVED BENEFITS TO SELF AND CLIENT

Leighsa Sharoff, EdD, RN, NPP, AHN-BC
CITY UNIVERSITY OF NEW YORK
HUNTER COLLEGE-BELLEVUE SCHOOL OF NURSING
425 East 25th Street
New York, NY 10010
917-842-7902
lsharoff@hunter.cuny.edu

BACKGROUND: Holistic nurses incorporate the concepts of body-mind-spirit into their personal and professional life; this professional has a unique connection with their clients. The intent to practice holistically, to bring a sense of calmness and understanding of the client’s needs, leads to an improved and enhanced healing process for the client. Holistic nurses use a variety of modalities in the healing process. Modalities are different techniques that can be included in the healing process to assist the nurse and client in achieving maximum health potential. In nursing, therapies are sometimes differentiated on the basis of doing and being...“doing” therapies include almost all forms of modern medicine, e.g.: medications, procedures, radiation. In contrast, “being” therapies do not employ ‘things’ but utilize ‘states of consciousness’, i.e.: imagery, prayer, meditation and quiet contemplation, as well as the presence and intention of the nurse. Energy work is a general term for modalities that are based on the idea that the human body consists of energy fields that can be stimulated through various techniques in order to promote wellness.

PURPOSE: To describe the experience that holistic nurses have in incorporating holistic modalities as they participate in the care of their clients; and gain a deeper understanding of the holistic nurse and the perceived benefit of utilizing a holistic modality with their clients and themselves concurrently as providers of the modality.

METHODOLOGY: Purposeful sampling of holistic nurses’ who include modalities in their healing process provided the participants in this exploratory research, which entailed data collection through the use of critical incident reports and open-ended interviews.

ANALYSIS: Verbatim transcripts were subject to content analysis by the researcher.

FINDINGS: All participants in this study described personal and professional growth and development through the inclusion of a modality into the healing-caring process and positive benefits for self and clients with the inclusion of a modality into the healing-caring process.
**CONCLUSIONS:** The researcher has drawn 6 conclusions based on the findings of this interpretative qualitative study. Holistic nurses’ who are: (1) motivated to learn new ways of caring for self and others have awareness of what they need to foster their own growth and development; (2) open and willing to explore different modalities of the healing-caring process are dedicated to their own personal growth and development; (3) dedicated to fostering a sense of balance in and providing sacredness to their work are committed to maintaining congruency between personal needs and professional goals and ethics. Additionally, (4) caring for oneself is an important prerequisite to helping others. Holistic nurses’ who include a modality receive caring in a variety of positive ways; (5) nurse-client relationship is integral to the healing-caring process of both nurse and client and (6) benefits to clients’ continued health promotion and comfort care is integral to the healing-caring process.
Assessment of the effectiveness of a patient orientated harm reduction booklet on cocaine use amongst intravenous substance misusers.

Poster being presented by Rose Sheppard

Authors

O’Shea Jacinta, Research Registrar, jacinta.oshea@mailm.hse.ie

Elliffe Sarah Jane, Research Assistant, Degree in Psychology,

Spiro David, RPN Staff Nurse nursemanager.bri@mailm.hse.ie

Geoghegan Noreen, RGN, H Dip Midwifery, BSc Nursing. Assistant Director of Nursing, noreen.geoghegan@mailm.hse.ie

Keenan Eamon, Consultant Psychiatrist, Clinical Director. eamon.keenan@mailf.hse.ie

Address
Addiction Services, Bridge House, Cherry Orchard Hospital, Ballyfermot, Dublin 10.
Telephone no: 6206400

Background and Context
The use of cocaine has increased threefold in drug treatment centres in Ireland over the past three years, with 9% of patients testing positive for its use. The nursing health promotion initiative produced a patient orientated booklet to educate patients of the risks of cocaine use. The National Health Promotion strategy 2000-2005 action (5) recognises the need to improve the health and social gain of those who are disadvantaged or by developing sensitive and appropriate health promotion programmes to meet their needs. One of the mid term reviews of the National Drug Strategy (2005) key themes within a prevention strategy was education.

Aim
To evaluate the effectiveness of the booklet regarding the dangers of cocaine use amongst intravenous drug users.

Methods

Setting: Crumlin Drug Treatment Centre. A community based Addiction Treatment Centre.
Design: Cross sectional survey using a structured questionnaire.

Participants: All patients attending for methadone maintenance were approached to take part in the study.

Method
Sixty two patients completed a structured questionnaire regarding the demographics and knowledge of cocaine and its effects. They were then given an information booklet and asked to read this. Approximately two weeks later the researcher approached all patients and re-administered the questionnaire.

Results
The percentage positive for cocaine on urinalysis was 14.9% at the start of the study. The percentage of patients testing positive for cocaine urinalysis one month after the study was 13%. 94.7% of participants reported that they felt the booklet was worthwhile.

Conclusion
The increasing prevalence of high-risk behaviours, such as injecting and sharing practices associated with opiate and, more recently, cocaine has very serious implications for the future health of the population of drug users involved in these practices. This is particularly the case in relation to the transmission of infectious diseases such as HIV, Hepatitis B & C.
From these results we can see that although this group of patients appear to have a high prior level of knowledge regarding the risks of cocaine use, this innovative information booklet appears to be effective in further increasing this.
A recent survey of Drug Clinics in the South Western Area suggests that text messaging may help to reduce non attendance.

Authors

Sheppard, Rose, RGN, BNS CNM II
nursemanager.bri@mailm.hse.ie

Brady Sharon, RGN
Staff Nurse sharonbrady75@eircom.net

Geoghegan Noreen, RGN, H Dip Midwifery, BSc Nursing.
Assistant Director of Nursing, noreen.geoghegan@mailm.hse.ie

Address
Addiction Services, Bridge House, Cherry Orchard Hospital,
Ballyfermot, Dublin 10.
Telephone no: 6206400

Background and connection to conference theme
A high rate of missed appointments was noted within the Addiction Services. There may be clinical implications for the service user, as well as economic implications for the health service. Therefore it is in the best interest of both parties to maximise the uptake of appointments.

Objective
- To ascertain whether appoint reminders were a good idea.
- To determine choice of reminders.

Methods:
There were 7,521 people in treatment with the Addiction Service in March'05, of these 1,533 people were in treatment with The Addiction Services: HSE-SWA. A questionnaire of 10 questions was devised and distributes to each addiction clinic. Nursing staff facilitated completion of the questionnaire with the service users. Participants were selected at random and verbal consent was given to carry out the survey.

Analysis
The results from the survey reveal that the majority of service users feel that reminders in general are a good idea. Their main choice of delivery appointment reminder is by letter. However it is clear from the feedback that there is interest in text messaging as a potential method of appointment delivery in the future.
Outcome

- 595 (38.8%) of service users participated.
- 561 (94.3%) agreed that reminders were a good idea.
- 517 (86.9%) had a mobile phone.
- 116 (31.4%) chose letter as their preferred choice of reminder.
- 69 (18.6%) chose phone as their preferred choice of reminder.
- 69 (18.6%) chose text message as their preferred choice of reminder.
- 1 (0.3%) chose e-mail as their preferred choice of reminder.

Conclusion

This is the first survey of its kind to be carried out within the Addiction services, which sought the service user’s own perspective. The majority of service users agreed that appointment reminders are a good idea.

A sizeable minority of participants chose text messaging as their preferred method of reminder. This preliminary study suggests that text messaging could be a way of reducing non-attendance in the Addiction service in the future.
CLINICAL COURSE PREDICTOR VARIABLES ON NCLEX-RN READINESS EXAM PERFORMANCE

Elizabeth Simon RN, PhD, CCRN, CEN
Hunter College, City University of New York
New York, New York 11010
Tel: 212-481-1424, email: esimo@hunter.cuny.edu

Introduction
The nursing profession is in the midst of a major shortage in the United States (AACN, 2002, 2004, RWJF, 2004, Kimball 2004). Despite a large number of applicants for nursing programs at present, colleges cannot admit them because of the nursing faculty shortage. To alleviate the shortage and increase the supply of nurses, nursing schools are committed to improve the National Council Licensure Examination for Registered Nurses (NCLEX-RN) passing rate.

Research Problem
Numerous studies have been completed on the preadmission variables (input) that predict the outcome in the NCLEX-RN. However, few studies are available that evaluate the relation between the tests scores in five major clinical areas: foundations in nursing, adult health nursing, maternal and child health nursing, community health nursing, and mental health nursing. The five core clinical courses are the foundations of the nursing process and comparable to the throughput in a system. The nursing faculties have control of the throughput process but not the input variables. Therefore, estimating a significant correlation between NCLEX-RN and these clinical courses can provide essential information for strengthening the program to improve the NCLEX-RN passing rates and, consequently, the supply of nurses available to provide quality health care.

Since the NCSBN changed the mode of testing from paper and pencil to computerized adaptive testing (CAT), it is not possible for nursing programs to obtain scores for the NCLEX-RN, and it is difficult to know the graduate’s first-time pass/fail status unless the students themselves inform the college. Without this information it is possible to learn only from the boards’ Websites whether a particular graduate is licensed or not. The nursing schools receive quarterly reports of aggregate passing rates with no personal identifiers. On the other hand, the NCLEX-RN readiness exam administered by National League of Nursing (NLN) assesses the potential performance for the NCLEX-RN. Therefore, it is crucial to investigate which clinical course grade has the highest correlation
with NCLEX-RN readiness exam score. Along with these courses, there are supporting foundational science courses such as biology, chemistry, mathematics, nutrition, pathophysiology, and pharmacology that contribute to the knowledge base of clinical courses. Pathophysiology is an elective course for a number of nursing schools, and an investigation would reveal the influence of this course on the NCLEX-RN readiness exam. Previous studies have established statistically significant correlation among clinical course scores, preadmission scores, and NCLEX-RN readiness exam results. Nevertheless, there are few studies that investigate the predictor ability of individual courses.

**Purpose**
The purpose of this study was to examine the relationship between nursing clinical course variables and NCLEX-RN readiness exam scores and to strengthen the course having the highest correlation with passing performance. Once the significant courses and the related variables were identified, pedagogical measures could be delineated and implemented to strengthen overall NCLEX-RN performance and eventually NCLEX-RN pass rates.

**Theoretical Base**
The theoretical base for this study is founded in general systems theory, systems thinking, and the application of these theories to nursing education. Systems theory can offer great potential for achieving a workable design for nursing education. Systems analysis serves as a valuable tool for decision making and problem solving. By breaking a larger system into subsystems and detecting the connections between the subsystems, an analyst can focus on multiple factors, scrutinize them, and ascertain how alterations affect total system function. In this process, a system is defined as drawing a boundary around objects to include input, throughputs, outputs, and feedback loops (Bertalanffy, 1972., Putt, 1978).

When systems theory is applied to nursing education, the input becomes the personal system of the student: values, beliefs, and knowledge, which is evidenced partially by scores on standardized tests such as the Standardized Achievement Test (SAT) and the Nurse Entrance Test (NET), and by the student’s grade point average (GPA). Throughput is the interpersonal system that encompasses students and faculty in the educational environment. This interaction is the process that influences the output. Output will be passing the NCLEX-RN and effective clinical practice (King, 1981).
Literature Review

- Percoco (2001) general education courses (foundational science courses) predicted success in the program, but not NCLEX-RN success.
- Collins (2002) also found significant but weak correlations between NCLEX-RN test results and the preprogram science courses.
- Engelmann’s (2002) study demonstrated correlation among the NCLEX-RN passing rate, preadmission GPA, and the midcurricular examination scores.
- Gidden’s (2002) study showed that critical thinking skills are related to NCLEX-RN performance.
- Spelic et al. (2001) asserted that teaching learning/strategies that stimulate a spirit of inquiry, self-reflection, and inductive and deductive aspects of problem solving in clinical situations foster critical thinking in nursing students.
- Beckie, Lowry, and Scott (2001) stated that the “ability to think critically underlies competent clinical practice” (p.19).
- Henriques (2002) supported that not only the content of the clinical courses in the nursing curriculum but also the students’ reading and thinking abilities can have an effect on NCLEX-RN performance.
- Sevcik (2002) investigated the influence of three preadmission variables: the Nurse Entrance Test, math score, GPA, and the nurse entrance test reading score. It was found that the reading score and GPA were correlated with the NCLEX-RN passing rate.
- Stuenkel (2002) NLN community health nursing achievement test score was the best predictor of NCLEX-RN success. Difficult to agree with this finding since community health nursing (health promotion and maintenance) covers only 6 to12% of the NCLEX-RN content.
- Elliott (2003) no relationship between the methodologies used and the NCLEX-RN passing rate. She concluded that there could be other variables that influence NCLEX-RN passing scores.

Research Design

This longitudinal correlation study investigated the relationship between a dependant variable (NCLEX-RN readiness exam performance) and five independent variables (course grades in foundations of nursing, adult health nursing, maternal and child health nursing, community health nursing, and mental health nursing). Data were collected from northeastern university’s baccalaureate program’s graduate records between 2001 and 2004. Pearson correlation $r$ was used to determine the correlation among the course grades and the performance in the NCLEX-RN readiness
exam. Factor analysis was done to detect the score for each of the five areas from the course grades of NURS 310 (Nursing I), NURS 312 (Nursing II), NURS 410 (Nursing III), NURS 412 (Nursing IV). NURS 310 introduces foundations of nursing practice across the life span with a special emphasis on childbearing families. In NURS 312 the major areas covered are child health nursing, mental health nursing, and adult health nursing. In NURS 410 adult health nursing is the major component along with mental health nursing. NURS 412 deals with adult health nursing and community health nursing. NURS 343 emphasizes biological disruptions that influence levels of wellness across the life span. These major nursing courses are 8 credits each for 4 hours of lecture and 14 hours of labs per week. Other supporting nursing courses provide students with a broad scientific foundation for approximately 30 credits. In addition to that, liberal arts foundation and open electives contribute another 60 credits. The influence of these science course grades on the total score of the exam was also examined.

**Findings**

- There is a statistically significant correlation between mean academic grades in foundational science courses and NCLEX-RN readiness test results. The results indicated that the first factor (component) is correlated .826 with NUR1, and .808 with NUR2, and so on (see Table 2). These are also the weights given to the individual scores in each course to determine the factor. So the first factor is essentially an equally weighted average of all four courses, general nursing background, and no differentiation among the five topics. The second factor has negative weight on the first two courses, positive weights of the second two. The first two have child health in common. The second two have adult health in common. The second factor looks at the difference between child health scores and adult health scores. The third factor looks at the ways NUR3 is different from NUR4. Both have adult health in common, and the difference is between mental health and community health. The fourth factor looks at the differences between the first two courses: mental health vs. no mental health. The first factor, the average of all the courses, accounts for the 60% of the variation. Only the first factor, the average of everyone, is correlated with NLN NCLEX-RN readiness examination.

- The Pearson correlation \( r \) (two-tailed at significance level \( p < 0.01 \)) indicated that all of the foundational science courses (biology, chemistry, mathematics, nutrition, and pharmacology are significantly related to NCLEX-RN readiness exam scores (and to each other) except for mathematics.
The students who took NURS 343 have a higher score in the NCLEX-RN readiness exam compared to those who did not take it. In fact, those students taking NURS 343 (PATHO) had a slightly lower score (111) than those who did not (PATHO, averaging 115). This difference is not statistically significant (P = .694). It is possible that students were able to understand the pathophysiological concepts behind health alterations without taking that course.

**Implications**

This study’s findings suggest that input variables such as students’ ability (personal system), evidenced by GPA and scores in foundational science courses, are important variables that influence success in the NCLEX-RN readiness exam. Input variables may be more significant in predicting student success than the throughput variables such as methodologies, pedagogical principles, and course content. The expected output in nursing education is successful NCLEX-RN performance on the first attempt and effective clinical practice. This study was designed to identify a single course that influenced the outcome, in order to recommend changes in the nursing curriculum. Findings indicated that change is needed in the area of student selection and that ongoing support in the educational institutions augments students’ personal system. Nurse educators are encouraged by regulatory bodies and professional organizations to devise strategies for better output in nursing education. This study, supported by previous studies, suggests that enhancing students’ ability to apply nursing knowledge is vital to student success. Recruiting students with good academic standing, and enhancing their decision-making skills, clinical judgment ability, self-efficacy, and self-direction can improve the NCLEX-RN passing rate. These skills can be enhanced through pedagogical strategies and not through changing the content of the courses.
REFERENCES


A phenomenological study of vicarious traumatisation among ward based registered oncology nurses.

Ms Helen Sinclair BSc (Hons), Specialist Practice in Oncology, PGCHET, Diploma in Counselling
Teaching Fellow
School of Nursing and Midwifery
Medical Biology Centre
Queens University Belfast
Lisburn Road
Belfast BT9 7AB
Northern Ireland
+ 44 28 9097 5848
h.sinclair@qub.ac.uk

Abstract

Background and context
Trauma not only affects individuals who are primarily present, primarily traumatised, but also those with whom they discuss this experience. The potential impact this could have on the listener is entitled, secondary trauma or vicarious traumatisation. If the listener is a nurse, anecdotally, there may also be a risk of vicarious traumatisation in this population.

It is widely documented that nurses can, and do, experience work related stress as a result of caring for patients and their significant others. Some of the terminologies used to capture this impact, are burnout, compassion stress, emotional contagion or simply the cost of caring. However, in mental health professionals, such as counsellors or psychologists, there appears to be an exclusive terminology that is used, vicarious traumatisation. Vicarious traumatisation is a process through which the therapist’s inner experience is negatively transformed through empathic engagement with client’s trauma material. As yet it appears there is no empirical evidence to determine whether vicarious traumatisation exists in oncology nursing, therefore, this exploratory research will determine whether vicarious traumatisation may exist in this population.

Aim of the study
The aim of the study is to listen to ward based registered oncology nurses, lived experience of caring for patients with a diagnosis of
cancer, to determine if vicarious traumatisation may exist in this population.

**Methodology including research design and sampling**
A Husserlian phenomenological qualitative approach was used with non probability convenience sampling. Semi structured face to face interviews were undertaken with six ward based registered oncology nurses.

**Analysis**
Data was analysed using Colaizzis seven step approach with themes emerging.

**Summary of key findings**
Findings will be finalised in September 2006.

**Conclusions**
As vicarious traumatisation has not been researched within oncology nursing, this research is innovative. The findings will highlight registered nurses experience of caring for patients diagnosed with cancer and reveal whether there is any indication that vicarious traumatisation may exist in oncology nursing.
Birth technology: models and mechanisms of birth technology induction in Jordan

Dr Reem Hatamleh, Lecturer in Midwifery, Jordan University of Science and Technology

Professor Marlene Sinclair, chair in Midwifery Research, Institute of Nursing Research, University of Ulster

Professor George Kernohan, chair in Health Science, Institute of Nursing Research, University of Ulster

Professor Brendan Bunting, chair in Psychology, University of Ulster

In 1985 the World Health Organization provided guidance on the appropriate use of technology in childbirth and stated that no country should have an induction rate higher than 10%. However, research indicates that the frequent use of induction technology in childbirth is leading to technological birth becoming the norm in many countries. Jordan is one of many countries in which the use of technology in childbirth appears to be increasing.

Aim: To provide information on birth technology for induction and to test a model of the association between induced labour and maternal and infant morbidity, while taking into account relations between labour type, obstetric risk, method of monitoring, oxytocin, number of ultrasound scan and analgesia for women who gave birth in one major maternity hospital in Northern Jordan.


Main Findings: The majority of women (n=161, 81%) underwent induction of labour. Almost half of the babies were admitted to the neonatal intensive care unit for resuscitation 50% (n=100). Nineteen babies (10%) were admitted to hospital in the early weeks of birth and 15 of these were in the induced group. The highest proportion of mothers who were readmitted to the hospital 12% (n=19 out of 161) were from the induced group. Urinary tract infection, blood transfusion, mastitis and wound infection were the major reasons for readmission to hospital. Statistical modelling confirmed that Induction of labour leads to significant morbidity for mother and baby (P=.068, GFI= .925, RMSEA=.030, CI (.000-.047). Lower infant Apgar scores, admission to ICU and readmission to hospital were significant outcomes (P<.005). Operative
deliveries, perineal trauma, lower haemoglobin and postpartum haemorrhage were significant higher for mothers (P<.005).

**Conclusion:** Technological birth is common in Jordan and the outcomes from induction indicate high morbidity for mother and baby. The (WHO) guidance on induction of labour does appear to be having any impact on rates.
**EPI-No Birth Technology: Outcomes from an Exploratory Investigation**

**Dr Marlene Sinclair** PhD, MEd, DASE, BSc, RNT, RN, RM  
Senior Lecturer  
School of Nursing  
University of Ulster Jordanstown  
Northern Ireland BT37 0QB  
+ 44 2890 368118  
m.sinclair1@ulster.ac.uk

**Aim**
The purpose of this paper is to share knowledge about a new medical product (Epi-No) designed to train women to give birth more naturally. The paper will focus on presenting facts from data analysis of published literature on effectiveness and qualitative data from telephone interviews with women who have recently used the product.

**Methodology**
We undertook a structured literature search, an Internet search and telephone interviews to obtain a comprehensive understanding of this new medical device.

**Findings**
In summary, we found rather little support in the published literature for the claims of ‘proven clinical effectiveness’ advanced for EPI-NO, claims which rely rather heavily on the results of one, possibly non-randomised, study, although it is of course possible that larger randomised studies would provide stronger evidence for some or all of the claims made, particularly regarding the prevention of perineal injury, or the lessening of its severity, the claim for which existing evidence is strongest. However, telephone data from women who have experienced the product would indicate increased maternal confidence regardless of birth outcome.

**Conclusions/Recommendations**
Our specific recommendation concerning EPI-NO is therefore that one or more randomised controlled trials should be performed in primagravid women. These studies should be assessor-blind, and should have adequate power to confirm or refute the specific clinical claims made for EPI-NO, all of which we argue have not currently been proven. Furthermore, qualitative studies need to be undertaken to explore the reasons why women choose this technology.
A Systematic Review and of Reviews of Predictive Factors for Preterm Birth

**Valerie Smith** RM, RGN, BNS, BSc (HONS)
Midwifery Research Student.
School of Nursing and Midwifery,
Trinity College Dublin,
24 D’Olier Street,
Dublin 2,
Ireland.
Correspondence: vasmith@tcd.ie

**Declan Devane** RM, RGN, RNT, DipHE, BSc (HONS), PgDip (Stats), MSc.
Doctoral Student/Midwifery Research Assistant.
School of Nursing and Midwifery,
Trinity College Dublin,
24 D’Olier Street,
Dublin 2,
Ireland.

**Cecily M. Begley** RGN, RM, RNT, FFNRCrSI, MA, MSc, PhD, FTCD.
Professor of Nursing and Midwifery/Director,
School of Nursing and Midwifery,
Trinity College Dublin,
24 D’Olier St.
Dublin 2,
Ireland.

**Mike Clarke**
Professor of Clinical Epidemiology
Director, UK Cochrane Centre
NHS R&D Programme
Middle Way
Oxford
OX2 7LG
England

**Shane Higgins** MB, BCh, BAO, MRCOG, FRANZCOG.
Consultant Obstetrician/Clinical Director,
Department of Obstetrics,
Our Lady of Lourdes Hospital,
Drogheda,
Co-Louth,
Ireland.
ABSTRACT

Rationale; If preterm birth can be predicted reliably, this may allow for the use of interventions, such as corticosteroid therapy for fetal lung maturation, to improve neonatal outcomes. Predicting preterm birth might also provide an opportunity to provide psychological support to women and their families.

Objective; This systematic review sought reviews of studies of predictive factors for preterm birth, so that these could be appraised and the findings from good quality reviews highlighted. Reviews, rather than individual studies, are the basis for this systematic review because of the proliferation of reviews and the benefits of a single, consistent appraisal and assessment of evidence from these reviews, rather than further attempts to find and appraise the many individual studies in the literature.

Methodology; Potentially eligible reviews were sought primarily through searches of the electronic databases MEDLINE, EMBASE, CINHAL, Science Citation Index and The Cochrane Library. Our systematic review consists of a description of factors that might be predictive of preterm birth and for which at least one relevant review was found. The scope and quality of the identified review(s) is described, and their conclusions and the strength of these conclusions discussed. Ten reviews were identified, of which seven were included in this systematic review of reviews.

Findings; The reviews we identified show that cervicovaginal fetal fibronectin and transvaginal sonographic cervical length measurements are clinically useful factors in predicting preterm birth. Consideration might be given to the use of both the measurement of cervicovaginal fetal fibronectin and transvaginal sonographic assessment of cervical length to identify women at increased risk of preterm birth and, potentially, to improve the outcome for these women and their babies.
The Challenges of Assessing Student Nurses’ Competence Using Objective Structured Clinical Examinations

Author: **Siobhan Smyth**. RPN, Dip. CPN, RNT, PG Dip. CHSE, BNS (Hons.) MSc.
Job Title: Lecturer
Address: Department of Nursing & Midwifery Studies.
National University of Ireland, Galway
Telephone: 353-91-492832
e-mail Address: siobhan.smyth@nuigalway.ie

Author: **Evelyn Byrne**. RCN, RGN, RCNT, MSc.
Job Title: Applied Teacher
Address: Department of Nursing & Midwifery Studies.
National University of Ireland, Galway
Telephone: 353-91-493686
e-mail: evelyn.byrne@nuigalway.ie

**Background and Context:**
Nurse educationalists are required to develop assessment methods that reflect the primacy of integrating theory and practice. OSCEs are a valuable tool in assessing the clinical competence of healthcare professionals. Furthermore, they have a positive effect on the curriculum and impact on the students’ learning and their clinical practice. OSCEs as an assessment strategy are rapidly evolving in nursing education in Ireland. The assessment of clinical skills is complex and presents numerous difficulties for educators. Designing effective OSCE stations is compounded by its complexity and resource intensiveness. The success is dependent on knowledgeable and skilled personnel.

**Aim:**
The paper identifies the factors that enhance and inhibit the process of developing OSCEs from nurse educationalists’ perspectives.

**Methodology/Analysis:**
Focus group interviews were undertaken with the lecturers involved in OSCEs and the data was analyzed using Colaizzi’s framework.

**Summary of Key Findings:**
OSCEs are an effective method of assessing clinical skills. This assessment strategy should be introduced across the BSc. nursing curriculum. The development of multiple stations for each examination is essential. The findings alluded to all students
performing the same skills during each examination. Lecturers involved in the teaching of a skill should devise the marking criteria for the skill and partake in the assessment. Simulated clients added realism to the assessment process and enhanced the creation of a clinical setting.

**Conclusions:**
This paper highlights the benefits of implementing OSCEs as an effective assessment strategy in the education of BSc. nursing students.
An Exploration of Social Support among Pregnant Women

Submitting and Presenting Author

Valerie Spillane, RGN, BN, RM, MA
Department of General Practice
1 Distillery Road
National University of Ireland, Galway
Tel: 091 - 493961
Fax: 091 - 495558
Email: valerie.spillane@nuigalway.ie

Authors
Nic Gabhainn, S. (PhD) ¹
Spillane, V. ²

Institutions
¹ Department of Health Promotion, NUI Galway
² Department of General Practice, NUI Galway

Abstract

Background
There is a positive relationship between social support and health. An individual’s social relationships are associated with health status independently of a wide range of medical and other social factors. Observational studies of social support in pregnancy have shown a relationship which suggests that social support improves maternal and infant well-being; reduces the risk of having a low birth-weight baby; and has beneficial physical, psychological and behavioral effects for the woman.

Aims of the Study
1. Identify the predictors of social support for pregnant women and describe their social support networks.
2. Explore the reported level of social support in the antenatal period.

Methodology
A quantitative research approach was adopted, a cross sectional design implemented, and a self-administered questionnaire employed. The accessible population comprised an aggregate of pregnant women attending the Antenatal Clinic of a large teaching hospital in the West of Ireland. A random sample was drawn from those women attending the clinic during the time point that data were collected.
Analysis
Data were entered into SPSS Version 12.0. Socio-demographic data gathered were analysed and then total scores obtained from the PRQ, the MSPSS and SSQ6 Questionnaires were calculated and then reviewed to determine if a difference could be identified between those who reported high compared with low levels of social support.

Key Findings and Conclusions
The crucial positive social support role provided to women was conferred by their informal social network. The inclusion of demographic variables was important because their inclusion rejects the suggestion that the effects of social support are simply attributable to persons of higher socio-economic status.

One test of maturity for an area of social science research is its ability to translate accrued knowledge into policy. The central and fundamental question remains: if social support provides health advantages, can pregnant women increase and improve the level of social support they receive through specific efforts?
Intervention Implementation: the process of monitoring the delivery of the intervention for Secondary Prevention of Heart Disease in General Practice (The SPHERE Study).

Submitting and Presenting Author

Valerie Spillane, RGN, BN, RM, MA
Department of General Practice
1 Distillery Road
National University of Ireland, Galway
Tel: 091 - 493961
Fax: 091 - 495558
Email: valerie.spillane@nuigalway.ie

Authors

Byrne, M.C. (PhD) 1
Byrne, M. (PhD) 2
Leathem, C. (RGN, BSc) 3
O’Malley, M. (RGN, H.Dip) 4
Spillane, V. 1

Institutions

1 Department of General Practice, National University of Ireland Galway
2 Department of Psychology, National University of Ireland Galway
3 Department of General Practice, Queen’s University Belfast
4 Department of Public Health and Primary Care, Trinity College Dublin

Abstract

The aim of this paper is to describe how treatment fidelity is being monitored during the implementation of a RCT of a complex intervention. Treatment fidelity describes the methodological strategies used to monitor and enhance the reliability and validity of behavioural interventions. Such strategies are used in assessing and monitoring the implementation of a study intervention to account for variance in intervention delivery and report any deviations from the agreed standard treatment. The research nurse has an important role in this process of monitoring intervention implementation which will be outlined. Treatment fidelity procedures are included in trials of complex interventions to inform and account for inferences made from study outcomes. The overall objective is to minimise errors in the interpretation of outcomes, and to ascribe those outcomes directly to the intervention at hand. It is hoped that this paper will help researchers’ understanding of TF and increase its use in their work. The use of treatment fidelity
procedures will be directly explicated in relation to the implementation of the SPHERE intervention, which aims to improve the process of care and objective clinical outcomes for patients with established coronary heart disease in general practice. The two principal components of the SPHERE study intervention include facilitating behaviour change and improving medication prescribing. In this paper, the Behaviour Change Consortium’s ‘treatment fidelity recommendations’ are used to outline how treatment fidelity is monitored in the SPHERE Study.
Leading with Integrity: a qualitative research study

Lorna Storr
Lecturer Clinical Leadership and Service Improvement
Department of Health Sciences
C Block
Alcuin College
Heslington
York
England
YO10 5DD
Email: ls533@york.ac.uk
Tel: 01904 321367

Concurrent Paper


This research paper gives an account of a study into the relationship between leadership and integrity. There is a critical analysis of the current literature for effective, successful and ethical leadership particularly integrity.

Aim
The purpose and aim of this research is to build on current notions of leadership within the literature, debate contemporary approaches, focussing specifically on practices within the UK National Health Service in the 21st century. This leads to a discussion of the literature on ethical leadership theory, which includes public service values, ethical relationships and leading with integrity.

Methodology and Findings
A small study was undertaken consisting of 18 interviews with leaders and managers within a District General Hospital. Using the Repertory Grid technique and analysis, 15 themes emerged from the constructs elicited, which were compared to the literature for leadership and integrity and other studies. As well as finding areas of overlap, a number of additional constructs were elicited which suggested that effective leadership correlates with integrity and the presence of integrity will improve organisational effectiveness.
Analysis and Summary
The study identified that perceptions of leadership character and behaviour are used to judge the effectiveness and integrity of the leader. However, the ethical implications and consequences of leaders’ scope of power and influence such as policy and strategy are somewhat neglected and lacking debate.

Conclusions
The findings suggest that leaders are not judged according to the ethical nature of decision making and leading and managing complex change but that the importance of integrity and ethical leadership correlated with higher levels of hierarchical status and that it is assumed by virtue of status and success that leaders lead with integrity.

Finally, the findings of this study seem to suggest that nurse leadership capability is developing as a consequence of recent national investment.
The amelioration of avoidable suffering in the context of critical care end-of-life decision-making: A critical interactionist study.

Dr Deborah Jane Sundin-Huard PhD, RN, RM
Lecturer
School of Nursing and Midwifery
University of Newcastle
Callaghan, 2308
Newcastle
Australia
+ 61 2 49216759
Deborah.Sundin-Huard@newcastle.edu.au

BACKGROUND: The contemporary medical standpoint of treating death as the ultimate enemy means that the health care system seems compelled to battle disease and injury with all available technology but this results in much avoidable suffering.

AIM: This study sought to describe and explain the interactions between the key stakeholders in end-of-life decision-making in critical care in the interests of developing strategies to ameliorate avoidable suffering.

METHODOLOGY Denzin’s Interpretive Interactionism was modified to incorporate methodological principles from critical post-structuralism. Semi-structured, in-depth interviews were conducted with patients’ families, nurses and doctors from a variety of critical care units in Australia.

ANALYSIS Crucial interactions related to decision-making concerning initiation, maintenance or withdrawal of life-sustaining treatments were the focus of analysis. Denzin’s methods of bracketing, (re) construction and contextualization were used and extended to consider not only what was actually said but also what might or should have been said in interactions to minimize or eliminate avoidable suffering.

KEY FINDINGS Avoidable suffering for families, nurses and doctors can be minimised through organisational, procedural and educational strategies. For example, for families, avoidable suffering can be minimised if nurses and/or doctors:

- Ensure they are oriented to the critical care environment
- Explain the technology surrounding the patient
- Prepare them for the patient’s appearance (attached to this technology)
- Keep the family updated with regular progress reports
- Ensures discussions with families are held in a private area (preferably a room dedicated to this purpose).
- Assess families’ knowledge base/s and ensure adequacy of knowledge to participate in end-of-life decisions
- Encourage family members to ask questions
- Invite family members to participate in decision-making
- Provide basic needs for families (somewhere to rest, phone, meal dockets etc.)
- Provide spiritual and psychological support prior.

This paper presents these findings and recommendations drawing upon participants’ stories as illustration.
Professional Development Programme in Promotion of Continence and Management of Incontinence in the North West

Catherine Cannon  Specialist Co-ordinator Centre For Nurse Midwifery Education St Conals Hospital Letterkenny BSc (Hons) RGN, RM

Frances Sweeney  Regional Continence Advisor HSE North West Area. RGN, Certificate in Promotion of Continence and Management of Incontinence.

Lorna Baldric  CNM2 Urodynamics Department Letterkenny General Hospital Co Donegal . RGN, Certificate in Promotion of Continence and Management of Incontinence. Diploma in Microbiology and Communications

The Centre for Nurse Midwifery Education in collaboration with the Regional Continence Advisor, and Practice Development staff developed this unit of learning in response to demand from Service managers, integrated continence group and through Educational Needs Analysis in the Health Service Executive West.

The aims of the course are to;

- Endeavour to assist the health care workers gain evidence-based knowledge and competence in caring for a patient/client with continence issues
- To provide preparation for health care workers to function as specialist practitioners in the prevention of continence problems, promotion of continence and management of incontinence
- To improve/promote awareness of continence issues in health care workers in Donegal area.

The duration of the course was six months. The content was theoretically and clinically based and reflected the varying themes specific to all aspects of continence. Assessment was divided into three areas; @Case study/ Written Assignment (b) A ten minute presentation on an aspect of written assignment (c) competencies in Continence Clinics. Seventeen nurses plus one physiotherapist have successfully completed the course and a number of nurses in the community are now assisting with nurse led continence clinics.
Evaluation was conducted on a weekly basis with an overall evaluation at the end of the course that included feedback from service managers. This has been incorporated into the second course.

The accreditation process has commenced and it has been submitted at a level Eight (Minor Award within the National Qualification Framework).

In conclusion the funding from the National Council provided seed funding in setting up this course and allowed expert speakers from outside the HSE West area to deliver part of the programme. It will be run annually to meet the needs of the service and will be updated in alignment with national guidelines and research.
Perceptions and experience of birth space: a questionnaire survey of newly-delivered mothers

Dr Andrew Symon RGN, RM, MA (Hons), CTHE, PhD
Senior Lecturer
School of Nursing & Midwifery
University of Dundee
Dundee DD1 9SY
Scotland
+ 44 1382 632304
a.g.symon@dundee.ac.uk

Abstract

Background and context
Women in Britain give birth in a variety of maternity care facilities. Their perception of the birth space, and their sense of control over it, are crucial factors in their overall experience.

Aim
We sought to elicit the views of mothers from a variety of units about their perceptions and experiences concerning the birth environment.

Method
All newly-delivered mothers over a three-month period in three obstetric- and six midwife-led units (OLUs; MLUs) were invited to participate in a questionnaire survey, comprising closed and open questions. On-site evaluations of design were carried out using the Achieving Excellence Design Evaluation Toolkit.

Analysis
Data entered into SPSS. Descriptive and inferential statistics used. Thematic analysis of free text responses.

Key findings
558 (50%) mothers responded (OLUs n=238 [42%]; MLUs n=320 [57%]). Models of care clearly influence the overall birth experience; perceptions of environment and of care are inextricably mixed. Spatial size was less important than a sense of control. Women in MLUs felt more able to move around, even in smaller spaces. Women who self-rated as ‘no’ or ‘low’ risk were far more likely to have clinical interventions and pharmacological analgesia, and to have longer labours in the unit, if birthing in OLUs (all p<0.01). Women in the OLUs rated the birth space less favourably (p<0.01), and felt less in control over environmental factors such as temperature and ventilation (p<0.01), but not lighting. Views
concerning having a window in the birthing room were mixed. Maternal responses and the on-site evaluations were poorly correlated.

**Conclusions**

New build units and modifications of existing units have to strike a balance between cost, efficient use of space, and a facilitative environment for both staff and labouring women. User input is essential. How care is presented affects the experience of the environment.
Antenatal assessment of quality of life: an exploratory study

Dr Andrew Symon RGN, RM, MA (Hons), CTHE, PhD
Senior Lecturer
School of Nursing & Midwifery
University of Dundee
Dundee DD1 9SY
Scotland
+ 44 1382 632304
a.g.symon@dundee.ac.uk

Abstract

Background / Aim
Quality-of-life assessment is increasingly used in healthcare. This study sought to assess the Mother-Generated Index (MGI – previously used postnatally) in the antenatal period. Ethical approval was obtained.

Method / Analysis
The MGI is a single-sheet three-step questionnaire in which the woman / mother specifies, scores and ranks the most important areas of her life. Face-to-face interviews were conducted with 35 antenatal women between 28 and 36 weeks, using the MGI and the General Health Questionnaire (GHQ). Cited areas of the woman’s life were assessed thematically. Quantitative data were analysed in Excel and SPSS. Stepwise regression of all comments against the MGI score was used to assess those comments most predictive of antenatal MGI score.

Key findings
The most commonly cited areas were ‘tiredness’ (26); ‘looking forward to baby’ (24); ‘work’ (21); ‘aches and pains’ (20); ‘social life’ (15); ‘physical health’ (12); and ‘social support’ (11). 38% of comments were positive; 50% were negative. MGI and GHQ scores were significantly correlated (r=-0.622; p<0.01). Women who expected their birthing partner to be ‘very helpful’ had significantly higher MGI scores. Those citing positive physical health displayed a 2.2 point increase in MGI; a positive pregnancy outcome comment - 1.9 point increase; a negative work comment - 0.9 point decrease; negative emotional wellbeing - 1.4 point decrease; concerns about parenting - 0.8 point decrease (r=0.857; p<0.0005).

Conclusions
Identifying those aspects that are associated with good or poor quality of life can give midwives a more holistic appreciation of the woman’s situation. This small study suggests that the MGI may be a
valid tool for measuring quality of life antenatally. Because it is possible to follow up postnatally, it can also contribute towards a longer-term holistic understanding of the pregnant woman / mother and her unique situation.
Transcultural Nursing Education: Racism in the Nursing Classroom

Details of presenters:

Mary Tilki (PhD, MSc, BA, RN, RNT)
Principal Lecturer,
School of Health and Social Sciences,
Middlesex University,
Enfield Campus,
Queensway,
Enfield,
Middlesex,
EN3 4SA
United Kingdom

Tel: (0044 208 411 5150)
Email: m.tilki@mdx.ac.uk

Kathleen Markey (MSc, PGCHE, BSc, Dip HE, RN, RNT)
Senior Lecturer,
School of Health and Social Sciences,
Middlesex University,
Enfield Campus,
Queensway,
Enfield,
Middlesex,
EN3 4SA
United Kingdom

Tel: 0044 208 411 6504
Email: m.tilki@mdx.ac.uk
Transcultural Nursing Education: Racism in the Nursing Classroom

Mary Tilki and Kathleen Markey, Middlesex University UK

Introduction:
The need for transcultural nursing education for nurses and midwives to address the poor care received by people from minority ethnic groups is well documented (Papadopoulos et al 1995, 1998, Gerrish et al 1996, Holland and Hogg 2001). It is also argued that nursing education needs to move beyond the delivery of information about the culture and customs of different groups to examine the factors in the wider society which impinge on health (Papadopoulos et al 2004). In the last two decades a growing body of evidence has emerged which demonstrates the negative impact of racism on health (Kreiger 1990, Kreiger 2000, Kennedy et al 1997, Karlsen and Nazroo 2003). There is evidence of racism in the Higher Education system (Law et al 2002) and although nursing education is within this system there is little attention to the potential for racism within nursing curricula (Sawley, 2001, Nairn et al, 2004, Cortis and Law 2005).

Nursing curricula aim to prepare students for clinical practice and some go to great lengths to address the cultural needs of clients. However there is limited if any attention to the way in which racism is addressed in nursing curricula (Shaha 1998, Foolchand, 2000). Curricular content frequently recognises that conflicts exist between minority ethnic groups and the majority community, as well as between different minority ethnic groups. They are also cognisant with the problems experienced when accessing and using services. However anti-racist and anti-discriminatory strategies have been largely ignored in the education of caring professionals (O'Hagan 2001). There is still reluctance to explore racism, the conflicts that exist and the perceptions and experiences which contribute to and reinforce tensions (Shaha 1998, Cortis and Law 2005). Evidence indicates that lecturers in nursing are unskilled in recognising or handling racism (Papadopoulos et al 1995). In addition Burnard (2005) highlights the need for nurse lecturers to understand how students from other cultures cope with studying outside their homeland.

The transcultural nursing and cultural competence literature recognises the need to address racism (Alleyne et al 1994, Papadopoulos et al 1995, Narayanasamy and White, 2005), however, there is limited attention to how this might be achieved in nurse education. This paper sets out to report on the findings of a
project that investigated racism in the nursing classroom as experienced by undergraduate nursing students and their lecturers. The study (http://www.mdx.ac.uk/www/rctsh/racism_project.pdf) examined the impact of racist attitudes, beliefs and behaviours on students and in addition, explored lecturers’ ability to confront prejudice and deal with insensitivity and racism in the classroom.

**Methodology and research design**

The research aims and questions required a research approach which would uncover perceptions, meanings and experiences and as such were appropriate to a qualitative methodology, within an exploratory design, incorporating a purposive sampling strategy. The methods involved focus groups with thirty six nursing students from each year of their undergraduate programme and one focus group with eleven lecturers. Semi-structured interviews were undertaken with two students and four lecturers.

A general inductive analytic approach informed by the work of Bryman and Burgess (1994), Miles and Huberman (1994) and Thomas (2003) was undertaken. All members of the research team participated in coding, analysing and interpreting data using this inductive analytic approach, researcher, method and data source triangulation.

**Discussion of findings:**

The findings provide new insights into a largely under researched area and highlight issues to be addressed by the School of Health and Social Sciences, while at the same time being broadly applicable to other courses within and outside Middlesex University.

A number of common themes emerged across all of the data and there was a degree of consistency between students and lecturers and between focus groups and interviewees. The findings are described under four different themes:

- Understanding racism and its predisposing factors
- Racism and the lecturer
- The comfort zone
- Challenging racist or potentially racist behaviour
Understanding racism and its predisposing factors:

The findings of the project demonstrated the complex ways in which racism is manifested and revealed that it is not solely a Black against White phenomenon but has many permutations beyond skin colour. Examples of racist attitudes or behaviour between different Black groups and by Black people against White colleagues were cited by students and lecturers as evidence of growing awareness of the different manifestations of racism. Although not all of these episodes had racist motivations, there was unequivocal evidence that at times racial or cultural tensions were strongly involved.

"....racist is not just white people, even us Blacks, we can also be racist" (Black student FG1)

"The racism I see is from black to black (pause). Black people were questioning about my accent" (Black student FG3)

The findings highlighted the different perceptions of racism which make the concept highly abstract and difficult to define. Although, there was some reluctance or an inability to identify certain types of behaviour or attitudes as racist, the study demonstrated considerable evidence of racism in the classroom. Lecturers clearly described examples of conflict but not all had considered underlying racial motivations.

"It can be difficult to decide whether it is racism or just poor interpersonal skills" (Black Lecturer interviewee)

Whatever the reasons for, or the nature of racist experiences, it had a serious impact on the victim and participants felt marginalised and not fully accepted.

"It makes me feel isolated.....my opinion isn't valid, because I'm Jamaican and maybe I'm not like her" (Black Student FG3)

Students became suspicious or certainly on guard with unfamiliar people and at worst avoided attending classes, where they might feel uncomfortable.

"It had an impact on her because she said she was afraid to come to lecturers" (Black student FG2)

Although the boundaries are not crystal clear, lecturers must be able to differentiate between intolerance and unacceptable or racist behaviour. They must deal sensitively with attitudes and behaviours
which are offensive regardless of race and encourage a mutual respect within the classroom. They should understand hypersensitivity to racism where none is intended and ensure they are objective and fair when dealing with diverse students.

While ignorance and insensitivity might explain much of the discrimination, individuals and organisations are no longer able to hide behind a veil of institutional racism. The Race Relations Amendment Act (2000) places a clear duty on public authorities and this means taking active measures to address institutional racism as well as more direct and deliberate forms. There is a need for lecturers as individuals to examine their own ethnocentricity and consider the impact it has on relationships with students. In addition there is also a need to question the “whiteness” of the institution (Husband 2000, Purwar 2001) and the Anglocentric or Eurocentric norms and values embedded in organisational culture, practice and provision.

The failure to address and tackle racism in the classroom not only contravenes the mission and vision of the University and is at odds with the NMC code of Professional conduct but is potentially in breach of the Race Relations Amendment Act (2000). More importantly given the evidence of racism in the health care system it is crucial that students not only learn what attitudes and behaviours are unacceptable, but how they can be challenged and addressed professionally.

**Racism and the lecturer:**
Lecturers have a key role to play in facilitating student learning; nonetheless the data demonstrated that they can also be racist or perceived of as racist, as well as being the victims of racist behaviour.

"*Five students sitting in the back row and they glared at me, but when an ethnic minority student asked a question they would snigger....*" (Black Lecturer TFG)

"*They (White lecturers) were giving her (White student) more information; sometimes you would find her giving handouts that they didn't give us*" (Black Student FG2)

Focus group participants were adamant that racism within the classroom from any source had a negative impact on the learning process. However when racism is demonstrated by a lecturer, the impact can be particularly poignant and destructive.
"She (lecturer) says if you keep writing this English you won’t finish your nursing….when you come out of the door you see your tears on you" (Black Student FG2)

Students repeatedly perceived the way some lecturers dealt with English as a second language as insensitive or discriminatory. Participants felt some lecturers adopted an inappropriate approach to dealing with language barriers that existed and this caused feelings of anger and frustration and as a result hindered the learning process.

"I’m trying to express myself…..so you might give me that look, oh please hurry up. I’m thinking she is racist" (Black Student FG2)

"….you know when I was trying to say something, she was doing this <rolls eyes up to heaven and sighs heavily>. So I think our lecturers should be a bit more understanding" (Black Student FG1)

There are other examples of unacceptable behaviour which are not necessarily racially motivated but originate through ignorance, thoughtlessness and prejudices which are arguably the characteristics of institutional racism. Racism in any form can impact negatively on the student experience but the project showed that it is not always recognised, challenged or dealt with effectively by lecturers. This originates in different factors such as the size of groups and the inability to become acquainted with the students. Because some lecturers were relatively inexperienced, they lacked confidence and were often uncertain about how to deal with such sensitivities.

Nurse lecturers have considerable clinical and managerial experience and have often dealt with racist situations, but may need help in translating this into the practice of teaching students. This suggests the need for better preparation and mentorship for lecturers around teaching transcultural issues and particularly about detecting and handling racism. Given the multi-ethnic nature of nursing groups and the need to prepare students to work with and among diverse peoples and cultures, it is imperative that lecturers are well prepared and supported. This must be addressed by continuing professional development which is delivered sensitively and in a non-judgemental and non-threatening manner and must engage both White and Black lecturers. The Papadopoulos, Tilki and Taylor Model (1998) offers a simple and effective framework for training seminars, workshops and distance learning.

The data clearly show evidence of direct discriminatory behaviour by a small number of lecturers and varying degrees of cultural
insensitivity among several others. The study does not demonstrate how widespread such behaviours are but any form of racial discrimination is clearly unacceptable and if reported by the student may have incurred disciplinary procedures. Although a few of the incidents were overtly racist, the majority are more correctly categorised as institutional racism as defined by Macpherson (1999).

The comfort zone:

The term “comfort zone” is a term used by the research participants to describe the tendency of students to congregate with colleagues from their own communities for group-work because they felt comfortable and safe. The data indicate that it is both a cause and effect of racism inside and outside the classroom. The narratives demonstrate that students choose to work with people from their own or similar cultures to protect them from isolation, alienation and for support in unfamiliar surroundings. Language difficulties and religious affiliations compound the tendency to stick with familiar, comfortable people.

"I want a sense of belonging, at least she speaks my language" (Black Student FG2)

However while students and some lecturers recognised the rationale for “safe” groups, not all had the opportunity to choose who they worked with and some students felt excluded. Students who were the only person from a different cultural group felt isolated and either had to work hard to be accepted or withdrew from the learning experience.

"I was the only one from my county. I find it very difficult and that nearly put me off" (Black Student)

"I was the only white person in the class and I was completely ignored when I first started" (White student FG)

Burnard (2005) argues that nurse educators must make greater efforts to understand the experience of overseas students and endeavour to reduce the culture shock and alienation they encounter in an unfamiliar environment. Although referring to qualified nurses from overseas, Alexis and Vydelingum (2004) and Winkelmann-Gleed (2005a, 2005b) highlight the need for support if minority ethnic nurses are to function effectively and feel valued as individuals. Student nurse narratives highlight the stress associated with being marginalised or unsupported by colleagues or lecturers.
They demonstrate the damage to self-esteem which occurs but more importantly the additional pressure to do well in order to refute presumptions of stupidity. Although attrition was not considered in this study, a number of student narratives highlight how close to giving up they came and this must be considered in view of current completion rates.

Nurse lecturers must facilitate a welcoming and empowering environment if students are to break their dependence on comfort zones. However, notwithstanding the protection offered by the familiar group, a balance must be maintained between limiting the risk of alienation and preparing the student for reality. If students are to learn about other cultures (and arguably their own) to build a platform of understanding and respect, they have to move out of the comfort zone. The data show that when students were required to work in multi-cultural groups, it took time but it was a positive learning experience. The nursing classroom can provide a safe and empowering experience where students learn to challenge their own ethnocentricities and begin to empathise, respect and accept diversity.

"Socialising with different cultures is the best part of group work.....I find it is a good experience because you learn" (Black Student FG1)

**Challenging racist or potentially racist behaviour:**

Although the data highlight several examples of good practice, a number of lecturers were not always conscious of potentially racist episodes and lacked confidence in establishing whether behaviour was merely inappropriate or racially motivated.

"I don’t feel particularly well equipped" (Black Lecturer LFG)

"There is too much emphasis on curriculum planning without looking at what goes on in the classroom and what is taught. There is a need for attention to methodology, how things are taught, around classroom management (White Lecturer interviewee)

The data demonstrate that lecturers were occasionally accused of bias when they challenged a group of Black students, for example when they disagreed with a White student. The lecturers who described this felt comfortable with their actions but it is not inconceivable that others might be reluctant to intervene for fear of
such accusations. It is understandable that inexperienced lecturers might not feel confident to challenge intolerant attitudes or inappropriate behaviours. Sadly the data also show that a few lecturers are reluctant to challenge attitudes and behaviours or to encourage students into mixed working groups.

"I challenged those who laughed at her. It says more about them than you. The group responded positively but were clearly uncomfortable with my level of challenge“ (White Lecturer Interviewee)

Notwithstanding the legal and professional responsibilities, lecturers must challenge unacceptable behaviour if they are to be credible and respected role models.

Concluding comments

While there is much cause for concern about the existence of (predominantly) institutional racism in classrooms where nursing is taught, it is also clear that there are examples of good practice across nursing curricula and by individual lecturers. Several of the lecturers interviewed for the project were experienced, confident and skilled and there is no reason to assume that this is unusual across the school. It is also clear that despite a lack of confidence or experience, the majority of lecturers are committed to equal opportunities. Lecturers are from different cultural backgrounds and bring experiences of working and living within diverse multicultural communities. The Research Centre for Transcultural Studies in Health at Middlesex University is internationally recognised and respected for its contribution to transcultural nursing. There is therefore much scope to capture the expertise, commitment and motivation that exist within the school and harness it to provide a better, fairer and richer experience for student nurses.

Summary of Recommendations

The study makes four main categories of recommendations, most importantly the need for continuing professional development to enable lecturers understand and manage racism. Attention to teaching strategies and issues of classroom management is imperative if universities are to model a fair and inclusive learning environment which is transferable to clinical practice. Further recommendations relate to curricula, support for non-English speaking students, recruitment and organisational policies.
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EMERGING ISSUES FOR THE MATERNITY CARE OF SECOND GENERATION ETHNIC MINORITY WOMEN IN ENGLAND

Katherine Twamley BA, Msc City University,  
Dpt. Of Midwifery  
24 Chiswell Street  
London EC1Y 4TY  
UK  
Tel. ++ 44 20 7040 5314  Fax. ++ 44 20 7040 5866  
Email. katherine.twamley.1@city.ac.uk  
Shuby Puthessery Bsc, MSW, Msc, DrPh, City University  
Alison Macfarlane BA, Dip Stat, C Stat, FFPH, City University  
Seeromanie Harding Bsc, Msc, University of Glasgow

Background and context  
UK health policy and research on the maternity care needs of women from ethnic minority groups has focused on first generation migrants. With more second generation women giving birth in the UK, there is an increased need for information about their specific needs within the context of maternity care. This study comes at an opportune time as more countries in the EU are expected to follow a similar increase in second generation numbers and it will therefore contribute to future service planning and development.

Aim  
To explore second generation ethnic minority women’s needs and experiences of maternity care in England and the implications that these have for future service delivery practises.

Design and analysis  
The original design included focus groups and in-depth semi-structured interviews with health care providers and second generation mothers in London, Birmingham and Bradford from the following ethnic groups: Black Caribbean, Black African, Indian, Pakistani, Bangladeshi and Irish. Due to logistical issues, we modified the design to include only interviews; the sample consisted of 30 healthcare professionals and 34 recent mothers. All interviews were transcribed and are currently being analysed by two researchers using the Grounded Theory approach.

Outcomes  
The presentation will aim to examine the diverse social and cultural influences on maternal care needs and experiences. An investigation of the relationship between parents’ country of origin and beliefs/practices of care including perception of care received
will be completed. A comparison will be made between health care professionals’ perceptions of second generation mothers’ needs and those of the mothers themselves. Implications for service provision will be explored in light of this information.
Men in Nursing: Implications for Recruitment

Creina Twomey  M.N., R.N.

Robert Meadus  PhD, R.N.

Memorial University School of Nursing

Contact person:  Creina Twomey
Apt 14 Linden Ct.
St John’s, NL
A1B 2X1
(709) 753-3156
ctwomey@mun.ca

Abstract

In Canada, nursing still remains predominately a woman’s profession. While women have been moving into previously male-dominated professions, the movement of men into nursing has been slow. This study investigated why men choose nursing as an occupation, the perceived barriers they experience in practice and the strategies they recommend for recruiting more men into the profession. Data were collected using a self-report questionnaire. The target population for this descriptive study was male RNs in the province of Newfoundland and Labrador (N = 237). Data were analyzed using SPSS. Indices of central tendency were calculated and depending on the level of data, tests of difference were computed. At Alpha p < .05 there were no significant differences between age groups, levels of education or practice roles in terms of reasons for career choices or barriers experienced. Respondents (n=62) identified that the most common reasons for entering the nursing profession were in descending order: career opportunity; job security; and salary. Other reasons identified as important were opportunities for career mobility and having a family member in the profession. Reasons not included on the questionnaire but identified as secondary were: to be involved in a caring profession; desire for a professional career; and felt it was “a calling.” The most commonly perceived barriers in descending order are: sexual stereotypes, a female oriented profession, lack of recruitment strategies and few males nurses portrayed in the media. Regardless of age, educational background and practice role, men in nursing agreed on the main reasons they choose nursing as a career and the barriers they experienced in practice. Findings from this research may help with identification of new strategies for recruitment by attacking both the myths and barriers associated with men in nursing.
An exploratory study of healthcare professionals’ experience of team working in the acute hospital setting

Elizabeth Jane Walsh  RGN  BNS  MHSc
Health Service Executive Western Region, Portiuncula Hospital, Ballinasloe, Co Galway
0909 648315
lisa.walsh@mailn.hse.ie

Abstract
A qualitative research study was carried out to explore healthcare professionals’ experience of team working in the acute hospital setting. Data was gathered using one-to-one interviews and analysed through engaging in the hermeneutic circle. The participants’ experiences indicated overall benefits of teamwork, and also factors that enhanced or impeded teamwork. Five themes emerged: the concept of team, knowing each other; the distribution of power; opportunities for enhancing the concept of team; and organisational infra-structures. It was concluded that team working is a most effective and efficient way to provide patient-focused care and treatment. Confusion is manifest with regard to the terminology used to describe such collaboration. Well-functioning teams share power and respect each member’s contributions, and they effectively manage conflict. Team working enables quality learning in the work place and promotes a sense of job satisfaction for those involved. The use of an holistic approach to patient care appears to significantly benefit team working. These findings have implications for health service managers, educators and healthcare professionals engaged in clinical practice.

Introduction
Teamwork is accepted as a most effective way of delivering products and services within diverse settings. In the highly complex and rapidly changing field of healthcare, effective team working is likely to provide the most therapeutic environment for patients (Watkins et al, 2001). It is associated with better outcomes, including decreased risk of mortality and morbidity (Carr et al, 2003; Lathlean and LeMay, 2002) and increased job satisfaction (Curley et al, 1998). Teamwork is also considered to be an essential element of modern management practices informed by concepts such as empowerment, quality management and change management (Mullins, 2002).

The impetus for team working in the health services is both political and professional. The current health strategy of the Department of
Health and Children (DoHC) places emphasis on multidisciplinary team working and the use of integrated approaches to care and treatment planning (DoHC, 2001). Service users are placing increased demands on healthcare professionals to serve the interests of society and patients through engaging in effective professional partnerships (McNair, 2005). Healthcare professionals’ journals are replete with articles concerning collaborative practices. These range from exercises such as concept analysis (Henneman, 1995), literature reviews (Faulkener Schofield and Amodeo, 1999; McCallin, 2001) and Cochrane Reviews (Zwarenstein and Bryant, 2000; Rogers, 2001) through to educational preparation (Parish, 1999; Davies and Bheenuck, 2003; Ker et al, 2003; and Sheldon et al; 2003), team working (Rafferty and Ball, 2001; McPherson et al, 2001; Pethybridge, 2004) and professional boundaries (Carter et al, 2003; Coombs and Ersser, 2004). While the literature review indicated that the experience of team working was poorly researched (McCallin, 2001), Zwarenstein and Bryant (2000) and McPherson et al (2001) contend that if working well together is necessary for quality patient care, then gaining an in-depth insight into the experience of collaborative-working would contribute towards finding ways to be good collaborators and competent team members. This study aimed to gain insight into the participants’ everyday experiences of teamwork.

**Methodology**

The basic aim of qualitative research is to explore and understand people’s experiences, feelings and beliefs and to make statements about how people interpret their lives (Holloway and Wheeler, 2002). This study concerned healthcare professionals’ experience of team working in the acute hospital setting. The research question was exploratory in nature and best considered using a qualitative approach, given the focus on the emic (insider/participants) perspective of a socially constructed phenomena and its suitability for the study of topics about which little is known.

Interpretive phenomenology (Byrne, 2001; Maggs-Rapport, 2000; van der Zalm and Bergum, 2000) was the chosen methodology and areas for exploration included clarity regarding use of the term ‘multidisciplinary’ and factors that enhance or impede collaborative working practices.

In phenomenological studies sample size is often small (Corben, 1999), as it is the extent to which the phenomena under study is explored rather than the sample size that is important (Mays and Pope, 1995). Eight participants were drawn from the disciplines of nursing, medicine, social work and the therapies.
The data were gathered using one-to-one interviews, analysed through engaging in the hermeneutic circle (Crist and Tanner, 2003), and discussed in the context of available literature.

Qualitative research must be ethically sound, and the study was conducted with cognisance of the World Medical Association’s Declaration of Helsinki (2000) and was guided by Beauchamp and Childress’ Four Principles (2001).

Trustworthiness in qualitative research means methodological soundness and adequacy. Holloway and Wheeler (2002) indicate that there are a number of ways to demonstrate trustworthiness. In this study, the following were used: member checking; searching for negative cases and alternative explanations; peer review; keeping a decision trail; obtaining a thick (full and rich) description; and reflexivity.

Findings and discussion
Five themes emerged: team, knowing each other, power distribution, opportunities and structures. Each of these themes held a number of categories, as indicated below:

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Team
This theme refers to the meaning the participants attached to ‘multi-disciplinary team’. Each participant considered the meaning of multi-disciplinary team based on his/her experience, and discussion centred on terminology and the composition of the team.

The findings of the study are similar to McCallin (2001), who suggests that the labels assigned to people working together are relatively unimportant. What is important is what teams do, how
they do it and whether it improves patient outcomes, benefits the organisation and provides value for the service funder.

The participants held a largely common view of teamwork and membership in the acute hospital setting. Teams were recognised to exist in two essential forms with the most readily recognised being teams engaged in providing patient care and treatment, and the other being teams concerned with projects such as guideline development or involvement in new service developments. Of the teams engaged in providing patient care there were two kinds: those with formal arrangements to meet and discuss patients’ plans of care, and those whose structure was much less formal, simply comprising the disciplines that contributed during a patient’s admission.

**Terminology**

No constancy in the use of terminology was found, and there was confusion with regard to meanings. As with Masterson (2002), the terms ‘multi-disciplinary team’, ‘teamwork’ and ‘inter-disciplinary’ were used by the participants to describe collaborative approaches to patient care and treatment and, at times, they were used interchangeably. ‘Multi-disciplinary’ was the term most commonly used, with reference being made to the influence of past experience and workplace introduction to working with other disciplines, for example:

“I suppose multidisciplinary is the one I’m most familiar with myself, in the sense that I have worked in lots of environments where ‘multi-disciplinary’ has been used.”

Participants had experience of other terms, interdisciplinary being most frequently cited by those who had recently been involved in academic programmes:

“Multidisciplinary and interdisciplinary, when I was leaving college, and I suppose any of the research from previous places we have worked, where the buzz-word was interdisciplinary.”

Although a difference in meaning was recognised, it was also noted that the terms are used interchangeably:

“I think that they say interdisciplinary would be something that would have more goal-setting and there would be more communication. Multidisciplinary wouldn’t be as cohesive, but then sometimes I know they’re used interchangeably.”

The literature proposes that a lack of clarity regarding terminology is an issue of significant concern, as confusion surrounding the
terms used to indicate collaborative working practices hampers the effectiveness of service provision (Faulkner Schofield and Amodeo, 1999). And collaborative working cannot be achieved without a clear understanding of what it means (Finch, 2000). Notwithstanding, the study’s findings appear to suggest that the importance of clarity is somewhat diminished when practice is underpinned by an holistic approach. In such cases the simple term ‘teamwork’ was favoured:

"I think, at the end of the day, it [multidisciplinary team] is a very holistic approach to the work that we do, because it basically pools people and attitudes and knowledge from a variety of backgrounds, and I think each have their place in terms of looking after the patient... I think teamwork is basically the same thing: team working, multidisciplinary working, to me it means the same thing.”

Composition
All participants considered that the multidisciplinary approach to care and treatment encompassed the range of healthcare professionals involved with the patient during contact with the hospital. This may include healthcare staff who are co-opted for specific services:

"... within the hospital setting it’s usually the professionals...all of the people who would probably be coming into contact with the patient. We may not always be commonly meeting, and there may be people who don’t attend the multi-disciplinary meeting, but who would be part of the team. They would be referred to: you might have a chiropodist who may never attend meetings, but he is very much part of the group.”

The participants also made reference to the multidisciplinary team having a common goal:

"... individuals, professionals coming together in optimising patient care.”

This common understanding across all participants with regard to what is generally termed multi-disciplinary team is converse to Mackay et al (1995) who have indicated that each professional group holds its own view. The commonality found here appears to indicate that the participants have found ways to work together despite the fact that, as Mackay et al (1995) indicated, most healthcare professionals’ development has equipped them to work independently and autonomously, and learning to work with many different types of professionals in a team is recognised to be extremely difficult. This finding is more reflective of Øvretveit
(1997), where the reality of modern healthcare is that the care and treatment received by the patient depends upon the synergy of professionals and upon individual competence within fields of expertise.

**Knowing each other**

Knowing the other members of the team did not emerge as a significant issue in the initial review of the literature. However, its importance was cited by all of the study’s participants, where the categories of roles and contributions and learning together emerged. Chapman et al (1995) and Parsley (1999) indicate that time spent together helps the professionals get to know each other, and that reservations about collaborative working may disappear once people know each other better. This enables members to be more sympathetic to the circumstances of others and to help solve work problems. This study’s finding concur:

"...the friendliness does assist very much: you can pick up the phone, that there is a good air of ‘I’m here to assist and I’ll do what I can’.”

And reference was made to the value of knowing each other and effective communication in supporting working practices:

"The lines of communication are more effective because they’re open, and I think the people are closer to each other, as they have more contact. If they are walking down the corridor and see a member of the multidisciplinary team, they feel free to go up if they have new information. It doesn’t always wait until the next meeting.”

The use of team approaches and getting to know each other can be used to manage potential conflict and adverse events:

"I think it provides you with an opportunity to bear-out problems and the team’s operational activities, and I think it’s important to get to know the people. I think that’s half the battle. You can solve a lot of things if you know the people. And not saying that you are conniving or manipulative, but if you know them personally it is a lot easier to choose your tack in terms of how best to navigate a potential difficulty.”

The study’ findings appear to indicate that a clear understanding of other team members’ roles and contributions, and the ability to manage boundaries and respect diversity within the team would help. Kane’s 1975 review of teamwork (cited by McCallin, 2001 p422) indicated that prerequisites include a common purpose, professional contributions, cooperation and joint thinking. The
findings of this study indicate that this still stands more than thirty years later.

**Roles and contributions**
The participants’ experiences indicated that roles and contributions could be considered from two aspects: the professional discipline to which the participant belonged and the professional as a team player. Watkins et al (2001) indicate that teamwork depends upon close collaboration between healthcare professionals and that it is the only way to meet the requirements of service users with complex needs. This implies that the healthcare professionals need to know well their own contribution to the patient’s care and treatment. They also need to have a clear understanding of other roles and how they compliment their own. Participants in this study clearly appreciated that the knowledge and expertise of other disciplines was a prerequisite for team working. However, there appeared to be tensions with regard to how boundaries between roles were managed:

“I might be speaking to somebody about drugs and things like that, or their swallow, so I might cross-over a few peoples’ different areas ... if people aren’t happy or comfortable with that, they need to be, because a lot of roles are changing in healthcare. People need to be comfortable that you are not taking on their role, but that you are basically backing-up. You might be just trying to bring the whole thing together so that somebody can actually apply it in their lives, and that can cause problems if somebody has an issue with you covering something they feel is their role.”

“... sometimes people can get a bit sensitive about their own roles... but I think that the borders need to be fairly fuzzy, and there has to be a bit of an overlap between.”

“... if somebody is trained to do a job, then you should let them. I would never try to encroach... But I just think members of the team are reluctant to let you do your job... this is our role, let us get on with it.”

This sentiment is reflected in the literature: Lax and Galvin (2002) propose that interprofessional working is not about fudging the boundaries between the professions and trying to create a generic care worker. Rather, it is about developing professionals who are confident in their own core skills and expertise, and fully aware of and confident in the skills and expertise of fellow health and social care professionals. In turn, this would lead to the generation of a
common understanding of teamwork and the generation of common
goals for the team.

Kohn et al (2000) indicate the importance of being able to communicate effectively. They consider a lack of competence in interprofessional communication poses an important barrier to interprofessional working, which is further compounded by a lack of knowledge of the capabilities of other professionals, leading to a lack of respect for their contributions. The study’s findings concur:

"... before a team can be interdisciplinary they need to clearly know each others’ [role and contribution] and respect. I think the biggest thing here is respect."

The participants made reference to staff-turnover, particularly the medical staff’s six-monthly rotation. This was considered to impact on the team’s ability to function effectively, indicating a need for healthcare professionals to be committed to working as team members:

"With different people stepping in and out of teams, it’s very important that people not only know their own roles, but also where other people are coming from when they approach their whole patient care and assessment and goal setting...people have to be committed to and be interested in working together with other people."

This concurs with Pederson and Easton (1995) who emphasised that teamwork has to be worked at by the individual team members who have a personal involvement in the team’s success. There also needs to be a philosophy of collaborative practice that is underpinned by cooperation and interdependence. The absolute need for the healthcare professional to have the ability to work as a team player was made clear, as safety in practice was recognised to be closely associated with effective teamwork:

"...if I hear the word team working coming out of somebody, there is a reasonable chance. Because that’s what you want: I don’t need somebody who’s a whiz at radiology; I don’t need somebody who’s a whiz at ECGs or whatever, but I do need somebody who will work as a team member...At the end of the day, number 1 as far as I’m concerned, to work in this department you have to be a team-player. And really and truly, if you can do that you’ll be safe in the work place, because you get your cues from other people, you listen to other people..."
Learning together
All participants made reference to their experience of both workplace learning and their professional education with regard to preparing them for work as a healthcare professional.

Freeman et al (2000) consider that, in the context of team working, healthcare professionals are being urged to learn from and about each other so that they may more effectively work across professional boundaries for the benefit of the patient/client. The literature makes repeated reference to the promotion of collaborative working through education programmes at undergraduate and postgraduate level (Finch, 2000; McPherson et al, 2001; Ker et al, 2003; Sheldon et al, 2003). The participants’ experiences agreed, for example:

“I know certainly, within the hospital setting there is a lot of multidisciplinary case-conferencing ... certainly cross-discipline education is something I would be involved in”

Experiences relating to their more formal academic preparation ranged across a continuum. At one end experience in the academic setting had greatly supported the participants in working within the healthcare team:

“The tutors really empowered: you were made to feel that you had the ability to achieve whatever you put your mind to... the healthcare environment is changing so much... your roles and functions would be extending and expanding.”

“When we were in college we had to do a learning contract for every placement, and one of them was to get to know the team ... I suppose before I started [work] I knew what their role was, I knew the basic, as in what they do... you develop a wider understanding”

However, moving towards the other end of the continuum, participants could not point to shared lectures or interprofessional education as having made any contribution towards generating understanding of other healthcare roles and contributions:

“I think there was [shared lectures] in the first year, but it was nothing where we would be interacting as such with the other. We may have had two or three shared lectures; I think it was with medical... I’m not sure”

This is in keeping with McCallin (2001): few healthcare professionals are taught teamwork skills, and this leads to a poor understanding of roles, skills and expectations, causing team conflict and
subsequent failure. It is indicated that health care professionals need to be taught team skills early in their careers— as undergraduates—if the negative stereotyping associated with particular professions is to be avoided (Pietroni, 1991). It is evident from this study’s findings that this needs to be acted upon today:

“maybe it’s our training in college we were told that we would have these battles to put up with, and that maybe it is something in the profession that we feel we’re always defensive and fighting our corner.”

And reference was made to the isolationist outcomes of uni-discipline educational practices:

“...it’s hard to break habits, and if you are taught one way to what your job is, and if you are working in isolation or trained in isolation, I can see that you wouldn’t be aware of how other people work.”

This concurs with McNair’s (2005) finding that separatism denies students the opportunity to develop collaborative relationships essential for cross-fertilisation between disciplines.

Experience in the academic setting also indicated that preparing healthcare professionals for team working simply did not feature on their syllabus. One of participants stated that the first time they heard of ‘multidisciplinary team’ was well into their first year following graduation, and consternation was expressed with regard to its omission during the years of training:

“Never, never. I mean I’ve never had any formal teaching or training in terms of teamwork”

The participants’ experiences concur with Berwick (1996), indicating that professional single-mindedness is contrary to the concept of collectivity that underpins teamwork, and that individuality can be integrated into the team approach. Practice underpinned by the use of an holistic model appears to promote development of connections and recognise the interdependency between the members of the team, regardless of the profession to which the team-member belongs. The literature indicates that non-medical health care professionals tend to seek mutually collegial relationships and that medical staff are more likely to favour authoritarian interactions. However, it can be seen that personal attributes have a part to play in how the individual develops professionally. Notwithstanding, Berwick (1996) notes that holism and citizenship skills emphasising connections and interdependency have not been central to the training of health care staff or to the development of professional identity. This study’s findings would indicate that this situation remains largely true today.
Power distribution
All participants made reference to the use of power within the multidisciplinary team. Porter (1999) indicates that the literature is replete with reference to the distribution of power between members of the healthcare professions. Wilkinson and Miers (1999) make reference to the exercise of autonomy with regard to the authority of medical practice and how this affects the practice of non-medical healthcare professionals. Evidence of mutually supportive relationships is scarce, while antagonism about medical monopoly and medical control is well documented (Atkinson, 1983; Freidson, 1986; McCallin, 2001). With regard to the use of power within the multidisciplinary team in the acute hospital setting, leadership and the key role of the consultant became apparent as a category, along with power sharing and hierarchical attitudes. Each of these had a bearing on a further category of referral arrangements.

Leadership of the team, role of the consultant
The view of the consultant as leader of the team in the acute hospital sector was of particular note:
"You find a lot of multidisciplinary teams are run by consultants, or led by the consultant. And that’s usually because they are seen as a person with the power to."

And a clear leadership function was very much vested in the consultant role:
"It would appear not to work so well if the consultant is not available, or if he hasn’t actually delegated the task. A structural/leadership role is very important."

The legal responsibilities inherent in the consultant’s role were also recognised, as he/she carries ultimate responsibility for the care of the patient. Nonetheless, the part played by the other members of the team was also acknowledged, and it was considered that the team should be lead by a person in authority, and that this person should be vested with the appropriate skills:
"That key role should be given to somebody who has adequate training."

Power sharing
Where power was shared across all members of the group participants considered work progressed well:
"A consultant I used to work with used to say that as part of a multidisciplinary team, there’s no one person who is more important that anybody else. And I think really that is the crux ... that each person can contribute
Language in terms of value and respect became a common feature as the participants recounted their experience:

"Now the leadership needs to very much value the contributions of every member of the team. And if the expertise is there in the group you use it, and listen to it. And if there are disagreements and if the group feels it’s not achievable, that needs to be taken on board as well. So you may have conflict sometimes”

The inference here was that conflict could be managed constructively.

It was quite clear from the experiences recounted by the participants that sharing power within the team was not only beneficial for the provision of services, it also contributed to a sense of well-being for the participants as individuals and as team members.

**Hierarchical attitudes**

The traditional hierarchy in the health service sees the consultant, or the doctor, at the top of the pyramid (Wilkinson and Miers, 1999), and historically inter-professional interactions have been authoritarian and dominated by physicians (Fagin, 1992). Davies (1995) would consider this to be an out-dated approach; the findings of this study concur:

"I think that sometimes the consultant feels that, as the leader, the facilitator of the group, need to tell everybody their job or what they need to do, because we have to go by their way of thinking. So I think that’s maybe where the conflict of interest comes in, and it’s a challenge to deal with it.”

"We’ve had situations where doctors have refused to accept anything the nurses say, and have basically said, ‘Well I’m the doctor, I’m taking care of the patient’. And it really doesn’t work like that.”

This could lead to practices referred to by Stein (1967) as engaging in the doctor-nurse game:

"Doing it by a roundabout way, and saying, ‘Look, I was thinking about that- erm, I wonder if we tried such and such’ .... they don’t see that they need a team, you know, to provide patient care. So we often access the information for them [patients], but we don’t actually refer the patient to them [other healthcare
professionals]. So that again it’s got to do with good working relationships with these people and using their expertise, and they understanding the logistics of what is happening, so they give us the information.”

But this was not considered to be constructive behaviour:

“But you know, this is a bit silly that at this stage in my life that I am not saying, 'Look here you...', but I couldn’t be bothered with the politics that goes on. It can be a little wearing at times, but as long as the patient gets good care.”

Hummel (1998) considers the effective use of conflict, and argues that nearly every executive team experiences conflict- and that it is unavoidable when people are passionate about the work that they do. He proposes that a good leader’s job is to bring to the surface the dynamics that are important enough to create conflict. When managed well, conflict can increase the team’s ability to find the value in an issue and to explore multiple dimensions through discussion of ideas and perspectives. Managing conflict serves to elevate the level of respect and communication in the team by valuing everyone’s view, listening, giving helpful feedback and acknowledging contributions. It can add depth to the team by recognising that a collective work effort is better than a collection of individuals’ pieces of work. It can also generate opportunities for the team to successfully think through difficult issues together.

**Referral arrangements**

Referral arrangements were perceived as being closely aligned to the use of power by members of the team. This had clear implications for autonomous practice by non-medical healthcare professionals:

“Often referrals have to come from the consultant. So if I want to refer someone to the social worker, I can’t refer directly to my colleague. I have to go to the consultant for the form to be signed, or the doctor in the team...but the doctor has to be in agreement...even if the need of the patient is there and is quite plain. You still have to go up the hierarchy”

The findings here concur grossly with McCallin (2001): non-medical disciplines emphasize role sharing, whereas medical people do not appear to share that same perception, and hierarchical attitudes are maintained. However, it is also apparent from the study’s findings that, where practices are underpinned by holistic approaches and power is shared amongst the members of the multidisciplinary team, increasingly effective progression of patient care and
treatment planning is enabled. This leads to appropriate use of time and resources.

Opportunities
Capturing or missing opportunities was recognised by all the participants. They considered that adopting a formal multidisciplinary team approach greatly supported them in identifying patients’ needs and exploiting the opportunities that were then recognised.

Captured opportunities
Team working enabled the staff to coordinate activities and have a common view of the patient’s needs with regard to planning an appropriate discharge:

“We can coordinate things, and there’s a level of interdependency there between the disciplines. And to progress with, you know the occupational therapist mightn’t be able to progress until they have the physio side of the story, or the medical side of things- if the patient is wound-up and short of breath, and we haven’t got their treatments optimised, and we can’t even get the patient out of bed to mobilise or get a home assessment from the OT, or the social worker to see what the home setting is like. So it’s coming together to see where we’re all at, and coordinating in that manner.”

The importance of pooling expertise was also indicated:

“So we’d go through each patient, there would be in-put on how the patient is progressing: any problems, what can we do to improve things and, you know, when you’re in something you don’t see another way, but we’d help each other in that regard. So it increases the effectiveness again I suppose.”

Coming together was recognised to support discharge planning. Due to circumstances beyond the team’s control, patients may be discharged in advance of the originally planned date. When this arises, advance planning enabled by team working serves to support individual and collective efforts:

“You always have to be planning, you can never say that you would do it the day before they were due to go, as they might be gone two days before, and what you were going to do was vital for that person.”

Missed opportunities
Clear reference was made to missed opportunities in circumstances where a structured team-working approach was not used, and here
the study’s findings concur with Zwarwenstein and Byrant (2000). Missed opportunities were particularly felt with regard to discharge planning for those with complex needs:

"Then somebody is about to go home, and they haven’t been referred on, and then that affects everybody really: the liaison nurse and trying to set up supports; it affects the social worker, we don’t know what kind of home environment the person is going to, do we need more work on stairs, you know [frustrating] so it is."

Language of frustration featured in recounting the absence of a coordinated approach to discharge planning. This appeared to enable one of two likely outcomes: increased length of stay in hospital or inappropriate discharge home.

The findings appear to indicate that the inherent value of the team is in the time spent sitting together discussing goals, progress and discharge plans:

"It’s not enough to say that different professions are involved in a particular patient’s care. That people can sit down, draw-up their goals and see where each other person is coming from- what their approach is to the whole patient care."

All participants found that using a multidisciplinary approach helped them to deal with the shortcomings they viewed as inherent to current service provision:

"There are a few people coming together with the same argument, so of course it’s much easier. And, as well as that, I think that in people- when we have our multidisciplinary meetings- it’s less likely for people to slip through the net. It’s very, very unlikely that a referral won’t have gone through when you are having a multidisciplinary team meeting."

"You have a good picture ...I mean that you are not groping in the dark."

Frustration in the absence of the multidisciplinary team was related to missing opportunities and the resultant impact on patient care. However, frustration within the multidisciplinary team was related to its structure and dynamic. Even so, when these were found to be less than optimal it was recognised as better than not having a multidisciplinary team at all. And such a simple solution was recognised for the shortcomings experienced:
“...there are missed opportunities if you don’t sit together... and such a simple solution you know, to sit down for a few hours and let the people put the work in.”

**Structures**

This theme reflects the participants’ experience regarding organisational processes and physical structures. Organisational processes concerned the operational practices of the team, the development of policies and guidelines for practice, hospital management structures and the use of ventures such as Accreditation and Partnership. The physical structures related to meeting rooms that allowed for private conversation and upheld the principle of confidentiality and respect for patients’ privacy and dignity.

**Organisational structures**

The way in which the multidisciplinary team organised itself featured in the participants’ experience. The articulation of aims and objectives was found to be beneficial:

“we generally set it so that it was documented, and I found that very focused: you set goals and objectives, with an expected discharge date, and how you were going to achieve them, who was going to be involved, and somebody was always assigned to give feedback to the patient. ”

In the absence of this structured approach, difficulties were recounted:

“But there is nothing formalised, and I document, but nobody else documents that this meeting has taken place. And there aren’t goals that we want to achieve, we might say that we’re aiming for discharge next week...which is a bit vague you know.”

The use of policies and guidelines, and documentation in the form of nursing notes and the patient’s medical record, were recognised as supportive of working practices. For example, use of a common assessment tool:

“So everybody could use it, and put in what they thought the patient scored at, and if there was a discrepancy we discuss that discrepancy...so we did use a formal sort of assessment tool to guide where we were going.”

And in considering the patient’s progress record, the need for a common approach is indicated:

“...there’s very much a team approach, it’s all very informal. We don’t use a unified patient care pathway...
that is multidisciplinary; that the nurses write in the nursing kardex, and everyone else writes in the patient’s progress notes in the file. But, funnily enough, not so much the doctors, but the other disciplines come and read the nurses’ notes, because it gives them good information."

The findings here concur with Pedersen and Easton (1995), who identified that the characteristics of a winning team include common goals, clearly defined roles, commitment, communication and the ability of team members to function as a unit rather than a group of individuals.

A further aspect to organisational structures was recognised in the participants’ experience concerning hospitals’ management structures; they did not readily associate them with their every day practice. Experience centred upon them working as a communication conduit, and not closely associated with day-to-day practice or associated with supporting the multidisciplinary teams:

“we have a directorate system which is quite good, as in if something is happening in one directorate, information is communicated.”

“On a practical level it [the hospital’s management structure] is something that has never really occurred to me to be honest. It’s something that happens at a higher level, but doesn’t necessarily translate into day-to-day influences. I suppose it does [support team working], but it’s something I haven’t thought about before I have to say.”

The participants also made reference to other ventures used to support service provision, namely Accreditation (Irish Health Services Accreditation Board, 2004) and Partnership (Health Services National Partnership Forum, 2002)). These schemes draw teams together from across all directorates and involve stakeholders from relevant services and departments:

“Accreditation, I think it was brilliant to actually get to liaise with other colleagues, I thought it was super. I’ve met and am known to a lot of other people that I would never have met or known anything about prior to the whole accreditation process.”
"Even though the partnership process takes a bit longer to get things going, I think that it’s good, because of the round table discussions"

"I think initiatives like accreditation are very important; they bridge that gap between directorates."

The findings here concur with West and Poulton (1997), who found that effective teamwork declined when individual team members had separate lines of management.

**Physical structures**
The layout of wards and availability of meeting rooms had impact on the workings of the multi-disciplinary team and the involvement of the patient, and his/her family:

"With the multidisciplinary teams, you do need space. I mean, if you have a meeting you have possibly ten people meeting together, and you cannot have that around someone’s bed because, for confidentiality reasons, and you need a room where you can come and discuss the patient’s case."

"Due to the nature of the ward environment, the physical environment, confidentiality is a major issue, especially in the six-bedded wards. There’s only so much you can be professionally asking to maintain patient confidentiality... There is no actual set aside area to have a meeting, even if it’s a breaking bad news situation to family members... The corridor is the office for many of these interactions... they [meetings] might take place in the nurses’ station. But I think there is a need for a meeting room, because phones are ringing, people have to get bloods off the computer- people in and out."

It is clear from this finding that meeting rooms are required in all clinical areas. These would enable meetings with patients and their families that uphold confidentiality and facilitate conversation in a private setting as opposed to the more public areas of the hospital, namely communal offices such as the nurses’ station and corridors. These rooms would also provide a venue for the multi-disciplinary team meeting.
Summary
Through gaining an in-depth insight into healthcare professionals’ experience of teamwork it has been possible to determine practices that contribute to, or detract from, effective team working.

The literature indicates that there has been scant research into the processes of collaborative practices and their value questioned. However, this study clearly indicates significant advantage, as working collaboratively with other healthcare professionals is considered to be highly beneficial for both patients and staff. Over and over again the respondents gave examples of teamwork as they tailored care to meet patient’s needs- once opportunities were identified and exploited.

All participants had positive experiences of team working. However, they also had experienced circumstances where collaboration and a collegial approach to the use of power were absent. There was a lack of coordination leading to breakdown in communication, increased workloads and timeframes, and less than optimal use of resources. This was found to be frustrating, and did not promote a sense of satisfaction with work done, nor the feeling that their knowledge and expertise were being used to fullest potential. And all this with the uneasy knowledge that care and treatment plans were not serving the patients’ interests in the best way possible.

Each participant recognised that their professional preparation should prepare them for collaborative working practices and that workplace practices should continue to support integrated professional education and development. The current lack of preparation to work in a team and the development of good team leadership skills were seen to present significant challenges. Not least in members having their voice heard and contribution valued, but also in enabling the effective management of conflict. It was clear that there was a wealth of knowledge and skills vested in these healthcare professionals, of whichever discipline. It was also clear that coordinating their efforts and using collaborative approaches unlocks their collective potential, thereby leading to efficient and effective delivery of care for the patients, and promotion of a sense of wellbeing amongst the team members.

Finally, the following quote illustrates the value placed on team working by the participants, drawn from medicine, nursing, social work and the therapies:

"I think, given half the chance, if the system was to change what these individuals could then do"
Recommendations
In making recommendations it is recognised that the issues which emerged from the data are complex; they involve the educators of healthcare professionals, those managing the health service and those working in clinical practice. With this in mind, the following recommendations are made:

Further research
- This small-scale study has provided much information with regard to factors affecting teamwork by healthcare professionals in acute hospitals. Further research is required in a variety of settings in order to develop a richer description and fuller understanding of teamwork.
- The study’s findings indicate that where power is not shared between the health professions members of the team feel disrespected and dissatisfied. An action research project exploring the use of team working in the hospital setting is recommended to identify problems and possible solutions. This methodology emphasises the use of experiential knowledge to inform an agenda for change. It is particularly valuable when practitioners consider themselves marginalised in some way (Winter and Munn-Giddings, 2001).
- The literature indicates that effective team working is likely to provide the most therapeutic environment for patients in a highly complex and rapidly changing field of healthcare (Watkins et al, 2001). The literature and this study have shown that effective team working generates a sense of wellbeing and satisfaction in its members. Further research into changes in staff morale related to team membership would be of benefit. Although little empirical data has been published, some suggests that this is an important area of investigation for a health service that is becoming increasingly complex (Faulkner Schofield and Amodeo, 1999).

Education
- The study’s participants recognised the value of interprofessional education, and the students’ training environment is recognised to be extremely powerful in shaping values and attitudes (McNair, 2005). Interprofessional education fosters respect and consequently enables cohesive and effective collaboration between healthcare professionals. The increased use of interprofessional education at undergraduate and postgraduate levels involving all healthcare disciplines is therefore recommended. This would serve to develop understanding of the contribution of each profession to patient care and the overall running of the health service. It should be supported by employment of strategies that promote close collaboration
between healthcare providers and the third level sector. This will expose healthcare students, early in their careers, to the range of expertise present in the clinical area, and they can experience positive role models with regard to clinical practice and dealing with its complexities (Carr et al, 2003).

- The study indicated that where practice was underpinned by an holistic approach it was associated with effective teamwork and respect between the professions. The undergraduate level introduction of models for care and treatment ranging from holistic to biomedical is recommended. This would help students to focus on patient need and place value on the roles and contributions of other healthcare professionals. In this way they would have a good understanding of their own contribution and the interdependent nature of their work with colleagues. There would be less tendency to work from a uni-professional service focus and engagement in the unproductive practice of turf-guarding (Kenny, 2002).

- This study found the ability to communicate effectively was recognised to be crucial for effective teamwork, and this finding is supported in the literature (Kohn et al, 2000). It is recommended that communication skills for all healthcare professionals be introduced at undergraduate level. This timely introduction would begin the fostering of requisite competency. Teaching and learning strategies should promote communication skills with both patients and colleagues. This should include the ability to communicate on a one-to-one basis as well as with groups.

Health service managers

- The study’s findings and the literature (Davies, 1995) indicate that hierarchical attitudes are recognised to be outdated and that well-functioning teams share power. There is a definite role for health service managers, both clinical and non-clinical, in generating the ethos of the hospital and supporting staff in the delivery of quality patient care (Lucas, 1999). It is recommended that health service managers make use of transformational leadership styles. This leadership style is about sharing power (Trofino, 2000); it promotes staff involvement in decision-making and is reflective of the relationships present in effective teams. Moreover, this approach supports staff as the services move away from their traditional hierarchical attitude (Davies, 1995).

- The study’s participants valued the hospital management structures and referred to administrative and communication functions. Notwithstanding, these structures were not associated with their everyday work or recognised as a supporting structure for the teams of staff involved in delivering patient care. West
and Poulton (1997) found that effective teamwork declined when individual team members had separate lines of management. It is recommended that hospital managers implement organisational structures that support team working. These structures should be reflective of the mix of disciplines involved in providing patient care. Management should promote the use of ventures such as Accreditation and Partnership, as they have been seen to cross professional and service boundaries and promote teamwork.

- A need for meeting rooms in the clinical areas was recognised by all participants. These rooms would support team working and also provided a private space affording uninterrupted discussion with the patients and/or his/her family. Making these rooms available should be incorporated in the organisation’s service planning process.

**Health care professionals engaged in clinical practice**

- It is recommended that health care professionals engaged in clinical practice should collaborate in the cross-discipline development, implementation and audit of policies, guidelines and care pathways. This reorganisation of working practices offers a significant learning opportunity and should include a revision of referral arrangements that is respectful of the knowledge and expertise of all healthcare professionals.

- The study’s participants clearly placed great value on their experience of interprofessional learning in the work place. It was found to be most relevant to everyday working practices, and it helped them get to know each other and promoted collegiality. It is recommended that opportunities for workplace interprofessional learning are actively sought and developed.

**Terminology**

- Finally, it is recommended that consensus be reached with regard to terminology. Clarity of definition has not emerged. Finch (2000) indicates that this clarity is more than just an important principle, as approaches to collaborative working cannot be achieved without a clear understanding of what it means. Such ambiguity does not present a common language for use by health professionals, nor contribute to effective communication. Establishing a shared language in any field is important, however in healthcare it is a fundamental requirement.
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Motherhood, parenthood and associated vulnerability: outcomes from a phenomenological exploration of the lived experience of pregnant women with a mild to moderate learning/physical disability

Mrs Dympna Walsh-Gallagher RNID, RGN, BSc, RNT, MSc
Nurse Lecturer
St John's
Donegal Road
Ballybofey
Co Donegal
Ireland
+ 353 74 9130856
dcwalsh@stacs.edu.ie

Abstract

Background
The literature provides us with very little information about the lived experience of pregnant women with a disability. Research studies that are currently published are predominantly focused on sexuality, relationships and ethical implications.

Current maternity services are reporting an increase in the number of women with mild to moderate learning/physical disabilities using their services and therefore there is a need to explore the suitability of the services to meet the specific needs of this marginalized group.

Aim
This study aims to explore the impact and challenges that these women face during pregnancy and childbirth as this is perceived and constructed by them.

Method
This study uses a multi-method approach to obtaining a holistic perspective of the women’s experience. An interpretative Husserlian phenomenological approach is used to describe the women’s experiences of antenatal, intranatal and postnatal care.
Data is collected from in-depth interviews in the person’s home setting.

Sample
The sample has been deliberately purposeful and data saturation will determine the final number.
Analysis
Smith’s (1995) sequence of analysis for interpretative phenomenology is used to interpret the data.

Findings to date
Three major themes have emerged: being a mother, continuous support and being a good parent.

Focus of the Paper
This paper argues that pregnancy is a particularly heightened experience for women with a mild to moderate disability and the concerns of the women are more to do with concepts and perceptions of motherhood, parenthood and a associated vulnerability for them as individuals.
State of the Science:
Diabetes Self Management and the Migrant Latino Population in the United States

Dawn M. Weiler, MS, RN, ANP
Assistant Professor
Department of Nursing
Boise State University
1910 University Drive
Boise, Idaho 83725
USA
dweiler@boisestate.edu
(208) 426-1239 (office)
(208) 465-4896 (fax)
Abstract

This manuscript will present an in-depth exploration and synthesis of current literature that informs nursing knowledge of diabetes self-management for the migrant Latino population.

Extensive research in diabetes care has been conducted however, there is a significant gap related to the factors that influence the achievement of glycemic control and self-management practices of the Latino population. Based on well-documented disparities in complications and health outcomes among Latinos compared to Anglo-Americans, there is sufficient evidence to question whether traditional Anglo beliefs about self-management are successful or appropriate for the Latino population, in general, and migrants specifically. Traditional models view self-management as an individual responsibility. Whether this view is congruent with the collectivist cultural tradition held by many Latinos is unclear. Equally unclear is the degree to which using traditional Anglo-American models of self-management, in teaching about managing Type II Diabetes, influences health outcomes.

Orem, 2001). Whether this view is congruent with the collectivist cultural tradition held by many Latinos is unclear. Equally unclear is the degree to which using traditional Anglo-American models of self-management, in teaching about managing Type 2 Diabetes, influences health outcomes for the migrant Latino. This knowledge gap needs to be addressed in order to provide culturally congruent care to improve health outcomes of this population. The purpose of this paper is an in-depth exploration and synthesis of current literature that informs nursing knowledge of diabetes self management for the migrant Latino population.

**Search and Review Methodology**

Computer searches utilizing Medline, PsychInfo, and CINHL were completed. Search criteria included diabetes, self management, Hispanic, Latino, family, culture, and migrant. Individual terms in addition to combinations were included. Current and trended statistical data was obtained from the Centers for Disease Control and the National Council of Farmworker Health and National Alliance for Hispanic Health. An abbreviated list of literature sources reviewed can be found in the tables in Appendix A.

**Review of Literature**

**Diabetes**

Diabetes poses a significant public health challenge for the United States. It is estimated that 800,000 new cases are diagnosed each year or 2,200 each day (Clark, 1998, Burk et all, 1999, King et all, 1997, CDC, 1997, CDC, 2003, CDC, 1999). Diabetes is a chronic disease, the prevalence of which has increased steadily over the past decade. Presently 10.5 million persons have been diagnosed with the disease while 5.5 million persons are estimated to have the disease but are undiagnosed (Clark, 1998, Burk et all, 1999, King et all, 1997, CDC, 1997, CDC, 2003, CDC, 1999). Diabetes remains the seventh leading cause of death in the United States, primarily from diabetes related cardiovascular disease. Additionally, diabetes is the leading cause of non-traumatic amputations in the United States, (57,000 /year or 150/day), blindness among working –aged adults (20,000/year or 60/day), and end stage renal disease (28,000/year or 70/day (CDC 2003).

The devastating, cardiovascular, renal, retinal, and microvascular health problems associated with diabetes contribute to an impaired quality of life and substantial disability among people with diabetes (CDC, 2003) In addition, diabetes is a very costly disease with an estimated $100 billion attributed cost annually. Hospitalization for diabetes associated illnesses, rehabilitation, disability related loss of income and employment, and long-term kidney dialysis account for the largest portion of these costs (American Diabetes Association,

Diabetes is one of the fastest growing disease classifications within the United States, especially among the Latino population (CDC, 2003). Nationally 2.0 million or 8.2% of all Latinos, 20 years of age or older, have diabetes. Latinos are over twice as likely to have diabetes compared to non-Hispanic whites of similar age (CDC, 2003). These numbers are on a steady increase and only account for diagnosed cases of diabetes. Prevalence rates for the common complications of diabetes, obtained from the Centers for Disease Control and Prevention 2002 data (CDC, 2003), for the Latino population clearly indicate developing strategies for preventing the complications from diabetes is a critical need. For example, 20.3 per 100 Latino adults with diabetes have visual impairments; 413 per 100,000 Latino adults with diabetes have end-stage renal disease; and 29.8 per 100 Latino adults age 35 years or older with diabetes have cardiovascular disease (Clark, 1998). Comparable figures for non-Hispanic whites are 19.7, 277.8, and 34.7 respectively. In addition, less than 50% receive annual eye and foot exams, and participate in daily blood glucose monitoring (Clark, 1998).

Among Mexican Americans, Type 2 Diabetes has reached epidemic proportions with concomitant devastating health complications, morbidity and mortality. Fortunately many of these complications can be prevented through self-management techniques that promote tight glucose control. The costs, financial, physiologic and psychologic, associated with this disease and its complications are extreme. The need to explore culturally congruent, cost reducing and health promoting disease self-management strategies is
imperative for this high risk population. The benefits of this new insight may provide a mechanism to improve health outcomes and decrease costs associated with this chronic disease and move away from the belief that “diagnosis of diabetes is a death sentence” in the Latino population (Hakes, Blanco, Foxcroft, Compean-Rincon, & Sanchez, 2003, pg. 18).

**Vulnerability among the Latino Migrant Population with Diabetes**

The term Hispanic was created by federal statisticians for whom no precise definition of group membership exists and Latinos do not agree among themselves on an appropriate group label. The labels Hispanic and Latino conceal variations in the family characteristics of Latino groups whose differences are often greater than the overall difference between Latinos and non-Latinos (Baca-Zinn & Wells, 2000). Individuals from several ethnic backgrounds are lumped together under these terms including Cuban, Mexican and Puerto Rican. Each of these ethnic groups has unique views and approaches to health and illness and therefore must be explored separately (Baca-Zinn & Wells, 2000, Luna, Torres de ARdon, Young, Cromwell, Phillips, & Russell, 1996, Rodriguez-Reimann, Nicassio, Reimann, Gallegos, & Olmedo, 2004).

Latino families are not merely an expression of ethnic differences but like all families are products of social forces. “Family diversity is an outgrowth of distinctive patterns in the way families and their members are embedded in environments with varying opportunities, resources, and rewards. Economic conditions and social inequalities associated with race, ethnicity, class, and gender places families in different ‘social locations’. These differences are the key to understanding family variation” (Baca-Zinn & Wells, 2000, pg. 254) and the influence these variations have on the process of disease management for the migrant Latino with Type 2 Diabetes.

Within the diverse Latino population in the United States are those individuals who are long term residents of the United States and are well acculturated (a process in which members of one cultural group adopt the beliefs and behaviors of another group evidenced by changes in language preference, adoption of common attitudes and values, membership in common social groups and institutions, and loss of separate political or ethnic identification) (Hakes et all, 2003) individuals who have recently immigrated to the United States, and those who are migrant farm workers (individuals who relocate in order to work in agriculture and are unable to return to their permanent residence at the end of the work day) (Hakes et all, 2003). These characteristics have differential effects on cultural
beliefs and practices, health outcomes and self-management practices. The focus of this literature review is migrant farm workers due to special health problems and vulnerabilities associated with migrant status.

Much research has been completed related to vulnerability and the identifying factors that produce the greatest risk for poor health outcomes which include ethnic/racial, economic, educational and health care related factors. (Aday, 2001, Flaskerund & Winslow, 1998, Rogers, 1997). Latino migrants meet all of these criteria. First, ethnic/racial factors, which include but are not limited to language barriers, apply because cultural norms of this group may not be well understood by health care providers and may clash with typical Anglo approaches to health. This group may experience a lack of support or feelings of isolation when migrating from region to region in search of work. Economic factors apply because they frequently have minimum wage field work that does not provide for health coverage, experience increased financial burden related to migration from state to state, from work area to work area, with periods of unemployment (US Census Bureau, 2003) Educational factors apply because few have a high school education (US Census Bureau, 2003). In addition to lack of education, they are often confronted by a new society and legal system. Health related factors apply because of inconsistency of health care caused by frequent moving. Many of these individuals move from provider to provider and often run out of medications in the process.

The consequences for diabetes control are monumental. Extended periods with elevated blood glucose levels increase the likelihood of retinopathy, cardiovascular disease and kidney failure (DCCT, 1993, DCCT, 1996). If and when these individuals seek medical assistance, often no records are available to the provider who must then start over (Hakes et al, 2003). This often leads to new medications and dosages that may already have proven ineffective, in turn extending the time frame of poor glucose control (Clement, 1995). The increased expense of repetitive laboratory work, medication changes, and office visits increases the financial burden for this population, leading to further delays in treatment and follow up. In addition, routine screening and evaluation is limited or omitted due to lack of continuity of care. Typically, only the acute management issues are addressed, leaving recommended annual exams (dental, dilated eye, urine protein and creatinine) incomplete, further leading to increased risk of complications from non-intervention (Clement, 1995. Hakes et al, 2003). Additionally, these individuals are at increased risk for work injuries due to the nature of fieldwork (Clement, 1995. Hakes et al, 2003, NCFH, 2005, National Alliance for Hispanic Health, 2005). When the risk of
unidentified injury secondary to peripheral neuropathy resulting from prolonged blood glucose elevation is added, these individuals are likely to become disabled and unfit to continue working. Unfortunately these individuals frequently continue to work, due to financial concerns, often resulting in further injury that leads to lower extremity amputation (CDC 1997, American Diabetes Association, 1998, Hodgson et all, 1999, DCCT, 1993, DCCT 1996, Clement, 1995, CDC, 2003).

Diabetes significantly increases the risk of serious debilitating and life threatening complications if not aggressively treated and tightly controlled. Many devastating disabilities can be minimized if the client has the knowledge and ability to follow through on self-management. All of these issues point toward the need for strong self-care management skills since they are the major directors of their own care. This knowledge is unavailable in current research.

There is an extensive amount of literature related to self-care/self management and health management practices (n=5432), with only 133 related to Mexican Americans or Latinos. None of these are specific to migrant workers, and only 1 related to chronic pain management (which recommended family involvement and recognition and acceptance by healthcare providers of traditional and complimentary health practices). A majority of research in this area has investigated compliance to disease management regimes but the unique problems that contribute to poor glycemic control have not been studied.

**Self-Management**

Self-management, also referred to as self-care in the literature, has been defined in a number of ways depending on the disciplinary focus (i.e. sociological, physiological, ecological, medical, or related to nursing or health promotion). Because of this diverse array of historic roots for self-management, there is no universally agreed upon definition of the concept. Despite this, the concept of self-management consistently reflects individual behavior that is voluntary, universal, and self-limited (Lewis, 2003, Leenerts & Magilvy, 2000, Peterson & Vinicor, 1998).

Orem’s theory of self-care has been used often in self-care research. Orem defined self-care as “the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being (Orem, 2001). Orem also states that knowledge about cultural group norms that influence self-care is best obtained from the client’s perspective.
Self-management has also been described as “caring about oneself”, “not harming oneself”, and “having relationships that motivated self-care practices” (Leenerts & Magilvy, 2000). In their research with white, non-Hispanic, English speaking, HIV positive women Leenerts & Magilvy (2000) identified four self-care categories, focusing self, fitting resources, feeling emotions, and finding meanings. The utility of this middle range theory with a culturally diverse population appears not to have been researched.

According to Maddox (1999), “self-care activities are actions directed toward self or environment to regulate one’s functioning in the interest of one’s life, integrated functioning, and well-being”. This definition is based on research with elderly non-Hispanic white females.

A large knowledge gap related to self-management in the Latino population exists. This group has a high rate of diabetes complications (CDC, 1997, 1999, 2003) which leads one to wonder if the problem relates to a mismatch between the assumptions of self-management among the Latino migrant population and those of Anglo Americans. Research is needed to fill this much needed knowledge gap.

**Mexican Cultural Traditions**

The term “Familism” was first introduced in the 1940’s to describe the commitment of family members to family and family relationships (Heller, 1970). Familism was defined by Burgess and Locke (1945) in terms of family members focusing activities on the achievement of family rather than individuals, identifying the social environment as insiders, that of family and extended family, and outsiders, anyone outside the family structure. In addition family resources were used for the good of the whole and unconditional support of other family members. Adding to this definition, Acre (1978) further delineated three types of familism as demographic—emphasizing family intactness and size, structural—emphasizing the attitudes of the importance of family, and behavioral—emphasizing ongoing contact with family and the exchange of mutual aid.

Culture is viewed as the driving force behind familism. Family structure and attitudes toward family are rooted in cultural traditions and are passed from one generation to the other (Arce, 1978). Although research on familism has been conducted among Anglos, Canadians, Greeks, Portuguese, Indians, and Arabs, it has come to be viewed as a defining characteristic of Mexican families (Bardis, 1959, Blair, 1968, Aldrich, Lipman & Goldman, 1973, Kassess, 1976, Luna et all, 1996, Roa & Roa, 1979) and their attitudes toward caring for themselves (Crist & Escandon-
Some researchers believe familism is the most important value embedded in the Latino culture (Arce, 1978).

Mexican familism includes expression of family solidarity, ethnocultural determinants of informal care giving, distrust of culturally alien institutions and a desire to care for individual members within the family context regardless of personal cost or consequences (John, Resendiz & De Vargas, 1997). The Mexican culture is characterized by a strong value attached to family. Multigenerational households and active extended family networks provide support to family members. This is accompanied by cultural beliefs, attitudes, and values that place the needs of the family above the needs of the individual, an orientation to fulfill the needs of the family instead of the needs of the individual (John et all, 1997). With this family oriented worldview and the impact poor diabetes control for the individual can have on the health and well-being of the entire family, how does this influence the process of diabetes management? Does this change the focus for diabetes control from an individual responsibility to that of a family responsibility?

Most Mexicans are socialized to believe that the needs and welfare of the family as a whole or other individual family member, particularly the very young or very old, should take precedence over one’s own needs. Thus children and older adults alike are often reminded that during good times or bad, la familia comes first (John et all, 1997, p. 146). These values and beliefs translate into a normative expectation of familial responsibility and duty among Mexicans---a need for loyalty to the family institution. The family is the dominant source of advice and help in all generations. For the migrant Latino worker, the family structure may be disrupted. Some workers must live apart from their families; they travel, work, and live in groups of single men, often under the supervision and control of a crew leader. Other workers travel with some or all of their family members. Migrant Latino households may include families with children, single men, and older men and women (NCFH, 2005).

Community is viewed as a family-based personal network made up of people living within a limited geographical area in which face to face interaction occurs frequently. A strong commitment to family is present. Regardless of acculturation levels, Latinos perceive a high level of family support and desire geographic closeness to their families. In addition to blood relatives, Latinos include compadres and comadres (godparents) as well as other community members as part of “family”. How does this effect diabetes management for the migrant Latino farm worker? Do the “community family

Dominguez, 2003). Some researchers believe familism is the most important value embedded in the Latino culture (Arce, 1978).
members” carry out roles in the process of diabetes management when the individual is separated from the nuclear family and if so, what is this process?

Women tend to be relied upon for health matters. Same sex family members are relied upon for financial issues and personal problems and feelings of solidarity are greater with same sex family members as well. Multigenerational families are not uncommon and appreciation of this fact is important in understanding Latino family life. “Men have power and authority relative to outside institutions and women are responsible for the daily affairs of the family.” (Luna et al., 1996, p. 55). Based on these cultural characteristics, it is anticipated that the process of diabetes management will vary based on gender and its associated cultural characteristics and therefore exploring the social processes of diabetes management for both males and females is needed.

Longitudinal studies exploring families living with renal disease suggests that family beliefs and structures have a significant effect on disease management and patient survival (Reiss, Gonzalez, & Kramer, 1986). Linkages between characteristics of the family and changes in disease management over time suggest family context merits attention in long-term diabetes management (Chesla et al., 2003).

**Implications for Research**

This overwhelming lack of available research; strong cultural ties to familism in the face of the sometimes disrupted family structures characteristic of migrant status; the epidemic rate of diabetes in the Latino population; and the vulnerabilities that arise as a result of migrant status; strongly support the need for research on the social processes of diabetes management within the families/households of Latino migrant workers. Improved levels of understanding gained from research would allow for the development of interventions and education programs to improve the health of this population utilizing culturally appropriate methods.

With this new information, interventions could be implemented and tested to ascertain their effectiveness and impact on diabetes management and control. Further studies of the applicability of intervention strategies could then be tested for other disease classifications.

Additionally, exploring the barriers faced in diabetes management as migrant workers moving from state to state also needs to be explored. What is seen from the etic viewpoint may not be important or challenging from the emic view. How better to serve
this population than to ask them what challenges they face and how they see them resolved? This is best approached from a community action research design.

The paucity of research focused specifically on the migrant farm worker population leaves much to speculation and trial and error. Much more information is needed to better meet the health needs of this population. As new information comes forward, nurses will have the ability to expand the knowledge base of this dynamic cultural group.

**Implications for Clinical Practice**
The Healthy People 2010 identifies (US Department of Health and Human Services, 2000) the goal for diabetes is: “Through Prevention programs, reduce the disease and economic burden of diabetes, and improve quality of life for all persons who have or are at risk for diabetes.” Multiple objectives are listed, many of which are issues of self-care behaviors. Included are education, annual dental and eye exams, and self blood glucose monitoring. Currently, Mexicans with diabetes who participate in annual eye exams is 38%, annual dental exams 32%, daily self blood glucose monitoring 36%. These percentages are approximately 50% lower than goal targets outlined in Healthy People 2010 (US Department of Health and Human Services, 2000). These statistics illustrate the need for improved healthcare interventions for this high risk population.

Unfortunately, many healthcare providers view poor diabetes control in this population as non-compliance to the prescribed regime and fail to explore why diabetes management goals are not being met. This failure is viewed from the individual responsibility of the patient with no recognition that the providers may be approaching education and care from a culturally incongruent framework. The unanswered question is “what are we as healthcare providers failing to provide for the patient that would improve their health and promote disease management?”

Clinical practice and health promotion for this population of migrant farm workers could be improved through the identification and support of social capital resources present in the environment as identified by the population itself. Asking the members what they need and value in relation to disease management would be the springboard to improved health outcomes.

Health policy changes informed by research are likely a needed outcome. Potential changes that would improve the health of this unique population would include provisions for trans-state
prescription refills, access to medical records via electronic sources, such as community health clinics or health departments nationwide. Access to this information would decrease the likelihood of missed screening exams, improve continuity of care, and eliminate the challenges faced in obtaining medications and treatments key to diabetes management. Developing strategies that are culturally congruent rather than dictating care based on traditional Anglo-American beliefs is imperative to improve outcomes in diabetes management for the migrant Latino.

**Conclusion**

Despite extensive diabetes research, overwhelming gaps exist in the literature specific to migrant populations of Mexican descent. The social processes utilized by this population to manage their diabetes need exploration in order to advance nursing knowledge and improve health outcomes for this at risk population.
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Sheelagh Wickham, RN, RM RNT, MSc. FFNMRCrSI.
School of Nursing, Dublin City University, Dublin 9
Ph: 01-7005610, Fax: 7005688 E-mail: Sheelagh.wickham@dcu.ie

Background and context: The recognition of “clinical expert” as part of the Clinical Nurse Specialist role is evident in much of the literature, (Benner, 1984, Bamford & Gibson, 1998, Armstrong, 1999, Dunn et al., 2000, McCreddie, 2001, Bryant Lukosius and Di Censo, 2004, NCNM 2004). Yet while there is much literature surrounding the topic of expert care by Clinical Nurse/Midwife Specialist there is a limited research into the active facet of this role, particularly in Ireland. Expert clinical practice is recognised as a key part of the clinical nurse/midwife specialist work. This study explores the activity of the clinical nurse/midwife in Ireland in expert practice.

Aim of the study: The study aimed to explore the active role of the clinical nurse/midwife specialist in Ireland. The results of exploration of the activity in the area of expert practice will be presented here.

Methodology: including research design and sampling. A questionnaire was sent to the total population of clinical nurse/midwife specialists on the National Council database (over 1400 in number). There was a response rate of over 50%. The questionnaire explored activity in the various roles of the clinical nurse/midwife specialist.

Analysis: Quantitative data was analysed using SPSS. The data was entered and each role component analysed individually. The questionnaire contained a number of negatively worded questions to help ensure reliability; the responses to these questions were reversed prior to analysis. Following reversal of the negatively worded questions the reliability for each section was assessed. Cronbach’s alpha was measured in this assessment and results ranged from .709 to .858, indicating reliability.

Summary of key findings: The results show the clinical nurse/midwife specialist to be active in this role. There was some variety in the level of activity between different disciplines and areas of practice of clinical nurse/midwife specialists. Correlations
between levels of activity in this role and levels of education were also explored.

**Conclusions.** The clinical nurse/midwife is active in the area of expert practice but there are differing levels of activity which correlate with different discipline and areas of nursing practice.


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An exploration of the factors that cause stress in student midwives.

Presented by

**Linda Wylie** RGN RM RMT BA (Open) MN
Department of Nursing, Midwifery and Health Care, **University of Paisley**, Scotland, UK
Telephone; 0141 849 4280
Email: linda.wylie@paisley.ac.uk

And

**Catriona Jones** RM BSc (Hons) PG Cert. Ed.
Faculty of Health and Social Care, Department of Nursing and Midwifery, University of Hull, Cottingham Road, Hull, England, UK, HU7 6RX
Telephone: 01482 464624
Email: C.Jones@hull.ac.uk

An increasing number of student midwives are leaving midwifery education without completing their studies. Since the Nursing and Midwifery Council (2004) (NMC) have identified that the level of financial support for students remains a contentious issue, one may assume that often students leave due to financial hardship, however, no one has asked the students what the real issues are. Research in this area is minimal and has looked at issues as perceived by Higher Education. Research into student attrition rates on the Common Foundation Programme (CFP) by White Williams and Green (1999) suggested that more attention should be focused on the student, rather than on course content or structure.

The issue of attrition has gained much interest of late, not least due to the suggestion that Government targets regarding the NHS workforce will not be met if drop out rates continue to increase, this alongside the financial penalties incurred by higher education institutions (HEI’s) as a result of student wastage should encourage all healthcare professionals and educators to consider student attrition as an area of concern. Completion or non completion of the programme will not be proposed as an area for discussion by the researchers, however it is accepted that this subject may arise as a result of the students identification of stressors.

Examination of the literature shows that little research has been undertaken in the subject of stress within the student population and much of this has been aimed at student nurses. Additionally, every research project has identified the perceived stressors and constructed the method around these rather than asking the students for their perspective.
Previous research undertaken within the student nurse population consider the reasons for student attrition to be complex, including issues relating to perceived lack of support in placement, travelling difficulties, financial hardship, personal and family problems, and misperceptions surrounding academic requirements (White Williams and Green 1999). However, it is well known that the midwifery profession has a distinct identity from that of nursing; therefore we surely must explore the possibility that the issues which affect nursing students may well be different from those of midwifery.

Students from the University of Paisley who are undertaking the Midwifery 3 year programme have been used; additional focus groups from an 18 month midwifery programme from the University of Hull were used to identify factors in the English system. There are noticeable differences specific to funding between Scotland and England for the 18 month Midwifery degree students, and therefore establishing stressors within this group of student midwives is essential for this study. At present, students studying on an 18 month midwifery degree programme within the Scottish system remain funded by a means tested bursary, however within the English system these students are employed by the Trust and salaried at a level reflecting their previous status in nursing. Their status therefore is not supernumerary. It may be that students undertaking different programmes may have differing stress experiences given the contrasts in their circumstances; however it is felt that this will add richness to the study itself and provide the researchers with more of an insight into the individual needs of different cohorts.

The typical student midwife across the UK has also changed. Many of the students come into the degree with family and financial commitments. They travel long distances without recompense (travelling expenses are paid minimally and inequitably). They work within a highly stressful environment on shifts that include nights, weekends and twelve hour stretches. In Scotland, many more student midwives leave the degree programme than when they worked as employees.

This research sets out to explore the factors that may prevent the students learning effectively whilst on the programme. The proposed gains of the research are that of a greater understanding by educational providers of the factors that cause stress in student midwives. From the local and wider perspective this will possibly enable those involved in midwifery education to consider these factors in curricula design and in funding issues, an area where there is currently considerable debate.
Alongside these factors, there are current issues that exist within education and the NHS which have driven this study forward. Firstly, the current focus on the importance of “student experience” highlights the need to ensure that all students are provided with an environment which embraces and fosters learning. This should not be merely applicable to students whilst in the University setting; currently students are expected to spend 50% of their learning experiences in an environment where contact time with academic staff is minimal. How can we ensure that students within the clinical setting are having their student experience taken into consideration? It is to be hoped that supernumerary status increases the quality of student learning; however, can we rely on clinical staff to provide a complete package of quality learning experiences? And what of those midwifery students who do not have supernumerary status? The lack of clarity in the role of teachers/lecturers within the clinical setting, alongside the demise of lecturer practitioner roles makes this issue even more challenging. According to the NMC (2004) the crucial determinants of a positive and beneficial learning experience appear to be climate (a welcoming, enquiring and reflective culture), structure (clarity about the learning opportunities available) and focused attention (the facilitation of an interested and skilled mentor). If we are to consider the midwifery student in the same context as any other fee paying student within a higher education institution then we surely must accept that the focus has to be on quality and value for money - as with any consumer, in any market.

When considering climate and environment as part of the student experience one must also take into account working relationships. Midwifery is a profession which historically has been exposed to tension and conflict, the ongoing dispute with the medical profession surrounding their desire to usurp control over the non pathological processes of childbearing to name but one. More recently however conflict within midwifery has been apparent in relation to individuals who, having specific beliefs surrounding the different routes students take to access midwifery as a profession, question the quality of a midwifery practitioner who has had no formal nursing training. This may or may not be having an impact on the midwifery students’ experiences. With the structure of midwifery education soon to be undergoing further change, this is an area which should be examined in relation to its impact on the students themselves.

The unsavoury subject of bullying within midwifery is one which has recently been attracting media attention, indeed the NHS in its entirety is being considered as an area of some concern where negative relationships have been found to exist and flourish.
Whilst considering the need to maximise opportunities for learning, building positive relationships within that environment should be considered as a crucial component to the student experience.

Currently, midwifery remains an attractive potential career with applications to places far exceeding those available; in order to ensure an ongoing plentiful supply of potential recruits more should be done to demonstrate that the needs of the present day midwifery students re being taken into account. If we in the business of educating midwives are to be considered as part of a dynamic and flexible profession, we must demonstrate this to the consumers, namely the students.

The study itself takes the form of two stages. Ethical approval was gained from the ethics committees of both the University of Hull and Paisley for stage one of the study. In stage one; focus groups were undertaken with a convenience sample from two universities. The focus groups were held within a day in the university to ensure that no constraints such as time or finances would prevent all those who wished to attend doing so. Open ended questions were used to guide the students through the various arenas that may impact on their midwifery education. Focus group sessions were tape recorded with consent of the participants and transcribed.

Consent forms were issued to participants of the focus groups and they were given full information regarding the purpose of the research with reassurance that participants would not be identified by name at any point. The students were offered an individual opportunity to debrief after the focus groups at a time convenient to them. Telephone numbers for local support groups and agencies were made available in the form of a hand out to all students taking part in the focus groups. These focused specifically upon financial and relationship advice, as this appeared to be an area of some ethical concern. Students from the University of Hull received information about contacting the University of Hull’s Counselling Services; furthermore they were advised about the Student Advice Centre within Hull University Union which offers advice relating to problems associated with academic performance, debt, employment and sexual health. Participants were also be reminded of the role of their personal supervisors.

The information sheet supplied to participants clearly stated that there was no obligation to take part in the research, and that they could withdraw at any time.
The facilitators of the focus groups were the researcher and a fellow lecturer, it was recognised that they have the skills to deal with actual or potentially sensitive issues. Each researcher ran the partners University focus group to avoid pressure on the students to be involved etc.

Content analysis was undertaken in order to identify relevant “common themes”. (Burnard 1991) the method of identifying themes which was used was one proposed by Burnard (1991) which involves 14 stages. Furthermore, we believe that the approach taken in order to identify themes was that of a bottom up approach, i.e. themes were not predetermined. Transcripts were read repeatedly as Burnard (1991) recommends, and many points were written down from the content, from the transcripts there were in excess of 300 issues raised, which were then grouped under headings. The headings were then classed as categories and where possible the categories were grouped together to eventually provide common themes, although many of the points were difficult to assign to one category in particular, for example, “difficulties arranging childcare around unpredictable timetable” Is this an a academic stressor or a family stressor? Equally, “Cost of travelling” Is this financial stressor or a stressor related to distance from home to workplace. At this stage in the process, we are currently re examining the data to establish if it can be reworked in such a way that an overlapping can be minimised.

Current common themes seem to focus on travel and finances, timetabling, assessment, childcare, family needs; the most problematic aspects of the programme which appear to cause most stress are directly related to practice. The students have identified many areas within the clinical setting which cause them stress and these can be identified into themes within a theme, for example, mentors issues, lack of support, unsuitable allocations, lack of learning experiences, learning experiences not matching theory taught, again highly complex as some of these themes could be linked to timetabling and programme issues.

Further research is planned with the outcome of the focus group findings. A questionnaire will be devised to quantify the identified stressors and will be distributed across the UK to a representative sample of the student midwife population.
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Analysis of a Population-Based Dataset, The National Survey of Children’s Health, for Health Planning and Policy: Factors Associated with Not Having a Medical Home Among U.S. Children

Mary Beth Zeni, ScD, RN, and Dan Thompson, MPH
Florida State University, Tallahassee, Florida

Mary Beth Zeni, ScD, RN
Assistant Professor
Florida State University
College of Nursing
413 Duxbury Hall
Tallahassee, Florida 32306-4310
Phone: 850.644.5355
Fax: 850.644.7660
mzeni@nursing.fsu.edu

Background: The American Academy of Pediatrics (AAP) and the National Association of Pediatric Nurse Practitioners promote primary pediatric care through a medical home. A medical home includes comprehensive, accessible, continuous, coordinated, family centered and culturally effective care (AAP).

Aims: 1) To investigate factors associated with U.S. children not having a medical home, and 2) to discuss health policy implications, comparing primary care access in Western European countries.

Methodology: NSCH, a nationally-represented study of 102,000 U.S. children with adequate sampling for each state, includes information on the overall health of U.S. children. The free dataset is available to researchers for analysis. This analysis, using Aday and Andersen Access to Medical Care model, examined US children at risk for not having a medical home, the outcome variable. Independent variables were identified based on the model.

Analysis: Bivariate and multivariate analyses were conducted with SUDAAN statistical software. The outcome variable, medical home, was derived from a set of survey questions.

Summary: 53.9% of US children lacked a medical home. Multivariate analysis indicated the odds of lacking a medical home were significantly increased for parental assessment of child’s health status as good (1.39) and fair or poor (1.28) (versus excellent/very good), age 1-4 (1.68), age 5-12 (2.79), age 13-17
(3.38) (reference is age < 1), Hispanics (1.25), primary household language Spanish (1.87), Blacks (1.28), below 100% poverty level (1.93), poverty 100-200% (1.60), poverty 200-400% (1.24), household education less than high school (1.31), and moderate-severe emotional/behavioral condition (1.51). Health insurance and being in a 2-parent family reduced the risk of lacking a medical home.

Conclusions: Factors affecting lack of a medical home are not driven primarily by the child’s health status. A multi-faceted approach is needed to achieve comprehensive health care for US children and warrants examining effective access models in Western European countries.