Conference Proceedings

8th Annual Interdisciplinary Research Conference
7th – 9th November 2007

Transforming Healthcare through Research, Education and Technology

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QUALITY OF LIFE IN HIV/AIDS PATIENTS IN LEBANON

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Background
The Joint United Nations Programme on HIV/AIDS (2006) reported that in the past year, an estimated 4.1 million persons were newly infected with the disease worldwide, and around 2.8 million died of AIDS. A total of 38.6 million people were estimated to be living with HIV in 2005, and nearly 40 million lives have been claimed since the start of the pandemic in the 1980s.

Significance of the problem
In the Middle East and North Africa (MENA) region, the number of people living with HIV has been increasing tremendously. Although the estimates are based on inadequate and inaccurate data because of underreporting, the number of people reported to have HIV increased from 380,000 in 2000 to 440,000 in 2005. Although the prevalence rate of HIV/AIDS in the MENA region is low (0.2%), this does not mean that the MENA region is at low risk for HIV/AIDS epidemic, in view of the underreporting of cases (Yong Kim, 2002).

The problem of HIV/AIDS is steadily growing in Lebanon since the diagnosis of the first case in 1984 (Kalaajieh, 2000). With a prevalence rate of 0.1%, 2000 people were estimated to be infected with HIV in 2001, and 2900 in 2006 (The World Bank, 2005; UNAIDS, 2006; UNAIDS/WHO, 2004). However, by November 2006, only 958 cases of HIV/AIDS were reported to the Lebanese National AIDS Control Program (Ministry of Health, 2007). This discrepancy in the numbers highly reflects the underreporting of HIV/AIDS in the country.

Nowadays, with the presence of Highly Active Anti Retroviral Therapy, patients with AIDS are living longer; nevertheless the clinical course of their disease remains unpredictable, thus affecting their quality of life on all levels. The Lebanese culture gives high
importance to traditions, social norms, religion, and family values. Taking this into consideration, and the fact that HIV/AIDS is associated with homosexuality, sex workers and injecting drug users, HIV/AIDS patients might be at risk of being rejected by their families, friends, and colleagues, losing their jobs, economic deprivation, and social isolation (Dahdah, 2005). In fact, in Lebanon, heterosexuality was found to account for 47% of HIV/AIDS cases, men having sex with men for 28%, injection drug use for 3%, mother to child transmission for 6.7%, and transmission via blood products for 15.6% (UNAIDS/WHO, 2004). All these factors play a major role in the quality of life of AIDS patients. In Lebanon, there is no reported information about the quality of life of patients living with HIV/AIDS.

The aim of the study was to determine the impact of HIV/AIDS on the quality of life of Lebanese adult patients living with the disease.

The research questions in this study were:
1. How do HIV/AIDS patients in Lebanon perceive their overall quality of life?
2. How are demographic factors, symptoms, stigma and discrimination, and clinical variables (HIV/AIDS status, comorbidities, and medical treatment) associated with the quality of life of HIV/AIDS patients in Lebanon?
3. Which quality of life domains show the strongest relationship with overall quality of life perception?

Methodology

Design, sample and setting
The study design was a cross-sectional descriptive survey, using self-administered questionnaires. The target population was adult (18 years and above) Lebanese HIV/AIDS patients; the sample included outpatients recruited from two major medical centers in Lebanon over five months.

The questionnaire included three instruments. The first one was the Multidimensional Quality of Life-HIV (MQOL-HIV) (Smith et al., 1997), a 40 item scale that measures 10 different domains (mental health, physical health, physical functioning, social functioning, social support, cognitive functioning, financial status, partner intimacy, sexual functioning, and medical care), on a 7-point Likert scale. The second one was the HIV Symptom Index (Whalen et al., 1994), that measures the frequency of twelve most common and bothersome symptoms reported in HIV/AIDS patients (fatigue, paresthesias, skin problems, headaches, sadness, cough, memory loss, sleep disturbances, fevers, imbalance, diarrhea, and nausea);
items are rated on a 4-point Likert scale. The third one was the HIV Stigma Scale (Sowell et al., 1997), a 13-item scale with three subscales (distancing, blaming, and discrimination). A single-item quality of life question was added to assess the participants’ overall perception of their quality of life, rated on a 5-point Likert scale.

Participants were also asked about their demographic characteristics.

The questionnaire was translated to Arabic, back translated to English, and validated for cultural appropriateness by a panel of experts.

Statistical analysis
Descriptive statistics included means, standard deviation (SD) and frequencies. Bivariate analyses used were t-test, ANOVA, chi square, and correlation coefficients.

Results
Fifty seven questionnaires were distributed and 41 returned, yielding a 71.92% response rate. The majority of the sample were males (77.5%), single (46.3%), with up to secondary level education (43.8%). The mean age was 38 years (SD=9.93). The subjects were equally distributed between working full time (43.9%) and unemployed (43.9%), and only 32.5% had health insurance.

Over half of the participants (57.5%) reported being asymptomatic HIV positive patients but 22.5% did not know in which stage they were. Also 34.1% of participants reported not knowing their HIV mode of transmission.

The mean MQoL-HIV was 176.85 (SD=39.66). The MQoL-HIV domain scores ranged from 4 to 28. The highest score was for the cognitive functioning domain (21.63, SD=5.81), followed by social functioning (21.10, SD=6.03) and medical care (20.50, SD=6.36); the lowest domain scores were for the financial status (12.49, SD=11.00), followed by sexual functioning (14.75, SD=6.65), and mental health (16.90, SD=5.20). The single item overall quality of life was reported to be neither poor nor good by 47.5%, good or very good by 27.5%, and poor or very poor by 25% of the participants.

The mean Stigma scale score was 25.10 (SD=7.19). Ten respondents (25.6%) reported that they lost their job because of HIV/AIDS and they were all males; 33 respondents (80.5%) reported telling someone that they are infected with HIV/AIDS.
The mean HIV Symptom Index score was 0.60 (SD=.44), which means that symptoms mostly occurred from never to up to three days per week. The most prevalent symptom was fatigue (48.8%), followed by sadness and headache (34.1% each?). The least prevalent symptoms were skin problems (14.6%) and paresthesias (19.5%). Pain intensity was minimal (mean = 2.56, SD=2.36 scale of 0 to 10).

Although no gender differences were noted in the mean MQoL-HIV score, females reported better quality of life in social functioning than males (22.55, SD=3.39 vs. 20.69. SD=6.57, p=.005). No gender differences were noted in stigma and symptoms scores.

Married respondents reported better MQoL-HIV mean quality of life than single ones (206.50, SD=38.77 vs. 158.42, SD=34.34 respectively, p=.002), in the social function domain (18.53, SD = 7.03 vs. 24.50, SD = 3.57, p = .023) and the sexual function domain (12.11, SD=6.56 vs. 18.57, SD=5.54, p=.027).

The level of education was significantly related to the mean MQoL-HIV (p=.006). Respondents with up to elementary education with higher quality of life scores than those with university education (197, SD=45.05 vs. 150.60, SD=27.56, p=.048); and those with secondary/technical education reported higher quality of life scores than those with intermediate level (203.62, SD=37.35 vs. 159.67, SD=25.27, p=.011). The level of education was also significantly associated with level of stigma [F (3, 37) = 2.97, p=.044]. Moreover, those with secondary or technical education reported more frequent symptoms than those with intermediate education (p=.006). Participants who did not know what their HIV serostatus had the highest score on partner intimacy, while the AIDS group had the lowest score (26.2, SD=2.68 vs. 14.5, SD=10.02, p=.038).

Higher MQoL-HIV scores were significantly associated with lower mean symptoms (spearman’s rho=-.617, p=.000), the symptoms of imbalance (spearman’s rho=-.435, p=.004), sadness (spearman’s rho=-.576, p=.000), sleep disturbance (spearman’s rho=-.587, p=.000), fever (spearman’s rho=-.473, p=.002), nausea (spearman’s rho=-.340, p=.030), diarrhea (spearman’s rho=-.396, p=.013), and skin problems (spearman’s rho=-.432, p=.005). In addition, higher stigma scores correlated with lower overall quality of life scores (spearman’s rho=-.555, p=.000).

Correlations between the single item of overall quality of life and the MQoL-HIV score were significant with the overall MQoL-HIV mean (r=.517, p=.001), the mental health (r=.427, p=.006), social
functioning ($r=.592$, $p=.000$), and medical care domain scores ($r=.563$, $p=.000$).

Conclusion

This sample, which included mostly asymptomatic and well functioning individuals, reported a fair level of quality of life. The frequency of symptoms and perception of being stigmatized strongly predicted poor quality of life in this sample of HIV/AIDS patients. The determinants of perceived quality of life in this group revolved around psychosocial aspects of their lives.

References


To evaluate the introduction of person centred planning in one intellectual disability service in Ireland

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The draft national standards for disability services makes explicit reference to person centred planning as key to the development and delivery of services for people with disabilities. Supporting good practice in person centred planning will help the government to deliver on its commitment to provide quality services.

Person centred planning was introduced in one voluntary organisation in two geographical areas across 11 sites. In each geographical area a steering group was established and a half time person centred planning coordinator employed.

The aim of the study was to evaluate the development and implementation of person centred planning within the service. In one geographical area 25 people volunteered to participate in the study and the other 10 participants were randomly chosen.

Mixed methods were employed to evaluate the impact of person centred planning on all persons involved. Semi-structured interviews were used with focus persons, family members and facilitators; this information was then collated into a case study for each participant. Postal questionnaires were adopted with unit managers, administrators and the steering group in order to gather information regarding the future development of person centred planning.

Information gathered was analysed around four key areas. These areas being challenges, facilitating factors, impact and recommendations; these areas were addressed separately for the participant, facilitator and circle of support member.
The results of the evaluation showed that 29 persons developed plans over the 12 months. Of these all persons involved considered that person centred planning had increased the quality of life of the participant. Recommendations mainly centre on the existing challenges and how to overcome them coupled with strengthening the facilitating factors.

The impact of the person centred planning study included; services users having more control (choice and decision making) over the direction of their lives, increased contact with family members, increased quality of communication and skills for the service user and facilitator, increased confidence, increased happiness, increased use and more appropriate use of departments within the organisation (i.e. speech and language, social work etc), increase in use of community services, family members and service users are more relaxed with this type of planning, the service has become more person centred, it did not cost a lot, more people know what being person centred is about.

The main facilitating factors to support the person centred planning process included; when the service user had strong family support; when a service user had a facilitator who was really interested in person centred planning; where managers supported person centred planning and its activities; participating in support groups (service user, family and facilitators); and where a good relationship already existed between the service and family members.

The main challenges were; lack of understanding and necessary skills to facilitate person centred planning; lack of support by managers; perceived lack of time; lack of knowledge of advocacy; lack of accessible information regarding person centred planning; lack of involvement of community members; and general lack of understanding of what being person centred means.

The main recommendations included; develop ‘implementation teams’ in each area to progress person centeredness and planning; train people in awareness of being person centred; develop accessible information; link with advocacy groups within and external to the organisation; involve service users in all levels of service planning and development.

The conclusions are that many challenges exist within the service when considering implementing person centred planning but the impact of doing so will increase the quality of lives of the persons who use that service.
Early postnatal transfer home: A phenomenological study

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Background: It is evident from the literature that postnatal care is a neglected area. Increasing strains on the provision of maternity services further affects care following delivery. This study investigates women’s “lived experience” of an alternative method of postnatal care, which is relatively new to Ireland.

Aim of the study: To explore and give meaning to the experience of women who choose to go home early following a normal delivery.

Methodology: A qualitative study, utilising a hermeneutic phenomenological design was undertaken. Open, unstructured interviews were conducted with nine women. These women, who had all availed of an Early Transfer Home Programme, were selected by purposive sampling.

Analysis: The data collected was analysed according to the hermeneutic research approach. This approach of interpretative analysis utilises three interrelated processes, these are thematic analysis, analysis of exemplars and the search of paradigm cases.

Findings: The core category “it worked very well for me” highlights the individuality of each woman’s experience. This experience appeared to be influenced by the following main categories: (1) choice; (2) normality/wellbeing; (3) support from the midwife; (4) support from family and friends; (5) home to family. The categories identified emerged from the interviews with the women.

Conclusions: The women interviewed emphasised the individuality of their experience and appreciated the voluntary nature of their choice. The women generally appeared to recognise the normality of childbirth however were unanimous in their need for “rest”. Support provided by both the midwife and the family was a significant factor in relation to the satisfaction of their experience. To return home to their family was an important benefit of early transfer home. Consequently this resulted in an increased involvement of family members, particularly the father, in the postnatal experience.
Nurses experiences of delivering spiritual care to patients in an Irish hospice palliative care unit.

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Aim of the study
To described nurse’s experiences of delivering spiritual care to patients in an Irish hospice/ palliative care unit.

Methodology
In a qualitative descriptive design the experiences of 22 purposefully sampled nurses were described using semi-structured interviews.

Analysis
Data analysis was facilitated by Burnard’s (1991) Framework for Data Analysis.

Summary of key findings
Responses indicate that the concept appears to be at the very essence of nursing in palliative care and is rated as a very significant component of holistic nursing. Challenges of note in spiritual caring were described as the complexity of the concept often resulting in undocumented assessments, conflict between religion and spirituality and the concept of time, timing of interventions and time management within finite resources.

Conclusions
The findings of this study indicate that while nurses rate their role in spiritual care highly, their work poorly recorded in nursing documentation and may therefore be undervalued by others. A need for further research in identifying a method of documenting spiritual care without reducing its essence to a ‘tick box’ is required.

Key words: spirituality; spiritual care; palliative care; religion; culture and religion; patient assessment
Concept analysis: a research method to illuminate the concept of advocacy

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Background and Context
Advocacy has increasingly appeared in British nursing literature since its explicit inclusion in the pre-registration nursing programme in the 1980s. Despite confusion about the nature of advocacy and the challenges regarding the legitimacy of nurses acting as advocates, it remains a requirement of contemporary professional nursing practice.

Concept analysis is a method of enquiry that clarifies the meaning of concepts and can contribute to a body of knowledge. In providing a knowledge base for practice it enables understanding. To illuminate advocacy an eclectic approach to concept analysis was adopted synthesizing Wilson’s and Walker and Avant’s concept analysis methods.

Aim of the Study
To determine the defining attributes, antecedents and consequences of the concept of advocacy.
To develop a model of advocacy.

Methodology
Concept analysis: a research method to illuminate the concept of advocacy
Concept analysis is a method of enquiry that is capable of increasing what is known specifically about concepts. It is an enquiry method that can result in clarification, identification and meaning of words (Norris 1982, Walker and Avant 1988, 1995). It can be justified as a research method on the basis that the purpose of research is to expand a body of knowledge through a process of systematic and scientific enquiry (Polit and Beck 2006).
There are several methods of analyses and much reference in the literature to Wilson’s approach (1971). Walker and Avant (1983) adapted Wilson’s method for the study of nursing concepts. The approach has been used by many in nursing e.g. dignity (Mairis, 1994), grief (Jacobs, 1993), intimacy (Timmerman, 1991) and presence (Gilje, 1992). The contribution of concept analysis to knowledge can be seen in Bu and Jezewski’s (2007) clarification, also, of advocacy. Bu and Jezewski (2007) propose a mid-range theory of advocacy.

Wilson’s (1971) and Walker and Avant’s (1983) concept analysis methods have been criticized for simplifying complex concepts (Morse, 1995), for being reductionist and offering a static view of concepts (Rodgers 1989). Entity and dispositional views of concepts are identified by Rodgers (1989): the focus being on the concept as an entity in itself, and the use of concepts in reality respectively. The entity approach removes the concept from context. This is the approach inherent in Wilson’s (1971) and Walker and Avant’s (1983) method.

Rodgers’s (1994) evolutionary cycle of concept development acknowledges that concepts are influenced by ‘significance’, ‘use’ and ‘application’. This method seems to facilitate analysis that is practice related as it focuses on application of a concept in practice. Morse (1995) on the other hand favours an alternative approach to establish a concept’s maturity. Drawing on ‘rules of relation’ (Bolton 1977, cited by Morse 1995) Morse (1995) recommends analysing primary and secondary data to decide whether the object of enquiry can be considered a concept. This is followed by applying the ‘rules of relation’ to clarify which of six concept analysis approaches is best for analysing a particular concept (Morse 1995). Wilson’s (1971), Walker and Avant’s (1983) and Rodgers’s (1989) work on concept analysis and development, along with Morse’s (1995) qualitative thematic analysis will influence the research approach to the study of concepts.

In that the purpose of research is to contribute to scientific knowledge (Burns and Grove, 1999; Hockey, 2003) it is essential to be clear about what science and scientific knowledge. Dictionaries define knowledge as the act or process of knowing. The Dictionary of Philosophy (Lacey, 1986) and Leddy and Pepper (1993) suggest that it is "justified true belief" but one can argue that what counts as justification is open to interpretation (Lacey, 1986). Similarly Doyal (1993) invites one to challenge authority rather than accept it in the pursuit of growth of knowledge.
There have been two distinct approaches to gaining knowledge. The way of pure reason epitomized by Plato and subsequent philosophers (eg. Descartes) and the way of empiricists who assert that all ideas originate in sense perception. Whatever way ideas are gained, concept analysis highlights consistency and coherence of ideas with the existing body of knowledge and the evidence upon which those ideas were constructed.

Concept analysis is therefore an intellectual enterprise in the claims to knowledge by methods of reason or experience. Wilson (1971) states "concept analysis gives framework and purposiveness to thinking that might otherwise meander indefinitely and purposelessly among the vast marshes of intellect and culture" (p. ix).

The first aspect to concept analysis is to isolate "questions of concept". Wilson (1971) suggests that a model case of the concept is a good place to start which is then followed by contrary, related, borderline and invented cases. According to Wilson, it is important to examine the social context, underlying anxiety and practical results and Wilson (1971) completes his technique of analysis with a stage entitled "results in language". Not all the techniques are equally useful in all cases and he suggests that taking each stage in order might be a wise method. An omission from the literature is the lack of a clear explanation of the method of concept analysis in action.

An eclectic approach was used to clarify the concept advocacy. Data sources included nursing, research and scholarly literature focusing on the interpretation and application of advocacy to British nurses and nursing practice.

**Analysis**

Qualitative thematic analysis informed analysis. It involved organizing data into the categories labelled attributes, antecedents and consequences. Further analysis produced subcategories illuminating the concept of advocacy. Three attributes were elicited from the analysis. Antecedents and consequences were identified. Attributes, antecedents and consequences combined, form a model of advocacy.

**Findings**

Advocacy comprises three essential attributes. These are valuing, appraising and interceding (Baldwin 2003). The antecedents to advocacy are vulnerable patients and nurses prepared to take responsibility for advocating. The consequences of advocating can be positive and negative for both patient and nurse: freedom and
self-determination associated with autonomy and professional satisfaction respectively. The negative outcomes are discomfort for the patient and risk for the nurse.

**Conclusions**
Concept analysis is a pragmatic and rigorous approach to defining concepts that can make a significant contribution to knowledge and nursing practice. Advocacy has been illuminated by means of concept analysis.

**References**


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Psychometric Evaluation of the Arabic Brief Pain Inventory in a Sample of Lebanese Cancer Clients

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Background
Pain is a frequently encountered phenomenon by nurses, especially in oncology clients; 50% of those receiving cancer treatment report pain, the number increasing to 70% in the advanced stages of the disease (Carrier-Kohlman, Lindsey & West 2003). Studies documented suboptimal pain management in cancer clients, which negatively affects their quality of life. In light of the high prevalence of pain in cancer clients, its reported under-treatment and consequences on patient well being, the importance of pain assessment as an essential step in its management becomes paramount for improving patient care. Adequate pain assessment requires clinically appropriate and culturally sensitive tools that are valid and reliable (Miaskowski 2004). The Cancer Relief Unit of the World Health Organization selected the Brief Pain Inventory (BPI) as an index of the efficiency of cancer pain relief protocols. The BPI was validated in many cultures (McGuire, Kim, & Lang 2004).

Study aim and Research Questions
The aim of this study was to evaluate the psychometric properties of the Arabic Brief Pain Inventory in a Lebanese sample of cancer clients. Research questions were:

1. Is the Arabic BPI culturally sensitive to the Lebanese cancer patient population?
2. Is the Arabic BPI internally consistent in a Lebanese cancer patient sample?
3. Do the dimensions obtained in other versions of the BPI replicate in a Lebanese sample of cancer clients?
4. What is the relationship between pain intensity and its interference with various aspects of the participant’s life in a Lebanese sample of cancer clients?

5. What is the relationship between the average pain intensity and perceived relief from pain from treatment?

**Methodology**

**Sample and setting**

A convenience sample of 75 oncology clients was recruited from inpatient and outpatient units in a major tertiary care center in Beirut, Lebanon. The sample inclusion criteria were:

1. Adult clients aged 18 years and above
2. Clients diagnosed with cancer; primary or metastatic.
3. Clients complaining of pain as a result of their cancer.
4. Clients receiving treatment for their pain.

Clients who underwent surgery or an invasive procedure during the past month were excluded.

**Instrument**

The BPI is a self-administered questionnaire that measures the presence and location of pain in 2 items, pain severity (at its worst during past 24 hours, least during the past 24 hours, on average and now) in 4 items, pain relief in 2 items, and pain interference with general activity, mood, walking ability, normal work, relationships with people, sleep, and enjoyment of life, in 7 items (Nejmi, Wang, Mendoza, Gning, & Cleeland 2002). A Visual Analog Pain Scale was added to the BPI. Chart data included age, gender, medical diagnosis and medications.

**Procedure**

Medical records of clients admitted to the inpatient and outpatient oncology units were screened for inclusion criteria. The treating physician or nurse were asked whether the clients knew of their cancer diagnosis. Eligible clients were approached by the primary investigator and given explanation about the study. An informed consent was obtained then the BPI was administered.

**Results**

The majority of the sample (88%) were married, males (78.7%) and older than 46 years (56%). All clients were medically insured and 84% had at least secondary education. The primary cancer sites were the gastrointestinal tract, pancreas, or liver (29.3%); bladder, testicles or prostate (17.4%); and breast (14.7%); remaining sites included the lungs, retroperitoneum, hematologic
system, and skin. Over half of the sample (50.7%) had metastasis. Two thirds of clients (66.7%) knew about their cancer diagnosis.

The majority of the sample (98.7%) reported having pain other than minor everyday pains, occurring most frequently in the abdomen, back, lower extremities, or a combination of areas. The mean pain rating during the past 24 hours at its worst was 8.42 (SD = 1.33) and at its least 3.10 (SD = 1.56). The mean pain severity on average was 5.30 (SD = 1.66); for pain right now, the mean was 4.22 (SD = 2.00). The interference items had mean ratings ranging between 5.29 and 7.02 (SD = 1.95 to 2.47). All clients reported receiving pain medications, with opioids the most frequently used (46.6%) alone or in combination with other drugs. The majority of clients (78.4%) reported more than 50% pain relief with treatments.

The cultural sensitivity of the Arabic BPI was evaluated by a panel of oncology physicians and nurses, and a pain specialist. The items were rated on a 4-point scale (1 = Not at all culturally sensitive to 4 = very culturally sensitive). The mean rating was 3.8 for all items, suggesting that the tool was culturally sensitive.

The reliability of the Arabic BPI was tested with Cronbach’s alpha coefficient. The values were 0.82 for the severity items and 0.92 for the interference items.

Construct validity was assessed by factor analysis using the principal component method with varimax rotation. The items loaded on two factors, with a structure replicating the dimensions of severity and interference reported in previous studies. Convergent validity was assessed by correlating the mean of the item inquiring about pain now in the Arabic BPI with that of the Visual Analog Scale; Pearson r = 0.680 (p= 0.00)

Correlations between the severity and interference items were positive and significant, with Pearson r values ranging between 0.246-0.569 (p<0.33). A severity scale was created by computing the mean of the severity items and an interference scale from the mean of the interference items. The correlation between the two scales was positive and significant (r = 0.63, p=0.00)

The correlation between pain on average and percent pain relief from treatments was negative as expected, but not statistically significant (Pearson r = -0.187, p = 0.10).
Conclusion

Results of this study support the validity, reliability and cultural sensitivity of the Arabic BPI in the Lebanese culture of oncology clients. This practical tool can thus be used to assess pain and subsequently improve its management in this population.

References


NPIRS/COMCAR – A database to capture both inpatient and community care mental health services activity in Ireland

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Background
The National Psychiatric Inpatient Reporting System (NPIRS) was established in 1963 and collects data on all admissions and discharges to inpatient services nationally. NPIRS is managed and maintained in the Mental Health Research Unit (MHRU) of the Health Research Board (HRB) which provides national and local reports on the data for the health services.

In response to changing patterns of patient care, the HRB developed a Microsoft Access database called COMCAR (COMmunity CARE) in 2003. COMCAR was designed to record activity at community care level, including outpatient clinics, day centres and day hospitals and was implemented on a pilot basis in a number of sites. In 2005, a decision was taken to combine both COMCAR and NPIRS into a single integrated web-based application.

NPIRS/COMCAR
NPIRS/COMCAR will record and report data in real time on mental health activity in both hospital and community care facilities. It is a joint project between the Health Research Board and the Health Service Executive. The system will be implemented in a phased approach and it has been agreed that the pilot phase of the project will take place in Co. Donegal in early 2008.

NPIRS/COMCAR will be a seamless mental health information system which will:

- Record a variety of patient demographic details, such as name, address, sector, age, gender, socio-economic group and GMS status securely and confidentially;
- Record clinical and service provider information, for example diagnostic details, referral source, health professional activity.

End-users of NPIRS/COMCAR will be able to create reports on in-patient facilities, out-patient clinics, day centres and day hospitals activity which can be used for service monitoring, policy and planning, clinical decision making and research purposes. The MHRU will also have access to anonymised national data which can be used for research and analysis.

**References**

The Hidden Curriculum in Post registration Children’s Nursing.

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Background and Context

Messages are emitted to student nurses via the structure, rules and routine of the clinical areas. A large proportion of the messages that the students learn are carried in the hidden curriculum. The hidden curriculum describes the values that are transmitted via the ward culture and environment to students.

Aim of the Study

The aim of the study was to explore the experiences of post registration children’s nursing students in the first clinical placement.

Methodology & Analysis

A hermeneutic phenomenological approach was employed to interpret the experiences of post registration children’s nurses during the first placement. Data was collected on a purposive sample of six students, using unstructured interviews. Thematic content analysis was utilised to produce an interpretation of the nurses’ experience within the first clinical placement.

Summary of Key Findings

The students discussed learning and working in the clinical area as part of the labour force as a rostered member of staff and the messages they received in relation to this. Specific areas discussed within this were:
I am here to learn
Your job is the obs
Unwritten rules

The findings reflect the unwritten rules and routines that the participants learned within the first clinical placement. This shaped their learning for the remainder of the programme. Having considered the findings of the study in the light of available literature related to children’s nursing, implications for nurse practice and education are explored.

Conclusions
It is envisioned that the findings will illuminate this area of nursing education and will contribute to the development of post registration children’s nurse education where a quality clinical learning environment can be pursued.

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Title: An Investigation of Influences on College Choice Decisions of Student Psychiatric Nurses; A Case Study.

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Background and Context: Nurse training in Ireland has gone through a transition from traditional service led and based training to degree programs (Wells, 1999). In the past, access to the nursing profession was based on direct entry through training programs based in individual hospitals approved by An Bord Altranais. The numbers of training places were effectively determined to meet local service needs. Today all nurse training is delivered at third level. Applicants now apply for nurse training through the central applications office the same as any other third level course. Entry is based on the points system. A feature of the new system is that mature students can apply for nurse training; this was not always the case. Under the previous system the number of mature students applying for nursing courses was extremely low.

Aim of the Study: The purpose of this study is to explore and analyse factors that influence college choice within the context of college choice theory and to analyse the significant influences, which inform such factors. The study also analyses the significance of college characteristics in relation to college choice.

Methodology: The subjects of this study included the total population of first year psychiatric students (N=43) in the Waterford Institute of Technology. Individual students were asked to participate and complete a questionnaire based on Chapman’s (1981) model of college choice; data from the questionnaire was then used to develop the topic guide for the focus group interviews. The qualitative element of this study involved the establishment of three focus groups to discuss the quantitative research findings.
The method of data analysis used was Framework Analysis (Ritchie and Spencer 1994).

**Summary:** Results of this study reveal a combination of influences affecting college choice: significant others; college location; cost implication of college choice; college characteristics; quality of information and level of satisfaction with course choice are the main findings of this study.

**References.**


Good quality information and knowledge is essential to improve the population’s health and decrease health inequalities. How to manage such knowledge in an effective and efficient manner has been the subject of much debate in both international and national arenas and was identified as a major theme within the Review of the Public Health Function in Northern Ireland and the Information Strategy in the Republic of Ireland. One of the key elements underpinning the management of public health knowledge is the accessibility of key information to practitioners and decision makers.

In 2006 Ireland and Northern Ireland’s Population Health Observatory (INISPHO), at the Institute of Public Health in Ireland, lead the development of an All-Ireland electronic Health Library (AIeHL) with the aim of providing a rational approach to the management of knowledge resources across the island of Ireland.

The Library consists of a network of interoperable websites. Each member website contains a range of knowledge resources including policy and strategy documents, data (quantitative and qualitative), research reports, details of programmes and interventions, contacts and websites. The AIeHL links these websites and makes it possible to search all the resources held on its member websites via a single search.

To make this approach possible the Library has promoted the use of consistent metadata for classifying all resources including the use of the National Public Health Language (NPHL) – a common public health language which describes the subject of resources.

The initial pilot project for the Library made the following repositories interoperable:

- Archive of Irish Health Publications (Health Services Executive)
- Healthdata (Health Services Executive)
- INISPHO (On-Line) Library (Institute of Public Health in Ireland)
- National Documentation Centre on Drug Use (Health Research Board)
• Wellnet (Investing for Health, Eastern Health and Social Services Board)

Further websites are being systematically added to the Library throughout 2007.

The Library provides a rational approach to the management of knowledge resources across the island of Ireland allowing users to retrieve different types of knowledge resources from a variety of sources in an effective and efficient manner. It also facilitates effective sharing and integration of knowledge and could be used as a successful model for knowledge management in other countries.

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The use of mixed methods to examine the transition experiences and intent to stay of degree graduate nurses

Authors: Ms. Anne-Marie Brady; Prof. Cecily Begley and Prof. Charles Normand. Trinity College Dublin

Background
Recruitment and retention of nurses has been identified as the highest priority managerial issue for research in the Nursing and Midwifery Research Priorities Report (National Council for Nursing and Midwifery, 2005:52). The shortage of nurses is a global problem due, in part, to staff attrition, changing demographics, and enhanced patient survival with chronic illness (Antonazzo, 2003; DOH&C, 2002). Recent transformations in nursing education have placed Irish Nursing in a unique position across Europe as the entire workforce has been converted to degree-based education on entry to practice. In 2006, the first degree graduate nurses entered the health service workforce at a time of unprecedented career choices and these graduates will find themselves with much greater mobility than previous cohorts, should they decide to leave the profession.

Aim
To gain an understanding of the labour supply behaviour of degree graduate nurses, and thus contribute to appropriate health policy planning in relation to retention of an adequate and consistent number of motivated nurses in the Irish Health Service.

Specific objectives
- To identify the employment profiles of new degree graduate nurses
- To ascertain the nature and quality of support given to new graduates on entry to practice and to compare this support across different clinical settings and geographical locations.
- To ascertain the perceived working conditions of degree graduate nurses and how this impacts on their career decisions
- To explore the impact of the experiences of new graduate nurses on entry to nursing practice on their subsequent career expectations and decision-making
- To identify the factors that positively influence new graduate retention and the factors that influence intent to leave

Methodology
The foundation that informs the process of enquiry to be used in this study is pragmatism. Pragmatism is concerned with the outcomes of research more than the methods used. It is practical and orientated to what work best to answer the question at hand.
Pragmatism represents a view of the world that recognizes that they are singular and multiple realities (Creswell, 2007). Mixed method research enables the mixing of qualitative and quantitative approaches throughout the research process (Creswell, 2003). Mixed method research responds to the pressures for outcomes in healthcare but it can also report on the context of those outcomes.

**Research Design**
A concurrent mixed method triangulation mixed method design will be used. Triangulation is a one phase study that will use quantitative and qualitative methods within the same time frame (Creswell, 2003). A quantitative national survey of recent nursing graduates who have made the transition into the nursing workforce will be undertaken to examine the educational preparation, career intentions, employment profiles, employment patterns, professional progress, occupational demands, personal demands, and support during transition from student to staff nurse and to determine the factors that influence the intent of degree graduates to stay in or leave the profession. This will be complemented by qualitative interviews with a sample of registered nurses 9-12 months after entry to practice to examine their experiences on transition into practice particularly in relation to their reactions and support on transition, factors that influence intent to stay and leave and future career expectations. The data will then be integrated in the interpretation phase of the study.

**Ethical Considerations**
This study has full ethical approval from the Ethics Committee of the Faculty of Health Sciences Trinity College.

**Sample**

**National Survey**
The target population is all newly registered nurses entering the general, psychiatric and learning disability divisions of the register in 2007. All new graduates from nursing degree courses across 13 third level institutions engaged in the education of undergraduate nursing students will be invited to participate in the survey six months after entry to practice.

**Interviews**
All participants in the initial survey phase will be invited to participate in the qualitative interviews, and a proportional stratified sampling strategy will be used to select participants for the interviews. The smaller purposive sampling for the qualitative phase of the study is designed to focus on the experiences of new graduates during the first months of practice across all disciplines.
Access to participants
Each participant, following registration, will be contacted through An Bord Altranais sampling service and will be sent a personalised envelope containing a letter of invitation to participate outlining the details of the study, the research instrument and a Freepost envelope.

Pilot study
Exploratory work has been undertaken with a sample of 2006 degree graduate nurses as these will be the cohort with greatest similarity to the new graduates. Pilot questionnaires were administered to a sample of graduates’ representative of 10% (n=150) of the anticipated sample size and across disciplines using the An Bord Altranais sampling strategy to gain access to participants. The responses to date are 25 (response rate of 16%). Eight have volunteered to contact for interview.

Data analysis
Descriptive statistics will be generated to illustrate the characteristics and employment profiles of newly graduated nurses. Inferential statistics will be used to find relationships between variables. T-test and ANOVAs will be used to establish if there are differences between the groups. Multivariate regression analysis will be used to examine and elicit the relative influences on the intent to stay. All qualitative data will be transcribed and subjected to content analysis, coding and thematic analysis.

References

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A Quantitative Comparative, Prospective Study of the Couvade Syndrome in the Male Partners of Pregnant Women within the UK

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Introduction
The Couvade syndrome is an involuntary disorder consisting of psychosomatic symptoms in the male partners of gestational women (Trethowan and Conlon, 1965; Klein, 1991). It occurs mainly in industrialised countries around the globe. However, one case study has reported a Couvade syndrome equivalent in an African-American woman (who was not pregnant) during both of her twin sister’s pregnancies (Budur et al, 2005). The course of symptoms appears to follow a U-shaped pattern over the duration of pregnancy (Schodt, 1989) as they appear in the first trimester, temporarily disappear in the second and reappear in the third trimester. This has been confirmed by the timing of medical consultations (Lipkin and Lamb, 1982; Quill et al, 1984). The symptoms classically cease abruptly at birth or shortly within the postpartum period. Early accounts tended to medicalise the syndrome as a psychosomatic disorder (Trethowan and Conlon, 1965; Trethowan, 1968). Enoch et al (1967) refer to it as an “uncommon psychiatric syndrome”. Despite this, the syndrome does not appear in the nosologies of the DSM-Version 1V, (American Psychiatric Association, 2000) or the International Classification of Diseases: ICD-Version 10, (World Health Organisation, 1993). The reason for this is unclear, but the syndrome is idiopathic and, according to classic definitions, is not specifically related to physical, psychological illnesses or injury. While the somatic symptoms of the syndrome are chronologically connected with pregnancy the fact that they are not associated with disease in the strict sense of the term may cause some to question whether they constitute a syndrome at all? Nevertheless, the syndrome is mentioned in the Dictionary of Medical Syndromes (Magalini and Magalini, 1997), where it is proposed as a neurotic disorder which occurs in men
whose partners are pregnant, usually within the first and third trimesters of pregnancy.

In 1991 Klein argued that the syndrome was a poorly understood phenomenon which still holds true today even among professionals within the realms of medical and antenatal care. Limited knowledge might be explained by problems of definition, inconsistencies in its criteria and the use of multiple and varied measures across studies. Moreover, the fact that the syndrome is an unconsciously and involuntarily determined phenomenon (Klein, 1991; Brennan et al, 2007a) may complicate efforts by physicians to explain it, and attempts by those affected to understand it. Therefore, one could summarise the presumptive definition of the Couvade syndrome as a psychosomatic phenomenon with little or no recognised physiological basis that affects male partners mainly during the first and third trimesters of gestation and disappears early in the postpartum period (Brennan and Marshall-Lucette, 2004).

**Incidence**
The syndrome’s incidence has a wide international variation, and early reports from the U.K. have a wide range of 11-50% (Trethowan and Conlon, 1965; Dickens and Trethowan, 1971). Bogren (1984) found an incidence of 20% in Sweden. In the USA, Clinton (1987) and Brown (1988) reported a much higher incidence of 94-97%. Khanobdee et al (1993) estimated an average incidence of 61% among Thai males; while Tsai and Chen (1997) reported a similar incidence of 68% among Chinese men. The global incidence of the syndrome has also been demonstrated by reports of its presence in France (Sizaret et al 1991), South Africa (Chalmers and Meyer, 1996), Russia (Marilov, 1997) and Serbia (Koić et al, 2004). However, one country where the syndrome has sparsely been reported is Australia (Condon, 1987), which might reflect reluctance to admit such symptoms and be an anathema in what is perceived to be a “macho culture”. Thomas and Upton (2000, p.221) endorse this view when they state...

> “Many men hide the physical symptoms of the syndrome as they may be ashamed to admit them lest this indicate weakness”.

Therefore, the incidence of the syndrome shows a global variability with an overall range of 11-97%, which is a significant proportion of all pregnancies. This provides a good rationale for further investigating the explanatory factors that might account for such variance across countries in particular patterns of healthcare consultation and referral as well as socio-demographic characteristics.
Socio-demographic Factors
The relationship between the syndrome and socio-demographic factors such as age, educational level, social class, number of previous children and planned or unplanned pregnancy all show inconsistent findings with ethnicity being the only exception. Brown (1983) confirmed a greater presence of the syndrome in men younger than thirty years old, while Bogren (1989) found it was more common among those older than thirty of a higher educational level and social class while Munroe and Munroe (1971, 1973); Trethowan in Howells (1972); Lipkin and Lamb (1982) all indicate a greater prevalence of the syndrome among those with lower education. Strickland (1987) reported that working class men experienced a significantly higher number of somatic and psychological symptoms compared to those who were middle class. Clinton (1986) refutes the findings of age and educational level as correlates of the syndrome. Ethnicity consistently shows a higher incidence of the syndrome among black men (Taylor, 1951, Munroe and Munroe, 1971, Munroe et al, 1973, Clinton, 1986). These disparate findings might be explained by problems of sample size variation, cultural and age differences across studies, socio-economic class variability, and geographical distributions.

Theoretical Perspectives
A plethora of theories have been offered to account for the origins of the Couvade Syndrome. Psychoanalytical theories propose that it emanates from the man’s envy of the woman’s procreative ability (Bohem 1930; Van Leeuwen 1965; Osofsky and Culp in Cath et al 1989; and Raphael-Leff, 1991). Another psychoanalytical perspective maintains that pregnancy for the expectant man acts as a catalyst for the emergence of ambivalence and resurgence of Oedipal conflicts (Gerzi and Berman 1981; Osofsky, and Culp in Cath et al 1989). Others propose that the syndrome arises because of the man’s rivalry with his unborn child (Malthie et al 1980; Mayer and Kapfhammer 1993), (Mayer and Kapfhammer in Brahler and Unger 1996). Psychosocial theories argue it occurs as a reactive process to the marginalisation of fatherhood (Clinton, 1986; Mayer and Kapfhammer, 1993). However the feminist perspective rejects this arguing instead for the increased and active participation of men in pregnancy and the birthing process (Clinton 1986; Jordan, 1990; Scopesi and Repetto 1990; Klein 1991; Masoni et al 1994; Polomeno, 1998). Another psychosocial theory proposes that the syndrome is a consequence of men’s transitional crisis to parenthood (Jordan 1990; Imle 1990; Klein 1991; Polomeno, 1998). Paternal Involvement theories argue for a relationship between men’s involvement in the pregnancy, role preparation and the syndrome (Weaver and Cranley 1983; Clinton 1987;

To date only one study by Storey et al (2000) support a biological basis for the syndrome. There is a dearth of studies for many of these theories except those examining the syndrome’s relationship with pregnancy involvement, role preparation and anxiety. Those which have been done demonstrate disparate findings arising mainly from some of the methodological problems mentioned earlier.

**Study Aim**

The aim of the study is to investigate the type, severity and distress and time frame of physical and psychological symptoms of the Couvade syndrome in an experimental group of men with pregnant partners during the first and third trimesters of pregnancy and four weeks into the postpartum period. This group is compared with a control group of men whose partners are not pregnant measured over a 3 and 6-month comparative time periods.

**Study Objectives**

- To compare differences in the type and incidence of physical and psychological symptoms experienced by men with pregnant partners compared to those with non-expectant partners.
- To assess the severity and distress of physical and psychological symptoms experienced by men with pregnant partners compared to those with non-expectant partners.
- To compare the impact of time upon symptom severity and distress for both study groups.
- To assess the relationship between socio-demographic variables with symptom severity and distress.

**Design**

This is the second phase of the study deploying a prospective design (Figure I). The study whilst observing control of variables could not randomly allocate the participants to experimental and control groups for obvious reasons. A number of strengths justify the selection of the design for this phase of the investigation. It is ideally suited to the time requirements of the study spanning over the course of pregnancy and four weeks into the postpartum period. It enables symptoms to be monitored in terms of their presence/absence, levels of severity and distress, and duration and variability over time as opposed to a snapshot view as with a cross-sectional design. Hoskins and Mariano (2004) argue that longitudinal designs enable more realistic variations of the phenomenon being studied across time unlike cross-sectional
designs which study the phenomenon at a single point in time. The selection of comparative time periods for the control group matching those of the 1st and 3rd trimesters in the experimental group allow for the possible impact of time to take place.
Administer Couvade Symptom Questionnaires to Experimental Group (Men with pregnant partners) at different time periods during Pregnancy

**Figure 1. Study Design (2nd Phase)**

**Time 1**  
1st Trimester

**Time 2**  
3rd Trimester

**Time 3**  
4 weeks postpartum

Administer Couvade Symptom Questionnaires to Control Group (Men without pregnant partners) at comparative time periods

**Time 1**  
3-months

**Time 2**  
6-months
Sampling for Experimental Group

Access to the men (Experimental group) was from the Foetal Medicine Unit of a large teaching hospital in London which serves a large Caucasian, Asian and Afro-Caribbean population. Posters outlining the study details were also used and located in the antenatal clinic and the unit itself. Men were also accessed from an Internet website specifically designed for the study to ensure the recruitment of a heterogeneous sample. A total of \( n = 282 \) men agreed to participate. (http://www.geocities.com/pregnancyandfathers/).

Given the limited incidence of the Couvade syndrome within the general UK population and the likelihood of under-recruitment, the use of a non-probability method of sampling was considered appropriate. Inclusion and exclusion criteria were established in keeping with the requirements of convenience sampling (Fowler, 2002) due to a range of physical and psychological conditions which may give rise to similar confounding symptoms, a challenging methodological problem facing past investigators in the area.

The inclusion criteria:
- Over 18 years of age.
- Can read (study information sheet and consent form), and write English at a level suitable for the full understanding and completion of the questionnaires.
- Partner has a confirmed pregnancy for which the recruited person is the biological father.
- Be willing to complete the two questionnaires on three occasions.
- Has 4 or more physical or psychological symptoms associated with the syndrome occurring with the onset of pregnancy.

The exclusion criteria:
- Under 18 years of age.
- Unable to read (study information sheet and consent form), and write English at a level suitable for the full understanding and completion of the questionnaires.
- Receiving current treatment for illnesses that might produce physical symptoms that might give rise to similar symptoms to those of the syndrome, e.g., inflammatory bowel disease, viral infections like chronic fatigue syndrome, herpes, glandular fever, meningitis, thyroid problems, any form of cancer, anaemia or relevant chronic disease.
- Receiving current treatment for any form of mental disorders that might produce psychological symptoms that might give rise to similar symptoms to those of the syndrome, e.g. depression or manic phases of affective disorder, anxiety...
disorders, schizophrenia and other relevant psychoses or neuroses.

- Partner has confirmed medical problems with her pregnancy, e.g., antenatal haemorrhage, foetal/maternal blood group incompatibility gestational diabetes, hypertension, pre-eclampsia or other relevant maternal disorders.

Social classes were classified according to the National Statistics Socio-Economic Classification (NS-SeC, DoH, 2003). An overview of the socio-demographic characteristics of the sample can be found in Table 1.
Table 1. Socio-demographic Characteristics of Experimental Group  
(Men with Pregnant Partners $n = 182$ who responded)

<table>
<thead>
<tr>
<th>Category</th>
<th>Study Population $(n)$</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-25</td>
<td>8</td>
<td>44%</td>
</tr>
<tr>
<td>26-32</td>
<td>64</td>
<td>35.2%</td>
</tr>
<tr>
<td>33-39</td>
<td>72</td>
<td>39.6%</td>
</tr>
<tr>
<td>40-46</td>
<td>31</td>
<td>17.0%</td>
</tr>
<tr>
<td>47-55</td>
<td>7</td>
<td>3.8%</td>
</tr>
<tr>
<td><strong>Social Class</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class I (Professional)</td>
<td>29</td>
<td>15.9%</td>
</tr>
<tr>
<td>Class II (Intermediate)</td>
<td>73</td>
<td>40.1%</td>
</tr>
<tr>
<td>Class III (Non-manual / Skilled)</td>
<td>28</td>
<td>15.5%</td>
</tr>
<tr>
<td>Class IV (Manual / Skilled)</td>
<td>15</td>
<td>8.2%</td>
</tr>
<tr>
<td>Class V (Unskilled Manual)</td>
<td>33</td>
<td>18.1%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>142</td>
<td>78%</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>40</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Number of previous children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>137</td>
<td>75.3%</td>
</tr>
<tr>
<td>1</td>
<td>29</td>
<td>15.9%</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>5.5%</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>2.2%</td>
</tr>
<tr>
<td>&gt;3</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Ethnic group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>111</td>
<td>61%</td>
</tr>
<tr>
<td>Black African</td>
<td>13</td>
<td>7.1%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>15</td>
<td>8.2%</td>
</tr>
<tr>
<td>Black other</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>39</td>
<td>21.5%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
Sampling for Control Group

Access to the men (Control group) was from two higher educational institutions in London and Surrey using the same sampling method as that for the experimental group. A total of $n=230$ men agreed to participate. An overview of the socio-demographic characteristics of the sample can be found in Table 2.
Table 2. Socio-demographic Characteristics of Control Group (Men without Pregnant Partners $n=181$ who responded)

<table>
<thead>
<tr>
<th>Category</th>
<th>Study Population ($n$)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-25</td>
<td>29</td>
<td>16.1%</td>
</tr>
<tr>
<td>26-32</td>
<td>47</td>
<td>26.0%</td>
</tr>
<tr>
<td>33-39</td>
<td>44</td>
<td>24.4%</td>
</tr>
<tr>
<td>40-46</td>
<td>28</td>
<td>15.5%</td>
</tr>
<tr>
<td>47-55</td>
<td>21</td>
<td>11.8%</td>
</tr>
<tr>
<td>56-64</td>
<td>11</td>
<td>6.2%</td>
</tr>
<tr>
<td><strong>Social Class</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class I (Professional)</td>
<td>6</td>
<td>3.3%</td>
</tr>
<tr>
<td>Class II (Intermediate)</td>
<td>24</td>
<td>13.3%</td>
</tr>
<tr>
<td>Class III (Non-manual / Skilled)</td>
<td>35</td>
<td>19.3%</td>
</tr>
<tr>
<td>Class IV (Manual / Skilled)</td>
<td>36</td>
<td>19.9%</td>
</tr>
<tr>
<td>Class V (Unskilled Manual)</td>
<td>80</td>
<td>44.2%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>81</td>
<td>44.8%</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>33</td>
<td>18.2%</td>
</tr>
<tr>
<td>Single</td>
<td>67</td>
<td>37%</td>
</tr>
<tr>
<td><strong>Number of previous children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>132</td>
<td>72.9%</td>
</tr>
<tr>
<td>1</td>
<td>20</td>
<td>11.0%</td>
</tr>
<tr>
<td>2</td>
<td>23</td>
<td>12.7%</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>2.8%</td>
</tr>
<tr>
<td>&gt;3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ethnic group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>103</td>
<td>56.9%</td>
</tr>
<tr>
<td>Black African</td>
<td>62</td>
<td>34.3%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>14</td>
<td>7.7%</td>
</tr>
<tr>
<td>Black other</td>
<td>2</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
Ethical Considerations

Seeking Permission, Consent and upholding the Principle of Volunteerism
Permission for the study was obtained from the Local Research Ethics Committee for those in the experimental group and the Student Research Ethics Committee at the higher educational institutions for those in the control group. The researcher approached those in the experimental group when they attended for scanning information sessions on the Foetal medicine Unit with their pregnant partners around the 11th week of gestation. They were provided with details of the study and assured that their decision to participate/not participate or opt of the study at anytime without giving reasons for doing so would not affect the subsequent care that they and their pregnant partner’s received. Those who indicated their interest and satisfied the study entry criteria were invited to participate. The men in both groups were sent a study information pack. This consisted of a covering letter, a study information sheet, consent form, demographic details questionnaire, three copies of Men’s Health during Partner’s Pregnancy Questionnaire (but entitled differently for the control group: “Men’s Health Questionnaire”) as well as three stamped addressed return envelopes.

Persevering Anonymity and Confidentially
Anonymity was preserved in the questionnaires with each participant being assigned an identification code and whose actual name was only known to the researcher for the purpose of follow-up. Strict confidentiality was maintained as all forms of data were saved on a computer protected by a security password. Hard copies of the questionnaires and other documents relating to the study were stored in a locked cupboard in a secure room. Data was kept for a period of three years for the purpose of secondary analysis and with the intention of disposing of it in a safe manner thereafter.

Maintaining Beneficence and Non-malevolence
The benefits of the study were outlined to both groups. The lack of contemporary research in the UK was explained which prompts the study to be done and that participants could, if they wish, make a valuable contribution in redressing this. Another obvious benefit for those in the experimental group is raising awareness of men’s health needs in antenatal care. This was important for men in their supportive role as their concerns and anxieties may if acknowledged might positively affect the pregnancy outcome for their partners. For those in the control group the benefits of entering into the study were also outlined and included serving as a comparative group to support the existence of symptoms in men and those which are not
related that would occur in the general population in any case. Additional benefits of their inclusion would allow the impact of time in relation to symptoms in the experimental group to be assessed more accurately, strengthening of the research design and contributions to the body of knowledge in the area which was previously lacking.

The researcher was mindful that completing psychological questionnaires concerning psycho-physiological symptoms might be distressing for some respondents given their severity and distress at the time when they were experienced (O’Donohue and Ferguson, 2003). In these cases participants would be offered the opportunity to opt out of the study and in the case of men with pregnant partners, referral to an antenatal councillor if they so wished.

**Data Collection**

**Men’s Health during Partner’s Pregnancy Questionnaire**

The first questionnaire was developed from the interviews in the first qualitative phase of the study (Brennan et al 2007b). It measured the specific physical and psychological symptoms of the syndrome across the trimesters of pregnancy as well as their severity and distress and time course. The same questionnaire was also used for the control group and entitled ‘Men’s Health Questionnaire’. The study instrument contains a total of 44 items covering physical symptoms including gastrointestinal (10), respiratory (5), genitourinary (2), dental/oral (3), musculo-skeletal (2), miscellaneous (5). Psychological symptoms included those relating to sleep (3), mood (2), emotional affect (6), cognition (3), miscellaneous (3). No reversal of scores was required for the study instrument. The questionnaire is scored nominally for the presence (yes) or absence (no) for each symptom and numerically on a scale of 1-9 for the three descriptors of levels of symptom severity and distress (1-3 not at all severe/distressing; 4-6 moderately severe/distressing and 7-9 extremely severe/distressing). The term “distress” in this context is defined by the American Psychiatric Association (2004, p.9) as “a state of discomfort resulting from an inability to adapt to internal or external stressors or conditions experienced, resulting in negative affects on the health of the individual”. The duration of each symptom is rated on a sub-scale ranging from 1 day to more than 28 days. The questionnaire was administered to men in the experimental group during the 1st and 3rd trimesters of gestation and four weeks postpartum. For the control group it was administered at 3 and 6-month comparative time periods which matched those in the experimental group during the 1st and 3rd trimesters of pregnancy.

This questionnaire was piloted among a sample of 23 male partners of pregnant women and subjected to a test of internal consistency...
(Cronbach Alpha Reliability Coefficient), Spearman’s Rank Correlation Coefficient test and re-test and Paired sample t-test and re-test measures over a 3-week time period). The Cronbach Alpha Coefficient of Reliability for the total scale was 0.89. However, 5 physical and 4 psychological symptoms showed an α coefficient of <0.70 which was below the accepted minimum and were subsequently removed from the questionnaire. Spearman’s correlation coefficients between the test re-test periods were excellent with r-values for the severity and distress of physical symptoms falling within the range of 0.98-0.99 and those for psychological symptoms falling within the range of 0.92-0.99. P-values were highly significant within the range of 0.002 and 0.001 with the majority being of the latter. Test re-test paired sample t-tests for the severity and distress of all symptoms showed no statistically significant differences between the two test periods.

**Response Rates**

Response rates for those in the experimental group varied according to trimester and were most likely influenced by the level of commitment required for the study (i.e. completion of 6 questionnaires over the study time periods). Of the 282 men in the experimental group, 65% responded in the 1st Trimester, 61% in the 2nd Trimester and 58% in the postpartum period. Those in the control group numbering 230 men showed a higher rate of response by comparison with 79% responding at 3-months falling to 70.4 at 6-months. The higher response rates in this group may be explained by fact that they were recruited from two university institutions and were more highly educated.

**Method of Analysis**

Data was analysed using the Statistical Package for Social Scientists (SPSS-Version 12.5 for Windows). Descriptive statistics was used to summarise the percentage of symptoms within the study groups. Chi-square tests were performed to examine differences in the incidence of symptoms between the groups. Independent sample t-tests were used to compare differences in the mean severity and distress scores for symptoms between the groups. Spearman’s rank correlation coefficient tests assessed correlations between selected demographic variables such as age, social class and previous number of children with symptom severity and distress scores. Inter and intra variability of the mean severity and distress scores for physical and psychological symptoms over time in the experimental and control groups were analysed using One-way Analysis of Variance (ANOVA).
Results

Group I: Physical and psychological symptoms of statistically higher incidence (Table 3) and mean severity and distress scores in experimental group compared to control group (Tables 4, 5)
Table 3: Chi-square test indicating higher incidence of physical and psychological symptoms in experimental group

<table>
<thead>
<tr>
<th>Physical</th>
<th>Incidence</th>
<th>Chi-square test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach pains/cramps</td>
<td>P=0.01</td>
<td></td>
</tr>
<tr>
<td>Stomach distension</td>
<td>P=0.001</td>
<td></td>
</tr>
<tr>
<td>Unable to keep food down</td>
<td>P=0.001</td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td>P=0.001</td>
<td></td>
</tr>
<tr>
<td>Poor appetite</td>
<td>P=0.01</td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td>P=0.02</td>
<td></td>
</tr>
<tr>
<td>Pain while urinating</td>
<td>P=0.01</td>
<td></td>
</tr>
<tr>
<td>Urinating more than usual</td>
<td>P=0.01</td>
<td></td>
</tr>
<tr>
<td>Toothache</td>
<td>P=0.01</td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td>P=0.05</td>
<td></td>
</tr>
<tr>
<td>Leg cramps</td>
<td>P=0.01</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological</th>
<th>Incidence</th>
<th>Chi-square test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping less than usual</td>
<td>P=0.001</td>
<td></td>
</tr>
<tr>
<td>Early morning waking</td>
<td>P=0.05</td>
<td></td>
</tr>
<tr>
<td>Feeling low in mood</td>
<td>P=0.05</td>
<td></td>
</tr>
<tr>
<td>Feeling annoyed</td>
<td>P=0.05</td>
<td></td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>P=0.05</td>
<td></td>
</tr>
<tr>
<td>Feeling anxious</td>
<td>P=0.03</td>
<td></td>
</tr>
<tr>
<td>Feeling preoccupied</td>
<td>P=0.05</td>
<td></td>
</tr>
<tr>
<td>Loss of concentration</td>
<td>P=0.01</td>
<td></td>
</tr>
<tr>
<td>Feeling distracted</td>
<td>P=0.04</td>
<td></td>
</tr>
<tr>
<td>Unable to cope with daily life</td>
<td>P=0.01</td>
<td></td>
</tr>
</tbody>
</table>
Table 4. Independent Sample t-test Showing Statistically Higher Mean Values for Group I Physical Symptoms Severity and Distress Scores in Experimental Group compared to Control Group

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Score</th>
<th>P-Value</th>
<th>Mean Distress Score</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach pain/cramps</td>
<td>2.6</td>
<td>1.5</td>
<td>0.001</td>
<td>2.4</td>
</tr>
<tr>
<td>Stomach distension</td>
<td>2.4</td>
<td>1.2</td>
<td>0.001</td>
<td>2.2</td>
</tr>
<tr>
<td>Unable to keep food down</td>
<td>1.5</td>
<td>1.1</td>
<td>0.01</td>
<td>1.5</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1.8</td>
<td>1.1</td>
<td>0.001</td>
<td>1.8</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>1.7</td>
<td>1.2</td>
<td>0.001</td>
<td>1.5</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1.8</td>
<td>1.2</td>
<td>0.001</td>
<td>1.5</td>
</tr>
<tr>
<td>Pain while urinating</td>
<td>1.5</td>
<td>1.0</td>
<td>0.02</td>
<td>1.6</td>
</tr>
<tr>
<td>Urinating more than usual</td>
<td>2.1</td>
<td>1.2</td>
<td>0.001</td>
<td>1.8</td>
</tr>
<tr>
<td>Toothache</td>
<td>2.3</td>
<td>1.4</td>
<td>0.001</td>
<td>2.2</td>
</tr>
<tr>
<td>Back pain</td>
<td>2.6</td>
<td>1.6</td>
<td>0.001</td>
<td>2.4</td>
</tr>
<tr>
<td>Leg cramps</td>
<td>2.2</td>
<td>1.2</td>
<td>0.001</td>
<td>2.1</td>
</tr>
</tbody>
</table>
### Table 5. Independent Sample t-test Showing Statistically Higher Mean Values for Group I Psychological Symptoms Severity and Distress Scores in Experimental Group compared to Control Group

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Score</th>
<th>P-Value</th>
<th>Mean Distress Score</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
</tr>
<tr>
<td>Sleeping less than usual</td>
<td>4.0</td>
<td>1.9</td>
<td>0.001</td>
<td>3.1</td>
</tr>
<tr>
<td>Early morning waking</td>
<td>3.0</td>
<td>1.9</td>
<td>0.02</td>
<td>2.5</td>
</tr>
<tr>
<td>Feeling low in mood</td>
<td>2.7</td>
<td>1.5</td>
<td>0.007</td>
<td>2.5</td>
</tr>
<tr>
<td>Feeling annoyed</td>
<td>2.6</td>
<td>1.7</td>
<td>0.01</td>
<td>2.3</td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>3.1</td>
<td>1.7</td>
<td>0.01</td>
<td>2.7</td>
</tr>
<tr>
<td>Feeling anxious</td>
<td>3.0</td>
<td>1.9</td>
<td>0.02</td>
<td>2.6</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>1.9</td>
<td>1.4</td>
<td>0.05</td>
<td>1.7</td>
</tr>
<tr>
<td>Loss of Concentration</td>
<td>2.4</td>
<td>1.3</td>
<td>0.005</td>
<td>2.1</td>
</tr>
<tr>
<td>Distracted</td>
<td>1.7</td>
<td>1.3</td>
<td>0.05</td>
<td>1.6</td>
</tr>
<tr>
<td>Unable to cope with daily life</td>
<td>1.4</td>
<td>1.1</td>
<td>0.05</td>
<td>1.4</td>
</tr>
</tbody>
</table>
Group II: Physical and psychological symptoms of similar incidence but statistically higher mean severity and distress scores in experimental group compared to control group (Tables 6, 7)

**Physical**

- Heartburn
- Indigestion
- Increased appetite
- Weight gain
- Breathlessness
- Tiredness

**Psychological**

- Mood swings
- Feeling frustrated
- Feeling stressed
- Lack of motivation
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Score</th>
<th>P-Value</th>
<th>Mean Distress Score</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental (n=282)</td>
<td></td>
<td>Control (n=230)</td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td>2.1</td>
<td>0.001</td>
<td>1.9</td>
<td>0.02</td>
</tr>
<tr>
<td>Indigestion</td>
<td>2.0</td>
<td>0.01</td>
<td>1.9</td>
<td>0.01</td>
</tr>
<tr>
<td>Increased</td>
<td>1.9</td>
<td>0.01</td>
<td>1.5</td>
<td>0.05</td>
</tr>
<tr>
<td>Appetite</td>
<td>1.9</td>
<td>0.001</td>
<td>1.5</td>
<td>0.05</td>
</tr>
<tr>
<td>Weight gain</td>
<td>2.2</td>
<td>0.001</td>
<td>1.9</td>
<td>0.05</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>1.5</td>
<td>0.05</td>
<td>1.4</td>
<td>0.05</td>
</tr>
<tr>
<td>Tiredness</td>
<td>4.0</td>
<td>0.001</td>
<td>3.0</td>
<td>0.01</td>
</tr>
</tbody>
</table>
Table 7. Independent Sample t-test Showing Statistically Higher Mean Values for Group II Psychological Symptoms Severity and Distress Scores in Experimental Group compared to Control Group

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Score</th>
<th>P-Value</th>
<th>Mean Distress Score</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
</tr>
<tr>
<td>Mood swings</td>
<td>1.5</td>
<td>1.2</td>
<td>0.05</td>
<td>1.5</td>
</tr>
<tr>
<td>Feeling frustrated</td>
<td>2.4</td>
<td>1.8</td>
<td>0.02</td>
<td>2.1</td>
</tr>
<tr>
<td>Feeling stressed</td>
<td>3.8</td>
<td>2.5</td>
<td>0.01</td>
<td>3.4</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>2.1</td>
<td>1.5</td>
<td>0.01</td>
<td>1.9</td>
</tr>
</tbody>
</table>
Group III: Physical and psychological symptoms of similar incidence, mean severity and distress scores in experimental and control groups (Tables 8, 9)

**Physical**

- Constipation
- Feeling restless
- Sore throat
- Nosebleeds
- Sore gums
- Mouth ulcers
- Headache
- Fainting

**Psychological**

- Sleeping more than usual
- Feeling restless
- Loss of memory
### Table 8. Independent Sample t-test Showing Similar Mean Values for Group III Physical Symptoms Severity and Distress Scores in Experimental Group and Control Group

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Score</th>
<th>P-Value</th>
<th>Mean Distress Score</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
</tr>
<tr>
<td>Constipation</td>
<td>1.6</td>
<td>1.3</td>
<td>NS</td>
<td>1.3</td>
</tr>
<tr>
<td>More colds than usual</td>
<td>1.4</td>
<td>1.3</td>
<td>NS</td>
<td>1.4</td>
</tr>
<tr>
<td>Sore throat</td>
<td>1.5</td>
<td>1.6</td>
<td>NS</td>
<td>1.4</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>1.1</td>
<td>1.0</td>
<td>NS</td>
<td>1.1</td>
</tr>
<tr>
<td>Sore gums</td>
<td>1.3</td>
<td>1.2</td>
<td>NS</td>
<td>1.2</td>
</tr>
<tr>
<td>Mouth ulcers</td>
<td>1.3</td>
<td>1.3</td>
<td>NS</td>
<td>1.3</td>
</tr>
<tr>
<td>Headache</td>
<td>1.9</td>
<td>2.0</td>
<td>NS</td>
<td>1.8</td>
</tr>
<tr>
<td>Fainting</td>
<td>1.1</td>
<td>1.0</td>
<td>NS</td>
<td>1.1</td>
</tr>
</tbody>
</table>
Table 9. Independent Sample $t$-test Showing Similar Mean Values for Group III Psychological Symptoms Severity and Distress Scores in Experimental Group and Control Group

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Score</th>
<th>P-Value</th>
<th>Mean Distress Score</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental ($n=282$)</td>
<td>Control ($n=230$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping more than usual</td>
<td>1.2</td>
<td>1.1</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Feeling restless</td>
<td>1.6</td>
<td>1.4</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Loss of memory</td>
<td>1.2</td>
<td>1.2</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>1.0</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>1.3</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>1.2</td>
<td>NS</td>
<td></td>
</tr>
</tbody>
</table>
Group IV: Other symptoms of similar incidence but varied mean severity and distress scores between the experimental and control groups (Table 10)

**Physical**

- Diarrhoea
- Cough
Table 10. Group IV Physical Symptoms: Independent Sample t-test showing similar Mean Scores for Severity but Statistically Higher Mean Distress Scores for Diarrhoea and Lower Mean Severity Scores but Similar Mean Distress Scores for Cough in Experimental Group compared to Control Group

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Score</th>
<th>P-Value</th>
<th>Mean Distress Score</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental (n=282)</td>
<td>Control (n=230)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>1.6</td>
<td>1.4</td>
<td>NS</td>
<td>1.6</td>
</tr>
<tr>
<td>Cough</td>
<td>1.3</td>
<td>1.6</td>
<td>0.05</td>
<td>1.3</td>
</tr>
</tbody>
</table>
The Impact of Time upon the Severity and Distress Scores of Group I Symptoms

One-way ANOVA reveals statistically significant differences in the increase for severity and distress scores for the majority of physical (Tables 11, 12) and psychological symptoms (Tables 13, 14) between the 1st and 3rd trimesters of pregnancy for those in the experimental group. Between the 3rd trimester of pregnancy and the postpartum period the severity scores for physical symptoms show a significant decrease except for “poor appetite” which is non-significant. The severity and distress scores for psychological symptoms show a similar trend except for two symptoms “sleeping less than usual” and “early morning waking” which show a statistically significant increase over this period. Four symptoms show no statistically significant differences here.

By contrast in the control group, one-way ANOVA of the severity and distress scores for both physical (Tables 15, 16) and psychological symptoms (Tables 17, 18) between 3 and 6-month comparative time periods are not statistically significant: severity and distress of physical symptoms). The only exception is the symptom of “toothache” which reveals a significant decrease at the 6 month compared to the 3-month period.
Table 11. One-way Analysis of Variance of Group I Physical Symptoms
Mean Severity Scores in Experimental Group over the 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>1\textsuperscript{st} Trimester</th>
<th>3\textsuperscript{rd} Trimester</th>
<th>Postpartum</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach pain/cramps</td>
<td>2.81</td>
<td>3.68</td>
<td>1.16</td>
<td>0.001</td>
</tr>
<tr>
<td>Stomach distension</td>
<td>2.61</td>
<td>3.40</td>
<td>1.13</td>
<td>0.001</td>
</tr>
<tr>
<td>Unable to keep food down</td>
<td>1.55</td>
<td>1.93</td>
<td>*</td>
<td>0.001</td>
</tr>
<tr>
<td>Vomiting</td>
<td>2.03</td>
<td>2.37</td>
<td>*</td>
<td>0.001</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>2.02</td>
<td>2.07</td>
<td>1.25</td>
<td>0.001</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1.84</td>
<td>2.14</td>
<td>1.23</td>
<td>0.001</td>
</tr>
<tr>
<td>Urinating more than usual</td>
<td>2.19</td>
<td>2.83</td>
<td>1.10</td>
<td>0.001</td>
</tr>
<tr>
<td>Toothache</td>
<td>2.58</td>
<td>3.15</td>
<td>1.11</td>
<td>0.001</td>
</tr>
<tr>
<td>Back pain</td>
<td>2.92</td>
<td>3.43</td>
<td>1.30</td>
<td>0.001</td>
</tr>
<tr>
<td>Leg cramps</td>
<td>2.44</td>
<td>2.91</td>
<td>1.04</td>
<td>0.001</td>
</tr>
</tbody>
</table>

* Insufficient reporting of symptoms does not allow for statistical analysis in the postpartum period
Table 12. One-way Analysis of Variance of Group I Physical Symptoms
Mean Distress Scores in Experimental Group over 1st, 3rd Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Trimester</td>
<td>3rd Trimester</td>
</tr>
<tr>
<td>Stomach pain/cramps</td>
<td>2.82</td>
<td>3.31</td>
</tr>
<tr>
<td>Stomach distension</td>
<td>2.40</td>
<td>3.03</td>
</tr>
<tr>
<td>Unable to keep food down</td>
<td>1.57</td>
<td>1.90</td>
</tr>
<tr>
<td>Vomiting</td>
<td>2.12</td>
<td>2.26</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>1.64</td>
<td>1.70</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1.52</td>
<td>1.68</td>
</tr>
<tr>
<td>Urinating more than usual</td>
<td>1.95</td>
<td>2.40</td>
</tr>
<tr>
<td>Toothache</td>
<td>2.57</td>
<td>3.00</td>
</tr>
<tr>
<td>Back pain</td>
<td>2.89</td>
<td>3.12</td>
</tr>
<tr>
<td>Leg cramps</td>
<td>2.44</td>
<td>2.73</td>
</tr>
</tbody>
</table>

* Insufficient reporting of symptoms does not allow for statistical analysis in the postpartum period
### Table 13. One-way Analysis of Variance of Group I Psychological Symptoms Mean Severity Scores in Experimental Group over 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>1\textsuperscript{st} Trimester</th>
<th>3\textsuperscript{rd} Trimester</th>
<th>Postpartum</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping less than usual</td>
<td>2.80</td>
<td>3.95</td>
<td>5.29</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>Early morning waking</td>
<td>2.65</td>
<td>2.80</td>
<td>3.63</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>Feeling low in mood</td>
<td>2.41</td>
<td>3.00</td>
<td>2.65</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Feeling annoyed</td>
<td>2.37</td>
<td>2.92</td>
<td>2.43</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>2.60</td>
<td>3.38</td>
<td>3.21</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Feeling anxious</td>
<td>2.56</td>
<td>3.35</td>
<td>3.07</td>
<td>0.002</td>
<td></td>
</tr>
<tr>
<td>Preoccupied</td>
<td>1.98</td>
<td>2.38</td>
<td>1.27</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Loss of concentration</td>
<td>2.31</td>
<td>2.81</td>
<td>1.92</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>Distracted</td>
<td>1.87</td>
<td>2.05</td>
<td>1.17</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Unable to cope with daily life</td>
<td>1.38</td>
<td>1.51</td>
<td>1.45</td>
<td>NS</td>
<td></td>
</tr>
</tbody>
</table>
Table 14. One-way Analysis of Variance of Group I Psychological Symptoms Mean Distress Scores in Experimental Group over 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1\textsuperscript{st} Trimester</td>
<td>3\textsuperscript{rd} Trimester</td>
</tr>
<tr>
<td>Sleeping less than usual</td>
<td>2.80</td>
<td>3.95</td>
</tr>
<tr>
<td>Early morning waking</td>
<td>2.65</td>
<td>2.80</td>
</tr>
<tr>
<td>Feeling low in mood</td>
<td>2.41</td>
<td>3.00</td>
</tr>
<tr>
<td>Feeling annoyed</td>
<td>2.37</td>
<td>2.92</td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>2.60</td>
<td>3.38</td>
</tr>
<tr>
<td>Feeling anxious</td>
<td>2.56</td>
<td>3.35</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>1.98</td>
<td>2.38</td>
</tr>
<tr>
<td>Loss of concentration</td>
<td>2.31</td>
<td>2.81</td>
</tr>
<tr>
<td>Distracted</td>
<td>1.87</td>
<td>2.05</td>
</tr>
<tr>
<td>Unable to cope with daily life</td>
<td>1.38</td>
<td>1.51</td>
</tr>
</tbody>
</table>
Table 15. One-way Analysis of Variance of Group I Physical Symptoms
Mean Severity Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Stomach pain/cramps</td>
<td>1.45</td>
<td>1.47</td>
</tr>
<tr>
<td>Stomach distension</td>
<td>1.22</td>
<td>1.19</td>
</tr>
<tr>
<td>Unable to keep food down</td>
<td>1.09</td>
<td>1.09</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1.14</td>
<td>1.12</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>1.23</td>
<td>1.20</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1.17</td>
<td>1.15</td>
</tr>
<tr>
<td>Pain while urinating</td>
<td>1.02</td>
<td>1.04</td>
</tr>
<tr>
<td>Urinating more than usual</td>
<td>1.17</td>
<td>1.18</td>
</tr>
<tr>
<td>Toothache</td>
<td>1.46</td>
<td>1.25</td>
</tr>
<tr>
<td>Back pain</td>
<td>1.55</td>
<td>1.61</td>
</tr>
<tr>
<td>Leg cramps</td>
<td>1.21</td>
<td>1.14</td>
</tr>
</tbody>
</table>
### Table 16. One-way Analysis of Variance of Group I Physical Symptoms

**Mean Distress Scores in Control Group over 3 and 6-Month Time Periods**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Stomach pain/cramps</td>
<td>1.36</td>
<td>1.32</td>
</tr>
<tr>
<td>Stomach distension</td>
<td>1.25</td>
<td>1.16</td>
</tr>
<tr>
<td>Unable to keep food down</td>
<td>1.10</td>
<td>1.09</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1.17</td>
<td>1.14</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>1.09</td>
<td>1.06</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1.07</td>
<td>1.01</td>
</tr>
<tr>
<td>Pain while urinating</td>
<td>1.01</td>
<td>1.03</td>
</tr>
<tr>
<td>Urinating more than usual</td>
<td>1.14</td>
<td>1.15</td>
</tr>
<tr>
<td>Toothache</td>
<td>1.36</td>
<td>1.18</td>
</tr>
<tr>
<td>Back pain</td>
<td>1.39</td>
<td>1.50</td>
</tr>
<tr>
<td>Leg cramps</td>
<td>1.14</td>
<td>1.13</td>
</tr>
</tbody>
</table>
### Table 17. One-way Analysis of Variance of Group I Psychological Symptoms Mean Severity Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Sleeping less than usual</td>
<td>1.88</td>
<td>1.81</td>
</tr>
<tr>
<td>Early morning waking</td>
<td>1.76</td>
<td>1.87</td>
</tr>
<tr>
<td>Feeling low in mood</td>
<td>1.59</td>
<td>1.46</td>
</tr>
<tr>
<td>Feeling annoyed</td>
<td>1.74</td>
<td>1.64</td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>1.75</td>
<td>1.73</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>1.40</td>
<td>1.40</td>
</tr>
<tr>
<td>Loss of concentration</td>
<td>1.37</td>
<td>1.23</td>
</tr>
<tr>
<td>Distracted</td>
<td>1.35</td>
<td>1.22</td>
</tr>
<tr>
<td>Unable to cope with daily life</td>
<td>1.07</td>
<td>1.11</td>
</tr>
</tbody>
</table>
Table 18. One-way Analysis of Variance of Group I Psychological Symptoms Mean Distress Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Sleeping less than usual</td>
<td>1.66</td>
<td>1.70</td>
</tr>
<tr>
<td>Early morning waking</td>
<td>1.50</td>
<td>1.59</td>
</tr>
<tr>
<td>Feeling low in mood</td>
<td>1.56</td>
<td>1.42</td>
</tr>
<tr>
<td>Feeling annoyed</td>
<td>1.50</td>
<td>1.61</td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>1.58</td>
<td>1.66</td>
</tr>
<tr>
<td>Feeling anxious</td>
<td>1.71</td>
<td>1.71</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>1.29</td>
<td>1.32</td>
</tr>
<tr>
<td>Loss of concentration</td>
<td>1.35</td>
<td>1.25</td>
</tr>
<tr>
<td>Distracted</td>
<td>1.29</td>
<td>1.19</td>
</tr>
<tr>
<td>Unable to cope with daily life</td>
<td>1.06</td>
<td>1.09</td>
</tr>
</tbody>
</table>
The Impact of Time upon the Severity and Distress Scores of Group II Symptoms

One-way ANOVA shows statistically significant differences in the increase of severity and distress scores for all this group of physical symptoms over the 1\textsuperscript{st} and 3\textsuperscript{rd} trimesters of pregnancy (Tables 19, 20). However, in the postpartum period the severity and distress scores for the majority of physical symptoms reveals a significant decrease with the exception of “tiredness” which continued to increase. There is a significant increase in severity and distress of scores of psychological symptoms (Tables 21, 22) during the 1\textsuperscript{st} and 3\textsuperscript{rd} trimesters of pregnancy. Only one symptom “mood swings” severity shows no statistically significant difference over time here.

By contrast in the control group one-way ANOVA of the severity and distress scores for both physical (Tables 23, 24) and psychological symptoms (Tables 25, 26) show no statistically significant differences over 3 and 6- monthly time periods.
Table 19. One-way Analysis of Variance of Group II Physical Symptoms
Mean Severity Scores in Experimental Group over the 1<sup>st</sup>, 3<sup>rd</sup> Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th></th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1&lt;sup&gt;st&lt;/sup&gt; Trimester</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; Trimester</td>
<td>Postpartum</td>
</tr>
<tr>
<td>Heartburn</td>
<td>2.23</td>
<td>2.68</td>
<td>1.20</td>
</tr>
<tr>
<td>Indigestion</td>
<td>2.20</td>
<td>2.58</td>
<td>1.27</td>
</tr>
<tr>
<td>Increased appetite</td>
<td>1.96</td>
<td>2.65</td>
<td>1.16</td>
</tr>
<tr>
<td>Weight gain</td>
<td>2.12</td>
<td>3.16</td>
<td>1.28</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>1.57</td>
<td>1.78</td>
<td>1.05</td>
</tr>
<tr>
<td>Tiredness</td>
<td>3.12</td>
<td>4.30</td>
<td>4.59</td>
</tr>
</tbody>
</table>
Table 20. One-way Analysis of Variance of Group II Physical Symptoms
Mean Distress Scores in Experimental Group over 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1\textsuperscript{st} Trimester</td>
<td>3\textsuperscript{rd} Trimester</td>
</tr>
<tr>
<td>Heartburn</td>
<td>2.11</td>
<td>2.40</td>
</tr>
<tr>
<td>Indigestion</td>
<td>2.05</td>
<td>2.29</td>
</tr>
<tr>
<td>Increased appetite</td>
<td>1.49</td>
<td>1.84</td>
</tr>
<tr>
<td>Weight gain</td>
<td>1.88</td>
<td>2.47</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>1.55</td>
<td>1.74</td>
</tr>
<tr>
<td>Tiredness</td>
<td>2.60</td>
<td>3.25</td>
</tr>
</tbody>
</table>
### Table 21. One-way Analysis of Variance of Group II Psychological Symptoms Mean Severity Scores in Experimental Group over 1st, 3rd Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Trimester</td>
<td>3rd Trimester</td>
</tr>
<tr>
<td>Mood swings</td>
<td>1.57</td>
<td>1.68</td>
</tr>
<tr>
<td>Feeling frustrated</td>
<td>2.43</td>
<td>3.23</td>
</tr>
<tr>
<td>Feeling stressed</td>
<td>2.87</td>
<td>4.09</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>2.15</td>
<td>2.41</td>
</tr>
</tbody>
</table>
Table 22. One-way Analysis of Variance of Group II Psychological Symptoms Mean Distress Scores in Experimental Group over 1st, 3rd Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Trimester</td>
<td>3rd Trimester</td>
</tr>
<tr>
<td>Mood swings</td>
<td>1.62</td>
<td>1.62</td>
</tr>
<tr>
<td>Feeling frustrated</td>
<td>2.17</td>
<td>2.69</td>
</tr>
<tr>
<td>Feeling stressed</td>
<td>2.60</td>
<td>3.71</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>1.92</td>
<td>3.71</td>
</tr>
</tbody>
</table>
### Table 23. One-way Analysis of Variance of Group II Physical Symptoms

Mean Severity Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Heartburn</td>
<td>1.56</td>
<td>1.69</td>
</tr>
<tr>
<td>Indigestion</td>
<td>1.57</td>
<td>1.64</td>
</tr>
<tr>
<td>Increased</td>
<td>1.33</td>
<td>1.35</td>
</tr>
<tr>
<td>appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight gain</td>
<td>1.49</td>
<td>1.57</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>1.19</td>
<td>1.23</td>
</tr>
<tr>
<td>Tiredness</td>
<td>2.57</td>
<td>2.60</td>
</tr>
</tbody>
</table>
### Table 24. One-way Analysis of Variance of Group II Physical Symptoms

**Mean Distress Scores in Control Group over 3 and 6-Month Time Periods**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Heartburn</td>
<td>1.56</td>
<td>1.69</td>
</tr>
<tr>
<td>Indigestion</td>
<td>1.57</td>
<td>1.64</td>
</tr>
<tr>
<td>Increased appetite</td>
<td>1.33</td>
<td>1.35</td>
</tr>
<tr>
<td>Weight gain</td>
<td>1.49</td>
<td>1.57</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>1.19</td>
<td>1.23</td>
</tr>
<tr>
<td>Tiredness</td>
<td>2.57</td>
<td>2.60</td>
</tr>
</tbody>
</table>
Table 25. One-way Analysis of Variance of Group II Psychological Symptoms Mean Severity Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Mood swings</td>
<td>1.21</td>
<td>1.23</td>
</tr>
<tr>
<td>Feeling frustrated</td>
<td>1.77</td>
<td>1.84</td>
</tr>
<tr>
<td>Feeling stressed</td>
<td>2.46</td>
<td>2.58</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>1.50</td>
<td>1.50</td>
</tr>
</tbody>
</table>
### Table 26. One-way Analysis of Variance of Group II Psychological Symptoms Mean Distress Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
<td></td>
</tr>
<tr>
<td>Mood swings</td>
<td>1.15</td>
<td>1.21</td>
<td>NS</td>
</tr>
<tr>
<td>Feeling frustrated</td>
<td>1.68</td>
<td>1.72</td>
<td>NS</td>
</tr>
<tr>
<td>Feeling stressed</td>
<td>2.23</td>
<td>2.36</td>
<td>NS</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>1.49</td>
<td>1.40</td>
<td>NS</td>
</tr>
</tbody>
</table>
The Impact of Time upon the Severity and Distress Scores of Group III Symptoms

One-way ANOVA shows statistically significant differences in the severity for all this group of physical symptoms with an increase over the 1st and 3rd trimesters of pregnancy and (Table 27). The distress scores display a similar trend over the same time periods. However, three symptoms “constipation”, “sore gums” and “mouth ulcers” whilst decreasing during these time periods are not significant (Table 28). Between the third trimester of pregnancy and the postpartum period the severity scores for two psychological symptoms show a statistically significant decrease and a further symptom “sleeping more than usual” reveals constant scores between both periods. The distress scores for psychological symptoms also reveal a statistically significant increase over the 1st and 3rd trimesters of pregnancy time periods except for “loss of memory” which is not statistically significant (Tables 29, 30).

By contrast, in the control group one-way ANOVA of severity and distress scores for physical and psychological symptoms over a 3 and 6-month time period show no statistically significant differences (Tables 30, 31, 32, 33). The only exception is the physical symptom of “sore gums” where its severity shows a statistically significant lower score at 6 months compared to the 3-month period.
Table 27. One-way Analysis of Variance of Group III Physical Symptoms
Mean Severity Scores in Experimental Group over 1st, 3rd Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Trimester</td>
<td>3rd Trimester</td>
</tr>
<tr>
<td>Constipation</td>
<td>1.69</td>
<td>1.74</td>
</tr>
<tr>
<td>More colds</td>
<td>1.76</td>
<td>1.33</td>
</tr>
<tr>
<td>than usual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td>1.94</td>
<td>1.36</td>
</tr>
<tr>
<td>Nosebleeds</td>
<td>1.12</td>
<td>1.24</td>
</tr>
<tr>
<td>Sore gums</td>
<td>1.41</td>
<td>1.34</td>
</tr>
<tr>
<td>Mouth ulcers</td>
<td>1.41</td>
<td>1.43</td>
</tr>
<tr>
<td>Headache</td>
<td>2.18</td>
<td>1.91</td>
</tr>
<tr>
<td>Fainting*</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Insufficient reporting of the symptom of “fainting” did not allow for statistical analysis across the 1st, 3rd trimesters of pregnancy and the postpartum period.
### Table 28. One-way Analysis of Variance of Group III Physical Symptoms
Mean Distress Scores in Experimental Group over 1st, 3rd Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Trimester</td>
<td>3rd Trimester</td>
</tr>
<tr>
<td>Constipation</td>
<td>1.61</td>
<td>1.60</td>
</tr>
<tr>
<td>More colds than usual</td>
<td>1.71</td>
<td>1.23</td>
</tr>
<tr>
<td>Sore throat</td>
<td>1.87</td>
<td>1.33</td>
</tr>
<tr>
<td>Sore gums</td>
<td>1.10</td>
<td>1.21</td>
</tr>
<tr>
<td>Nosebleeds</td>
<td>1.36</td>
<td>1.25</td>
</tr>
<tr>
<td>Mouth ulcers</td>
<td>1.28</td>
<td>1.30</td>
</tr>
<tr>
<td>Headache</td>
<td>2.08</td>
<td>1.70</td>
</tr>
<tr>
<td>Fainting*</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Insufficient reporting of the symptom of “fainting” did not allow for statistical analysis across the 1st, 3rd trimesters of pregnancy and the postpartum period.
Table 29. One-way Analysis of Variance of Group III Psychological Symptoms Mean Severity Scores in Experimental Group over 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1\textsuperscript{st} Trimester</td>
<td>3\textsuperscript{rd} Trimester</td>
</tr>
<tr>
<td>Sleeping more than usual</td>
<td>1.45</td>
<td>1.12</td>
</tr>
<tr>
<td>Feeling restless</td>
<td>1.91</td>
<td>1.77</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>1.36</td>
<td>1.25</td>
</tr>
</tbody>
</table>
Table 30. One-way Analysis of Variance of Group III Psychological Symptoms Mean Distress Scores in Experimental Group over 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

| Symptom                  | Mean Distress Scores |  
|--------------------------|----------------------|--------------------------|
|                          | 1\textsuperscript{st} Trimester | 3\textsuperscript{rd} Trimester | Postpartum |  
| Sleeping more than usual | 1.36                 | 1.07                     | 1.12       | 0.001  
| Feeling restless         | 1.91                 | 1.77                     | 1.12       | 0.05   
| Loss of memory           | 1.36                 | 1.25                     | 1.10       | NS     

P-Value
**Table 31. One-way Analysis of Variance of Group III Physical Symptoms**

**Mean Severity Scores in Control Group over 3 and 6-Month Time Periods**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Constipation</td>
<td>1.24</td>
<td>1.35</td>
</tr>
<tr>
<td>More colds than usual</td>
<td>1.28</td>
<td>1.30</td>
</tr>
<tr>
<td>Sore throat</td>
<td>1.54</td>
<td>1.69</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>1.04</td>
<td>1.04</td>
</tr>
<tr>
<td>Sore gums</td>
<td>1.34</td>
<td>1.09</td>
</tr>
<tr>
<td>Mouth ulcers</td>
<td>1.31</td>
<td>1.28</td>
</tr>
<tr>
<td>Headache</td>
<td>1.89</td>
<td>2.06</td>
</tr>
<tr>
<td>Fainting*</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Insufficient reporting of the symptom of “fainting” did not allow for statistical analysis across the 1st, 3rd trimesters of pregnancy and the postpartum period
**Table 32. One-way Analysis of Variance of Group III Physical Symptoms**

**Mean Distress Scores in Control Group over 3 and 6-Month Time Periods**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Constipation</td>
<td>1.18</td>
<td>1.28</td>
</tr>
<tr>
<td>More colds more frequent</td>
<td>1.24</td>
<td>1.23</td>
</tr>
<tr>
<td>than usual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td>1.42</td>
<td>1.47</td>
</tr>
<tr>
<td>Male bleed</td>
<td>1.04</td>
<td>1.01</td>
</tr>
<tr>
<td>Sore gums</td>
<td>1.29</td>
<td>1.06</td>
</tr>
<tr>
<td>Mouth ulcers</td>
<td>1.22</td>
<td>1.04</td>
</tr>
<tr>
<td>Headache</td>
<td>1.68</td>
<td>1.76</td>
</tr>
<tr>
<td>Fainting*</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Insufficient reporting of the symptom of “fainting” did not allow for statistical analysis across the 1st, 3rd trimesters of pregnancy and the postpartum period
Table 33. One-way Analysis of Variance of Group III Psychological Symptoms Mean Severity Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Sleeping more than usual</td>
<td>1.13</td>
<td>1.06</td>
</tr>
<tr>
<td>Feeling restless</td>
<td>1.43</td>
<td>1.32</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>1.20</td>
<td>1.20</td>
</tr>
</tbody>
</table>
Table 34. One-way Analysis of Variance of Group III Psychological Symptoms Mean Distress Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Sleeping more than usual</td>
<td>1.04</td>
<td>1.00</td>
</tr>
<tr>
<td>Feeling restless</td>
<td>1.35</td>
<td>1.32</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>1.15</td>
<td>1.20</td>
</tr>
</tbody>
</table>
The Impact of Time upon the Severity and Distress Scores of Group IV Symptoms

One-way ANOVA shows statistically significant decrease in the severity and distress scores for the physical symptoms of “Diarrhoea” and “Cough” over the 1st, 3rd trimesters of pregnancy and the postpartum period (Tables 35, 36). For the control group one-way ANOVA of the severity and distress scores for these symptoms over 3 and 6-month time periods show no statistically significant differences (Tables 36, 37).
Table 35. One-way Analysis of Variance of Group IV Physical Symptoms
Mean Severity Scores in Experimental Group over 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1\textsuperscript{st} Trimester</td>
<td>3\textsuperscript{rd} Trimester</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>1.97</td>
<td>1.81</td>
</tr>
<tr>
<td>Cough</td>
<td>1.61</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Table 36. One-way Analysis of Variance of Group IV Physical Symptoms
Mean Distress Scores in Experimental Group over 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters of Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1\textsuperscript{st} Trimester</td>
<td>3\textsuperscript{rd} Trimester</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>1.96</td>
<td>1.68</td>
</tr>
<tr>
<td>Cough</td>
<td>1.52</td>
<td>1.21</td>
</tr>
</tbody>
</table>
### Table 37. One-way Analysis of Variance of Group IV Physical Symptoms Mean Severity Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Severity Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>1.49</td>
</tr>
<tr>
<td>Cough</td>
<td>1.59</td>
</tr>
</tbody>
</table>

### Table 38. One-way Analysis of Variance of Group IV Physical Symptoms Mean Distress Scores in Control Group over 3 and 6-Month Time Periods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean Distress Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Months</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>1.38</td>
</tr>
<tr>
<td>Cough</td>
<td>1.40</td>
</tr>
</tbody>
</table>
The Overall Impact of Time upon the Mean Severity and Distress scores of all Physical and Psychological Symptoms for Men in the Experimental and Control Groups

In men with pregnant partners one-way ANOVA test reveals significant increase in the mean severity and distress scores for the majority of physical symptoms over the 1st and 3rd trimesters of pregnancy. There is a significant decrease in the severity and distress scores for these symptoms in the postpartum period (Tables 11, 12, 19, 20, 27, 28, 35, 36) and (Figures 2, 3). However, the distress scores for three of these symptoms whilst showing similar trends were non-significant. The severity and distress scores for many of the psychological symptoms also show a statistically significant increase between the 1st and 3rd trimesters (Tables 13, 14, 21, 22, 29, 30) and (Figures 4, 5). However, six symptoms although showing a tendency to increase are all non-significant over these periods. By contrast for those in the control group the severity and distress scores for physical symptoms (Tables 15, 16, 23, 24, 31, 32, 37, 38) and (Figures 6, 7) reveal no statistically significant differences over 3 and 6-month comparative time periods. However, two of these symptoms show a significant decrease between the two periods. There are also no statistically significant differences for the severity and distress of psychological symptoms across both time periods (Tables 17, 18, 25, 26, 33, 34) and (Figures 8, 9).
Figure 2. Scatter Graph of all Physical Symptoms Severity Scores During 1\textsuperscript{st}, 3\textsuperscript{rd} Trimesters and the Postpartum Period in Experimental Group

Results of ANOVA are shown on Tables 11, 19, 27, 35
Figure 3. Scatter Graph of all Physical Symptoms Distress Scores during 1st, 3rd Trimesters and the Postpartum Period in Experimental Group

Results of ANOVA are shown on Tables 12, 20, 28, 36
Figure 4. Scatter Graph of all Psychological Symptoms Severity Scores during 1st, 3rd Trimesters and the Postpartum Period in Experimental Group

Results of ANOVA are shown on Tables 13, 21, 29
Figure 5. Scatter Graph of all Psychological Symptoms Distress Scores during 1st, 3rd Trimesters and the Postpartum Period in Experimental Group

Results of ANOVA are shown on Tables 14, 22, 30
Figure 6. Scatter Graph of all Physical Symptoms Severity Scores Over 3 and 6 Month Time Periods in Control Group

Results of ANOVA are shown on Tables 15, 23, 31, 37
Figure 7. Scatter Graph of all Physical Symptoms Distress Scores Over 3 and 6 Month Time Periods in Control Group

Results of ANOVA are shown on Tables 16, 24, 32, 38
Figure 8. Scatter Graph of all Psychological Symptoms Severity Scores Over 3 and 6 Month Time Periods in Control Group

Results of ANOVA are shown on Tables 17, 25, 33
Figure 9. Scatter Graph of all Psychological Symptoms Distress Scores Over 3 and 6 Month Time Periods in Control Group

Results of ANOVA are shown on Tables 18, 26, 34.
Discussion

Assessment of the Incidence of Physical and Psychological in Experimental and Control Groups

This section attempts to address deficits evident with some previous studies that only focus on the incidence of physical symptoms but not psychological ones. While many studies have reported the syndrome’s symptom incidence, few offer psychosocial interpretations for their findings. Furthermore, many investigations fail to make a comparison of symptom incidence between expectant and non-expectant men using experimental approaches. Instead they use self-selected groups of men with pregnancy-related symptoms whose incidence is often descriptively presented and analysed without comparison to those in the general population. These are some of the omissions and limitations which this study attempts to address.

In keeping with the first study objective, four groups of 11 physical symptoms were identified as having a higher incidence in the experimental group and are most prominently associated with the Couvade syndrome. The first group included gastrointestinal symptoms: (“stomach pains”, “stomach distension”, “and vomiting “and” appetite disturbances”) all of which are reported by others. The second group comprised of genitourinary symptoms: (“painful miturition” and polyurea”) also confirmed in previous studies by Fawcett and York, (1987) and Conner and Denson, (1990). The next group were dental symptoms: particularly (“toothache”) widely reported in the literature by Trethowan and Conlon, (1965); Munroe et al, (1973); Benvenuti et al, (1989); Conner and Denson, (1990) and Sizaret et al, (1991). The final group were musculo-skeletal symptoms: (“back pain” and “leg cramps”) also confirmed in previous reports within the literature. Of notable interest was the similarity with the findings of the qualitative phase of the study where “stomach pains”, “vomiting”, “appetite disturbances” and “back pain” were among the most commonly reported symptoms. The groups of physical symptoms showing a similar incidence between the study groups included six gastrointestinal, five respiratory, two oral/dental and miscellaneous. The literature corroborates that seven of these recorded in the study are less commonly associated with the syndrome particularly “constipation”, “diarrhoea”, “breathlessness”, “sore throat”, “nosebleeds”, “sore gums”, “mouth ulcers”, “headache” and “fainting”.

There was also a higher incidence of ten psychological symptoms in the experimental group commonly associated with the syndrome. These included sleep disturbance: (“sleeping less than usual” and
“early morning waking”) previously reported by Trethowan and Conlon, (1965); Conner and Denson, (1990); Masoni et al, (1994); Chalmers and Meyer, (1996); Tsai and Chen, (1997) and Thomas and Upton, (2000). Other symptoms, all of which are reported in the literature, include mood disturbance: (“feeling low in mood”), emotional affect: (“feeling annoyed” and “irritable”) and cognitive disturbance: (“loss of concentration”, “feeling preoccupied” and “feeling distracted”).

An interesting similarity between the findings of this phase of the study and that of the qualitative phase is that “insomnia” and “feeling depressed” were among the most commonly reported psychological symptoms associated with the syndrome. However, “anxiety” which was less commonly reported here is surprising and contrasted with the findings of the qualitative phase and other reports in the literature. The groups of psychological symptoms showing a similar incidence between the experimental and control groups included sleep disturbance: (“sleeping more than usual”), mood disturbance: (“mood swings”), emotional affect: (“feeling frustrated”, “feeling stressed” and “feeling restless”), miscellaneous: (“lack of motivation”) and cognitive disturbance: (“loss of memory”). These symptoms apart from “feeling stressed” are confirmed by other studies as less commonly associated with the syndrome.

A number of interpretations can be offered for the higher incidence of physical symptoms. The first is “abdominal distension” most probably suggestive of “pseudocyesis” or “phantom pregnancy” and whose presence has been linked to the Couvade syndrome (Mayer and Kapfhammer, 1993; Kojić et al, 2004). This symptom was unlikely to be related either to “increased appetite” or “weight gain” given their similar incidence between the two study groups. The higher incidence of “vomiting” in the experimental group confirms one of the most common symptoms of the syndrome reported in other studies by Trethowan and Conlon, (1965); Benvenuti et al, (1989); Conner and Denson, (1990); Sizaret et al, (1991); Khanobdee et al, (1993); Tsai and Chen, (1997) and Thomas and Upton, (2000). The interpretation for “vomiting” could resemble that provided in the qualitative study i.e. male partners hearing or smelling their female partners vomiting especially in the early stages of the pregnancy (Brennan et al, 2007b).

An interesting symptom reported was “toothache” euphemistically known as “love pain” in historical times (Shakespeare, 1600). This could have occurred either coincidentally or as a consequence of the male partner’s “symptom attunement” to his pregnant partner’s display of the same symptom as suggested by (Hugosson and Koch,
1979; Fawcett and York, 1986a; Holditch-Davis et al, 1994). However, this explanation of symptom identification between partners during gestation has been refuted by Drake et al, (1988). The higher incidence of “back pain” in the experimental group reflects its extensive reporting within the literature by Liebenberg, (1967); Drake et al, (1988); Schodt, (1989); Conner and Denson, (1990); Brady-Freitag, (1994); Chalmers and Meyer, (1996) and Tsai and Chen, (1997). Its cause may be related to the physical demands upon male partners as the gestational period progressed such as lifting weighty items in support of a heavily pregnant partner.

Interpretations for psychological symptoms of a higher incidence such as “sleep disturbance” and “early morning waking” whose association with the Couvade syndrome is widely reported may be due to the men’s pregnancy-related anxieties or the nocturnal restlessness of their pregnant partners as gestation progressed. “Feeling low in mood” another prominent symptom of the syndrome reported by Longobucco and Freston (1989); Conner and Denson, (1990); Raskin et al, (1990); Goodman, (1992) and Tsai and Chen (1997) may have occurred because of unplanned pregnancy and/or feelings of hopelessness due to the man’s lack of control over this life event (Barclay et al, 1996).

Expectant men’s “anxiety” although not widely reported in this phase of the study may have arisen because of health and financial worries relating to the pregnancy, the unborn child and the impending responsibilities of future parenthood especially with first-time fathers. Alternatively it might lend support to Cutrona’s (1996) theory of the interrelationship of anxiety between conjugal partners. However, caution with these interpretations is advised given the fact that “anxiety” might also have been constitutional for some men since the investigation did not distinguish between ‘State’ or ‘Trait’ anxiety. The most probable explanation for symptoms of emotional affect such as, “feeling annoyed” and “feeling irritable” was as a response to the increased and multiple demands of the pregnancy. The symptom of “being unable to cope with daily life” has rarely been reported within the literature having no known association with the syndrome but its presence may have arisen due to the increased socio-emotional and financial demands of the pregnancy (Barclay et al 1996). Those symptoms which showed a similar incidence between the study groups including “mood swings”, “feeling frustrated”, “feeling stressed”, “lack of motivation”, “sleeping more than usual”, “feeling restless” and “loss of memory” may have no association with the syndrome at all with some having higher incidence in the general population anyway.
Measurement of Severity and Distress of Symptoms in Experimental and Control Groups

The discussion in this section addresses a much neglected area of research namely quantification of the severity and distress of symptoms of the Couvade syndrome. The few investigations, which have attempted to include similar measures, are Bogren’s (1983) Swedish study which measured global ratings of discomfort and Clinton’s (1987) which explored seriousness of symptoms. The absence of these measures across the majority of studies may impact on the level of reporting of these symptoms and patterns of consultation with health care professionals.

The second study objective was to compare the severity and distress of physical and psychological symptoms between the study groups. A sizeable number of physical (17) and psychological symptoms (14) showed statistically significant higher severity and distress in the experimental group compared to the control group. The relationship between symptom incidence, severity and distress show inconsistent findings. For example, some physical (11) and psychological symptoms (10) of higher incidence also showed higher mean scores for severity and distress. Others showed a similar incidence of physical (8) and psychological symptoms (3) yet similar mean severity and distress scores between the study groups. This might cast doubt on a clear interrelationship between symptom incidence, severity and distress. For the most part the mean severity scores for each symptom were similar to those of distress. This does not mean that one was related to the other since the physical symptom of “increased appetite” might be severe but not necessarily distressing. The findings do, however, suggest that the physical symptoms particularly those of a gastro-intestinal (6), genitourinary (2), dental (1) and musculo-skeletal (2) nature are confirmed as significantly more severe and distressing for those in the experimental group who experienced them. Psychological symptoms including those of sleep disturbance (2), mood disturbance (1), emotional affect (4), cognitive function (2) and miscellaneous (1) are confirmed likewise.

The Impact of Time on Severity and Distress of Symptoms in Experimental and Control Groups

The discussion in this section addresses the impact of time on the severity and distress of physical and psychological symptoms in men with pregnant partners and those without. While past investigations have identified the types of symptom experienced over the trimesters of pregnancy and the postpartum period they have not researched the severity and distress of these over the
same time periods. In doing so this study addresses important research questions previously overlooked such as is there variability in the severity and distress of symptoms between the 1st and 3rd trimesters of pregnancy and the postpartum period? Are there differences in symptom severity and distress between men with pregnant partners and those without over comparative time periods? These questions relate to two of the objectives for this phase of the study namely to assess variability in symptom severity and distress for both study groups over time and to assess the severity and distress of symptoms experienced by men with pregnant partners compared to those with non-expectant partners.

One interesting and novel finding was the impact of time on symptom severity and distress within and between the two study groups. Symptom severity and distress for the majority of physical and psychological symptoms significantly varied with time for those in the experimental group but hardly showed any statistically significant differences for those in the control group. The results support the view that Couvade symptoms are time-specific over the 1st and 3rd trimesters of pregnancy as the literature suggests (Trethown and Conlon, 1965; Schodt, 1989; Magalini and Magalini, 1997). The studies of Lipkin and Lamb (1982) and Quill et al, (1984) lend further support to this since both confirmed that men with the syndrome consulted health professionals for symptoms during the 1st and 3rd trimesters of gestation. This finding might suggest that the presence of symptoms in men with the syndrome remain constant during these periods but that their severity and distress progressively increase. Interestingly, evidence from the qualitative phase of the study partially supports this. In the postpartum period all symptoms decreased in severity and distress for those in the experimental group except for three psychological ones “sleeping less than usual”, “early morning waking” and “feeling stressed”. This is not a surprising finding given the demands of the newborn baby including his/her nocturnal crying and men’s transition and adaptation to parenthood, especially those who were first-time parents numbering 111 in the experimental group. However, the persistence of these symptoms into the postpartum period does not concur with previous findings.

**Relationship between Socio-demographic Factors, Severity and Distress of Symptoms in Men with Pregnant Partners**

While many studies have investigated the broad relationship between the Couvade syndrome and socio-demographic factors, few have examined the relationships between severity and distress of its specific symptoms with these. This section of the study discusses the results which have redressed this deficit. No significant relationships were found at all between the severity and distress of
physical and psychological symptoms with age, previous number of children and social class for men in the experimental group. Unfortunately comparisons are difficult given the dearth of research on these novel measures of symptom quantification mentioned previously. Yet one would have expected a relationship with the presence of certain physical and psychological symptoms identifiable with the syndrome and socio-demographic factors reported in previous studies. The most probable explanation for a null relationship between symptom severity and distress with these socio-demographic factors was because of the heterogeneity of the sample. The sample was diluted because of men of different age groups, different social classes and numbers of previous children which does satisfy the requirement for larger samples in order to detect such correlations. Alternatively the finding could reflect inconsistencies in previous findings mentioned earlier and which have been highlighted (Brown, 1983; Clinton, 1986; Strickland, 1987; Bogren, 1989). Nevertheless this finding does replicate those of Khanobdee et al, (1993) and Thomas and Upton (2000) who also found no relationship between Couvade symptoms and the number of previous children and social class.

**Limitations of the Study**

A number of methodological challenges were evident in this phase of the study. One methodological problem is the use of a non-probability convenience sampling method which can affect representativeness and limit generalisability of results. This problem was circumvented by the fact that the those in the experimental group were of large size and heterogeneous. However, there were a small number of Chinese men who were difficult to recruit which may have reflected a low distribution of this ethnic group in the geographical area where the study was conducted. Some of the sample in the experimental group were recruited from the Internet which also poses a number of problems such as issues of confidentiality relating to disclosure of personal details over the web, the genuineness of respondents and lack of personal contact with the study researcher. Another limitation is that those in control group (n-230) were drawn from staff and student populations from two educational institutions and were perhaps more educated which could have accounted for a higher response rate compared to the experimental group over the comparative time periods.

Another issue is the timing of data collection for the experimental group which did not include the 2nd trimester of pregnancy where symptoms of the Couvade syndrome are reported to temporarily disappear. The reasons for this omission are twofold. Firstly, men’s symptoms during this trimester were already explored in the qualitative phase of the study and had shown diminution or
cessation during this period. Secondly, to offset further attrition arising from the increased level of commitment involved in repeatedly completing a new total of four Couvade symptom questionnaires over the study time periods. This begs a further question: why was the control group only compared at two time periods and not three as the experimental group had been? The reason for this was, unlike those in the experimental group with pregnant partners, pregnancy has very specific and defined time stages which lend themselves to investigation in contrast to the control group which had no pregnant partners and which therefore did not require an additional time comparison. Nevertheless, the timing of the administration of the questionnaires did take account of “practice effects” by allowing a sufficient time interval between the measures for both study groups. One final problem related to data collection was the measure of the symptom of ‘anxiety’ which did not distinguish between ‘state and trait anxiety’. So there was the possibility that some men could have been constitutionally anxious as opposed to exhibiting this as a symptom of the Couvade syndrome.

The analysis of the data omitted to include correlations between physical and psychological symptoms in the partners of pregnant women. Had it done so the psychosomatic nature of the syndrome with the interrelationship between physical and psychological symptoms would have been confirmed. It would also have been useful to compare similarities and differences between men’s symptoms with those of their pregnant partners. If men’s symptoms were different then this would substantiate that the fact that men do not consciously imitate or mimic the symptoms of their pregnant partners thus upholding the involuntary nature of the syndrome.

Clinical Implications
The Couvade syndrome presents diagnostic challenges for those clinicians to whom men are referred. The symptoms of the syndrome can give rise to similar ones indicative of more serious illness such as clinical depression which includes insomnia, feelings of depression, weight loss, lack of motivation and cognitive deficits (DSM: Version IV: American Psychiatric Association. 2000). This study has shown that the male partners of pregnant women do experience significantly greater severity and distress of physical and psychological symptoms compared to men whose partners are not pregnant. This research finding needs to be addressed at a clinical level where all too often men with the syndrome and its symptoms are dismissed and ridiculed both publically and even professionally. One reason for this is that the syndrome crosses gender boundaries in its relationship with pregnancy, the domain of the woman. Traditional hegemonic expectancies of masculine and feminine roles
and behaviours during pregnancy and reproduction continue to persist in some quarters and can influence attitudes during professional consultations. Men’s health in this context must be treated sensitively and empathetically. A greater awareness of the syndrome is needed along with appreciation of the severity and distress of its symptoms without being alarmist for men who experience it. It may be that the syndrome is not an “illness” or “disease” as the medical label suggests but rather an uncommon, normal response to a major life event. Those men afflicted with the syndrome might be reassured by the fact that the symptoms of the syndrome are transitory and do not necessarily reoccur in successive pregnancies.

**Conclusion**

This is the second phase of a mixed methods study which sought to investigate the incidence, severity, and distress and time course of symptoms of the Couvade syndrome in an experimental group of men with pregnant partners over the 1st and 3rd trimesters of pregnancy and four weeks postpartum. This group was compared to a control group of men whose partners were not pregnant over comparative 3 and 6-month time periods. Results indicated a higher incidence of physical symptoms associated with the Couvade syndrome in the experimental group including those of a gastrointestinal, genitourinary, dental, and musculo-skeletal nature. A higher incidence of some psychological symptoms of the syndrome was also evident in this group such as sleep disturbance, mood disturbances, emotional affect and cognitive functioning also associated with the syndrome. The incidence of those physical and psychological symptoms which were similar between the groups might suggest their occurrence in the general population or doubtful association with the syndrome. The severity and distress for the majority of physical and psychological symptoms were statistically higher for men with pregnant partners compared to those whose partners were not expectant. In the experimental group symptom severity and distress for the majority of physical and many psychological symptoms showed significant differences over time in contrast to the control group which showed no significant differences. No correlations were found to exist between socio-demographic variables and symptom severity and distress for those in the experimental group. The negative result may have arisen due to the heterogeneity of the sample when it was diluted into men of different social classes, age groups and numbers of previous children. After all correlations due require large samples otherwise none may be detected, as was the case here.

This study has increased public awareness by raising the profile of the Couvade syndrome in the UK and International media as its
results have been reported in the Evening Standard (Smith, 2007), The Irish Examiner (Collins, 2007), The Daily Telegraph (Fleming, 2007), The Daily Mail (Sims, 2007) and Daily Mirror (Courtney-Smith), as well as BBC Breakfast and ITV This Morning in June and August 2007 respectively.

Suggested directions for future research might include a closer comparison of the type of physical and psychological symptoms of gestational women and their male partners, and the relationship between male personality types and the syndrome. Further investigation might also question whether this syndrome is exclusive to men only or might it also include women? Achieving this would include assessment of the equivalence of pregnancy-related symptoms and their duration among cohabiting lesbian couples where one becomes pregnant through surrogacy or otherwise, where no research has been done before, and/or between twin sisters as evidenced in only one case-study to date by Budur et al, (2005).
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This paper will draw from a data set that has been developed by the author, which maps the rise and fall of psychiatric hospital utilisation in Ireland from 1817 to 2000. This data demonstrates that the Irish experience contrasts sharply with other countries particularly as Ireland had the highest rate internationally of psychiatric hospital utilisation. As such the Irish case should be a model that illustrates established theories, or ‘grand narratives’ that seek to explain the trajectory of asylum usage. However this paper will argue that is not the case, and in fact the Irish experience of asylum usage challenges the logic on which such grand narratives are premised. Three theories relating to asylum usage will be explored and rebutted with both historical and empirical evidence. Firstly, theoretical perspectives that link a classic pattern of industrialisation with the development and expansion of asylums will be explored. It will be argued that this theory is diametrically at odds with the socio-economic reality of Irish life which remained predominantly rural and un-industrialised through the period of asylum growth. Secondly, explanations that link private enterprise with asylum provision will be problematised, asylums in Ireland being publicly owned and managed. Lastly theories of church intervention will be rebuked and it will be demonstrated that Irish asylum provision remained outside of church control, which is unusual both internationally and within the context of an established pattern of church / state partnerships in Irish social service provision.
Psychiatric Nurses Satisfaction Levels’ Using the Tidal Model Holistic Assessment.

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Background: Nurses working within acute psychiatric admission units are key stakeholders in meeting the challenges and reform of acute inpatient services. A Vision for Change (DOH&C 2006) highlights the importance and need for therapeutic partnerships to be an explicit element of care planning and assessment. The Tidal Model Holistic Assessment is an evidenced based nursing model that can assist the process of nursing assessment and care planning (Barker, Jackson & Stevenson, 1999)

Aim: The aim of this study was to investigate psychiatric nurses’ levels of satisfaction using the Tidal Model processes of holistic assessment within four acute psychiatric admission units of the Health Service Executive- Southern Region.

Design: A descriptive correlational study design was undertaken for this study. A self completed questionnaire was distributed to 110 qualified nurses working in the acute psychiatric admission units, using a convenience sample. The response rate was 90 (82 %) from across the four hospital sites.

Findings: Through utilising the processes of the Tidal Model Holistic Assessment satisfaction expressed by nurses achieved high ratings, 90.9 % of respondents indicated it enlisted collaboration with the client. 93.2% of nurses indicated that through use of the model they were able to develop their relationships with the client. 93.3 % of nurses’ felt it supported person centred care also 91.9 % of nurses felt it supported them developing the nursing care plan.

Conclusion: The implementation of the Tidal Model seems to have been successful from the point of view of nurses. Findings suggest that it facilitates a collaborative approach in providing acute inpatient assessment. This study provides evidence that psychiatric nurses within one HSE region are working in evidenced based ways use of the Tidal Model holistic assessment provides a promising
framework for the development of psychiatric in-patient nursing. However there is a need for nurses’ satisfaction levels to be correlated with users’ testimonies to gain richer insights.

References


A Transformative Learning Approach: Returning to Nursing Practice (RTNP) in Ireland

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Background and context: All pre-registration education transferred into the higher education institutions between 1999-2002. As a consequence of this there was a period of readjustment in resource planning. As a counter-active measure to this potential loss of resource, An Bord Altranais established a programme to encourage Registered Nurses-Midwives to revitalise their careers

Aim: To demonstrate the learning transitions made by RN’s returning to nursing practice (RTNP)

Methods: Utilising an interpretive paradigm of critical social theory, course members identify through personal narratives their experience as the facilitator of their educational journey. A personal reflective strategy was the vehicle employed to create a critically reflective process designed to realign their previous professional schema. Each RN contributed in a three phase process: A focus group meeting at the outset of the programme, another at the end of the six week programme and finally an evaluative meeting three months after the programme has concluded. Purposive sample of three cohorts of RTNP (n=28). Qualification: RGN = 22, RSCN = 6. Demographic profile: Mean age 39, age range 28–51. Gender profile 27 Female and one male

Data collection & interpretation: Established through collecting field notes taken during the first and subsequent meetings. The notes were then interpreted through three thematic criteria established by the Steering committee (expert panel) of the Adult Higher Education Alliance Conference (www.ahea.org/conference-themes2006). Identified as ‘conversations, deliberations and collaborations’ and perceived to be the mediator for demonstrating
their transition back into education and evidence of their transformative learning for professional practice.

**Summary of findings:**

- Initial conclusions show that many of the course members are transforming their learning through interaction with new teaching-learning methods
- Through their conversations with their re-established peer group membership they engineer a renewed professional identity
- Through sophisticated support strategies within clinical practice they evolve their personal and professional confidence and competence to be fit for practise
- Transitions are seen to cross boundaries of a personal, professional and organisational identity.

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Nurse Prescribing of Antibiotics: the path of most resistance?

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Background – Since 2001 a group of specially trained UK nurses have been allowed to prescribe a limited selection of oral and topical antibiotics for selected conditions. Theoretically at least, this means that nurses within Grampian may be contributing to the problems of over-prescribing and inappropriate prescribing of these drugs. This, in turn, may impact on the development of antibiotic resistance.

Aim - To describe antibiotic prescribing practices of primary care Extended Nurse Prescribers in Grampian.

Methodology - Quantitative - Anonymous, self-completed, postal questionnaire of all regional Extended Nurse Prescribers, informed by a preliminary content-setting focus group.

Analysis – Descriptive statistics (thematic analysis of focus group).

Key Findings – Response rate was 74% (35/47) and 57% (20) of respondents were practice nurses. Eighty eight percent (28) of respondents were active prescribers, and urinary tract infections (UTIs) were the condition for which antibiotics was most often prescribed, with the majority (65%/20) of prescribing for UTIs done on the basis of symptoms alone. Almost 60% of respondents did not feel their ENP course had prepared them for antibiotic prescribing, and 67% (10) of those who answered would like to see more specific information about prescribing for common conditions added to the course. Thirty percent (10) of respondents did not think that resistance was a problem in their work area, but 97% (34) thought that decreasing inappropriate antibiotic prescribing would lead to a decrease in antibiotic resistance.

Conclusions – There is considerable disparity in antibiotic prescribing practices, with current guidelines being adhered to in some cases (bacterial vaginosis) but not always in others (otitis
externa). There are also deficits in the ENPs’ knowledge of factors around antibiotic resistance. These findings, together with the ENPs’ feelings of being unprepared by their ENP course, suggest that changes to the ENP course at RGU are required to improve prescribing practices.
Use of Accelerated Laboratory Evaluation by Extended Nurse Prescribers: A tool to improve practice?

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Background – Because of the link between inappropriate antibiotic prescribing and antibiotic resistance, several strategies have been implemented to decrease inappropriate prescribing and improve prescribing practices. As 80% of antibiotic prescribing takes place in primary care, this area has often been the focus of these attempts. An example of such a strategy is the Accelerated Bacteriological Laboratory Evaluation (ABLE) service in Grampian, which provides an overnight microbiology results service.

Aim - To describe the knowledge and use of the Accelerated Bacteriological Laboratory Evaluation (ABLE) service by Extended Nurse Prescribers in Grampian (UK).

Methodology – Quantitative - Anonymous, self-completed, postal questionnaire of all regional Extended Nurse Prescribers, informed by a preliminary content-setting focus group.

Analysis – Descriptive statistics (thematic analysis of focus group).

Key Findings – Response rate was 74% (35/47) and 57% (20) of respondents were practice nurses. Eighty nine percent (31) of respondents knew about the ABLE service, and 88% (30) had used it, with 73% (22) using it often. Over half of respondents (55%) stated that they had insufficient information to allow them to make best use of the service. The main barrier to ABLE use was difficulty accessing results (50%/6). The main motivator for ABLE use was the desire to prescribe the correct antibiotic (71%/17).

Conclusions – Although the majority of respondents were aware of the ABLE service and have used it, more information at more regular intervals is needed to encourage maximal use. Respondents were more likely to use the service for some conditions than others. Inclusion of information about ABLE in the
Extended Nurse Prescribing course followed by regular postal and/or electronic reminders/updates would be preferred. These changes and the expansion of accelerated laboratory evaluation nationwide may help to reduce and improve prescribing practices.
Cognitive and social stimulation for older adults: impact on quality of life.

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In Ireland, the number of people aged 65 years and over is projected to increase from 11.2% to almost 25% of the total population within the next 30 years. A substantial increase in life expectancy along with advancements in healthcare has placed greater emphasis on the well being of our older population. An important challenge is to ensure that the years added to life are healthy, active and productive. Thus, research endeavours must make a more concentrated effort to enhance independent living through health maintenance and health promotion initiatives. Although involvement in social activity has been clearly correlated with self-efficacy and independence in later years, there is a paucity of Irish research exploring this phenomenon.

This research aims to explore the impact of cognitive and social stimulation on the quality of life among older people in extended care settings in Ireland.

The research design is guided by a grounded theory approach. The sample consists of care staff and residents from two Care of Older Persons establishments in the South of Ireland. Employing a theoretical sampling strategy, data was collected by means of semi-structured interviews and focus groups. Data analysis, using a manual thematic analysis method to identify emerging themes is ongoing.
In light of the study’s aims, objectives and research design it is anticipated that this research will yield valuable data, which may contribute towards the development of policy and best practice guidelines in the psychosocial dimensions of health care for older people. This research will enhance our understanding of older persons’ perceptions of quality of life, enabling more accurate needs assessments and responsive interventions.

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Care priorities and postpartum provision, a survey of Northern Ireland health visitors working in one Health and Social Services Board

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Systematic reviews have produced evidence that antenatal and postpartum home visitation by public health nurses can benefit families. Traditionally, health visitors and midwives within the UK have offered care to all families with young children. The latest Health for All Children report (Hall and Elliman, 2003) has advocated prioritising care according to professional judgement of ‘higher risk/need’. Little is known, however, about the basis of health visitors’ professional judgements. The aim of this study is to assess health visitors’ care priorities and basis of postpartum care decisions.

In this quantitative study, undertaken in Northern Ireland, the researcher selected survey data from health visitors working in one Health and Social Services Board. All 108 health visitors were invited to take part and 99 returned postal questionnaires. Survey questions concerned work priorities and postpartum care, using a theoretic framework derived from an earlier qualitative study undertaken by the author. Data was analysed using descriptive, parametric and non parametric statistics using SPSS version 11.

Health visitors gave child protection work highest (mean 9.9), and antenatal care lowest workload rating (mean 2.5). The professionals visited low-risk families on average 4.7 and higher-risk 5.8 times to 8 weeks postpartum. Paired t-test comparison of mean frequency of postpartum home visitation found higher preferred than actual visitation patterns for low-risk families (except bottle feeding mothers with more than one child, 1.412, p=0.161). Health visitors decided fortnightly (Friedman; 19.593, p=0.000) and weekly (28.618, p=0.000) home visits to low-risk families according to personal value placed on specific aspects of health visitor care. The
study provides evidence for a proposed mid-range theory of postpartum visitation and highlights variations within the health visiting workforce regarding workload and care priorities. These variations have the potential to affect the content and outcomes of public health nurse care.

Reference
Title: A systematic review of Inter-Professional e-Learning and reusable learning objects within a Virtual Learning Environment to enhance the physical examination of the newborn course.

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AIM OF REVIEW

This review aims to explore the definitions of Inter-Professional e-Learning (IPeL) and examine the meaning of the term Reusable Learning Object (RLO). With a major shift into web based technologies and an increasing focus on learning being interactive, accessible via the Internet and flexible in both time and space. Consideration is given to how both concepts can be achieved within an interactive media-rich Virtual Learning Environment [VLE].

SEARCH AND REVIEW METHODOLOGY

An initial part of the search strategy has been to consult with experts in this field at Coventry University within the Centre for Inter-Professional e-Learning. Further to this an electronic literature search of the major electronic databases is in progress. A comprehensive list of key terms was developed for use in searching the databases such as;

Key Words: Inter-Professional Learning (IPL); Inter-Professional e-Learning (IPeL); Learning Object (LO); Reusable Learning Object (RLO); Virtual Learning Environment (VLE)

ANALYSIS

Inter professional learning is not a new initiative. Numerous government policy documents such as A Health Service for all the Talents: Developing the NHS Workforce (DoH, 2000), The NHS Plan (DoH, 2001) and The Expert Patient (DoH, 2002) advocate inter professional learning and the need for education and training which
prepares students for collaborative work in practice. The aim of inter-professional learning is to produce a workforce that can work effectively as a team, across all boundaries thereby facilitating collaborative practice to improve the quality of care (CAIPE, 2000). More recently *The NHS Improvement Plan* (DoH, 2004) emphasised the desire to modernise the NHS and in doing so reinforce the vision that inter-professional learning is the way forward.

Several definitions of Inter-Professional Learning (IPL) and Inter-Professional Education (IPE) exist. The most widely accepted and embraced definition of inter-professional education states that IPL occurs when two or more professions learn from and about each other to improve collaboration and the quality of care (Barr, 1997). This learning is primarily achieved through interactive; group based learning building upon learning from, about and with each other. The Centre for Inter-Professional e-Learning (CIPeL) endorses this definition and emphasises that the fundamental elements of inter-professional learning involves inter-professional exchange that is patient-centred.

Electronic (e) -learning is the means by which inter-professional learning can be delivered and facilitated. It involves online learning, web-based training, and technology-delivered instruction. Kurubacak (2007) identifies the use of Project –based on line learning (PBOL) as a pedagogical aid to guide and reinforce independence learning by engaging learners in complex reusable activities, ie the RLO. Advantages of e-learning are cited ranging from allowing a flexible pace of learning to allowing learners to access digital spaces for discussion and reflection with and through others. Bonk (2004) states that e-learning presents training professionals with both potentials and challenges; enormous learner demand for training when needed, and ever present erased or significantly reduced budgets through which one has to navigate to deliver e-learning that truly impacts on work and lives. It is reliant upon learners being receptive to this method of delivery and having good reliable Internet Access.

RLO’s are developed as the catalyst to encourage the inter-professional learners to achieve learning from and about each other. Debate is ongoing as to what a RLO actually is and how it can be defined. The fundamental idea behind learning objects is that instructional designers can build small (relative to the size of an entire course) instructional components that can be reused a number of times in different learning contexts. Edmunds & Barron (2002) indicate the RLO may consist of applets, graphics, video, and other forms of data and elements. RLO’s are generally understood to be digital entities able to be delivered over
the Internet, meaning that any number of people can access and use them simultaneously (as opposed to other instructional media, such as a PowerPoint presentation or video tape, which can only exist in one place at a time).

Moreover, those who incorporate learning objects can collaborate on and benefit immediately from new versions. The production of the RLO must ensure mergence of new learning theories with cutting edge communication technologies (Wiley, 2000).

To facilitate the widespread adoption of the learning objects approach, the Learning Technology Standards Committee (LTSC) of the Institute of Electrical and Electronics Engineers (IEEE) formed in 1996 to develop and promote instructional technology standards (LTSC, 2000). Without these standards, universities, and other organisations around the world would have no way of assuring the interoperability of these instructional technologies, specifically their learning objects.

A recent secondment to CIPeL has allowed the authors space for creating an interactive media-rich resource with a range of reusable learning objects for professionals undertaking a suite of modules in the physical newborn examination. It has also resulted in a deeper and broader understanding of what the terms IPeL and RLO mean and how they can be effectively used.

SUMMARY OF KEY FINDINGS
After reviewing a range of sources defining Inter-Professional Learning (IPL) it is acknowledged that inter-professional education is about professionals recognising that their focal point is the recipient of care. It acknowledges how professionals can learn together through collaboration. The review has yielded a wide range of definitions for RLO; and in summary that reusable learning objects are the most effective way of creating interactive activities and content, or e-learning. A VLE is an arena where resources and RLO’s can be accessed and used to facilitate the process of e-learning.

CONCLUSION
IPL is achieved through a well designed and supported learning object that is digital. Once a LO has been designed and created the reusability of such within different contexts results in it becoming a RLO.

Creation of effective RLO’s to enhance learning and meet Government initiatives for inter professional care provision is a challenge to the educationalist in terms of developing a teaching
product that is innovative, functional and creative. IPL with the assistance of RLO’s as a learning tool is an interactive, creative and experiential way of learning with, from and about each others professional roles.

References


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SATISFACTION WITH ACUTE PSYCHIATRIC HOME CARE COMPARED WITH HOSPITAL IN PATIENT CARE.

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Background and context:
A shift from in-patient to home-based acute care for mentally ill patients was signalled in Planning for the Future (1984) and empathised more recently in the Vision for Change (2006) document. The evidence base for such a shift is provided by a large number of studies in many centres over the last 25 years, initially focussing on patients with enduring mental illness, which found that clinical outcome with home based care was equal to that achieved by hospital care without incurring increased financial costs (Stein & Test 1980, Muijens et al 1992, Marks et al 1994).

Aim of study:
The North Kildare psychiatric home based acute care service was set up as part of an agreement made with the South Western Area Health Board partnership forum and went ‘live’ in May 2004. A research evaluation was designed to compare the level of satisfaction of patients and their carers with the provision of home-provided acute care with traditional inpatient care.

Methodology:
The evaluation further aimed to compare the subjective level of family burden experienced by families in each treatment setting. Satisfaction among service users with the North Kildare psychiatric home care services and the inpatient hospital service was assessed using the Verona Service Satisfaction Scale (adapted VSSS-EU, Ruggeri & Dall'Agnola, 1993). The subjective level of burden experienced by the relatives/carers was also measured using the Burden Interview (Zarit & Zarit 1990). The questionnaires were posted to all patients who had been accepted into the home care treatment programme in the initial nine months of the home based acute care period. As a comparison group, questionnaires were also circulated to patients who had been treated as inpatients in the inpatient unit from another sector over the same period.
Analysis:
Analysis of the questionnaire data was carried out using SPSS (Statistical Package for Social Sciences version 10.0). For ease of interpretation, reverse-coded items were inverted prior to analysis. Qualitative data from the comments made by service users and carers on both questionnaires were analysed using Colaizzi’s framework for descriptive data analysis (Colaizzi 1978).

Findings: The results suggest a clear preference by patients and carers for home care as against inpatient care for acute mental illness. Families and carers also reported a lower level of subjective burden associated with the former option.

Conclusions: The findings suggest that in meeting the urgent need for increased capacity to provide acute psychiatric care, investment in the development of home care services should take priority.

References


Ruggeri M. & Dall'Agnola R. (1993) The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services to patients, relatives and professionals. Psychological Medicine, 23, 511 -523

Student nurse experience of problem-based learning

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Problem-based learning is being adopted in many UK nursing curricula reflecting the need for engagement in contemporary educational theory and practice. Extensive research into PBL has evaluated the impact of the process on student outcomes. In nursing this research has predominantly been about pre-registration students undertaking three or four year courses. This study is different because it focuses on post registration student nurses undertaking a one year full time PBL course to become registered children’s nurses.

The aim of this qualitative study was to explore the group’s experience of PBL using focus group interviews at the end of the course and six months following completion. This aimed to capture the student’s perceptions of how they experienced learning to be a children’s nurse on this type of course and subsequently the impact of the course following their return to practice.

Data analysis identified themes that centred on the transitions students have to make to this type of learning and the need to let go of previous educational expectations. Adapting to the PBL process led to a range of strategies being employed by the group to cope with the new demand, resulting in largely negative perceptions of PBL on course completion. The second focus group allowed the group time to reflect on their experience and the impact of it on their role and presented a positive balanced view of their experience. The group identified that following their new registration they had increased confidence, assertiveness, were
questioning and more likely to search for and use evidence to underpin practice than before this PBL course.

This research provides support for PBL as an educational strategy however it does highlight the demand placed on students undertaking this approach to learning. Therefore it is important that programme developers take account of student perspectives of their experience to inform ongoing course design and delivery.
Do Hospital employees get enough exercise at work? The calorie expenditure of hospital staff during an eight hour working day.

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Introduction. The American College of Sports Medicine recommends that every adult accumulate a minimum of thirty minutes of moderate intensity physical activity on most, or preferably all days of the week in order to prevent ill health (Pate et al, 1995). This is equivalent to enough moderate intensity physical activity to expend 200 calories (kcal) per day. Importantly, while they recommend moderate intensity, they acknowledge that additional benefits arise from physical activity which is of higher intensity and of longer duration.

In summary, moderate or higher intensity activity that results in a minimum of 200kcal’s/day is recommended for all.

Aim. The aim of the study was to objectively measure work related physical activity amongst diverse groups of health care workers in an Irish Hospital setting, in order to compare it to minimal activity recommendations.

Materials. Physical Activity was measured using a Triaxial RT3™ Accelerometer (Stayhealthy, Inc. Monrovia, CA). This pager like electrical device worn on the waist band (see figure 1.0), senses movement and determines the calories per minutes expended by the wearer in physical activity.

Figure 1.0  1.5 volt battery, and RT3™ accelerometer

Procedure. Between August and October 2005 occupational sub groups were targeted. They were invited or volunteered to take part using a quota population sampling method. Those agreeable were met individually and their stated height, weight, age and sex pre programmed into the accelerometer. Subjects then wore the
accelerometer for eight consecutive hours during their usual working day.

**Data Analysis.** After being returned, data from the Accelerometer for each individual was saved onto Microsoft Excel Software and analysed descriptively using the following definitions.

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedentary Intensity</td>
<td>$&gt;0$ and $\leq 1.2$ kcal/min.</td>
</tr>
<tr>
<td>Low Intensity</td>
<td>$\geq 1.3$ and $\leq 3.4$ kcal/min.</td>
</tr>
<tr>
<td>Moderate Intensity</td>
<td>$\geq 3.5$ and $\leq 6.9$ kcal/min.</td>
</tr>
<tr>
<td>High Intensity</td>
<td>$\geq 7$ kcal/min</td>
</tr>
</tbody>
</table>

**Summary of main findings.** The final study sample consisted of 26 staff members, 10 were male and 16 female (see table 2.0).

<table>
<thead>
<tr>
<th>Age, years</th>
<th>Range</th>
<th>Mean (SD)</th>
<th>Range</th>
<th>Mean (SD)</th>
<th>Range</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26 - 55</td>
<td>(7.5)</td>
<td>32 - 45</td>
<td>(3.6)</td>
<td>26 - 55</td>
<td>36.4 (9.2)</td>
</tr>
<tr>
<td>Height, inches</td>
<td>60 - 76</td>
<td>(4.1)</td>
<td>68 - 76</td>
<td>(2.4)</td>
<td>60 - 71</td>
<td>65.3 (2.9)</td>
</tr>
<tr>
<td>Weight, Ibs</td>
<td>105 - 228</td>
<td>(35.07)</td>
<td>154 - 195.6</td>
<td>228 (24.19)</td>
<td>105 - 172</td>
<td>138 (18.4)</td>
</tr>
</tbody>
</table>

**Table 2.0 Physical characteristics of study participants, SD = Standard Deviation, n = 26**

Professionals represented included Nurses (7) and Doctors (2) working in diverse fields, Care assistants (1), Porters (1), Dieticians (1), Social Workers (1), and Maintenance (1), Catering (3) and Information Technology personnel (1). Also included were Physiotherapists (1), Radiographers (1), Supplies Officers (1), Cardiac Technicians (1) and representatives of diverse Clerical /Administration jobs (4).

There was a large variation in the amount of work calories expended in various occupations, in all intensities. There were also differences between individual subjects with the same occupation.
Opposite to what one would expect, a member of the Information Technology (IT) Department burned the least (40.83 kcal/8 hours) sedentary intensity calories while, a Senior Physiotherapist burned the most (380.72 kcal/8 hours). Similarly, an Admissions Officer burned the least low intensity calories (23.32 kcal/8 hours) while a Senior Physiotherapist burned the most (672.35 kcal/8 hours).

Looking at moderate intensity only, a Consultant Gynaecologist burned the least calories (11.09 kcal/8 hours) followed closely by an
Admissions Officer, while a member of the Portering Department burned the most (809.46 kcal/min). Thirty eight percent (38%) of staff studied did no high intensity activity at all during work hours, while a CNS in Haemovigalence did more than twice as much as all other subject (580.35 kcal/8 hours) who were active at that level.

In the recommended intensity filed (see figure 2.0), the sum of moderate and high intensity, a Porter was again most active (946 kcal/8 hours), while a Consultant Gynaecologist was least active (11 kcal/8 hours).

Overall more total activity calories were expended by the Senior Physiotherapist (1,290.15/ 8 hours), while the least amount of total activity was performed by a Senior Nurse in the Emergency Department (176.45 kcal/8 hours).

Only forty two percent (42%) of staff achieved the minimal amount of recommended daily physical activity to prevent ill health (≥ 200 kcal/day in the sum of moderate and high intensity activity) during working hours.

Professionals listed on figure 2.0 from and including the Radiography Services Manager upwards, failed to meet the minimal daily activity guideline from work related activity alone.

**Conclusion.** In general, hospital staff do not get enough physical activity from work alone.

**Recommendation.** While at work, hospital workers ought to consider supplementing their activity levels by taking the stairs instead of the elevator, or walking a little more briskly when possible. In addition, regular moderate intensity home exercise is advised.

**References;**


Medical Clinical Trials: the experience of finding a ‘hidden’ nursing and midwifery research resource.

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Context: Current Irish government strategy points to clinical research as an area of future economic and knowledge development. The government is providing funding to support this development but, finance alone will not ensure the success of this policy. The human resource required means that this scenario warrants a response from nursing and midwifery. One national nursing agency has established a project to meet this requirement.

Project aim and process: The project aims to develop guidance for nurses and midwives on clinical trials research as a potential career option. The career guidance document will be based on three project phases: a literature review of the international experience of the nurse or midwife’s role in medical clinical trials, a web search to identify centres of excellence for site visits and a consultation with a sample of nurses and midwives working in such roles in Ireland. The information generated will be formulated into a guidance and resource document.

Key findings and conclusion: A key finding from this project is the ‘hiddenness’ of this particular professional resource. In this paper, project process issues from this finding will be explored. Examples include the searching of peer review literature for empirical evidence highlighting problems on role identification and title usage; the lack of a research focus on this particular role in contrast to others within nursing and midwifery; the lack of employment metrics to develop a rigorous sampling for the consultation phase and issues around accessing a sample. In addition, the paper will highlight how some of these process issues were resolved.
Pilot Testing a Massage Intervention for Rural Caregivers

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Background and Context
Providing care for chronically ill family members is stressful and demanding and negatively impacts all aspects—physical, social, emotional, and financial—of a family caregiver's quality of life (McMillan 1996). Caregivers of chronically ill rural-dwelling persons experience additional burden because of the limited availability of formal services (Buehler & Lee, 1992) and because of personal characteristics such as self reliance, a distrust of “outsiders” and a preference for help from friends and relatives rather than through formal channels (Bushy 2000; Long & Weinert 1989). Research indicates that rural-dwelling caregivers who are able to “do for” in addition to “be with” their family members assign positive meaning to their caregiving experience (Enyert & Burman 1999), which has important consequences for their health and well-being. Massage therapy can yield reciprocal benefits to both the recipient and provider. For the recipient, massage reduces pain, stress, and anxiety and positively affects despair, depersonalization and somatization (Ferrell-Torry & Glick 1993; Field et al. 1992; Fraser & Kerr 1993; Groer et al. 1994; Kempson 2000; MacDonald 1995; van der Riet 1993). For the provider, it lowers stress hormone (salivary cortisol) levels and lessens anxiety and depression (Field et al. 1998).
The researchers hypothesized that teaching rural caregivers to provide gentle massage to chronically ill loved ones is consistent with their personal characteristics and health beliefs and would result in benefits that for both the caregiver and care recipient. However, it was anticipated that recruiting and retaining rural-dwelling family caregivers for an intervention study could be challenging because of their personal characteristics as well as their pre-existing stress and time constraints (Carrick 1998).

**Aim of the Study**
The purpose of this pilot study was to determine whether a) rural caregivers would learn and provide gentle massage to their chronically ill loved ones, b) study participation and protocol implementation were burdensome for caregivers, and c) study participants would realize perceived benefits.

**Methodology**
In this pilot intervention study, volunteers from a Western frontier state who cared for a chronically ill family member were taught gentle massage techniques which they administered to their loved ones over four weeks. The Brief Profile of Moods State (POMS), a quickly administered self-report tool consisting of 18 items scored on a 5-point scale from 1 (not at all) to 5 (extremely). This instrument measures general distress or mood disturbance over the past seven days and is sensitive to change over short periods. It has excellent internal consistency (alpha=0.91 – 0.92), is highly correlated with the longer 65-item POMS (r=0.92 – 0.93), and may provide a better measure of psychological distress than the longer POMS (Cella et al. 1987). Following the intervention period, caregivers were interviewed and their perceptions and responses to the protocol were recorded.

**Setting and Sample**
Institutional Review Board approval was obtained prior to recruitment. Participants were recruited from Western frontier state through newspaper advertisements, word of mouth, and through the social services director at a long term care (LTC) facility. One of the researchers, a certified massage therapist, met with interested persons either individually or in small groups at their home or a mutually convenient location, such as a conference room at the LTC facility. During this initial meeting the study was described, informed consent was obtained. Participants were briefly interviewed to determine their comfort level and any former experience providing massage, and they filled out a demographic data form and completed a pre-intervention Brief POMS. The gentle massage techniques of effleurage and pettrisage were then demonstrated for the participants and a return demonstration was
obtained. Any questions they had were answered. Participants were given a gift basket containing massage oil, a CD of relaxing music and a phone card so they could call the researchers for any problems or questions.

The sample consisted of 11 female caregivers ranging in age from 29 to 74. Over half the sample was from minority populations. Two caregivers cared for a child; five cared for a husband or significant other, and four for a mother with one of said four caring for a father as well. Three provided personalized care for their relative in a LTC facility and the remainder lived with the person for whom they provided home care. Five of the caregivers were employed outside of the home. The massage recipients had a variety of chronic conditions including kidney failure, muscular dystrophy, chronic obstructive lung disease and diabetes, severe arthritis, and seizure disorder. One massage recipient suffered from bipolar disorder a chronic mental rather than physical health condition.

Protocol
The study protocol consisted of caregiver administration of gentle massage too their chronically ill loved one as often as it was convenient for a four-week period. One participant was only able to provide the intervention for her elderly mother for two weeks because shortly after she enrolled in the study her mother was admitted to hospice care and died two weeks later. None of the other 10 participants were able to provide the massage daily, but most provided it several times per week and maintained a simple log detailing the dates of administration.

Following the intervention period one of the researchers revisited the caregivers individually to re-administer the Brief POMS and conduct a brief tape recorded interview. This semi-structured interview was guided questions designed to determine caregivers’ reactions to participating in the study and providing the intervention and to obtain their perceptions of the massage recipients’ reactions to obtaining the intervention.

Analysis
Data consisted of demographic information, results of the pre and post intervention Brief POMS, and interview results.

The POMS data were used in two ways: First, pre and post intervention results were analyzed as an aggregate to determine whether group inferences could be made despite the small sample size. Secondly, individual results were used to inform results of individuals’ perceptions about participating in the study and administering the intervention obtained from the interviews.

Interview transcripts were analyzed using a constant comparison method. Results were informed by demographic data obtained.
Findings and Conclusions

Although minorities constitute only 7.9% of Wyoming’s population, 63% of those who volunteered to participate were either African-or Mexican-American. Despite the stress and burden that caregivers routinely experience, the majority of participants (n = 9) did not see providing massage to their loved one as a burden. The two who did received poor feedback from their loved ones and were fatigued from work and saw it as “one more thing to do”. None of the participants were able to give the massage intervention to their loved ones every day. The major barriers were fatigue, stressful life events (including family illness and moving), busy schedules, forgetfulness because it was not part of an established and poor timing. When the chronically ill family members were ambulatory and able to verbalize their preferences, they sometimes asked for the massage at an inopportune time for the caregivers.

Participants who gave the massage intervention more frequently were able to work it into their caregiving routine and received “feel good” feedback from the massage recipients. Some, especially caregivers who worked outside the home, provided the massage in the evenings. The mother of a child with cerebral palsy found that providing massage was most beneficial after her child’s warm bath, which set a relaxing pre-bedtime tone that was enhanced by the massage. Another woman massaged her mother just before her afternoon nap because it relaxed her and help her sleep better.

The predominant emergent theme was that of a personal, physical connection between the caregiver and care recipient. Most caregivers enjoyed giving the massage, which enabled them to physically do something beneficial for their loved one on a personal level, and provided a concrete connection between the two that was calming and relaxing.

Analysis of the between subjects effects of the Brief POMS data revealed an extreme variation in scores (F=15.303, significant level of .003). The within-subjects contrast of scores F=3.836, significance level of .079) is not statistically significant, but does suggest that there may be a difference in individuals’ mood state from the beginning to the end of the intervention.

Discussion

Study results indicate that rural-dwelling caregivers are willing to learn and provide gentle massage to their loved ones and that providing this care may improve their mood states. Touch interventions and/or participation in touch therapy studies may be particularly acceptable to minority populations. Caregivers more likely to find participation burdensome were challenged by lack of time, fatigue, and minimal verbal or nonverbal feedback from the massage recipient. Teaching rural caregivers to provide massage to
their chronically ill loved ones can provide them with both a milieu for communicating and connecting on a personal level and a tool that can potentially provide benefits for both persons.

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BOSTON 1942: LESSONS LEARNED FROM CARE OF THE COCOANUT GROVE NIGHTCLUB FIRE VICTIMS

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In war-time 1942, as Boston and the rest of the country were in a state of readiness for World War II, almost five hundred people were killed as the result of a devastating fire in a popular Boston nightclub. The Coconut Grove Nightclub fire remains one of the worst catastrophes in United States history. The disaster rocked the city of Boston, leaving thousands of relatives grieving during the war-time holiday season while nurses and doctors spent arduous hours caring for survivors at two major hospitals in Boston. Using a nursing history approach, this paper will reconstruct the crisis faced by the nurses and physicians of Boston City Hospital and Massachusetts General Hospital in the care of victims from the 1942 Cocoanaut Grove nightclub fire. Their response to the disaster played a major role in the advancement of both American and international burn care, forcing them to initiate creative methods and implement newly-research interventions in caring for the large number of severely-injured victims. The depth of the crisis demanded that nurses at both sites assume broader roles and responsibilities, and tested their ability to provide care under adverse conditions of limited resources and personnel.

Care of the nightclub fire victims would lead to dramatic improvements topical burn care, fluid resuscitation, skin grafting, nutritional support in burn injury, recognition of smoke inhalation injury, war-time readiness, and the development of specialized burn care units. The disaster would also result in advances in disaster preparedness and fire prevention.
A NURSING ANALYSIS OF BURN PAIN AND OF THE MODALITIES FOR ITS RELIEF

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Pain following burn injury has been viewed as one of the most intense pain experiences known to mankind. It is the common experience of all burn patients regardless of thermal agent, burn size or depth. Wound care is the primary source of burn pain. The multi-factorial nature of burn pain makes it difficult to prevent and manage on a consistent basis. Despite advances in both topical burn care and pharmacology for sedation and analgesia, the literature suggests continued inadequacy in assessing, preventing, and relieving burn pain. Inadequate control of burn pain adversely affects both patient and nurse. Nursing is at the bedside of the patient throughout all phases of recovery from burn injury, and plays a major role in pain assessment and decision-making regarding pain relief modalities.

To fully describe burn pain, a nursing analysis of burn pain and of the modalities for its relief was performed using the Wilson approach for conceptual analysis. Following a brief overview of burn injury, research literature on burn injury was analyzed to define the attributes of burn pain: timing and pattern of burn pain, wound care procedures, burn depth and size, physical and psychological aspects of burn pain, pain assessment, and available modalities for pain relief. A concept definition of burn pain is provided, covering both acute background and procedural pain as well as chronic burn pain. Three different case studies are presented to illustrate differences in the burn pain experience across the continuum of recovery from injury.

Medical advances have resulted in patients now surviving burn injuries that were considered fatal in the mid-twentieth century. Yet pain continues to be a reality following burn injury. Defining attributes of pain vary per phase of recovery from burn injury. The analgesic needs of the critically-ill burn patient within hours of injury differ from those of the ambulatory burn patient requiring scar revision surgery. Narcotics remain the standard treatment of
acute burn pain, but non-pharmacological options can be effective adjunct modalities. Further research that focuses on burn pain at each phase of recovery from injury will lead to effective evidenced-based pain relief modalities.

**Burn Case Study #1**

John, a 37 year-old married male, sustained a 45% total burn surface area (T.B.S.A.) injury following a trailer home fire. His injuries consisted of 25% full-thickness burns surrounded by 20% partial thickness burns over his face, chest, back, and bilateral circumferential upper extremities. The fire investigator suspected that John was drinking alcohol and fell asleep while smoking a cigarette. The patient’s blood alcohol level (B.A.L.) was high upon admission, and his family reports a past history of both smoking and substance abuse (both alcohol and marijuana). The paramedics at the trauma scene were concerned about the patient’s airway patency due to his obvious facial burns and suspected smoke inhalation injury. John was then pharmacologically paralyzed and sedated for rapid endotracheal intubation followed by mechanical ventilation. He received a total of 8 m.g. of Morphine by I.V.P. during transport. After a ninety minute medical air transport, he was directly admitted to the Burn Intensive Care Unit (I.C.U.) of a regional Level 1 trauma center. Due to intubation and medication received, John was unable to verbalize of burn pain upon admission.

John’s full-thickness burns presented as tan-colored and charred, with the leathery skin changes associated with eschar. These areas lacked capillary refill and felt stiff to palpation. The surrounding partial-thickness burns were red to pale in color, with various levels of capillary refill, and were covered with scattered blebs and bullae (both ruptured and unruptured). Clothing was adherent to the burn eschar in some sites. Initial wound care was performed under I.V.P. administration of Fentanyl (sublimaze) in 50-100 m.c.g. increments, supplemented with I.V.P. administration of Versed (midazolam hydrochloride) in 1- 0.5 m.g. increments. A total of 600 m.c.g. of Fentanyl, and 4 m.g. of Versed were administered during wound care. The patient remained non-responsive at this time, but exhibited tachycardia and elevated blood pressure immediately following position changes or aggressive wound care. The burn unit nurses interpreted these vital sign changes as indicators of uncontrolled pain, and administered additional narcotic analgesia. Towards the end of the procedure, the patient began to be restless and agitated at times despite analgesia. Continuous intravenous infusions of narcotic, sedative, and paralytic agents were then initiated by the nursing staff per physician order.
After removal of clothing and jewelry, the patient was assessed for burn depth and definitive % T.B.S.A. Burns wounds were then photographed for documentation. Initial burn wound care consisted of bedside escharotomies to the circumferential burns of both arms, removal of blebs and bullae, and hydrotherapy using a shower gurney with Dial ® liquid soap and warm tap water. Pluronic F68 (poloxamer 188) was applied to full-thickness and deep partial-thickness burns. Polysporin (polymyxin B/bacitracin sulfate) ointment was applied to superficial partial thickness burns. The anti-microbial topical agents were smeared onto opened gauze, which was then layered onto the burn wounds. Fine mesh gauze was used for face and fingers, with coarse mesh gauze applied to the other affected areas. The fingers were wrapped with gauze individually. The anti-microbial dressing layer was then covered with bulky gauze pads, Kerlix gauze rolls, and held in place with stockingette. Temporary splints were applied to both hands. The patient manifested brief facial grimacing following the application of the Pluronic F68 to areas of partial-thickness burns. The patient was scheduled to undergo daily wound care, with the first of serial surgical debridements with autologous skin grafting scheduled for Day #3.

**Burn Case Study #2**

Lou, a 28 year old adult married male, returned to the Plastic Surgery Clinic for follow-up following a 15% T.B.S.A. burn injury experienced ten days ago. He sustained partial-thickness burns to the face, chest, and both upper arms. Arm and chest burns were non-circumferential in nature. The injury occurred during a barbecue when Lou “fed the flames” with additional lighter fuel on a windy day. His partial-thickness burns did not require surgical debridement or skin grafting. The burn wounds are now clean and healing, without indication of cellulitis. Daily wound care consists of showering at home with anti-bacterial liquid soap, topical application of Polysporin, followed by petroleum-impregnated gauze dressings to promote healing under a moist anti-microbial environment. The patient now performs his own daily wound care with his wife’s assistance, and without the routine need for narcotic as either pre-medication or post-medication. Lou reports the intensity of his procedural pain as 2-3/10, and the intensity of his background pain as 0-1/10. He describes his procedural pain as tolerable and “stinging” in nature. He exhibits no overt physical indications of pain. He admits to taking Tylenol (acetaminophen) 650 m.g. orally on a P.R.N. basis, and an occasional Percocet (5 m.g. oxycodone/325 m.g. acetaminophen per tablet) tablet orally at night, for pain. This patient appeared to be coping well with his burn
injury. He does not verbalize any flashbacks, nightmares, or anticipatory fear of his wound care.

**Burn Case Study #3**

Peter, a 48-year old unmarried male was admitted to the Emergency Room. Peter sustained a 22% T.B.S.A. full-thickness non-circumferential burn to the lower anterior aspects of both legs as a result of flame contact from a welding accident. The full-thickness burns were not surrounded by partial-thickness burn injury. Burn eschar appeared tan in color, charred, non-blanching to pressure, and with a leathery skin texture to touch. Most of the traumatized area was insensate to touch and painless at the time of admission. However, the patient reported acute pain at the burn margins, which he rated as 7/10 in intensity and “burning and intolerable” in nature. The patient received Morphine 4 m.g. I.V.P. during Emergency Medical System (E.M.S.) transport to the E.R. Wound care was implemented using a shower gurney for hydrotherapy, followed by the application of Silvadene (silver sulfadiazine)-covered gauze dressings. The initial wound care session was successfully completed under intravenous conscious sedation using Fentanyl (sublimaze) 350 m.c.g. and Versed (midazolam hydrochloride) 2 m.g. given in small I.V.P. increments. Two hours after wound care, Peter reported background burn pain as 3-4/10 in intensity and “now tolerable.” Both oral and parenteral narcotic analgesia were available on a P.R.N. basis. The patient was admitted to the burn stepdown unit, and scheduled for surgical debridement and skin grafting within forty-eight hours. Pre-operative education included anticipated surgical pain from both the skin donor site and the debrided/grafted burn site areas, and the use of a patient-controlled analgesia (P.C.A.) for post-operative pain management.
Using Participatory Action Research Techniques as a Qualitative Methodology.

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Background and Context: Participatory Action Research (PAR) has emerged as a significant methodology for intervention, development and change within communities and groups. It has been promoted and implemented by many international development agencies and local community organisations around the world. It offers the opportunity to go beyond consultation and promote active participation of communities in the issues and interventions that shape their lives. The authors of this paper have been recently trained in PAR techniques and now have adopted them in their PhD research work on older people and Filipino nurses. PAR techniques enable all community members to participate, regardless of their age, ethnicity or literacy capabilities.

Methodology:
PAR techniques are a set of tools to develop an understanding ‘their perspective’, the emic approach so the participants tell how they view things. The researcher may have decided that no ‘objective’ reality exists from which to create categories of inquiry, so the participants create the categories. In this presentation the authors will demonstrate how to develop an understanding of an individual or a group’s greatest problem using pie charts, gain an insiders view of an individual or groups using emic questioning techniques and finally using a matrix to find possible solution to causes and problems.
Analysis:
Most analysis of qualitative data is a tacking back and forth between deduction and induction (Kane and O’Reilly –De Brun 2001). PAR techniques do contribute to the analysis process. Each technique must be analysed before moving on to another technique so that an appropriate technique will be used. For example pie chart analysis can assist the researcher identify relevant categories in which to carry out a survey or in the development of an interview schedule. Likewise, a matrix can provide the analysis of possible solutions to a problem, which has been identified, from participants. PAR is not just research, which is hoped, will be followed by action. It is action that is researched, changed and researched, within the research process by participants.

Conclusion
Participatory Action Research (PAR) has been of value in our PhD work and we would envisage using this methodology with a wide range of co–researchers both within health care, community groups and as an educational tool. In our experience it has offered the opportunity to refine our research questions in consultation with both older people and Filipino nurses.
Student nurse perceptions of the effectiveness of interdisciplinary multi-patient simulation to enhance prioritization and delegation skills

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Abstract

Background and context:
Simulation of mass-casualty incidents is a common way for interdisciplinary response teams to develop and refine triage, prioritization, collaboration, and patient management skills. Professional nurses who work in acute and critical care settings are expected to continually triage and prioritize patient needs, collaborate effectively with healthcare providers and appropriately delegate nursing care responsibilities to support staff. Although didactic instruction is important in developing these skills, it is limited in its ability to prepare students for real time problem solving. Practicing prioritization and delegation skills in the hospital setting during clinical instruction is also useful, but variations in
patient census and acuity preclude standardization of what the student will encounter on any particular day. Because of this, it is impossible to ensure that every student has the same opportunities to develop and practice these essential skills.

**Aim:**
To review the development and implementation of an intermediate fidelity interdisciplinary simulation and determine if student nurses found a laboratory setting that replicates management of eight acutely ill medical-surgical inpatients effective in developing interdisciplinary collaboration, patient prioritization and delegation skills.

**Methods:**
Students participated in a complex intermediate fidelity simulation as a requirement for completion of their senior-level capstone clinical course. Student perceptions of the simulation experience were measured during the course evaluation process using the following well-validated Likert scales developed by the National League for Nursing (NLN):
1) Student Satisfaction and Self-Confidence in Learning
2) Educational Practices Questionnaire (Student Version), and
3) Simulation Design Scale (Student Version)

**Sample:**
A purposive sample of forty nine (49) undergraduate nursing students enrolled in the final clinical course of their Bachelor of Science program.

**Analysis:**
Descriptive statistics regarding student perceptions were generated based on aggregate scores and selected individual items from these instruments.

**Summary of Key Findings:**
Seventy seven to eighty two percent of the students agreed that the simulation provided them with a positive active learning experience and allowed them to collaborate with one another. The majority of students (73 – 85%) also approved of the simulation design and found that it allowed them to problem solve while being supported and given constructive feedback. Self confidence in learning and satisfaction with current learning was generally high, however, an unexpectedly large percentage of students (8-38%) responded with “undecided” to many survey items.
Conclusions:
Intermediate-fidelity simulation can be a powerful teaching tool when an interdisciplinary approach is used and the complexity is designed to challenge, but not overwhelm students.

Introduction
Simulation use in health education dates back to the 1960s with the invention of the mannequin that later became the prototype for teaching cardiopulmonary resuscitation (Cooper & Taqueti, 2004). Simulation has been used as a teaching strategy in medical education for decades with anesthesia being the primary medical discipline involved in the early design and development of simulation technology. Within the nursing discipline, simulation was first implemented as role play and has since advanced to include computerized technology such as SimMan® and virtual reality programs to enhance the fidelity or realism of the nurse-patient interaction.

In an era of increased awareness regarding medical errors, simulation is gaining popularity as a teaching strategy that allows faculty from all disciplines to safely teach students complex skills and high risk procedures in real time. Despite its perceived benefits, evaluative evidence that positively correlates simulation with effective skill performance is limited (Thurman & Dunlap, 1999). Bradley (2006) asserts that if the evidence to support the use of simulation is not developed, the "potential of simulation [use] at all levels and across all disciplines will not be realized."

The authors used an intermediate fidelity clinical simulation to provide student nurses with an opportunity to develop skills in prioritizing patient care, critically think, and perform routine and complex procedures. This simulation was also used as a strategy to review National Council Licensure Examination-RN (NCLEX-RN) content. The interdisciplinary approach that was employed increased both the fidelity and complexity of the experience and gave novice healthcare providers the opportunity to practice interdisciplinary collaboration. In this paper the authors discuss their experience with the development, implementation, and evaluation of this intermediate fidelity interdisciplinary clinical simulation and student perceptions regarding its effectiveness.

Literature Review
Simulation is described in terms of its fidelity or realism. The level of technology incorporated into the simulation determines whether it is characterized as low, intermediate, or high fidelity. Low fidelity simulation, more commonly known as role play, does not incorporate the use of technology. Intermediate fidelity simulation blends role play with the technology that is more commonly associated with high fidelity simulation. As the name implies, high
fidelity simulation is characterized by the exclusive use of
technology. It typically includes the use of simulation mannequins
such as SimMan®, MediMan®, or virtual computer technology.
Although high fidelity simulation is currently garnering the most
attention in the healthcare literature, we caution educators against
dismissing the benefits of intermediate fidelity simulation. We
assert that intermediate fidelity simulation is a valuable teaching
method when it is highly complex, challenges the learner, but does
not exceed their ability.
Current evidence supporting the effectiveness of simulation as a
teaching strategy is limited. However, simulation techniques are
being used widely in health care to teach novice practitioners to
respond to medical emergencies, perform procedures, and critically
think. The use of high fidelity simulation has been shown to be
effective in teaching junior-level baccalaureate nursing students
how to respond to a pre-term labor event (Schoning, Stitner, and
Todd, 2006). The authors found that students also reported an
increase in confidence that directly resulted from the opportunity to
practice clinical decision-making and priority setting in a non-
threatening environment. Similar findings with the use of high
fidelity simulation to teach physical assessment skills to
baccalaureate nursing students were reported by Bremner,
Adudder, Bennett, and VanGeest (2006). In their study students
were asked to perform complete physical assessments of the human
patient simulator. Assessments were conducted before and after
“pre-programmed changes”. Students then evaluated the
simulation activity on its overall value, realism, and effect on
confidence in performing physical assessment. The authors
determined the use of simulation was beneficial in providing novice
students the opportunity to build confidence and become
comfortable with performing “newly acquired assessment skills
while in an environment that is supportive.”
The use of role-play to emphasize critical care course content and
evaluate the performance of nursing skills is described by Comer
(2005). She describes the use of a two-phased role-play scenario
wherein one student assumed the role of patient while another
assumed the role of nurse and remaining students functioned as a
resource to the student in the nurse role. Students were presented
with patient data and were then asked to perform and delegate
nursing interventions as appropriate. Students were evaluated on
their ability to correctly identify the clinical condition and
appropriately respond to deterioration in the patient’s condition.
Comer reported that the majority of students “responded favorably
to the clinical simulation as a means of reinforcing lecture content”.
In addition, she observed a decrease in the failure rate on the
course examination from 33% (10 of 30) to 16% (five of 30).
Clinical Simulation Scenario Development
Simulation as a means to validate physical assessment and procedural skills was already being used by Virginia Commonwealth University School of Nursing when the delegation and prioritization scenarios were introduced. The scenario development was driven by a review of NCLEX-RN pass rates and anecdotal reports from graduates who indicated they were most challenged by NCLEX-RN questions that assessed their ability to prioritize and delegate the care of patients. Consequently, scenarios were developed to achieve the following objectives:
1. teach the skills of delegation and prioritization,
2. synthesize previously acquired nursing knowledge,
3. enhance student knowledge of the scope of practice of licensed and unlicensed nursing personnel, and

Given the objectives of the simulation, it was determined that the most appropriate learners would be senior nursing students who already had experience in a variety of clinical settings. The simulation was introduced to senior nursing students enrolled in their final senior clinical course. This course is designed to be a capstone experience that allows students to obtain concentrated study in a clinical area of interest while working with individually assigned baccalaureate prepared preceptors.

Faculty members collaborated with a graduate student majoring in nursing administration and leadership who was completing a three-semester practicum to design the elements of the simulation. The graduate student developed scenarios using authentic patient data that was sanitized of identifying information. Patient data were obtained by conducting chart reviews of patients admitted to a busy 35-bed acute care medical unit and selected for scenario development based on both the complexity of the clinical presentation and the frequency with which the diagnoses were encountered on the unit. Common diagnoses included diabetes, HIV, and hepatic failure. Comorbid conditions included impaired cognition and alcohol dependence and withdrawal. Scenarios were developed to challenge student knowledge, assessment ability, and critical thinking skills while also serving as a platform for review of NCLEX-RN content. A sample scenario is provided in Appendix 1.

Simulation Design
The simulations were staged in a full service simulation laboratory. All appropriate patient equipment such as IV pumps, PCA pumps, feeding pumps, monitoring equipment, and imitation medications were available to the participants. Students also had access to the on-line policy and procedure manual for Virginia Commonwealth University Health System.
The simulation was designed to replicate the care of eight patients by six direct care providers plus members of other disciplines such as pharmacy and medicine. The patients are divided into two, four-patient teams. One team of patients is assigned a registered nurse and a licensed practical nurse, while the other team consists of a registered nurse and a care partner or nurse’s aid. One student is assigned to the role of charge nurse. Interdisciplinary team members included physicians, nurse practitioners, and graduate pharmacy students. The simulation takes place in the following four phases:

1) Phase One: Data dissemination and assessment,
2) Phase Two: Initiation of unplanned events,
3) Phase Three: Intermission and role exchange (patient roles are exchanged for caregiver roles) and
4) Phase Four: Resumption of the simulation

Following the experience the students had an opportunity to meet with faculty and debrief and evaluate the simulation. Formal evaluation of the experience was later done during the course evaluation process using the following well-validated Likert scales developed by the National League for Nursing (NLN):
1) Student Satisfaction and Self-Confidence in Learning
2) Educational Practices Questionnaire (Student Version), and
3) Simulation Design Scale (Student Version)

**Simulation implementation**

**Pre-simulation preparation:**
At least one week prior to the simulation, all students were provided with an overview of the experience. Instructions and expectations for conduct and performance were reviewed and students were given an opportunity to ask questions. Patient scenarios were distributed to students assuming patient roles in advance. The patient scenarios consisted of an additional review of the instructions for the simulation experience, a patient history, medication list, procedures, laboratory results, discharge planning information and information regarding the psychological persona for their assigned patient. Students assuming the role of patients in the first phase are also provided with information regarding planned actions to be performed during the simulation and are instructed that they might be asked to perform additional actions during the simulation event.

**Phase 1:**
Clinical information for students who are functioning as care providers is given on the day of the simulation via a digitally taped
report. The taped report consists of information that is complete for some patients and deliberately incomplete for others. This is done to assess the students’ level of preparation, critical thinking skills and ability to articulate additional information that is needed to deliver safe and effective nursing care.

Students functioning as care providers listen to the taped report in a separate area of the laboratory. Following report the student who assumes to the RN role delegates patient care to the LPN or nurse’s aide. A faculty member evaluates the appropriateness of the assignment and asks the student to provide rationale for the choices they have made.

During patient report, those students who are assuming the patient role don examination gowns and attach themselves to the equipment required for their care. Once students are settled into their respective hospital beds they are interviewed by faculty members to determine their level of preparation for the simulation. Students are asked to present their assigned patient role and are questioned about their admitting diagnosis and associated pathophysiology. Students are then asked to identify clinical priorities for the patient they play.

At the completion of report and faculty interviews, the care providers assess patients, plan and give required treatments and medications, and collaborate with interdisciplinary team members to meet patient needs. The time frame from the beginning of report to the end of Phase One is approximately 90 minutes.

Phase 2:
In the second phase, unplanned or “wildcard” events are initiated by faculty members. The unplanned events are not disclosed to any of the students prior to the simulation and are meant to challenge the critical thinking and assessment skills of those students in the care provider roles. These events also assess the students’ ability to prioritize and delegate patient care needs. Examples of these events are listed in Table 1 below:

Table 1 – Unplanned Events

<table>
<thead>
<tr>
<th>Event Description</th>
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<tbody>
<tr>
<td>Patient asks to be discharged against medical advise</td>
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<tr>
<td>Patient falls out of bed</td>
</tr>
<tr>
<td>Patient experiences an adverse drug reaction</td>
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<tr>
<td>Patient is unable to void and requires the nurse to recognize the need for insertion of a urinary catheter</td>
</tr>
<tr>
<td>Patient experiences instability in his/her hemodynamic status</td>
</tr>
</tbody>
</table>
• Patient becomes agitated and confused
• Physician orders an inappropriate dose of medication

If students become overwhelmed or confused, the student or faculty member stops the action and discusses any unclear or unfamiliar content. During this teaching moment, faculty members facilitate group discussion until clarification regarding nursing assessment, nursing intervention or necessary nursing action is achieved. The time frame for Phase 2 is approximately 45 – 60 minutes.

Phase 3:
The third phase begins with an intermission that allows students to take a short break and continues with role exchange and “change of shift” report. Students who played the role of care providers then assume patient roles and previous patients become care providers. The time frame for Phase 3 is approximately 30 minutes.

Phase 4:
The final phase of the simulation is a continuation of the nursing care that was initiated in the first two phases. The new care providers must consider issues of continuity of care, reassess patient status, and respond to unexpected events. This phase lasts for approximately 90 minutes.

Debriefing session:
At the conclusion of the simulation, faculty and students participated in a debriefing session. The purpose of this session is to review any content that remains unclear to students and to provide faculty and students with an opportunity to evaluate the experience. Interdisciplinary team members, including physicians and pharmacists, were welcome to attend the debriefing session and often offered valuable feedback to the student nurses. Debriefing sessions typically ran for 30 – 45 minutes.

Outcomes
Student responses to the Student Satisfaction and Self-Confidence in Learning, Educational Practices Questionnaire (Student Version), and Simulation Design Scale (Student Version) surveys is summarized in Appendix 2. In general students agreed that the simulation provided them with a positive active learning experience and allowed them to collaborate with one another (77 - 82%). The majority of students (73 – 85%) reported that the simulation design allowed them to problem solve while being supported and given
constructive feedback. Self confidence in learning and satisfaction with current learning was generally high. It should be noted that an unexpectedly large percentage of students (8-38%) responded with “undecided” to many survey items. This may be due to the students’ unfamiliarity and inexperience with this form of learning or it may simply reflect a bias toward the middle response.

Verbal reports from faculty and students during debriefing sessions confirmed that the clinical simulation was largely seen as a positive experience. Students indicated that the experience “is a good experience that gives us a realistic view of what it is like to be both a care provider as well as a patient.” Faculty members reported that the simulation provided an opportunity to evaluate the students’ ability to synthesize knowledge and translate that knowledge into practice in a safe and controlled environment. Along with providing the students an opportunity to learn, faculty also reported that knowledge deficits uncovered in the laboratory were addressed after the simulation during didactic sessions in the classroom.

Although most students valued the simulation experience many reported the same important concerns. Despite best efforts to support learning and create a non-threatening environment, during each simulation some students expressed fear about their ability to effectively perform. Faculty members continue to struggle with lessening the intimidating nature of the experience.

Students also perceived a disparity of learning opportunities due to differing role assignments. Students assigned to nonprofessional roles reported that they did not have as satisfying a learning experience as those performing in professional roles. Difficulty in role playing was also observed by the faculty. Faculty reported that it was difficult for nursing students to convincingly play the role of the patient. This was especially true if their “nurse” was another student with whom they had a social relationship.

**Revision of the simulation based on findings**
The simulation has been revised to include Virginia Commonwealth University theater students under the supervision of drama faculty to play the eight acutely ill patients. This collaboration with the School of Arts is expected to give student nurses the opportunity to observe improvisational role play by those trained in the art. At the same time the authors hope it will give theater students an appreciation for the demands placed on nurses.

Since students will not be playing patients, the need to exchange roles no longer exists. The simulation design has been streamlined
so that groups of students move through a modular format that now includes an interdisciplinary care conference and a critical incident station. The revised design is described in Appendix 3.

**Strategies to Ensure Success**
Faculty members who are considering developing this type of intermediate fidelity simulation event are encouraged to conduct at least one rehearsal session prior to implementing the simulations with students. The authors found that the rehearsal session was beneficial as it allowed us to evaluate the amount of time to allot for the simulation events, identify necessary equipment that may have been inadvertently omitted, and to discern how to manage participants who overplay or underplay their roles. The most significant benefit of the simulation rehearsal was that it gave us the opportunity to determine whether or not the simulation design in fact lent itself to achieving the aforementioned goals.

**Implications for the future**
While additional nursing research is necessary to link simulation to educational outcomes, it is evident that simulation can be used as a strategy to develop and evaluate clinical competence. Moreover, intermediate-fidelity simulation can be a powerful teaching tool when an interdisciplinary approach is used and the complexity is designed to challenge, but not overwhelm students. With the exception of being personnel intensive, our team of cooperating professionals believes that our simulations have few limits. In an era of increased scrutiny regarding the safe delivery of care, this experience offers an effective strategy for developing the skills and abilities of all health care professionals.

**References**
Appendix 1
Sample Patient Profile and Scenario

You will be role-playing the part of the patient. It is expected that you are prepared and that you are knowledgeable of your assigned diagnosis, medications, laboratory tests and associated procedures when you report to the simulation lab. An assessment of your knowledge of the clinical information associated with your assigned scenario will be performed by your instructor or his/her designee prior to, during, and following the clinical simulation session. Be prepared. **Failure to adequately prepare for or fully participate in the clinical simulation will result in an unsatisfactory rating for the clinical experience.**

History
You are a 28 year old female patient with end stage AIDS. You were sent to the Emergency Department from the Infectious Disease Clinic to be evaluated for fever, severe anemia, questionable sepsis, and rectal pain secondary to a possible recto-vaginal fistula. You are extremely cachetic and you are in extreme pain. You have a history of noncompliance with the medical treatment plan and you often refuse treatment, examinations, and procedures. You have not had your medications filled because of limited financial resources. Your family support is limited and many of your family members are misinformed / uninformed about your diagnosis and prognosis. After being evaluated in the Emergency Department, you have been admitted to a busy medical surgical floor to treat your anemia, rule out sepsis, manage your pain, and determine if you have a recto-vaginal fistula.

Procedures
You have been scheduled for a colonoscopy and a pelvic exam.

Labs
Your intern has ordered the following labs for you:

- Blood culture
- Arterial Blood Gas
- CBC w/ differential
- Hemoglobin
- Histoplasma antigen
- Potassium
- Respiratory culture
- Type and screen
<table>
<thead>
<tr>
<th>Medications</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acyclovir</td>
<td>800mg tab</td>
<td>po</td>
<td>4x/day</td>
</tr>
<tr>
<td>Azithromycin</td>
<td>600mg tab</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Darbepoetin Alfa</td>
<td>100 mcg inj</td>
<td>sc</td>
<td>every 7 days</td>
</tr>
<tr>
<td>Docusate</td>
<td>100mg cap</td>
<td>po</td>
<td>every 12 hours</td>
</tr>
<tr>
<td>Esomeprazole</td>
<td>40 mg cap</td>
<td>po</td>
<td>Before breakfast</td>
</tr>
<tr>
<td>Ferrous Sulfate</td>
<td>325 tab</td>
<td>po</td>
<td>2x/day</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>100mg tab</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>1 mg tab</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Levofoxacin</td>
<td>500 mg tab</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Megestrol</td>
<td>400 mg suspension</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>5 mg tab</td>
<td>po</td>
<td>2x/day</td>
</tr>
<tr>
<td>Morphine (MS Contin SR)</td>
<td>90 mg tab</td>
<td>po</td>
<td>every 8 hours</td>
</tr>
<tr>
<td>Multivitamin</td>
<td>1 tab</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Senna</td>
<td>2 tabs</td>
<td>po</td>
<td>at bedtime</td>
</tr>
<tr>
<td>Bactrim DS</td>
<td>1 tab</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Thiamine</td>
<td>100mg tab</td>
<td>po</td>
<td>every day</td>
</tr>
<tr>
<td>Morphine</td>
<td>15 mg tab</td>
<td>po</td>
<td>every 3h, prn pain</td>
</tr>
<tr>
<td>Promethazine</td>
<td>12.5 mg</td>
<td>IV push</td>
<td>every 4h, prn N/V</td>
</tr>
<tr>
<td>Sorbitol</td>
<td>30 ml</td>
<td>po</td>
<td>every 12 hours, prn no stool X 48 hours</td>
</tr>
</tbody>
</table>
Discharge Planning

The medical team has explained that you are in the end stages of the disease process and recommends that you should consider either being admitted to the Palliative Care Unit or receiving hospice care at home. However, you are in denial about your prognosis and refuse to consider either option.

You are to do the following during the clinical simulation:

- Complain frequently of intense pain. You are to give your health care worker an initial pain rating of 6/10. Despite medication, when assessed, you should rate your pain at increasing levels.
- You are to refuse your pelvic exam
- You will be traveling for a colonoscopy at noon and you request to be accompanied to the procedure by your RN
- Question the RN about your medications when she comes to administer them

During the clinical simulation, you may receive further instruction regarding additional actions that you must perform.

The RN would receive the following information during report:

The patient is well known to the unit and has a primary diagnosis of end stage AIDS. She is noncompliant with the medical plan of care. She was sent to the ED from the clinic and was subsequently admitted to “N5”. Vitals: T=103°F, HR=164, BP=71/38. Labs: CD4= 2, Na=145, K+= 3.7, BUN=12, Creatinine= .75, Hgb=7.6 (pre-transfusion), WBC=6.9, HCT=27.6, most recent weight is 68 lbs. The patient’s admitting diagnosis is anemia with secondary diagnoses of rule out sepsis and rule out recto-vaginal fistula. The patient is complaining of generalized body aches. Currently rates pain at 6/10. Patient sleeps for long periods of time and does not want to be disturbed. The patient refused bedtime medications. The medical team is recommending that the patient be admitted to the Palliative Care Unit or be discharged home with hospice when ready for discharge. The patient is refusing these options at this time and the night shift staff believe that she is depressed and in denial about her prognosis. The patient has friends and family that provide emotional support, but they too are in denial. A social work consult has been ordered. The patient is scheduled for a pelvic exam and a colonoscopy on your shift.
### Appendix 2

**Simulation Design Scale (Student Version) Results**

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives and information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. There was enough information provided at the beginning of the</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>31</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>simulation to provide direction and encouragement.</td>
<td>(8%)</td>
<td>(14%)</td>
<td>(8%)</td>
<td>(63%)</td>
<td>(6%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>2. I clearly understood the purpose and objectives of the</td>
<td>2</td>
<td>5</td>
<td>14</td>
<td>23</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>simulation.</td>
<td>(4%)</td>
<td>(10%)</td>
<td>(29%)</td>
<td>(47%)</td>
<td>(10%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>3. The simulation provided enough information in a clear matter for</td>
<td>2</td>
<td>11</td>
<td>9</td>
<td>25</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>me to problem-solve the situation.</td>
<td>(4%)</td>
<td>(22%)</td>
<td>(18%)</td>
<td>(51%)</td>
<td>(4%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>4. There was enough information provided to me during the</td>
<td>4</td>
<td>12</td>
<td>7</td>
<td>26</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>simulation.</td>
<td>(8%)</td>
<td>(24%)</td>
<td>(14%)</td>
<td>(53%)</td>
<td>(0%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>5. The cues were appropriate and geared to promote my understanding.</td>
<td>2</td>
<td>8</td>
<td>6</td>
<td>29</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(4%)</td>
<td>(16%)</td>
<td>(12%)</td>
<td>(59%)</td>
<td>(8%)</td>
<td>(0%)</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Support was offered in a timely manner.</td>
<td>0</td>
<td>3</td>
<td>10</td>
<td>27</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(0%)</td>
<td>(6%)</td>
<td>(20%)</td>
<td>(55%)</td>
<td>(18%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>7. My need for help was recognized.</td>
<td>0</td>
<td>5</td>
<td>11</td>
<td>18</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(0%)</td>
<td>(10%)</td>
<td>(22%)</td>
<td>(37%)</td>
<td>(29%)</td>
<td>(2%)</td>
</tr>
<tr>
<td>8. I felt supported by the teacher's assistance during the</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>28</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>simulation.</td>
<td>(0%)</td>
<td>(2%)</td>
<td>(16%)</td>
<td>(57%)</td>
<td>(24%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>9. I was supported in the learning process.</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>22</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(0%)</td>
<td>(4%)</td>
<td>(27%)</td>
<td>(45%)</td>
<td>(24%)</td>
<td>(0%)</td>
</tr>
<tr>
<td><strong>Problem solving</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Independent problem-solving was facilitated.</td>
<td>0</td>
<td>4</td>
<td>14</td>
<td>25</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(0%)</td>
<td>(8%)</td>
<td>(29%)</td>
<td>(51%)</td>
<td>(12%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>11. I was encouraged to explore all possibilities of the simulation.</td>
<td>1</td>
<td>12</td>
<td>13</td>
<td>15</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(2%)</td>
<td>(24%)</td>
<td>(27%)</td>
<td>(31%)</td>
<td>(16%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>12. The simulation was designed for my specific level of knowledge</td>
<td>2</td>
<td>6</td>
<td>12</td>
<td>22</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>and skills.</td>
<td>(4%)</td>
<td>(12%)</td>
<td>(24%)</td>
<td>(45%)</td>
<td>(14%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>
13. The simulation allowed me the opportunity to prioritize nursing assessments and care.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>6%</td>
<td>3</td>
<td>13</td>
<td>16</td>
<td>14</td>
<td>7</td>
</tr>
</tbody>
</table>

14. The simulation provided me an opportunity to goal set for my patient.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2%</td>
<td>18</td>
<td>14</td>
<td>7</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Feedback/Guided Reflection

15. Feedback provided was constructive.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>4</td>
<td>31</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>

16. Feedback was provided in a timely manner.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>4</td>
<td>35</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>

17. The simulation allowed me to analyze my own behavior and actions.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4%</td>
<td>4</td>
<td>9</td>
<td>27</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>

18. There was an opportunity after the simulation to obtain guidance/feedback from the teacher in order to build knowledge to another level.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>9</td>
<td>29</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>

Fidelity (Realism)

19. The scenario resembled a real-life situation.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>20%</td>
<td>7</td>
<td>10</td>
<td>14</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

20. Real life factors, situations, and variables were built into the simulation.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>6%</td>
<td>4</td>
<td>6</td>
<td>24</td>
<td>12</td>
<td>0</td>
</tr>
</tbody>
</table>

---

**Educational Practices Questionnaire (Student Version)**

**Item**

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Learning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I had the opportunity during the simulation activity to discuss</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>32</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>and concepts taught in the course with the teacher and other</td>
<td></td>
<td>(10%)</td>
<td>(13%)</td>
<td>(67%)</td>
<td>(10%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>students.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I actively participated in the debriefing session after the</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>24</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>simulation.</td>
<td></td>
<td>(4%)</td>
<td>(15%)</td>
<td>(50%)</td>
<td>(31%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>3. I had the opportunity to put more thought into my comments</td>
<td>0</td>
<td>5</td>
<td>12</td>
<td>21</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>during the debriefing session.</td>
<td></td>
<td>(10%)</td>
<td>(25%)</td>
<td>(44%)</td>
<td>(19%)</td>
<td>(2%)</td>
</tr>
<tr>
<td>4. There were enough opportunities in the simulation to find out</td>
<td>1</td>
<td>10</td>
<td>11</td>
<td>25</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>if I clearly understood the material.</td>
<td></td>
<td>(21%)</td>
<td>(23%)</td>
<td>(52%)</td>
<td>(2%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>5. I learned from the comments made by the teacher before, during,</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>28</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>or after.</td>
<td></td>
<td>(6%)</td>
<td>(6%)</td>
<td>(59%)</td>
<td>(29%)</td>
<td>(0%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. I received cues during the simulation in a timely manner.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>10</td>
<td>6</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>(4%)</td>
<td>(21%)</td>
<td>(13%)</td>
<td>(33%)</td>
<td>(29%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

7. I had the chance to discuss the simulation objectives with my teacher.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>10</td>
<td>10</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>(2%)</td>
<td>(21%)</td>
<td>(21%)</td>
<td>(46%)</td>
<td>(4%)</td>
<td>(6%)</td>
</tr>
</tbody>
</table>

8. I had the opportunity to discuss ideas and concepts taught in the simulation with my instructor.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>5</td>
<td>12</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>(2%)</td>
<td>(10%)</td>
<td>(25%)</td>
<td>(56%)</td>
<td>(6%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

9. The instructor was able to attend to the individual needs of learners during the simulation.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>7</td>
<td>9</td>
<td>26</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>(0%)</td>
<td>(15%)</td>
<td>(19%)</td>
<td>(54%)</td>
<td>(13%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

10. Using simulation activities made my learning time more productive.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>12</td>
<td>18</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>(15%)</td>
<td>(10%)</td>
<td>(25%)</td>
<td>(36%)</td>
<td>(13%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

Collaboration  

11. I had the chance to work with my peers during the simulation.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>6</td>
<td>1</td>
<td>11</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>(0%)</td>
<td>(13%)</td>
<td>(2%)</td>
<td>(23%)</td>
<td>(63%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

12. During the simulation, my peers and I had to work on the clinical situation together.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>8</td>
<td>1</td>
<td>20</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>(0%)</td>
<td>(17%)</td>
<td>(2%)</td>
<td>(42%)</td>
<td>(40%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

Diverse Ways of Learning  

13. The simulation offered a variety of ways in which to learn the material.  
<table>
<thead>
<tr>
<th></th>
<th>SD</th>
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<td>10</td>
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<tr>
<td>(0%)</td>
<td>(21%)</td>
<td>(23%)</td>
<td>(42%)</td>
<td>(15%)</td>
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14. This simulation offered a variety of ways of assessing my learning  
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<td>0</td>
<td>14</td>
<td>18</td>
<td>11</td>
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<tr>
<td>(0%)</td>
<td>(29%)</td>
<td>(38%)</td>
<td>(23%)</td>
<td>(10%)</td>
<td>(0%)</td>
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</tbody>
</table>

High Expectations  

15. The objectives for the simulation were clear and easy to understand.  
<table>
<thead>
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<tr>
<td>4</td>
<td>9</td>
<td>9</td>
<td>19</td>
<td>7</td>
<td>0</td>
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<tr>
<td>(8%)</td>
<td>(19%)</td>
<td>(19%)</td>
<td>(40%)</td>
<td>(15%)</td>
<td>(0%)</td>
</tr>
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</table>

16. My instructor communicated the goals and expectations to accomplish during the simulation.  
<table>
<thead>
<tr>
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<tr>
<td>1</td>
<td>5</td>
<td>4</td>
<td>29</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>(2%)</td>
<td>(10%)</td>
<td>(8%)</td>
<td>(60%)</td>
<td>(19%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

S Student Satisfaction and Self Confidence in Learning Survey  

N=49  

Satisfaction with Current Learning  

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The teaching methods used in this simulation were helpful and effective.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The simulation provided me with a variety of learning materials and activities to promote my learning the medical surgical curriculum.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. I enjoyed how my instructor taught the simulation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The teaching materials used in this simulation were motivating and helped me to learn.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. The way my instructor(s) taught the simulation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6. I received cues during the simulation in a timely manner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I had the chance to discuss the simulation objectives with my teacher.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I had the opportunity to discuss ideas and concepts taught in the simulation with my instructor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. The instructor was able to attend to the individual needs of learners during the simulation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Using simulation activities made my learning time more productive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 173 -
was suitable to the way I learn. | (0%) | (6%) | (20%) | (51%) | (22%)

<table>
<thead>
<tr>
<th><strong>Self-confidence in Learning</strong></th>
<th>SD</th>
<th>D</th>
<th>UN</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. I am confident that I am mastering the content of the simulation activity that my instructors presented to me.</td>
<td>0 (0%)</td>
<td>5 (10%)</td>
<td>8 (16%)</td>
<td>32 (65%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>7. I am confident that this simulation covered critical content necessary for the mastery of medical surgical curriculum.</td>
<td>1 (2%)</td>
<td>6 (12%)</td>
<td>7 (12%)</td>
<td>33 (67%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>8. I am confident that I am developing the skills and obtaining the required knowledge from this simulation to perform necessary tasks in a clinical environment.</td>
<td>0 (0%)</td>
<td>9 (18%)</td>
<td>7 (14%)</td>
<td>33 (67%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>9. My instructors used helpful resources to teach the simulation.</td>
<td>0 (0%)</td>
<td>4 (8%)</td>
<td>14 (29%)</td>
<td>27 (55%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>10. It is my responsibility as the student to learn what I need to know from this simulation activity.</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>2 (4%)</td>
<td>33 (67%)</td>
<td>13 (27%)</td>
</tr>
<tr>
<td>11. I know how to get help when I do not understand the concepts covered in the simulation.</td>
<td>0 (0%)</td>
<td>3 (6%)</td>
<td>5 (10%)</td>
<td>24 (49%)</td>
<td>17 (35%)</td>
</tr>
<tr>
<td>12. I know how to use simulation activities to learn critical aspects of these skills.</td>
<td>0 (0%)</td>
<td>7 (14%)</td>
<td>16 (33%)</td>
<td>20 (41%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>13. It is the instructor’s responsibility to tell me what I need to learn of the simulation activity content during class time.</td>
<td>0 (0%)</td>
<td>13 (27%)</td>
<td>15 (31%)</td>
<td>21 (43%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
Appendix 3
Revisions to Simulation Design

Groups of six or seven students are divided into two care-giving teams and will rotate through the following stations. In the interest of time and resource conservation, some groups will begin with the report station while others will begin with the critical incident station. Each simulation day can accommodate 35 students.

**Report Station:** Patient report will be posted online in MP3 format. Students will be instructed to listen to report before their scheduled simulation and complete an assignment sheet and develop a format for organizing report data. Both the assignment and the patient notes will be turned in on the day of their simulation. This portion of the simulation will receive a letter grade that is weighted as part of their didactic grade. The report station will run for 30 minutes and entail a faculty facilitated discussion of the students’ identified priorities and how they delegated care when creating the assignment.

**Patient Care Station:** This 60 minute segment will focus on patient assessment, pain management, medication administration, and documentation. One faculty member will facilitate clinical decision making while a second faculty member will facilitate a patient transfer and admission. Interdisciplinary team members (medicine, pharmacy, social work, hospital administration) will be present during this time.

**Interdisciplinary Care Conference Station:** This 30 minute session will focus on the interdisciplinary needs of select patients. Participants will include the nursing care team and members of various health care professions including medicine, pharmacy, dietary, physical therapy and social services. Patient focus will change between groups to ensure that discussion between student groups does not provide one group with an advantage over the other. A faculty member will facilitate discussion.

**Critical incident station:** Three faculty members will facilitate this 45 minute station that addresses key critical incidents that every new graduate should be familiar with managing: patient restraints, patient falls, and working with a patient with a depressed mood and potential for self-harm. Students will divide into groups of 2 or 3 and rotate 15 minutes between each segment.

**Debriefing:** This 30 minute session allows students to provide feedback regarding the experience as well as for the faculty facilitator to reinforce key clinical points when a knowledge deficit is
identified. Students will be asked to complete evaluation tools designed by the NLN to measure student responses to the simulated learning environment.

### Sample Schedule for Simulation Days:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
<th>Group 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report station</td>
<td>8:00 - 8:30 am</td>
<td>9:00 - 9:30 am</td>
<td>10:00 - 10:30 am</td>
<td>2:00 - 2:30 pm</td>
<td>3:00 - 3:30 pm</td>
</tr>
<tr>
<td>Patient care station</td>
<td>8:30 - 9:30 am</td>
<td>9:30-10:30 am</td>
<td>10:30-11:30 am</td>
<td>2:30-3:30 pm</td>
<td>3:30-4:30 pm</td>
</tr>
<tr>
<td>Interdisciplinary care conference</td>
<td>9:30-10:00 am</td>
<td>10:30-11:00 am</td>
<td>11:30-12:00 pm</td>
<td>3:30-4:00 pm</td>
<td>4:30-5:00 pm</td>
</tr>
<tr>
<td>Critical incident stations:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Restraints</td>
<td></td>
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<tr>
<td>Falls</td>
<td></td>
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<tr>
<td>Pt with a depressed mood</td>
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<tr>
<td>10:00-10:45 am</td>
<td></td>
<td>11:00 - 11:45 am</td>
<td>9:15 - 10:00 pm</td>
<td>1:15 - 2:00 pm</td>
<td>2:15 - 3:00 pm</td>
</tr>
<tr>
<td>Debriefing</td>
<td>10:45-11:15 am</td>
<td>11:45-12:15 pm</td>
<td>12:15-12:45 pm</td>
<td>4:00 - 4:30 pm</td>
<td>5:00 - 5:30 pm</td>
</tr>
<tr>
<td>Completion time</td>
<td>11:15 am</td>
<td>12:15 pm</td>
<td>12:45 pm</td>
<td>4:30 pm</td>
<td>5:30 pm</td>
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<tr>
<td>Total time in lab</td>
<td>3’15”</td>
<td>3’15”</td>
<td>3’30”</td>
<td>3’15”</td>
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[Back to contents page](#)
The effectiveness of pre-admission visits for children (and their parents) undergoing day surgery.

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Ann Kelleher  RGN, RCN
Staff Nurse
St. Anne’s Children’s Ward
Mercy University Hospital
Te: 353 (0) 21 4271971

Background: Hospitalisation is stressful for both children and their families. The literature suggests that the use of pre-admission visits to wards helps to reduce the anxiety that comes with hospitalisation. Having reviewed this literature a pre-admission programme was developed for children (aged 3-9 years) and their parents who were scheduled for day surgery.

The development and implementation of the pre-admission visits for children undergoing day surgery has been a very exciting venture for both the researchers and staff in the hospital. There are only two other hospitals in the Republic of Ireland that offer a similar type of service for children. Having reviewed the literature and visiting and liaising with the staff on these units, the researchers developed a pre-admission visit that lasts one hour approximately. This visit includes: a tour of the paediatric ward, meeting the staff on the ward, viewing of a specifically prepared DVD which shows a little boy and his mother coming to hospital for day surgery, gown up, visit and meeting of theatre staff, visit and play in the playroom.
**Aim:**
To evaluate the effectiveness of the pre-admission visit for children (and their parents) who are scheduled to have day surgery.

**Method:** This was an evaluative study. Data was collected from 15 parents who had attended the pre admission visit using a questionnaire specifically designed for this study.

**Analysis:** Data was analysed using Statistical Package for Social Science (SPSS) and thematic analysis.

**Findings:** Pre-admission access to the paediatric ward and theatre department enhanced the perioperative experience for both the child and their parents.

**Conclusion:** Results of this evaluation study indicate that the pre-admission visit is very successful in terms of: knowledge gained preparation for the hospital experience, reduction of anxiety and parent and child satisfaction.
Mothers’ Need for Information and Support following their Child’s Diagnosis of Epilepsy

Abstract

Miss Ann Cummins R.G.N., R.C.N., BSc, MSc, Diploma in Integrated Computer Applications.
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University College Cork
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Email: a.cummins@ucc.ie

Background: Research on childhood epilepsy suggests that a diagnosis of epilepsy is a challenge for children and parents. Children with epilepsy and their parents are faced with a multitude of medical, developmental, social and emotional issues that can place additional demands on the rearing of children requiring comprehensive, continuing health care. Numerous research studies have identified parents’ requirements for information and support essential in caring for a child with a chronic illness. Only a select number of studies have examined parents’ requirements for information and support following their child’s diagnosis of epilepsy.

Aim of the study: The aim of this study was to explore the experiences of mothers of a child with epilepsy with specific emphasis on their informational and support needs.

Methodology: A phenomenological hermeneutic methodological design provides an invaluable opportunity to gain an understanding and appreciation of the lived experiences and perceptions of mothers’ needs for information and support following their child’s diagnosis of epilepsy. Purposive sampling was utilised in this research study to selects participants because of their knowledge of the phenomenon to ensure credible and knowledgeable participants in the research study.

Analysis: Colaizzi’s (1978) data analysis six procedural steps was utilised in this research study to permit understanding of the phenomenon under investigation and facilitated participants with the opportunity to validate the credibility of the findings

Findings: The findings in this study revealed that mothers have a real need for information and support to enable them to care for their child with epilepsy. Their information and support needs are currently not being met by healthcare providers.
Conclusion: There is a gap in provision of information and support needs specific to children with epilepsy and their parents. It is imperative that the specific needs of the child with epilepsy and their family are identified and met to ensure this ideal is espoused. The implications of these findings for nursing education, practice and research are discussed.

Back to contents page
Title: Overseas nurses attitudes and perceptions of integration into the perioperative workplace setting

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Ireland
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Background:
The nursing shortage in Ireland has resulted in the recruitment of nurses from all corners of the globe to deal with the shortage. However, our healthcare system now appears to be somewhat dependant on overseas nurses. As a result it is imperative that we fully appreciate the challenges these overseas nurses may face on arrival and during integration in order to gain a greater understanding of the integration process. This study aims to identify and measure these challenges and the extent to which the challenges can effect the nurses’ integration into the perioperative setting. To have a global nursing workforce that can be transferable from one country to another is a nursing issue worth researching.

Method:
A quantitative descriptive approach was taken using an anonymous questionnaire to collect the data. The questionnaire consisted of four sections to obtain demographic data from the sample, perceptions of their integration, attitudes in relation to working in the perioperative environment and concluded with two open-ended items which asked the participants to comment on the integration process and any other aspects of integration they found a challenge. Non-probability convenience sampling was used and overseas perioperative nurses from four major teaching hospitals were recruited for the study. Following ethical approval from all study sites questionnaires were distributed to 220 nurses, 113 questionnaires were returned and analysed.

Analysis
For the purpose of this study quantitative data was collected from the questionnaires and analysed using SPSS. Descriptive data retrieved from the two open-ended items on the questionnaire was analysed using a thematic approach to add depth to the data

Summary of Key Findings
The findings of the study concur with previous findings in relation to the benefits of induction and ‘buddy’ programmes to assist in the
successful integration of overseas nurses. However communication
difficulties and different work practices remain a challenge for the
overseas nurses within the workplace setting.

Back to contents page
Title: An analysis of employers’ views on disability policy and the employment of people with enduring mental health problems.

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Background and context: The Mental Health Commission (2006) proposes that all mental health services adopt a recovery model in which open employment is a central focus in the rehabilitation of people with enduring mental illness. As yet there is a lack of published research on employers and people with mental health problems in an Irish context. The European Commission recently issued a Green Paper on Mental Health indicating that people with mental health problems have the highest rates of unemployment amongst all people with disabilities and called for more research in this area.

Aim of review: This ongoing research project aims to investigate employers’ views on Irish disability and equal opportunities policy with specific reference to the employment of people with mental health problems.

Methodology including research design and sampling: Research design consists of a mixed method approach, utilising surveys, individual depth interviews and focus groups as methods of data collection. Data will be collected and analysed from a random sample (n=145) of the local business population in the south east of Ireland.
Analysis: Statistical analysis will be conducted through entry into SPSS version 13. Data derived from individual depth interviews and focus groups will be analysed after each interview, charted and indexed thematically using the ‘Framework’ method of analysis. Data will then be comparatively analysed across themes and within cases.

Summary of key findings: As this research project is ongoing key findings will be summarised in October 2007.

Conclusion: It is anticipated that likely research findings and applications will include: information on the effectiveness of current employment support initiatives from the business perspective; identification and dissemination of good business practice when dealing with mental health issues in the workplace; dissemination to clinical and rehabilitation settings in mental health to inform recovery based service development and delivery.
PERCEPTIONS OF ORGANISATIONAL CLIMATE:
ARE NURSES IN THE REPUBLIC OF IRELAND SATISFIED
WITH THE CLIMATE OF THEIR ORGANISATIONS?

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

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

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

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

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

**Conclusion and Implications:** This is probably the first study of its kind to be completed in the Republic of Ireland. Therefore, the findings are significant and relevant to nurses and the nursing profession in this country. Creating a climate that offers interesting and challenging work and where employees are informed, involved, and respected is no doubt a major challenge for all managers. Nevertheless, it is incumbent on them to design and implement strategies that will promote a climate high in *humanistic thrust*, *esprit*, and *intimacy* and low in *aloofness*, *disengagement*, and *hindrance* within their organisations.
A randomised controlled trial of the psychological and quality of life effects of daily diary cards on patients undergoing chemotherapy

Noreen Cushen, Clonearl, Daingean, Co Offaly. RN, BSc (Hons), PgDip Research, Doctorate of Nursing Mob. 087-7976869 Email: noreen_cushen@hotmail.co.uk

Introduction
Cancer has a historical reputation for being a killer disease, a death sentence. Despite major advances in cancer therapies in recent years, cancer remains a leading cause of death in our society. A diagnosis of cancer still generates a range of responses, including fear, anxiety, treatment-related discomfort, anticipation of bodily disfigurement, and existential uncertainty. Counterbalancing this somewhat pessimistic outlook, the evidence in the literature suggests that cancer is one of the most curable of chronic diseases (Zollo 2000).

Aim of the study
To explore the possibility that the completion of daily diary cards by patients undergoing chemotherapy treatment for cancer can produce a classical conditioning response.

Primary objective of this study
To compare the patterns of nausea and vomiting between a group of patients using daily diary cards and another group not using daily diary cards.

Secondary objectives of this study
To identify the levels of anxiety of patients as they progress through their treatment regimen.
To explore the patients’ experience of completing the daily diary cards.

Research Hypothesis
There is a relationship between the use of daily diary cards (DDCs)and an increase in the incidence of nausea/vomiting and anxiety in patients receiving chemotherapy.

Research Design
As the primary objective of this study was to compare the nausea and vomiting scores between two groups of patients undergoing chemotherapy, priority was given to the approach needed for the principal data collection method. Therefore, a randomised controlled trial (RCT) was used to explore the patterns of nausea and vomiting.
from the Rotterdam Symptom Checklist (RSCL) and the possible psychological effects that completing DDCs had on patients. This was complemented by semi-structured interviews to explore the patients’ experience of completing the DDCs.
By adopting a complementary design approach, it was possible to delineate the data each method generated and analyse it separately.

**Design**
This study is a randomised controlled trial, comprising two groups: an intervention group and a control group.
Patients with breast or colorectal cancer receiving adjuvant chemotherapy (that is chemotherapy treatment after potentially curative surgery) were therefore randomly assigned to the treatment or control group. Randomisation was achieved as follows: the data manager within the cancer unit randomly allocated a patient number to either the intervention or the control group. Patient allocation was only revealed to the researcher after the patient had been given a study number. Through such randomisation, every participant had an equal chance of being included in the treatment or control group.

**Study setting, sample and selection**
All the patients recruited to this study were from a population of patients attending a cancer unit pre-assessment chemotherapy clinic at a large District Hospital. They had been diagnosed with pathologically confirmed breast or colorectal cancer needing adjuvant chemotherapy. Patients with a colorectal diagnosis received 5-fluorouracil (5FU) chemotherapy via a continuous infusion over twenty-four weeks changed weekly or as a weekly injection of 5FU over twenty-four weeks. Patients with a breast cancer diagnosis received either epirubicin at three weekly intervals for four cycles (Epi) followed by cyclophosphamide, methotrexate and 5FU (CMF) at three weekly intervals for four cycles, or 5FU, epirubicin and cyclophosphamide (FEC) given at three weekly intervals over six cycles.
All new patients who fulfilled the entry criteria were approached by the researcher or a research nurse and asked to participate in this study prior to the commencement of their first chemotherapy treatment.
All participants were given a description of this study including a written information sheet at their pre-assessment chemotherapy visit. A week later, and prior to commencing their chemotherapy, patients who had agreed to participate in the study were asked to sign a consent form. They were then randomised to either the intervention or control group by the data manager. Although patients were receiving chemotherapy for six cycles or twenty-four
weeks, data were collected for a total of five cycles or for fifteen weeks from patients in both groups.

**Inclusion Criteria**
All patients included in this study were older than sixteen years of age. They had a diagnosis of either breast or colorectal cancer requiring adjuvant chemotherapy. The reasons for choosing this group of patients was that their cancer had hopefully been removed at the time of their surgery and therefore the chemotherapy was being given to prevent further recurrence of their disease. Their overall long term survival was likely to be similar. They all either required six courses of chemotherapy at three weekly intervals or continuous chemotherapy over a twenty-four week period. They all had normal blood full blood counts and urea and electrolytes and were able to give written informed consent.

**Exclusion Criteria**
No pregnant participants were included. Patients with cerebral metastasis were excluded, as they would be receiving palliative rather than adjuvant chemotherapy. The visually impaired were excluded as the study involved completing several forms which may have proved difficult for them. Patients receiving radiotherapy to the abdominal or pelvic region were excluded as it would indicate advanced disease and may also have caused severe abdominal disturbance resulting in the patient complaining of vomiting or diarrhoea not related to chemotherapy. Patients unable to give informed consent were excluded as it would have been unethical to recruit them to the study.

Any patients that the health care team identified as extremely anxious or as having a known psychiatric illness were also excluded as these patients may have skewed the study. Different arrangements are made for this group of patients within the department which rendered them ineligible for this study. Patients receiving palliative chemotherapy were excluded as their disease progression could actually contribute to an increase in patterns of nausea and vomiting which again would have skewed the results.

**Outcome Measures**
Having considered many of the tools that were rigorously tested and found to be reliable in quality of life cancer studies, the RSCL and the HADS were chosen for this study. These two tools represent the most practical and reliable measures for assessing quality of life issues for cancer patients (Slevin 1992). In a study conducted by Hope-Stone et al (1997) these tools were used together to measure quality of life issues in advanced colorectal cancer research patients and were found to be easy to complete by most patients.
Hospital Anxiety and Depression Scale (HADS)
The HADS scale is a 14 item self assessment scale developed by Zigmund and Snaith (1983) for detecting anxiety and depression in a medical outpatient setting. As anxiety can contribute to the symptoms of nausea and vomiting, it was important to identify patients’ levels of anxiety using this tool. It is quick and easy to complete and does not present a significant intrusion for patients (Clark and Fallowfield 1986).

The HADS scale allows for careful differentiation of anxiety and depression using two seven item subscales. Scores indicate the severity of symptoms suggestive of anxiety and depression using a scale of 0-21. Overall scores of 0-7 are considered a non-case, 8-10 borderline, and 11-21 a case. The HADS scale is able to avoid somatic symptoms that could be attributed to physical disease rather than anxiety or depression.

The Rotterdam Symptom Checklist (RSCL)
The Rotterdam Symptom Checklist (RSCL) was originally developed as a tool to measure the symptoms reported by cancer patients participating in clinical research trials in the Netherlands by de Haes et al (1996). It comprises 30 items, each rated on a 4 point scale measuring physical and psychological dimensions of quality of life. It is easy to score and has been used in several cancer studies.

The RSCL is a self-report measure used to assess the quality of life of cancer patients. It is designed to cover four domains, physical symptom distress, psychological distress, activity level and overall global life quality. These domains form the main scales. The items regarding psychological distress have been interspersed among the items regarding physical distress in order to avoid response sets in the first place. It is easy to score and can be divided into different subsets. There are two main subscales, one for physical symptoms and the other for psychological issues. The scores given in the RSCL are 1= (not at all), 2 = (a little), 3 = (quite a bit), 4 = (very much); the highest score indicates the level of impairment (de Hanes 1996). The QOL item scores range from 1 = (excellent) at the top to 7 = (very poor) at the bottom. Scale scores are obtained by summatting scores of individual items.

Daily Diary Cards
The UK Medical Research Council (MRC) Daily Diary Card (DCC) for quality of life (QOL) assessment was first designed over twenty years ago and since then has been used continuously in cancer clinical trials organised by the MRC. However clinical trials using DCCs have only reached maturity since 1989. According to Fayers
(1995), results from a series of clinical trials confirm that the DCC appears to be a valid, reliable and sensitive instrument which is able to detect the transient changes in health and QOL which occur on a day to day basis during therapy for cancer. It is well documented that DDCs can be an extremely useful way of collecting data and that they are being used more often in many health care settings, for example in paediatrics as well as in the community (Oleske et al 1990).

Data Collection
Patients receiving chemotherapy for breast or colorectal cancers were invited to participate in the study. Participation involved the patients completing a number of self-completion quality of life questionnaires (both groups), DDCs (intervention group only), and following the RCT, some of the patients (ten of the patients in the intervention group) also had a tape-recorded interview with the researcher. Demographic data was obtained from all patients attending the pre-assessment chemotherapy clinics, and this was used to describe the characteristics of the sample as a whole.

Intervention group
All patients had a nausea and vomiting risk assessment prior to starting their first course of chemotherapy. This assessment was conducted to ascertain the patients’ understanding of their disease, treatment and side-effects. It included assessment of their anxiety levels, previous history of nausea and vomiting, for example motion sickness and age. The risk assessment tool was developed using recommendations and evidence from the literature on anticipatory nausea and vomiting and from an audit I had previously conducted using a similar tool a few years earlier with breast cancer patients undergoing chemotherapy.

It is suggested in the literature that approximately 25% of patients suffer from anticipatory nausea and vomiting. If patients are to suffer from anticipatory nausea and vomiting it can develop gradually and may only become evident after the fourth or fifth three weekly cycle of chemotherapy (Lee et al 2005; Duigon 1986; Pickett 1991; Quinton 1998). However, some individuals develop the symptoms after only one cycle, particularly if they have experienced poor control of nausea and vomiting with previous chemotherapy (Morrow 2002; Duigon 1986; Pickett 1991). Therefore data were collected on all patients up to and following the completion of their fifth cycle of chemotherapy for breast cancer patients and for 15 weeks for patients receiving weekly chemotherapy for colorectal cancer.
All patients were asked to complete the Hospital Anxiety and Depression (HADS) questionnaire and a Rotterdam Symptom Checklist (RSCL) prior to starting their chemotherapy and at the beginning of each cycle of chemotherapy for a total number of five cycles for breast cancer patients. Patients receiving weekly chemotherapy for colorectal cancer completed the HADS and RSCL prior to starting chemotherapy and then at weeks, 3, 6, 9, 12, and 15.

Patients randomised to the intervention group received daily diary cards to complete following each cycle of their chemotherapy treatment. They were also asked by the researcher or the chemotherapy nurses prior to their next cycle to describe any episodes of nausea or vomiting they had experienced since their last course of chemotherapy. Their responses were recorded in the patients’ notes and their patient information folders.

**Control group**

All participants in the control group had a risk factor assessment relating to nausea and vomiting prior to the commencement of their chemotherapy regimen that was completed by the research team. They also completed a HADS and RSCL questionnaire at the beginning of each cycle of chemotherapy, or every three weeks if they had a colorectal diagnosis. Following each cycle of chemotherapy or every three weeks they were asked to describe to the researcher or the chemotherapy nurses any episodes of nausea or vomiting or other symptoms that they had experienced following each course of chemotherapy. This information was documented in their medical notes and in their patient information folders.

**Data analysis**

The first stage in the analysis of quantitative data is to organise the raw data in a way that makes it easily understood. This involved scoring the quality of life questionnaires (QOLs) using the scoring criteria already available for them (HADS and RSCL). Once the scoring was complete, the scores were transferred onto an Excel spreadsheet. A simple scoring method for analysing the data from the DDCs was developed and this data was also transferred onto a spreadsheet in Excel. Once this process was completed all the data was transferred on to SPSS (Pallant 2001). Data was then checked for accuracy and missing data examined.

The differences of means of variables that provided interval data and between group changes were examined using the t-test. These variables included anxiety and depression scores from the HADS and physical and psychological scores such as nausea and vomiting.
from the RSCL. A non-parametric chi-squared test was used to examine variables that provided nominal data containing discrete categories such as age, sex, diagnosis and chemotherapy regimens. A significance level of p<0.05 was used throughout.

The data from the DDCs was examined using descriptive statistics to establish the average number of days per week that patients reported experiencing various problems with the different variables over the five cycles of chemotherapy. These included incidence of nausea and vomiting, activity levels, quality of life, sleep disturbance and anticipatory nausea and vomiting.

**Qualitative Research**

Qualitative research is an umbrella term that covers a variety of styles of social research that draw on a variety of disciplines such as sociology, social anthropology and social psychology (Denscombe 1999). It is a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that makes the world visible. These practices turn the world into a series of representations, which include fieldnotes, interviews, conversations, recordings and memos to the self.

Qualitative data, whether words or images, is the product of a process of interpretation. Sample sizes are small in scale and are either purposive or theoretical. Both approaches rely on the use of prescribed selection criteria.

The analysis of qualitative data is open to emergent concepts and ideas and may produce detailed description and classification, identify patterns of association, or develop typologies and explanations. Its outputs tend to focus on the interpretation of social meaning through mapping and ‘re-presenting’ the social world of research participants (Robson 2002).

**Sample and selection**

Qualitative samples are usually small in size. There are four main reasons for this. Firstly, if the data is properly analysed, there will come a point where very little new evidence is obtained from each individual fieldwork unit. Secondly, statements about incidence or prevalence are not the concern of qualitative research. Thirdly, the type of information that qualitative research studies yield is rich in detail. Finally, and related to this, qualitative research is highly intensive in terms of the research resources it requires and it would therefore be unmanageable to conduct and analyse hundreds of interviews (Ritchie and Lewis 2003).
Having had many consultations with all the participants in this study on several occasions throughout their treatment, a purposive sample of ten patients was selected. As one of the secondary objectives of this study was to get a greater understanding of the patients’ experience of completing DDCs, interviewing patients in the control group was not considered. Therefore, a sample was chosen from the main intervention group who had completed DDCs and included two male patients, aged 68 and 70, and eight female patients, aged between 60 and 74. Six patients had completed treatment for colorectal cancer (two male and four female) and four had completed treatment for breast cancer (See table 1). These patients were chosen as they represented both genders as well as both cancer sites and would give a range of opinions that would provide rich data. Although five males were approached to take part in the interviews, only two of them agreed. The other three were happy to be interviewed but did not want to be taped; therefore they were excluded from the interviews. All patients were interviewed for approximately thirty minutes and each interview was taped.

Table 1 - Number of patients interviewed about their Diary Cards:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Data collection

Having selected a purposive sample of patients to be interviewed, they were approached and invited to take part in a semi-structured interview. Following an explanation of the procedure, written consent was obtained from those willing to take part. The DDCs were used as the basis for questions and prompts but there was flexibility in terms of the order of the topics being considered during the interviews. This allowed the participants to develop ideas and speak more widely on the issues raised in the DDCs. Notes were also taken during the interview even though it was taped. This allowed comparison of the notes with the transcripts. It was also a useful safe proof mechanism in case of a taping problem. The interviews lasted approximately thirty minutes and were taped so that analysis of the whole interview could be achieved.

Data analysis

The data was transcribed on to A4 sheets in a way that allowed notes and comments to be added on the right hand margin. Other data such as field notes and comments from the diary cards was also transcribed onto A4 sheets. Having transcribed the audio-recording and having made some checks on the validity of the data
by returning them to the patients for comment, analysis of the data was begun. Decisions were made as to what meaning could be attributed to the words and what implications the words had in relation to the topic under investigation, which was the development of a conditioning response in patients completing daily diary cards.

The questions from the diary cards were used as a framework to obtain the information that had been collected (see table 2).

**Table 2 - Reference coding of questions from the taped interviews**

1. How did they find the presentation of the diary card and how easy did they find them to use?
2. Did they recall how many episodes of sickness that they had during their chemotherapy?
3. Was their sleep pattern disturbed?
4. Did their fluid or dietary intake alter?
5. If so was it due to nausea or vomiting?
6. Were their normal activities disrupted?
7. Did they use rescue sickness medication and if so did it help?
8. Did they ever feel sick before their treatment started? (ie 24hrs before)
9. When did they complete the diary card?
10. Any other comments?

By using this method, a reference code could be put on the raw material very easily. Each piece of raw material was allocated with a reference code ranging from one to ten as indicated in table 2. Each separate item could then be identified exactly in terms of where it should be located. The importance of this was twofold: when analysing the data it enabled a return to points in the data which were of particular interest and it also avoided getting muddled and losing the place where the raw data was originally located.

It was then possible to begin ‘open coding’ and categorising the data. The aim of open coding is to discover, name and categorise phenomena and also to develop categories in terms of their properties and dimension (Strauss and Corbins 1990). Following close scrutiny of the transcripts, field notes and text from the diary cards, comments and reflections were added in the margins alongside the raw data, and as the analysis progressed new interpretations were added to some of the data. Memos were kept as reminders of any new thinking on facets of the research. The memos also provided a log of the developing line of thinking which helped with an audit trail. In this way patterns and processes, commonalities and differences were identified (Miles and Huberman...
1994). Each time the data was revisited I was looking for themes and interconnections that recurred between the units and categories that were emerging. By doing this two main themes were developed which incorporated all the categories identified.

Sample and selection
The target recruitment sample for this study was seventy six. Eighty nine patients fulfilled the eligibility criteria and were approached during the data collection period to take part, but eighteen patients refused to participate mainly due to other commitments to drug trials in the unit. Therefore, only seventy one patients were recruited into this study between September 2003 and November 2004 (Table 3). This included sixty three females and eight males; 36 were in the control group (50.7%) and 35 in the intervention group (49.3%). The demographic characteristics of the sample are presented in Table 3 below. There are approximately 1000 patients diagnosed with cancer each year in the district hospital where this study was conducted, of which breast and colorectal cancers represent approximately fifty percent.

Table 3 - Number of patients recruited into the study:

<table>
<thead>
<tr>
<th>Patients</th>
<th>Male</th>
<th>Female</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer</td>
<td>8</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>0</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Totals</td>
<td>8</td>
<td>63</td>
<td>71</td>
</tr>
</tbody>
</table>

The number of females recruited into this study was 63 in total 34 (53.9%) in the control group and 29 (49.3%) in the intervention group compared with 8 males (11.3 %), 47 of the females had a breast cancer diagnosis 24 (51%) in the control group and 23 (48.9%) in the intervention group whereas 16 had colorectal cancer. All male patients had a colorectal cancer diagnosis. The mean age was 58.2 years for the control group and 59.4 years for the intervention group. Although 71 patients were recruited into this study, only 65 completed it. This included 31 in the intervention group and 34 in the control group. Six female patients did not complete the required documentation following the first cycle. Four of them were from the control group and two were from the intervention group (see figure 1: Flow of patients through the study). There were no extreme scores in the data from these six patients.
71 Patients recruited (63 female, 8 male)

47 patients Breast cancer, 24 Colorectal cancer

Chemotherapy regimens
33 = FEC
21 = 5FU

INTERVENTION GROUP
n = 35
19 = breast cancer
12 = colorectal cancer

CONTROL GROUP
n = 36
24 = breast cancer
12 = colorectal cancer

6 female patients dropped out following the 1st cycle of chemotherapy
4 = intervention group
2 = control group

65 patients completed the study in total

HADS/RSCL Questionnaires
Documentation of sickness
Diary Cards
31 = Completed all the documentation for the first five cycles of chemotherapy

HADS/RSCL Questionnaires
Documentation of sickness
No Diary
34 = Completed all the documentation for the first five cycles of chemotherapy

Following completion of the above,
10 patients were selected by the researcher from the intervention group group

Consent obtained by researcher

Interviews conducted by researcher

Analysis of quantitative data

Analysis of qualitative data
Although many more males were approached to take part in this study they refused as they were already participating in other clinical trials, thus accounting for the high proportion of females to males. All but three of the participants were white middle-aged British citizens. The other three were originally from China. All participants received adjuvant chemotherapy on either a weekly or three weekly basis. Thirty three of the females received FEC chemotherapy (44.7% in the control group and 51.5% in the intervention group) on a three weekly basis. Sixteen females received epirubicin and CMF (28.9% in the control group and 15.2% in the intervention group) on a three weekly basis. One female received CMF only and her data is included with the EpiCMF group of patients. She refused to have epirubicin due to the high risk of hair loss. Twenty one patients received 5FU chemotherapy (26.3% in the control group and 33.3% in the intervention group) on a weekly basis; eight were male and thirteen were female.

Findings

1 Analysis of quantitative data (Quality of life questionnaires)

Summary of results

Using a t-test to explore the relationship of the mean scores at baseline between the treatment and control groups on vomiting, nausea, anxiety, depression, psychological, physical and quality of life from subscales from the HADS and RSCL, no statistically significant difference was noted at the 5% level (p-value <0.05) between the two groups. However using a t-test to compare the mean score between the intervention group and control at baseline and over the five cycles, there was a statistical significance noted post the first cycle of chemotherapy at the 5% level (p-value <0.05).

The vomiting levels for patients in the intervention group (DDCs) increased throughout their treatment. The levels of vomiting for the patients in the control group increased slightly following the first cycle of treatment. This suggests that overall the patients in the control group had less episodes of vomiting than those in the intervention group.

The nausea levels for patients in the intervention group (DDCs) increased throughout their treatment. The levels were higher than the control group levels post cycles two and four. The levels of nausea for the patients in the control group were lower than at base line following the first cycle of treatment. However there was an increase in the levels for the second third and fourth. This suggests
that the levels of nausea increased for both groups as they progressed throughout their treatment.

Using a t-test to compare the mean score between the intervention and the control groups at baseline and over the five cycles of chemotherapy on anxiety (from the HADS), there was a statistical significance noted post the second cycle of chemotherapy at the 5% level (p-value <0.05). Overall the anxiety scores for the patients in the control group were higher at baseline and following the five cycles of chemotherapy. This suggests that the patients in the control group were more anxious than those in the intervention group.

Overall the mean depression scores (from the HADS) were higher in the control group at baseline and over the five cycles of chemotherapy. The difference reached statistical significance post the first cycle of chemotherapy (p=0.032) only. This suggests that the patients in the control group were more depressed that the patients in the intervention group. However, none of the patients’ scores from the HADS in either group suggested that the patients were suffering from depression.

On the psychological mean scores from the RSCL there was a statistically significant difference (p=0.001) between the intervention and the control groups post the first cycle of chemotherapy. Overall the psychological scores were lower in the intervention group at baseline and up to the fifth cycle of chemotherapy. This suggests that the patients in the intervention group suffered less psychological morbidity than those in the control group.

There was also a statistical significance noted in the physical mean scores from the RSCL (p=0.02) post the first cycle of chemotherapy. The scores were lower in the intervention group at baseline and up to the fifth cycle of chemotherapy. Both group scores increased as they progressed through their treatment but overall the control group scores were higher at baseline and throughout treatment. This suggests that the physical activities for both groups decreased as they progressed through their chemotherapy treatment but that the patients in the control group were physical less active than those in the intervention group.

There was no statistical significance noted in the activity mean scores between the treatment and control groups. The scores for both groups increased as they progressed through their treatment, which suggests that their activities of daily living reduced. The scores were generally higher in the intervention group which
suggests that the patients in the control group were able to do more for themselves than the patients in the intervention group.

There was a statistical significance noted in the quality of life scores from the RSCL post the first cycle of chemotherapy \((p=0.026)\) between the control and the intervention group. The scores in the control group were higher up to the fourth cycle of chemotherapy; however the scores were the same post the third and fourth cycles of chemotherapy for both groups. This suggests that the quality of life for patients in both groups decreased as they progressed through their treatment but was worse for patients in the control group for the first three cycles of chemotherapy.

2 Analysis of quantitative data (Daily Diary Cards)

Summary of results
The patterns of vomiting noted from the DDCs suggest that patients’ episodes of vomiting were worse at weeks four and seven. Patients reported vomiting on two and a half days out of seven on each of these weeks. Patients in all chemotherapy groups reported days of vomiting for all fifteen weeks but the patients who received FEC chemotherapy for breast cancer appeared to vomit the most out of the three groups of chemotherapy. The pattern of nausea reported appears to have been worse at weeks seven and ten. Patients in all chemotherapy groups appear to have reported nausea for at least one day each week for fifteen weeks. Patients who received FEC chemotherapy reported a higher incidence of nausea than patients in the other two chemotherapy groups.

The pattern of anticipatory nausea was noted at its highest on weeks four, nine, and twelve. No patients reported anticipatory nausea for week six, and patients who received FEC chemotherapy reported the highest levels of anticipatory nausea. The pattern for anticipatory vomiting scores was at its highest on weeks, three, six, twelve and fifteen. There were no incidences of anticipatory vomiting reported at weeks one, two, nine, ten and eleven. Patients in all groups reported having one day of anticipatory vomiting.

Patients’ sleep patterns were disturbed more on week eight of their chemotherapy treatment than any other week. Patients in the EpiCMF group reported the highest sleep disturbance than the patients in the other chemotherapy groups. Patients reported the incidence of interrupted activity relating to nausea and vomiting as highest on week thirteen. Patients in the EpiCMF group reported the highest incidence, however patients in all chemotherapy groups reported at least one day of interruption to their usual activities due to nausea and vomiting.
The comments written on the DDCs suggest that some patients experienced high levels of fatigue as they progressed through their chemotherapy. Hair loss appeared to have been very distressing for several patients and appeared to have had a big impact on their body image. Many recorded dietary concerns regarding altered taste and lack of appetite. Some suggested this was due to nausea. Some patients used complementary therapies to help them combat nausea and vomiting. Many found indigestion to be the worst symptom of their chemotherapy. Many of these comments were echoed in the semi-structured interviews and will be explored further in the next chapter.

3 Analysis of qualitative data (Daily Diary Cards)

Summary of results

The patients who completed the DDCs recorded a range of side-effects and issues that were important to them whilst undergoing adjuvant chemotherapy for breast or colorectal cancer. Their issues and side-effects were analysed within two themes, physical and psychological. Nausea and vomiting, including anticipatory nausea and vomiting, anxiety, fatigue, dietary needs, body image and sexuality problems were reported by the patients as being problematic at some stage of their chemotherapy treatment. Compliance with completing the DDCs varied amongst the patients interviewed, with only three out of the ten completing them as they were instructed by the research team. Some patients used denial to help them cope with their cancer diagnosis and treatment and some patients’ comments suggested that the completion of the DDCs reinforced a conditioned response to illness for them. Many patients used complementary therapies, which they self-funded, to help them cope with their cancer diagnosis and the effects of the chemotherapy treatment. These key points from the interviews are presented in Table 4 and together with the results from the quantitative data will be discussed in more detail in the following chapter.
Table 4 - Summary of the key points identified from the qualitative interviews

| 1. Compliance with completing DDCs. | Only 3 of the 10 patients completed the DDCs as instructed by the research team. |
| 2. Coping strategies and complementary therapies | Coping strategies such as denial and complementary therapies were used by patients. |
| 3. Completing the DDCs evoked a conditioned response | Some of the patients suggested that completing the DDCs made them think about their illness and made them feel sick |
| 4. Dietary and sensory changes during chemotherapy | Several of the patients reported indigestion, food avoidance and sensory changes as they progressed through their treatment. |
| 5. Fatigue as a problem | Most patients described fatigue as very debilitating for them at most stages of their chemotherapy treatment |
| 6. Chemotherapy nurses used avoidance or blocking behaviours to deal with sensitive issues such as sexuality and altered body image | Some patients suggested that they would have liked to discuss personal issues such as relationship difficulties with the chemotherapy nurses but they felt that the nurses were always too busy |
| 7. Patients’ symptoms were not always assessed or managed appropriately as they progressed through their treatment | Many patients suggested that their symptoms such as indigestion, fatigue, dietary problems were not addressed by the health care team |

4 Discussion following analysis of quantitative and qualitative data

Introduction

The aim of this study was to explore the psychological effects on patients of completing daily diary cards relating to nausea and vomiting and to get a greater understanding of the difficulties they experience when undergoing adjuvant chemotherapy for breast or colorectal cancer. The study design included a combination of quantitative and qualitative methods. The results identified a
number of factors that could impact on the care that oncology nurses provide to patients undergoing chemotherapy.

This study has clearly demonstrated that using DDCs to collect information from patients undergoing chemotherapy, especially in relation to their nausea and vomiting symptoms, can provide useful information. The information obtained from the DDCs, the QOL questionnaires and the semi-structured interviews indicate that the range of side-effects experienced by patients can be extensive. Patients reported and described a range of both psychological and physical symptoms as being problematic at some stage of their chemotherapy treatment. In an attempt to cope with the side-effects of the chemotherapy treatment, complementary therapies were used by several patients to assist them in combating some of the difficult symptoms such as nausea.

Section 1: Patterns of nausea and vomiting
Cytotoxic chemotherapy has a reputation for causing severe and unpleasant side-effects. Those most frequently reported by patients are nausea and vomiting (Lee et al 2005; Kaye 1991). Patients have reported that nausea and vomiting are their first concern when receiving chemotherapy (Dibble et al 2004; Morrow 2002) and it was an issue raised by most of the participants in this study.

The most dramatic development in recent years has been the introduction of highly selective antagonists of the type three serotonin receptor anti-emetics. These anti-emetics are now used widely in the prevention of nausea and vomiting in cancer patients with variable success (Grunberg et al 2004) and all patients in this study received them. Patterns of nausea and vomiting from the DDCs and nausea and vomiting scores from the RSCL were explored in this study and the results suggest that nausea and vomiting is still a problem for patients undergoing chemotherapy. The nausea and vomiting scores from the RSCL from baseline and between courses showed that the patients in the intervention group had more nausea and vomiting episodes than the patients in the control group.

The characteristics of the patients in both groups were similar at baseline so perhaps the daily reporting of nausea and vomiting episodes in the DDCs reminded patients in the intervention group of their chemotherapy and induced more nausea, but particularly more vomiting episodes. As in Pavlov’s classical conditioning paradigm, the injection of chemotherapy drugs (unconditioned stimulus) produced physiological nausea and vomiting (unconditioned response). The pairing of neutral stimuli, the daily diary cards, with the injection of the drugs (unconditioned stimulus) results in these
previously neutral stimuli becoming conditioned stimuli and thus the completion of the DDCs may have induced more episodes of nausea and vomiting. This conditioned response to nausea and vomiting is not new (Pratt and Lazar 1984; Warr et al 2005). Some patients reported that completing the DDCs reminded them of their illness and for some it evoked symptoms of nausea and vomiting. In this instance the DDCs were the trigger that caused the anticipatory nausea/vomiting (ANV). Comments included: ‘every time I filled in the DDCs I thought about my next chemotherapy and it made me feel queasy’. Morrow (2002) found that the frequency of ANV increases almost linearly with the number of chemotherapy cycles given. This study showed the pattern of ANV increased as patients progressed through their chemotherapy cycles, peaking at the third and fourth cycles.

Bloechi-Daum et al (2006) and others have reported the adverse effects of chemotherapy induced nausea and vomiting on patients’ daily lives. Anecdotal evidence and comments from the patients who participated in this study suggest that anticipatory nausea and vomiting (ANV) may have a major impact on their quality of life. Some of the patients who completed the DDCs also suggested they found it ‘a struggle’ emotionally to fill them in, especially after their first cycle of chemotherapy. Others said the presence of nausea contributed to the decrease in their overall wellbeing. It is documented in the literature that at least 20% of patients suffer from ANV before their second cycle of chemotherapy (Lee et al 2005; Morrow 1998). In this study breast cancer patients receiving FEC chemotherapy in the intervention group documented more episodes of ANV than patients in the other chemotherapy groups. ANV is a highly unpleasant symptom that precludes other mental and physical activity and according to Fabi et al (2003), greater attention is required in clinical practice to manage these symptoms. Behavioural intervention strategies for anticipatory symptoms have achieved varying levels of success after the symptoms have become apparent (Marchioro et al 2000). There are several suggestions within the literature (Dibbble et al 2004; Blasco et al 2000; Morrow 1998; Pickett 1991) that identifying patients who are at high risk of anticipatory symptoms before they receive any chemotherapy could prevent some of these problems. Age under 50, female gender, a history of motion sickness, and previous experience of emesis are generally considered risk factors for emetogenic therapies. There is also evidence of a gender difference in that the most sensitive patients appear to be pre-menopausal women (Gall 1998).

In a study conducted by Dibbble et al (2004) with a group of breast cancer patients receiving chemotherapy, it was found that patients with a history of motion sickness had significantly more vomiting
than those who did not suffer from motion sickness. However the findings from this study did not confirm their findings. At the risk assessment prior to treatment, twenty patients reported suffering from motion sickness; eight of these were in the intervention group and twelve in the control group, but the patients in the control group reported less nausea and vomiting. Sixteen patients reported suffering from emesis in pregnancy with equal numbers in each group. Thirteen patients were identified as having moderate levels of anxiety and only five of these were in the intervention group. Many researchers suggest that anxiety increases the potential for ANV (Love et al 1882; Andrykowski and Gregg 1992; Pickett 1991; Morrow 2002) and higher levels of nausea and vomiting. The findings from this study suggest that the patients in the control group had higher levels of anxiety than those in the intervention group but the patterns of nausea and vomiting reported by the control group were lower. Eleven patients in total were under fifty years, four of these were in the intervention group.

Considering the risk factors and the numbers of patients identified as being at risk of developing ANV in both groups at pre-assessment, the patterns of nausea and vomiting reported did not reflect the potential numbers identified. There were more patients identified as having potential tendencies to suffer from nausea and vomiting in the control group, however the patterns for both nausea and vomiting were lower in this group of patients. It may be that the recording of symptoms in the DDCs produced a conditioned response and therefore induced more episodes of nausea and vomiting in the intervention group, or another explanation for this may have been less reliable recording of symptoms by the patients in the control group. Many patients receiving 5FU chemotherapy (which is expected to induce much less sickness) described incidence of nausea and vomiting and ANV throughout their treatment, and some of the patients interviewed who had received 5FU chemotherapy described nausea as the most distressing symptom of their treatment ‘and having to complete the DDC every day did not help’.

Several patients in the intervention group reported taking extra antiemetics to help combat their nausea. Anti-emetics do not control ANV once it has developed, and indeed has been found by some researchers to paradoxically increase symptoms (Harman 1996; Olver 2005) perhaps by causing a conditioned stimulus themselves. As a learned phenomenon, ANV is treatable by means of behavioural approaches based on learning principles such as progressive muscle relaxation training, systematic desensitisation, hypnosis and cognitive distraction.
Section 2: Daily Diary Cards

One of the secondary objectives of this study was to explore the patients’ experience of completing the daily diary cards, as well as obtaining a greater understanding of the patterns of nausea and vomiting they experienced as they progressed through their chemotherapy treatment. Compliance among the patients completing the DDCs in this study varied. Although most of them completed all the sections of the diary card, only three out of the ten patients that I interviewed actually completed them as they were instructed. Therefore, it is difficult to ascertain how many of the other remaining twenty-one patients completed them as instructed. It was assumed that the patients would complete them themselves on a daily basis. However, it is quite likely that in some cases discussion with their spouse or some other persons may have influenced the responses given. It is also possible that these other people may have assisted or indeed in some instances completed the DDCs. The impact of this remains unknown.

Compliance has frequently been found to be a problem in quality of life assessments (Baum et al 1979). In a study conducted by Verschelden et al (1996) on the compliance with, and accuracy of, daily self-assessment of peak expiratory flows in asthma patients over a three month period, they concluded that compliance was generally poor and that a substantial percentage of the values were invented. This concurs with the findings in this study as the information recorded on the DDCs of the ten patients who were interviewed did not match with what they described at interview. Fayers (1995) suggests that to improve compliance, clinicians and nurses should encourage patients to complete the cards and then discuss with them what they have recorded. He suggests that clinicians should use the DDCs as a convenient method of capturing information about how the patient has been feeling since last attending the hospital. This may improve compliance but it is not always feasible for a health care professional to do so due to time constraints or lack of trained staff in a busy clinic.

de Haes et al (1996) suggest that the compliance of patients, especially when ill, will be enhanced if an instrument is short and easy to complete. However, as seen in completing this study, the length and ease of the instrument used does not appear to matter, as all ten patients interviewed said that the DDCs was easy to complete and well presented, yet most of them were completed in a rather haphazard way.

It is difficult to know which patients in any study or clinical setting will comply with completing data as requested by the research or clinical teams and their lack of compliance can lead to serious
biases. Therefore, when looking at compliance, researchers need to understand that a completed diary card or indeed a quality of life questionnaire may not always be a true representation of a patient’s symptoms or experience.

Section 3: Psychological Issues

Anxiety

Many researchers have suggested that an increase in anxiety levels pre chemotherapy and throughout treatment can contribute to increased levels of nausea and vomiting (Blasco et al 2000; Andrykowski ang Gregg 1992). Therefore, as a secondary objective of this study, the anxiety and psychological distress levels were measured using the HADS and the RSCL for patients in both the intervention and the control groups. Detecting and managing anxiety and depression in physically ill individuals, and especially those with cancer, can be difficult. Normal fears of death, disfigurement, pain and disruption of relationships may be especially difficult to distinguish from severe, disabling distress far beyond normal anxiety or depression. Receiving chemotherapy has been likened to riding a ‘psychological roller coaster’ of alternating sickness and health (Cohn 1982). The RSCL and the HADS questionnaires which were used to measure psychological morbidity included subscales such as irritability, worrying, depressed mood, nervousness, despairing about the future, tension and anxiety. Anxiety and depression were measured by both the RSCL and the HADS in this study. The findings showed that there was a statistically significant difference between the mean scores noted on all the psychological factors of the intervention and control groups following the first cycle of chemotherapy with the scores in the intervention group being significantly lower than those in the control group. This was surprising but may have been due to the fact that all the patients in the intervention group were assessed and supported throughout their treatment by a member of the research nursing team whereas the patients in the control group were seen routinely by the medical or chemotherapy nursing teams. In a study conducted by Hope-Stone et al (1997) using the RSCL for patients with advanced colorectal cancer undergoing phase I/II studies, it was concluded that their quality of life was not adversely affected and this in part was attributed to the high level and intensity of support they received from the research nurses. In this study, the support given to the intervention group of patients by the research nursing team was more intensive than the control group and perhaps this attributed to the difference in their psychological scores.

The diagnosis, course and treatment of cancer has extensive psychological repercussions for the individual and their family
Anxiety related to health status is the second most frequent source of anxiety for patients receiving treatment for cancer (Massie 1990). Some of the patients who were interviewed described ‘cancer’ as such a ‘scary word’ to them. Others described how they were ‘frightened that they would become a burden on others during their chemotherapy treatment’. Therefore it is important that patients are allowed time to discuss these issues and that health care professionals are aware of the impact this could have on patients’ well-being and imperative that it is managed appropriately.

There is increasing evidence that cognitive behavioural techniques for managing psychological difficulties are helpful (Moorey and Greer 2002). These techniques have been shown to be easy to use, for example relaxation and distraction, and have proven to be effective in decreasing mild to moderate depressive symptoms (Holland et al 1991; Satterley 2006). However these services are not usually routinely available to cancer patients.

The enhancement of patient well-being through maximising beneficial coping strategies is another means of reducing psychological distress. Patients described how they used various coping strategies to get them through their treatment. One of the descriptions used was: ‘I had to change the way I did things. Instead of helping others I found that accepting help from my friends and family with household chores helped me to cope with it all (FP2)’. Coping strategies are those processes people use to try to manage real or perceived deficiencies between demands imposed by a crisis such as a diagnosis of cancer and the resources available to respond to it (Holland et al 1991).

For some individuals a diagnosis of cancer and its many associated complications may reactivate a pre-existing anxiety disorder (Krishnasamy 2001). Most of the patients said that their emotional distress got better as they progressed through their chemotherapy cycles as they knew what to expect but they also mentioned how scared they felt as their treatment completion date was approaching. This was confirmed by the quantitative analysis. The psychological scores for both groups of patients from the RSCL showed that their scores after the third cycle of chemotherapy were lower than their scores at baseline (their emotional distress improved as they progressed through their treatment) but then their scores increased after the fourth cycle of their chemotherapy as their completion date was approaching.

The anxiety scores from the HADS showed a statistically significant difference between the mean scores between the intervention and
the control groups after the second cycle of chemotherapy. Although the patients who were interviewed suggested that they felt less anxious as they progressed through their treatment, there was an increase in the anxiety scores for patients in both groups from baseline following all courses of chemotherapy. The findings also suggest that the completion of the DDCs did not cause an increase in the anxiety levels for the patients in the intervention group but again this may have been due to the level of support they received from the research nursing team. The levels of anxiety were generally higher in the control group and other studies (Morrow 2002; Jimenez et al 2006) have found that increased anxiety levels can cause an increase in nausea and vomiting, but the patterns reported in this study were lower for the patients in the control group.

**Depression**
The incidence of depression has been found to range from 4.5% to 42% in populations of people with cancer (Golden et al 1991). The depression mean scores from the HADS in this study showed a statistically significant difference between the treatment and the control groups post the first cycle of chemotherapy. The scores in the intervention group were lower than the control group. The scores were lower throughout the treatment for the patients in the intervention group though none of the scores indicated that the patients were suffering from depression. If the statistics on the incidence of depression from Golden’s study are correct then it could be assumed that some of the patients in this study would be suffering from depression. However, as already discussed, documentation of symptoms on questionnaires may not always reflect the real situation. During the interviews, some of the patients described symptoms of depression they had experienced whilst undergoing chemotherapy but this was never highlighted in the scores from the HADS or the RSCL and one patient had even elected to undergo a course of cognitive behavioural therapy to help her cope with life following the completion of chemotherapy treatment. This highlights the difficulty of recognising and diagnosing patients who are suffering from depression in practice.

**Quality of Life**
Health-related quality of life is increasingly recognised as an important outcome measure in patient care, not least with regard to oncology treatment-related morbidity (Porzsolt et al 1996). Over the brief history of quality of life research, there has been a trend away from the clinician ratings to patient self-ratings. Jarrett and Payne (1995) recommend that QOL assessments should be made by the patient.
This study compared the quality of life scores between the control and the intervention groups on the RSCL. There was a statistical significance noted after the first cycle between the mean scores of the treatment and control groups. The scores in the intervention group were much lower. The comparison of scores showed that the patients in the control group improved as they progressed through their treatment but the QOL of the patients in the intervention group decreased. However, overall the scores in the intervention group were lower than the control group and the scores for both groups post the third and fourth cycles were the same. Perhaps the scores increased in the intervention group because they were given several opportunities to discuss specific symptom and personal issues with one of the nursing research team at various intervals throughout their treatment, whereas the control group may not have focused as much on their personal or symptom issues or indeed have had an opportunity to discuss them with the healthcare team. Or maybe it was to do with the coping styles that cancer patients used and the influence this has on the possible side-effects of chemotherapy as examined by Lerman et al (1990) and discussed earlier in the literature review, which suggests that information seekers experience more symptom problems than those who avoid any information.

**Body Image**

It is not difficult to understand how the experience of cancer can affect body and self. It can remove the certainty that the body can be relied upon. Most of the females interviewed said that they found having breast surgery very difficult. One patient described how she was unable to look at her body image in a mirror since having her surgery. This is not surprising as in our society breasts symbolise motherhood, nurturing, child rearing and the traditional woman’s role and are also viewed as an essential part for seduction and sexual pleasure (Wellard and Joyce 2000). The prospect of breast surgery and associated treatment creates fear and concern about future survival, and also raises anxiety related to alterations to body image, loss of femininity and changes in personal relationships. Another patient described how she would not allow her husband see her naked as she ‘felt like a freak’ since she had her mastectomy.

Women today equate body image, their sense of attractiveness, and personal worth with sexuality and gender identity. Two of the female patients said that there were occasions when they would have liked to discuss their problems about their altered body image with the chemotherapy nurses but they felt the nurses were far too busy and were more concerned with giving them their chemotherapy than listening to them. This is an example of how nurses use blocking behaviours to prevent patients discussing sensitive issues with them and needs to be addressed. Having
surgery such as a mastectomy can be devastating as highlighted by some of the patients’ comments, but other physical symptoms such as hair loss can be just as devastating to some patients.

Ever since the increased use of drugs in the treatment of cancer in the 1970’s, the distressing effect of alopecia has been recognised. Many female patients in this study mentioned this. It was described as ‘the worst moment of their treatment’ and ‘totally devastating’. Although alopecia is usually reversible and wigs are made available routinely through the National Health Service, it appears that health care professionals are perhaps rather blasé when it comes to recognising and addressing the traumatic emotional effect it has on patients. The patients in this study said that the wig service which was provided by the NHS and the private sector was variable and their experiences ranged from excellent to very poor. Choosing a wig is a very emotional and distressing time for patients, therefore they need all the support possible to make this a good experience. Psychological distress due to alopecia is also generally considered to be worse for females as opposed to males. This may be true but the men who participated in this study did not receive a drug that causes hair loss, so it was not an issue for them anyway. Batchelor (2001) suggests men are probably able to cope more easily with alopecia because male baldness, even in young males, is more socially acceptable.

Attempts have been made to overcome this problem by reducing the blood supply to the hair follicles during drug administration by using scalp cooling but this is not effective in all cases. In this study patients were not offered scalp cooling as an option because the equipment was not available in the department and some health care professionals did not see alopecia as a major priority for investment. Patients interviewed described how their ‘femininity was gone’ when their hair fell out. Others described how they knew there was nothing that anyone could do to prevent their hair loss but having someone to listen and support them through this difficult time was very important to them. As already discussed, chemotherapy nurses are well placed to help manage some of the difficulties that these patients face. Nurses could therefore highlight the choices available to patients, provide a willingness to listen, have the knowledge and skills to identify patients’ needs and worries and adapt a collaborative approach to maintaining the physical and psychological well-being to produce an overall positive impact. Collaborative and negotiated care that fully integrates the patient’s view of care promotes compliance and is essential to the planning of treatment (Gower et al 1995).
Sexuality

Despite a wealth of literature and an increasing quantity of research about sexuality it is apparent from some of the comments on the QOL questionnaires and made by patients during their interviews that the subject of sexuality is avoided by health care professionals. The RSCL QOL questionnaire was completed by all patients in this study, but the section on *decreased sexual activity* was either ignored by some patients or completed with a flippant comment such as ‘*what sexual interest?’* or ‘*it would be good to talk to someone about it’* or ‘*what’s that!*’. Sexuality and sexual functioning can be disrupted either by the psychological and physical effects of cancer and its treatment at any stage of the illness. Even before the confirmation of a diagnosis of cancer, the psychological and physical effects of the illness can impinge upon a person’s sexuality.

Cancer can cause a loss of sexual desire throughout the illness experience. Patients in this study described how they felt sexually unattractive due to alopecia, mastectomies and nausea and vomiting. These comments were generally responses from the female patients and were usually volunteered when the patient’s husband or partner were not present.

Cancer and its treatments can expose and emphasise previous sexual and relationship difficulties. Most of the literature on ‘how to help’ with sexual concerns comes from America which may suggest that this is an issue which is either ignored or not considered important enough to explore by health care professionals in the United Kingdom and indeed this was reflected in the comments made by some of the patients in this study. Although within society today there is an expanding awareness of sexuality at all ages, people still seem to experience difficulties in asking for information or help with sexual concerns. One of the female patients interviewed mentioned how she was concerned about the effect that her treatment was having on her physical relationship with her husband and that she would have welcomed an opportunity to discuss it with a health care professional. Another patient mentioned the fact that the chemotherapy nurses were always so busy and that she did not want to waste their time over her ‘*silly relationship queries*’. Nurses need support to discuss the difficulties they experience both positively and negatively on sexual issues to build confidence in this area so that they can support their patients (Dennison 2001). Challenging the taboo of sexuality, and overcoming the fears and embarrassment of talking about sexuality, can be satisfying for the health care professional. Helping and supporting patients to understand and cope with sexual concerns enables the health care professional to cross the boundaries of
intimacy and view the person holistically with individual desires, needs, attitudes and behaviours.

Section 4: Physical Issues

Changes to physical appearance from the effects of cancer and its treatment can have a significant effect on patients. The following section will reflect on the impact of the physical issues that patients experienced as they progressed through their chemotherapy; these include fatigue and dietary and sensory needs. Various strategies will be explored from the literature to help nurses to identify and support their patients with these issues as they progress through their treatment trajectory.

Fatigue

Fatigue continues to be for the greater part a 'socially invisible' consequence of cancer, the experience of which is far more complex than simply a lack of visibility (Thorne 1993). It has a profound effect on an individual's ability to live a 'normal life'. All aspects of life may be affected, forcing withdrawal from family, work, social and recreational activities. It was certainly seen by most patients in this study as an issue for them during their chemotherapy treatment.

When asked to document any other comments on the DDCs or when asked to add any other information during their interviews, most of the patients reported issues related to quality of life. Of these, fatigue was reported by most of them as being a problem at some stage of their chemotherapy treatment. This is not new as it is considered one of the most frequently reported symptoms in patients with cancer and as a consequence of anti-cancer treatment (Stone et al 2000). A number of theories have been put forward to explain chronic fatigue though as yet no conclusive explanation exists. For example, one theory is that fatigue is caused by an accumulation of waste products and metabolites (Corner 2002).

Simple everyday tasks such as personal care, walking, cooking for their home and eating can become an uphill struggle for patients with cancer. This was mentioned in some of the comments on the DDCs: 'I can’t do my housework or cook like I used too, I get so tired’. This is a side effect which is often not seen by clinicians as being as important as other symptoms such as pain. Stone et al (2000) found that fatigue affects more patients for more of the time than any other symptom and is regarded by patients as being more important than pain, nausea or vomiting.

Little attention has been paid to assessing the value of specific interventions for managing fatigue. Activity pacing, goal setting,
The identification and priority activities have repeatedly been identified as potentially helpful interventions to manage fatigue. In this study, men referred to their fatigue in terms of *loss of energy* and *muscle weakness*, so having programmes that concentrate on physical interventions may be very useful for them. If we accept that caring is attending to the ‘whole’ person, we must develop skills to work with individuals in such a way that phenomena such as fatigue cannot be reduced to specific component parts. McIntyre (2005) and others have designed gentle exercise programmes to help combat fatigue, which has catered for the needs of patients with different levels of fitness and different types of cancer. These programmes have been evaluated well and perhaps they should be made available to all patients. However, like most interventions, to develop these programmes would have financial implications that would need to be addressed by health care commissioners. For patients who suffer from this debilitating symptom, the potential benefits that gentle exercise programmes may have for them could outweigh the costs and may in fact reduce other health costs. It could reduce the volume of referrals to other specialist clinics or the need to have extra nutritional supplements prescribed and for some patients the administration of erythropoietin which can be very expensive.

**Dietary and Sensory Issues**

Food usually has an important role in any culture and most of us generally associate food with an enjoyable use of time. While food may be seen as a normal part of daily living, health care workers concentrate sometimes on the physical impact of eating rather than the broader social or cultural issues. Cachexia and weight loss can be characteristic symptoms in a person with cancer. Nutrition is a problem that affects all cancer patients to varying degrees during their illness. As with other symptoms of cancer or side-effects of chemotherapy, identifying the cause or causes is an important part of devising an effective therapeutic strategy.

Cancer patients receiving chemotherapy frequently report changes in their sense of taste (Berteretche et al 2004). Most patients who participated in this study were affected by alterations in their sense of taste and smell. This occurred immediately following their chemotherapy for some, but with others it was an ongoing problem throughout their treatment. This led to some patients avoiding certain foods or indeed ‘going totally off their food’. However, it is not clear whether these alterations result from changes in taste or olfactory perception (Beidler and Smith 1991), since taste, smell, and somatosensory stimuli are tightly integrated during eating (Corneau et al 2001). Chemotherapy reduces appetite through nausea and vomiting, but the development of conditioned food
aversions because of association of certain foods with the memory of treatment-induced nausea or vomiting can also contribute to anorexia and weight loss. Many of the patients described how they had developed an aversion to peppermint tea and ginger because of the association of these foods with their chemotherapy treatment. This suggests that it may be possible to develop a conditioned response to these foods as it correlates with Pavlov’s theory of classical conditioning (Siegel and Kreutzer 1997)

Berteretche et al (2004, p575) suggest that

‘In order to prevent the risk of anorexia and the enhanced morbidity relating to this deficit, treatment should include relevant information to the subject for anticipating objective taste modifications and a psychological follow-up during the actual change of taste quality perceptions in everyday life’

In theory, this may work, but the reality is that there are not enough people trained in psychological interventions to this level who could provide such support. Health care professionals are striving to ensure that patients’ information needs are met at every stage of their disease trajectory and this has greatly improved over the past few years. However, without the appropriate levels of psychological intervention and support, prevention of anorexia and reduction of morbidity relating to sensory changes are still a long way off.

Indigestion was rated as a very troublesome symptom for many of the patients in this study. Indeed, it was reported by half of the participants as being problematic at some stage of their treatment. It was described by all patients in terms of ‘acid indigestion’. Patients avoided certain foods such as fruit and vegetables as they felt these foods contributed to their ‘acid indigestion’. This is a side effect which is not reported in the literature as having any great impact on patients’ quality of life while undergoing chemotherapy. However, the findings from this study suggest that patients see it as significant. Almost all of them are prescribed steroids as prophylaxis against nausea and vomiting and it is well documented that steroids can cause upset to the gastrointestinal tract. Perhaps if all patients were prescribed an antacid alongside the steroids this might help to reduce or even prevent this troublesome symptom.

Many of the female patients reported gaining weight as they progressed through their chemotherapy. This is not new and it has been demonstrated that a high percentage of women treated for breast cancer with chemotherapy gain weight (Rafferty 1995; Hoskin et al 1992). Part of the explanation may be that patients are
unwell when undergoing chemotherapy and therefore reduce their normal activity and avoid exercise. Helping patients control their weight whilst undergoing chemotherapy can be very difficult for health care professionals as they are faced with a dichotomy: on the one hand they are advising patients to eat as healthily as possible encouraging them to include plenty of fresh fruit and vegetables in their diet, but as mentioned earlier, many patients in this study suggested that fresh fruit caused them to have severe indigestion and stopped eating it. Due to alterations in taste, some patients reported ‘going completely off their food’ during their chemotherapy, this also causes concern amongst health care professionals and they advise patients to eat small amounts of food regularly. Sometimes the only foods that patients can then tolerate contain high concentrations of fats and carbohydrates and this advice can contribute to their gaining weight.

Section 5: Information needs and denial as a coping strategy

Many individuals have described the diagnosis of cancer as ‘devastating’, producing a more alarming response than that of any other disease process (Wells 2001). Newly diagnosed patients find themselves thrust on a journey which disorganises their daily function, and which is surrounded with much fear and uncertainty. One patient described how she was ‘devastated when I was told I had cancer’ and how she thought ‘I was going to die’. At the onset patients have to assimilate important information about their condition and treatment options, and many embark on treatment regimens that can threaten their physical and psychological well-being. An informed patient is one who can anticipate and prepare for events that may occur and an informed patient is one who has the best chance of coping and benefiting from treatment (Swinbourne and Tattersall 1999). However, this is not always the case and one of the patients interviewed described her experience as ‘confusing’ and ‘overpowering’ when given her information at a surgical outpatient clinic before she started her treatment.

Many described the diagnosis of their cancer as ‘devastating.’ It was evident from patients interviewed that the experience of cancer chemotherapy and its side-effects varies greatly not only between individuals but also for the same individual over time. Most of the patients interviewed said that they coped differently at different times. The importance of information, explanations and dialogue at every stage of the disease trajectory is important so that patients can adapt to their illness (Veronesi et al 1995). Many patients said that their information needs changed as they progressed through their treatment. They said they appreciated the information they received before they started their treatment but some of it only made sense to them as they progressed through their
chemotherapy. Therefore, it is important to assess and reinforce information at different stages of the treatment period (Knowles et al 1999).

However, there are always patients who do not want information or explanations at any stage of their disease trajectory and who use denial as a coping strategy. Many of the patients who were interviewed suggested that they did use denial at certain times as a coping strategy while undergoing chemotherapy, as this was how they always reacted to bad news. Comments such as ‘I just wanted to forget about what was happening to me’ were not uncommon. Indeed many nurses share the same concerns and fears about cancer as the general public (Corner 1993) and may use denial as a coping mechanism if faced with a cancer diagnosis themselves; therefore they should be aware of and understand the significance for patients of using denial as a coping strategy.

Denial can be a useful coping strategy when faced with a life-threatening event and can be described as ‘positive avoidance’ whereby a patient can minimise the impact of the diagnosis and the resulting treatment (Greer et al 1990). In a study conducted on breast cancer patients with metastatic disease, Greer et al found that denial can be associated with a reduction in psychological distress and that it may even contribute to prolonged survival. Therefore, health care professionals should be aware of this, and understand that some patients will use denial to help them cope with their illness and that it is acceptable for them to do so.

For those patients using denial as a coping mechanism, completing the DDCs may have been difficult. Some of them referred to the completion of the DDCs as a trigger that reminded them of their illness which they described as ‘not very nice to be reminded of it every day’. Perhaps this is something that health care professionals should consider when asking patients to complete documentation relating to their illness.

During the past two decades, the literature concerning information provision for patients with cancer and patient education has grown immensely, with each profession of the multidisciplinary care team being an active contributor (Knowles et al 1999). The provision of information about diagnosis and treatment modalities is now regarded as being of positive value in assisting patients with cancer to cope with life threatening illness (Meredith et al 1996). The Cancer Plan 2000 suggests that all patients should have documented information about all aspects of their care (DOH 2000). Almost all oncology units and centres have introduced and developed patient information booklets over the past few years to
meet this government target. Patients in this study suggested that some of the information they were given was not always applicable to them and therefore they stopped using these booklets. Others said that the booklets reminded them of their illness and therefore they did not use them. Health care professionals need to be realistic about the amount of patient information given to patients and this should reflect their actual needs and not their perceived needs.

**Section 6 - Complementary therapies**

The use of complementary therapies or medicines as an adjunct or alternative to conventional treatments has increased dramatically over the past decade. Increasing demand and use of alternative therapies may be due in part to the changing health and social needs of our society. The more holistic patterns of care associated with complementary therapies cater for wide-ranging health needs, rather than the more mechanistic, mainstream view of diagnosis and treatment required by people who are ill. Several patients documented on the DDCs or mentioned in the interviews that they had used some complementary therapy to help them ‘cope with their chemo or help combat nausea’. These patients were predominately female and had a breast cancer diagnosis. This is not surprising perhaps, as the literature suggests that women are more likely to seek complementary therapies and the majority are aged between 30-59 years (Risberg et al 1988). Also, self help and choice are increasingly emphasised in this group of patients. Those patients who use alternative therapies were found to be younger with a higher income, a more positive belief in the alternative causes of cancer, a strong desire for control and a strong desire to live (Yates et al 1993).

The exact numbers of complementary therapists and people seeking complementary therapies are unknown. It is difficult to determine the number of practitioners owing to the lack of regulatory bodies and registration details. Likewise, it is impossible to assess how many people receive complementary therapies because of the lack of central registries. However, from a patient’s perspective complementary therapies can generally enhance quality of life and help counteract the adverse effects of conventional treatment. Patients who used complementary therapies in this study described how it made them feel better: ‘It really was very nice, it made me feel good’

Within the NICE Palliative and Supportive Care guidelines (NICE 2004), cancer networks are being asked to include complementary therapies as part of the integrated care package for cancer patients. This is very difficult to cost, as there is scant evidence in the literature as to the costs and resources needed to provide
complementary therapies. However, as Burke and Sikora (1992) and Richards (2006) suggest, the many and varied therapies need to be integrated into conventional care in an organised way, and chosen by and for patients depending on their acceptability and therapeutic value. To achieve this, comprehensive evidence about the effect and applications of complementary and alternative medicine (CAM) within cancer care is required. This can only be achieved by conducting research studies to evaluate specific therapies and assess their efficacy within a variety of clinical conditions. However, CAMs are not readily available in most NHS cancer centres and until the development of integrated models of health care that include CAMs is achieved, most patients who are interested in using any complementary therapy will probably have to continue to fund them themselves.

Summary
Findings from the study have demonstrated that the use of DDCs and QOL tools to collect information from patients receiving chemotherapy can be useful. Many patients did not complete the DDCs as requested by the research team therefore some of the data recorded could bias the results. The patterns of nausea and vomiting recorded varied between each chemotherapy group and over time between the intervention and the control groups. Increased levels of anxiety were not found in the intervention group compared with the control group, but the incidence of nausea and vomiting was higher in the intervention group. The DDCs may have induced a conditioned response in some patients which may account for the higher levels of nausea and vomiting experienced by patients in the intervention group.

Fatigue, indigestion and alterations in taste and smell were found to be distressing to some patients. Several patients developed an aversion to foods which reminded them of their chemotherapy treatment. Many patients used complementary therapies to help them cope with chemotherapy and to combat symptoms such as nausea and vomiting. Some patients found it difficult to cope with body image issues and would have liked the opportunity to discuss this with the health care team. Patients’ information needs varied and some used denial as a coping strategy.

5 Conclusions, Limitations and Recommendations of the study
Limitations of the study
The recruitment of patients into the study was difficult as most of the patients undergoing adjuvant chemotherapy, particularly patients with colorectal cancer, in the cancer unit were involved in other national drug trials. Therefore, the nursing research team
were very aware of the potential to overburden patients by inviting them to participate in this study. This may account for the low ratio of males to females and this made it difficult to discuss comparisons between the genders on many issues. The design of the study ensured that all patients in the treatment arm were supported at each of their treatments by the research nursing team whereas the patients in the control group were dependent on the chemotherapy nurses for support, which appeared to be limited at times. This may have caused some bias in the results. The data collection for the patients in the control group was difficult on occasions because patients often forgot to give the completed questionnaires to the chemotherapy nurses. This then involved the nursing research team spending a lot of time chasing up the questionnaires.

There were occasions when I found it difficult to separate my roles as an oncology nurse supporting patients through their chemotherapy and as a researcher. Within interpretative research, there is an appreciation that the research participants, the research field and the researcher are involved in an interactive, dynamic process whereby each affects the others. This dynamic interplay within social settings is known as reflexivity (Oliver 2004). Although I conducted all of the interviews with the patients, which on reflection may not have been ideal, I was very aware of the possible effect I may have had on their responses. To help combat this, before and during the interviews, I endeavoured to maintain a high level of critical self-awareness and constantly reminded myself of the effect my identity and any preconceptions I had about the issues being investigated could have on the patients’ responses. However, having recruited, assessed and supported most of the patients that were interviewed, my role as a nurse-researcher is likely to have contributed to some bias in the results.

Although the qualitative data expanded on the quantitative findings, the semi-structured nature of the interview schedule focused on the DDCs, which did not allow for much time in exploring other patient issues in depth. The sample size of patients interviewed was small and perhaps if more patients had been interviewed there may have been a greater range of symptoms and issues reported by them.

Conclusions
In spite of the study limitations, the patients provided a valuable insight into their strategies for coping with chemotherapy and how the side-effects of chemotherapy affected them both physically and psychologically. The aim of this study was to explore the psychological effects on patients of completing daily diary cards and to test the hypothesis that completing a DDC causes a conditioned response to treatment. The patterns of nausea and vomiting and
the other difficulties that patients experience when undergoing adjuvant chemotherapy for breast or colorectal cancer were also explored. In addition, strategies for adaptation that patients used throughout their treatment were explored further in interviews and it was therefore valuable to use qualitative methods to complement the RCT.

Seventy-one patients were recruited into this study. Thirty-three patients were randomised to the intervention group and they completed DDCs. From this group of patients ten were purposely chosen to take part in semi-structured interviews. The qualitative interviews revealed specific issues of importance for the patients. This study has demonstrated that using DDCs to collect information from patients undergoing chemotherapy, especially in relation to their nausea and vomiting symptoms, is useful to health care professionals.

The patterns of nausea and vomiting varied between the groups, the patients in the intervention group documenting more vomiting episodes than the patients in the control group. The overall incidence of vomiting reported by patients was low and it appears to be controlled by the 5-HT3 antagonists. However, most patients still reported nausea as being problematic despite the improvements made over the years in the management of vomiting. Anticipatory nausea and vomiting was recorded on the DDCs as being problematic for some patients especially females receiving FEC chemotherapy for breast cancer. However, overall there was no significant difference noted from the nausea and vomiting scores from the RSCL between the two groups. Therefore, the research hypothesis that DDCs cause an increase in symptoms and evokes a conditioned response to treatment was not supported and the null hypothesis stands.

Compliance with the completion of the DDCs was found to be an issue with some patients in that they did not complete them as instructed. Health care professionals and researchers need to be aware of this as it could lead to serious biases whose magnitude is difficult to assess. The completion of the DDCs had different effects on patients with some describing how completing them made them feel better and gave them some control over their treatment. Others, however, said the DDCs reminded them of their illness and they described how they hid them from their families as they did not want them to be reminded either. One patient was very distressed that the word cancer appeared on the DDCs. She suggested that it was such a scary word it should not have been included on it. Perhaps for some patients completing the DDCs was similar to a classical conditioning response in that each time they
completed it they were reminded of their cancer or chemotherapy treatment.

The information needs of patients differed as they progressed through their treatment and some patients did not want to know anything about their potential treatment or illness. These patients described how they used denial as a coping mechanism and health care professionals should be able to recognise when denial is being used in a positive way and not force information on patients or label them as ‘not coping with their illness’. Many patients were using complementary therapies to help them cope with their cancer diagnosis and the effects of treatment, especially nausea but most of them using them in this study had to self-fund.

The analysis of the quality of life questionnaires gave an insight into the levels of psychological and physical morbidity that patients experienced whilst progressing through their treatment. The results indicate that the range of side-effects experienced by patients can be extensive. The anxiety and depression scores from the QOL questionnaires were higher in the control group but the fact that the research nursing team supported the patients in the intervention group throughout their treatment may have resulted in their scores being lower, as has been suggested by other studies (Hope-Stone et al 1997). Many researchers have found that anxiety can lead to an increase in patterns of nausea and vomiting (Dibble et al 2004; Morrow 2002; McDonald & Fleisher 2005). However the findings from this study did not support this as the patients in the intervention group reported more episodes of vomiting than the patients in the control group.

Most of the patients complained of indigestion at some stage of their treatment and this may have been due to the steroids prescribed for them to help combat nausea and vomiting or from the chemotherapy treatment itself. Many of them needed an antacid prescribed or had to change their dietary habits drastically to help combat it. This side-effect of chemotherapy caused much distress to the patients in this study and its effect on the QOL of patients has been underestimated or underreported in the past. Fatigue has a profound effect on an individual’s ability to live a normal life whilst undergoing chemotherapy. Most of the patients described it as having an adverse effect on their everyday quality of life. To date only a small number of studies on fatigue have been evaluated through empirical research and there is conflicting evidence relating to the effectiveness of management strategies. Nevertheless, the findings from these studies can be of some use in supporting patients with fatigue, although it must be remembered that fatigue is a very personal experience and what benefits some individuals
may not be useful in others. Strategies that patients have reported as helpful centred on a need for others to understand what was happening to them and the opportunity to partake in gentle exercise programmes which catered for individual needs with different levels of fitness and different types of cancer.

Other symptoms such as alopecia were reported as being very distressing for patients and although scalp cooling has been proven beneficial in reducing hair loss with certain chemotherapy regimens, this was not available in the unit where this study was conducted. Many patients described how their hair loss made them feel less feminine and others described how it made them feel like an alien. Some worried about the effect their hair loss would have on their families, especially younger children. Others found wearing wigs very stressful as they thought it attracted more attention to them and they were concerned about the possibility of wigs falling off in public areas. Some patients suggested that the personnel providing the wig service both within the NHS and the private sector were not prepared to cope with their emotional needs and this made them feel even more vulnerable.

Some health care professionals avoid subjects that they are not comfortable with, despite patients’ wishes to have an opportunity to explore them. Sexuality and relationship issues were mentioned by patients as not being addressed appropriately by the health care team.

Patient information booklets are usually given to all patients so that they and all health care professionals have information about their treatment. This includes instant access to a record of their treatment plan, investigations carried out, results of investigations and any side-effects they may have experienced from their treatment. Some patients described how they were confused and overwhelmed with the amount of information they received. Interviewed patients suggested that their information needs changed as they progressed through their treatment. Therefore, it is important that appropriate information is given at various stages throughout the treatment pathway. This study presents oncology nurses and nursing as central to ensuring that patients are cared for and facilitated throughout their disease trajectory.

**Recommendations for practice**
The management of chemotherapy induced nausea and vomiting remains suboptimal despite the use of 5-HT₃ antagonists and other antiemetics, and indigestion is a largely unrecognised side-effect of chemotherapy. Increased use of drugs to combat indigestion,
complementary therapies and strategies to counteract anticipatory nausea and vomiting may be helpful.

Although this study demonstrates that the use of daily diary cards does not evoke a conditioned response in patients undergoing chemotherapy treatment for cancer, some patients report that their use can have adverse effects. Despite the fact that many patients fail to complete them as instructed, useful information can be obtained from them. Healthcare professionals need to be aware that the information provided on them may not report the real significance of patients’ symptoms.

The degree of support provided to patients undergoing chemotherapy needs to be increased. This might include greater use of complementary therapies, greater psychological support of patients, and increased concentration on patients’ symptom control rather than just disease control.

**Further research**

The findings from the study generated ideas for possible future research that support collaborative working between researchers, nurses and patients, helping to inform nursing practice and the development of cancer services that meet the needs of patients. It would be interesting to conduct a study which would compare and contrast different treatment interventions, such as complementary therapies with conventional treatments with regards to specific patient outcomes, for example, nausea and vomiting. Indigestion was documented in the DDCs and mentioned by several of the patients interviewed as being problematic therefore it might be valuable to explore the benefits of using prophylactic antacids to ease or prevent this unpleasant symptom.
References


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Re-admissions to Irish Psychiatric Hospitals and Units 2001–2005

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Introduction
The re-admission rate has been proposed as one indicator of the effectiveness of the transition to community care (Lien, 2002) with some studies proposing that the increasing number of re-admissions to psychiatric hospitals is a consequence of the policy of deinstitutionalisation and the resulting transition to community care (May, 1976; Kastrup, 1987a; Kastrup, 1987b). Revolving door or heavy users have been defined as those patients with four or more admissions during a minimum of a five-year study period (Kastrup, 1987b; Lewis and Joyce, 1990; Korkeila et al., 1995; Gastal et al., 2000). Some studies have found certain diagnoses such as schizophrenia, affective disorders and personality disorders to be associated with re-admissions whilst other studies have found revolving door patients to be younger, male, single or divorced, unemployed and in the lower socio-economic groups (Woogh, 1986;
Kastrup, 1987a; Weissman et al., 1994; Rabinowitz et al., 1995; Mahendran et al., 2005).

**Aims**
The aim of this study was to examine re-admissions to Irish psychiatric units and hospitals and to identify the characteristics of those who were re-admitted. Secondly, the study attempted to identify frequent users of the in-patient services as a subgroup of re-admissions and thirdly, it examined if staffing levels had any impact on re-admissions to in-patient services.

**Method**
First admissions to the National Psychiatric In-patient Reporting System (NPIRS) for those hospitals using a unique patient number were extracted for 2001 and followed for the five-year period 2001–2005. In 2001, 22 hospitals out of a total of 51 (43%) used a unique patient identifier.

**Results**
Thirty-seven per cent of the sample (1,274/3,473) had one or more re-admissions during the study period while 7% (246/3,473) of the sample were frequent users i.e. had four or more re-admissions. Those who were re-admitted and those who were frequent users tended to be female, younger and had a diagnosis of depression, schizophrenia or alcoholic disorders. Lower staff numbers were associated with more re-admissions, a greater number of frequent users and a longer length of stay.

**Conclusions**
Patients with enduring and recurring illnesses, because of the nature of their illnesses, will require frequent in-patient admissions. Thus re-admissions will continue to be a feature of in-patient services regardless of any future expansion in community-based services. More progress on the treatment of alcoholic disorders on an outpatient basis needs to be made. The high proportion of younger persons among those re-admitted and among frequent users remains a concern and is one which needs to be addressed.

**References**

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Research Study: An Exploration of Children Bullying Other Children in the Residential Setting as Seen Through the Eyes of the Social Care Worker.


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The aim: The study set out to explore the problem of children bullying other children in the residential setting in Ireland. Sinclair and Gibbs (1998:p523) undertook a study of 224 children/young people living in the residential settings in Britain, a total of 44% said they had been bullied during their stay. A total of 41% said they had been bullied before moving into the residential setting. The author considered these figures to indicate that bullying behaviour is a real problem for children living in such an environment. Such studies are not to be found in the Irish setting.

The reasons for undertaking this small-scale study was to inform practitioners about the problems the child faced, if she/he exhibited this behaviour and the problems faced by the victim and to look at ways to prevent/manage the situation based upon the research findings.

Methodology: The first part of the study involved an exploration analysis of national and international literature. The second part of the study involved interviewing six social care workers. The participants were chosen using the semi-purposive sampling technique. The author designed a semi-structured interview topic guide, which allowed the participants to describe in detail their experiences. The process of analysis was undertaken using constant comparative analysis.

Findings: Much of the research undertaken into children bullying other children centres upon the school environment. Corby (2000:p83) highlights that bullying in schools was considered a school behaviour problem. However he notes that more and more linkages are being made between bullying behaviour and the behaviours outside the school setting, such as in the context of the home and other settings. All of the participants of this study noted
the bullying behaviour is a problem. The behaviour exhibited included verbal abuse, physical abuse, intimidation, and racism, stealing, hiding and causing damage to personal property, and space. A parent, a sibling, fellow resident, a peer, a gang of children/young people, a child in school, a child on the street were all mentioned as people engaging in bullying.

Prevention of the behaviour was undertaken in the form of highlighting that the behaviour was unacceptable within the environment. Incidents of bullying were dealt with on an individual basis guided by the agreed Health Service Executive Policy/Procedure document. The Key Worker was noted to play a vital role for working with the child/young person who is exhibiting bullying behaviour and the victim of such behaviour. Including parents in the process (depending upon the child’s/young person’s care plan) was felt to be very important. Strong links between the residential setting and the school were recommended. All the participants were aware of the impact of bullying upon the child/young person, such as self-harm and suicide.

**Conclusions.** The findings of this study helped both the social care workers and the children/young people to understand the meaning of “Bullying Behaviour in the Residential Setting”. When the author presented her findings to the social care workers, they felt that the children/young people would learn from the research findings. The author presented the research findings to the children/young people who found the session very interesting and helpful in terms of preventing /managing the behaviour. A two day training course was set up based upon the research findings and the recommendations for best practice in the area of bullying behaviour prevention. The author notes what started out as a small study, has become a real influence upon the prevention/management of bullying behaviour in the residential setting.

**References.**


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Discharge Planning: Role of Discharge-Coordinators

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Abstract
Changes in systems of care and changes in patient populations have contributed to the emergence of discharge planning as a complex area of practice (Cannaby Parker & Baker, 2003; Central Statistics Office, 2006). A major causal factor in delayed discharge is not the individual needs of the patient, but the process and efficiency of current discharge planning systems, limited range of community based services and supports available to support discharge and the lack of a whole systems approach (Health Service Executive, 2007). The aim of this study was to describe the role of the discharge co-ordinator from the perspective of discharge co-ordinators and through documentary review. An exploratory descriptive research design was used. A convenience sample of six nurses who co-ordinate patient discharges in a variety of health care settings participated in guided interviews which were tape recorded, transcribed and thematically analysed. A review of documents pertaining to the role was also conducted.

The role of discharge co-ordinators is multifaceted mainly dealing with complex cases. Discharge co-ordinators role included assessment, communication and liaison, multidisciplinary and multi-
agency working and audit of service use. There were variations in relation to assessment, communication and documentation practices and there was no systematic comprehensive multidisciplinary assessment in place. Discharge co-ordinators play a vital link in facilitating continuity of care. This study has identified core elements of the role of the discharge co-ordinators. The findings have important implications and provide insights into the complex role of discharge co-ordinators for nurses, managers and policy makers.

**Keywords:** discharge planning, role, process, hospital, community care.

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Ensuring the Quality of Health Care Among Mothers and Children: Maternal and Child Health Handbook Movement in Southeast Asia

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ABSTRACT
The maternal and child health (MCH) is a major concern in Southeast Asia (SEA). According to WHO, of the 50,000 maternal deaths every year in the Western Pacific Region, nearly 40% occur in Cambodia, Laos, Philippines and Vietnam. Furthermore, more than one million infants die before their first birthday with more than 300,000 babies die at birth. SEA countries also have high maternal mortality ratios. One public health measure feasible for the promotion of MCH is the MCH handbook (MCHH). The role of the MCHH is two-fold – it serves as a health education material which contributes to the mother’s knowledge and serves as a comprehensive health record book which integrates health records. It has been part of health programs in Indonesia and Thailand, with others following suit. This study aimed to determine the utilization of MCHH in SEA countries. Specifically, it aimed to determine the country-to-country situation and identify successes achieved and challenges faced by each of the countries. To attain these, in addition to records and documents review, an interview was conducted among health administrators involved with their country’s MCH program. The MCHH is currently promoted among pregnant women and children under 6 years of age. A copy costs 0.25 to 5 dollars to produce, typically free of charge for the target population. The common information included in the handbook are: family data, pregnancy records, maternal immunization record, delivery information, Apgar score, infant information, child’s weight and height, child’s immunization, child’s illness history, family...
planning information and nutrition information. Persistent challenges identified are: lack of funds and lack of human resources. Low educational attainment among mothers was also considered. A regional network system is also favorable in strengthening the MCHH in each country.

**SOUTHEAST ASIA AND MCH**

According to the World Health Report in 2005, hundreds of millions of mothers and children have no access to basic life-saving care. Deaths could have been prevented through the use of key interventions and a “continuum of care” approach for mother and child that begin before pregnancy, extending through childbirth, and further into childhood. About 530,000 women die in pregnancy or childbirth, more than three million babies are stillborn, more than four million newborns die within the first few days of life, and altogether 10.6 million children a year die before their fifth birthday. Out of a total of 136 million births in a year worldwide, only a third of women in less developed countries have their babies delivered by skilled attendants; even less are those women who have access to healthcare facilities necessary to sustain an adequate healthy living.

UNICEF estimates that most under-five deaths occur in Southeast Asia. More than one million infants die before turning one, with more than 300,000 babies die at birth in the region. Also according to the World Health Organization, 40% of the 50,000 maternal deaths every year in the Western Pacific Region occur in Cambodia, Laos, Philippines and Vietnam. The leading causes of under-five mortality rates are prenatal concerns, diarrhea and acute respiratory infections (ARI) - all known to be highly preventable. The maternal and child health (MCH) is indeed a major concern in Southeast Asia (SEA).

**MCH HANDBOOK**

One public health measure used for the promotion of MCH is the MCH handbook (MCHH). It is an essential tool in promoting the health of mothers and children. The utilization showed promise in improving MCH indicators in several countries. In Asia, Japan is one of the success stories when it comes to the use of the MCH Handbook. For 50 years since its introduction, it was successful in keeping mothers informed. Other countries such as Thailand and Indonesia also have a successful MCH Handbook introduction. Other countries in Southeast Asia are currently following suit.

The handbook has two functions: (a) as a health education material which contributes to the mother’s knowledge and (b) as a
comprehensive health record book which integrates health records. As a health education material, health professionals, village health volunteers and parents can easily understand minimum standard of MCH care. Also, various activities in health sectors, such as nutrition, immunization, communicable diseases control, dental health and family planning are integrated through MCHH activities.

As a comprehensive record book, it enables integration of existing health cards which have been used for community health services. This was not possible with conventional health cards because each card served for a different purpose in a different period: keeping track of mothers’ health during pregnancy and growth monitoring of children. Since the mother’s and child’s health records are integrated, from pregnancy, delivery and child development, it can be useful as a referral document when a mother or a child is referred from a health center to a clinic or a hospital.

The common information included in the handbook are: family data, pregnancy records, maternal immunization record, delivery information, apgar score, infant information, child’s weight and height, child’s immunization, child’s illness history, family planning information and nutrition information. The families are responsible in safe-keeping the MCHH. In SEA, it is typically provided free of charge to pregnant mothers.

**MCH HANDBOOK IN SOUTHEAST ASIA**

**CAMBODIA**

In Cambodia, the MCHH had been distributed to selected communes (2 in Memut district and 2 in Thboung Khmum district) in 2007. Since it was an initial endeavor, the cost of the handbook is yet to be determined. The handbook initiative is led by the local government. For the development of the handbook, funding is provided by donor agencies. Health professionals, health volunteers and traditional birth attendants are trained on the use of the handbook. They are also responsible in the distribution and recording of the handbook. The handbook is useful from pregnancy until the child reaches the age of five.

**INDONESIA**

The MCHH was first initiated in only one district of Central Java in 1994. Since then it has been expanded to other districts. JICA has been responsible for technical support since 1998. Currently, the handbook is distributed nationwide. The number of MCHH distributed nationwide in 2005 were 1,768,560 copies. The production cost of each MCHH ranges from $ 0.50 to $ 2.00. The MCHH project is a collaboration between the central and local government, several professional organizations, local NGOs and
international donor agencies. Health professionals and health volunteers are trained on the use of the handbook. They are also responsible in the distribution and recording of the handbook. The handbook is useful from pregnancy until the child reaches the age of five.

**LAO Peoples Democratic Republic**
In 1995, MCHH was introduced in two selected provinces (Xiengkuang and Vientiane), with the support of JOCV. In 2002, the MCHH was introduced to 6 districts by UNICEF. Each MCHH costs $1.00. The national government is the main proponent of the MCHH, with financial support coming from the national budget as well as international NGOs. Health professionals and health volunteers are trained on the use of the handbook. They are also responsible in the distribution and recording of the handbook. The handbook is useful from pregnancy until the child reaches the age of five.

**PHILIPPINES**
The MCHH is nationally initiated and decentralized to the provinces. Thirty provinces are currently using the handbook. Initially 500,000 copies were printed by the central office of the Department of Health, with reprinting as a responsibility of the local government unit. Each copy is estimated to be at $0.50. It is currently subsidized by the Philippine National Health Insurance as part of the Maternity Care Benefit Package. The handbook is useful from pregnancy until the child reaches the age of five.

**THAILAND**
The MCHH was initiated in 1985. It costs around $0.25. The financial source for the MCHH program is the national government. Among a surveyed group, it was found out that the coverage was at 90%, the bringing rate was at 90% and the loss rate was at less than 5%. The MCHH is also a part of the university curriculum. Health professionals and health volunteers are trained on the use of the handbook. They are also responsible in the distribution and recording of the handbook. The handbook is useful from pregnancy until the child reaches the age of six.

**VIETNAM**
In 1992, the MCHH program piloted in 1 commune in Ben Tre, with the aid of The Support of Vietnam Children Association, a Japanese NGO. In 1998, it was further expanded to 7 more communes/ In 2004 160 communes were covered by the SVCA MCHH. The current copy of the MCHH costs $3.00 with a funding from the local government. Since 1998, the MCHH became a part of the university curriculum. Health professionals and health volunteers are trained
on the use of the handbook. They are also responsible in the distribution and recording of the handbook. The handbook is useful from pregnancy until the child reaches fifteen years old.

**CHALLENGES AND FUTURE PERSPECTIVE**

The MCHH is instrumental in promoting healthcare among mothers and children. It has a great influence among mothers’ MCH knowledge and attitudes. Thus, it can also change behaviors from pregnancy to child care. However, the MCHH alone cannot create wonders – such as reducing MMR and IMR. It is most effective where there are adequate health care programs and services in the locality. The contents of the handbook should be appropriate to the target population in order to foster the sense of ownership in the community.

Current challenges of sustaining the MCHH in the community are numerous. Some these concerns are: lack of funding, lack of research activities, lack of human resources and low educational attainment of mothers. It is necessary to address these matters to effectively promote the MCHH. To establish the MCHH it is necessary: to create an international network system; to share MCHH experiences; to evaluate and monitor programs related to MCHH and research activities toward the handbook; to provide funds for implementation; to strengthen community network; and to encourage the Ministry of Health in championing the handbook. The biennial International Symposium on the Maternal and Child Health Handbook proved to be an effective venue in addressing these concerns.

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Use of Motivational Interviewing by Nurses to Promote Behavior Change in Persons with Type2 DM

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Objectives

1) Describe motivational interviewing as a strategy to promote life change
2) Discuss how motivational interviewing can be used with clinical populations
3) Apply concepts of motivational interviewing to nursing practice

Background and context:
As a chronic disease with serious co-morbidities, diabetes care accounts for over $130 billion U.S. health care dollars per year because on average, expenses for a person with diabetes are six times those of a healthy person. Hypertension and hyperlipidemia, two common diabetic co-morbidities, can lead to increased mortality and further escalate the cost of care. However, even a 1% drop in HbA1c can lead to a 33% reduction in microvascular complications.

In addition to physical complications, diabetes adversely affects patient quality of life, with clinical depression occurring more frequently in those with diabetes. Since cognitive function
influences the ability to self-manage, psychological difficulties can in turn impact negatively on glycemic control.

As with other chronic illnesses, self management of exercise, diet, medication adherence, monitoring, routine follow up care, and other health promoting behaviors can prevent complications and enhance wellbeing. In one study of patients with diabetes, this regimen would require an extra two hours each day to carry out. In addition to time constraints, patients may not make life style changes because of denial, clinician communication style, lack of confidence or belief in importance, financial or transportation problems, availability of health care providers, and/or cultural belief systems.

Due to lack of time or communication skills, many Primary Care Providers (PCPs) fail to fully explore whether patients follow through on their recommendations, or to determine whether barriers to self management can be modified or not. Consequently, patient adherence rates are low, and in the U.S., mean HbA1c levels have not changed in the last decade. Currently, only 7% of patients are at goal for A1c, LDL, and BP levels.

When polled, diabetes educators said the greatest challenges to improving outcomes were better techniques to address behavior change. Strategies traditionally used by health care providers to encourage behavior change include “scare tactics,” advice-giving, badgering, and other highly directive approaches. In contrast, interventions that include patient empowerment, education, psychosocial understanding, and more recently, brief behavior change counseling approaches such as Motivational Interviewing (MI) are more effective.

Our study uses MI and nursing case management (NCM) to promote behavior change in patients with Type 2 Diabetes Mellitus. NCM is a cost effective practice model that improves patient outcomes through education, support, and care coordination. Nurses are optimal case managers because they spend more time with patients and have a professional background that enhances this method of patient care. NCM has been used with success in several chronic diseases, but cost-effectiveness and long-term sustainability of this approach in diabetes management has not been rigorously tested.

MI is a patient-centered counseling approach that actively engages patients and draws on their underlying motivation for change. MI specifically stresses the importance of understanding each patient's unique perspectives and priorities when developing a treatment plan, and uses reflective listening, therapeutic communication, and rapport-building skills to empower the patient to make behavior
changes. The success of this strategy within the substance abuse field has prompted its application to other medical and psychological problems such as HIV, cardiac rehabilitation, and eating disorders. Results have ranged from slightly effective to significant. Nurses, who have extended and intense contact with patients, have only begun to explore the use of MI.

**Aim of the study:**
Our study is designed to translate empirical knowledge regarding diabetes treatment and management into a clinical intervention which improves patient outcomes. As such, the use of MI to encourage behavior change was a key focus.

**Methodology including research design and sampling:**
Our randomized clinical trial is a three year study of adult patients with Type 2 DM (length of time not considered) from diverse primary care clinics throughout central Pennsylvania, a largely rural location with many medically underserved areas. The control group (n=159) receives standard care and the treatment group (n=163) receives standard care plus the NCM/MI intervention. Purposive sampling was used to obtain a substantial number of underserved patients, primarily of Hispanic origin given the more severe nature of Type 2DM in this cohort.
### Table 1. Baseline patient demographics:
(* responses are incomplete for most demographics)

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<td>Gender:</td>
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<tr>
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<tr>
<td>married</td>
<td>51.7 %</td>
</tr>
<tr>
<td>divorced</td>
<td>11%</td>
</tr>
<tr>
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<td>5.5%</td>
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<tr>
<td>widowed</td>
<td>10.4%</td>
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<tr>
<td>Medical insurance carrier:</td>
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<tr>
<td>Medicaid</td>
<td>2.9%</td>
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<tr>
<td>Blue Cross</td>
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<tr>
<td>Blue Shield</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>51.2%</td>
</tr>
<tr>
<td>No medical insurance</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

Enrollment rate averaged 22%. Reason for nonparticipation included time (~20%), transportation issues (~15%), other competing health issues (10%), denying they needed help (~25%), 10% gave no reason, 5% had other family responsibilities.
Intervention:
Three experienced registered nurses were trained in case management and motivational interviewing. Techniques for learning MI included role plays, lectures, videoconferencing, journal article reviews, attending a conference, and mock interviews with standardized patients. They were provided continuous feedback from experts based on live performance, feedback from audio and videotapes, and regular analysis of taped visits to assure fidelity.

Using an evidenced based protocol for glucose, cholesterol, blood pressure, and depression management, the nurses work in collaboration with PCPs to provide care to patients with diabetes. Outcome measures include: clinical parameters, quality of life, self care behavior, depression, treatment satisfaction, provider satisfaction, emotional distress, and cost effectiveness.

Clients are initially seen at 2, 4, and 6 weeks, then typically at a minimum of every 3-6 months, although the schedule is tailored to individual preference as needed. Patients are in the intervention for three years.

In addition to the standard assessment, content of initial interview includes a status report on lab values and intake survey results, nursing assessment of medications, exploration of the patient’s goals, and evaluation of current satisfaction with diabetes health. Deliberate attempts to establish rapport through a non-judgmental approach, understanding other aspects of patient’s life, and active listening are used. Typical intake visits last one hour, with subsequent visits varying between 15 minutes to one hour.

Subsequent visits are based on results of intake visit, but use MI to identify ‘the agenda’ which, if any, self care behaviors the patient would like to change, and how health can be improved or maintained. The nurse-patient relationship is enhanced by the use of MI, which helps identify aspects of the care plan amenable to behavior change, and establish goals for change and a plan to achieve them. The nurse case managers are integrated into the primary care clinic setting and have a continuous relationship with study participants through providing both direct clinical interventions and collaborating with other members of the health care team.

Patients randomized to NCM continue to see their PCP at regularly scheduled visits and also meet individually with a nurse case manager as detailed below. Patients randomized to the usual care group remain solely under the treatment of their PCP. Each nurse has a patient caseload of approximately 140 to permit incorporation
of MI in the intervention. In order to provide optimum care for Hispanic patients at the Reading location practices, a bilingual (English/Spanish) and bicultural nurse with experience providing care to Hispanic patients is working at that site.

**Intervention Implementation Tracking:**
To ensure consistency of the intervention and reproducibility of the results several strategies are utilized.

1) The NCM is based on a standardized curriculums developed by the investigators prior to implementation of the study. The curriculum addresses management of blood glucoses, hypertension, hyperlipidemia, and depression, and is based on the American Diabetes Association’s Clinical Practice Recommendations, and the Institute for Clinical Systems Improvement (ICSI) guidelines. Regular supervision and feedback on NCM is provided by a qualified physician and nurse team who dialogue with the nurses, review taped clinical sessions, and observe clinical interventions.

2) The use of MI is promoted through a standardized ongoing MI training curriculum, which involves weekly sessions on relevant topics and a trained MI therapist’s review of nurse performance through audiotaped patient sessions. This provides a level of structure and standardization that guides the nurse case managers in implementing new skills and strengthen the integrity of the MI component of the intervention.

**Analysis:**
Descriptive statistics were used to analyze baseline data. Zero percent of participants were at goal as compared to 7% nationally. Daily journaling was used by nurses to document their role in implementing the NCM/MI intervention. At six months, a series of focus groups were conducted to evaluate patient response to the intervention. These interviews were taped, coded, and content analyzed by a team of researchers with expertise in qualitative methods.

**Study outcomes:**
The primary study outcomes are percent of patients reaching goal HbA1c, BP, LDL, and percent of patients at goal for all three parameters. Important secondary outcomes include number of patients with depression as measured by the CES-D tool, process measures (% receiving eye exams, foot exams, etc.), cost-effectiveness and psychological/behavioral outcomes of the intervention.
Cost effectiveness is determined from the perspective of the provider, payor, and society within the US healthcare system. Evaluation of costs and cost-effectiveness of the intervention is through the record of outpatient and inpatient health care utilization by the patients, including the cost of medications. Additional data is collected through surveys to evaluate societal costs.

**Summary of key findings:**

Preliminary analyses reveal that study participants have more diabetes-related psychological distress, lower adherence to most self care behaviors, lower satisfaction with treatment, and more depression than generally reported in the literature. They are, therefore, a group at risk for poor outcomes.

Results of our focus group analysis reveals the intervention has empowered many study participants to make lifestyle changes related to nutrition and exercise. Some dramatic improvements have been documented in patients’ emotional acceptance of disease, stress levels around specific self care behaviors such as monitoring, improved coping with chronic illness, and taking a more active role in self management. Some measurable changes observed include weight loss, lab values normalizing due to medication or lifestyle change, more trust and better rapport with PCPs, honesty and sharing confidences with the study nurses, and describing the nurses as their advocates. Not surprisingly, depression and stress management are two issues that often need addressed.

Among the underserved group, patients were more open about use of alternative therapies to manage diabetes and co-morbidities. Despite more geographic transitions, Hispanic participants continued with the study at a rate equal to non-Hispanic patients.

The nurses note that PCPs generally overestimate adherence, whereas providing empathy and being nonjudgmental facilitates accurate reporting of self care behavior by patients. They also describe MI as a technique which allows “natural nursing tendencies toward empathy” to be made manifest. Barriers to care such as provider availability, transportation access, suspicion, and mistrust have been removed as part of the intervention. Although clinical inertia is considered a common problem in diabetes medical care, the nurses’ experience is that patients often did not make prescribed behavior changes because they were not ready, or for easily remedied reasons unknown to the physician. MI is a strategy that the nurses find effective in helping them to facilitate a patient’s acceptance of PCP recommendations, such as taking a new medication, monitoring on a regular basis, and/or taking insulin.
Conclusions:
MI is a therapeutic communication strategy that has great relevance for both nursing and medicine. When working with patients whose chronic illnesses require self care and monitoring, this technique allows PCPs, nurses, and patients to function as a true team. Deciding when it is more appropriate to use MI or standard health care approaches is one challenge that emerged, and specific training strategies for medical personnel (as opposed to therapists and counselors) are indicated.

We found that MI is feasible to use and well accepted by patients in the primary care setting. While it is different for patients to be placed in an active role, initial resistance (especially among older adults) can be effectively transformed into active participation. Nurses felt this intervention led to better relationships with PCPs, empowering of patients, and support of self efficacy. Their sessions to promote behavior change were described as: “more of a dance than a wrestling match, as usually occurs.”
Student’s views on the facilitation of competence and confidence development through rostered placement

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The development of clinical competence in undergraduate nursing programmes is an important area of educational knowledge. In Ireland nurse education has moved from a largely apprenticeship model to a four year undergraduate programme. In this new model, full time exposure to a clinical role, known as the rostered year, occurs at latter part of their educational experience. The aim of this research project was to explore the perceptions of a cohort of students completing the new BSc programme in nursing in one third level institution in Ireland. Data collection occurred in two stages; stage one consisted of the administration of a questionnaire, based on the Domains of Competency (An Bord Altranais 2000) to the entire undergraduate cohort (N=99, response rate 84%). Stage 2, focus group interviews, occurred following analysis of the questionnaire data. The results from the survey were depth explored through five focus group interviews with a sample (n=40) from the cohort. The focus groups examined students’ experience of the rostered clinical placement and the degree to which it contributed to their development of clinical competence. This data was analysed using a thematic approach which generated four principal themes; competence and confidence; inter-personal relationships for learning; abandonment; learning through reflection. The significance of the results lies in knowledge ascertained from the students’ perspective on learning while on rostered placement. These findings will impact on how clinical exposure is structured, particularly in the facilitation of reflective practice, and clarify and strengthen the links between the academic institution and the clinical sites.
Operationalising Multiple Intelligence Theory in the classroom using a Multiple Intelligence Teaching Approach

**Presenters:** Margaret Denny (Lecturer); Dr. John Wells (Head of the Department of Nursing); Suzanne Denieffe (Lecturer)

**Workplace:** Waterford Institute of Technology

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**Overall aim of workshop:** The aim of this workshop is to explore and inform educationalists about the application of Multiple Intelligence (MI) theory, as explicated by Gardner (1993, 1995), using a multiple intelligence teaching approach (MITA) in a third level educational setting (Denny 2007).

**Abstract**
Multiple intelligences theory has only recently entered the teaching and learning dialogue in education and research. It is argued that despite the rhetoric of a student centred approach, nurse education remains wedded to conventional teaching approaches, which fail to engage with the individual and unwittingly silence the student’s voice. This workshop will examine the concept of multiple intelligences (MI) and outline Gardner’s (1983) contention that the brain functions using eight intelligences, which can be employed to improve learning at an individual level. It will then outline how the use of a five-phase model, developed by Weber (1999), known as a multiple intelligence teaching approach (MITA) can impact on student learning. It is contended that MITA has great potential in nurse education, particularly in terms of reinforcing learning beyond the educational domain and into the individual’s professional development and clinical practice. It is contended that MITA has great potential in nurse education, particularly in terms of reinforcing learning beyond the educational domain and into the individual’s professional development and clinical practice. Arguably this departure will contribute to the present post-technocratic model of education, and to the conceptual understanding of MITA brain-based approaches and impart a more in-depth understanding of the significance of MI and MITA approaches to teaching and learning in third level education.
Learning outcomes

1. To critically discuss the contribution of MI and MITA brain approaches to teaching and learning in nurse education.
2. To examine the processes involved in implementing MI approaches, utilising MITA in the classroom thereby augmenting our understanding of the nature of theory application.
3. To examine the effectiveness of MITA in nurse education in Ireland based on a recently conducted study at Waterford Institute of Technology.

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Medication administration to older adults with mental illness: a survey of nurses’ views and an observational study of nursing practice in an inpatient setting

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ABSTRACT

Background: Medication Administration Errors (MAE’s) cause significant patient morbidity and mortality but little is known about the difficulties experienced by nurses administering medication in psychiatric settings or about their related training needs.

Aim: To describe the issues faced by nurses undertaking medication administration in an elderly psychiatric setting and identify their training needs.

Methods: We used a questionnaire survey to explore nurses (N=27) views and needs, and observed nurses (N=9) administering medication over the course of 36 medication rounds (1423 doses).

Results: Most nurses (85.2%) had undertaken training in relation to medication administration in the past year and two-thirds (65.2%) reported that the training received was adequate and relevant. MAE’s were frequent (one in every four doses) and, while nurses commonly faced difficult situations when administering medications, they had received little formal guidance.
Conclusion: Regular, standardised training incorporating clear guidelines on issues including tablet crushing and minimisation of potential distractions would prevent many MAE’s. Training should also cover covert administration of medications and the use of Health Care Support Staff in administration.

Keywords: Drug administration, Medication error, Adverse Drug Event, Nursing Practice, Elderly Mentally Ill

BACKGROUND
Adverse Drug Events (ADE’s) cause significant patient morbidity and mortality (Phillips et al, 2001) and occur at all stages of medicines management from prescribing to dispensing and administration. The administration of medications is usually done by nurses (Hand & Barber, 2000). A Medication Administration Error (MAE) has been defined as ‘a deviation from a prescriber’s valid prescription or the hospital’s policy in relation to drug administration, including failure to correctly record the administration of a medicine’ (Haw et al, 2005). MAE’s are estimated to occur in 5% of all administered doses in UK general hospitals (Department of Health, 2004). However, observational research, in which researchers directly observe nurses administering medication to patients, suggests the true rate may be as high as 19% (Barker et al, 2002). A series of literature reviews (O’Shea, 1999; Pape, 2001; Armitage & Knapman, 2003; McBride & Foureur, 2006) have summarised a number of studies of medication administration and MAE’s in general hospitals. Surprisingly, little is known about medication administration in psychiatric settings, and none of the review papers address this.

AIMS
We decided to study medication administration and MAE’s in a psychiatric setting. We surveyed nurses about their views and training needs in relation to medication administration for older adults with mental illness. We also observed nursing practice on two inpatient wards in order to describe issues and difficulties experienced by nurses undertaking medication administration to older adults with mental illness.

LITERATURE REVIEW
A literature search (CINAHL, British Nursing Index, AMED, PsycInfo and MedLine) only found eight studies of medication administration and MAE’s in psychiatric or learning disability settings. MAE’s detected by incident report (Haw et al, 2005; Sawamura et al, 2005; Ito & Yamazumi, 2003; Maidment & Thorn, 2005) or chart review (Grasso et al, 2003) indicate that the most common types of MAE in psychiatry are wrong drug, improper dose, and omission.
errors. Reported errors and chart review tend to grossly underestimate MAE rate when compared with direct observation (Flynn et al, 2002). Our recent observational study (Haw et al, submitted) undertaken in an inpatient unit for the elderly mentally ill found an error rate of 25.9% based on a total of 1423 observed doses. Prior to this, observational studies in mental health settings were virtually non-existent. Thurtle’s (2000) study of MAE’s in learning disability group homes consisted of only sixteen observations. Branford et al (1997) observed the general characteristics of medication administration in day centres for people with learning disabilities but reported no empirical data on MAE’s. Haglund et al (2004) observed medication administration on two short-stay acute psychiatric wards in an ethnographic study, but only reported a very brief description of nursing practice. Interviews with nurses and patients suggested that time spent undertaking medication administration is an opportunity to develop interpersonal contact with patients. The authors concluded that nurses should be given guidelines about how to perform routines connected with medication administration.

A recent report (Commission for Social Care Inspection, 2006) has again highlighted the issue of medicines management in UK elderly care settings. In elderly psychiatric care, issues of capacity, consent, and patient confusion compound the difficulties of medication administration (Dewing, 2002; Griffith, 2003a). Other issues include the covert administration of medicines (Treloar et al, 2001), tablet crushing (e.g. Griffith, 2003b), swallowing difficulties (Mistry et al, 1995), hiding, spitting out, or chewing medication (Wright, 2002) and use of Health Care Support Staff (HCSS) to assist with medication administration (CSCI, 2006b). Little is known about the prevalence of such difficulties in care environments for older adults with mental illness or the nurses’ related training needs.

METHODS
Design
We used information from our literature searches to devise a questionnaire to investigate nurses’ views about medication administration and their training needs using a cross-sectional survey design.

Our observational study of nursing practice during medication rounds was quantitative, but data was supplemented by descriptive accounts of nursing activity made by the researchers. The full methodology of the observational study is reported elsewhere (Haw et al, submitted).
Setting
The survey was undertaken in the Townsend Hospital, a six-ward, 105-bed inpatient unit for older adults with mental disorder. The hospital is a part of St Andrew’s Healthcare, a UK charitable sector provider of mental health care. The observational study took place on two wards, here called Ward A and Ward B. Ward A is a 13-bed mixed-sex, locked ward for older people with dementia and challenging behaviour. Ward B is a 20-bed mixed-sex ward for physically frail older adults with enduring mental illness including dementia, and offers nursing-home type care.

Participants
All nurses (N=49) were invited to participate in the survey. All nurses from Wards A and B (N=12) were asked to participate in the observational research.

Procedure
The study was approved by an NHS Research Ethics Committee. The questionnaire was distributed in December 2005, consent was assumed by its return and participation was anonymous.

Written, informed consent was sought from nurses for participation in the observational study. Observation was undertaken by two of the researchers. JS recorded the activity of the administering nurse (e.g. medication given, whether tablets were crushed, use of single or dual nurse administration) while GD recorded notes about environmental distractions and patient activity. Nurses were told the observers were looking at the difficulties with medication administration including medication errors. The study took place on Ward A during March 2005, and on Ward B during June and July 2005. MAE’s were detected by comparing observational data with medication charts, and were assigned an error type and error severity rating by consensus between all three researchers. Each medication round was discussed on its completion by the observers in order to identify salient issues.

Numerical data for both the survey and observational studies was entered into SPSS 14.0 (SPSS, 2005) for analysis.

RESULTS
Survey of Registered Nurses.
Twenty seven (55.1%) completed questionnaires were returned. Twelve (44.4%) respondents had been qualified for more than five years, and two (7.4%) for less than one year. Twenty respondents (74.1%) were D or E grade nurses and the remaining seven (25.9%) were F grade and above. Twenty three (85.2%) respondents stated they had undergone some form of training in
medication administration in the past 12 months. Of these, four (15.4%) had received some formal training, 10 (38.5%) had received ‘on the job’ training, for instance with a colleague, and 19 (70.4%) had undertaken self-directed learning such as reading articles or using the internet. Some nurses reported receiving more than one type of training. Fifteen of the 23 (65.2%) nurses who had received some form of training said that the training received was adequate and relevant to their role.

Our questionnaire included a list of nineteen issues that can cause difficulty in medicines administration and we asked respondents whether, in their experience, each item occurred frequently, occasionally or never. Table 1 shows that the items most often cited as ‘frequent issues’ were related to characteristics of the patient group (‘confused patients who do not understand the need to take medication’, ‘patients with swallowing difficulties’ or ‘patients refusing to swallow medicines’), the crushing of tablets as part of overt or covert administration, and environmental factors including noise and distraction.

Finally, we asked under which circumstances respondents would surreptitiously administer medication. Twenty four (88.9%) respondents said they would administer disguised medication without the patient’s knowledge if a multidisciplinary team decision had been made to do so. Thirteen (48.1%) respondents stated that they would administer disguised medication if the patient lacked capacity to make an informed decision. Of these, six commented that this would be contingent upon the multidisciplinary team having made the decision to do so. Five respondents (18.5%) would administer disguised medication ‘to a patient who has capacity to make an informed decision but refuses’. Eleven (40.7%) respondents had seen disguised medicines being given but most of these had not viewed this in their current workplace.

Observational study
Of 12 nurses who were approached, nine (75.0%) agreed to participate. Participants had been registered from 6 months to 21 years. We observed 36 medication rounds (20 on Ward A and 16 on Ward B). Five each of the 8am 12am 5pm and 10pm rounds were viewed on Ward A and four each on Ward B. In total, we observed 1423 medication events (1312 administrations of medicines and 111 omissions). The number of medication rounds observed per nurse ranged from 1 to 6 (median = 4). The median number of medication events observed per nurse was 146 (range 14 to 309). Administration to 32 patients was observed and there were 369 MAE’s (25.9% of all events) in total. The most common types of errors were the unauthorised crushing of tablets or opening of
capsules (30.0%), omission errors (28.6%) and failure to sign the medication chart (23.3%). Most (n=255) errors were rated as of minor or negligible severity (69.1%) while 27 (7.3%) errors could have resulted in slight harm and one (0.3%) could potentially have resulted in serious harm. For the eighty six (23.3%) clerical errors it was not possible to rate error severity. The frequency of errors made by individual nurses varied from none to one in every two doses administered. The median error rate was one error in every six doses administered. Prescriptions involving topically applied lotions and creams were particularly prone to omission error (50/52 or 96.2% of all doses prescribed).

Thematic analysis of our descriptive notes suggested that a number of issues made medication administration in this setting difficult:

**Noise and environmental distraction**
We noted numerous examples of noise and other obvious distractions. Specific examples included one patient shouting sexual remarks loudly and repeatedly, and another frequently screeching. There were several instances of patients using verbal and physical aggression in the close vicinity of the nurse undertaking medication administration. Distractions were not solely caused by patients; we noted noise from the activity of workmen, distractions caused by other staff making unrelated enquiries during medication administration, telephone calls and pagers. The environment on both wards was often bustling. This was particularly noticeable when medication was administered in the dining room at meal times (occasionally on Ward A and almost always on Ward B). Administration in the dining room on Ward B contributed to cramped conditions, and this was exacerbated by heat and poor lighting.

**Patient characteristics**
Administration of medications to 32 patients was observed. Twenty-one (63.6%) were judged by their consultant psychiatrist to lack capacity to consent to treatment. We noted numerous examples of patients appearing confused, for example patients approaching the medicines trolley and attempting to touch medicines. Thirteen (40.6%) patients reportedly regularly refused or spat out medicines. Thirteen (40.6%) patients had swallowing difficulties (dysphagia). We observed a number of patients spitting out or refusing medicines.

**Medication issues**
Of 1044 doses of medicine given in tablet or capsule form, 265 (25.4%) were crushed or opened. Crushing or capsule-opening had not been authorised by a doctor on the prescription chart on 106 of
265 (40%) occasions. Nurses frequently voiced doubt about the correct procedures for crushing tablets. Medicines were served in food, for example stirred into yoghurt or mixed on a spoon with jam, on 179 occasions (13.8% of all oral doses), but this was almost always authorised. Food portions with medication in them were frequently left partially uneaten making it difficult to ascertain the dose ingested. Crushed or liquid medications placed in patients’ food did not appear to be done so covertly. Some patients received multiple medications (range 1 to 14 items) at one time.

**Single or dual nurse administration**

We observed three distinct practices related to single or dual nurse administration. In *single nurse administration* the administering nurse prepared medications and then gave them to the patient. In *dual nurse administration* two nurses undertook the medication round together. Sometimes, the second nurse checked the actions of the first (e.g. right drug, right dose) and usually acted as a ‘runner’ by taking and giving medicines to the patient. A third practice utilised HCSS to undertake the role of ‘runner’ and give medications to patients that had been prepared by a registered nurse. Administration of multiple medications was the norm, and the 1322 doses offered to patients during our observation comprised 404 interactions. Single nurse administration accounted for 108 interactions and dual nurse administration for 207. A HCSS administered medication prepared by a nurse on the remaining 89 occasions. On 49 (55.1%) of these 89 occasions the HCSS was in direct sight of the administering nurse, and was out of her sight on 40 (44.9%) occasions.

**DISCUSSION**

Nurses working in an inpatient service for older adults with mental illness frequently experience difficulties when administering medicines. However, only just over half of respondents in our survey (55.6%) stated that the training they had received was adequate and relevant to their role. Most training undertaken was self-directed (70.4%). The overall MAE rate was high (25.9%; one error in every 4 doses) and there was wide variation in the number of MAE’s made by nurses, suggesting considerable differences in their training experience. This suggests a lack of appropriate and relevant training. Our study demonstrates the need for regular training for nurses incorporating clear guidelines about medication administration. The development of training interventions and guidelines should incorporate our findings from the observational study.

The crushing of tablets and opening of capsules was common. This may partly explain the relatively high MAE rate in this study.
compared with studies in settings with fewer incapacitated, dysphagic and non-concordant patients. Adherence to clear guidelines on crushing tablets, including ensuring the prescriber has authorised crushing (who has in turn ascertained the safety of crushing), would have eliminated many of the errors in the current study and ongoing training should address this.

In our study we observed both single and dual nurse administration, with dual nurse administration being most common. We also observed the use of HCSS to assist in administration. Kruse et al (1992) found that double-checking by a second nurse significantly reduces the incidence of medication errors. Training should address the issues of double-checking and the appropriate role of HCSS in the medication administration process. In particular, delegation of the physical act of giving medication may diminish the valuable interpersonal contact time between registered nurses and their patients.

About one in five (18.5%) respondents said they would administer disguised medicines to a patient who had capacity to consent but refused them. Some respondents commented on the circumstances under which such administration might be justifiable, usually citing issues of physical emergency such as a diabetic collapse where administration against the explicit wishes of the patient might be life-saving, or in the patient’s best interest. Such views are not without controversy: Kellett (1996) describes a case where a nurse was suspended for administering disguised tranquilising medicine to a hypomanic 91-year old man in a day hospital on the instruction of the consultant. The judgement remained on the nurse’s record even though the consultant was found to be behaving professionally. Our finding indicates that ongoing training should address professional guidance on covert administration of medicines (United Kingdom Central Council for Nursing & Midwifery, 2001) and the legal and ethical issues of covert administration.

**Study Limitations**

There are a number of limitations to this exploratory study. The survey was small-scale and was conducted on one site in a hospital caring for some very challenging patients. The hospital is a charitable sector provider and results may not generalize to NHS settings. Response rate was moderate (55.1%), and was limited by participant anonymity and our subsequent inability to send personalised reminders. We do not know if non-respondents differed from respondents. Generalisation of findings from our observational study to other areas may also be limited by its scale and independent sector setting. We only report on observable behaviours and not on unobservable processes. The presence of
observers may have affected the number of errors made by nurses administering medicines, although the observational methodology is not thought to affect the underlying error rate (Dean & Barber 2001).

**Conclusion**

MAE’s are common, though fortunately most are minor. Our investigation indicates that nurses experience many difficulties in medication administration to older adults with mental illness. Regular, standardised training should be provided and this should include guidance on crushing medicines, the use of HCSS in administration, and surreptitious administration. Priority must be given to minimising potential environmental distractions and ensuring medication administration occurs in a calm, quiet setting whenever possible. Reporting of all errors and near misses should be encouraged, and individual blame avoided, in order to facilitate an open, learning culture.
Table 1: Reported frequency of the ‘regular occurrence’ of difficult or problematical issues in medication administration (N=27)

<table>
<thead>
<tr>
<th>Medication administration issue</th>
<th>Regularly occurring issue N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confused patients who do not understand that they need to take medicines</td>
<td>13 (48.1)</td>
</tr>
<tr>
<td>Having to crush or dissolve medicines in order to administer them (when the patient IS aware of what you are doing)</td>
<td>10 (37.0)</td>
</tr>
<tr>
<td>Patients refusing to swallow medicines</td>
<td>10 (37.0)</td>
</tr>
<tr>
<td>Patients having difficulty swallowing medicines</td>
<td>9 (33.3)</td>
</tr>
<tr>
<td>Having to administer a large number of medicines to one patient at the same time</td>
<td>9 (33.3)</td>
</tr>
<tr>
<td>Difficulty in concentrating as distracted by noise or other patients or staff</td>
<td>8 (29.6)</td>
</tr>
<tr>
<td>Having to crush or dissolve medicines in order to administer them (when the patient is NOT aware of what you are doing)</td>
<td>8 (29.6)</td>
</tr>
<tr>
<td>Patients who become aggressive when you attempt to administer medicines</td>
<td>7 (25.9)</td>
</tr>
<tr>
<td>Time pressures (many tasks to complete in a limited time)</td>
<td>7 (25.9)</td>
</tr>
<tr>
<td>Problems with the layout of the clinic room or area where drugs are administered</td>
<td>5 (18.5)</td>
</tr>
<tr>
<td>Having to leave (and lock) the medicines trolley whilst administering medicines to a patient</td>
<td>5 (18.5)</td>
</tr>
<tr>
<td>Complex prescriptions with frequent dosage changes</td>
<td>4 (14.8)</td>
</tr>
<tr>
<td>Difficulty in reading the prescription as doctor’s handwriting is not clear</td>
<td>4 (14.8)</td>
</tr>
<tr>
<td>Ambiguous prescriptions – it is not clear what the prescribing doctor intended</td>
<td>3 (11.1)</td>
</tr>
<tr>
<td>Having to calculate the dosage e.g. when administering a liquid medicine</td>
<td>2 (7.4)</td>
</tr>
<tr>
<td>Patients who are drowsy or asleep and hard to wake up to give them their medicines</td>
<td>2 (7.4)</td>
</tr>
<tr>
<td>Communication problems with other staff e.g. the doctor has said to omit a medicine but has not written in the notes</td>
<td>1 (3.7)</td>
</tr>
<tr>
<td>Difficulty in concentrating as feeling tired or upset</td>
<td>1 (3.7)</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>‘Runner’ unfamiliar with identity of patients on ward</td>
<td>0 (0.0)</td>
</tr>
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</table>

REFERENCES


Mental health problems and service use in the Irish population: findings from the HRB National Psychological Wellbeing and Distress Survey

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Introduction
There is little information available on the level of psychological distress in the Irish population or the use of health care services and professionals by individuals experiencing mental health problems. The Health Research Board (HRB) National Psychological Wellbeing and Distress Survey (NPWDS) sought to address this gap in information. It is envisaged that the survey will be completed every two years to identify trends and monitor changes and to assist national planning and evaluation of mental health in the Irish population. In addition, the survey will be used to carry out research on the determinants and correlates of psychological distress and service use and to explore the relationship with underlying psychological theoretical concepts. This is the first report from the series. It is important to stress that this report details descriptive baseline data only, while future work will exploit the data to address a range of research questions relating to psychological wellbeing and distress in the Irish population.

Methods
The NPWDS was a telephone survey of a nationally representative random sample of 2,711 adults aged 18 years and over and living in private households. The data were collected by the Economic and Social Research Institute (ESRI) between the period December 2005 and April 2006 over three two-week intervals. Telephone numbers were drawn on a random, probability basis. In order to ensure
geographical coverage, an initial set of sampling areas was selected from the GeoDirectory. This initial sample of areas was then employed to generate a random telephone sample using random digit dialling. The survey received ethical approval from the HRB Research Ethics Committee. In line with best practice the completed sample was re-weighted to ensure that it was representative of the population from which it had been selected. Comparisons with relevant census data showed that the profile of the sample was comparable to that of the general population aged 18 years and over.

Aims
The main aims of the survey regarding mental health and service use were to:

- produce much-needed data in relation to mental health issues from a representative sample of the population
- determine the proportion of the Irish population who were experiencing psychological distress or had experienced psychological distress in the previous year
- describe the help-seeking behaviour of the Irish population when experiencing mental health problems, including use of primary care, use of secondary mental health services and use of other professionals / support persons
- investigate the perceived effectiveness of the support used in the previous year
- describe the willingness to use professionals / support persons for mental health problems in the future

Results
A summary of the main findings from the HRB NPWDS are presented below.

Mental and physical health status and quality of life
The majority of the respondents reported ‘good or very good’ mental health in the past year, with 15% reporting ‘less than good’ mental health. Those aged 50–64 years were most likely to report less than good mental health. A total of 14% (one in seven) of respondents reported experiencing mental health problems in the previous year, with females more likely to report mental health problems and the youngest and oldest age groups least likely to report such problems. Current psychological distress, as measured by the General Health Questionnaire 12 (GHQ12), was evident in a total of 12% of the sample (one in eight). Again, females were more likely to exhibit high scores on the GHQ12 as opposed to males, and the youngest and oldest age groups were least likely to exhibit high scores.
Approximately 21% of the respondents reported 'less than good' physical health. A greater proportion of females reported less than good physical health compared to males. There was a steady increase in the proportion reporting less than good physical health across the age groups.

Of all respondents, 19% reported 'less than good' quality of life, with females more likely to do so than males. As in the self-reports of physical health status, the proportion reporting less than good quality of life increased over the age groups.

**Use of health care services and willingness to seek help**

The majority of the respondents had attended a general practitioner (GP) in the previous year for physical health problems, while only 9% reported that they had spoken to a GP about mental health problems. However, those who had spoken to a GP about mental health problems had, on average, a greater number of visits (4.4 visits) than those attending with physical health problems (3.9 visits). Females were more likely than males to report general practice use for physical or mental health problems. As expected, the older age group was more likely to attend a GP for physical health problems, while the 50–64 year age group was more likely to discuss mental health problems with a GP.

A total of 16% of the sample reported that there were barriers that prevented them from attending a GP in the previous 12 months. The most frequently reported barriers were cost of visits, the length of time involved in visits and embarrassment / feeling awkward. However, in the 65+ age group the most frequently reported barriers preventing respondents from attending a GP were length of time involved in the visit followed by difficulties in transportation to the general practice. It is not unexpected that cost was not an issue for the 65+ age group as the majority of these individuals had free medical care.

Not surprisingly, the proportions of respondents reporting attending secondary mental health services were much less than the proportion reporting attending general practice for mental health problems. For example, nine per cent reported attending a GP, reported attending outpatient clinics, while less than one per cent reported attending inpatient services.

A total of 6% of the sample reported attending other professionals / support persons for mental health problems in the previous year and the most frequently attended were psychiatrist, nurse or counsellor. Alternative practitioners were reported as the least likely to be contacted for mental health problems. Most of the
respondents reported that the professionals / support persons they contacted had been effective or very effective in the treatment of their problems.

A total of 93% of the respondents were willing to seek help for mental health problems if required and a GP was the preferred source of help followed by a psychiatrist, counsellor or psychologist. While almost 90% were willing to contact a GP, only 31% to 48% were willing to contact a psychiatrist, counsellor or psychologist. Of the respondents who reported that they would use other professionals or support persons than those listed, the majority reported that they would seek help from family and / or friends.

Conclusion
This is the first national survey of the extent of psychological wellbeing and distress within the Irish population. It is important to highlight that many adults within the Irish population report ‘good’ or ‘very good’ mental health, physical health and quality of life. Yet a significant number of adults will experience psychological distress at some point in their lives that will, for the most part, require some form of support or intervention, whether formal or informal. While the majority of these will experience short-term mental health problems, others may require the help of specialised mental health services. Thus, as is in other European countries, psychological distress is an under-acknowledged feature of Irish society and the findings have implications for policy and service planning in a range of sectors.

The failure of individuals and civic society to acknowledge psychological distress has a number of important and fundamental consequences, from the philosophical to the political, which require detailed exploration. For present purposes, individual and civic reluctance to ‘own’ psychological distress can result in psychological problems going unrecognised yet wreaking personal, familial and societal trauma. This deficit in ownership also contributes to the stigma associated with mental illness / distress in Irish society. A further consequence is that formal and informal supports which could provide healing, support and hope go undeveloped or underused, with inevitable social and economic costs for individuals, families and society.

The NPWDS found that approximately 12% of the Irish adult population report feeling psychological distress at any particular time – a figure which is similar to that found in other countries (e.g. UK, ESEMeD project). It is evident that formal services as currently provided cannot respond to the demand for support and it may not be appropriate that they do so in all cases. The decision to seek
help can depend on a number of health beliefs such as the perceived need for help, the perceived efficacy of treatment and the barriers and facilitators to seeking help.

There is an evident need to develop new models of support for persons experiencing psychological distress – many of these could be informal and inexpensive, operating at individual (recognition and ownership of stress / distress), interpersonal (seeking informal support from family, friends) and societal (development of social capital in communities) levels in a wide range of situational contexts (schools, homes, resident associations). Individuals and communities need to be provided with strategies aimed at reducing or coping with psychological distress so as to reduce the chances of symptoms reaching diagnostic criteria. This would, of course, reduce the chances of the symptoms requiring formal health care services.

With regard to formal supports, this survey has highlighted the important role the GP plays in the assessment and treatment of mental health problems. GPs are often the first and only port of call for those seeking help and are also the primary gatekeepers to specialised mental health services. These findings raise a number of important issues relating to the assessment and treatment of both short-term mental health problems to more enduring mental health problems within the primary care setting. There is a need for training in mental health care for GPs and those working within the primary care setting. Importantly, there is a need for mental health professionals within the primary care network who can provide a range of psychological therapies. And finally, the interface between primary care and secondary mental health services needs to be evaluated so there is a continuity of care for those who require specialised mental health services.

The survey has highlighted a number of important issues in relation to psychological distress. As in other European countries, the extent of psychological distress needs to be acknowledged, not only at the societal level but also at the individual and interpersonal level. The acknowledgement that psychological distress is a part of Irish life will reduce the stigma surrounding mental health problems.

There is a need for individuals and communities to be provided with strategies that can help alleviate or reduce psychological distress. These strategies can be provided within a range of situational contexts, such as schools, community groups and employment settings, ensuring that a variety of audiences is reached. Mental health care policy and service planners should acknowledge the need for early detection and treatment, ensuring that as many
individuals are treated as soon as possible to prevent the symptoms from escalating unnecessarily.

The important roles of the GP and the primary care network in the assessment and treatment of mental health problems need recognition. The development of primary care networks should provide a range of mental health professionals who can be accessed by the GP. The most recent mental health policy document, *A Vision for Change 2006*, highlights many of these issues.

The present survey has taken the first step of capturing and describing the reality of psychological distress in the Irish adult population, exploring its gender and age correlates, the formal and informal supports used and their perceived effectiveness. To date, population-based information on the prevalence and correlates of psychological distress has been limited, as has information relating to the use of formal and informal supports. Successful policies and service planning need to be based on reliable and valid information. It is anticipated that the findings from this and future surveys will provide this important information. Further reports from this survey will focus on specific aspects of the survey data and will investigate the important correlates of psychological distress and service use. It is important that the findings are debated within an inter-sectoral arena so that appropriate responses for mental health care delivery can be developed.

For a full report contact dtedtsonedoherty@hrb.ie or www.hrb.ie

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An Exploratory Descriptive Study of what Shared-Decision Making with Patients Means to Nurses in an Acute Hospital Setting

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Background: The researcher is a recently appointed Education Officer in a Centre of Nurse Education and has more than twenty years of clinical experience. Government and the Irish nursing professional organisation recommend that nurses’ should promote shared decision making with patients. However the researcher has observed through observation of clinical practice and conversation with nurses’, that there is a lack of understanding of this concept and what it means in practice. On a search of nursing journals there was a paucity of studies of shared decision making in acute setting. Hence the decision to explore with nurses what shared decision making means to nurses in an acute hospital setting.

Aim: The aim of this study was to explore what shared decision making means to nurse in an acute hospital setting

Methodology: Using purposeful sampling and a qualitative descriptive approach, data was collected from semi structured interviews with six nurses from three acute hospitals in the Republic of Ireland. An analysis framework devised by Bradley, Curry and Devers (2006) was adapted for use.

Results: Findings from the study indicated that when nurses shared decisions with patients they ‘worked with the patient’. When they did not share decisions with patients they ‘worked for the patient’. Giving information was a key attribute of shared decision making. Factors that influenced shared decision concerned the nurse, the patient, the environment and the nurse as ‘self’. 
Recommendations:
The findings of the study had implications for nursing practice, nurse education and future research. Among the eight recommendations for nursing practice were improved communication channels between community and hospital staff, conflict resolution, and a shift in focus of care planning from problem solving to solution focus. As the study showed that nurses were often placed in a dilemma of balancing ethical decisions with legal implications, it is recommended that more time be devoted to ethical decision making at undergraduate and post-graduate level programmes. The study used a qualitative design gathering information from nurses, it is recommended that further studies would all include all key participants in shared decision making identified in the study using a mixed method approach to gather data.

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Personal factors as determinants of activity and participation following stroke

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Introduction  
The impact of stroke may cause several limitations an individual has in executing everyday activities and restrict their participation in life situations. Functional limitations and restrictions as a result of stroke have primarily been explained by clinical variables such as impairments (Kwakkel, Kollen, & Lindeman, 2004; Sturm et al., 2004). According to the WHO International Classification of Functioning (2001) multi-dimensional framework, activity and participation may also be influenced by personal factors. Personal factors refer to the experiences of an individual (which are objective) and their resultant expectations, beliefs, goals and aspirations (which are subjective) (Wade, 2000). These factors that may influence how disability is experienced by the individual include gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern and character (WHO, 2001). Therefore psychological variables in addition to clinical variables may have an important role in determining post stroke recovery. A recent review of the literature highlighted the limited evidence on psychological adaptation processes post stroke and their relationship to stroke outcome (Donnellan, Hevey, Hickey, & O'Neill, 2006).
The action-theoretical model of Selective Optimisation with Compensation (SOC) (Baltes & Baltes, 1990) and perceived control (Partridge & Johnston, 1989) were proposed in this study to explore the contribution of psychological processes in determining recovery after stroke. The SOC model provides a general theory for conceptualising processes of successful development in general and was originally designed and developed as an explanatory framework for adaptation to ageing (Li & Freund, 2005). It has been applied mainly to the process of successful ageing and successful life management (Baltes & Lang, 1997; Freund & Baltes, 1998). Greater use of SOC adaptive strategies have been associated with higher levels of psychological well being (Freund & Baltes, 2002) and better physical health (Freund & Baltes, 1998) in general ageing populations. Perceived control has been conceptualised as the extent to which individuals’ believe that they control key processes over their internal state and behaviour and has been supported as a valid construct of control over recovery from chronic conditions or illness (Turk, Rudy, & Salovey, 1986). Empirical research has confirmed the predictive value of perceived control in determining functional recovery three years after stroke (Johnston, Pollard, Morrison, & MacWalter, 2004). The aim of this longitudinal study is to examine the influence personal factors such as adaptive strategies, perceived control and socio-demographics have on activity limitations and participation restrictions one year after stroke. The specific objectives are to examine the association between personal factors and activity and participation; and to examine if personal factors predict improved activity and participation one year after stroke.

Method

Patient selection and sociodemographics

Patients were recruited from three large urban teaching hospitals and one small district general hospital in the Republic and Northern Ireland. All consecutive admissions with a confirmed diagnosis of stroke (defined as symptoms of rapid onset lasting more than 24 hours and of presumed vascular origin reflecting a focal disturbance of cerebral function, excluding isolated impairment of higher function) were considered eligible for the study. Patients admitted with transient cerebral ischaemic attacks and related syndromes, traumatic intracranial and subarachnoid haemorrhage and pre-stroke vascular dementia were deemed unsuitable and excluded from the study. Patient socio-demographic and clinical background information included age, gender, marital status, living arrangements, socio-economic status (manual and other social classes including self-employed and non-manual), past medical history, other co-morbidities during this admission, stroke subtype,
lesion location and length of stay in hospital on this occasion. 153 stroke patients (49% female) mean age 70 years ±12.4, were interviewed within 4 weeks of admission (Time 1=T1) and followed up (n=107) at 12 months (Time 2 = 2). Patients lost to follow-up were as a result of declines (n=21, 14%), mortality (n=14, 9%), proxy information only obtained (n=9, 6%) and relocation (n=2, 1%).

**Measures**

All patients were first screened for language and cognitive deficits to determine their eligibility into the study. Memory and cognitive function were assessed using the Hodkinson’s Mental Test Score, more commonly known as the Abbreviated Mental Test (AMT) (Qureshi & Hodkinson, 1974). The Frenchay Aphasia Screening Test (FAST) was used to classify language and communication problems (Enderby, Wood, Wade, & Hewer, 1987). Strategies of adaptation – selection, optimisation and compensation (SOC) were assessed using a modified version of Baltes original SOC-48 Questionnaire (P. B. Baltes, Baltes, Freund, & Lang, 1999) called the SOC-15. Perceived control was assessed using The Recovery Locus of Control Scale (RLOC) (Partridge & Johnston, 1989). The Stroke-Specific Quality of Life (SS-QOL) was used to assess participation and has been reported to be a valid, reliable and responsive measure in assessing participation in acute stroke trials (Salter et al., 2005; Williams, Weinberger, Harris, Clark, & Biller, 1999). The Nottingham Extended Activities of Daily Living Scale (NEADL) was used to assess functional activity (Nouri & Lincoln, 1987). Stroke severity was assessed using the Orpington Prognostic Score (OPS) (Kalra & Crome, 1993) and depression with the depression subscale as part of the Hospital Anxiety Depression Scale (HADS) (Zigmond & Snaith, 1983).

**Results**

Comparison analyses indicated significant improvement in activity scores from T1 to T2 (t=-3.58, p<.001) but not in participation. There were no significant differences in adaptive strategies or perceived control from T1 to T2. Univariate analyses using Pearson’s Correlation identified significant associations between stroke severity, depression at T1 and activity and participation at T2 (p<.001). Hierarchical linear regression was used to identify what variables predicted activity and participation at T2. Socio-economic status (β = .18, p<.05) and activity at T1 (β = .48, p<.001) were the only significant predictors of activity at T2. The overall regression model was significant for activity (F(12,90)=6.14, p<.001) and explained 22% of the variance in activity at T2. Socio-economic status was also a significant predictor (β = .21, p<.05) for
participation at T2 along with participation scores from T1 (β = .62, p < .001). The overall regression model for participation was also significant (F(12,90)=3.33, p<.001) and explained 38% of the variance in participation.

Discussion

Results confirmed improved performance in activity but not in participation one year after stroke. Although individuals had better functional ability from stroke onset to one year later, their role function in life situations and their experiences remained restricted. Additional analyses not presented in this paper, has indicated some association between participation and mood after stroke. Hence levels of depression may be influencing the degree of participation in life situations. The personal factors adaptive strategies and perceived control remained consistent from acute stroke onset to one year later. This would signify a dispositional component to these psychological variables. Stroke severity and depression during acute stroke determined activity and participation one year later at a univariate level only. Further analyses showed that stroke severity, depression or personal factors adaptive strategies and perceived control were not predictive of activity and participation one year after stroke. However, socio-economic status was a significant predictor of activity and participation one year after stroke. Individuals from a manual social class had a worse outcome in terms of activity and participation compared to those self-employed and from a non-manual social class. Although large socio-economic inequalities have been found for stroke prevalence in Europe (Dalstra et al., 2005), this finding may be explained by previous evidence in the literature that indicates socioeconomic status affects access to some health services after stroke (Kapral et al., 2002) which may result in worse functional recovery. Activity and participation scores during acute stroke predicted activity and participation one year later. These findings are in keeping with the literature which suggests that functional outcome and patterns of recovery are largely defined within the first weeks post stroke (Kwakkel et al., 2004).


Service User’s Self Medication Programme in a 24hr Nurse Community Mental Health Residence

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“Take charge of administering a patient’s medication and he’ll be compliant while he is in hospital. Put him in charge, with supervision and he’s likely to stay compliant even when he goes home” (1984 Clarke-Mahoney)

The programme is set in a 24-hour nurse community mental health hostel. It has seven residents aged between 21 years and 53 years, two female and five male.

In keeping with the philosophy of self-care in Bredagh House this programme is to facilitate maximum development of our service users potential in an effort to promote independent living skills.

“Increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any other improvement in specific medical treatments.” (2002 Haynes et al) This programme is directed towards helping the service user to manage their own medication with minimum or no supervision. It will provide the service user with the education and knowledge re the names of their medication, dosage, effects and side effects.

At first a literature review was carried out and a project plan was put in place. After negotiations with management a policy was drawn up for a pilot study.

Each resident was assessed by medical and nursing staff re suitability to self-medicate and their consent was sought to participate. The programme commenced in July 2006 involving two participants. In August 2006 five more participants were recruited, making a total of seven.
An evaluation will be carried out in 2007. It will comprise of two parts. Part One: a questionnaire to evaluate service’s users knowledge of their medication, following participation in self-medication programme. Part Two: a questionnaire to evaluate service users perception of self-medication programme.

There are three phases to this programme, which will be depicted in the Poster.
Oncology nurses’ descriptions of intimacy with patients: mirroring Edith Stein’s phenomenological conceptualisation of empathy.

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Introduction
This paper highlights the relevance of Edith Stein’s philosophy on empathy in understanding oncology nurses’ expressions of intimacy with their patients, as revealed from narratives in an interpretive phenomenological study.

The nurses interviewed in this study revealed identification and empathy essential to the process of developing intimacy with their patients. Empathy, in itself, is a complex concept and is used in various ways in the literature. Kristjansdottir (1992) traces the early work of German psychologist and philosopher Lipp, who in 1907 distinguished empathy from sympathy. Morse et al. (1992) identify four components of empathy: moral, emotive, cognitive and behavioural. Another conceptualisation of empathy is proposed by Kunyk and Olson (2001) who consider empathy as a human trait, as a professional state, as a communication process, as caring and as a special relationship. Rawnsley (1980) presents empathy, firstly, as a concept of characteristics and abilities and, secondly, as a construct including a developmental progress and/or a behavioural and cognitive process. The view of empathy as a special relationship requires a reciprocal relationship to build over time between the nurse and the patient (Kunyk & Olson, 2001). Moreover, the term ‘friendship’ is used in this view of empathy, which is in opposition to the view of empathy where a professional distance is presented (Kunyk & Olson, 2001). None of these aforementioned views provided adequate explanation for the process of empathy revealed in oncology nurses’ narratives from this study. However, the view of Phenomenologist Edith Stein on empathy mirrors the description of empathy provided by nurses in this study.

The study
The aim of the study was to explore the meaning of nurse-patient intimacy in oncology care settings. An interpretive phenomenological (also known as philosophical hermeneutics)
design was chosen, with insights from the philosophy of Phenomenologist, Gadamer (1975) utilised to guide the study process. Twenty-three nurses who volunteered to participate, were interviewed twice by the researcher, over a 10 month period (March-December 2005). All the interviews were audio-taped.

Ethical approval for the study was granted from three hospitals offering oncology services in one health service area. All oncology nurses working in the three hospitals were informed about the study and invited to participate. Each study participant was given written information about the study before the first interview and signed an informed consent. Thirty oncology patients were also interviewed once, however, their narratives are not the focus of this paper.

Much deliberation went into how the opening question in the first interview with nurses would be phrased. Although it is argued that in the conversational interview the interview process “needs to be disciplined by the fundamental question that promoted the need for the interview in the first place” (van Manen, 1990, p.67), intimacy is not a word normally applied in descriptions of nurse-patient interactions. Indeed, Williams (2001) reports that some nurses she interviewed in her study, exploring their perceptions and experiences of intimacy in their relationships with patients, expressed the view that intimacy was an inappropriate term to describe closeness in the bonding or closeness in the nurse-patient relationship. Also, surrogate terms for intimacy have been identified as ‘sexuality’ and ‘sex’ (Dowling, 2003). Therefore, the opening question of the first interview asked nurses to describe their interactions with their patients. With an abstract concept, such as intimacy, by asking participants about their interactions with patients, it would identify for them a more “concrete, specific experience” (Kahn, 2000, p.63). In addition, Walsh (1996) reports that when he asked psychiatric nurses about their relationships with patients, they would look at him blankly or give a psychological treatise on the helping relationship. So instead, he asked about their ‘encounters’, similar to the approach taken in this study of asking about interactions.

The repeat interview for each nurse began with the researcher giving a short summary of the first interview and asking if the summary was correct. This is a process also employed in a study reported by Lindseth et al. (1994). The repeat interview then became a collaborative dialogue on the issues raised in the first interview, similar to that described in hermeneutic research by Street (1995). Repeat interviewing in hermeneutic research acknowledges that the understanding of researcher and participants changes over time (Fleming et al. 2003), and considers interviewees
as collaborators of the research project (van Manen, 1990). This allows reflection on the text (transcripts) of the previous interview in order to aim for as much interpretive insight as possible, and determine the deeper meanings or themes of these experiences (van Manen, 1990).

Data analysis
Direction on data analysis was provided by the writings of van Manen (1990), and Colaizzi’s (1978) framework. van Manen’s activities of data analysis proposes describing the phenomenon through the art of writing and re-writing, as was adopted in the study. However, a framework was required to reach the phase of describing the phenomenon, therefore, Colaizzi’s procedural steps provided direction for this aspect of the process of analysis. This combination of van Manen’s work with others in the field of phenomenology is not unusual. For instance, Jongudomkarn and West (2004) utilise Colaizzi’s and van Manen’s work in their phenomenological study. Moreover, others have utilised van Manen’s phenomenology with Benner’s paradigm cases (Fielden 2003, Hassouneh-Phillips 2003).

Utilisation of the qualitative package, ATLAS. ti assisted in managing the large amount of data collected. Such a package cannot automatically result in interpretation of the text (Muhr, 2004). Its strength lies in its ability to store the inputted memos and creation of codes, and offer transparency in how the analysis process proceeded. Moreover, the package facilitated smooth movement between the narratives, assigned codes, highlighted quotations, and memos, during the analysis process.

Three major themes were revealed following data analysis, i.e. Developing intimacy, experiencing intimacy, and the outcome of intimacy. Identification and empathy for patients was revealed as a central sub-theme to developing intimacy. In addition, the need to balance intimacy with detachment was revealed as a major sub-theme in the outcome of intimacy. Both these sub-themes are relevant to Edith Stein’s descriptions of empathy.

Trustworthiness
Narrative studies, such as this one, do not have formal methods of reliability (Polkinghorne, 1988). However, the views of Eberhart and Pieper (1994) on the procurement of reliable information in a hermeneutic study was adhered to in the study. This included, selection of an appropriate sample, a preliminary research question, information to be relayed to participants before the interview, and repeat interviewing with participants. Moreover, Eberhart and Pieper (1994) suggest that the transcription of the audiotaped
interviews into a written text should be carefully checked against the audiotape to ensure the language in the text accurately reflects the verbal description of the experience. Consistent attention to reflexivity was also adopted by the author throughout the study, and a diary was kept during data collection and analysis. Finally, similar to the method outlined by Lindseth et al. (1994), each nurse was given a short summary of their first interview at the beginning of their second interview, as well as the researcher’s interpretation of the narrative, with the second interview probing the issues raised in the first interview further.

Findings
Nurses revealed in their narratives that their first meeting with the patient was critical to the relationship that developed. Nurses described a process of identification with certain patients occurring during that first meeting. The term, ‘identification’, in this context, is the process revealed in the nurses’ narratives, whereby the nurse identifies something in the patient that triggers the encounter to move to another level, prompting empathy on the part of the nurse.

The nurses’ narratives reveal that they ‘click’ with certain patients, and this ‘clicking’ seals the identification process. This is evident in the following nurses’ narratives, where the use of the terms ‘clicking’ and ‘identify with’ are used.

Nurse 4 “…there was a girl [patient] in recently and I kind of clicked with her as she’s the same age as myself, has young kids as well... I think you’ll always meet up with some patients that are you’ll click with, and a lot of the time it’s probably similar lifestyles to yourself”.

Nurse 15 “I suppose it’s human relations really that...just...I suppose there are just patients that you just click with, and there’s...I feel myself I’m pretty much not bad at clicking with a large number of patients, but there’s always people that you will really identify with, I guess some of it must be identification, you know...you’re identifying...”.

The nurses’ narratives also suggest that the process of identification is actively pursued by nurses, in an attempt to find something in common with patients.

Nurse 5 “I might identify a certain trait in a patient and say ‘oh gosh, I know how that could feel’...I suppose in your forties, you meet so many people in their forties with cancer, who would be married, who would have teenage children, whose parents would still be alive, and that you have a lot in common,
and then you interact with that...We’ll just have a small chat really, but it may build into finding out that we have this in common.”.

Nurse 12 “If you relate to them, the first thing would be like you’d say ‘have you children?’ or ‘are they at home?’ or ‘where are they?’ or whatever. Or for a younger person ‘are you in college, what are you doing?’ and all that... I think it makes them realise that yes, on a personal level she has the same things I have. I know what it is like to have 3 teenagers, so obviously she’s going through the same thing as me with hers”.

Nurse 15 “If I meet say, a seventy year old lady and she’s from way out the countryside or something, right, and really, I, I straight away, will try and sort of find something that puts us on a balance, on par”.

Being a Mother, and caring for oncology patients with children, was expressed by some nurses as a common trait that propelled the identification process. This is evident in the narrative of Nurse 6 below.

Nurse 6 “I think it’s when they’re really young as well, because you identify with that. Or if they have really young kids, I think it’s just...I really, I’m always looking at how they’re coping, or how the kids are, or who’s minding the kids, or...I’d nearly be asking them who’s doing their washing...you know”.

Other nurses with children also talked about their identification with patients who had children and expressed a heightened empathy. This is evident in the three narratives below.

Nurse 13 “I know that we’ve one young patient who is similar age to my own age. She has a daughter that’s 8. And she’s a single mother...she’d be someone that I would have kind of a strong link with because I suppose, in a sense, maybe because she has a child, I maybe identify with that as well”.

Nurse 22 “I suppose there are people [patients] I get a bond with because I suppose I have kids, and I suppose I just feel that if I was in the same situation, how I’d cope”.

Nurse 4 “I mean I empathised with her [patient] at the time, when she had a child, but I think the fact that I have a child now as well, that I think I’d find it even harder, because you know definitely...you know what it feels like for her then to be leaving something behind”.

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Identification, therefore, reveals itself as a critical antecedent to nurse-patient intimacy, and results in nurses’ empathy for patients. The central role of empathy in the development of nurse-patient intimacy is described eloquently by nurse 15 in the following narrative.

Nurse 15 “The presence and the response and the people around them [patients] at that time is huge as well, in so far as my empathy towards that person... I can’t change the fact that this person has a diagnosis...if I’m sympathising with somebody, then really I’m taking on their stuff, whereas I can be empathetic and step back and be completely empathetic with somebody...”.

Other nurses too, described empathy for the patient as a feeling of being at their ‘level’ and an awareness of how they are feeling. Suggestions of ‘clicking’ and identification are also evident in the following narrative.

Nurse 2 “Well I think you have to be at the one level with them [patients]. That you’re not thinking, not a step above that you’re like you’re talking with them, you know as if you were. Like empathy maybe like you were...as if picture yourself in their shoes. How you’d like to be treated... ”.

Most nurses interviewed also revealed to that they needed to be careful about getting too intimate with patients because of the possible emotional effects on them. Many nurses described the need to maintain a professional distance in their relationship with patients, as revealed in the following narratives:

Nurse 6 “You do just have to hold back a little bit...you have to maintain some kind of professional level”.

Nurse 23 “I think it’s trusting, I think it’s good to be open, but not too open. Like you have to be careful as well”.

Nurse 10 ”I mean obviously you have to be careful how, how deep a relationship you form or what have you... Well, obviously sometimes you can get too, too emotionally involved with, and you find yourself getting upset with a patient that you become particularly fond of, dying or getting very ill or. I just try not to get just too involved. I suppose it’s something you can’t ....it’s just sometimes hard to ...but there are sometimes ways you can I suppose prevent yourself getting too involved in the
whole thing, by not getting too knowledgeable about the whole family dynamics, and not getting too involved in taking on what is their journey at the end of the day”.

The need to maintain professional distance was viewed by some nurses as a way of avoiding the risks of identifying too much with patients, which they equated as over-involvement. The following narrative from Nurse 12 illustrates how she manages this risk.

Nurse 12 “I make myself stand remote from it...when I’m talking to them, I’d be talking about the children, talking about whatever, but I suppose I’m never really...I probably don’t let myself get totally into it. I don’t...I mean how into it do you get? I just...I talk about it, I feel that I put it out of my mind then, but I can relate to them because if I thought about it, I’d get very upset. If I kept thinking about it, I’d get very upset”.

Nurse 15 expressed an interesting view of what she believed over-involvement to be. She considered it to arise out of a nurse’s sympathy, as opposed to empathy, for the patient, illustrated in the following narrative.

Nurse 15 “…if I’m sympathising with somebody, then really I’m taking on their stuff, whereas I can be empathetic and step back and be completely empathetic with somebody, and I just think that that’s why self-awareness is so important ...but I think that it’s the fine line and the knowing, you know, because at that point you become no good to the patient, and that’s huge”.

Discussion
The study narratives reveal that the first nurse-patient encounter begins a process of identification that results in empathy for the patient. Identification is described as, “to involve a growing sensitivity to the ‘movement’ within” another person (Smyth, 1996, p. 935), and is highlighted as a characteristic of empathy (Rogers, 1975; Rawnsley, 1980; Smyth, 1996). In a similar vein, Scott (1995) discusses empathy in the context of constructive caring as imaginatively identifying with the patient that requires working of the imagination, “which are unbounded by rules or laws, because beginning with preconceptions is likely to be damaging” (p.1199).

In an analysis of the writings of Scheler, Campbell (1984) discusses empathy and identification in the context of caring in the helping professions. Scheler (1992) describes emotional identification as an “infection” to illustrate its limiting capacity and argues that identification is something that is not rational or deliberate but a
letting-go of self, and childlike in nature (p. 50). The reference to childlike is important to this discussion. The nurse’s empathy for the patient must be naïve in nature so that the patient is viewed as a unique being and his/her experience of illness is also viewed as unique to them. Moreover, this view would suggest that identification fits with the description of the ‘lifeworld’ (Lebenswelt) proposed by Husserl (1970), where individuals experience pre-reflexively, without resorting to interpretations.

**Edith Stein’s conceptualisation of empathy**

The view of empathy proposed by the German philosopher Edith Stein (1917/1970) is helpful in understanding the nurses’ narratives described in this study. Her work is one that combines the philosophical, psychological, aesthetic and the interpersonal (Davis, 2003), and is described in a three-level model of empathy where a field of tension between views on closeness and distancing in relationships is evident, and sympathy is considered part of empathy (Maatta, 2006).

Moreover, Stein’s view of empathy appears ‘active’ in contrast to that of another phenomenologist, Emmanuel Levinas (1905-1995), in that Stein suggests that I go out of myself and encounter the other, through “the emergence of the experience” (Stein 1917/1970, p.11), whereas Levinas suggests that the other initiates the relationship (Moran, 2000). Stein’s conceptualisation of empathy is, therefore, useful in explaining the active nature of nurses’ pursuit of identification with patients described is this study.

**Level one of empathy**

Davis (2003), drawing on Stein’s view of empathy, describes level 1 as a cognitive process whereby there is an attempt to enter into another’s feelings and to put ourselves in their place. This first level of empathy requires the ability to use imagination and reflects the art of empathy (Davis, 2003). By reading the facial expressions or other signals, we attempt to obtain an idea of the person’s emotional and mental state. This represents a determined aspiration to enter into the feelings of another and an attempt to position ourselves in another’s place (Davis, 1990). Stein (1917/1970), describes this as, “When it [empathy] arises before me all at once, it faces me as an object (such as the sadness I “read in another’s face”), but when I enquire into its implied tendencies (try to bring another’s mood to clear givenness to myself), the content, having pulled me into it, is no longer really an object”(p.10). Davis (2003) uses the term *self-transposal*, one proposed by Speigelberg (1982), to describe this first level. This description is also similar to that of caring by Noddings (1984) who argues that “all caring involves engrossment” (p.17) which results
in the carer investing full attention in the one being cared for and is characterised by a “move away from the self” (p.16), and suggests the primacy of ethical comportment in relationships with the other. However, it is important to note that the counselling literature rejects the view of empathy proposed by Stein in favour on one that only involves the first of the three stages (Davis, 2003).

**Level two**

Level 2 of empathy is one that follows closely after the first and is a gut feeling of identification following a shift from intellect to emotion. Davis (2003) calls this second phase a “crossing over” (p.269), a term derived from the work of Buber (1955/2002). It is argued that nursing empathy “may or may not involve emotion” (Lemonidou, et al. 2004, p.132). However, it is difficult to imagine empathy being mobilised in the absence of emotion. Level 2 involves an attempt to clarify the person’s emotional state and a sudden feeling of being in the person’s place (Davis, 1990). The empathiser feels that s/he is identifying with the other, but it occurs as “a parallel experience” (Maatta 2006, p.6).

Travelbee (1971) too, like Stein, differentiates between identification and empathy. She describes identification as: “an unconscious process and a mental mechanism wherein an individual strives to be like another...it is an unconscious imitation process” (Travelbee 1971, p.132), and argues that the person is unaware of identification when it occurs. Moreover, Travelbee (1971) similar to Stein (1917/1970) suggests that empathy is an antecedent to sympathy, and “the sympathetic person takes action to relieve the distress of another” (p.144). Travelbee’s view of empathy is, therefore, curiously similar in orientation to that of Stein. However it is not evident if her work has been influenced by the writings of Stein, since she makes no explicit reference to such influence in her book (Travelbee, 1971).

Davis (2003) reveals that ‘crossing over’ (the second phase of empathy) is the most powerful of the three stages. She reached this view following her study with physical therapists who could not describe this second phase completely, but did reveal that it seemed to happen without them doing anything, but just listening. This ‘crossing over’ appears similar to the ‘clicking’ referred to by many nurses in the study described here.

Others, too, describe emotions in the identification stage of the empathic process. One of the nurses in a study by Henderson (2001) talked about identification and how the patient’s characteristics promotes this: “So I think it’s a characteristic that somehow touches you, and whether it comes from within you or
reminds you of someone else, that you care about, that’s probably where a lot of it comes from” (Henderson, 2001, p.134). Moreover, she reports that nurses’ responses to specific patients are possibly mediated by previous personal or professional experiences (Henderson, 2001). This can be explained by the words of Stein (1917/1970) who describes “reflexive sympathy” as one “where my original experience returns to me as an empathized one” (p.18).

It is also reported how student nurses described, in their journals of clinical practice experience, that “the act of identifying and empathizing with patients appeared natural and immediate” (Lemonidou et al. 2004, p.125), and that the students’ “thoughts and actions were driven by their emotions and by compassion” (Lemonidou et al. 2004, p.131). Moreover, it also suggests the impulsiveness of empathy, and its ability to ‘just happen’. The work of Scheler (1992) on identification supports this notion. He argues that irrespective of the type of identification, it is “always automatic, never a choice or of mechanical association” (p.66). Furthermore, the “unconscious dimensions” of identification influence the development of interactions with others “beyond our conscious awareness” (Bondi, 2003, p.68).

Many raise the role of imaginative identification in relation to empathy. Lemonidou et al. (2004) discuss empathy as requiring “imaginative identification” (p.133). Similarly, Patistea (1999) relates “imaginative identification” with “pseudo-engagement” (p.89), while Smyth (1996) discusses empathy as an art and argues that it is “the most critical dimension of the caring relationship...and demands imagination and creativity” (p.934). This view is supported by the writings of Scheler (1992) on identification, who presents a useful perspective on this topic. He suggests that to attain identification with the other, the one identifying must be “at least unmindful, of all spiritual individuality; he must abandon his spiritual dignity and allow his instinctive life to look after itself” (p.66).

Returning to the description of ‘clicking’ with patients described by nurses in this study, Stein’s theory argues that empathy is given “after the fact” in that it cannot be made happen but “catches us in its process” (White, 1997, p.254). This is termed the “Z factor, an unspecified relational quality” (van Manen, 2002, p.279) that cannot be described. The writings of Buber (1955/2002) are also relevant to the interpretations gleaned in the study. He proposed that dialogue between ‘you’ and ‘I’ can lead to a special moment where empathy erupts suddenly and spontaneously. He further proposes that this flash of empathy cannot be manufactured. Maatta (2006) argues, however, that Buber’s view of empathy is perhaps a bit
simplistic in comparison to the complexity of the empathic process outlined by Edith Stein. Nevertheless, Buber’s view adds clarity to the process of empathy and further suggests its naïve quality.

**Level three**

Davis (2003) cautions that the crossing over to level 2 is “true identification” (p.270), but cannot be sustained. The final stage of empathy therefore, is a movement described as a “reaching out to the other” in an effort to reinforce the reality that this is happening to the other person and not themselves, resolving into “a deep fellow feeling for the other person, or sympathy” (Davis, 2003, p.269). Level 3, a form of self-recovery, is represented by a cessation of this feeling of affinity, and the empathiser becomes himself or herself again. “Sympathizing with the sense of affinity that just arose, we stand side by side with the person again” (Maatta, 2006, p.6). Travelbee (1971) also views sympathy as “a step beyond empathy” (p.141). However, Travelbee considers sympathy as active in orientation, with a “desire to alleviate distress, absent in empathy” (Travelbee’s emphasis, p.142), as opposed to the “neutral process” of empathy (Travelbee 1971, p.143). Moreover Baillie (1996) reports that nurses in her study viewed sympathy as “feeling sorry for” (p.1302), whereas empathy required a closer relationship as it needed an understanding of the other’s experience. However, the use of empathy and sympathy is often muddled. Related cases for empathy include sympathy and pity (White, 1997). Nevertheless, Davis (2003) argues that empathy can be distinguished from other similar interactive exchanges such as sympathy, pity, identification and projection because of its three overlapping stages and the fact that it is “given to us after the fact, or nonpriordially” (p.270). Davis (2003) therefore concludes that empathy is transcendent in nature and “introduces the spiritual aspect of experience” (p.271).

According to Davis (2003) empathy is not achieved unless level 2 is breached. Maatta (2006) suggests that Stein’s (1917/1970) description of level 2 helps explain how nurses manage closeness and distance in their relationships with patients. The third step described by Stein is reflected in the view of Holden (1990) who describes empathy as emotional knowing where the nurse “projects herself into the physical being of the patient while simultaneously retaining her detached objectivity” (p.72).

Stein explains that because level 2 is of a temporary nature, it is not a “danger nor a threat to the ego” (Maatta, 2006, p.9). This is similar to the view of Travelbee (1971), who places the phase of empathy before sympathy in her theory of nursing as a process. Moreover, the movement from the second to the third level of the
empathic response, as described by Stein, also helps explain nurses’ views in the study, that an approach similar to a ‘disinterested love’ (Meehan, 2003) is the most appropriate response to patients in order to offer the nurse some emotional protection from being overwhelmed by their empathic response.

**Conclusion**

The findings presented here highlight a philosophical explanation of the process of nurse empathy evident in nurse-patient intimacy. Moreover, the significant role of the first meeting between the oncology nurse and patient in the initiation of identification has been identified.

Identification and empathy represent reflections of the quality of relationships that nurses can offer to patients they care for. However, Campbell (1984), in his proposal of a moderated love assumed by professionals, differentiates between empathy and identification, which, he argues, may prevent the professional helper giving effective help. This view is in opposition to the findings reported here, where identification is necessary before empathy. However, Campbell (1984) does clarify that identification is ineffective if it is prominent over empathy. Such a view is also reflected in the work of Stein (1917/1970) who argues that the one empathising must move through the three levels for empathy to occur.

The narratives presented here and the supporting discussion, strongly suggest that empathy “just happens” (Baillie, 1996, p.1303). Moreover, Stein’s conceptualisation of empathy, describes empathy as one given *primordially* or after the fact, because it happens only after you realise it, as it happens so quickly (Davis, 2003). The dominant aesthetic aspect of empathy is therefore evident, and illustrates the importance for the nurse to develop self-understanding into his/her own values and beliefs in order to raise awareness and mediate cultural biases and maximise the potential for cultural sensitivity (Kleiman, 2006).

The unconscious nature of empathy and its importance to developing intimacy with patients poses a question mark regarding the teaching of empathy to student nurses. One nurse participant in the study reported by Turner (1999) questioned if it was possible to teach nurses about involvement since the experience happened almost unaware to them: “I think [being involved] is something that you can’t be taught. Because nobody knows how they’re going to react to a situation until they’re in it; nobody knows how close they can become to a patient until they’re actually in that situation” (Turner, 1999, p.159). This suggests that raising nurses’
awareness of their emotions is the first step in the approach to the teaching of empathy, and also highlights the central role of intuition in the emphatic process. Of relevance also, is the view of Roth (1972), who argues that the nurse who admits a patient has a major role to play in applying a judgemental label on patients, which can influence their subsequent care. The possible lack of nurse identification with patients at this first meeting, therefore, has potential significance for the caring experience of both nurses and patients.

Scheler (1992), writing on emotional identification argues that it is “the act of identifying one’s own self with that of another” (p.59). This view is supported in the descriptions of identification and empathy provided by nurses in this study, and highlights the centrality to self-awareness to nurses’ empathy and subsequent intimacy with patients.

Finally, it could be argued that empathy and intimacy are closely related concepts. Empathy is intimately associated with the concept of ‘closeness’, and simultaneously requires closeness (Baillie 1996). Yegdich (1999), however, questions this conclusion and asks: “Can ‘closeness’ be sustained as the key defining feature of empathy? ...closeness could reduce objectivity, affect commitment to other patients and cause personal stress to the nurse when their feelings were aroused.” (p.90). Yegdich (1999), however, in this argument appears to be focusing on the possible consequences of over-identification, rather than on closeness, which further illustrates the difficulties in untangling the concept of empathy from intimacy.

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Overcoming the complexities of developing and implementing the first Irish integrated children’s and general nursing undergraduate degree programme.

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**Background and Context:**
There have been many influential publications in Ireland that have altered the education process and development of children’s nursing. None was more influential than the Commission on Nursing (1998) which 8 years later has seen the commencement of an Integrated Children’s and General Nursing undergraduate degree programme.

**Aim of the Paper:**
The aim of this presentation is to confront and explore the complexities of developing and implementing an Integrated Children’s and General Nursing undergraduate degree programme.

**Summary:**
The development and implementation of the Integrated Children’s and General Nursing undergraduate degree programme has provoked many challenges for its nurse lecturers. One demand of the new programme was the mammoth development of the curricula taking into consideration the ideals of EU (1977) and WHO directives and An Bord Altranais Standards (2005). The integration of both Children’s and General Nursing content has become a balancing act and one which necessitates delivery of content in equal parts. While sharing the content of other BSc peers from the different strands, students on the integrated programme must undertake paediatric theory modules. Lecturers endeavour to incorporate elements of both children’s and general nursing care into their teaching in order to balance and maximise the students learning. While this strategy has been adopted it has proved
challenging for staff in the clinical area where the focus of practice teaching must integrate both disciplines.

In order to assess the programme all modules must be assessed in an integrated manner and the production of these assessments has been demanding for all involved. In addition, new links were required and therefore fostered between health service providers and the University to ensure the security of new practice placements. This process necessitated much consideration between all the stakeholders and agreement on an appropriate marketing strategy for the programme was also sought.

**CONCLUSIONS:**
The development and implementation of the Integrated Children’s and General Nursing undergraduate degree programme provoked many challenges for its nurse lecturers including: the development of a suitable curricula, the integration of teaching, the integration of practice teaching and the fostering of open communication between all stakeholders some of which are new to this education process. The mechanisms used to overcome these challenges will be explored in the presentation.

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Stop, Ready Go! Portfolio A traffic light framework for Portfolio Development

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Background and context
The development of Reflective portfolios has gained substantial discussion in the field of nursing over recent years. Portfolios are well established means of demonstrating both personal and professional development in nursing practice. Many Universities in Ireland and elsewhere have embraced portfolio development as an essential part of the learning process, with portfolios becoming part of the assessment process. Practitioners often find the exercise daunting and uncomfortable. A traffic light framework was devised to enable practitioners develop a systematic and structured approach to portfolio development.

Aim of the study
The aim of this study is to pilot the implementation of “the Traffic light” framework for portfolio development with Post Graduate and MSc Nursing students in an Irish University.

Methodology including research design and sampling
An action research approach was chosen to implement the traffic light framework to guide students through the reflective process of portfolio development. The framework is currently being piloted as part of the 'planning the action' phase of a first action research cycle. Rolfe’s reflexive action research model was employed to guide the process.

Analysis
In its current stage of development the framework is constructed as a three pronged approach. Red: stop to reflect, Orange: critically consider the challenges and enablers to achieving effective practice and evaluating the effect and impact of these factors on the critical
incident. Green: structure narratives around a Clinical Competency framework to demonstrate learning through reflective practice, analytical skills, critical thinking skills and problem solving skills.

**Conclusions**
There is no correct way to organise and develop a portfolio which caused much concern for post graduate nursing students required to develop a reflective portfolio. The traffic light framework was created to assist Post -Graduate nursing students structure the reflective component of the portfolio in an organised fashion.

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**Congruence of pain assessment between nurses and ED patients: A replication**

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**SUMMARY**

Aim: To ascertain congruence between patients’ self-report of pain intensity and nurses’ assessment of their pain intensity.

Methods: This study adopted a replication methodology which aimed to ascertain congruence between patients self-report of pain intensity and nurses’ assessment of their pain intensity. Raw statistical data was analysed using SPSS for windows.

Results: This study supports the findings of the original U.S. study that emergency nurses frequently underestimate patients’ pain intensity. However this study also found incidents where nurses accurately assessed their patients’ pain intensity, and incidences of overestimation.

Conclusions: This study illustrates underestimation of patients pain intensity by emergency nurses which is both clinically and statistically significant.

Relevance to Clinical Practice: Implications for nursing practice include a need for assessment of patients’ pain intensity, the development of pain management protocols, and increased emphasis on education in both undergraduate and postgraduate nursing curricula. Also there needs to be continued clinical audit of pain management standards.
Introduction

Since the seminal 1973 publication of Marks and Sachar’s paper which examined the prevalence of drug seeking behaviour among medical inpatients there has been persistent debate regarding the inadequate treatment of patients’ pain in hospital environments (Marks and Sachar, 1973; Ducharme and Barber, 1995; Puntillo et al, 2003; Nelson et al, 2004).

Oligoanalgesia that is, the inadequate prescribing of analgesia for patients in pain remains common among ED patients despite initiatives such as the publication of the Joint Commission of Accreditation of Health Care Organizations and JCAHO (2000) pain standards, (Ducharme, 1994; Alexander and Manno, 2003; Fosnocht et al, 2003; Todd, 2004; Godwin et al, 2005).

Internationally the assessment of patients’ pain has been identified as a pivotal area for pain management by the U.S. Joint Commission on Accreditation of Healthcare Organisations (2000). Similarly, it has been asserted that excellence in pain assessment is crucial to pain management yet it has been identified that studies which compare clinicians’ assessments with patients’ actual pain ratings frequently confirm that clinicians underestimate the patient’s level of pain (Gunnarsdottir, et al 2003).

In an article focusing on the standards set by the JCAHO on standards for pain management, Curtiss (2001) identified the most powerful predictor of poor pain management was a discrepancy between the patient’s perception of pain and that of the clinician. Further evidence of the discrepancy between nurses’ perceptions of pain, and the patient’s level of pain can be found in Puntillo et al. (2003), who researched congruence between emergency nurses’ assessment of their patient’s pain intensity and patients’ self-report. Puntillo and colleagues study involved a total of 156 patients and 37 nurses. It assessed patient’s pain intensity both at triage and in the clinical area, and in both areas poor levels of assessment were noted. Concordance between nurses’ and patients’ pain intensity was 50% or less, i.e. where nurses’ pain intensity scores were within one point of the patients’ using a horizontal 0 to 10 numeric rating scale.

Oligoanalgesia may exist because of a misconception regarding who is the authority on a patient’s pain (Hunter, 2000). Pasero and McCaffrey (2001), assert that because pain cannot be proved or disproved, the patients’ report of pain should be accepted as the gold standard, even over patient behaviour and vital signs. In support of this view the AGS Panel on Persistent Pin in Older Adults
(2002) has identified patients self-reports of pain intensity as the most accurate and reliable evidence of pain presence and intensity.

This study was conducted to assess the congruence between nurses’ assessment of their patient’s pain intensity and patients’ self report. It was motivated by the dearth of Irish or European literature on this subject and a concern by the researchers that failure to address the issue of underestimation of pain by emergency nurses would result in this practice continuing. Ethical approval was obtained both from the hospitals ethics committee and the ethics board of Trinity College Dublin.

Research Design
Aim
To determine congruence between assessment of pain intensity by nurses in Irish emergency departments when compared with patient assessment of pain.

Method
Following consideration the researchers felt that approximate replication was an appropriate methodology for this study. Replication is defined as the deliberate repetition of research procedures in a second investigation for the purpose of determining if earlier results can be repeated (Polit, et al 2001; Burns and Grove, 2005). Approximate replication involves repeating the original study using the original methods as closely as possible, however it may involve different subjects and different experimenters (Heffner, 2004). As a research method it is essential to the construction and continued development of any discipline (Connelly, 1986; Fahs et al, 2003).

A search for appropriate research papers was performed using the CD-Rom systems of Cumulative Index to Nursing and Allied Health Literature (CINAHL), medline, MD consult, and relevant library texts. The most appropriate paper identified was by Puntillo et al (2003), who researched congruence between emergency nurses’ assessment of their patient’s pain intensity and patient’s self-report, whose methodology has been described earlier.

The methodology adopted for this study was a descriptive cross-sectional study of a purposive non-probability sample of emergency department patients who presented to the department with a primary complaint of pain, and a convenience sample of emergency nurses. Patients were observed once in this current context, and not followed up longitudinally. Upon presentation to the department the patient was asked to rate their pain intensity using a horizontal 0 to 10 Numeric Rating Scale (NRS) and the nurse who reviewed the patient was also asked to rate the patients pain intensity using the same numeric rating scale following an initial
assessment. The emergency nurse did not have access to the patients’ self assessment of pain intensity.

Sample
The sample population was obtained by employing inclusion and exclusion criteria. These inclusion and exclusion criteria are similar to those used by Puntillo et al. (2003), (although to obtain ethical approval for this study prisoners and young offenders had to be excluded). In Puntillo et al. (2003) the study included an approximate 4:1 patient to nurse ratio (156 patients and 37 nurses). This study aimed to replicate this ratio and, as 16 emergency nurses work in the ED, the study recruited 64 patients.

Inclusion Criteria-
Patients who were eligible to participate were:
1. Adults over 18 years;
2. Patients who did not have a life or limb threatening condition (i.e. Manchester Triage categories one or two, which are defined as patients who necessitate immediate intervention and should be seen by a doctor within ten minutes);
3. Patients who were able to use the numeric rating scale as determined by the triage nurse.

Nurses who were eligible to participate were:
1. Emergency nurses including clinical nurse managers working in the E.D.

Exclusion Criteria
Patients who were excluded from participation were:
1. Patients who had a life or limb threatening condition (i.e. Manchester triage categories one or two);
2. Those who were unable to use the NRS due to communication difficulties, mental illness, learning disability or dementia;
3. Prisoners or young offenders (mandated by ethics committee).

Furthermore as there is no way of eliminating potential bias with convenience sampling (Brink and Wood, 2001), the researcher introduced objectivity, so that the researcher did not deliberately select subjects. This was achieved by appointing a gatekeeper between the researcher and patient participants who informed patients about the study and invited them to speak to the researcher if they were interested in participating.

Results
The mean patient pain intensity rating (while at rest) was found to be 6.4, while the mean nurse assessment of patient’s pain intensity
at rest was 5.2. The parametric analysis technique used to determine significant differences between patients’ and nurses’ estimation of pain intensity was t test for independent samples. The t test found that nurses’ estimation of patients’ pain significantly differed (t=-3.046, df 126, p=0.003).

Although nurses were found to have underestimated patients’ pain in the majority of cases, this was not exclusive. Some congruence occurred between the pain intensity scores of patients and emergency nurses, and there are incidents of overestimation of pain intensity by emergency nurses as demonstrated in Figure 1 (Boxplot). This figure illustrates that while the mean differences demonstrated underestimation, there was agreement in some instances in pain intensity ratings between patients and emergency nurses (at 0.00). The box itself contains the middle 50% of the data, the upper edge of the box indicating the 75th percentile of the data set and the lower edge indicating the 25th percentile. This figure clearly indicates that the majority of nurses underestimated patients pain intensity (where patients pain is 0.00). The ends of the vertical lines indicate the minimum and maximum data values, and a number of outliers are also seen on this figure.

Clinical Significance of Pain Intensity Scores
As it is recognised that statistical significance is not synonymous with clinical significance (Chu 1999), both nurse and patient pain scores were recoded in SPSS 12. This was undertaken to reflect the
pain categories on which Serlin et al. (1995) established, clinicians base their treatment decisions. On a 0 to 10 NRS these categories are 1-4 mild pain, 5-6 moderate pain, and 7-10 severe pain. In just over half of cases emergency nurses estimated their patients’ pain intensity in the same category as patients themselves (n=35, 54.7%). However, this means that in a large number of incidents nurses estimated their patients’ pain in a different category (n=29, 45.3%). Of those nurses who estimated patients’ pain to a different category the majority (n=26, 89.6%) placed their patient in a lower pain category, underestimating patients’ pain by one category.

The majority of nurses who did estimate their patients’ pain intensity to a different category did so by one category (n=28, 95.5%). Only one nurse underestimated their patient’s pain by two categories. Therefore, as almost half of the sample underestimated their patients’ pain by at least one category it can be concluded that a clinically significant difference exists between patients’ estimation of their pain intensity and nurses’ estimation of patients’ pain intensity.

Factors Accounting for Observed Differences
To determine possible causes for the difference between patients’ self report of pain intensity and nurses’ assessment of the patients’ pain intensity a number of factors were examined. The variables associated with the emergency nurses themselves were initially examined using scatter-plots to identify visual correlation patterns and then examined using Pearson’s Correlation Coefficient (Table 1).

Table 1: Pearson’s Correlation Coefficient for Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>R Value</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-0.214</td>
<td>0.089</td>
</tr>
<tr>
<td>Gender</td>
<td>0.87</td>
<td>0.495</td>
</tr>
<tr>
<td>Experience In Emergency Nursing</td>
<td>0.117</td>
<td>0.355</td>
</tr>
<tr>
<td>No. of Professional Qualifications</td>
<td>-0.227</td>
<td>0.355</td>
</tr>
<tr>
<td>Level of Academic Award</td>
<td>0.032</td>
<td>0.799</td>
</tr>
<tr>
<td>Qualification in Emergency Nursing</td>
<td>-0.041</td>
<td>0.750</td>
</tr>
<tr>
<td>Previous attendance at Pain Management Course</td>
<td>-0.041</td>
<td>0.97</td>
</tr>
<tr>
<td>Current Nursing Grade</td>
<td>-0.125</td>
<td>0.325</td>
</tr>
</tbody>
</table>

Application of Pearson’s Correlation found no significant correlation between difference in pain scores and any of the variables tested. These variables included age, gender, experience in ED nursing, number and level of professional qualifications, previous attendance at a pain management course and current nursing grade. Differences in pain intensity ratings were also examined based on the patient’s chief complaint (see Figure 2). The greatest
underestimation in pain intensity ratings between patients and nurses were noted for abdominal pain, musculoskeletal pain and cellulitis. Overestimation of pain intensity by one emergency nurse in a patient with a painful throat was also found.

**Figure 2: Mean Difference in Pain Intensity Scores by Presenting Complaint**

<table>
<thead>
<tr>
<th>Presenting Complaint</th>
<th>Mean Difference in Pain Intensity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>-2.00</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>-1.00</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>0.00</td>
</tr>
<tr>
<td>Earache</td>
<td>1.00</td>
</tr>
<tr>
<td>Fracture/Dislocation</td>
<td>2.00</td>
</tr>
<tr>
<td>Headache</td>
<td>3.00</td>
</tr>
<tr>
<td>Laceration</td>
<td>4.00</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>5.00</td>
</tr>
<tr>
<td>Painful Throat</td>
<td>4.00</td>
</tr>
</tbody>
</table>

**Discussion**

It is well documented in the literature that pain is the most common reason for presentation to emergency departments (Illingsworth and Simpson, 1994; Tanabe and Buschmann, 2000 Ducharme, 2005). Despite the issue of oligoanalgesia being initially highlighted eighteen years ago by Wilson and Pendleton (1989) studies illustrate that the issue of under-treating pain in emergency departments continues to exist.

The mean patient pain intensity score in this study was found to be 6.45 (SD 2.1). This pain intensity rating is slightly less than the mean patient pain intensity scores presented by Puntillo et al.
(2003) who found mean intensity ratings of 7.5 (SD 2.2) in the triage area and 7.7 (SD2.2) in the clinical area. Nurses in this Irish study estimated their patients’ average pain intensity as 5.2 (SD 2.55), which is similar to the findings of Puntillo et al. (2003) who found nurses mean score as 5.1 (2.4) in the triage area and 4.2 (SD 2.3) in the clinical area. Both patients’ pain intensity ratings and nurses’ estimation of patients’ pain intensity are indicative of moderate pain in this study, while in the Puntillo et al. (2003) study patients mean pain was estimated as severe, while nurses estimated patients’ pain to be moderate (Serlin et al, 1995). In the current study, differences in patients’ and nurses’ pain intensity ratings were found to be statistically significant at \( p= 0.003 \) which is in agreement with Puntillo et al. (2003) who found the difference in pain intensity ratings to be statistically significant at \( p<0.001 \).

More important than statistical significance is the issue of clinical significance (Chu 1999). Clinical significance is especially important in this study as the literature indicates that clinicians use categorical pain severity classifications to make important treatment decisions (Jensen et al., 2001) and that an appreciation of pain severity is the crucial first step towards successful pain management (Serlin et al, 1995). In this study 45% of nurses estimated their patient’s pain into a different category, with 90% of those underestimating their patient’s pain. Only three patients’ pain was overestimated into a different category representing less than 5% of the population sampled.

A number of reasons were explored to explain the differences in pain intensity estimations. One possible reason, which was explored, was the nurses’ characteristics. Variables such as nurse’s age, gender, ED experience, number and level of professional qualifications, grade and previous attendance at a pain management course were all examined. None of the variables tested were found to be correlated with differences in pain intensity ratings. This is an interesting finding especially with regard to those variables, which are education based. There has been considerable debate in the literature regarding whether education results in a change of behaviour. Twycross (2002) demonstrated in an observational study that education about pain did not result in a behaviour change while conversely Tanabe and Buschmann (2000), who surveyed 305 emergency nurses using a 52 item questionnaire, found that nurses who had attended a one day pain seminar had significantly better knowledge regarding pain management. This position is supported by Bernardi and colleagues (2007) who surveyed 66 hospice nurses using ‘The Nurses Knowledge and Attitudes Survey’ and found higher mean correct answer scores from those nurses who had attended courses on pain education. Nurses in this study who had previously attended a pain
management study day did not estimate patients’ pain intensity significantly better.

Another possible contributory factor, which was examined to see if it could explain the mis-estimation of patients’ pain, was the patients’ presenting complaint. The greatest overestimation was found in a patient with a painful throat, although this is an outlier and needs to be treated cautiously. The greatest underestimation of pain intensity ratings occurred with abdominal pain and musculoskeletal injuries. This is similar to the findings of Puntillo et al. (2003) who found the greatest mean difference occurred with musculoskeletal pain followed by abdominal pain. The least mean difference in this study was found in those patients who sustained a fracture dislocation. This was also a low ranking category in Puntillo et al. (2003) and may be because of the visible nature of the injury.

Conclusion
This research study demonstrates that universal adequate pain management remains an elusive goal within the emergency nursing setting. It has been demonstrated in the literature that under treatment of pain in the ED setting can result in detrimental outcomes for patients. It is envisioned that this study can contribute to the body of knowledge informing practitioners in the clinical setting and assist in narrowing the gap that exists between the ideal of universal effective pain management and the reality of clinical practice. The study focused on determining congruence between emergency nurses and patients in assessment of patients’ pain, and the findings support those of the original study by Puntillo et al. (2003) that considerable underestimation of patients’ pain occurs in the emergency department. It is hoped that this study will strengthen the findings of Puntillo et al. (2003), and strengthen the existing body of nursing knowledge.

References


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Psychiatric Nurses’ Perceptions of the Factors Influencing Nurse-Patient Interaction within an Acute Mental Health Setting.

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A large part of in-patient psychiatric care remains based on the therapeutic interaction that takes place between the nurse and the patient (Shields, Morrison and Hart, 1988). The development of the nurse-patient therapeutic relationship is a prominent feature here (Repper, 2000). Peplau (1988) described this relationship as an interactive process and considered it to be the hallmark of psychiatric nursing. However, the development of this relationship largely depends on the nurse setting time aside to spend with patients on a one to one and individual basis. The literature suggests that psychiatric nurses spend a relatively small amount of time in potentially therapeutic nurse-patient interactions (Ryrie et al, 1998). Several studies highlight numerous factors, which limit the availability of time to spend with patients on an individual basis (Krikorian and Paulanka, 1982; Cleary and Edwards, 1999).

The aim of this study was to explore psychiatric nurses’ perceptions of the factors influencing nurse-patient interaction within an acute mental health setting. Conducted in a rural psychiatric hospital in Ireland, a qualitative descriptive research design was used to allow the perceptions of seven participants to be recorded in their own words (Sandelowski, 2000). Face-to-face semi-structured interviews containing a set of predetermined questions based on the analysis of the literature review were used. Data analysis was undertaken using Burnards’ (1991) method of thematic content analysis. Lincoln and Guba’s (1985) framework for establishing rigour was also incorporated. Factors influencing nurse-patient interactions were determined by the health care system, the profile of patients on the
ward and the daily organisation of duties and tasks performed by nurses. The significant findings of this study have implications for nursing practice, education and research. This study reveals a need for psychiatric nurses to become more involved in psychotherapeutic ward programmes and less involved with organisational aspects of the ward. In absence of research on nurse-patient interactions within an Irish context, this study respectively suggests further exploration of the complexities within our health care environment and its impact on the delivery of patient care.

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A Cross-Cultural Examination of the Perception of Medical Codes of Ethics

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Introduction:
The intent of ethics, in an applied context such as health care, is to establish a set of standards that will provide a framework to modify, regulate, and possibly enhance moral behaviour. Specifically, the code of ethics for an organisation or profession dictates to the membership the behaviour that is acceptable and unacceptable. The code acts as a written and sanctioned guideline that must be followed in order to maintain not only one’s own professional status but also the public trust of the profession itself. It is therefore of utmost importance to the individual and to the vocation that the code of ethics be an effective means to moderate behaviour rather than an organisational platitude.

Objectives: Our intent in this research was to discern how medical codes of ethics were perceived by a sample of physicians from five nations. Specifically, to what extent were codes used in the decision-making behaviour of physicians and whether or not culture (i.e., the relative strength of Hofstede’s (2001) Individualism index (IDV) influenced the use of the professional code.
Methods: We used thematic content analysis (de Groot, 1969) of eleven focus groups conducted with physicians from five different countries representing varying cultures (n= 15 Canadian; 9 Indian; 9 Irish; 9 Japanese; 11 Thai). Within our qualitative framework, we compared each culture in terms of similarities and differences evident in the use of the medical code.

Results: The following six themes emerged from the content analysis:
Lack of Awareness (24%),
Personal and/or cultural codes dictate behaviour (22%),
Other codes have more influence (17%),
Medical code is useful (15%),
Marginal Impact (13%),
No Impact (9%).

Of those that were aware of their code of ethics, Irish physicians appear to be the least influenced; Canadian and Thai physicians seem to place a higher value on their respective code; and Canadian and Indian physicians indicate that personal codes of ethics are the strongest referent point for ethical behaviour. None of these findings are consistent with the scores on Hofstede’s (2001) IDV dimension that would have hypothesised that individualistic countries, such as Canada and Ireland, would have been more apt to reject codes than would collectivist countries, such as Japan, India, and Thailand.

Conclusion: The over-riding theme among this sample of physicians was that, regardless of culture, their medical code of ethics was not an integral part of their decision-making behaviour. This may be a function of the extent to which the code is part of their medical training and/or the manner in which the codes are written and understood by the practitioner. In order for codes of ethics to be effective tools in educating physicians, further investigation is needed to explore content and delivery of these potentially important documents.

* Thanks to J. Mafukidze, M.Sc.: Faculty of Kinesiology & Health Studies, University of Regina for her assistance in the collection and partial analysis of the Thai data.

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MAKING DIABETES COUNT – A SYSTEMATIC APPROACH TO ESTIMATING POPULATION PREVALENCE ON THE ISLAND OF IRELAND

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This study developed a systematic approach to estimating the population prevalence of diabetes across the island of Ireland by adapting a model developed in the UK (the PBS model) for use in an Irish context. The model accounted for age, sex, ethnicity and socio-economic factors which are known to affect the prevalence of diabetes.

Population prevalence estimates were produced for All diabetes, Type 1 and Type 2 diabetes (diagnosed and undiagnosed), disaggregated by age, sex and ethnicity. Estimates were produced at national and sub-national level, including an adjustment for local socio-economic circumstances.

Estimates of the number of people with undiagnosed diabetes in Northern Ireland were also produced by comparing the population prevalence estimates from the PBS model to registered numbers of people with diabetes obtained as part of the new General Medical Services contract.

The model estimated that in 2005 141,063 adults in the Republic of Ireland (4.7%) and 67,063 adults in Northern Ireland (5.4%) had diabetes (diagnosed and undiagnosed). The estimated prevalence of diabetes in adults varied slightly across the Health Service Executive Regions with the highest prevalence evident in the Western Region (5.2%). Variations in prevalence were also seen across Local Health Office Areas.

This model was developed in conjunction with key organisations involved in the care of people with diabetes and represents the first systematic approach to estimating population prevalence for a chronic condition across the island of Ireland. The project is an excellent example of cross border working to develop information to
support the promotion of health and the delivery of health services across the island.

The estimates produced will allow us not only to describe the patterns of the disease in the population but also to plan and deliver services in a rational way and the approach can be used as a model for the development of population prevalence estimates for other chronic conditions.
SIMILARITY DISCERNMENT IN GENERAL AND NURSING REPRESENTATIONS

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OBJECTIVE

Ability to discern similarities is critical for nurses who develop, implement, and evaluate patient care. It was assumed that knowledge and experience affect this ability. This study tested the hypotheses that subjects with an Associate Degree in Nursing (ADN) or a Baccalaureate Degree in Nursing (BSN), and those with varying years of medical-surgical experience (MSE) would differ in their similarity descriptions of general and nursing images.

METHOD

A comparative descriptive design was used. Similarity was measured as the presence, quantity, and patterns of analogy, thematic, literal, and surface-level responses. The level of similarities was measured through written descriptions produced when subjects compared two general and two nursing images. A convenience sample of eighty nurses was recruited from four hospitals. Of the sample, 65% had less than ten years’ experience. Fifty-nine percent had an ADN.

RESULTS

All levels of similarity were used, but analogy, the highest and most complex form, was used least. For general images, BSN subjects used significantly more literal level (p = .033); for nursing images, use of surface (p = .031) and literal levels (p = .008) was higher than the ADN cohort. For general images, subjects with less than ten years’ experience used significantly more surface level (p = .046); thematic descriptions were higher (p = .004) for nursing descriptions. For ADN and BSN groups, there was a significant correlation (contingency coefficient = .588, p = .000 for ADN and contingency coefficient = .631, p = .004 for BSN) between literal and surface similarity levels used in describing general and nursing images. There was a strong significant correlation (contingency coefficient = .627, p = .017) between the presence of analogy and thematic similarity responses for both image sets by the BSN cohort. Subjects with ≥ 10 yrs’ MSE showed a strong significant correlation (contingency coefficient = .616, p = .039) when
thematic and analogy responses for general and nursing images were analyzed. Subjects with an ADN or < 10 yrs’ MSE showed a strong correlation in the use of analogy and literal levels in response sets (contingency coefficient = .639, p = .000; .534, p = .015) respectively.

**CONCLUSIONS**

Unexpected differences appeared in subject groups’ ability to discern similarities. This study informs our knowledge base regarding how nurses think about what they observe and adds to our understanding of how differences in patient care might occur.

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The Affective Domain of Learning is an Effective Domain of Learning.

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Background
Learning encompasses many domains. Usually, but not exclusively the domains of learning referred to are, the cognitive, psychomotor and affective domains. However, the affective domain does not appear to get the recognition it deserves. The affective domain deals with a combination of attitudes, feelings, values and beliefs, however there is general agreement that attitudes belong to this domain.

Aim
In an attempt to consider learning from the affective domain regarding breastfeeding support, this study assessed student midwives’ attitudes to breastfeeding support in Ireland.

Methodology
A descriptive survey design where the theory of reasoned action and values of feminism were used. A random national sample (n = 130) of student midwives was obtained from An Bord Altranais. The Support for Breastfeeding Questionnaire (Bernaix 2000) was used. It was tested using the content validity index, reliability tests and a process of cognitive interviewing. Data analysis involved descriptive and inferential statistics using SPSS.

Results
Student midwives have moderately positive attitudes (mean 54.25, range 36-69) towards breastfeeding support. They consider it to be important and necessary, but find it tiring and difficult. Perceived outcomes for the mother were moderately high. Perceived outcomes for the baby were very high. Personal outcomes for the student midwife were low by comparison. Student midwives perceive moderate social pressure to provide support with least pressure perceived from medical colleagues. They also have strong intentions to provide support. Finally, the theory of reasoned action was partly supported, it demonstrated that student midwives’ attitudes significantly influence their intention to provide breastfeeding support.
Conclusion
The findings reveal that learning from the affective domain has subtle yet significant influence on the student’s learning. Educational strategies that incorporate all domains of learning need to be considered by educators to ensure that student midwives are adequately prepared to support breastfeeding mothers.
Women at War: Our History and New Challenges for the 21st Century

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Background and Context: Throughout military history, there have been few women’s accounts of their experiences, except for those females in healthcare duties. In current military situations, women are manning M60 machine guns on HMMWVs (Humvees) and on patrols and performing other functions traditionally allocated for male combatants. To date, few studies have reported the effects or consequences of this unique stress on women in combat. Furthermore, few accommodations have been implemented for these women or special debriefing sessions put into place to facilitate healthy readjustment upon returning home. The phenomenon is simply too new to have been fully explored.

Aim of the Study/Methodology: This study used a participant-observer approach to collect a broad range of data during a deployment from January to May 2005. With command and participant consent, recorded interviews were used to explore the backgrounds, military jobs, stressors and the management of such, health care issues and needs, and recuperative resources for the women serving in the war in Iraq. This method of data collection will also contribute to the historical account of women in the military for future generations, once archived.

Analysis/Findings: This project discovered numerous successes, problems, and potential solutions the new generation of female combatants face. These issues included, but were not limited to women’s need for connection, healthcare issues, equality and job related concerns as well as personal reactions to the experience of war. Fertility concerns, childcare, future physical constraints and sexual assault were also noted as additional anxieties for women. The findings further examined the implications of military, medical/nursing and political policy related to women’s military roles, jobs and combat.

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Enhancing quality of life for older people in receipt of palliative care and older people in continuing care facilities

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Background
As the proportion of Irish people aged 65 years and over continues to grow over the coming years, it is likely that demands for health care services, including residential care settings will increase.

Aims
1. To explore older people’s perceptions of factors which impact on their quality of life with particular emphasis given to exploring non-illness related factors, particularly dignity and respect.
2. To explore older people’s needs in relation to factors impacting on their quality of life, particularly dignity and respect.
3. To explore with older people any interventions which they can identify which would contribute to their quality of life given their particular circumstances.

Research Design
The study has two phases Study 1 uses a qualitative grounded theory approach by implementing one-to-one in-depth interviews to examine participants’ perceptions and experiences of the factors impacting on their quality of life, particularly dignity and respect. Study 2 involves a survey measuring physical, psychological,
social, and spiritual well-being using a number of scales including the Network Assessment Instrument, the Modified Edmonton Symptom Assessment Scale, the Palliative Care Dignity Inventory, the Structured Interview Assessment of Symptoms and Concerns in Palliative Care, the Mini Mental Status Examination, and the Functional Assessment of Chronic Illness Therapy Spiritual Well-being Scale.

**Selection of Sample**
Two cohorts of individuals aged 65 years or over are included in the study:

A) Older people in long-term care
B) Older people in receipt of palliative care as an outpatient or as an inpatient

**Analysis**
Data analysis was undertaken using the constant comparative method of grounded theory. This method involves the researcher identifying similar and deviant elements and grouping them together around a theme for comparison. Data from the interview transcripts was managed using the computer package NVivo, which allowed a large data set to be managed and ensured that a clear decision trail was authenticated from the data.

**Outcomes**
This paper outlines preliminary qualitative findings of work in progress. Themes representing older people, in particular reference to dignity and respect, provide important evidence concerning older people’s perspectives on their quality of life.

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Older People and Attendance at the Hospital Emergency Department (ED): an investigation into their health care needs and other factors related to emergency department attendance.

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Background
As the proportion of Irish people aged 65 years and over continues to grow over the coming years it is likely that demands for health care services, including community care, emergency assessment and admission to hospital will increase.

Aims
1. To develop a profile of people aged 65 years and over living in the community who present to the ED with respect to their demographic functional, social and psychological characteristics.
2. To explore and describe from the perspective of the older person the circumstances that led to their decision to attend the ED.

Research Design
This research involves a survey of community dwelling older people attending the ED and further depth interviews with a sub-sample. Survey instruments include the Network Assessment Instrument, Nottingham Health Profile, Hospital Anxiety and Depression Scale, CASP-19 and also the Mini Mental Status Examination. Depth interviews are used to explore and describe in more detail the circumstances that led to each patient’s decision to attend the ED.

**Selection of sample:**
Individuals aged 65 years or older (on the date of presentation at the ED) who reside in the community are considered for inclusion. Participants are selected using a structured random sampling method.

**Analysis**
Descriptive statistics will be used to develop a profile. Inferential statistics will be used to identify any significant differences between various demographic groups. Regression techniques will also be used to determine which factors are predictors of attendance at the ED.

**Outcomes**
1. Profile of older people living in the community who attend the ED in terms of their demographic, functional, social and psychological characteristics.
2. The circumstances and experiences preceding their use of the ED.
3. Strategies as perceived by older people that would have alleviated their need to attend the ED or may have provided a more appropriate source of care.

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Abstract

Over 4000 wrong-site surgeries occur each year within the United States, and the number is rising. In an attempt to reduce that number, healthcare professionals are trying to establish a “Culture of Safety” in which operating room communication is clear, precise, and has a sense of conjoint meaning-making among team participants.

This study described communication patterns among team members in an operating room in an acute care medical center. The participants included nurses, physicians, technologists, and non-clinical personnel. Drawing on ideas from the traditions of ethnography and narrative interviewing, the data were analyzed both by thematic coding and using some of the heuristics from the theory of the Coordinated Management of Meaning (CMM).

The themes revealed that to develop a culture of safety, the healthcare environment and team relationships needs to be free of intimidation and avoidance, where communication flows openly and that all of the voices on the team need to be heard in an atmosphere of equality. Most important in the creation of a culture of safety, is that patients should always be the prime focus of all team members.

The findings suggest that to develop a culture of safety, professionals in healthcare need to increase their abilities to partner, trust each other as a care delivery team, treat each other with respect, and to develop collaborative meaning making in an effort to deliver safe patient care.

Healthcare Communication and the Creation of a Culture of Safety

The Study: Healthcare Communication and the Operating Room Team
This study is an unfolding of the socially constructioned reality of communication as seen through the perspectives of the operating room team members. To develop this study I borrowed from the traditions of ethnography and narrative interviewing. Within the frame of culture and relationships I wanted to understand how the operating room team members perceive their communication as related to creating a culture of safety. Specifically, this was a search for information as related to the social construction of team interactions in healthcare within the context of the medical hierarchy and communication, does the team sense that there are specific communication patterns due to the hierarchy, and how do they think these patterns may alter potential patient outcomes.

Background and Importance of Effective Healthcare Communication

The background idea for this study comes from the notion that healthcare professionals have found through observation and research that human communication is highly variable and at times ineffective due to professional, cultural, individual, and environmental differences, and technological change (Chillers, 1998; Mckinney, Barker, Davis & Smith 2005; Pearce, 1989; Pearce, 2005; Shotter, 1995; Steier, 1992). A specific example of communication variability and ineffectiveness is found in the area of surgical intervention. Healthcare professionals now understand that wrong site surgeries are linked to problems with communication, and due to frequent communication issues there are still a multitude of wrong site surgeries occurring per year (Spath, 2005; Joint Commission Accreditation on Healthcare Organizations, 2004).

Culture of Safety

In reaction to this issue and a heightened awareness for the need to increase patient safety, in the year of 2004 healthcare professionals recognized that clearer communication patterns must be developed to ensure patient safety, particularly in the operating room (OR). Therefore in the OR, healthcare professionals set themselves to establish communication that is clear and precise in an effort to develop a culture of safety (Joint Commission Accreditation on Healthcare Organizations, 2004).

Universal Protocol

The culture of safety is based on the model of feedback in communication where conversation creates clear meaning (Joint
Commission Accreditation on Healthcare Organizations, 2004). In theory and within the frame of a culture of safety, the surgeon is supposed to initiate the use of Universal Protocol (i.e., the surgery is about to happen on the correct patient and surgical site) in the surgical suite immediately prior to the actual surgical incision to ensure a safe patient outcome. However, in the reality of the OR environment and in part due to resistance by many surgeons, it is the nurse who initiates the use of Universal Protocol.

**Issue**

To initiate the use of Universal Protocol, the nurse has to be assertive and at times a dominating presence with physicians. This is a drastic change in traditional medical nurse-physician hierarchal roles and in fact is a role reversal between nurse and physician. The usual practice within the traditional medical healthcare delivery model is reflected in the image of the physician who gives orders and the nurse who takes them; in their interaction, the nurse is expected to be submissive to the physician’s authoritative and dominating presence.

**Statistics and the use of Universal Protocol**

Since the establishment of Universal Protocol in 2004, wrong site surgeries have actually increased. During the same time, use of Universal Protocol has decreased (OR Manager, 2006, pp. 1, 7). Why did this happen? Why are wrong site surgeries increasing and the use of Universal Protocol decreasing?

**Thoughts Concerning Communication and Role Reversal**

I believe that these troubling statistics report a situation that has to do with communication and role reversal. I continued to wonder how role reversals between nurse and physician affect the communication patterns between team members within the healthcare environment as related to a culture of safety. Also, I wondered in a larger sense with the advent of this role reversal how does the operating room team communicate in an effort to function within the parameters of a culture of safety? And in particular, how do the team members view their communication patterns in relation to a culture of safety?

**Communication and Role Change**

The use of Universal Protocol is only one example of role reversal between the nurse and physician which has created a
change in communication patterns. There are many other instances where role reversal between nurse and physician complicate communication in today’s healthcare hierarchy and delivery of safe patient care. Thus, the use of communication within the context of a role reversal is worth studying to begin to examine the potential need for change in the structure of healthcare and the roles that hold the hierarchy together as we try to develop a culture of safety.

The Social Construction, Communication and Culture

Within the culture of healthcare and the operating room the social construction of the nurse-physician relationship is a dominant factor in healthcare delivery. Due to this dominant relationship I do believe this relationship does influence team communications such as in the use of Universal Protocol.

And, as related to this study I take a particular approach to communication, one grounded in the social constructionism perspective. From the perspective of social constructionism in healthcare, professionals have socially constructed rules by which they communicate known as the rules of engagement. In healthcare, the rules of engagement follow the structure of the medical hierarchy in that as individuals communicate some roles function to be subordinate while others are dominant. The individuals within these roles then follow in varying types of subordinate and dominant communication patterns.

Within the context of the rules of engagement and how nurses and physicians communicate, this communication and socially constructed relationship stems from the many years that nurses and physicians have developed as a care delivery pair. Thus, there is a legacy of social construction between nurses and physicians.

The Nurse Physician Relationship, Healthcare Environment and Communicative History

The nurse-physician relationship has primarily been one of subordination and domination, not collaboration. This pattern has traditionally followed gender and hierarchal relational issues (Brimblecombe, 2005; Godden & Forsyth, 2000, Group & Roberts, 2004). In contrast, nursing today has become a blend of roles that are contextually developed through the nursing education process and actual professional working hours of preparation and continued practice (McGarvey, Chambers, & Boore, 2004).

And even though nurses have the responsibility for taking charge in the patients’ interests, contemporary nurses are still positioned as subordinates in the healthcare profession. This leads to communication patterns that reproduce the subordinate responses ostensibly transformed by the culture of safety. Instead
of open, clear and precise communication, the residual culture of subordination and domination creates restricted communication patterns.

The Operating Room Culture

As a participant in the operating room culture for the past 18 years, I know that it is a complex environment. It is also evident that there is great variation in the communication between team members.

In the operating room, team members are trained to be attentive to the surgeon and anesthesiologist in an effort to care for the patients within the OR proper. This training comes with at least these four assumptions. First, the surgeon is the leader in the OR, or better known as the captain of the ship. Second, everyone else’s speaking is secondary to that of the surgeons. Third, nurses, technologists and non-clinical personnel are to speak only when spoken to, unless there is an urgency and or emergent situation with a patient or the environment. Fourth, open fluid communication is not the norm and or even understood by the team members.

One consequence of the culturally-appropriate dominance of the surgeon in the OR is that conversational contributions by any other team member may be ignored; the surgeon maybe the only person who is heard. Although this pattern of dominance and subordination is culturally sanctioned, it generates negative feelings and invidiously affects the OR team’s ability to communicate with the openness that they sometimes need.

Healthcare Communication, Current Research and Relevance

In one way of thinking about the OR as a social setting, it “consists of a complex mixture of materials, stories, and skills in which not all voices are granted equal hearing, not all skills are equally appreciated and not all practices are facilitated” (Pearce, 1989, p. 197). Due to the hierarchies and varying professionals that exist within the context of healthcare there is variability in communication and meaning (Miller, 2005), which then increases inconsistency in our care delivery process. This variability stems from the development of our language in that each professional group has its own roots which contribute to the use of professional meanings (Wittgenstein, 1981). Due to the communication variability of meanings among healthcare professionals and the complexity of the many hierarchal relationships (Thomas, et al., 2004) and overlapping processes within the context of healthcare delivery it is difficult to discern where to begin in trying to develop improved communication.
This communication variability translates into inconsistency with team performance as related to the healthcare delivery process. This variability is compounded in the communication situation as each team member brings their own understanding to the communication space in the premise of hierarchy, role function, interaction and social construction (Shotter, 2005a; Shotter 2005b; Pearce, 1989; Weick, 1987; Weick & Roberts, 1993).

An example is the nurse acting as a subordinate to a physician; to appease the physician in some situations, a nurse may alter what is said in a conversation. When someone alters their speech there is then a potential alteration as related to intent, which may unfold as increasing variability within a communication and thus care delivery process. In healthcare, this type of conversation may exist in multiple situations when we encounter a subordinate and dominant relationship.

A specific example of the nurse-physician hierarchal communication relationship and issue is reflected in a recent study regarding “Communication in Emergency Medicine: Implications for Patient Safety”; still evident today is that “Many nurses simply remained silent when they disagreed, following physician orders and only later expressing their objections to other nurses. This hierarchical behavior is a serious weakness in the system, . . .” As the nurses stated “ ‘You never tell a physician ‘No.’ Instead, you say. ‘Are you sure this is what you want to do?’”, “an important issue here is that the nurse must go out of their way to approach the physician with questions or concerns” (Eisenberg, et al., 2005).

In reflecting upon the nurse and physician interaction and the idea of hierarchal boundaries, it is these boundaries that create a communication space which perpetuates a certain amount of indifference about one another. In particularly, if one is not in a position of authority and or what is believed to be an important presence to pay attention to (i.e., the nurse is thought of as subservient, and therefore of less importance) voices may remain unheard (Shotter, 2002a). Thus, due to the hierarchal boundaries and the subsequent inability to have an openly communicative relationship between nurses and physicians patient care issues may be missed.

To continue to pursue a culture of safety in an atmosphere of hierarchy and boundaries I believe that we as healthcare professionals have a responsibility to develop an understanding as to how our social construction does alter the outcomes of communication and ultimately patient care.

**Research Question(s):**

To develop a better understanding of operating room team communication I posed the primary research questions:
- RQ 1: What are the common communication patterns found in the conversations between nurses, physicians, technologists and non-clinical professionals?
- RQ 2: What are the relations between these patterns and a culture of safety?

In asking these questions there is an assumption that there are specific patterns found in the communication among team members in the operating room. The patterns lead to a reflection of the types of relationships that abound between team members, how these communication patterns and relationships develop, and provide insight into the communicative environment, and is the communication conducive to providing safe patient care, and thus the creation of a culture of safety?

**Study Design**

This is a qualitative study based in the concepts of ethnography. I use the term ethnography in the traditional sense of understanding the environment from the natives’ perspectives, micro ethnography as this is a small group within the larger culture of healthcare, and critical ethnography as there are suppressed voices on the OR team within the medical hierarchy. So, to begin to define the operating room environment, I used my knowledge as a 20 year native in the operating room, and to define the analysis I used the narratives from the OR team participants.

**Study Site**

The setting for the research was Banner Thunderbird Medical Center (BMTC) which is an acute healthcare facility in the southwest, U.S. BMTC was chosen for the research site because the medical center is embarking on creating a model for communication for the purpose of further developing a culture of safety for improved patient care delivery. Banner has been developing concepts to standardize language related to team communication and specific patient populations. My sense is that to understand how to develop a new consistency within language and communication, first we as a healthcare delivery team have to begin to understand the current social construction of our communication patterns.

**The Study Process**

To begin the process, IRB approval was obtained from both the Fielding Graduate University and Banner Healthcare. Next, subjects were recruited from the operating room staff of nurses, technologists and nonclinical personnel and also surgeons and anesthesiologists on staff at Banner Thunderbird Medical Center. Participation was strictly voluntary and the consent was obtained in person.

Using a structured interview protocol developed by the researcher, healthcare professionals were interviewed over a two
day period the summer of 2006 to find out their opinions and perceptions of healthcare communication within the context of creating a culture of safety. The participants did not see the questions prior to the interview. The transcripts were sent to a transcription service in a digital format and returned electronically as word files. A thematic analysis (Polit & Beck, 2004, pp. 588-589) was utilized to describe the common communicative patterns found within the operating room environment and team members, as to how people relate, respond and interact to and with each other. The data coding and analysis were triangulated with another researcher by electronic and verbal communication. Next, by using the heuristics of the Coordinated Management of Meaning (CMM), the participants’ perceptions are reconstructed to develop images that represent ideas regarding communication patterns in relation to the creation of a culture of safety.

To develop the study, a pilot project was designed and implemented to test the methodology and to craft how to analyze the data. Through the use of the pilot and seven pilot participants the interview protocol and study framework proved to be adequate.

The Study Findings

The findings of the study came from the data collection which transpired at BTMC the summer of 2006. The data collection involved a panel interview process consisting of seven participants and a narrative one-to-one interview process encompassing 13 participants who were nurses, physicians, technologists and nonclinical personnel of the operating room. In particular, the narrative interviews provided a space for participants to openly share individual perspectives concerning patient safety and the affects of current communication interactions between operating room team members.

The participants spent time discussing the questions within the context of the medical hierarchy and often brought the conversations into the realm of the nurse-physician interactions. And, given my background as a nurse I have centered a majority of the analysis on the nurse-physician relationship as related to the nurse role and actual place of the nurse in the medical hierarchy. Also, the nurse-physician relationship is of importance in trying to create a culture of safety due to the reality in that the nurse-physician interaction is a prominent factor in the healthcare delivery process.

Typology

To start the concept of the analysis I designed a typology to create an initial structure of my thoughts regarding healthcare
communication. This was not done to bracket, but instead to bring myself into the research and exploration of the OR environment. I believe that it is important for a researcher to recognize, acknowledge, and embrace one’s bias as a socially constructed individual.

The typology pertains to common types of communication patterns and responses within healthcare between physicians and nurses. The typology is developed from my perspective as a nurse in acute healthcare with the use of the concepts from the logical force ideas of CMM. From a social space, the logical forces provide multiple contexts that give one an idea of what someone maybe experiencing within their specific conversational situation (Pearce, in press).

The main points of the typology are as follows. First, using a prefigurative thought process, as nurses enter conversations, nurses have a tendency to try to avoid confrontation with physicians. Second, nurses understand that there is a practical aspect to being non-confrontational in that they may then maintain a positive relationship with physicians. Third, nurses exist in a contextual environment and within the framework of the medical hierarchy nurses try to maintain a balance between being the patient advocate, and being non-confrontational with physicians in an effort to maintain the nurse-physician relationship. And fourth, at times the implicative force takes over in that the nurse knows if they speak in a certain way to a physician the nurse can or will provoke a specific response, be that good or bad (refer to table I).

Table I.
Typology: CMM Forces and Nurse-Physician Interaction

<table>
<thead>
<tr>
<th>CMM Forces</th>
<th>CMM Forces and Nurse &amp; Physician Interaction</th>
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<tr>
<td>The prefigurative force is the sense of obligation that one has as one responds within conversation because one senses that this is how the response should happen</td>
<td>Nurses avoid confrontation and therefore the nurses when interacting with the physicians may usually have this idea in mind before they proceed in any conversation. And, that conversation between these two parties has rules of engagement or</td>
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The “practical force is the sense of obligation that derives from things that occur after one acts” (Pearce, 1989).

From the nursing perspective, the practical way to interact with a physician is to be submissive to some extent as to not agitate and or blatantly challenge the physician. Here the physician may use intimidation to create a dominant authoritative presence within this aspect of this interaction so that they are not questioned and or challenged.

The contextual force is the blending of our obligations within the context of self, other and the relationship.

Nurses try to find a balance that gives them some presence and sense of a nursing self that can compliment the physician without challenging the hierarchy. And, that the building of relationship appears to be essential in developing an effective conversational space between these two parties.

The implicative force stems from the obligation of anticipated effects or what one may gain as an outcome as the conversation unfolds.

Nurses know that by agreeing with the physician to some extent that the nurse may be looked upon in a more favorable light from the physicians and this is problematic when one needs to be heard from their own perspective and with their own individual sense of a story and with a unique voice (Pearce, 1989, p. 40). And, to create a culture of safety nurses need to develop a relationship with physicians that perpetuates respect, which then allows for and or creates a space of trust between the nurses and physicians.

Research Analysis and Themes

After developing the typology and to continue with the research analysis I searched for prevalent themes in the data stemming from the perspectives of the nurses, physicians, technologists and non-clinical personnel. The emerging themes were developed by searching for like statements and words in the participants’ narrative responses.
Narrative Interview Participants’ Themes

The OR team relationship themes were found in the thematic coding as the importance of respect, relationships, collaboration, trust and open communication. These ideas stem from the analysis of the narrative interview participant reflections and they define several concepts which were continually discussed in the interviews. These concepts are mutual respect, developing relationships, the need for positive communicative intent, consistent use of language and meaning, the idea of trust, team collaboration, an importance of creating positive attitudes, supportive interactions, open communication, and a need to explore the use of the medical hierarchy. After compiling the narrative responses 83% of the participants’ ideas as related to the culture of safety pointed to the importance and use of open and collaborative communication within a team environment.

The Narrative Joining of Perspectives

Important things to remember. All of the participants’ perceptions pointed to the idea that there is no easy way to create the path to the culture of safety as it involves an evolution of communication interactions. However, it appears clear from the perspective of this study’s 19 participants that developing relationships encompassing trust, respect and open communication are important parts of establishing a culture of safety. The participants identified another idea in that healthcare professionals have to find a way to continue to redefine the use and or structure of the medical hierarchy in an effort to develop respectful relationships which encourage and value difference in professional backgrounds as potential contributors and team members.

Lost in the margins. Noticeable throughout these conversations is that the nurse-physician relationship continues to come to the forefront and dominate the conversation. The dominance is evident even when there are others speaking who are not individuals within these professional groups. Therefore, one would suspect that the other team players in this environment tend to get lost in the margins of conversations.

CMM Heuristics

Within the context of this study as I explored healthcare communication one of the values I found of thematic analysis is its ability to reduce a large amount of talk to recurring themes, and to sort those themes among the types of people producing that talk. However, my research questions asked about communication
patterns and relations to a culture of safety, and communication is sequentially patterned as well as thematic. Themes are chronologically static, and a list of themes gives little sense of the narrative structures in which they occur or the relations they have to the cultural environment. As a way of reconstructing these communication patterns and relations, I turned to some of the heuristics (i.e., these are theory and models joined to produce a clearer meaning of a concept) from the Coordinated Management of Meaning (CMM). First, I used the heuristics of CMM to help to define and conceptualize the participants’ perceptions.

**Daisy.** The daisy heuristic represents the notion of an idea or context, which is placed at the center of the image of the daisy. The petals encompass particular ideas that are associated with and support the main context (Pearce, 2007).

I used the daisy heuristic to define the OR participants’ perspectives in relation to the culture of safety; the participants’ ideas reflect the concepts of trust, collaboration, respect, open and clear communication, accountability and the importance of relationships. At the center is the culture of safety, as it is central to this conversation. The petals of the daisy then become the concepts that support and or contribute the culture of safety (refer to figure 4). Thus, trust, relationship, collaboration, respect, open and clear communication, and accountability embody the support for a culture of safety.

![Diagram of Daisy and Participants' Perspectives]

**Figure 4.** The daisy and the participants’ perspectives.

**Hierarchy and the LUUUUTT heuristic.** Next, to explore the healthcare hierarchy and the conversations that describe the hierarchy I used the Lived stories, Untold stories, Unheard stories, Unknown stories, Untellable stories, stories Told, and story Telling
(LUUUUTT) heuristic (Pearce, 2005, p. 48). This concept pertains to the many known and unknown stories that revolve and evolve within a communication context from the many varying points of view (Pearce, 2007). Within the context of this study each participant had their own particular idea of the medical hierarchy. They each discussed their own unique story as to how they view the healthcare hierarchy, and how this affects their own individual existence. Another point is that the staff and physicians see that there is a change in attitude between physicians of varying generations. The participants made yet another point that when there are dominating negative personalities of physicians, these traits tend to contribute to the constraints that exist in the hierarchy. Thus, as stated by the participants, it is the negative communication stemming from a personality trait which potentially contributes to the constraints within the hierarchal communication paradigm.

The following are the literal descriptions from multiple participants concerning the constraints found in communication. Within the context of CMM and in using the LUUUUTT heuristic, these quotes are examples of the stories Told and stories Telling.

These particular stories come from the varying professional participants as they discuss the notion of the surgeon profile within the medical hierarchy and how this profile influences the relationship and team interactions.

“... I can’t point to a specific incident but I can tell you that from being a nurse in the ‘70s, you know, ... the communication is better with the surgeons... the younger surgeons I should say. So ... the older surgeons... maybe that’s it. Maybe more of the older surgeons, where they grew up in the culture that they thought that you were God and then nobody really challenged them.”

“And that, you know, I don’t really understand where the surgeon’s coming from when ... they don’t play along with the rules. I don’t understand why they think the law doesn’t apply to them or unsafe things can’t happen to them. I think it’s a very juvenile response and very impractical and very destructive to a team approach. How can you have a team?”

“That’s... we need to also, you know, train physicians to listen better and also train people to be able to give a narrative, to be able to have the clinical knowledge to say well this, this, this and this.”

“Yeah, and it’s old school and new school too, you know. Certain surgeons are, you know, have a higher God complex or something, you know ... it’s personality is what I think. I mean, certain people are harder to deal with than others.”
"I think they kind of use you as their scapegoat, you know? You’re there, like, you know, I will use a spine case for example. I had this happen before, a surgeon couldn’t get the screws in right. And, then all of a sudden, everybody in the room’s getting yelled at because he’s frustrated, a case isn’t going right, you know, so, he’s got to yell at somebody and take it out on somebody, so there we are.”

"It’s frustrating. You know, when I first got into nursing, it was really hard for me. Because I’m like, hey, I didn’t do anything wrong, why am I getting yelled at? And over the years, I guess I’ve just grown accustomed to it.”

“And that’s just because when we do our time outs either the doctors make a joke about it and, you know, they’re just like, ‘Okay’ or they just ignore you completely and then they don’t observe that and the same with the counts.”

“Maybe they have that attitude going into med school that I’m a physician and you’re an RN, and I’m above you . . . I see it with some of the older ones, the ones that have been around for a long time, the ones that started back in the day when it was ‘I’m the physician, you’re the RN, end of discussion. I am better than you.’ I see some of the newer ones coming in that look at everybody as equal, . . .”

“I think, part of it is changing the culture, and it’s coming. It’s progressing . . . the older physicians and the newer physicians . . .”

In these responses each participant has a unique story yet there is a common thread which reflects a dominating and at times disruptive type of relationship between the team member and the physicians. The stories reflect the notion that there are unwanted repetitive patterns (URPs) in communication which lead to ineffective team partnerships in an atmosphere where we are trying to establish open and respectful communication.

Unwanted repetitive patterns (URPs). Thus, the URPs can perpetuate ineffective communication interactions. To elaborate the URPs help to define the disruptive communication patterns, and URPs have the potential to develop into strange loops of communication (Pearce, in press). The participants describe the operating room as an atmosphere of hierarchy that can perpetuate intimidation and avoidance. It is the intimidation and avoidance within the context of conversations that perpetuate the unwanted repetitive patterns. In this type of constrictive and suppressive communication atmosphere there are usually many untold, unknown, unheard and untellable stories such that these stories are buried within the constraints of the hierarchal communication environment. Therefore, the voices that are considered to be of lesser importance within this hierarchy such as the nurses, technologist and non-clinical personnel do not have a chance to
openly communicate their feelings and ideas about many patient care scenarios. Then perpetuated within this suppressive communication environment are the unwanted repetitive patterns that become communication rituals.

It is the avoidance and intimidation which then continues to contribute to, and or perpetuate the unwanted and repetitive patterns of this hierarchal existence. Hence, within this hierarchal experience the avoidance and intimidation perpetuates the URP cycle found within the staff-physician relationship.

In particular, as a new non-physician team member enters the operating room environment and then as this individual speaks with what may be considered a lesser and unknown voice, the individual has a tendency to avoid confrontation and what could be a potential embarrassment. Then through one’s own inner thoughts about how one should act as a patient advocate and team member, and gaining focus and self-acceptance that it is one’s duty to speak to protect the patients, the individual then gains confidence to speak and initiate this conversation. However, as a new team member entering into this situation, one may not be well received and then the individual may begin to feel intimidated and the cycle continues. It is within this space of intimidation and avoidance that the unknown stories define the unheard stories, which evolve into the untellable stories of self defeat and lack of confidence. It is the stories of self defeat and lack of confidence which individuals grapple with as new team members within the operating room environment.

Logical force. From a social space, the logical forces provide multiple contexts that give one an idea of what someone maybe experiencing within their specific conversational situation (Pearce, 2007). The logical forces as defined in this context are what healthcare professionals contend with internally and externally in a conversational space as one enters a dialogue.

Therefore, there is prefigurative force and thought process that happens before one enters the conversation. Within the context of healthcare each individual has an idea of how they will enter the conversation from their unique role definition and function. From the perspective of the hierarchal boundaries in healthcare there is a practical force and aspect to what one will say knowing that there are rules of engagement. There is also the contextual force of our interactions that transpires as all of the individuals come together as a social construction of influence within a dialogue in any particular situation. In addition, in healthcare there are many professionals that come into a situation at one time and bring with them varying ideas of what something means from the aspect of professional backgrounds, education and relationship development. Thus, at times there can be a mixing of meanings, which convolutes our interactions. There is also an implicative force that stems from
the notion that we as healthcare providers know the rules of engagement and we know what to expect as we engage in a conversation. The implicative force may come to the forefront at times when we opt to speak in a particular way in an effort to achieve a specific outcome. We see this as nurses avoid confrontation and carefully chose their words as not to disturb the rules of engagement between nurse and physician.

At times these types of interactions in healthcare communications move to form what become the strange loops within these conversations and as noted in particular the conversations between nurses and physicians.

The strange loop.

A (A is in opposition of C) ≠ C (where C is in opposition of A)

B (B is in opposition of D) ≠ D (D is in opposition of B)

Figure 5. Strange loop of CMM.

Strange loop. The strange loop provides an image of communication which seems to flow from one scenario to an opposing scenario and or opposing communication interactions (refer to figure 5) (Pearce, in press).
Within the frame of the analysis and then in viewing the strange loop (refer to figure 6) having a good relationship versus having a bad relationship within the nurse-physician paradigm is based in the prefigurative and practical forces. These contexts promote how the nurse and physician relate as collaborators. Using the example and context of the nurse and physicians, if the nurse has a good communicative relationship with a physician there is not a dilemma in speaking to the physician. Also, when the nurse has a good relationship with the physician, it is associated with communication that includes trust and respect. However, if there is a bad or poor communicative relationship then the nurse may want to avoid the physician.

The contextual interaction is the movement between the nurse and physician. The implicative force and practical forces are aligned with risk/dilemma or no risk/no dilemma. Thus, within the context of the implicative and practical forces, the nurse will make an attempt to speak in a way that will be accepted within the nurse-physician paradigm and medical hierarchy. The nurse will speak within the context of speaking the truth for the patient’s sake and the notion of trying to develop or keep the professional nurse ideals of self at the forefront. Yet, the nurse knows that confrontation is not acceptable in the nurse-physician relationship and it is in this controversial conversational space where nurses are caught between the two concepts of non-dilemma versus a dilemma.

The nurse wants to maintain a good relationship with the physician. However, the nurse has an obligation as the patient advocate to speak for the patient’s sake. If the nurse speaks out of
the boundaries of the hierarchal relationship, the relationship may swing from good to bad and the nurse may fall into a pattern of avoidance.

**Figure 7. Levels of Hierarchy in CMM**

*Hierarchy*. The hierarchy heuristic is a concept used within a specific context to imagine what level of importance events have for an individual or group. Therefore, the hierarchy heuristic can provide a visual context of themes and respective level of importance from an individual and group perspective (Pearce, 2007).

Using the hierarchy concept the nurse becomes trapped within the hierarchy, the flux of a decision between the concepts of self, the contextual existence of the relationship, the actual reflection of the episode, and the meaning within the conversational space. If the nurse finds the correct way to phrase the communication in that the communication remains within the construct of the hierarchal paradigm and thus contributes to a non-confrontational relationship between nurse and physician, the relationship can then be kept safe or thought of as a good relationship. So, it is when the nurse challenges the physician that risk is assumed and where the communicative relationship is at stake.

The social world of healthcare communication stems from the many hierarchies that exist in this setting. There is a medical hierarchy between nurse, physician, technologist and non-clinical personnel. There are hierarchies found within the many groups of nurses and physician specialties and within the operating room personnel. Within nursing there are hierarchies concerning skill level as related to specialty training and medical unit cultures, time in the
profession, educational levels, and leadership position titles and or the management structure. In addition, a hierarchy exists within the staff’s culture as related to length of time that one has worked in a specific acute care unit and acceptance as an individual and professional.

**The Serpentine**

![Diagram](image)

*Figure 8. The Serpentine*

_Serpentine._ The serpentine heuristic describes the back and forth motion between participants or ideas within a conversation. In this context the view of the serpentine heuristic reflects layers of hierarchal contexts that flow into the turns, which are taken within a dialogue. The layers of hierarchy then function as contexts that hold the meanings and then contribute to the many contextual turns in the dialogue. This social construction is complex and convoluted and as one thinks about this concept one can see how easily meaning might become lost within the dynamic communication environment of healthcare. Thus, healthcare communication is a function of the language and rules of engagement within the context of the layers and multiple dimensions in the healthcare hierarchy.
Figure 9. The serpentine and OR healthcare communication

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**Figure 9. The serpentine and OR healthcare communication**
Figure 10. The Daisy and Hierarchy in Healthcare Conversation.

The patient. In the traditional healthcare hierarchy the patient remains somewhat disconnected because the hierarchy and rules of engagement take precedence over everything including at times the patient. To visual this idea I will use the daisy heuristic; the daisy heuristic represents the notion of an idea or context, which is placed at the center of the daisy. The petals encompass particular ideas that are associated with and support the main context (Pearce, 2007). Using the CMM daisy heuristic (refer to figure 10) the hierarchy is placed at the center of the daisy as the context for all conversations within healthcare today. The surrounding stories become the contextual space shown in the petals of the daisy that then support the hierarchal nature of the situation. The patient petal is purposely placed as a disconnected presence in this conversational space because today in healthcare the patient at times gets lost in the tensions of the hierarchal conversation, and therefore remains somewhat detached from the center of the conversation.

The Intent of this Study

My hopes are to bring this study forward to encourage healthcare professionals to continue to develop clear and open communication within a culture of safety. The intent of this study is to take this information forward as a positive exploration of how healthcare professionals could coexist as collaborative team participants instead of the traditional hierarchal existence that has persisted. It is important in being able to create a culture of safety that healthcare professionals pursue an increased understanding of each other’s communicative existence. Healthcare professionals could then seek out and share each other’s stories so that as a group they can begin to develop greater understanding of the communication complexities that persist in this contextual professional environment. Most important and the main reason to develop an increased understanding of communication interactions for all in healthcare would be to develop and pursue the ideas of creating a culture of safety.

Recommendations for Creating a Culture of Safety

In an effort to change the characteristics and patterns found in the operating room concerning ineffective communication,
several factors need to change within the healthcare delivery team relationship. Therefore, several important points come to attention from this study.

First, open communication is an essential component to creating a culture of safety. Second, there should be a focus on developing relationships between healthcare professionals in particular between nurses and physicians given that this pair is one of the most prevalent/dominant pairs regarding communication in healthcare. Third, we have to find a way to establish and sustain a trust from the very beginning of the interactive communicative relationship between healthcare professionals. The fourth idea is that within the perioperative care delivery process, healthcare professionals need to continue to work on a standardized vocabulary for communication. And, fifth, to develop this new paradigm the healthcare professionals could continue to evolve the nurse-physician relationship as an interface for collaborative care delivery.

Limitations and Assumptions

In healthcare, professionals are seeking to be reflective co-joint meaning makers. Within the framework of this study there is an exploration of communication as an evolutionary experience. And, this study is not without limitations and assumptions.

Limitations. Participation is restricted to the participants/professionals of a specific operating room setting in a southwest regional medical center. Therefore, only a particular sample of professionals are part the conversations. And, because of the limited and specific participants there is no control group for testing as this is a qualitative study of what people are experiencing in this particular contextually defined setting and as unique individuals. Another limitation is that I have been an RN professional in healthcare for 19 years within the OR environment and this causes me to have potential bias and possible influence on the study design, findings and interpretation of the findings.

Assumptions. Humans create dialogue as a social construction and within this framework there are multiple influences that intertwine and mesh which then develop how as individuals they communicate as a system of communicators. The system of healthcare communicators has varying professionals who have diverse backgrounds from the aspects of educational, professional and cultural perspectives, which help to develop and create influence about who they are and how they communicate within dialogue.

Although, I do bring a certain bias to this research as a nurse of many years in acute healthcare and the OR setting, this is a part of my life experiences. These experiences were used to explore
deeper meanings that someone with my background does have, thus being able to create a better understanding as a healthcare delivery professional and participant/observer within the study process.

**Reflections**

As professionals move forward in healthcare in the creation of a culture of safety it would be beneficial for the patients and delivery of safe care to recognize what types of communicatively suppressive power relationships and conversational contexts currently exist. By acknowledging where the current conversations exist as a social construction, healthcare professionals then stand a chance of developing a better understanding of how to proceed to increase their understanding of how to develop open dialogue about these issues for the future increased creation of the delivery of safe patient care and the creation of a culture of safety.

**Promiscuous Conversations**

*Figure 11. Promiscuous Conversations*
In healthcare the medical hierarchy holds in place a constrictive and suppressive communication environment. As healthcare professionals communicatively function in this suppressive environment, promiscuous conversations prevail. In that healthcare professionals learn repetitive type communication patterns which are at times random turns in dialogues which for the purpose of this discussion I am naming promiscuous conversations. The conversations are promiscuous in the sense that as one speaks there is often a lack of awareness for what the conversation may cause in relationship to following or socially constructed events within the healthcare space. We function within the parameters of what we know to be acceptable within our roles. And, due to this conundrum of role appropriate behavior often subordinates in particular within this space predictably hold back from the conversation and alter what may need to be said. Thus, many stories remain untellable, untold, unheard and unknown.

I believe that within healthcare we need to continue to visit our communication patterns to be able to understand and dissolve ineffective patient care delivery behaviors. In addition we need to rethink our curriculums and professional learning to include interactive communicative spaces where all professionals come together as collaborative learners and teammates.

Next Steps

New study. A new study was developed as a recreation of the previously described study and was IRB approved, Winter of 2007 at 6 acute care sites in the Midwest, U.S. Sixty-eight interviews have been collected using participants of nurses, physicians, technologists and nonclinical personnel across the six operating rooms.

CMM summit, and simulation and team learning. After a preliminary analysis it is obvious that the various groups of professionals and individuals within these groups have varied ideas about what it means to be a culture of safety within healthcare. First steps will be to develop a CMM summit using a co-joint (i.e., there will be representation from all of the varying professional groups on the OR team) meaning making session to bring forth what it means to be a culture of safety, December, 2007. The first group session will incorporate the staff at one of the tertiary medical centers. The intent is to replicate this summit at the additional five acute care sites.

It is also evident from the original and current study that as the team members communicate there is a need for safe spaces to share their stories, a place where individuals feel comfortable and
able to tell their stories. Healthcare professionals need spaces where they can feel increasingly free from the aspect of intimidation and hierarchy constricitive communication relationships. In developing a safe space for the sharing of each other’s stories, healthcare professionals could use the sharing of stories and the creation of communication scenarios to actually help nurses and physicians to affect change in real time.

This could be done in a simulation lab with the nurse-physician-technologist-nonclinical personnel teams. With the presence of a CMM facilitator, the teams can role play, and as this happens the sessions can be taped. Together the members can watch the tapes and then discuss what could have been done differently from the aspects of communication and how each member feels when they are a part of the situation. They can then place these ideas into imagines such as the heuristics of CMM to develop a snapshot of what is transpiring as communicators. Just imagine what it would be like to be able to stop someone at the very point when they have said something that is less than positive or thoughtful and to then redirect the conversation to a space of positive intent. This is done by exploring the current patterns and having discussions as to what works and what does not and then to develop integrative and co-created scenarios that exemplify collaboration as an effort to be a team of positive communicators.

The first simulation is scheduled for the cardiac team at one of the acute care sites. After consulting the cardiac team, the plan is to reenact the placement of a balloon pump. The team decided that this is an important scenario to explore because this is usually a hectic situation and urgent patient care scenario where the individuals on the team have developed uncomfortable communication patterns. And, the team wants to try to change these patterns to develop what they think are considered more of an effective communication environment. The team will be taped and then debriefed on their communication. The team will go back into the simulation lab to practice more effective communication patterns. We are developing this situation as a template for simulation and team communication that can be replicated throughout healthcare delivery operations to be specific to particular scenarios as needed and or wanted.

Dissolving the Boundaries

By sharing stories, exploring team communications and learning to have an appreciation of individual expertise and knowledge, healthcare professionals can begin to dissolve the ineffective boundaries that exist within the context of the medical hierarchy and communication. These are the ineffective boundaries which are not conducive to the creation of collaborative healthcare
professional partnerships. Healthcare professionals need spaces that are safe learning zones for collaborative learning and interactions. These safe learning zones can bring the team players into a functional space of interaction contributing to the development of a culture of safety. By using communication tools such as CMM as an exploration of team learning there could be an appropriate dissolving of communication boundaries to perpetuate an open atmosphere of healthcare delivery team interactions resulting in the creation of a culture of safety.

References


Collaborative Partnerships in Curriculum Development: The gateway to success?

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Background and context
Manukau Institute of Technology’s Department of Nursing & Health Studies in Auckland New Zealand, was established in 1980. Between 1980 and 1997 approximately 1200 graduates successfully completed the Diploma in Comprehensive Nursing and subsequently passed the New Zealand Nursing Council State Examination for registration as a Comprehensive Nurse (Department of Nursing and Health Studies 2005).

In 1989, the Education Amendment Act of New Zealand gave polytechnics the right to offer and award degrees, which prior to this date, had been the domain of universities. The result of this change was the Bachelor of Health Sciences (Nursing) programme, which was introduced in 1995. This programme was offered to pre-registration and post-registration students, and replaced the Diploma in Comprehensive Nursing. Between 1998 and 2005 a total of 837 nurses graduated from the Bachelor of Health Sciences (Nursing) programme (Department of Nursing and Health Studies 2005).

Changes to the nursing education programmes of New Zealand became necessary because of recent changes in health strategies. The Ministry of Health published the Primary Health Care Strategy in 2001. This strategy deemed Primary Health Care to be “. . . central to improving the health of New Zealanders and, in particular, tackling inequalities in health” (King 2001, p.1).

In 2003 the Ministry of Health also published a report on Primary Health Care and Community Nursing, in which it stated that the fields of primary health care and community nursing recruited and retained low numbers of Maori and Pacific nurses. These nurses are needed to provide culturally sensitive health care services to these population groups (Ministry of Health 2003).
The Ministry of Health also acknowledged that nurses constitute the largest health workforce and therefore have the responsibility to deliver as much of the needed health care as possible. It is therefore deemed to be essential that this workforce be educated to meet the goals of the Ministry of Health (Ministry of Health 2003).

In 2005, the Nursing Council of New Zealand published a document on ‘The Standards for Competence Assessment Programmes’. In this document, it was stated, that new graduates from nursing education programmes had to meet the competencies for their scope of practice, as developed by the Council and that programmes in nursing education had to be accredited by the Council (Nursing Council of New Zealand, May 2005).

The Council prescribed the following standards that had to be fulfilled before nursing education programmes could be approved:

1. The programme complies with legislated requirements and the Council’s policies and guidelines.
2. The programme has a structured curriculum.
3. The scope and content of the curriculum includes theory and related practice experiences to enable students to achieve the expected outcomes of the programme.
4. The curriculum is implemented by lecturers who are qualified for their roles.
5. Facilities in resources are available to support the achievement of the expected outcomes of the programme.
6. The environment supports the teaching-learning process.
7. Student performance in assessed against learning outcomes relevant to nursing practice.
8. The application for registration complies with legislated requirements and Nursing Council policy and guidelines. (Nursing Council of New Zealand, June 2005, pp.2-3).

In educational circles it is now accepted that the information relevant to nurse education will double every 5 years (Barnard et al. 2005), which can be seen as further evidence for the need to change curricula regularly to keep up to date with the latest developments. This meant that irrespective of the changes in health strategies, a change in the curriculum was due.

Developing a new curriculum involves major decisions such as when and how to gain the input of stakeholders. A more traditional approach is to develop the curriculum and then to consult with stakeholders, while more contemporary approaches requires collaborative agreements with targeted stakeholders as part of the development process.
If one understands the need for collaborative partnerships between tertiary education institutions and stakeholders, then the benefits of such a process becomes clear. This was highlighted by Vilela et al. (2004), who stated that universities were created to meet the needs of the communities they served. It is therefore imperative, that schools of nursing should consider the needs of the community before they effect any changes to their curricula. This may be done by entering into a collaborative process with the communities they serve.

Collaboration is, however, not an easy process, as was demonstrated by Pardue (2006), who researched cooperation between service providers and educational institutions. It was found that 48% of the staff members did not partner with nursing service personnel to help them develop innovative educational programmes, and 39% of staff members did not cooperate with community services regarding their needs. These nurses reported several problems in implementing their degree programmes.

Collaboration can be seen as a very important aspect of modern education, as it is a process as well as a product of innovation, and will help focus the institution on competent and optimal practice (Lawson 2004). The need for cooperation becomes obvious if one takes the advances in health care delivery into account, and that taught material in nursing programmes often did not keep track of new developments. Lawson (2004, p.227) warned against the idea that “the professional knows best what clients and students need and must do”, simply because educators should rather view students and the clients as partners who have valuable experience and expertise. Knapp and Lowe (2001, p.14) found that Health Care Workers often believed that their professional knowledge enabled them to make decisions about their customers without involving them in the decision making processes. This approach is questionable, as the person might not be able to identify his or her own needs at the time, but they are experts in defining their own daily lives and the barriers they encounter when they need to access services.

But what is collaboration? Lawson (2004, pp. 227-228) defined collaboration by stating that:

“. . . autonomous stakeholders with their respective competency domains mobilize resources, and both harmonize and synchronize their operations to solve shared problems, meet common needs, capitalize on important opportunities and obtain prized benefits”.

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Aim
The aim was to develop, in a collaborative partnership with clinical colleagues and other stakeholders, a new and innovative degree programme that is responsive to future workforce needs.

The reasons for developing a new nursing degree programme could be summarised as:
- Meeting the changes in the health services e.g. the Primary Health Care Strategy and establishment of Primary Health Organisations.
- To strengthen the collaborative approach to nursing education in line with the directions of the Tertiary Education Strategy of New Zealand.
- To achieve more integration of pathophysiology and pharmacology.
- To generate more socio-political awareness amongst nurses.
- To have a futuristic focus.

Method
The Department of Nursing and Health Studies at the Manukau Institute of Technology decided to enter into a collaborative arrangement with the future employers of their graduates. Its Charter commitment to the Treaty of Waitangi, which underpins the concept of cultural safety, was an important aspect in its development. The Department already worked in partnership with Tangata Whenua and Te Komiti Kawa Whakaruruhau to ensure culturally appropriate education for Maori. Because of the strong Pacific Island community in South Auckland, the Department also actively recruited and encouraged Pacific Island staff and students to participate. This was the first step towards a collaborative partnership in developing the new programme (Department of Nursing and Health Studies 2005) and was demonstrated by the fact that the concept contained in the Charter permeates the Bachelor of Nursing programme.

Baker et al. (1998, pp.1-2) identified some of the changes that happened in nursing education, by stating that nurses will have to reflect on a broader definition of health, while simultaneously becoming more involved in their educational processes, having to think along the lines of prevention and care management, and aiming at improving the health of the entire population and not only the individual. In order to achieve this they asked the following questions: “What knowledge and skills are needed to accomplish these goals? How can health profession education programs better prepare their graduates to meet these challenges?”
The Department of Nursing and Health Studies used a ‘blank page’ approach to maximise creativity in the design and structure of the programme. In order to develop a programme that was both innovative and responsive to the needs of future employers of nursing graduates, the programme had to be designed in true partnership with stakeholders. This development in contrast with traditional approaches, involved stakeholders in every aspect of the development of the programme, from the start.

The key components for the development of the curriculum included the appointment of a project facilitator, a project plan, an extensive literature search, the establishment of an Operational Team and a Curriculum Development Team. The latter was the decision making body and consisted of representatives from all identified stakeholders. The Curriculum Development Team worked closely with their different constituencies to ensure that the programme represented the broader views of all stakeholders. The department used ‘snowball’ sampling methods to identify and involve organisations/persons that could become future stakeholders. The main tasks of the Curriculum Development Team included:

- the development of the graduate profile,
- identification of the major themes and values underpinning the programme,
- developing the conceptual framework,
- establishing the degree structure and
- determining the assessment philosophy.

The Department followed specific lines of consultation, and set up definitive partnerships outside the institution working jointly towards developing a new curriculum. The Department held a series of workshops called ‘The Nurse of the Future’ before commencing the curriculum development process.

**Analysis**

The department used the data from the workshops to guide the development process and the different groups within the Curriculum Development Team met regularly to consider information gathered from the various consultation cycles. The cycles consisted of consultation, change, and feedback to stakeholders and continued until the Curriculum Development Team was satisfied with the outcome.

The findings of the ‘Nurse of the Future’ workshops were constantly revisited to identify all the relevant programme themes, and a graduate profile and degree structure were developed (Department of Nursing and Health Studies 2005, p.9). This process is in
agreement with the curriculum development process described by Bush (2003, p.16), who asked a set of questions that could be very helpful for this process. Three important questions include:

- “Are there committees that focus on particular aspects of a curriculum?
- Does your school have a curriculum guide?
- Is there a philosophy or method of curriculum development that they follow?”

The Department fulfilled these requirements, by the different committees that were set up, while the curriculum was guided by the health legislation and the Nursing Council guidelines.

The Curriculum Development Team developed a graduate profile, to outline the competencies/attributes of the graduate and consciously decided against developing a philosophy to allow as much creativity as possible to meet the educational needs of the culturally diverse student population. This profile states the competencies of the graduate nurse, and refers to the cultural differences of the student population. Internationally, many nursing schools are still maintaining the Nightingale pledge, even if it had to be adapted frequently to fit modern nursing. Lee et al. (2006, p.10) thought that the Nightingale Pledge is still relevant as it could still be seen as an inward commitment to the nursing profession.

There are certain constraints within which to develop a curriculum for health professions. Luttrell et al. (1999, p.135) identified four fundamental questions that should guide the development of new programmes:

1. “What are the performance-based competency outcomes required for contemporary practice?
2. What are the measurable indicators of competence for each outcome?
3. What are the most effective learning strategies to achieve these outcomes?
4. What are the most effective methods to assess achievement of competency outcomes?”

Ultimately the curriculum was finalised after all stakeholders were satisfied with the graduate profile, major themes, the programme structure and various courses. The curriculum was submitted for external approval and accreditation in May 2005. It was accredited in August 2005, and the first students were admitted in February 2006.
Summary of key outcomes
The BN-Curriculum is evidence that The Department was prepared to embark on innovative processes to ensure that this new degree programme was going to meet the needs of the diverse student population, as well as the needs of future employers of the graduates. This innovation commenced by encouraging collaboration between The Department and a number of stakeholders. The need to change the curriculum was identified by all, including the stakeholders. The value of this collaboration was reflected in the positive comments made by the stakeholders concerned.

One should also not underestimate the effects of the changes on the employability of the students on graduation. The fact that they had the opportunity to choose their own specialities through the elective components of the curriculum would greatly enhance their suitability to work in specific fields of health care. All concerned therefore felt that the new curriculum was going to make a major contribution towards meeting the health needs of the New Zealand population, as stipulated in the Primary Health Care Policy.

The BN-Programme was developed to encourage greater cultural safety and sensitivity in the nursing students, which in turn will benefit the local community once they have graduated. This is an example of innovative thinking, as it incorporated and recognised the cultural diversity of both the students and the communities.

Conclusion
However, a word of warning about an overemphasis on the benefits of collaboration:

“... collaboration is not a panacea, nor is it a “cover all”, umbrella concept for every conceivable form of collaborative action. It follows that, as researchers, evaluators, policy makers, trainers, and practitioners adopt or promote a more coherent, theoretically sound, research supported and pragmatic conception of collaboration, participating stakeholders and their diverse constituencies will be able to obtain one or more of its multiple benefits” (Lawson, 2004, p. 235).

In this curriculum collaboration has evoked very positive responses from the stakeholders and the lecturing staff. The programme will be fully implemented by the end of 2008 and the collaborative partnerships will continue as each semester is being implemented. The Department has the task to oversee this implementation, and to evaluate the effectiveness of the curriculum once the first graduates enter the health care services of New Zealand.
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Establishing a research culture in the absence of postgraduate research programmes in a tertiary educational institution. Poster Presentation

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Background and context
The traditional research top-up funding in tertiary education in New Zealand has been replaced by a Performance Based Research Fund (PBRF). All tertiary educational institutions may compete for this fund by submitting the portfolios of their individual researchers. Portfolios were considered by expert panels and researchers were graded from A to C whereby A would receive the most funding and C the least funding. With the exception of 2 institutions, the polytechnic sector initially opted out of the PBRF as it felt that the system was heavily favouring universities. Three years on, in 2006 most polytechnics decided to opt into the PBRF and submitted portfolios of individual researchers.

Aim
The Department of Nursing and Health Sciences at Manukau Institute of Technology is faced with the challenge of developing a research culture for the 2011 PBRF round in the absence of a postgraduate research environment. In addition to nominated research outputs, staff must also develop their peer esteem and their contribution to the research environment.

Method
A research leader was appointed; research priorities were identified and a robust research plan was developed. A research committee was established and a research policy and incentive scheme was developed. Research was integrated into staff’s professional development while research funds are invested in key staff members to develop their research portfolios for the 2011 PBRF round.
Analysis
The success of this initiative is measured annually against the stated goals of the research plans. Research plans are adjusted on the basis of the analysis.

Summary of key findings
To date research outputs have shown a steady growth with 14 research projects in progress.

Conclusion
The department is well positioned to establish itself as a department with a strong research culture by the next PBRF round.

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Hepatitis C virus infection – knowledge and attitudes amongst primary care nurses in Ireland

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Background
Hepatitis C virus infection (HCV) is responsible for significant morbidity and mortality, with 3% of the world’s population infected (WHO 2000). In Ireland, the discovery of HCV provoked a health crisis. HCV is associated with high-risk groups inclusive of intravenous drug users, homeless people and sex workers. Amongst these cohorts, prevalence remains highest. HCV prevention and detection are pivotal to disease management. Nurses are key players in the primary care developments; they have a role in reducing the burden of this disease.

Aim
The aim of this study was to assess the knowledge and attitudes of primary care nurses towards persons with HCV.

Objectives
- Undertake a survey of community nurses to ascertain knowledge and attitudes to HCV
- Identify sources of information on HCV
- Identify a need for a HCV educational resource

Methodology
A census postal survey of community nurses working in the HSE eastern region was undertaken. Nurses invited to participate included the public health nursing service, practice nurses and nurses working in the addiction services. An Australian questionnaire was adapted for the Irish setting. It contained five sections - demographics, practice, knowledge, attitudes and education.
Analysis
The response rate was 57.1% (n=560). Statistically significant results highlighted differences in the mean levels of knowledge and attitudes amongst the nurses. 45% agreed 'they did not have the knowledge and skills to care effectively for people with HCV'. Results indicated lack of knowledge regarding treatment, transmission and risk. Less than 25% of respondents reported attending a HCV course. 87% of respondents reported a willingness to learn about HCV.

Conclusions
HCV infection is a silent epidemic; persons infected are often unaware of their disease status. Nurses need to be aware of this virus and their pivotal role in preventing and reducing the burden of disease.

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The Experience of Ageing for Women with an Intellectual Disability.

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Aim of Study:
The main focus of this study rests on analysing the experiences of a group of women with intellectual disabilities living in the Dublin area, who are ageing. It examines their experiences under the following headings:

1. The general physical and mental health concerns of participants.
2. Participant’s views on their current and future living arrangements.
3. Experiences of work and retirement, and the expectations of retirement for those who are still working.
4. Participant’s experiences of bereavement through death and life events.

The study concludes with recommendations for service providers in order to assist with planning supports and services for women with intellectual disabilities as they age.

Methodology:
A qualitative approach was employed for this study. The researcher used focus group interviews and photovoice to gather the data.

Analysis:
Thematic content analysis was used to analyse the data from focus group interviews. The results of photovoice proved more difficult to analyse and the researcher found that discussing the rationale behind each photograph was the most successful method.

Conclusion:
The findings of this study identified five areas that need to be addressed in order to support those who are ageing with an intellectual disability in this service.

1. Person Centred Planning
2. Accessible Information
3. Ageing in Place
4. Pre retirement Preparation
5. Bereavement Support
Coming to terms with in-hospital recovery post Myocardial Infarction – an exploration of the patients’ journey

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Abstract

This study aimed to describe the education needs of a sample of in-hospital patients post myocardial infarction (MI). The review of the literature revealed that previous studies on the topic have mainly employed quantitative designs and methodologies that limited or controlled the choice of topics for participating patients. In effect control rested with health professionals regarding the topics being included in patient education programmes.

Using a Heideggerian philosophy this study sought to address this imbalance and sought to obtain a patients’ viewpoint. In-depth interviews were used involving six patients, giving them an opportunity to provide their own perspective on their education post MI. The interview transcripts were analysed using an analysis model described by Holloway & Wheeler (2002). Four core themes were identified in the participants’ experiences, namely: ‘emotions experienced’, ‘adult learning – the patients’ perspective’, ‘the role of staff in the care and education of patients’, and ‘outstanding needs’.

Collectively they describe a life-changing event for the participants in this study.

Essentially this study charts the journey undertaken by patients after their MI. At the beginning they must come to terms with their own emotional turmoil and near death experiences. As they realise that they have actually survived the event they begin to seek out support and sources of information that they ultimately depend on to enable them to proceed on the road to recovery.

The approach adopted by healthcare staff at the bedside in the delivery of their care has a particular determining effect on how the patients experience this journey. Some patients describe this aspect
of their journey as being in an audience that depend on the performance of the actors on stage, yet they have no influence on it. On the basis of these findings healthcare staff need to reflect on how they deliver their care. In doing so it is imperative that they inform themselves with the perspectives of patients with a view to individualizing their care. It is hoped that this paper presentation will assist healthcare professional caring for patients on their journey towards recovery post myocardial infarction.

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Competencies required for successful interdisciplinary research

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There is increasing interest in health-related research that translates findings from laboratory bench to patient care, and from the hospital to the community. These translations require successful interdisciplinary collaboration, and research centers are beginning to develop scholars ready to do such work. However, key information about exactly what preparation is needed has not been available. Given the importance of knowing competencies to be achieved at the conclusion of education, the specific aim of the study reported here was to specify competencies needed by a scholar in order to successfully carry out interdisciplinary research. Each competency statement identified provides an individual measure of applied skills and knowledge that enable people to perform work, and consists of an action verb (observable or measurable performance of a worker), content (subject matter, type of performance, specific task) and the context (limitations or conditions of work environment).

Methodology including research design and analysis

The study was conducted using a Delphi process previously established as effective in specifying competencies in an emerging field of practice. 21 candidate competencies were identified through a literature review and research team consultation. The 30-member Delphi panel with expertise in interdisciplinary research was selected to represent a range of disciplines and research settings. Two rounds of feedback from the panel resulted in 17 competency statements that were reviewed for final comments by the Delphi panel. Candidate competencies were eliminated when unsupported by at

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least 75 % of the panel members; several were re-stated based upon comments.

**Conclusions** The following 17 competency statements describe the scholar who has completed doctoral work with an emphasis on interdisciplinary research, who is able to:

- **Advocate** interdisciplinary research in developing initiatives within a substantive area of study.
- **Engage** colleagues from other disciplines to gain their perspectives on research problems.
- **Express** respect for the perspectives of other disciplines.
- **Read** journals outside of his or her discipline.
- **Interact** in training exercises with scholars from other disciplines.
- **Communicate** regularly with scholars from multiple disciplines.
- **Attend** scholarly presentations by members of other disciplines.
- **Use** theories and methods of multiple disciplines in developing integrated theoretical and research frameworks.
- **Integrate** concepts and methods from multiple disciplines in designing interdisciplinary research protocols.
- **Investigate** hypotheses through interdisciplinary research.
- **Share** research from his or her discipline in language meaningful to an interdisciplinary team.
- **Collaborate** respectfully and equitably with scholars from other disciplines to develop interdisciplinary research frameworks.
- **Modify** his or her own work or research agenda as a result of interactions with colleagues from fields other than his or her own.
- **Draft** funding proposals for interdisciplinary research programs in partnership with scholars from other disciplines.
- **Disseminate** interdisciplinary research results both within and outside his or her discipline.
- **Author** publications with scholars from other disciplines.
- **Present** interdisciplinary research at venues representing more than one discipline.

These competencies can structure seminar and practicum experiences for pre-doctoral or post-doctoral research scholars, facilitating successful engagement in interdisciplinary work. Because this is an emerging field, the competencies should be revisited in 3-5 years for possible revision, expansion or contraction.

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Historically nurses have been less confident in some key skills than others, for example, information technology and application of number (numeracy), being better at the softer skills of communication. However, the number of errors in drug calculation has sharpened the debate regarding nurses’ ability to calculate drugs effectively. This has led to changes to nursing curricula to include calculation/numeracy testing where this was previously absent and for some admissions departments to acknowledge Key Skill qualifications in numeracy at level two or above as evidence of numerical skill. The acknowledgement of Key Skill development, namely numeracy, to nursing practice has clearly been driven by the recognition of aspects of poor practice, the importance of which cannot be underestimated. However, it is equally important to recognise the place of other Key Skills in improving professional practice. Whilst Key skills may currently be embedded in pre-registration nursing curriculum there is now a case for strengthening the role of Key Skill development as an integral part of nurse education. One way of doing this is through a structured approach to portfolio development using a Key Skills framework. However, there is little evidence of the efficacy and effectiveness of using key skills in portfolio development.

**Study Aims, methodology and methods:**
An in depth-literature review was undertaken to inform questionnaires and interview schedules aimed at exploring student nurses perception of portfolio building in education and qualified nurses’ perception of portfolio building in practice. Research findings from this first stage will be used to inform the development of portfolios for higher level courses and their use in performance review of practice.
Data Analysis and Key Findings:
Key findings from the literature review have been used to inform development of questionnaires and interview schedules. Data collection from student nurses and practitioners is ongoing.

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Quantitative Measurement of Perceptions of Self-Care Management Among Rural, Older Diabetics: A Pilot Study

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**Purpose:** The purpose of this quantitative pilot study was to examine the perceived adherence of diabetes self-care management among rural, homebound, 65 year and older diabetics. Investigation of effective self-management factors and behaviors in older, rural diabetics may provide unique perceptions of self-care.

**Literature Review:** The sixty-five year and older persons are disproportionately affected by diabetes. They are more likely than younger diabetics to have co-morbidities, disabilities and difficulty preventing diabetic complications. Guidelines for diabetes management and treatment developed by the American Diabetes Association (2007) are not specifically targeted for the 65-year and older population. This subset of older adult diabetics endemic in the United States has yet to be identified as a unique group in need of different treatment protocols. Past emphasis in self-care has focused on individuals in their own health management, teaching about the disease, and skills to improve outcomes. This approach has not been enormously successful in prevention of complications and co-morbidities. It is essential to identify those factors in self-management which include the client’s perceptions of adherence to their treatment.

There are several unique problems in the management of 65-year and older diabetic patients. Visual disturbances occur as a result of the normal aging process, which in this group, are further exacerbated by poor glucose control. Decreased activities of daily living result in decreased food intake and may contribute to a hypoglycemic state. If the elders are physically inactive, they are more predisposed to obesity. Adding to this conundrum, elderly may experience cognitive impairment, which further decreases
adherence with diabetes self-management. Although effective medications, methods of delivery, and methods for self-monitoring have improved diabetic clients’ ability to control hyperglycemia, normal metabolic control remains difficult to achieve for the older population.

Adherence by the elderly diabetic to dietary therapy, physical activity, and medication regimes may be compromised by co-morbid conditions and psychosocial limitations. The principles of managing diabetes in the elderly are not different from those in younger patients, but the priorities and therapeutic strategies need to be individualized. The objectives of treatment are to improve glycemic control in an approach that involves diet and exercise combined with insulin. Treatment decisions are influenced by age, life expectancy, co-morbid conditions, and severity of vascular complications. Suhl and Bonsignore (2006) reported that risk of cognitive dysfunction increase with age and evidence suggests the decline is more significant in older diabetics and is associated with poor diabetes control.

Individuals with diabetes provide about 95% of their own care (Anderson, Funnel, Butler, Arnold, Fitzgerald, & Feste, 1995) and diabetes education is used as a tool towards the development of self-management education. People with diabetes make many choices every day that affect their disease. The focus of diabetic education has been to provide effective education that promoted behavioral change, which improved choices, better health, and reduction of complications. This was accomplished with a pedagogical approach which included lecture content, knowledge tested for accuracy, and demonstration-return demonstration of the necessary skills to self-manage (Bradley, 1995; Brown, 1992). This strategy may not necessarily lead to long-term adherence to diabetes regimens. Consideration of extemporaneous factors with clients, who have had diabetes for several years, may show a different result.

Jack, Liburd, Vinicor, Brody, and McBride-Murry (1999), determined that diabetic education has not considered the impact of the patient’s experiences upon their social circumstances and physical environment. They assert that diabetes education research needs to examine both traditional psychological measures such as depression, coping or stress and the environmental context that influences diabetic patients.

In their study, these authors asserted that in many diabetes education studies, interventions are inadequately defined; with no rationale given that supports a particular education methodology.
The researchers are correct with this assumption. Nursing must consider defining interventions that not only support a specific educational method, but one that includes the individual’s experiences. The researchers contend the difficulties diabetics experience when trying to learn and maintain self-management skills may be related to external conditions, which restrict responses to their self-management. Directly applicable to rural, homebound diabetics, are obstacles in their physical environment that inhibit self-management. For example, the ability to move about in a wheelchair could be confined to circumscribed areas because a ramp was not available. Nurses must consider environmental factors because these factors influence the course and outcome of a person’s disease.

A new research paradigm in diabetes education was suggested by Jack, Liburd, Vinicor, Brody, and McBride-Murry (1999). The new paradigm would focus on a public health approach aimed towards comprehensively viewing diabetic clients and their challenges with diabetes self-management. The new paradigm could be a positive influence on rural, homebound diabetics because it may increase their visibility in the medical community.

Evidenced-based recommendations to improve outcomes of older, adult education in diabetes and symptom management are needed in nursing practice. Rutledge, Donaldson, and Pravikoff (1999), reported their evidence-based recommendations of disease management education programs must be tailored to self-care management needs and capacities of the client. They believe client education is the core to disease management, and the effectiveness of educational strategies depends upon a therapeutic, collaborative level of provider and client interaction. The authors contend that the basic structure of successful, diabetes management programs is built on mobilizing the patients as active participants and collaborators in their health care. This is a worthwhile diabetes intervention that appears based in the holistic care model and applicable to the older client.

The patient and healthcare provider need to agree upon a common goal, and elements of the plan must be adapted to the patient’s lifestyle, preferences, and environment to promote patient adherence. Undoubtedly, this is a vital component of adherence. Eliciting clients’ preferences are best served by listening to the older adult describe their experiences and offering choices based on what is available and realistic.

Fundamental for consideration in the development of diabetes education programs are: content, teaching method, and person
doing the teaching. A commonality with health education content is that the health professional often provides too much detail regarding pathophysiology and too little information in the daily management of diabetes (Tripp-Reimer, Choi, Kelley, and Enslein, 2001). It is important for the nurse to access the patient’s beliefs and current practices with their diabetes, and use that information as a foundation on which to build their diabetes regimen.

Diabetes research changed from evaluating achievement of multiple outcomes such as weight loss, glucose control, and regular exercise, to increased education. It became evident from the alarming increase in complication rates that improving a person’s knowledge did not necessarily lead to behavioral changes towards effectively managing the disease (Bradley, 1995; Brown, 1992). In a meta-analysis of the literature by Brown (1992), it was determined that utilizing diverse educational strategies in teaching self-management, produced the greatest effect on knowledge level, but not on self-management outcomes such as: injection skills, glucose control, and weight loss. Brown’s (1992) meta-analysis of research into diabetes patient education, described that glycemic control was shown to be more influenced by the person’s behavior.

In a randomized control study of patient empowerment, Anderson, et al., (1995) reported that health care providers need to identify and isolate specific behaviors which are thought to contribute to glycemic control and move from the focus on cognitive outcomes to behavior outcomes. There is a need to construct and test models which represent holistic approaches to diabetes and this may generate improved outcomes for the disease.

**Method:** The Self-Care Inventory (SCI) was specifically designed for evaluation of the diabetic client’s perceptions of adherence to self-care. It is a 14-item self-report measure developed by Weinger, et.al. (2005) and colleagues in 1988 (revised, 1992) which categorizes the daily regimen tasks the client performs to manage diabetes.

The SCR-R was administered to 12 participants, 65 years of age or older, male and female, African-American and Caucasian, diabetic, homebound, rural, living alone with multiple health problems.

**Data:** The statistical program for Social Science Software (SPSS) was used to analyze the data. Descriptive statistics, frequency tables, and percentages provided limited findings due to the small sample size (N=12). Correlations based on this sample yielded, in most cases, asymmetric distributions.
Results: Findings such as: Diabetic emergency precautions p=.001 indicated participants were not wearing diabetic identification. Self-care recommendations were not closely followed: only 40% ate properly, which included snacks, 40% did not exercise, and 66.6% of clients who tested their glucose also recorded it and clients administering insulin on time=33%.

Reliability Analysis: Statistical data determined the 12-item questionnaire had 11 items with an average standard deviation (SD) =1.5 and 1 item with SD=2.1.

Outcome: The outcomes of this study suggest this population requires a different approach to diabetes self-management. Health care providers need to understand the older person’s perceptions of their diabetes before prescribing how to manage diabetic protocols that may not be followed.

The reliability analysis scale (alpha) = 0.8190 is validated by the psychometric analysis of the Self-Care Inventory-Revised (SCI-R) with adults scale at alpha= 0.87, as described by LaGreca, 2005. Reliabilities may be lower in a new sample, especially if it is small. In this study, alpha=0.819 demonstrates quality of the scale.

It is determined the SCI-R is an objective and valid predictor of perceived adherence of diabetic self-care management among adults. Unlike other tools which measure specific identifiable behaviors, this tool measures the client’s perceptions. The data from the SCI-R offers a unique insight into management of diabetes in the older population.

Nursing Implications: Replication of this study with a larger sample may provide more substantive data to generalize findings. Utilization of this tool provides nurses an opportunity to measure client’s perceptions of self-care behaviors in their diabetic regimen. This study clearly demonstrated diabetics did not wear medical identification, indicating a need for teaching.

References


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Cognitive Information Processing: its influence on the teaching and learning that is employed in both the classroom and clinical area.

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Philosophical and psychological underpinnings adopted by the teacher influence the teaching and learning that is employed in the allocated setting. Nurse educators must become familiar these underpinnings to facilitate student learning, which has mammoth implications in the provision of quality nursing care.

According to contemporary psychologists and educators, learning is viewed as a constructivist process in which the learner actively seeks and constructs information on the basis of past experience and knowledge. Therefore, teachers with this philosophy would not have students memorise by rote learning but would give them opportunities to meaningfully construct the knowledge and understanding themselves. This philosophy suggests that human beings act upon the environment rather than simply responding to it, as the behaviourists would have it. Cognitive psychologists acknowledge the role of the stimulus response theory in relation to simple forms of learning however, the complexity of the learning process is emphasised within the domains of memory, perception and thinking. In nurse education these are of fundamental importance, given that the learning process involves all three domains.

Research on memory has received enormous attention in experimental psychology, however in contrast to research on learning; memory research has had little impact on education. This is unfortunate since the value of education depends largely upon the life span of what has been learned. Therefore, many cognitive psychologists adopt an information –processing framework which is based on the computer as a metaphor for the mind, to understand how people acquire new information, how they store information and recall it from memory and how what they already know guides and determines what and how they will learn.
From a constructivist philosophy, this poster will present an assessment of the usefulness of the cognitive information processing approach in both the classroom and clinical setting, to understand how student nurses can acquire and store information and recall it from memory, with the overall aim of adapting teaching strategies to enhance deep meaningful learning.

Particular attention will be paid to one domain of learning, memory, and its two salient functions, encoding and retrieval. The process of attention will be referred to briefly. Some teaching strategies, which can influence the processing of information to enhance deep meaningful learning within nurse education, will be explored.
The process of taking care in nurse-client interaction

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Background and context
Taking care is an act of reciprocity that structures nurse’s role. Reflection on what we do and how we do it, is an act that makes possible to take into consideration our professional identity like a continuous reconstruction, essential to change and transformation. The change, consists in clarifying and specifying our mental representation.
Each nurse has her referential scheme; each one has her appropriate concept of the profession, her way to understand her role.
However, it is difficult to indicate by words the mental image that she has about her profession. Many nurses are incapable to clearly explain the nature of their contribute for health promotion. A little image demands a clear definition, which is possible with a clear presentation of the situation. That is necessary to the scientific credibility of Nursing as well as the political and social recognition.

Aim of the study
With the purpose of giving visibility to the process of taking care in nurse-client interaction, to help turning conscious the orientation of nurses practice and to allow the personal reflection of nurses on its form of taking care, an analytic case study was developed with the following objectives: “To know elements of the theoretical referential that guides nurses practice” and “To analyse nurse-client process of communication in an emergency service.”

Methodology
An analytic case study was developed in a qualitative approach, using the interaction analysis method. Eight nurses of a Portuguese emergency unit have joined to the study voluntarily. The data was collected through participant observation and semi-structured in depth interviews.

Analysis
The data where analysed through the technique of the content analysis in the word processor Microsoft Word 2000. The analysis took place through the process of Categorization after the examination of all units obtained from the meaning of the transcription interviews and of the description of the observations. In a process of constant comparison and triangulation, we constructed one codification tree, constituted by the great emergent categories of the carried out analysis.

**Summary of key findings**

Nurse’s actions correspond to the caring processes that according to SWANSON (1991) include *Knowing, Being with, Doing for, Enabling* and *Maintaining belief*. Actions like *Enabling* and *Being with* were more valued.

Enabling actions reflected nurse’s pedagogic actions and their ability to act in partnership.

Nurses *Preserve client dignity*, and manifest an *Integration Paradigm* predominant orientation, according to the importance that nurses attribute to the trust relationship, proximity and client's well-being.

In the domain of Nurses practice, nurses seem to be fit in a model that seems to have underlying conceptions, beliefs and values where the center of the intervention is the person.

They reveal agreement among *Intentions expression*, *Care practice* and *Expected outcomes* and frequently express *Feelings of Well-being* and *Satisfaction* within client interaction.

**Conclusions**

The agreement among nurses intentions expression, Care practice and expected outcomes is representative of nurse’s coherence in the expression of their actions and intentions.

Description of nurse’s practice allowed to know and understand in depth the observed reality, and underlined a need of increasing reflection spaces on health units, to help turning conscious the orientation of nurses practice and to allow nurses personal reflection on its form of taking care.

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Physiologic stability and patient comfort during varying levels of sedation in mechanically ventilated adults.

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Background: Eighty-five percent of ICU patients receive sedation to attenuate the anxiety and agitation associated with mechanical ventilation. Inappropriately high levels of sedation prolong duration of mechanical ventilation and increase ventilator associated pneumonia; low levels of sedation increase risk for self-extubation, hemodynamic instability and physical injury. Sedation scales are used to assess sedation level, however, the extent to which varying levels of sedation actually achieve the goals of physiologic stability and comfort is unknown.
Aim: To examine the effect of sedation level on sedation outcomes of physiologic stability and comfort.

Methods: Twenty-four subjects in the Medical Respiratory ICU were continuously monitoring and data recorded every 15 seconds (326 patient hours). Sedation level was measured with the Patient State Index (PSI; processed EEG), physiologic stability was documented using heart rate (HR) and respiratory rate (RR), comfort was evaluated using arm and leg actigraphy, a method to detect patient movement. All data were downloaded for analysis and the percent of time outside normal range for HR, RR and actigraphy were evaluated. Sedation level was categorized as deep (PSI < 60), mild/moderate (PSI 60-80) or awake/alert (PSI > 80).

Findings: Subjects were predominantly female (73%), with a mean age of 55, and admitted for acute respiratory failure. Subjects were identified as physiologically unstable (either HR or RR outside of normal limits) 65% of the time during deep sedation, 62% during mild/moderate sedation and 60% when alert. Percent of time of patient was moving, which may indicate discomfort, was 2% during deep sedation, 10% during mild/moderate sedation and 13% while alert.

Conclusions: Although patient movement increases as expected with less sedation, physiologic stability is not being achieved more than half the time, even with deep levels of sedation. The present methods of sedation evaluation may not adequately assess all domains of sedation efficacy.
Exploring the Role of the Public Health Nurse in the HSE Dublin Mid-Leinster (Laois/Offaly and Longford/Westmeath) Local Health Office Areas in Promoting Population Health

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Abstract

Public health nurse’s (PHNs) work in the community, their experience and relationship with primary health care and other sectors situate them strategically for contributing their skills and expertise to the promotion of population health. Health promotion has a distinctive role to play in promoting population health. It adopts a holistic approach utilizing empowerment, participative and community development methods for reaching beyond the traditional public health nursing model to engaging with the population in promoting their health. There is a dearth of literature that examines PHNs current role in promoting population health. The aim of this study was to explore the role of the public health nurse in the HSE, Dublin Mid-Leinster Area in promoting population health.

A triangulation of methods was utilised in the methodology process and involved both qualitative and quantitative approaches. A non probability sample was used. Stage one involved facilitating a focus group with eight public health nurses. Subsequently, data collected from the focus group discussion was used to formulate the questionnaire. The results of the questionnaire were then used to design the interview schedule for the semi-structured interviews. Stage two involved distributing a postal questionnaire to ninety four PHNs, a response rate of 67% (n=62) was obtained. Finally, semi-structured interviews were conducted with two PHN managers.

In the study PHNs perceived personal lifestyle and work to influence their health. Fifty nine respondents (95.2%) perceived that health promotion was an integral part of their role and a majority conform to traditional definitions of health promotion. The terms health
promotion, health education, public health and disease prevention were used interchangeably. The respondents/participants commonly sited a child health, maternal health and a disease-orientated or lifestyle approach for engaging in health promotion. Their health promotion activity usually incorporated an educational, empowering or behavioural method. Their role in promoting population health was defined as working with specific population groups both within and beyond their case loads. Thirty seven respondents (62.7%) reported that they are currently working at a population health level. Approaches utilised include; advocacy, community health initiatives, area/community profiling and multidisciplinary team working. Workload priorities, lack of time, lack of management support and feeling undervalued, were identified as barriers to the role.

Overall, PHNs had varied views about a vision for their role in promoting population health. A number of PHNs welcomed the perspective of developing new approaches to working, having more support and greater role recognition. Managerial support and team working were seen as enabling factors. Further research is recommended to clarify the skills, knowledge and attitudes that PHNs perceive are required for working at a population health level.
A Descriptive Survey of Patient’s Perceptions of Support Received from a Nurse Specialist in a Hepatitis C Treatment Clinic

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Background
Hepatitis C is a worldwide health problem with increasing numbers of individuals being infected every year. However, hepatitis C is a treatable disease but treatment comes with a multitude of adverse side effects and patients require support from specialist nurses while on treatment. To date, there is little nursing research on hepatitis C treatment and its impact on nursing care in Ireland.

Methodology
This research used a quantitative approach in the form of a descriptive survey to identify patient’s perceptions of support received from the nurse specialist in a hepatitis C treatment clinic. Data was collected by questionnaires distributed to a convenience sample of 201 hepatitis C treatment patients at a large urban general hospital.

Aims
The main aims of this study were to determine the most common side effects and support needs of patients on treatment and investigate if patients were satisfied with the support they received from the nurse specialist. Another aim was to explore the relationships between key demographics and patient’s perceptions of support in a bid to highlight future recommendations for nurse specialists to improve the support they provide for patients on hepatitis C treatment.

Findings
Findings of this study showed a response rate of 53% (n=106). The majority of respondents were young ex-intravenous drug users with genotype 3 hepatitis C who had a good response to treatment. The main side effects reported were fatigue, sleep disturbances and weight loss. Another high scoring side effect was sexual dysfunction. Overall, patients were very satisfied with the support they received from the nurse specialist in helping them cope with side effects. High scoring areas of support received included advice on contraception and education on how to maintain a healthy lifestyle. Participants were also very satisfied with the amount of...
time they had with the nurse during clinic visits. However, low scoring areas of support received included support with education on sleep management, energy conservation and management of weight loss.

Findings also showed that while there were no statistically significant differences found in relation to the demographic variables of gender, age, genotype and risk factor and the overall satisfaction with the support in the hepatitis C treatment clinic, there were statistically significant correlations found between such variables and the perceptions of support received from the nurse specialist. Genotypes 1 indicated that they need more support than other types in relation to information on; side effects of antiviral treatment, quality of life while on treatment and information on support groups available to them.

**Conclusion**

This study can be used to show how hepatitis C patients in Ireland find that the support they receive from hepatitis nurse specialists is vital in helping them to cope and comply with antiviral treatment thus, improving their quality of life. Results of this study reinforce the need for nurse specialists to evaluate their roles in order to help to improve services for this unique group of patients. Furthermore, the knowledge gained from this study can be used to design strategies to manage patients on HCV treatment, decrease the amount of non-compliance to treatment protocols, diagnose, treat and prevent side effects of treatment and improve quality of life for individuals with hepatitis C.

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ASSESSING OLDER ADULTS PERSONAL ACTIVITIES OF DAILY LIVING (ADL) DO NURSES AND DOCTORS AGREE ON SCORES OBTAINED USING A STANDARDISED ASSESSMENT TOOL?

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Background  
Accurate physical functional assessment is essential for the evaluating changes in a patient’s functional ability. The Barthel index is a widely used scale comprising of ten activities of daily living (ADL) which measures functional ability.

Aims  
The aim of this study was to explore the inter-rater reliability between doctors and nurses in scoring the Barthel index.

Methods  
A prospective quantitative exploratory study was carried out. To standardise assessment between doctors and nurses a brief training session on the Barthel index was given. The guidelines on the Barthel index were available during this study to aid interpretation of the index. The Barthel index was recorded on different occasions by 4 independent raters (2 doctors and 2 nurses) within the first 5 days of a patient’s admission. As no ‘gold standard’ exists for which to compare the ratings, nurses were compared with nurses and doctors with compared doctors. The professional group with higher intra agreement would be more indicative of the most reliable profession for recording the index. Measurements of inter rater reliability was calculated for the total scores using Bland and Altman plot.

Results  
A sample of 65 patients with a variety of medical problems and a mental test score of >7 participated in this study. The mean age of participants was 81.56 years. Intra class correlation showed good agreement in all ADL, only grooming and bathing demonstrated bias error.
Conclusion
The opportunity to objectively measure the patient’s performance permitted a higher inter rater agreement between nurses. Nurses demonstrated low inter-rater variation while there was greater variation between doctors questioning their reliability in scoring fundamental ADL. The introduction of the guidelines minimised the amount of misclassifications and standardised the method of administration of the index between doctors and nurses The results from this study lend credence to the method of observing the patients performance when assessing ADL.

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HEALTHCARE ASSISTANT EXPERIENCE: IMPLICATIONS FOR NURSE EDUCATION

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Extended Abstract

**Background:**

Today many students have dual roles of learner and worker, this phenomenon has increased due to changes in government funding and changes in socio-demographic background of students resulting in an increase in the proportion of mature aged students. Consequently in the United Kingdom, it is estimated that over 1 million students are working on a part-time basis during term in the UK (Labour Force Survey 2000). Within nursing, it is estimated that 73% of student nurses in Scotland work part time to supplement their income (RCN 2003). Part-time work for a student can lead to both negative and positive outcomes. For example, failures in academic achievement, reduced well-being and stress, financial incentives, work experience as well as improving future employability have all been cited (Ferguson & Cerinus 1996; Lee et al 1999; Curtis & Shani 2002; Neil et al 2004). Evidence suggests that many nursing students are employed as health care assistants (HCA) while in nurse training (Seccombe et al 1995; English National Board 1996; Ferguson & Cerinus 1996; Garrity 1997; Lee et al 1999). However, operating dual roles of student and HCA raises a number of professional issues, particularly with respect the influence this has on their learning and professional development. A review of the literature revealed limited research in the nursing literature in this area.

**Aim of the study:**

This paper describes part of a large study funded by the Burdett Trust investigating the influence of the healthcare assistant role on students' clinical learning. The paper outlines how part-time working as a HCA affects the professional development of student nurses.

**Methodology including research design and sampling:**

For the purpose of this study a mixed method multi-strand sequential transformative research design was adopted (Tashakkori & Teddlie 2003). In total 45 pre-registration nursing students, from first, second and third year, participated in four focus groups (n=32) and individual interviews (n=13). With permission, all qualitative data were recorded and transcribed. The transcripts were subject to content analysis, employing Miles & Humberman (1994) guidelines.

Quantitative data were collected by means of a class-room based questionnaire. Pre-registration nursing students numbered 722 when the study was being undertaken. A pilot study was undertaken with 10% of this sample (n=72) and the questionnaire revised accordingly. In total 650 pre-registration students were sent
the questionnaire. Quantitative data were analyzed using the SPSS. Ethical permission was gained from the University’s Nursing Ethics Filter Committee and consent was also obtained from senior managers in the School and Faculty.

Summary of key findings:
Results of the questionnaire revealed that over half (51% n=225) of the students had worked as HCAs and over half 55% (n=243) of those were continuing to do so whilst in full time nurse education. Respondents indicated that they had worked and were working in a variety of clinical settings, including A&E, care of the elderly, maternity, surgical and acute care. When questioned 61% per cent (n=270) of all students felt that previous HCA experience was beneficial with 40% (n=177) believing that it helped them understand aspects of their nursing course.

Interviews and focus groups provided greater insight into the perceived benefits of such work. These included supplementation of their bursaries, increased clinical confidence and enhanced clinical skills. However, the dual role of student and healthcare assistant raised several potential problems such as time for study, role conflict, role confusion and role overlap. For example, students with HCA experience believed that they were already competent in undertaking basic patient care duties and therefore did not need to be taught this as part of their nurse training. Moreover the lack of role boundaries resulted in many students falling automatically into the HCA role whilst on placement. This resulted in link lecturers, mentors and/or ward managers reminding students that they were training to be a nurse and not an HCA.

Conclusions:
This study confirms that students are working as HCAs in a part time capacity. Responses indicate a mixture of both positive and negative effects of student nurses being employed simultaneously as HCAs. This study confirms earlier findings, on the motivating factors of part time work among nursing students (Lee et al 1999; Ford et al 1995; Seccombe et al 1995). Whilst this was a small scale exploratory investigation, involving one time-point and one institution, the study’s findings raises questions for those involved in nurse education and stimulates debate and ideas for further investigation.
References


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Evidenced-Based Nursing Practice Outcomes in Prevention of Ventilator Associated Pneumonia

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Background and context
Ventilator-associated pneumonia (VAP) is a nosocomial infection in critically ill patients who receive mechanical ventilation. Nosocomial pneumonia is the second most common hospital-acquired infection. VAP occurs forty-eight hours or more after intubation – largely due to the tube bypassing the lungs normal protection mechanisms. With its high morbidity rate; increased length of stay; prolonged mechanical ventilation; and increase in costs, interventions are essential in impacting the care and outcomes of these patients. The incidence rate of VAP can be as high as 65% and a mortality rate up to 71%. The risk for death increases by 4.3 times compared to patients in the intensive care unit (ICU) without pneumonia. In the United States alone, VAP results in yearly expenditures of approximately $1.5 million with an outstanding 1.75 million additional hospital days per year. The Center for Disease Control and Prevention states that the median rate per thousand ventilator days was 14.7 in trauma ICU’s and the patient had a greater risk by 6 to 21 times in developing pneumonia than those patients not ventilated. Therefore prevention of VAP must be regarded as one of the most important issues in critical care, and it has already become one of the core ICU performance measures proposed by the Intensive Care Advisory Panel of the Joint Commission on Accreditation of Healthcare Organizations.

The significance of preventing VAP is to improve patient care, improve outcomes, and decrease incidence rates. The Institute for Healthcare Improvement (IHI) has started a campaign to nationally improve patient care and prevent avoidable deaths in ventilated patients as a part of the 100,000 Lives Campaign.

Clinical practice guidelines which have been proven to decrease the incidence of VAP include basic hand washing, oral care, daily sedative interruption, assessment of readiness to extubate, semi-recumbent positioning, deep vein thrombosis and peptic ulcer
prophylaxis, avoidance of unplanned extubation, and avoidance of gastric over distention. Prevention of VAP is the focus applied to critical care nurses utilizing evidenced based practice. Proper use of these nursing interventions can facilitate an environment of optimal wellness for the critically ill patient.

Aim of the study
This study investigated the benefits of nursing practice outcomes in the prevention of ventilator associated pneumonia and understanding how nursing interventions exemplify the importance of evidenced based research in nursing practice.

Methodology including research design and sampling
Design: Quantitative: Descriptive, Longitudinal
Sampling was obtained from mechanically ventilated adult patients within the Intensive Care Unit. Inclusion criteria included all ethnicities, male and female, intubations originating in ICU, operating room, acute care, and emergency department. Exclusion criteria included preexisting pneumonia prior to intubation confirmed on X-Ray.
Data collection started in 1998 and continues through 2007.

Analysis
Ventilator associated pneumonia was entirely eliminated in the Intensive Care Unit during this descriptive, longitudinal study. Nursing interventions that integrated oral care, hand washing, and the “ventilator bundle,” which included: elevation of head of bed, sedation vacation, peptic ulcer and deep vein thrombosis prophylaxis, were major contributing factors to this outcome. These interventions have continued to prevent VAP for two consecutive years.

Also contributing to the study’s success were recommendations implemented from Institute for Healthcare Improvement, Centers for Disease Control, and extensive literature reviews.

Summary of key findings
From January 1998 until March 2005 there was an average of 38.4 VAP per 1,000 ventilator days. Nursing interventions that integrated oral care, hand washing, and the “ventilator bundle,” which included: elevation of head of bed, sedation vacation, peptic ulcer and deep vein thrombosis prophylaxis. As a result of these interventions, which have continued to prevent VAP for more than 2 consecutive years, there has been no documented ventilator assisted pneumonia from April 2005 until July 2007.
Conclusion
Implementations of nursing interventions help prevent ventilator-associated pneumonia. Data supports a collaborative approach to patient care. Current research, which identified best practice strategies, evaluated efficacy, and recommended the best evidenced-based guidelines, provided the focus for this study.

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Preceptorship: A comparison of responses from preceptors and student nurses.

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Background and Context:
The allocation of student nurses to the clinical placement area is an integral part and major component of the curriculum for the undergraduate Bachelor of Science Degree (BSc.) in Nursing. While on placement each student should be assigned a named preceptor. A preceptor is a registered nurse who has been prepared for their role by completing a Teaching, Assessing/ Preceptorship programme.

Aim of the Study:
The original study evaluated teaching, assessing and preceptorship programmes. The intention of this paper is to report on one aspect of this study which explores preceptor characteristics through a structured comparison of responses from key stakeholder groups of preceptors and student nurses.

Methodology:
A formative utilisation focussed evaluation approach was adopted. This approach values the opinions and experiences of stakeholders.

A sequential triangulation approach was implemented:
- Phase 1:
  - (a) documentary analysis
  - (b) focus group interviews.
- Phase 2: questionnaire formulation, distribution and analysis.

Sample:
• Phase 1:
  o (a) All end of programme evaluation forms (520) over a three year period
  o (b) Convenience sample (24)

• Phase 2:
  o The sample for questionnaire distribution represented a total population of 568 preceptors and 310 students from the programme area being evaluated.

Analysis:
Phase 1: Thematic analysis

Phase 2: Descriptive analysis carried out using SPSS version 14.0.

Summary of Key Findings:
The characteristics of a preceptor from an Irish perspective were explored. Student and preceptor comments were compared. Close agreement regarding important preceptor characteristics were highlighted. Key differences regarding the perception of preceptor demonstration of these characteristics were identified.

Conclusion:
Preceptors play an invaluable role in nurse education. An understanding what student nurses’ view as important and how this reflects or differs from the perception of the preceptor will assist in developing preceptorship in the clinical learning environment.
Stress and Coping Strategies of Adults in Accelerated Nursing Programs

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Currently there are 168 Accelerated Nursing Programs in USA representing the fastest growing type of program leading to RN licensure. Students must complete all pre-requisites before enrolment.

Candidates Either Hold Degrees in Other Fields OR are Honor Students in Top 10% of Class. They meet the same Student Learning Outcomes, experience the same class and clinical hours as traditional nursing students, but it is delivered in half the time. Class and clinical hours are doubled each week.

Adult students in Accelerated Nursing Programs come from varied backgrounds: Music Teacher, Elementary Teacher/Math Teacher, College Basketball Coach, Caterer, Bank President/Insurance Executive, Chiropractor Veterinarian, Social Worker, Biologist/Toxicologist/Chemist, Human Development Specialist, Emergency Medical Technician/Paramedic, Central Supply Manager, Athletic Trainer, Long Term Care Administrator, Farmer.

These students are struck by the complexity of nursing.

Health care is 20 times more complex than business or industry. A nurse must perform 74 separate functions, whereas most other professions routinely perform around 15-20.
Murphy, Ruch, Pepicello & Murphy (1997).

Condensed learning increases stress which may impede learning; could interfere with critical thinking; and will influence clinical performance.
(Youssef, Goodrich, 1996)
Condensed learning also increases recall resulting in better pass rates on RN licensure exam and better application of sciences into nursing practice.

The purposes of this study were to discover major stressors and their intensity, determine helpful coping strategies to deal with stressors, identify unhelpful coping strategies, and design effective interventions and support systems to help students cope with stress of accelerated program.

Literature on accelerated nursing students’ stress was lacking. Baccalaureate student stress has been studied for such factors as clinical experiences (Admi, 1997), clinical instructors (Oermann, 1998), heavy workload (Mahat, 1998), medication errors (Oermann, Lukomski, 2001), massive amounts of information (Oermann, Lukomski, 2001), personal chaos (Shipton, 2002), and environmental, financial, interpersonal factors (Kirkland, 1998).

The study design was descriptive survey of major stressors and coping strategies of Accelerated Student Nurses. Subjects consisted of 137 accelerated nursing students enrolled in six Accelerated BS Programs, 3 Public, 3 Private. They were in their last 12 weeks of a 12 month Accelerated Program. The tool was a survey that identified major stressors & their causes, rated the intensity of stress during the program on a 1-5 scale. The COPE Scales (Carver, Scheier, & Weintrau, 1989) were used to rate helpfulness of categories of coping strategies using a rating of 1-5.

Students reported the intensity of stressors during their enrollment in the accelerated nursing program as

<table>
<thead>
<tr>
<th>Stress Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Extreme</td>
<td>24</td>
<td>17.5%</td>
</tr>
<tr>
<td>4. Extensive</td>
<td>60</td>
<td>43.8%</td>
</tr>
<tr>
<td>3. Moderate</td>
<td>45</td>
<td>32.8%</td>
</tr>
<tr>
<td>2. Slight</td>
<td>5</td>
<td>3.6%</td>
</tr>
<tr>
<td>1. Negligible</td>
<td>2</td>
<td>1.5%</td>
</tr>
<tr>
<td>0. None</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

The mean stress intensity was 3.73 extensive.

Most helpful coping strategies were found to be turning to religion and seeking social support for emotional reasons. Least helpful coping strategies were denial, behavioral disengagement and alcohol abuse.

Students offered suggestions for future accelerated students that focused on organizational skills, building and keeping a social support network and focusing on the goal.
A safe learning environment is essential for accelerated nursing students. Such an environment would include trust & honesty, clear expectations, confidence in student abilities, accessibility, listening, and relationships.

Summary
Preparing for a nursing career is a major life transition. Students are between trapeze bars-hanging in midair. Faculty must provide a safety net to optimize this experience and foster learning.

References
A Grounded Theory of the Role of the Directors of Nursing in Band One Teaching Hospitals in Ireland

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It is commonly believed that concepts of power, authority and influence are synonymous. Luthans (1992) suggests that power and authority are separate but related concepts. He identifies power as the ability to get an individual or group to do something, while authority gives the person attempting to wield the power legitimacy and is actually a source of power. Unlike authority, power is not always nor does it need to be legitimate.

A grounded theory methodology was used to explore the role of a sample of the Directors of Nursing in the Band One Teaching Hospitals in Ireland. In-depth interviews were held with eleven Directors of Nursing.

A grounded theory of ‘Powerless Responsibility’ was identified. The level of responsibility for keeping the hospital functioning is not commensurate with the level of influence and/or power that Directors of Nursing exert. Directors of Nursing in Band One Hospitals in Ireland have responsibility for patient welfare and for keeping the hospital functioning safely, but have very few opportunities to influence the strategic direction of the hospital or the wider health care system. All of this occurs against a backdrop of working within a health service that is undergoing major structural reforms (Health Service Reform Programme 2004) and which has been identified as being ‘systemically maladministered’ (Travers 2005).

The study contributes to the body of knowledge about the role of the Directors of Nursing in Ireland in Band One hospitals, by helping to identify their position of Powerless Responsibility. The substantive theory indicates that Directors of Nursing need to understand power dynamics before they can successfully challenge the status quo. If nursing is to overcome its fixation with repressive power and begin to deconstruct nursing as an apolitical and powerless profession, self awareness of the history of the nursing profession within a feminist and sociological context must occur.
Insulin Glargine versus NPH Insulin for the Management of Pre-existing Diabetes in Pregnancy

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Insulin therapy becomes an integral part of management for women with pre-existing diabetes and pregnancy. Tight glycemic control can be attained with multiple daily injections of human insulin. Conventional therapy (NPH) may result in frequent hypoglycemic events with rebounding hyperglycemia. Serum ketosis may develop having a deleterious impact upon both mother and fetus. This study addressed the use of Glargine insulin (a recombinant human insulin analog) in pregnancy.

To date there is limited research and no well controlled clinical studies in the use of Glargine insulin in pregnancy as well as the lack of FDA approval. Therefore many practices are hesitant to have patients continue on the analog. Usually women are converted back to conventional therapy (NPH) which leads to a period of suboptimal control. During this period of hyperglycemia there is increased risk for perinatal complications. The lack of safety data (in the continued use of Glargine) usually becomes a clinical decision by the provider.

This study assessed a matched cohort of pregnant women with either type 1 diabetes or type 2 diabetes who chose to remain on Glargine insulin versus those women with either type 1 diabetes or type 2 diabetes who chose to remain or opted to switch to NPH insulin during their pregnancies. The purpose of the study was to evaluate the frequency of hypoglycemic events, the over all glycemic control of women in both groups, the incidence of perinatal complications as well as the incidence of neonatal complications.

It was proposed that glycemic control would be as good in those women who chose to remain on Glargine insulin versus the glycemic control of those women who chose conventional therapy (NPH). The rate of fetal /neonatal complications such as neural tube defects, cardiac anomalies, macrosomia, respiratory distress syndrome, neonatal hypoglycemia, and hyperbilirubinemia would be no greater in the offspring of those women who chose to remain on Glargine insulin Versus the offspring of those women on conventional therapy (NPH).
The study design was quantitative research applying ANNOVA. The setting was a Diabetes Center, in southern Maine. The sample consisted of 51 women (with either pre-existing type 1 diabetes or type 2 diabetes). Women were informed at their first office appointment of the FDA status regarding Glargine insulin in pregnancy. They were offered the option of staying on the analog or switching to a conventional therapy using NPH insulin. Notations were made in the charts recording the woman’s understanding of both therapies. Data were collected from clinical visits and hospital records.

Women in both groups were equally educated in SMBG and target ranges, meal planning (carbohydrate counting), exercise regimens (unless restricted by their OB provider) and stress reduction. They were expected to keep logs for glucose levels and food diaries.

The study findings concluded that HbA1c values for women on Glargine insulin equaled 6.42% while the women on conventional therapy (NPH) equaled 7.15%. Hypoglycemic events defined by a finger stick of less than 60mg/dl, was noted at 29% for the Glargine insulin group versus 30% for the conventional therapy (NPH). The causes for hypoglycemia were similar in both groups (over compensation for elevated values, miscalculation of carbohydrates, and hyperemesis). Perinatal complications included fewer SAB, lack of retinal changes and PTL in the Glargine insulin group. PIH was similar in both groups. In the Glargine group, 89% delivered at term gestation with less NICU interaction while in the conventional group 50% delivered at term with longer NICU stays.

The findings of this limited case study concluded that women on the Glargine regimen had as good as, if not better glycemic control than the conventional therapy (NPH). Hypoglycemic episodes were similar however none needing EMT assistance in the Glargine insulin group. Perinatal complications were less regarding retinopathy and pre-term delivery and there were fewer incidences of neonatal complications in the Glargine insulin group.

It is therefore recommended, that ongoing clinical trials are needed to define the efficacy and safety of Glargine insulin in pregnancy as well as the continued assessment of the offspring of these women for developmental issues during the first 5 years of life.
The Role of Simulation in Nurse Education

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The aim of this literature review is to examine research into the use of simulation in the Clinical Skills Laboratory. A comprehensive search strategy was conducted using CINAHL, Blackwell Synergy and MEDLINE. Keywords such as “simulation”, “simulated learning”, “skills learning” retrieved substantial nursing and medical research into this topic. Analysing the research highlighted three main areas of simulation under which to examine the area of simulation in nurse education. These are: Simulated Models; Standardised Patients and Computer-Based Simulation.

Simulated models can be classified as low, moderate or high fidelity which depends on their semblance to reality. Many of the studies examined found that their use develops critical thinking, self-assessment and confidence for practice. However, they also highlight some of the disadvantages which include anxiety and the modification of behaviour.

Standardised Patients (SPs) involves the use of real people coached to ‘act’ as real patients. In addition to the advantages highlighted in relation to the use of models, the research found the use of SPs useful for improving communication skills. However, there is a question over the reliability of the feedback that the SPs provide and some of the research has examined ways of trying to overcome this.

Finally, computer-based simulation is an evidence based way of learning that can be accessed outside of classroom hours. There is a question as to how it can actually improve the ability to
demonstrate a skill. However, this is dependent on the level of authenticity of the computer package and high-authenticity virtual learning packages have been developed in the UK.

Overall, this literature review should give an insight into the diversity and flexibility of this approach to skills learning and address some of the challenges to implementing simulated learning in the Clinical Skills Laboratory.

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Use of literature in nursing education: implications for BSN and BPN programs

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This paper will discuss how nursing can and should benefit from association with and access to Liberal Arts in a university environment. In Canada, nursing education finds itself in a decade long transition that has moved it from a diploma, technically based program into the realm of undergraduate, graduate and doctoral university preparation for professional nursing. Focus has tended to be on technical nursing despite attempts to incorporate a caring curriculum and holistic framework based on phenomenology and the human experience underlying health, wellness and illness. Finding itself within the university environment, nurse educators are called to re-examine their roles as part of the entire university fabric. This paper suggests this has not been entirely embraced by nurse-educators who have yet to value or appreciate the contributions of including liberal arts in the nursing curriculum with more emphasis. A literature review will provide support for the inclusion of literature into the nursing curriculum. The paper will provide an example of innovative practice in teaching and learning through the nursing programs at Kwantlen University College, BC. Finally, recommendations for transdisciplinary collaboration between nursing and liberal arts in course design and semester planning will be presented.

Key words: literature in nursing; liberal arts in nursing; innovate practices in nursing education
Daring to be different: creating curriculum for a 21st century undergraduate psychiatric nursing degree

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Abstract:

Registered Psychiatric Nursing is a proud career in Canada, existing as a unique profession for more than 75 years. Even so, it struggles to maintain its identity and its uniqueness as a profession in the realm of nursing. In recent years, undergraduate and graduate degrees in Psychiatric Nursing have been realized. This paper will discuss the development of the Bachelor of Psychiatric Nursing (2006) degree at Kwantlen University College in the Province of British Columbia, Canada. It will focus on the challenges faced by the BPN development team as they broke free of the constraints of traditional design for undergraduate psychiatric nursing and general nursing. It will describe the philosophy, concepts and approach to creating something new: a curriculum with vision for the 21st century psychiatric nurse.

Key words: Psychiatric Nursing, nursing education, degree development, RPNs
Are the terms forensic nurse and forensic psychiatric nurse interchangeable? No. This paper takes the position that forensic psychiatric nursing is a unique field and by this answers the question, ‘what differentiates this nurse from others’? A systematic review of literature on the subject of forensic psychiatric nurses is sparse, although mixed amongst articles on forensic nursing and forensic psychiatric nursing, there seems to be some common agreement: there is such a thing as a forensic psychiatric nurse. A good deal of confusion about prevails about the description of what this means. Some say that forensic psychiatric nursing is a subset of nursing and not a specialty at all: others that it is simply a subset of nursing in general, and again not a specialty. Still others assert that forensic psychiatric nursing is a specialized subset of psychiatric-mental health nursing. The writer concurs. This paper will also answer the question: ‘if forensic psychiatric nursing is a psychiatric nursing specialty, what special training or education does this nurse require?’ The writer will describe the roles and responsibilities of a forensic psychiatric nurse, differentiate him/her from other nurses, and then identify key components of curricula that need to be addressed by nurse-educators.

Key words: forensic psychiatric nursing, forensic nursing, correctional nursing, nursing education, criminal justice, mental health, nursing specialty, mental health/psychiatric nursing
An Exploration of the Concept of Pain Perception in Elders with Dementia

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Key Words:
Pain, pain perception, dementia, cognitive impairment

AIM: The aim of this paper is to a) describe the concept of pain perception in elders with dementia; b) apply Morse's Method of Critical Analysis of the Literature to pain perception in elders with dementia c) explore the application of the findings to increase the pragmatic utility of the concept of pain perception in elders with dementia for further research and concept advancement.

Search and Review Methodology: Morse's method of critical appraisal of the literature was used. Data was retrieved from CINHAL, AgeLine, Blackwell Synergy, ERIC, and several online dictionaries.

Analysis: Data was selected from the fields of nursing, medicine, psychology, sociology, and philosophy. 2,125 articles were retrieved, 83 articles were reviewed in depth, and an analysis was conducted of 46 articles specific to pain perception in the elder population with dementia.

Summary of Key Findings: The inquiry into the concept of pain perception revealed some confusion in the context of the cognitively impaired population and those who care for them. Often, the terms pain and pain perception were used interchangeably which may add to the confusion. An interdisciplinary understanding of the concept of pain perception in elders with dementia is essential in order to guide the research and identify strategies to provide comfort to all who experience pain, regardless of their cognitive status.

Conclusion: Concept analysis of the perception of pain in elders with dementia is necessary to clarify the confusion that ensued as a result of the phenomena of the "parallel concept" of pain perception in various disciplines. In order to understand and advance the concept in the context of dementia, it is essential to merge the most coherent commonalities from each discipline in order to expand the
interdisciplinary conceptual definition and guide the course of further inquiry.

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http://www.mw.com/dictionary/perception

Book review.


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An exploratory descriptive study of: Registered Nurses’ experiences of delivering oncology shared care in a paediatric unit in the Republic of Ireland.

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Background and context  
This study was undertaken in one of the sixteen-paediatric units, which delivers oncology shared care in the Republic of Ireland.  

Shared care has been defined as care which applies when the responsibility for the healthcare of the patient is shared between individuals or teams who are part of separate healthcare organizations or where substantial organizational boundaries exit (Pritchard and Hughes, 1995). Shared care was initiated in Ireland in the 1980’s for children who were at a palliative care stage in their oncology treatment to reduce the number of journeys children and families had to make to the specialist centres. Over the years the service has dramatically expanded and children are regularly admitted to paediatric units in General Hospitals throughout the country. Although shared care was initiated originally for children receiving palliative care shared care has now extended to children receiving treatment in the acute phase of their illness. However shared care has never been formally evaluated and indeed there are no studies investigating the experiences of nurses delivering shared care in the paediatric units throughout the country.
Aim of the study
The aim of this study is to explore Registered Nurses’ experiences of delivering oncology shared care in a paediatric unit in the Republic of Ireland.

Research design
A qualitative research methodology was chosen as the most appropriate means of achieving the purpose of this research study.

Sampling method
A study of the total population of nurses working in all paediatric units in the Republic of Ireland was desirable, but due to time limitations this was not feasible. Therefore the researcher carried out this research in a sample of one paediatric unit. The researcher accessed all of the nurses with one-year experience working in the paediatric unit through purposive sampling and voluntary participation.

Data collection
Data was collected by means of eight individual semi-structured interviews, which were conducted by the researcher.

Data analysis
Data was analyzed using procedures adapted from Colaizzi’s (1978) method of data analysis. Thematic analysis was then used. The themes and concepts highlighted in the findings are reflective of published research in the field although nurses’ experiences of delivering oncology shared care in a paediatric unit have not received the same attention in the literature.

Summary of key findings
The participants identified the following key issues;

- Their desire for additional education.
- Their lack of knowledge on current treatments which are carried out in the specialist centres.
- The need for support for staff when caring for very ill children.
- The need for more effective communication between the shared care centres and the specialist centre.
- The participants also highlighted that the level of responsibility had greatly increased as a result of the change in structure in shared care.
**Conclusion**

This study unique within the Irish context has provided insights into the current delivery of shared care practices in paediatric units in the Republic of Ireland. The experiences of the nurses interviewed in this study provide useful insights for nurses in practice, education and administration. Although the findings of this study cannot be generalized to a wider population, the findings will be of great benefit to the service in which the study was conducted. It is hoped that this research will act as a catalyst for discussion and debate about the issues relating to oncology shared care. It is envisaged that the knowledge generated from this study could be used to make recommendations to maintain and develop shared care in the Republic of Ireland.

**References**


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AN EXPLORATION OF ICU NURSES PERCEPTIONS AND EXPERIENCES OF PROVIDING END OF LIFE CARE

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Literature Review: According to the International Council of Nurses (2000) the primary responsibility of nurses is to provide good end of life care for their patients. E.O.L.C. is a topic that appears frequently in nursing literature but is never defined. Intensive care nurses are concerned with the quality of dying, human relationships and being a good advocate for their patient (Beland and Froman, 1995). A good death was defined by the Institute of American Medicine (1997:4) as:

“one that is free from avoidable distress and suffering for patients, families and caregivers; in general accord with patients’ and families’ wishes; and reasonably consistent with clinical, cultural and ethical standards.”

Several authors have defined what a ‘good’, ‘quality’ or ‘peaceful’ death is (Asch et al, 1997; Rittman, Rivera, and Godown, 1997; Steinhauser et al, 2000 and Yang and Mcilfatrick, 2001) even though it appears, neither has suggested how to provide good E.O.L.C. in ICUs.

Recent research shows that care of the dying patient receives poor attention in nursing degree programmes and in ICU course curriculum and only recently has published articles in critical care literature (Nelson-Marten, Braaten and English, 2001). According to Moss et al (2005) it can be difficult for professionals who have been educated in the intensive care behaviour of saving lives, to aid patients to die comfortably. Chapple (1999) suggested the reasons that E.O.L.C. in the ICU is so difficult are because the healthcare team do not have proper guidelines and protocols. The ICU has a standard of care for almost any clinical diagnosis, procedure or emergency response however for E.O.L.C. standardised protocols and policies have not been adopted.

As mentioned in the previous chapter there are many discrepancies in the literature with E.O.L.C. These include family dynamics, cultural differences, ethical problems and poor pain management.
Nurses Stress was a common factor in the literature in relation to E.O.L.C.

After reading through the literature the reality is that patients and their families who experience a good death in ICU are infrequent. The literature presented several issues of concern for patients, their families and health care workers for E.O.L.C. The mains ones highlighted were family dynamics, cultural differences, ethical problems and poor pain management. Family dynamics change in the ICU. Families that normally would be united and calm can be torn apart by the care of their dying loved ones. The literature suggests that poor communication between patient, families and medical staff can be the cause of unnecessary conflict. However other literature states that nurses can be the positive light in communicating between patient, family and doctors (Jamerson, Scheibmeir and Bott, 1996).

The literature acknowledges the need for cultural awareness in order to help with the care of dying patients (Le Var, 1998; Giger and Davidhizar, 1999 and ERHA, 2003). Education and training is important in this area although Joye (2003) stated that in Ireland this has been introduced recently in the nursing curriculum. There is a large percentage of the literature regarding E.O.L.C. which pertains to ethical issues. Chelluri and Grenvik (1995) identified nurses find ethical decisions difficult to make, as they were educated to use the necessary treatment to prolong life. Although Scanlon (1997) had stipulated that nurses have helped to solve these issues and give holistic E.O.L.C. According to the literature, pain management was highlighted as one important factor in providing good E.O.L.C. (Rocker and Dunbar, 2000), although it still remains poorly managed. The literature also shows how dealing with E.O.L.C. in ICU can cause stress and burnout for nurses. Despite the prevalence of E.O.L.C. literature, there is a lack of research specifically related to experiences and perceptions of intensive care nurses in this area. The researcher believes a better understanding of ICU nurses experiences and perceptions of their knowledge, beliefs and ethical concerns relating to practices in caring for dying ICU patients is essential in order to improve nursing practice in ICUs. Due to this challenge and the need to improve treatment of dying ICU patients this study was undertaken to assess the knowledge, expertise and thoughts that ICU nurses, working in the researchers ICU, have in regard to changes that would facilitate appropriate end of life care.
**Methodology:** The purpose of this descriptive qualitative study was to examine the experiences and perceptions of ICU nurses who had cared for patients at the end of life. The research method implemented was a qualitative research approach. Qualitative research approaches are centred on a holistic view of the world (Burns and Grove, 1997). The researcher for the purpose of this study followed the naturalistic inquiry that allowed the phenomenon to develop itself as if it was not being researched. Qualitative descriptive studies are normally the least “theoretical” of the qualitative methods. A Theoretical framework based on my literature review was used as the framework for this research. A purposive method of sampling was used to select participants. Parahoo (1997) stated that this is a method where the researcher chooses who to participate in the study in order to present the correct data. The researcher chose this method in order to use the best accessible nurses to provide data on the topic being researched. The selection of participants for this research was the result of specific guidelines set by the researcher. Twenty Nurses expressed an interest in partaking in the study. However, six participants withdrew from partaking in the study before it commenced due to personal reasons. Therefore fourteen ICU nurses out of a possible twenty agreed to participate.

Within this study, the data was collected using semi-structured interviews guided by open-ended questions. This study aimed to reveal nurse’s experiences, knowledge and thoughts on E.O.L.C. in ICU. The researcher wanted to be sure that all the information required on the specific topic was covered in this qualitative study so semi-structured interviews were employed. Semi-structured interviews ensure that researchers obtain all the information needed and allows participants the freedom to answer in their own words, providing as much detail as they wish (Polit and Beck, 2004). The open-ended interview questions were created by the researcher, which progressed from general to more specific inquiries. The structure of each question was guided by the theoretical framework of the phenomena E.O.L.C. The researcher carried out a pilot study using the semi-structured interview guide on two participants before commencing the core research. This was to practice the researchers interviewing skills, interview tool and data collection method. This helped to highlight any weaknesses in the design of the study before the major research began. The fourteen interviews took place in a private tutorial room off the ICU dept, which was distanced from the working environment. Observational notations were made post each interview for the purpose of data analysis. Verbal and non-verbal communication is a complex process consisting of two main components i.e. what is being communicated (essence) and how it is done (the exchange) according to Routasalo.
(1999). The researcher transcribed the interviews verbatim within two days of each interview for further review of the data collected. The interviews took place over an 8 week period.

The researcher chose to follow some of Lincoln and Guba (1985) ideas about trustworthiness to enhance the rigour, including Credibility, Dependability and Confirmability. However Guba and Lincoln (1989) expressed reservations about their own criteria and felt they relied too heavily on positivist assumptions and added the concept of authenticity, which was also included. The researcher felt it was necessary to include the concept of reflexivity within this study. Member Checking or validity check: as suggested by Green and Thorogood (2004) involves taking the findings back to the participants and guaranteeing that they agree. The researcher carried out member checking with the agreement of the participants. Lincoln and Guba (1985), Burnard (1991), Ashworth (1993), Holloway and Wheeler (1996) and Slevin and Sines (2000) consider it one of the most robust ways of promising truth and consistency in qualitative research. Peer Debriefing: is where another researcher is asked to verify the codes or analysis the data to ensure they would obtain similar themes. The researcher had a very experienced ICU qualitative health researcher, to peer debrief the themes. The researcher has a complete record of the decisions completed before and during the study and an explanation of the research process. There are many ethical considerations to take into account when carrying out research. These include autonomy of participants, protection of participants (nonmaleficence, beneficence and justice) and ethical approval in order to perform the research.

**Findings:** In conclusion the findings of the study were extremely interesting. While each participant had their own view on what the term E.O.L.C. was there were common themes which emerged from their responses. The nurses talked about what factors facilitated good E.O.L.C.: “peaceful passage”, “good communication”, “having a specific plan of care”, “experience/education”, “family present”, “continuity of care”, “good support”, “organ donation” and “personal experience of losing someone”. The participants also highlighted the barriers to a patient receiving good E.O.L.C.: “poor communication”, “no support”, “disregarding patient/ family wishes”, “types of death”, “poor family dynamics”, “hi-tech stuff”, “pushing things”, “no guidance”, “inexperiance” and “dying in pain”. Looking after the family was addressed by every participant. The nurses described how stress was caused by several factors, the ways they coped and supportive measures available in ICU and what could be introduced to relieve some stressors. Finally the participants expressed concerns about medical and nursing ethical and legal issues for E.O.L.C.
Recommendations for Practice:

- **Implementation of an ICU Policy and Patient Care Pathway**

  The participants highlighted the need for implementing a policy for E.O.L.C. and the development of a patients E.O.L.C. pathway in ICU, in collaboration with the Palliative care team of the hospital. These would empower doctors and nurses to provide high quality E.O.L.C. to patients and their relatives.

- **Increased Consultation with Nursing Staff, Patients and Families**

  Better communication within ICU between patients, relatives and the multi-disciplinary team. Daily discussions with the patient and their family about care and their wishes. Improving communication with nurses on the morning rounds. This will ensure they are aware of any new developments and can give their views on any E.O.L.C. decisions made. This could facilitate better E.O.L.C. for the patient, family and the multi-disciplinary team.

- **Facilitating daily discussion and decisions on patient status**

  Introducing new documentation in the patient’s chart and E.O.L.C. Pathway to chart the patients status e.g. DNR order or not for ventilation, on a daily basis. This will make the multi-disciplinary team more aware of the status and wishes of patients in the event of an emergency or after the hours of business during the week and especially the weekends.

- **Consider introducing the Palliative Care team for Consultation on patients**

  As stated by the participants in this study, involving palliative care in E.O.L.C. in ICU can only be an asset to the patient and the multi-disciplinary team as they are experts in their field. A member of ICU staff could be appointed to liaise with the palliative care team in difficult situations or as the need arose. They could also give in-service on the needs of the dying patient and their family and suggest available courses that may help staff with issues on palliative E.O.L.C.
Facilitating debriefing sessions, results of post-mortems and attending removal masses in the hospital

These issues were addressed by several participants in the study about how to help them cope with stressors of E.O.L.C. Commencing debriefing sessions on a regular basis, for all staff for 10 minute sessions may provide the necessary emotional support that participants reveal are lacking. Also if requested by the staff, the results of post-mortems should be made available to staff during these sessions. Finally if nurses want to attend removal masses this should be offered if staffing levels are sufficient on that day within ICU.

Develop alternative counselling service for staff

During the interviews participants mentioned that there was no other counselling service offered to them except pastoral care counselling which they all seem to decline even when needed. However the researcher is aware of the availability of an alternative confidential counselling service arranged through the hospital occupational health dept for staff use and this should be made a permanent fixture for ICU staff.
The relation/experiences between mother and premature children, during their first year.

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Background and context
The confrontation with the prematurity of a child demands, always, a period of adaptation that must be helped and guided, in the scope of promoting the best conditions to improve the capacity of communication between mother and child. This support will gain greater success if the health professionals know and understand, in a particular way, the maternal experiences related to the prematurity of the children.

Aim of the study
Being aware of this idea, we planned as main objective of our study, to know the maternal experiences with premature children during the first year of life, whose contribute will enrich the quality of our professional activity. The main purposes of this study follow:

- To program preventive strategies and of precocious intervention, adjusted to each premature child/mother
- To contribute for the enrichment of the field of scientific knowledge in the area of taking care of the premature child/mother.
- To contribute for the personalized development of the quality of the health services given to the premature child and to his mother.

Methodology
This study has a qualitative paradigm and an exploratory and descriptive approach, it has the foremost purpose of knowing the relation/experiences between mother and premature children, during their first year. Ten mothers with premature children born in 2001 in the “Região Autonoma da Madeira” volunteered to this study. These children are attended in the Children Development Center Dr. Óscar de Brito. The data were obtained threw semi structured interviews, that were taped and assisted with information’s analysis.

Analysis
The data were analyzed through the technique of the content analysis in the word processor Microsoft Word 2000. The analysis took place through one process of categorization after the examination of all obtained from the meaning of the interviews transcription. We constructed one codification tree, constituted by the great emergent categories of the carried out analysis.

Conclusions
From the main conclusions we mention: In the feelings/emotions category we determined that in 26 subcategories, fear was the most present feeling in mothers with premature children, while the children were still in hospital, in the other hand, satisfaction and hope were the most frequent feelings after the hospital discharge of their children. In the adaptation category we verified that acceptation is the most present subcategory present in the mother, with a variable period of time, depending on her personality and other circumstances that involved the child’s birth. In the category/organically alterations, we point out the pain was experienced by the majority of mothers, in the pre and pos delivery discomfort. In the auto knowledge category, the most referred category was learning of life importance. In the beliefs category most referred experience was the religious experience, which was felt by many mothers in any point of their lives. In the difficulty category, many mothers pointed out as their bigger difficulty the conciliation between motherhood and professional activity. The family interaction category, presented has most referred experience support, with a special mention to families and health institutions support. To conclude we refer to the bondage category, in this category mother/child bond has a primordial importance with nine enumerations units.

The results of this study allowed us to know and understand the perception that mothers have when are confronted with the prematurity of their children. Each child is born with its proper abilities, potentially incalculable, that need to be discovered and understood, from a new model of intervention applicable either in the primary care or in the day to day clinical practice. Not supporting the process of familiar genesis it is the same as to give a hand to stress and to the inefficacy of strategies. Removing the aid to the family and the baby, mainly when they live an experience of anguish and fear with the birth of a different child, we are failing in the discovery of the abilities and potential capacities of the diade baby/family.

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WINNICOTT, Donald (1986) – Communication between infant and mother and infant, compared and contrasted. In Babies and Mother, Massachussets: Addison-Wesley, Reading.
An evaluation of the new role of nurse prescriber within an acute care NHS Trust

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Context
As little is known about the implementation of nurse prescribing within the acute care setting in the UK (Latter and Courtenay 2004, Latter et al 2004), one acute hospital NHS Trust was used as a case study to evaluate the implementation of nine new nurse prescribing roles. The aims of the study were to identify the background and intended purpose of the nurse prescribing roles; to explore the experiences of the prescribers and their teams; and to test the null hypotheses that there were no differences in the roles of medical and nurse prescribers.

Design and analysis
A single-case embedded design was used (Yin 2003) with three clinical services used as units of analysis. Data were collected using multiple methods including semi-structured interviews with Trust staff (n=18), non-participant observation of patient-prescriber consultations (n=52) and a patient survey (n=122) that used validated rating scales (Horne et al 1999, 2001; Healthcare Commission 2005). The data were analysed using Ritchie and Spencer’s framework for qualitative data analysis (1994) as well as with differential and inferential statistics.

Key findings
The study found that within the chosen case nurse prescribing was clearly for patient benefit, through service delivery improvements and by using staff skills differently. The nurse prescribers and their colleagues were unanimously positive about the new roles and the associated service changes and the impact that these then had on patient care. For example that patients had more timely hospital appointments and quicker access to their medicines. Although no differences were found between the ways in which the doctors and the nurses performed their prescribing roles, there was a statistically significant difference between the satisfaction ratings of
patients who had seen a nurse as compared to those seen by a doctor.

**Conclusion**

The introduction of nurse prescribing was successful across the organisation because there was shared vision that directed the operational infrastructures needed for the implementation of the new roles. For example, an action learning set facilitated by the Deputy Directors for the nurse prescribers meant that policies and guidelines were developed iteratively to underpin their individual and collective practices. Also, the ‘fit’ of the roles into existing team structures helped to embed nurse prescribing within the study site. For example, where teams had reviewed joint ways of working in light of the need to manage increased caseloads. But, overall it was the nurse prescribers themselves that were crucial to the success of the implementation through their enthusiasm drive and desire to succeed.

**Contribution to new knowledge**

The study was distinctive from others to date because it explored the implementation of nurse prescribing roles within an acute care setting from an organisational perspective. Also data were collected from multiple levels including Executive Directors, clinical teams and patients from both white and minority ethnic groups. Replication studies within other acute hospital settings are now recommended to extend collective understanding of the influences on the implementation of new roles and to enable comparisons to be made with the more established body of knowledge relating to nurse prescribing in primary care (Luker et al 1997).

**References**


Satisfied carers and relatives of persons with enduring mental illness: Who and why?

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Background
The current study is based on the secondary analysis of qualitative data collected during the interviews for the exploratory Family Support Study (Kartalova-O’Doherty et al., 2006). Participants of the Family Support Study (N=38) were carers and relatives of persons with enduring mental illness, recruited via family support groups and mental health services.

Aims
The main purposes of the current study were to identify the key constituents related to the reported satisfaction with family services, and to establish what kind of services were considered effective by families.

Methods
Post hoc grounded theory coding (Strauss & Corbin 1998) and thematic content analysis (Hansen 2006) were used for the exploration of the narratives and validation of the identified themes and codes.

3 The article based on this study has been submitted to Qualitative Health Research. Please contact the authors for further details.
Key findings
The core identified code related to satisfaction with family support was that of mental health services perceived as ‘caring about’ in addition to ‘for’ the ill relative. Other codes included partnership between mental health services, family carers, and service users; community services and support; family support services; and trusting family relationships. All the identified five constituents were interrelated.

Conclusion
We recommend that all the five identified constituents are taken into consideration for planning and evaluation of family support resources.

Acknowledgements
Acknowledgements are due to all participants of the Family Support Study who voluntarily contributed their experience to the Health Research Board. We would also like to thank Schizophrenia Ireland and public mental health services of a Dublin area for their help with recruitment of the study participants.

References


A portrayal of organisational communications from the perspective of staff working in a former Irish Health Board – implications for managing change.

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Background and Context
Communication is a core organisational culture component. It is central to human resource policies, and is a key influencer of job satisfaction and trust within organisations. It also plays a pivotal role with regards to organisational change processes. Organisations need to understand their cultures to appropriately respond to the significant demands, changes, trends and developments in both their internal and external environments. However, the ‘softer’ informal cultural facets of change are frequently neglected during periods of large-scale structural and managerial reform processes. Indeed, given the dearth of organisational cultural analysis across Irish health service organisations and the unprecedented changes currently taking place within the health sector, such research is timely.

This presentation draws on a large study which examined staff’s perspectives of organisational culture in a former health board. The paper presents an analysis of communication within the organisation which was undergoing large-scale change at systemic
and organisational levels at the time of the research. It focuses on the openness of the organisation’s culture to change by presenting data on the core aspects of its internal and external communication. Various elements of organisational communications are analysed to see what impact they might have on the organisation’s capacity to manage change effectively, at a time when such significant changes were taking place.

**Aim of the study**
The aim of the research was to explore staff’s views on organisational culture in a former health board and this paper presents data on the nexus between communications and organisational culture. The research findings can be used, therefore, as a baseline, describing the nature of communications at both corporate and local levels in the organisation at a certain point in time. Given the interdependency of organisational culture and change, the data have particular applicability for staff with managerial responsibility for addressing significant changes in the organisation’s internal and external environment.

**Methodology**
Using a quantitative methodological approach, a self-administered questionnaire survey was sent to a random, representative sample of 1,500 staff in June 2004. The overall response rate to the survey was 46 per cent, representing just under one fifth of the organisation’s employees. The questionnaire comprised mostly closed-ended questions but a small number of open-ended questions were also included.

**Analysis**
SPSS was used to analyse the quantitative data. Univariate and bivariate analyses were conducted; frequency distributions in tabular and chart format were analysed and crosstabulations highlighting significant associations between variables were used to explore different perspectives based on respondents’ occupation and level of direct, frontline contact.

**Summary of key findings**
Noticeably more positive opinions of locally-based communications were found compared to views and experiences of corporate level communications. Problems were expressed regarding the flow of organisational communications as well as the timeliness of, and access to, pertinent work-related information. A lack of knowledge about organisational communications with external stakeholders was found. Furthermore, the organisation was perceived to have a negative public image. The sub-group analysis highlighted a need to address various communication aspects with particular
occupational groups, particularly with those groups that have high levels of direct frontline contact with patients and/or service users.

**Conclusions**
This paper focuses on communication which is a core dimension of organisational culture, and is central to the management of effective organisational change. Organisational leaders, managers and those planning change processes in the health arena need to understand the various cultural nuances associated with organisational communication. This study highlights management challenges in that process and argues that in order for organisations to develop and manage change, addressing deficits in communication is important. Learning from this research may inform other Health Service Executive organisations throughout the country in their endeavours to implement and manage similar changes particularly those associated with the current national reform programme.
Comparison study of multiple choice question and written question results in the assessment of second year undergraduate, pre-registration student nurses undertaking biological science at an Irish University.

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Background and context
Second year pre-registration, undergraduate degree Intellectual Disability, Mental Health and General Nursing students in the School of Nursing and Midwifery of an Irish University are examined in biological sciences using multiple choice question (MCQ) format and written format.

Both exams comprise knowledge based questions (not case histories or problem solving).

Aim of the study
To explore the use of multiple choice questions versus written questions in the assessment of second year student nurses undertaking biological science.
Objectives of the study
To identify performance variation by students partaking in multiple choice questions versus written questions.

To identify variation between General, Mental Health and Intellectual Disability Nursing students in examination performance, with regards to multiple choice questions or written questions.

To explore pedagogical / psychological determinants in the identified variation.

Methodology including research design and sampling
Results will be correlated from Hilary and Trinity second year biological science exams in 2006 and 2007 for all nursing disciplines. Only data in the public domain will be utilized. The multiple choice question papers consists of 30 questions with no negative marking. Each question has one correct answer out of four choices. The written papers consist of seen and unseen long answer questions and are marked out of 100% with the full range of marks allowed. Weighting is applied to each examination paper and varies throughout the year. Both exams comprise knowledge based questions (not case histories or problem solving).

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

Summary of key findings
Findings, analysis and discussion will be completed by the end of July 2007.

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The perceived role of the Public Health Nurse in pre-school child health.

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Aim: The aim of this study is to explore what the PHNs perceive their role is in child health. This study has as its aim the following objectives: 1) to ascertain the perceived role of the Public Health Nurses (PHNs) on their current role in child health, 2) to identify the barriers and facilitations to practicing this role, and 3) to recognise the perceptions of the PHNs future role in child health care.

Background: PHN in Ireland are generalist practitioner’s who practice within a geographical area and have a remit to care for clients from the ‘cradle to the grave’. Impacting on the PHNs role are the changes in child health practices and changes in the academic requirements for PHN education. Therefore, it was an opportune time to enquire from the PHNs what they do and what they hope to do in the future in relation to child health.

Methods: A qualitative approach using interviews with 10 PHNs in a rural area of Ireland. Data collection was continuous with data analysis and led to a number of themes. King’s template analysis was employed to interpret the data.

Findings: The main findings from the data were the uncertainty of the PHN in their role in child protection after a child is deemed at-risk. The findings also suggest that the current changes in child health education are welcome but fears are that they would not continue. Other findings suggest that the PHN sees a role for future practice in child health as CNS/ANP without losing the generalist specialist role.

Conclusion: The research highlights the necessity to define the role boundaries in child protection between health professionals. Future practice may require the development of a CNS/ANP role in this area of the PHN practice. However, keeping the role of PHN as a
generalist practitioner was still paramount with some of the participants. Child health screening has been standardised nationally, other aspects of the PHN role in child health also needs to be standardised.

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Collaboration in Curriculum Development: The Stakeholder’s Experience

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Introduction
The Department of Nursing and Health Studies at the Manukau Institute of Technology had to develop a new curriculum. This became necessary due to some changes in the health legislation of New Zealand and regulation changes made by the New Zealand Nursing Council.

Bevis and Watson (1989:27) warned against merely moving “subjects” around to create a new curriculum. This happens because nurse educators rarely really change curricula, and tend to stay with the familiar, to “switch, swap, and slide content around” This was not the case at MIT, as the Department was adamant about starting with a “clean page” (Interview with the Project Sponsors, 6th October 2006). This was easier said than done, as one tends to be influenced by experiences from the previous curriculum. However, if one sees designing a new curriculum as a challenge, and decides to use a structured process, and selects the team working on this curriculum carefully, it can become a very satisfying experience (Interview with Project Sponsors, 6th October 2006).

Developing a completely new curriculum gave the project leaders the opportunity to embrace an innovative approach, namely involving the stakeholders from the local region. This process of collaboration is quite new, and involves quite organisational skills if the process is to be successful. Collaboration between institutions is sometimes seen as “just another buzz-word” (Boswell & Cannon, 2005:1), but it could also be defined as being “... the process of toiling directly with other individuals in an attitude of teamwork that benefits organizations, individuals, and health care consumers” (Boswell & Cannon, 2005:2).

The big decision was to select the “right” stakeholders and then to invite them to participate in this process. The student population of...
the Department was identified as being “Multi-cultural”, which is also representative of the local community. 15 External stakeholders were identified, classified according to the services they represented, and invited to join the curriculum development team. Amongst these were representatives of both the public and private sectors, as the institutions governed by these authorities could be potential employers for the new graduates and simultaneously were in the best position to identify the needs of the service providers in these sectors (Interview with Project Sponsors, 6th October 2006). This demonstrated the Department’s commitment to meet with stakeholders from all the groups involved.

Background to the research project

The satisfying end to the process of collaboration was the new Bachelor of Nursing curriculum that was accredited in August 2005. The next step in the process of quality control was to initiate a research project to determine the satisfaction of the stakeholders who participated in creating this new curriculum. It was at this point that I was asked to conduct the research as an independent person.

Ethical Issues

A research proposal was submitted to the Manukau Institute of Technology ethics committee in May 2006 by the Deputy Head of the Department of Nursing and Health Studies. The application was approved before the project commenced.

Due to the fact that Māori people participated in developing the curriculum, they were included in the project as potential stakeholders. The protocols involving Māori stakeholders as well as individual interviews with Māori People were included in detail in the application submitted to the ethical committee, and strictly adhered to during the interviewing process. The Research Kaiawhina was involved in the process, thus causing the fact that not all researchers were fluent in Māori languages to be unproblematic.

After analysing the interviews, the analyses were sent to all the stakeholders by email, with the request, that they indicate their agreement with the transcript and the analysis of their particular interview. This method can be seen as triangulation of the interpreted data to enhance the credibility and confirmability of the analysed data. The stakeholders replied in the affirmative to this request.
The Methodology
Due to the fact that so many people were involved in the development of the new Bachelor of Nursing programme, it was decided to use a narrative analysis as the research design. By doing so the stakeholders, had the opportunity to tell their “stories” about their experiences in the process of developing the new curriculum (Polit & Beck, 2004:260).

The following research question was developed:

“How did the stakeholders experience the collaboration process with the Department at MIT while participating in the development of the BN curriculum?”

To answer the research question, the following aims were developed:
1. Describing the experiences of the different stakeholders in participating in the curriculum development process.
2. Determining the satisfaction of the stakeholders with regards to their contribution in developing the new curriculum.
3. Determining how the stakeholders valued their own participation with the view of involving them in future curriculum development processes.

Data was collected through semi-structured interviews with the stakeholders involved in developing the new BN-curriculum. These took place between the end of July and Mid-August, and included a focus group interview with the teaching staff who participated in developing the new curriculum.

All the interviews were tape-recorded with the consent of the stakeholders, and transcribed verbatim afterwards.

Data analysis was done using Mayring’s content analysis approach (Mayring & Glaeser-Zikuda, 2005: 9-11), because it enabled the researchers to break the content of the interviews down into manageable units that could later be analysed and classified into categories.

The Findings
The researchers used the approach of simultaneous interviewing and analysis. This meant that the analysis was happening throughout the data collection phase. On completion of this process, the data revealed 6 main categories. These were:

1. Existing Programme
2. The need to change
3. The Curriculum Development Process
4. The Stakeholders
5. Leadership
6. Ethnic minorities

Discussion

Category 1: Existing Programme
Although the process of developing new curricula has been amply described in available literature, it was interesting to note, that virtually no author ever mentions the “old” programmes offered in the Department. In this project the stakeholders felt a need to talk about the previous degree. All of them recognised the need to change the then existing BHSc. (Nursing) programme. "I firmly believe that the curriculum needed challenging I thought” (Participant 1:21-23), or "But certainly my impression was that the older programme, the original programme, the old degree seemed to be tired and dated. It had not kept up with the changes in nursing practice and it was time to revise it. I think both in terms of content but also in terms of approach and the actual structure of the degree, how the papers were structured and how the progress through the degree was structured” (Participant 7:13-20).

In educational circles it is now accepted that the information relevant to nurse education will double every 5 years (Barnard, Nash, and O'Brien, 2005:505), which support the stakeholders’ recognition of the need to change curriculum in order to keep up to date with the latest developments in the health sector. This was specifically necessary if it was expected of the graduates to meet all the needs of the New Zealand population in the future.

Category 2: The need to change
In this main category it became evident that there were many reasons for changing the previous programme. These “drivers for change” included the Government of New Zealand's Primary Health Care policy, which led, amongst others, to an extension of the registered nurses’ roles.

Baker et al. (1998:1-2) stated clearly that educational programmes for health care professions need to identify the knowledge and skills necessary to meet the goal of improved community health. At MIT the lecturing staff and the Stakeholders were in agreement with this statement. Moreover, they felt that it was necessary for students to identify their own learning needs before selecting their final placements. By doing so, students would be able to meet their educational needs, and take more responsibility for their own education. "So it was really to facilitate the student more. But also
to introduce nursing as primary health care and to design a programme in conjunction with our clinical context, we could see an ownership that was really important to the students” (Participant 3: 21-26).

However, some of the stakeholders also felt that the students did not necessarily have to work in hospitals, especially if they envisioned a career in community care for themselves. "We have got new grads out there in the primary health care. So we are finding out what some of those issues are and we are getting systems around that. This probably took about 15-20 years to develop here. You cannot be fast tracking that for primary health care. And the thing is that there is still an attitude that you have got to do med, surg., basic, before you go out into primary health care. It is just absolute necessary to get rid of that myth. Because my vision is that nurse who wants to practice at a hospice or in a community, don’t even have to work in a hospital, as long as they understand that continuum.” (Participant 4: 214-227).

Some academics might argue that a student who never worked in hospital will not be able to deliver quality care to the population. To this effect, Lawson (2004:229) said that collaboration will, eventually, penetrate "these core technologies because the stakeholders know they cannot achieve success or enjoy effectiveness without it.” This might have been the ground for the next statement: "Certainly what I did like about the process was the level of collaboration. Like being a Clinical Facilitator or whatever, like I did not deal with the students but I dealt with the Grads quite a lot and looking at preparedness for practice and that sort of stuff for me, it was not specific to MIT but certainly what we had been seeing was reduced confidence and sometime competence around clinical practices and new practitioner” (Participant 7: 37-46).

The stakeholders did not identify all the new approaches to nurse education as being positive. "A lot of it is government driven – funding and they tell you what to do and . . . elective surgery, it is all about the dollar” (Participant 2: 142-145). Here one could see the fact that the Nursing staff were not necessarily pleased with the way in which health care delivery had developed. However, one has to remember that the move away from health care delivery in acute care settings to community care settings is not unique to New Zealand (Gaines et al., 2005:505).

The curriculum change had to be based on the needs of the health care providers and the students. Knapp and Lowe (2001:14) identified the need to “listen” to the “customer”. In this case, one could define this “customer” to be the “Stakeholder”. Staats
specifically indicated that a move towards community care must be accompanied by lectures to promote cultural awareness, as health promotion services and risk reduction will happen in a variety of settings with services offered to diverse populations.

It is therefore important to reiterate the New Zealand Government’s commitment to Primary Health Care (King, 2001), as the “customer” could literally be anybody the nurse encounters professionally. King (2001:13) clearly stated that Primary Health Care services will include services that improve the health of the population through health promotion, education, counselling and helping people to adopt healthy life styles, thus widening the list of stakeholders in this study. These services can only be delivered if the educational programmes for health care professionals are changed. "I think there are clear directives from the government about what our health strategies have to be, and particularly with the funding arm” (Participant 2: 99:102). And: "I think that we are very much governed on how we change the way we deliver health. And a big push for community health. Previously it was all hospital based. You came to hospital for 3 days and then you go home and go to the GP. So that is not acceptable anymore“ (Participant 2: 113-118). Also: "And that was changed because of the changes in the NZ legislation. We did not want students to be disadvantaged” (FGR: 160-162). This demonstrates that the people participating in the development process were well aware of the need to change in order to accommodate the new governmental guidelines for health care provision. "And with the Bachelor of Nursing, we wanted to have a graduate that was in line with the new DHB focus” (Participant 4:18-20).

The Report on Primary Health Care and Community Nursing Workforce, which was published by the New Zealand Ministry of Health in 2003, also influenced the decision making processes. However not all the stakeholders supported this governmental strategy, as is demonstrated by the following: “I believe that the needs of Pacifica, although very high, we include Pacifica in the same group as you do Māori, which we tend to do a lot, then you have also got to include all those other ethnic diversities and the whole cultural milieu, which next week you will be asking the question Māori for Māori and Pacifica for Pacifica and Indian for Indian. Is that you wanted. If you are going to go down that track, then no I don’t feel.... it is a purely political thing and I feel it has nothing to do with health” (Participant 9: 89-100).

A critical remark to this category can be made, because it was found that all the stakeholders were very clear about their individual
roles in the curriculum development process and explaining how their needs were being met in the process. The changing health care needs of populations have been discussed worldwide and nurses have to meet these needs. Only through collaboration can a curriculum be developed that will meet the needs of the different population groups.

**Category 3: The Curriculum Development Process**

Time management was mentioned by many of the stakeholders. Baker et al. (1998:7) specifically mentions the logistical problems of getting all the stakeholders together at a time that would suit all concerned. This was mentioned by some of the stakeholders, although they perceived the first meetings to have been “very focussed”. "I think the curriculum development team was very focussed for a period of time. And then it sort of fell off a little bit and we didn’t have meetings. I think it was at the time over the Christmas time and so we did not have many meetings and all that stuff was going on, that was being finished and we did not really have, I don’t feel, that we had input into that really. Because the curriculum development team did not really need us, except on the odd occasion” (FGR: 211-220). And: Yes, they were very professional. You knew what was expected. Stuff arrived before you went to the meetings. Actually there was quite a bit of paper that came back” (Participant 7: 396-399).

The lecturing staff appeared to be having the most problems fitting their new tasks into their already busy schedules. However, Baker et al (1998:4) identified means of overcoming some of these problems and suggested that the universities enter into collaborative partnerships. The Department has done this, as already described and the comments made by some of the stakeholders created the impression, that they were also under pressure of work, but were very glad to be able to participate in the development process. "That was awesome. They have very quite strict processes and procedures. They had an administrator of the programme, who very much held everything well organised and structured” (Participant 9: 33-37).

There was a lot of information given by Team Members from the Department to all concerned. This approach is supported by Knapp and Lowe (2001:12), who stated that it was very important to spend time at the beginning of the process to clarify aims and define the terminology to be used during the curriculum development process. "When Norman came over and he constantly, I think that he has been in front of the charge nurses, he had opened forums for Seniors to come and provide feedback. I

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4 = Name changed
really commend MIT for doing that. Because often there was not a lot of attendance. Sometimes there was. It sort of came in a bit of a dribble really. But the fact that they came, and they kept repeating themselves. They kept asking for feedback. They kept providing opportunities for people to see them and say ‘yes this is what we want’ ‘yes this is what we need’. Wow that is fantastic, it really is” (Participant 8: 139-151). This process of providing information to people also served as motivation to commence the process and work on the new curriculum. “I think we are really looking forward to being involved in the changes” (Participant 1: 37-39).

It was sometimes necessary to ask the curriculum development team to discuss certain issues in the development team only, and once a final draft was available, to discuss that with the rest of the people involved. This is a means of getting the team focussed on working towards completing the final product, and not getting sidetracked by constantly talking to other people about the topic under discussion, thereby hindering the progress of the whole process. “But we were also told not to discuss anything outside the curriculum development team which made it difficult for us” (FGR: 279-281). This sometimes led to negative feelings, but at the same time, some stakeholders appreciated this “focussing” and “progression” of the whole process. “I was engaged as much as you, and I always felt that when I got there, it was ……..lets get on with it, lets focus and I found like that day when we did all that bits of paper and we could do this and we could do that. That was a huge day and the facilitator; they had an outside facilitator I think. To have that outside facilitation was great, because it created neutrality and against competing needs. And there were competing needs in the room at times, and you certainly sensed that” (Participant 8: 319-329).

However, the stakeholders doubted that it was always possible to have a consensus decision. “But it is very difficult to get some sort of consensus in such a large organisation in such a short period of time. I think sometimes, people have to be up front maybe and just say, ‘look we have got to make this decision’, instead of going through process of appearing that we all had a bit of input and we are going to discuss it” (FGR: 577-583). The difficulty of reaching consensus was also mentioned by another focus group participant, who said “I think it goes out there, it would have been a good decision we made, and yes we have to consult wider, no we can’t seek consensus but it is a possibility and ultimately the decision is going to be made by the people based on the ideas of the consultation and the constraints that they know about” (FGR: 633-369).
Some stakeholders indicated that they were really excited to participate in this project. “So the whole thing has been very exciting and I think for us, is that we have had such a collaborative partnership, now whether that has been unique in that I don’t know” (Participant 2: 83-87). One could literally hear and see the enthusiasm of this stakeholder. She was very excited about being invited to participate in developing a new curriculum, which could be an indication, that she consciously or subconsciously identified the gains already mentioned by Lawson (2004:226). The excitement was also identified about the gains for the profession on the level of patients and institutions. “So I think for us that has been one the most exciting things to be involved with and to being able to tie it into look at the health of our patients, but also to look at how we deliver our education and continue with education” (Participant 2: 66-71), and “So I think it is very exciting and think you can only benefit with Eastern Board’s and particularly with the fact of our diverse population” (Participant 2: 90-92). Here the diverse population serviced by the Department was mentioned, and on a patient level, one participant stated: “I think it is an exciting journey that we are starting and I look forward to them coming out in their 3rd year” (Participant 2: 234-236).

Some of the stakeholders were not involved in the process right from the beginning. “Yes, I thought the process was excellent. My only regret is that I could not be more involved. But that is life. I wouldn’t change anything either. I thought it was excellent from wow to go to be honest” (Participant 8: 391-395). This participant found the whole process excellent, but her mentioning the fact that she was not involved from the beginning, demonstrates the difficulty of entering a group once the work commenced.

With regard to the development process, one stakeholder indicated: “I don’t think I would do anything differently, I thought that it was really very well done. The only process . . . if they wanted to have another crack at something, I would be happy to be involved” (Participant 7: 381-385), and: “I would love to go through it again. Probably around the communication and just trying to find ways of having more resources available to free up” (Participant 3: 135-138). This participant continued to say: “I think for me that there was a commitment that we would try for less people and that we would make relief staff available. I guess as times I felt a sense of responsibility if people did not ask for that time” (Participant 3: 46-50). The last statement suggested, that the participant realised that some form of relief for some of the stakeholders was necessary.

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The accreditation process was taken very seriously in the Department, and caused a certain amount of trepidation amongst the stakeholders. "We were so stressed. . . . We had a couple of meetings about how to respond to the people who were asking questions about it, we had these special orange sheets printed up with all the little tips about them, and having to swot them overnight. I almost could see that department staff in frenzy and so worried and when we came to the day of presenting it, we did so well, we almost did over well. And we got through it and we just sat there like a pair of wrung out dummies" (FGR: 737-752). One of the Stakeholders was involved in accrediting processes and previously represented the Nursing Council of New Zealand. " . . . and was also involved in the nursing council and around the accreditation of that programme" (Participant 7: 26-28). This participant specifically knew how much work went into the preparation of the programme, and how easily the process could get off track.

However, the process was successful, and "There was an email saying ‘thank you for your input’. Honestly you were just exhausted and you still had to pick up the next day and just go on with it" (FGR: 760-763).

Lawson (2004: 227-228) stated that: "Collaboration is in evidence when interdependent, autonomous stakeholders with their respective competency domains mobilize resources, and both harmonize and synchronize their operations to solve shared problems, meet common needs, capitalize on important opportunities, and obtain prized benefits.” This defines the need to work together as a team in order to meet a common goal. To this idea of working as a team, one of the Stakeholders indicated "No, I think that it was very collegial. We had the opportunity for feedback all the time. I am in a privileged position, because my relationship is ongoing, with the advisory board” (Participant 2: 150-154). The importance of involving the stakeholders and even their employees was also demonstrated. "Also what was good was that nurses on the Ward were consulted too. There were lots of people, everybody could have a say. I think it could only grow, the way we are doing it” (Participant 2: 162-165). Not only were the stakeholders involved, some of the Educational Institutions were also involved, and information passed on to them. "And recently Norman came and gave a lecture to some post graduate students, which I will talk about later, about how they went about setting up the curriculum, and that curriculum development and the component parts and all the rest of it. Rich stuff that he is now sharing at South Coast University. So even that relationship between MIT and this

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university is strengthened. Because of this process” (Participant 8:241-249)

Lawson (2004:228) pointed out that the partners could work towards developing a single goal, which again was demonstrated by some of the Stakeholders. "I loved it. It was wonderful. I think that Agatha8 and I worked really closely together and we tried to put in place and organize a systematic way of doing it. So that people could have input and be confident that they were heard. So I think it was a very positive process, very exciting” (Participant 3: 30-35). The positive feelings about working together were also expressed by some other stakeholders. "There are no barriers. There is no such word as can’t. I think that goes right back to – there were no financial barriers, there were no, everything was positive, there were no barriers. . . . I was really impressed that MIT were so precocious that they could work along side another tertiary provider, who could be in competition, to support us at Counties. I just think that is why other DHB’s and other tertiary providers aren’t working together like our partnership. It just beats me. And I don’t, to be honest, understand why it is so difficult for everybody else. It is about leadership from the top. Just get on with it. Because our nurses, there is no conflict between us. . . .” (Participant 4: 255-277). And: "I thought that the process was well thought out. It was very good and you felt that you could actually contribute” (Participant 6: 17-19).

One of the stakeholders commented on the fact that the community to be served is very multicultural. The graduates from this new programme are going to be confronted with aspects of care to a multicultural community in a variety of service providing areas. "I think that I have developed here is a really good team. We had quite a structured team here. When I got here it was really little, but with a real focus on leadership. I have developed up senior nurse leaders. These are seniors in medicine, acute care and primary and people support. I have a senior nurse in mental health. One for surgical and ambulatory services, one for CND intermediate ....... And this position here covers off all the rest home residential care as well. This is primary health care. I have a pacific nurse leader based out in the PHO. A Maori nurse, a Maori PHO, I have full time CND for Kidz First. Then I am trying to get strategy and research a lot more embedded. So I have developed up a quite strong team” (Participant 4: 202-219).

Changing curricula could be a traumatic experience for some people. Candela et al. (2006:61) described this phenomenon extensively and indicated the difficulties project leaders could have

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to delete content from curricula. This was the case in this project as well. "I think there is always a sense that sometimes people are not ready, or not everyone at the same time says the thing for change. So I think for some people that may have made it difficult to participate” (Participant 3: 127-131). One participant actually indicated that people might be threatened by change. "Particularly from those people, it is very threatening to have change. And those people who have been teaching there for a long time” (Participant 1: 109-111). This aspect obviously had to be dealt with also.

The collaborative process could lead to a feeling of “ownership” for the new curriculum as well as a feeling of “collegiality” between stakeholders and the department. One participant said: “Oh I definitely do. Yep. I strongly feel that this is a partnership between us and MIT. I am also the chairperson of the advisory group that this group comes up and under. I have always been the chairperson at that. So I very much feel a part. I feel that it is ours, as much as MIT. It is a "we" effort. A lot of our nurses in the past joined MIT to dream the whole curriculum writing process” (Participant 4: 186-194). Another said: “Yes, quite strong really. I don’t know if ownership is the word, but I think that we had to get it right. Because they were going to be our future workforce planning, we must have some ownership and to what they deliver to us” (Participant 2: 186-191).

The feeling of "Ownership”, however, did not seem to pervade the general feelings of all the stakeholders about the BN curriculum. One participant indicated "Yes, I would be happy to say I was a really active member. I mean I wished I was more actively involved, but I do feel like I do have a sense of ownership in some respect” (Participant 8: 283-286). This participant felt she worked hard on the programme, but only slightly felt a sense of “ownership”.

In conclusion, one can say, that there were some mixed feelings in this category. Some stakeholders experienced a good feeling of collegiality, in working together towards a common goal, in developing a sense of ownership, and also in keeping contact to the lecturers, who were not involved in the curriculum development. On the other hand some of the stakeholders were not that optimistic about the whole process and expressed feelings of “loss”. They were not entirely convinced that all the needs of the stakeholders were met.

**Category 4: The Stakeholders’ view concerning collaboration**

Lawson (2004:235) mentioned that the success and effectiveness of collaboration can be deemed successful, will depend on the degree
to which needs are being met, opportunities utilised or conditions identified and solutions tailor made for these. In the partnership between MIT and the identified stakeholders, the effectiveness has been mentioned by all concerned. "So I guess that the other thing that I feel really good about is the partnership MIT have with Counties, is that we have an education provider that is responsive to what the changing need is. It will have to stay responsive, because the needs change as the application changes. So there is a macro political stuff and then we came down to the DHB and then we got down to developing a workforce that met the needs of the nation” (Participant 4: 50-59).

Moreover Lawson (2004:228) stated that collaboration could end in innovative programmes leading to integrated social and health services. If this was possible, the stakeholders should be quite satisfied with the collaboration process. To this effect, one of the stakeholders said: "It is the community mental health services which are beginning and there aren’t many places that do have community mental health people . . . So going forward into the future, that is going to be a role that we develop more and it may be something that will need to be adjusted over time, and that can be done by the clinical placements that people go into” (Participant 6: 102-111). With regard to mental health, a participant indicated: "I am uncertain around some of the other parts of it, and possibly it would be interesting to look at the mental health aspect of the curriculum. If we have moved forward and plans are changing, but in terms of the community. . . “(Participant 6: 97-102). The following comment indicated stakeholder satisfaction from the perspective of the acute care institutions,: "I do know and I have had feedback, from Sarah⁹, that they are much happier with, they feel much more involved with the students, they feel much more part of the curriculum and they feel happier with what they are seeing” (Participant 1:73-78). And: "I think MIT very much tried to capture up the traditional nursing partnerships, in fact they went out to find new partnerships, and we included primary health care, community services, mental health services, so we did our hospital, mental health community primary health care. We went out, met with all those groups, we had a primary health care nurse actually join and become part of the curriculum writer and . . . “ (Participant 4: 65-74).

Boswell and Cannon (2005:2) stated that the collaboration between institutions could be strengthened through networking, as one would have the opportunity to draw on resources outside these institutions, while simultaneously building a team working towards achieving common goals. A participant supported this idea by

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saying: “So you are really dependent often on the people in jobs and the processes that work. But once you get people on the job, trusting each other, it makes it so much easier” (Participant 1:97-100). Another participant also mentioned this aspect, but added the aspect of cultural sensitivity to it. “The stakeholders were saying that it was great, that they had had so much input and that the relationships had been well established and they felt that they had a significant role to play in how the curriculum was going to be developed. In terms of Maori stakeholder, I guess that was area that I felt a little bit anxious about because that was the part of my role that I had not quite understood and had not been made clear to me. I did not even know who some of these stakeholders were” (Participant 5: 88-98). In a multicultural society, the needs of the stakeholders representing minority groups, are of equal importance and must be addressed. The Department did just that, and this fact was mentioned by one of the stakeholders. “Oh most definitely. I am very proud that the programme has been through the internal Mäori consultation processes and has come out on top. Also that it has been through an external consultation process, with Mäori via the Iwi Providers. But I am satisfied that consultation with Mäori has been undertaken and that recommendations made by Mäori on the programme, have been taken on board” (Participant 9: 52-60). This reference to Mäori involvement proved that the Department was committed to incorporate the needs of minority groups in the new curriculum. It also demonstrates awareness for the cultural needs of the community utilising the services where the MIT students were having their clinical placements.

Pardue (2006:57) a true reform in nurse education can only be achieved once all concerned identify and discuss the needs of the services, the students and the lecturers. This seemed to have happened in this curriculum development exercise. "I think the charge nurses responded really favourably to that engagement as well, because they wanted what was described to us for a wee while. So I think the feedback that I got was that they were actually really quite excited about I think the level of commitment to it” (Participant 7: 158-163). The cooperation in working towards a common goal has actually been identified as a pleasant experience. “It was overwhelming, my goodness was anybody left back over at the DH. They were all over here having cups of tea. . . I thought that was really commendable to be honest” (Participant 7: 87-98).

The continuous involvement of the stakeholders throughout the whole process has been recognised by Lawson (2004:228). Working together can aid the stakeholders to develop a unity of purpose and to develop a collective identity. By not attending all meetings, the stakeholders gave a message of only being interested
in meeting their own needs, whereas the needs of the greater group were not deemed to be that important. This could actually hinder the progress of the whole process. A possible solution was a bigger drive to motivate the stakeholders to attend all the meetings. "Probably to this extent, I have certainly been involving in developing a number of programmes, but I think this time, we made significantly more effort to involve them" (Participant 3: 56-59). These sentiments were echoed by the next participant: "I think there was, it occurred to me that there had been a concerted effort to ensure that there was stakeholder input. And I already knew... from Smith Hospital 10 and I was already a member of the joint clinical advisory group, I already knew that discussion had been going on. I guess that the effort that the department was doing, I guess they were doing all that they could. That the final meeting that we had and the panels that we had when we were being approved and the approval, that was really evident" (Participant 5: 76-82).

In conclusion, one could say the overall impression leaned more towards a total satisfaction with their role in the process on the side of the stakeholders. The few negative comments can not be seen as an expression of discontent with the process. These comments are underpinning a wish that all the stakeholders utilised all their opportunities to a maximum.

**Category 5: Leadership**

One of the most important aspects of successful collaboration is having a strong leader, who is capable of guiding the stakeholders through this long and at times rather unpleasant process (Knapp & Lowe, 2001:13). The stakeholders in this project identified a specific person as being a very able leader. "I was really impressed with Agatha’s 11 ability to lead. I was impressed with her ability to manager her staff, to do it in a way that I could not have done it" (Participant 1: 137-140), and "She acknowledged everyone’s strength. I found her ability to manage the workload amazing" (Participant 1: 142-144), and "One of the outstanding things about * as the leader is that she listens and they acknowledge. I just rang her and said 'what do you teach for family violence’” (Participant 2: 191-195). It would seem that the leadership of this person stood outside of all criticism. Some stakeholders actually stated that they tried to steer certain aspects of the process along particular ways in an attempt to support the leader to an even greater extent. "Hopefully that supported Agatha in her, in seeing me having a desire to work for change and I suppose as an outsider pushing things in a change of process. People take it from you, when they

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would take it from colleagues” (Participant 1, 59-64). That might have been a reason for the successful progress of the process.

Buonocore (2004:172) stated that “effective leaders know how to surround themselves with the right people as resources”. One of the stakeholders indicated, that there was great appreciation for the way in which the process was developed, and stakeholders involved at all levels. "I was quite relieved that the infrastructure was being set up. The principles that we talked about were being considered but the structure was being set up, I would have liked to be on it although, because some of it is boring, hard work, that we had to do. There was a timeframe that was decided on and if we always stopped at every period, and got input from people concerned” (FGR: 249-257).

Boswell and Cannon (2005:3) quoted Cooper (2003) by stating that “. . . leadership is therefore about influence, but also about inspiration – those with inspiration inspire believe in ourselves”. This seemed to have been the case in this project as well. "I think we were just a brainstorming ideas team. I remember Waipuna Lodge day, all the whole staff came it was quite a good idea. But by that stage I think a lot of work had been done by a small group of people, mainly Agatha12 and Norman and other people in the Department, and I couldn’t understand why people they thought were on the curriculum development team and expected to know stuff (laughs) but we should not have let what happened happen, because it did” (FGR: 285-297). Cooperation between people, who might be leaders in their own right, was also mentioned as an enabling factor in this process. "I think that the other thing that was an enabler of it was the fact that Agatha and I worked so well together” (Participant 4: 100-102). This was also mentioned by stakeholders who were not from the nursing profession. "I thought, again as an outsider to the profession,. . . that it seemed to me to be stunningly successful.” (Participant 7: 24-27). This process can only be successful if the leader is supported by all, and the curriculum development team members support the process as well. "I think I felt huge gratitude at our lecturers because I know that they were busy and for our clinical colleagues who made contributions. I thought that if none of them had come to the party we would have had a much less successful outcome” (Participant 3:35-40). The negative aspects of not supporting the leader of the team, was also mentioned. " . . . and I don’t think you would have had Sarah 13 turn up here and spend some time with us, if she was not taking us seriously. Valuing your input, that you could get some community organisation like us” (Participant 6: 71-74).

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Knapp and Lowe (2001:13) mentioned the fact, that the leader could establish a solid team, and if the leadership is then maintained, the team would be able to sustain itself over a period of time. This fact is very important, because this process extended over a period of 2 years. If the group was selected carefully, the feeling of “being part of it” could have led to a very positive feeling for the team members. “So we got that initial excitement and we had those first couple of meetings, there were all sorts of people and high up people and all sorts of people there. That was really good and I think that we did do quite a lot of work in those first couple of meetings” (FGR: 465-470).

The opposite would also have been true. If there was no team-feeling, this process would either have failed, or would have extended into the next year. “I was head of staff development at MIT at the time. And the deputy head of department asked me if I would facilitate a lot of the meetings. So I was there as a person who facilitated the getting together, facilitated the discussion, the pulling together peoples thoughts and ideas as workshops concluded. I think there is a further role that you play when you take it on. It is more that being just a facilitator and that it to be the critical fend” (Participant 7: 80-89). And also being part of a very big group could have led to feelings of intimidation. “I think, one thing that I found a bit difficult was the group initially was very large and the membership was very difficult, it was quite daunting, those first few meetings were almost frightening they were just so big” (FGR: 233-237).

The aspect of time management was identified as the most controversial of all. It was also not possible to find any literature to underpin this section, as this aspect of curriculum development seemed to have not been identified as a probable problem area in developing new curricula.

“So no, I think with the time constraints with my own job, I think that we were well consulted” (Participant 2: 159-161). And even more positive: “Well I felt that when we went into the meetings that they were quite structured and from my point of view, I felt that we always either achieved what we set out to or if something new came up that was an issue, that we had a way forward to address is. So I was actually quite pleased” (Participant 3: 109-115). And: “Yeah, I thought the time was managed well. I struggled with the time commitments, just as I think we all did. Sometimes it did not get the priorities that it may have deserved, in terms of what was going on here or whatever. I was blown away, actually I still am, when
you could just say, 'ok, so we want to change a Degree.”’” (Participant 7: 334-340).

Some people actually saw this development process as part of their work, and therefore found that the time was used well. "It did not impact on my personal life at all. It didn’t impact on my work life, because my work was courses generate an enormous amount of work. We don’t just lecture, we are all on a marketing team, liaison team, committees in the role of curriculum development dom. It was part of my job to actually be part of that process” (Participant 9: 42-46). And: "But it was the fact that the people were all working fulltime, the all had full time commitments. Then they were taking time out to support MIT degree development. I guess that was partly as part of their job” (Participant 7:67-72). If the stakeholders saw their contribution as being “part of their jobs”, it might also explain the reason for them attending regularly.

Some of the stakeholders also mentioned the fact, that they experienced the process as being time consuming and infringing on their own free time. "No, I think the constraints of time, you know, fitting it in to your busy day. The ability to block out more time. Thinking about the, I don’t get tied up on the .... Of what we are teaching. It is more collaboration, but after just ....“ (Participant 2: 217-222). One could also develop strategies to cope with the stress by not mentioning the fact that one might have a free slot on a time table. "I some other examples, our timetables are always so full and we are all very busy and there is not sort of gaps to do that. If you look like you have a gap, you don’t admit to it, don’t tell anybody” (FGR: 859-863). Lack of time was a recurrent theme mentioned by several stakeholders, for example "He asked me about my project that I am doing and I just laughed at him, and he just laughs back at me. I think the nursing, there are appeals, there is all the sort of pastoral care that you get involved in” (FGR: 704-711). This item seemed to have caused the most stress amongst the stakeholders. When repeating the process at some future point in time, this aspect will need looking at in greater depth.

The reasons for the tight time frames were well known to people. One participant said: "And also too we have not got the staff. There is a shortage of doctors and nurses.” (Participant 2: 119-120). And: "There is always this time constraint around the development of curriculums, because you are always racing to meet a deadline, no matter how early you start and we started nice and early. You are racing to meet a deadline and the deadline when it comes up to hit you, it is has got to go to that standards committee, it has got to go to NZQA, it has got to go to nursing council, all those sorts of
constraints around it. But they still managed to give it reasonable time, I felt. I think there was another issue in there and I think some of the staff was not on board with the changes. They perhaps were clinging to the old ideas and they did not really want to budge. I don’t know how they are feeling now” (Participant 7: 144-158).

But due to certain circumstances, the whole process was delayed and commended a bit later than planned, which put extra stress on the development of the new curriculum: "In that because there was a really tight timeframe, in fact we had gone over things. It was six months later starting than it was envisioned originally. So it was really tight. They won’t have any time really to think about it, I don’t think” (FGR: 394-399). This demonstrates that people were aware of the need to commence the process and bring it to fruition within a certain timeframe, although that was going to put train on them.

Not attending meetings had consequences for the rest of the group. "Clearly these were really busy people, so one of the difficulties was that you did not always have the one meeting or workshop, you did not always have exactly the same group. So there was always a little bit of catching up with the group that had not been there. On the whole there were people who were very committed and who kept coming” (Participant 7:27-34). In fact, this “catching up”, or “revisiting” decisions because of non-attendance, was mentioned by some other stakeholders as well. "...some issues that came up, that had been addressed, and where people constantly tried to revisit. At times we had to be really clear that some decisions had been made and that we had moved on. And I think that was difficult for some people” (Participant 3: 117-121). This could have been avoided if the group was well informed. On the other hand, some stakeholders had the impression, that decisions were made without informing the people involved, thus causing embarrassing situations. "I know specifically for us, that was so frustrating. I know they got presented at the forum and then said these have been worked on already what you are presenting is old stuff. So we took it away and we went for it again and then another draft came out with the old stuff still in it. And then I found my original emails and sent this to them. I said it was not what I wanted, I just wanted the new work that had been done and to be there” (FGR: 532-541).

Such a situation should not have developed, and the programme sponsors should investigate this in order to prevent occurrences like these should a new curriculum be developed at some point in time in the future.

It would appear though, that the impression existed that some stakeholders were better informed than others. "I don’t know about the stakeholders, because I don’t know entirely what process was
I would say I was mostly informed, but there were definite things that were set up that weren’t mentioned, that I did not know anything about. It suddenly just appeared. That was at a little frustrating, because as was said, it was then assumed that we knew about it, because we were in the group together. We were the ones, facing our department team. They were saying ‘well what is all this about, where did this come from’ ‘We don’t know’. It was a little difficult in that way” (FGR: 510-522). It would appear that the perception existed that the internal flow of information was less effective. “The information flow was not, it was what was lacking. At that time information was not coming back to us” (FGR: 299-301). If this perception was true, then it would need looking at for future reference, but at the same time another perception also existed. "All I can say is that we did our best, we knew it was unfortunate but we did our best. But that certainly, I think our communication with people outside the department was effective, within the department there were just some little lags, where we could have perhaps been more onto it” (Participant 3: 100-106). So, some of the problems were known, but due to specific circumstances, these could not have been attended to at that particular time.

In conclusion, one could say that the team leader is the most important person in a curriculum development team. The leader can make or break the process, as he or she gives direction, recognition for work done well, and supports the individual team members.

On the other hand, the time aspect in any process can be critical, as stakeholders are normally people, who are continuing with the normal daily activities while taking on new tasks, and it is therefore imperative that this aspect be considered well in any development process. If people are under pressure to produce a product, that has to meet the needs of various institutions and people, and feel the pressure of work, feelings of anger and resentment could develop quite easily. On a positive note though, Successful communication could lead to feelings of satisfaction amongst the stakeholders. "I thought the person who I was liasing with and who was sending messages and so on, I though was well organized. The timeframes were set by the time I got there. There was enough time to read documents, but not too long that you would have lost it before you went back” (Participant 6: 53-59). This demonstrates the advantages of maintaining good time frames and good communication processes for any process, and must be recognised by the team leader as well.
Category 6: Ethnic minorities

King (2001:10) indicated that it is expected of all Primary Health Organisations to provide services for Māori and Pacific people in ways that are culturally competent and effective. In most countries in the world it is now expected of nurses to deliver care in a culturally competent and effective manner. The Nursing and Midwifery Council in the UK recently asked nursing departments to review their curricula to ensure that they produce nurses who are culturally sensitive (NA., 2004:7). To was already preceded by a research project on the extent to which undergraduate pre-registration programmes were preparing the future graduates to deliver culturally sensitive care in the fields of Adult Nursing, Mental Health Nursing and Midwifery (Gerrish, 1998:115).

The Department already reacted to the needs of their multi-cultural student population by developing a Graduate Profile instead of a Philosophy for the Department. One of the Stakeholders actually indicated, that the health model used in the curriculum based on the Māori Model of Health. “And we have based our framework on the Māori model of health, which is a foundation. It is about a house, and the foundation is the community and we have got to continue of care and the work is the strategy that we work under” (Participant 2: 245-250).

It is also important to remember, that students from minority groups would like to associate with lecturing staff from that same cultural background. This factor has been clearly described by Mills-Wisneski (2005:49) who indicated that “Minority faculty are a key to retention and change of workforce. The presence of minority faculty provide an opportunity for minority students to observe such faculty members in leadership roles, in the clinical area, and in other related university and community roles.” To this effect, one of the stakeholders indicated that “I think so, I think it does. It will change as the political climate settles, if it ever will. It is always going to be a changing thing. It will change in terms of how nursing sees it’s role, it will change in terms of how government strategy and it will change in terms of how Maori go socially and economically. I think in terms of these stakeholders, internally our Tanga Te Whenua have become a member and have been newly appointed as a Kaiawhina Been co-opted. Certainly if they weren’t involved enough in things like community development” (Participant 5: 146-157). The Department already made specific provision to support the Students from ethnic minority groups. “The department had already got a Kaiawhina which was on their advisory group, to the Degree development. So that was already in place when I came on board as a stake holder. The development process was very good” (P9: 25-30). This participant also had an idea for increasing
the number of students from ethnic minority groups. "They need to institute a quota system for bringing in Māori or Pacifica students. They need to introduce that. To retain them they need to have specialist Kaiawhina and I don’t know what the equivalent word is for Pacific people. But they need to employ those people as from the ground upward. Administrators, lecturing staff” (Participant 9: 117-122). This option would not be feasible, as it would go against the principle of democracy, where all students applying to the Department should have the same chances of being selected onto the programme, and would have to be considered very carefully if it has to be implemented.

Kleiman, Frederickson, and Lundy (2004) indicated that cultural awareness, sensitivity and competence have been incorporated in nursing programmes for the past 45 years, and by developing a cultural awareness in the students would be a definite method of improving the quality of care provided. There are ways of doing so, as indicated by this participant. "I am always attempting to maintain not just my relationship with the stakeholders, as well as their actual involvement in the paper. As guest speakers and I am talking about people from the industry from the providers, heads of department, Maori they come and teach on a paper. Absolutely that is what I want. I am sure that is what the department wants too. Because it is not a practice paper it is a theory paper, . . . if we get people to come into the classroom, people from the real world, people from the theory that we are talking about” (Participant 5: 165-177).

However, it is not always easy to maintain this, as also indicated by the same participant. "...my role in the curriculum development and the whole Māori content, whether it was just the paper or how we integrated it, I felt as if I was running behind the train in terms of what had been decided and where we were going. So I did a lot of fact finding myself” (Participant 5: 53-59).

Gerrish (1998:116) indicated that some of the ethnic minority stakeholders in the study conducted in the UK indicated positive experiences with regard to sensitive and caring professionals they could also identify areas of need pertaining to an understanding of the cultural needs of the community. In this project, some of the stakeholders had a more positive perception of the situation in New Zealand. "I think that in a way there is a struggle with the ethnic minority. I think they do very well” (Participant 2: 130-131).

Gerrish’s (1998:116) research indicated the complexity of developing cultural and intercultural communication competencies. "At the moment I don’t know if there are any providers in those
places that would provide clinical placements or experience for our students. My personal opinion, enough in number or sufficiently developed for us to be using these if the places, but I think ultimately that it would be my dream that it became a practice that students actually go out and work in any providers or initiatives that are Maori focus. Primarily to develop our Maori work force but also in terms of developing a general nursing workforce and our understanding on what the nursing role and responsibility in terms of Maori health providers” (Participant 5:184-198).

Teaching culturally sensitive material is also not that easy. In Europe, an attempt was made to solve this problem by offering a pre-registration European nursing degree, by offering components of the programme in the UK, The Netherlands and in the Basque Region of Spain (Scholes & Moore, 2000:61).

In the Department several attempts have been made to include content that would improve the cultural awareness of the future graduates. This tendency was noted by some of the stakeholders. 

"I really like the way that the Treating of Waitangi and our attendance to individuality goes right across the programme. It is not something you do in the first year, first semester and never visit again. It actually is that whole philosophy. I love the way it runs through the whole programme. I think that is really powerful, because it is not something that is compartmentalized. So I really support that. . . "(Participant 8: 128-137). And also: "For a long time we were wondering about how appropriately we add Maori-content into the curriculum and we were avoiding using the word insert or Maori perspective” (Participant 5: 240-243).

Gerrish (1998:116) stated that practitioners must understand the values and cultural prescriptions of the people receiving care from them, especially if their own views would be impinging on the values of their patient. This was recognised by some of the stakeholders, who referred to the specific status of the Māori People in New Zealand. 

"In actual fact, because to me, Māori are significant and unique part of this country. The Tanga Ta Whenua, in that under the Treaty of Waitangi, we are given that status” (Participant 9: 85-89). However, the diversity within the Māori-People has also been identified. "And remember too that, the Māori population is just so diverse that, and what we see is our student population quite diverse, as is our nursing population. And I think it just gives people more time to get into the organisational culture, acknowledging cultural differences within that culture and dealing with patients as well. Because that is a confidence related matter I think. What we do see is some Grads coming out and they are petrified and they are too scared to talk to the patient” (Participant 7: 178-189).
The only negative feedback on meeting the needs of all concerned, indicated a feeling that "All the needs of Māori will never be met" (Participant 9: 63). This participant continued by saying that "No, I am satisfied with the programme, but what I am not satisfied with the level of expertise and attention to Māori components in the programme" (Participant 9: 155-158). One can only hope that this is the opinion of a single person, as the BN curriculum will be preparing nurses to be sensitive to the cultural needs of all their future clients. Lawson (2004:229) stated that "Competent practice involves doing the correct things, at the proper times, in the right ways, with the right people, and securing needed results and other desirable benefits". This obviously means that the future nurse must be able to meet all the needs of all clients as identified above and when the people responsible for the curriculum doubt this ability, then certain problems might be pre-programmed.

**Conclusion**

Overall one can say that the stakeholders were very satisfied with being involved in the process of developing a new curriculum, which became “their curriculum” as much as it belonged to the Department of Nursing and Health Studies.

The study underpinning this paper proved beyond any doubt, that collaboration between the Stakeholders and the Nursing Department lead to a higher level of acceptance on the part of the service providers pertaining to the students and their learning needs, but it also enables the Department to educate the students in such a way, that the needs of both students and service providers are being met.

Even though collaboration has been positively presented, one ought to warn against an overemphasis on the benefits: "... collaboration is not a panacea, nor is it a "cover all”, umbrella concept for every conceivable form of collaborative action. It follows that, as researchers, evaluators, policy makers, trainers, and practitioners adopt or promote a more coherent, theoretically sound, research supported and pragmatic conception of collaboration, participating stakeholders and their diverse constituencies will be able to obtain one or more of its multiple benefits" (Lawson, 2004: 235).

This example of collaboration has evoked very positive responses from the stakeholders and the lecturing staff involved in teaching the programme. It can only be recommended, that other Departments also use a collaborative process when developing new curricula, but more important, to evaluate the results of the process afterwards. The benefits of true collaboration can thus be
evaluated. We are, after all, trying to meet the needs of the services, the community and our students.

References


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Do Pre-registration Undergraduate Student Nurses Learn Analytic and Problem Solving Skills in Clinical Practice?

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The Graduate Programme in Nursing was introduced in the Republic of Ireland in 2002. In order to achieve the aim of this programme it is necessary to produce nurse practitioners with well developed critical and analytic skills, who can critically evaluate nursing practice. The quality of the clinical placements which student nurses receive when undertaking the BSc Programme is central to the preparation of these analytic practitioners.

Aim: To explore how student nurses learn higher level skills through participation and engagement in nursing practice.

Research design:
A Qualitative research design was used in this study. It was considered suitable due to the exploratory nature of the study.

An Ethnographic Informed Approach was used in this study. This approach is well suited to answer the research questions posed in the study since it places major emphasis on cultural and social practices which are known to impact on students’ learning.

Sampling:
Purposive sampling was used since it was most appropriate in order to elicit answers to the research questions. A sample of 12 student nurses participated in the study during their rostered placement.

Data Collection:
Data were collected by participant observation, semi-structured interview and from patients’ documentation over a period of 7 months.

Data Analysis:
Data were analysed by narrative analysis.
Key Findings:
Students learned nursing care in practice placements. There were changes in the students’ perception of higher level skills over the course of the study.

Identification of higher level skills was intimately related to what the student could do and their area of nursing practice in the early part of the study.

Psychomotor nursing skills were perceived as higher level at the beginning of the data collection, this changed as the study progressed. The complex nature of Nursing practice was clearly identified in the study as students journeyed through the rostered clinical placements. Skills of communication, patient assessment, holistic care, enhancing safety, fitting into the ward and nursing practice in wards where the nature of practice was complex, were identified as higher level throughout the study. In order to develop these higher level skills students needed to be able to elicit information, apply standards, use analytic skills, logical reasoning and critical reflection.

Conclusions:
Students learned higher level skills in Clinical Nursing Placements. Their perception of what higher level skills were, changed over the period of the data collection. However some skills remained higher level throughout the data collection period and could only be learned in nursing practice.
AN EXPLORATION OF CHILDREN’S STUDENT NURSES’ EXPERIENCES OF CLINICAL ASSESSMENT

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Background
A recommendation, arising from an evaluation of a pilot general nursing registration/ diploma programme in Ireland resulted in examination of student nurses being devolved to third level institutions from An Bord Altranais (Simons et al. 1998). This coupled with a recommendation of The Commission on Nursing (Government of Ireland, 1998) that children’s nursing remain a post-registration qualification, led to major changes in the clinical assessment process for children’s student nurses.

Aim
The aim of the study was to explore the meaning of children’s student nurses’ experiences of clinical assessment.

Methodology
A phenomenological approach was chosen to underpin and guide the study. This approach was chosen as it sought to explore children’s student nurses’ experiences in order to understand and describe their perceptions of the phenomena and to interpret the impact of these experiences on them.

Analysis
Data was analysed using the procedural steps of Colaizzi’s (1978) research method of data analysis.

Summary of key findings
Three overarching themes ‘affirmation’, ‘activators to learn’ and ‘back to being a student’ emerged from the findings. Participants felt firstly that their experiences of being clinically assessed resulted in their need to be affirmed in order to know how they were progressing throughout the programme. Secondly as clinical assessment enhanced their motivation and self-confidence to care for children their desire to learn increased and finally they felt it was necessary to go through a transition period of being a student when they commenced the programme.
Conclusions

This study supports international findings that clinical assessment is a complex and challenging phenomena and those involved in student nurse education should consider further study of these findings.

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A Tale of Fifteen Men: male partner experiences of adverse prenatal diagnosis

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Background: Research into men’s experience of pregnancy suggests that men play a supportive rather than a participatory role in the birth of their children. It has been suggested that ultrasound has provided men with an opportunity to move from the periphery as fetal imaging allows them to form an image of their unborn child. However the experiences of men whose partner receives a positive prenatal diagnosis at a routine ultrasound examination have been less well-studied.

Aim: The aim of this study is to explore the emotional effects of prenatal diagnosis on men, by reference to the actual experience of a small sample of men during and after their partner’s diagnosis.

Methodology: Fifteen men in Ireland participated in 21 in-depth interviews before and after the birth. Fourteen couples choose to continue the pregnancy and one couple accessed termination of pregnancy services outside the state. Data were analysed using thematic analysis. Ethical approval was granted from the university and clinical site, and the usual tenets of written informed consent were obtained.

Findings: Several potentially conflicting male roles were identified. Men frequently spoke of their concern for their partner’s wellbeing
and the difficulties faced in supporting their partner whilst they sought to come to terms with their own reactions to the diagnosis. Societal expectations of masculinity that inhibit the display of emotion leave men in a double-bind as they consider the appropriateness of their reactions. A lack of acknowledgement of the emotional pain experienced compounds difficulties with emotional disclosure as the male sense of competence is challenged.

**Conclusion:** Male partner responses in the aftermath of fetal anomaly diagnosis are complex. Health professional acknowledgement of men’s feelings and emotions are required if male grief reactions are no longer to be condemned as secondary to their partner’s.
Hop into Evidence-Based Practice to Promote Quality Care: Kangaroo Care in the Healthy Newborn

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Aim of the review:
The purpose of this project is to depict a collaborative effort among staff nurses and clinical leaders to perform a systematic review of the literature and subsequently implement Skin-to-Skin Mother-Baby Care (also known as Kangaroo Care), with healthy mother-infant dyads.

Search and Review methodology:
An Evidence-Based Practice team was formed of key stakeholders. The team followed the “Iowa Model of Evidence-Based Practice to Promote Quality Care” developed by Marita Titler et al. in 2001. This model provided the structure for moving from a clinical question to changing nursing practice. A systematic literature review and analysis ensued.

Staff nurses designed the following clinical question: Is Kangaroo Care a safe and effective alternative to the overhead warmer for healthy newborn infants?

Analysis:
The group was fortunate to find thirty plus years of abundant research and over 400 articles which supported Kangaroo Care (KC). The body of evidence was of Meta-analyses and Randomized Controlled Trials. Nursing research journal club sessions were offered to critique the Kangaroo Care Cochrane review. Team members collaborated with leading experts in KC with questions...
regarding research findings. Ultimately, the team determined that research findings supported a change in practice.

Summary of Key Findings:
Outcomes of the project were designed by combining the Iowa Model of EBP with the hospital organization’s balanced scorecard quadrants for Quality of Care, Customer Service, Quality of Worklife, and Finance. Success was measured through newborn physiologic balance and safety during KC, mothers’ recommendation of KC, and nurse satisfaction in quality of worklife related to KC. There was minimal effect on the budget.

Conclusions:
This innovative approach to pairing a clinical issue with an EBP model has sparked enthusiasm for the movement toward transforming the quality of nursing care through research. Staff nurses comprehend how research findings are applicable to their practice. The Kangaroo Care project is the benchmark for other hospital evidence-based practice initiatives.
Multidisciplinary Team Support for Healthy Late Preterm Infants

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Aim of the review:
To create an interdisciplinary partnership to optimize care for healthy Late Preterm Infants (LPTI) which are defined as newborns who are 34-36 6/7 weeks gestation. Most healthy LPTI’s remain with their mothers in the postpartum period. In the absence of awareness and specific policies, LPTI’s may not be screened for complications associated with preterm birth.

Search and Review methodology:
Based on a systematic literature review and upon USA national and international organizations’ awareness campaigns, a perinatal department created a process improvement methodology to identify and manage infants born 34-36 6/7 weeks gestation and who reside in the mother-baby nursing unit at a large Women’s Health hospital department. An interdisciplinary team developed a plan of care to coordinate prompt identification and special monitoring/care of LPTI’s from birth through the 1st week after discharge. It was noted that the hospital delivered 821 LPTI’s in 2006.

Analysis:
A gap analysis revealed: Limited recognition of special needs for the LPTI; hospital policies did not address LPTI; specific lactation support and discharge plans were absent; an inadequate application of evidence-based practice guidelines existed. The Association of Women’s Health, Obstetric, and Neonatal Nursing (AWHONN) provided the conceptual framework for consumer and health professionals’ education. The recommendations of the National Institute of Child Health and Human Development’s Workshop on LPTI’s were most valuable.

Summary of Key Findings:
Outcomes of the project had a positive impact on both in-patient and out-patient/community patient care. 1. LPTI identification and protocol implementation occurred. 2. Awareness of the LPTI’s
unique needs was raised with all stakeholders – Labor & Delivery Nurses, Mother-baby Nurses, Lactation, Social Services, Medicine, and other support staff.
Hospital re-admission for common LPTI complications such as jaundice, feeding difficulties, dehydration, and infection need to be monitored and data collected and analyzed.

**Conclusions:**
Success in providing improved, evidence-based care is dependent upon the cooperation and collaboration of a multidisciplinary team of perinatal and community maternity specialists. Healthy late preterm infants now receive identification and management specific to their special needs.

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An exploration of women’s experience of labour and birth in Irish Hospitals: The control dimension.

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Background and Context
Women have expectations not only for the safe birth of their baby but also for the process of labour and birth. Maternity services should be responsive to these expectations. Involving women in determining the important elements of a service requires a thorough assessment of women’s needs. In Ireland, women’s experiences of childbirth have not been well documented.

Aim
To explore women’s experience of labour and birth in Irish Hospitals.

Methodology
Following ethical approval, a qualitative, descriptive study consisting of a series of five focus group interviews was conducted. To obtain a diversity of cultural, socio-economic, demographic and service provision perspectives, a purposeful sample of 27 postnatal participants was recruited from four randomly selected Irish maternity hospitals. Data were analysed using Colaizzi’s framework. Three broad themes were identified: ‘Getting started’, ‘Getting there’ and ‘Consequences’. This presentation focuses on the theme of ‘the control continuum,’ a category of the second theme.

Key Findings
Aspects of labour and birth related to ‘feeling in control’ were complex, but crucial to women’s experiences. There were five subcategories related to women feeling in control: information giving,
progressing in labour, relationship with professionals, choice, and pain relief. The relationship with professionals played a pivotal role in enabling other dimensions of control to be realised. Women were reluctant to criticise professionals but some women felt that you could be ‘unlucky with your midwife’. Many women empathised with the emotional and physical demands of caring for women during labour and birth.

**Conclusions**
All aspects of feeling in control during labour and birth are important to women. Women in this study understood the demands on professionals who are caring for women during labour and birth. The synergies of relationships with professionals had a pivotal positive or negative influence on women’s experiences of control.
Postnatal Depression: Prevalence, Mothers’ Perspectives and Treatments

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Aim: This paper presents an overview of research on postnatal depression conducted with postnatal women only.

Search and review methodology: Databases searched included those relevant to nursing, medicine, psychology and allied health over the past ten years. Criteria used for inclusion were research publications pertinent to prevalence rates, experiences of mothers living with postnatal depression, treatments and their efficacy. Seminal papers relevant to these areas published prior to this time were also included. The words postnatal and postpartum are used interchangeably throughout the international literature and for the purpose of this paper they are used synonymously.

Analysis: Research spanning three areas is reviewed namely: prevalence, mothers’ experiences and treatments.

Summary of key findings: The review shows prevalence rates to vary from 4.4% to 73.7% with the most recent systematic review suggesting a rate of 13%, indicating a serious clinical issue for nurses providing postnatal care to mothers. Mothers’ experiences of living with postnatal depression exemplify such feelings as
loneliness, anxiety, hopelessness and loss of control at a time when expectations of joyousness are anticipated. Results of research on treatment options show limited success with antidepressant medication, some success with psychotherapeutic options and the importance of social support to mothers with postnatal depression. Comparisons of studies are made from methodological perspectives drawing on their strengths and limitations.

**Conclusions:** Overall the review highlights the high prevalence rates of postnatal depression, negative feelings exemplified by mothers’ living with this condition and the limited success of treatment options available for mothers. Postnatal depression is a significant clinical issue for nurses providing postnatal care for mothers and is underassessed, misunderstood and very often poorly treated.
Joining up the dots – Employing patient perspectives on a booklet to connect lifestyle change to health gains in coronary heart disease.

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**Introduction**  
This study aimed to explore how coronary heart disease (CHD) patients’ opinions would inform the design of an information booklet for promoting healthy lifestyle behaviours. CHD morbidity and mortality in the Republic of Ireland and United Kingdom are among the highest in Europe. Lifestyle behaviours, such as smoking and physical inactivity increases the risk of CHD. There is currently no clear information on how best to design an information booklet which addresses issues surrounding lifestyle behaviour change identified by patients.
Four general practices in Ireland were purposively sampled to take part in a pilot study, which used focus groups to collect data on CHD patients’ priorities and information needs regarding healthy lifestyles. The data were used to design a booklet which was tested in a pilot intervention to improve secondary prevention of CHD in practice. The CHD patients who used the booklet were asked their opinion about the booklet being ‘fit for purpose’. The usefulness of the booklet in preventive consultations was assessed by interviewing practitioners. The pilot ran from March 2003 – May 2004.

Patients had a varied exposure to secondary prevention lifestyle information and gaps in information provision were identified such as knowing the purpose of their medications. Employing discussions allowed the patient perspective as ‘expert’ in their condition to be included in the booklet design and practitioners reported that understanding of the connection between lifestyle and health enhance a patients’ abilities to make healthier choices. Considering patients’ experiences and opinions in designing a health information booklet improves understanding of the patient role as expert and may help practitioners identify strategies which could lead to greater patient health gains.

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Practical Recruitment in Research for fun and profit - A research nurse perspective.

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Introduction
The challenge of successfully recruiting and retaining patients and practitioners to participate in studies which require changes in their everyday practice has been reported widely. Maintaining facilitative and supportive relationships throughout the duration of a study without compromising standards of good clinical practice and scientific rigour is an endeavor that may be likened to juggling numerous fragile balls. However practical guidance for researchers seeking maximal recruitment to randomised controlled trials is scant.

Our aim was to identify practical guidance for improving recruitment to future research studies in general practice based on the experience of issues encountered in a randomised controlled trial of an intervention for secondary prevention in coronary heart disease. We used a stepped approach method to deliver information about the study, matching details provided to questions asked after initial contact and ensured support provided was tailored to changes in the research setting. Forty eight general practices located across
the Republic of Ireland and Northern Ireland and 909 patients were recruited. We conducted focus groups to explore issues surrounding recruitment. The data collection began December 2004 and the study completed in July 2007. Results showed that identifying eligible participants required the cooperation of staff involved in health service administration and clinical staff. Allocating sufficient time in the recruitment process for the identification of eligible participants is vital. Practice staff who participated reported appreciation of tailoring of the delivery of information and support to meet their needs. Qualitative findings suggested participants were encouraged to take part by receiving clear information about the study, an invitation linked to their own practice and a helpline telephone number. In conclusion ensuring the participation of adequate numbers of practices and patients in randomised controlled trials allows increased confidence in the representativeness, validity and generalisability of study results. This has direct implications for both patient care and clinical outcomes.

References:


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Women’s experiences of disclosure of their drug use and dependence to the maternity services in Dublin.....“The stigma”

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Abstract

The number of pregnant opiate-dependent women accessing maternity services in the Republic of Ireland has increased. Although a drug-dependent woman’s pregnancy is deemed at risk, it is difficult to attribute the total risk to drug misuse alone as drug dependence is a symptom of the woman’s lifestyle. This group of women require a specialist midwifery service that links drug treatment and maternity care. In Ireland, this service has been developed through the Drug Liaison Midwifery Service. However, if this group of women fail to disclose their drug use to the maternity services midwives are obliged to enquire why. Yet, there are no published studies in Ireland on this topic.

The focus of this study was to explore women’s experiences of disclosing their drug use and dependences to the maternity services in Dublin. This study was conducted within the addiction service of the HSE Eastern Region.

A grounded theory approach utilising semi-structured interview was considered the most appropriate means to conceptualise the problem and facilitate exploration and understanding of the topic. Purposive sampling was used. Twelve women were interviewed. The data was analysed using a system of open coding. The findings centred on five major themes that emerged from the data: disclosure occurred to protect the baby; exposure of drug-using behaviour and methadone treatment; feelings of guilt and shame; stigmatised and judged; and the drug liaison midwife facilitated disclosure and normalised the situation in the maternity services. This paper will focus on the women’s perception of stigma.
The women felt that the stigma associated with drug dependency was intensified while pregnant and after delivery, and this emerged as a significant theme. Perceived judgemental attitude of staff exacerbated the women’s feelings of guilt and stereotyping. This was highlighted by the fear of rejection and acute sensitivity to the judgement of others.

The study highlights drug-dependent pregnant women’s experiences within the maternity services and offers implications for midwifery practice, service delivery and the uptake of services by drug-using mothers.

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Factors Influencing Caesarean Section Decision-Making in Taiwan

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Background
Statistics show that Taiwan has the third-highest rate of caesarean section at 33% of all births. This is double the World Health Organisation recommendation limiting the caesarean rate to 10-15% (WHO, 1985).

Aim
This paper reports data from the second stage of doctoral research exploring factors influencing high caesarean section rate and decision-making in Taiwan.

Methodology
Semi-structured interviews with two purposive samples (women and obstetricians) from a university hospital in Taiwan were undertaken to collect in-depth information. Interviews were audio-taped and transcribed verbatim. Women's experience and decision-making and obstetricians' opinions related to caesarean section were explored by content analysis. Ethical and administrative processes were adhered to prior to securing access to former patients who had had a caesarean and obstetricians.

Analysis
Data from semi-structured interviews were analysed by content analysis. Coding began from general concept of verbatim transcription and proceeded to specific concepts. Categories and themes were identified.
Summary of key findings
Two main factors: internal and external factors from women were explored. Two categories were identified as internal factors and three categories as external factors may affect women having a caesarean. Internal factors include: perceived differences between vaginal birth and caesarean birth, and personal reflections on previous or present birth experience. External factors contain: medical, social and culture aspects. Furthermore, five categories were revealed from the obstetrician: physiological, psychological, social and cultural, economic factors, and technology.

Conclusions
The process of decision-making related to caesarean is very complex and includes medical, social, and cultural aspects. This complexity must be fully acknowledged in the design of initiative to transform the incidence of caesarean section in Taiwan to WHO standard.

References
Just how male are male nurses?

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Aim. The aim of this study was to examine how male nurses perceive their gender and their caring roles, and to examine the relationship, if any, between them.

Background. Caring, the core concept of nursing, has become intractably associated with the female gender role. This may explain why the majority of nurses are female. However some men also chose to become nurses, thus adopting profoundly caring roles themselves. Must these men adhere to the female gender role in order to care? Alternatively, might these men maintain a sense of themselves as men, by perceiving of care in a more instrumental (masculine) than expressive (feminine) manner, and resultanty migrate to the more instrumental specialities in the profession (management, critical care, education)?

There is a dearth of evidence to support or refute these suppositions, and they therefore remain merely speculative underlining the need for the study at hand.

Method. A quantitative descriptive correlational approach was adopted. A random sample of 250 male registered general nurses were sent questionnaires to assess the extent of their adherence to male or female gender roles, and to assess whether they perceived caring in more instrumental or expressive terms. Respondents were also asked to state the speciality in which they worked.

Results. 104 valid responses were received. The vast majority of the sample (n=78) identified more with the female gender role. Only 21 of these men identified more with the male gender role. The largest single group of nurses were employed in the area of gerontology (not a stereotypically instrumental area). Only one small subset of nurses were consistently more strongly male gendered than the rest of the sample, these were the men employed in the learning disabilities sector.

Most respondents ranked both instrumental and expressive caring forms as very important, however respondents showed a small predilection towards expressivity. On correlation, those who
adhered to more female gender role characteristics had a tendency to perceive caring in an instrumental manner, rather than an expressive manner.

**Conclusion/recommendations.** The results obtained in this study have illuminated that this sample of male nurses are most adherent to female gender role norms. In addition, this study has found that male nurses perceive of care in almost equally expressive and instrumental terms, challenging the supposition that male nurses perceive of care in a one-dimensional instrumental manner. The main recommendations include the need for further research to investigate if these men’s gender findings are unique to male nurses, and whether these men’s gender perceptions change over time. In addition, research is warranted to explore the effects of gender on other dimensions of caring and to ascertain the reliability of examining gender and/or caring from a quantitative as opposed to a qualitative stance. Furthermore, implications for practice include an examination of whether male nurses actually do migrate to certain ‘masculine’ areas within the profession as widely purported. Recruitment recommendations stemming from this study include considerations of how to increase the number of males in undergraduate nursing programmes. Finally, educational recommendations include broadening the nursing curricula in order to familiarise students with all the dimensions of care.
From student to staff nurse – facilitating the transition using simulation

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Background and Context
This paper will give an overview of the development, implementation and evaluation of a ward based simulation exercise in Dublin City University School of Nursing. This simulation exercise was developed in response to students expressing concern about their role transition from student to registered nurse. The relative lack of opportunities for the development of higher level skills such as caseload management, prioritising care and decision making towards the end of the programme was identified as a deficit.

The exercise was piloted with a small group of student nurses in April 2006. The findings were extremely positive and the simulation exercise was provided for all fourth year general nursing students between November 2006 and January 2007.

Aim of Study
The aim of this study was to evaluate simulation as a teaching and learning exercise for one cohort of fourth year general nursing students.

Methodology including research design and sampling
All fourth year general nursing students took part in the simulation. Ninety student nurses from the general pathway participated in six different exercises. There were usually 16 students in each exercise with 4 playing the roles of nurses and 12 playing the roles of patients. A reflection and debriefing exercise took place after each session during which student comments regarding the exercise were noted. Participants were asked to voluntarily complete an anonymous questionnaire that collected data about the exercise, the students’ perceptions of their own learning during the exercise,
and their opinion of the exercise. The questionnaire had three sections:

1) The first section of the questionnaire consisted of a list of closed questions with yes or no answers about the exercise itself.

2) The second section consisted of 23 aspects of nursing. Students were asked to rate their own perception of their knowledge from very poor to excellent both before and after the exercise. The questions fell under the four category headings previously identified.

3) The final section consisted of three open ended questions to complement the quantitative data collected.

No demographic information was collected as this may have led to the identification of individual students. Sixty-eight of the ninety students who participated in the exercise completed the questionnaire giving a response rate of 75.5%.

Ethical approval was received from the Research Ethics committee in DCU

Data Analysis
Quantitative data was analysed using non-parametric statistics in SPSS. This was appropriate to the level of data collected. The open ended questions were analysed manually and coded into common themes.

Summary of key findings
Answers to the general questions in the first section suggest that the exercise was viewed positively by students and did contribute to their knowledge.

- 95.6% of students enjoyed the exercise.
- 97.1% of students would recommend the exercise to other students
- 94.1% would do the exercise again
- 96.6% felt the exercise reflected the reality of the clinical environment
- 82.4% felt it increased their confidence in their own ability
- 95.6% felt the experience gained in the exercise would help them in their role as a staff nurse

Students were asked if the exercise helped to consolidate their knowledge under the four key headings identified. The results are outlined in table 1.
Table 1

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation and Management</td>
<td>83.6%</td>
<td>6.0%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Clinical Practice</td>
<td>86.6%</td>
<td>3.0%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Communication</td>
<td>89.7%</td>
<td>2.9%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Ethical/professional/legal issues</td>
<td>77.9%</td>
<td>7.4%</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

Not applicable was given as optional answer for these four questions as some students may not have experienced all of the scenarios in the simulation depending on the roles they were allocated.

Overall students’ ratings of their own level of knowledge increased after the exercise. In some instances they were lower which would indicate that the exercise identified gaps in their knowledge that they were not aware of.

The answers to the open ended questions included comments as to how beneficial the exercise was and how they felt it prepared them for their roles as staff nurses. Comments in relation to facilitating the transition from student nurse to staff nurse could be grouped into the following headings:

- relating/integrating theory and practice
- development of caseload management skills
- development of professional practice
- confidence building
- identification of weak areas for further study/practice
- dealing with difficult situations

Students’ comments during the debriefing and feedback session supported these findings.

There were a number of limitations to this study.

- Students were asked not to tell their classmates about the exercise however we noticed that for certain areas where earlier groups had made errors or overlooked specific care later groups were more alert to these issues. While this in itself contributed to their learning we could not quantify to what degree.
- The questionnaire measures students’ perceptions of their own level of knowledge before and after the exercise. We did not measure whether or not learning had actually taken place.
- In general the students who acted as patients viewed the exercise more positively and had higher increases in their perceived level of knowledge than the students who acted as
nurses. The fact that there were twice as many patients as nurses may influence the overall results making them appear more positive.

In conclusion, the results of this study suggest that this simulation exercise is a valuable teaching and learning strategy that can assist in the transition from student nurse to staff nurse.

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Improving Nursing Documentation in an Irish Urban University Hospital
Phase 1 of an Action Research Project

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Modern healthcare systems require healthcare professionals to demonstrate the cost effectiveness of their interventions: nurses and midwives are therefore challenged to articulate what it is they do and its benefits to patients and clients in a way that is meaningful not only to themselves, but to their multidisciplinary healthcare, social care and health service administrative colleagues (National Council for the Professional Development of Nursing and Midwifery, 2006). At present this is not being achieved and there have been repeated concerns regarding nursing documentation. Nurses are striving to demonstrate, record and articulate what it is they do. An increase in the complexity of patients health problems, nursing and midwifery workload, the increase in the amount of data available and patients participation in the decision making can present challenges to nursing and midwifery care and to the accuracy of its documentation (Karkkainen and Eriksson, 2005).

The current system of documentation in the GUH (Galway University Hospital) has been identified as a risk from individual nurses, clinical nurse managers, Clinical nurse specialists, Risk advisors, Patient complaints officer and management.

According to An Bord Altranais’ inspection of the GUH in 2006, a more systematic approach needs to be taken in relation to nursing care plans where nursing priority needs are identified and patient outcomes recorded.

An audit of nursing documentation was carried out in the GUH in February 2007. All nursing observation charts, narrative notes and evidence of any care plans were included in the audit. 5 discharged patients charts were audited on every ward. The results proved disappointing with 100% non-compliance on some observation forms. However, this may be due to the many pieces
of paper that nurses have to record on which may also lead to
duplication of documentation as many aspects of nursing care were
documented twice in both the observation sheets and again in the
green evaluation sheets.

The second form of data collection for this project included focus
groups which were conducted in February – March 2007. There
were 6 focus groups in total, 4 in UHG and 2 in MPH (Merlin Park
Hospital). Approximately 10 people from staff nurses to clinical
nurse specialists and clinical nurse managers attended each session.
Many issues were raised at these focus groups. 4 pertinent questions
were asked in relation to nursing documentation. Firstly, the
participants were asked how they felt about the results of the audit.
The majority were not surprised but were quite fearful about the
legal repercussions that poor documentation may result in.

The second question raised was “What are the current challenges in
documenting patient care in the GUH”. The response to this
focused mainly on lack of time, too many documents to record in,
and lack of clarification as to the role of the nurse. In relation to a
better way of documenting most people aspired to pre printed
standardised care plans available on the hospital intranet and a tick
box system for documenting the daily basic nursing care

Also a better system of storing the nursing documentation was
discussed and a computerised paper less system was the response
of the majority and if that was not possible, a nursing booklet,
which would include the patient profile, nursing assessment and all
observation sheets, was recommended.

Everyone was then asked what he/she understood as his/her
responsibility in relation to documentation. In response to this the
majority knew that they were accountable and responsible for their
actions and documentation. However, many felt that the ward
managers have a key role in ensuring the documentation is up to
date, accurate and safe in case of legal scrutiny. A relevant number
of people did also recommend a documentation team to continually
observe nurses documentation on the wards.

Finally, in the current environment of health service reform and
service quality improvement, healthcare professionals are
increasingly required to demonstrate the effectiveness of what they
do and articulate how they are contributing to the quality of patient
and client care (Bjorvell et al, 2003). Nurses and Midwives have
the potential to carry out a wide range of interventions in a variety
of health care settings and with patients and clients with varying
diverse needs. By identifying their interventions and measuring
the outcomes of these interventions, nurses and midwives can articulate and clarify their roles and functions in relation to both the settings in which they work and the patients and clients to whom they deliver care (Thoroddsen, 2005).

**Introduction of a common nursing language using standardised nursing care plans**

In the past, nurses as well as other health care professionals had difficulty in describing nursing and what it is nurses do (Thoroddsen, 2005). Nursing is often described as a list of tasks, which requires certain skills. The North American Nursing diagnosis association (NANDA), The Nursing Intervention Classification system (NIC) and Nursing Outcome Classification (NOC) are comprehensive standardised classifications of diagnosis, interventions and outcomes of the interventions that nurses perform (Needleman et al, 2002). A classification of nursing interventions is needed to standardise the language that nurses use to describe their specific behaviours when delivering nursing treatment (Pelletier et al, 2005). When nurses systematically document the diagnosis of their patients, the treatment they perform and the resulting patient outcomes using a common standardised language, they then will be able to determine which nursing interventions work best for a given diagnosis and nursing as a profession will gain recognition for that demonstrated contribution to describe patient outcomes (Thoroddsen, 2005).

**What is the Nursing Language (www.nanda.org)**

- It is comprehensive in that it includes a full range of nursing interventions from general practice and speciality areas. Interventions include physiological and psychosocial, illness treatment and prevention, health promotion, those for individuals, families and communities, and indirect care; both independent and collaborative interventions are included.
- It is research based. The research, which began in 1987, used a multi method approach; methods include content analysis; questionnaire survey to experts, focus group review, similarity analysis, hierarchical clustering, multidimensional scaling, and clinical field-testing.
- It was developed inductively based on existing practice. Original sources were current textbooks, care planning guides, nursing information systems from clinical practice augmented by clinical practice expertise of team members and experts in specialty areas of practice.
- It reflects current clinical practice and research. A list of background readings that support the development of the intervention accompanies all interventions. Also all interventions have been reviewed by experts in clinical practice.
and by relevant clinical practice specialty organisations; and a feedback process to receive suggested changes has been developed.

- It has an easy to use organising structure. All interventions have definitions and interventions are numerically coded.
- It uses language that is clear and clinically meaningful. Throughout the work, the language most useful in clinical practice has been selected.
- A large and diverse research team developed it. Team members represent multiple areas of clinical and methodological expertise.

Benefits to Nursing Practice

- When nurses can describe what they do in terms that the public and others understand, they begin measuring it, evaluating it, and validating its impact on the nation’s health, research and public policy.
- Standardized languages provide clear terminology so that nurses can convey what it is that they do in a way that reflects the knowledge and skills that are essential to nursing practice.
- The standardized language provides consistent terms for nurses to use to describe and document their assessments, interventions and the outcomes of their actions. As a profession, this allows nurses to articulate the unique contribution of nursing to other members of the healthcare team, administrators and the public.
- Promotes continuity of care.
- Standardized languages can benefit nursing research. There is currently a demand for healthcare providers, including nurses to build on knowledge to support evidence-based practice. Nurses must test the way in which they carry out nursing care and determine if their interventions are producing positive patient outcomes.
- It can be used to facilitate critical thinking and develop curriculum in nursing programmes.
- Result in reduced amount of wring and will decrease duplication of information.
- Eliminate the use of inappropriate information that is being written on the progress notes.
- Facilitate the preparation for computerisation.
- Note taking will be more contemporaneous.

Benefits to Patients

- The use of standardized languages has the potential for a major impact on patient care. The main benefit is the enhancement of communication. Because nursing is an information intensive
activity, the ability to communicate accurately and in a timely manner with other nursing professionals as well as other disciplines is critical.

- It allows the capture of patient information in a more efficient manner. This leads to more effective patient care.
- Stepping stone to becoming a computerised documentation system. Can be used whether the method of entry is computerised or manual.
- Continuity of care is facilitated through the use of the standardized language. Having a clearly defined plan of care ensures that all team members have an understanding of the care to be provided to the patient.
- Quality Management. The use of standardized languages allows comparison of measurable patient outcomes based on the nursing interventions performed. In this way, nursing best practices are developed. Interventions can be evaluated based on the outcomes documented.
- Inform Health Care Administrators. Standardized nursing languages and the development of an information infrastructure provide a means to collect and analyse data to inform administrators of nursing contributions and to cost out nursing services. The inability to capture documentation that describe nursing practices and assign value to their professional contributions may lead to decisions to replace the professional nurses’ skilled services with those of less skilled workers.

Finally, in the current environment of health service reform and service quality improvement, healthcare professionals are increasingly required to demonstrate the effectiveness of what they do and articulate how they are contributing to the quality of patient and client care. Nurses and Midwives have the potential to carry out a wide range of interventions in a variety of health care settings and with patients and clients with varying diverse needs. By identifying their interventions and measuring the outcomes of these interventions, nurses and midwives can articulate and clarify their roles and functions in relation to both the settings in which they work and the patients and clients to whom they deliver care (MacNeela et al, 2006 and Voutilainen et al, 2004).

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Title: A specialist practice post-graduates’ evaluation survey to establish progression interest to a Master’s Degree programme.

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The purpose of this study was to evaluate the Higher Diploma in Specialist Practice programmes offered at a Department of Nursing located in an Irish regional third level college and identify interest (if any) in post-graduates progressing to a Master’s Degree programme if available. Currently post-graduates are required to travel to other third level colleges outside the region to access and progress to a Master Degree level programme.

The aim of the study was two-fold: to evaluate the existing specialist programmes and identify interest to justify development of a Master’s degree programme for the future.

All nurses who had successfully graduated with a Higher Diploma Award were deemed eligible to participate and were contacted on that basis. A self-completion questionnaire comprised of open and closed questions was administered to 30 post graduate nurses (n=30). Twenty-two (22) post graduate nurses completed the survey (response rate 75%). The questionnaire comprised of five different sections. Questions were divided into various categories covering a range of aspects pertaining to demographic details of graduates and their overall evaluation relating to the academic and clinical components of the Higher Diploma specialist programme completed. Nurses were also asked to indicate progression interest in participating on a Master’s Degree programme if available at the college.

Quantitative analysis using parametric and non-parametric tests was carried out on the data. Content analysis was used to analysis the open-ended questions.

Main findings suggest that completion of a specialist practice programme favourably affected clinical knowledge and skills. Study
groups strongly supported the development and provision of a Master's Degree programme with the majority (68%) expressing positive attitudes towards progression if such a programme is available at the college. This research study provides valuable recommendations for current programme improvements and justification for the future development of a Master Degree programme at the college.
Integrating Theory into Practice through the use of Educational Supervision

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ABSTRACT
Although formal clinical supervision is accepted as an essential aspect of reflective practice in nursing, uptake of this facility remains low. Clinical supervision does occur but generally as an informal peer support on an ad hoc basis. It is also true that generally the application of theory to practice also remains an ongoing issue within nursing. This is clearly demonstrated in the failure to maintain practice of learned skills following training in these skills.

As a component of a Psychosocial Interventions (PSI) pathway, educational supervision and subsequently clinical supervision were introduced as tools to help in bridging the theory/practice gap and encouraging the ongoing use of skills learned in training. A Cognitive Behavioural Therapy model and structured homework was used with small groups of students. It was evaluated through the review of the supervisor’s report on participation in supervision and by direct observation of supervision sessions. This was followed up six months post-training by individual interviews.

Although initially nervous of the process, the students soon found the supervision to be supportive of their practice and an excellent forum for the sharing of ideas and experiences whilst in training. However at the post training interviews it became apparent that those who maintained both practice of skills and regular supervision were those who worked in an environment which facilitated these activities. In other areas the use of skills was limited and supervision was described as difficult to maintain although the nurses concerned had maintained contact with those in their area who had also been members of their supervision group in training. Thus it appears that while educational supervision appears to allow the development of skills and reflection within a skills based programme of learning the ongoing use is dependant on both support in practice and the motivation of the staff involved.
Introduction
Clinical Supervision is viewed as a necessary part of nursing practice as a means of encouraging reflection on practice, developing skills and supporting staff. It has also been described as a means of enhancing patient care and protecting both patients and staff within the caring environment. (Mullarkey et al 2001) Despite this the uptake of formal clinical supervision within nursing generally remains poor although it is often carried out on an informal basis suggesting that nurses feel in need of the support that it can provide.

Formal supervision often takes second place to the demands of everyday practice being viewed by many as an elitist activity indulged in by those who are somewhat removed from ‘ordinary practice’ and facilitated by supervisors who are ‘expert’ in their field (Faugier, 1998). For this reason supervision is often avoided by nurses who fear of being seen as incompetent by others or feeling disempowered by a process with which they are unfamiliar (Bond & Holland, 1998). Frequently, nurses view it as yet another appraisal tool which can be used by management to monitor their clinical performance a view reinforced by the fact that supervision is often carried out by line managers. There is certainly a management function in supervision (Wilkin, 1998) but this is only one aspect of it, the other functions being educative and supportive.

It is also the case that in most instances 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).

This presentation will focus on the educative and supportive functions of supervision as they are used to engage students in educational and clinical supervision as they undertake a course in PSI.

There are various models of clinical supervision available that focus on its different functions. A Cognitive Behavioural Therapy (CBT) model was chosen in this instance, as it reflects the nature and structure of the interventions that the students learn (Sloan et al 2000). This approach is acknowledged as valuable by van Ooijen (2003) who suggests that one of the strengths of linking supervision to the theoretical model for practice is that it allows the supervisor to act as a role model within supervision.
Implementation of Supervision
Within the Psychosocial Interventions (PSI) programme students were brought together in small groups of up to five, usually in a practice area, to reflect on the homework given to them at the previous day of teaching. Group supervision was chosen as it facilitates a sense of belonging with all members working together and learning from each other’s experiences while developing from a similar level of knowledge. (van Ooijen 2003) The homework was focused on carrying out an exercise within the work area, relevant to PSI practice, and derived from that learned in the classroom. Time was allocated for each student to discuss their experience and reflect on its meaning to their practice. This allowed the student to transfer material learned in class into practice thus bridging the theory-practice gap (Bradshaw, 2002). Within this there was a gradual move from highly structured educational supervision to clinical supervision where the students had a more active role in the setting of agendas although this was guided by the requirements to meet the outcomes of the programme.

Feedback on Supervision
Feedback on the use of the acquired skills was obtained from the supervisor’s reports which are a requirement of the programme. Student responses to supervision was elicited by observation of educational supervision sessions and from interviews carried out at the end of the programme and six months after completion.

Initially the students appeared threatened by the process of supervision using a variety of excuses to avoid having to participate, including not having the time and being unable to get away from clinical areas. These are identified by Bond and Holland (1998) as being classic responses of nurses to supervision. Status within the groups also became an issue, particularly in the group which mixed pre-registration students with trained staff. The trained staff adopting a variety of behaviours designed to protect their own status.

As the sessions progressed the groups developed an ethos of sharing experiences and ideas and expressed the view that they were in fact learning together and from each other. The students generally agreed that by being closely linked to the previous theory session the supervision aided in bridging the theory/practice gap by encouraging the use of the skills in practice. Having identified, during this process, deficits in previous practice they also found the supportive nature of the supervision group valuable in helping change the way they practiced, often in environments where colleague support was not forthcoming.
All students agreed that the use of an agenda, guided by the homework, and the structure of the sessions was a useful element of the supervision particularly when dealing with complex issues arising from practice. This was felt to be helpful in maintaining the focus of the discussion which could potentially have digressed from the topic in hand.

**Follow-up data**
The group of student were interviewed 6 months post-completion with a view to identifying which, if any, skills were being utilised and the occurrence of ongoing use of supervision. In general the responses indicated that all students were utilising aspects of PSI, although those working in the in-patient areas were experiencing greater difficulties in implementing them than nurses in day hospitals and community. The use of clinical supervision also followed the same pattern with those staff in areas where it was regarded as the norm and a network already existed making greater use of supervision than those who did not.

**Conclusion**
It appears that, while the use of educational supervision allows students to integrate theory into practice while they are learning new skills, ongoing use of skills is very much influenced by the clinical area in which they work. Those nurses who have greater autonomy in practice are more likely to utilise new skills than those in the in-patient areas. The availability of supervision also seems to influence the use of new skills with this being more prevalent again in areas where autonomous practice is the norm. This suggests that more support is required in implementing supervision and utilising new skills in clinical areas where this is not the norm.

**References**


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ROLE EXTENSION AND EXPANSION:
A SURVEY OF NURSES’ ATTITUDES

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Introduction
The nursing profession has evolved considerably over the last century. This global evolution has been in response to issues such as changes in demographic and epidemiology, social and health policies (An Bord Altranais 1999), technology, economic and culture (Riley and Peters 2000, Cahill 1996) as well as introduction of quality assurance initiatives in efforts to establish standards of nursing care (Chang and Twinn 1995). With these changes, there is now a greater emphasis and demand for the provision of high quality and holistic nursing care. To meet these demands, nurses have had to develop and improve their practice.

However, there are concerns that these developments are not always for the benefit of patient care or the nursing profession. Previous research have identified that some nurses find the concepts of role developments such as role extension and role expansion ambiguous and confusing. Other concerns raised include inadequate level of training and education, lack of support and clear guidelines for nurses to extend and expand their roles. In addition, a number of researches have highlighted trepidation of the negative effects of the extension and expansion of nursing roles such as jeopardized standard and quality of patient care. This study aims to identify nurses’ current views on the extension and expansion of nursing role in relation to perceived benefits and concerns.

Conceptual Definition
The concepts under discussion include the Scope of Professional Practice, role extension and role expansion. In Ireland, the scope of nursing practice is defined as “the range of roles, functions, responsibilities and activities, which a registered nurse is educated, competent and has authority to perform” (An Bord Altranais 2000:3). This scope of nursing practice can be extended and expanded in respond to contemporary health needs.
Role extension was described as a growth in nursing practice through the mechanical addition of parts (Hunt and Wainwright 1994). It involved nurses adopting tasks and activities not included in the basic training for the register through training, supervision and certification by other healthcare professionals (Mitchinson and Goodlad 1996). These tasks and activities included intravenous venepuncture and cannulation, application of Plaster of Paris, suturing and changing of gastrostomy tubes.

This concept was criticized for its emphasis on the tasks and technical skills. In an era of high quality patient care using a holistic approach, this task-centered approach was found to be incompatible with the patient-centered approach that was advocated. In addition, role extension was found to limit the scope of nursing practice through the strict guidelines and protocols that were put in place to ensure that nurses were performing only the extended roles that they were trained and certified to perform. In addition, there was no obligation on nurses to bear responsibility and accountability for their clinical practice, as doctors were maintaining overall responsibility for these duties and tasks.

In response, nurses were encouraged to expand, rather than extend, their roles by adopting and performing duties from other healthcare professional within the philosophy of nursing. Mitchinson and Goodlad (1996:734) defined it as “a higher level of nursing practice within the existing boundaries of nursing.” The concept involves nurses performing a wider range of roles and activities facilitated by theory and knowledge of nursing, developed through research, experience and continuing education. In expanding their roles, nurses were encouraged to take into consideration the philosophy of nursing by incorporating the caring and holistic aspect of nursing.

Literature Review
There is a plethora of research highlighting the positive attitudes of nurses towards role expansion. In Goldman’s (1999) cross-sectional survey into intensive care nurses’ view of role expansion, findings revealed that respondents perceived that patients were the main beneficiaries to nurses expanding their role. The findings from Goldman’s (1999) study were supported by Carver’s (1998) phenomenological study, which found that respondents agreed that role expansion will lead to improved patient care through the promotion of holistic approach and increased time spent with the patients. The ability to expedite the care and treatment was also perceived as a benefit of the expanded role in a study carried out by Jones (2003).
Another significant and positive aspect of role expansion is the advocacy of responsibility, autonomy and accountability in nursing practice. Wiles et al (2001) found that nurses working in the unit perceived the high level of autonomy and responsibility had led to enhanced skills and confidence in their ability to make decisions regarding their patients’ care. Wilson-Barnett et al’s (2000) observation of the Advanced Nurse Practitioner roles found that nurses believed that a major change in their role involves the enhanced level of clinical autonomy and responsibility in not only the care of the patients, but also in initiatives to develop and improve the clinical environment, such as development of new protocols, encouraging the use of evidence-based practice and the professional development in colleagues.

However, nurses are also expressing concerns in relation to these new roles. Studies into nurses’ views of role extension and expansion have presented indication of confusion regarding the concepts (An Bord Altranais 1999, Bowler and Mallik 1998). In An Bord Altranais (1999) study, nurses had difficulty in articulating precisely the difference between role extension and role expansion. This finding is supported by Bowler and Mallik’s (1998) qualitative study, which showed that respondents were unable to provide a clear definition and differences between the concepts.

In addition, studies have shown that nurses believed that the developments of nursing roles have been in response to changes in other healthcare professions, especially medicine (Richardson and Cunliffe 2003, Calpin-Davies and Akehurst 1999). Crinson (1995) found that role expansion was also developed as a response to providing medical cover for junior doctors who were reducing their working hours. The findings from Crinson’s study are supported by An Bord Altranais (1999) review which highlighted nurses’ views that the development and expansion of nursing roles should be orientated around the philosophy of nursing rather than as a reaction to changes in other professions, which has occurred to date.

Another barrier to the development of nursing roles through role extension and role expansion is the perception of increased litigation in performing these new roles (Jowett et al 2001, Tye and Ross 2000, William and Sibbald 1999, Bowler and Mallik 1998, Edwards 1995). Tye and Ross (2000) found that nurses as well as doctors recognized the pressure that Emergency Nurse Practitioner’s experience in ensuring that they practice safely in order to avoid legal claims of negligence from patients. Both professions felt that nurses were more at risk of this then the doctors.
Methodology

The study employed a comparative descriptive survey methodology. Using a sample size calculator set at 5% level of error and 95% level of confidence, a sample size of 150 nurses was randomly drawn from a population of 250. The population for the study from which the sample was drawn consisted of all Registered Nurses working in acute clinical areas. The sample included full-time and part-time Registered Nurses employed on a permanent basis in the three acute hospitals in one health board, the formerly known Midland Health Board region (HSE Dublin/Mid-Leinster). Clinical Nurse Managers 1 and 2 were included as their roles involve elements of clinical practice in addition to their management roles and to enable the exploration of relationships between the different grades of nurses and their attitudes towards role extension and expansion. Registered nurses employed on a temporary basis or by agencies were excluded due to the variability in their clinical areas of practice.

Permission to conduct the research was obtained and granted from the Directors of Nursing of all three sites. Consent from nurses to participate in the study was by virtue of completion and return of the questionnaire. The right to privacy was observed through anonymity and confidentiality of participants of the study.

The constructs or variables that were observed and measured in the proposed study were nurses’ attitudes, the Scope of Professional Practice, role extension and role expansion. The study employed a questionnaire developed by Magennis et al (1999) for a dissertation on “the attitudes of practicing nurses to role extension and role expansion.” Permission to replicate the study was obtained and granted by the supervisor of the dissertation, Dr. Slevin.

The questionnaire contained thirty items. The first section consisted of five dichotomous ‘yes’ or ‘no’ questions developed to identify attitudes towards the Scope of Professional Practice. The second section consisted of ten items with degrees of agreement or disagreement on role extension followed by third section with eight items related to attitudes towards the expanded role. The final section of the questionnaire consisted of seven question on biographic data.

Data were collected using a self-administered survey questionnaire distributed by post. From a total of 150 posted, 88 completed questionnaires were returned giving an overall response rate of 58.7%. The low response rate, even though common, is slightly below the recommended 60%, resulting in a high risk of response bias (Polit and Hungler 1999).
Cronbach’s Alpha values for the instrument used in this study were 0.8022 for role Extension scale and 0.7822 for the Role Expansion scale. To add to the reliability of the instrument, Spearman-Brown prophecy formula was also used to test for association of items between scales. The results showed that most of the items were significantly correlated, with 6 items out of 45 correlating below 0.10 in the Role Extension scale and 2 out of 28 correlating below the recommended level of 0.10 in the Role Expansion scale. Fifty-one out of a total of 73 items correlated significantly at significance level set at 0.01 and 0.05 (2-tailed).

Findings

**Table 1** Summary of Statistics on Respondents’ Demographics

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Percentages</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>81</td>
<td>94.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>5.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>81</td>
<td>37</td>
<td>25 – 56</td>
<td></td>
</tr>
<tr>
<td>Staff nurse</td>
<td>62</td>
<td>72.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNM 1</td>
<td>8</td>
<td>9.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNM 2</td>
<td>15</td>
<td>17.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years Qualified as RN</td>
<td>85</td>
<td>14.7</td>
<td>1 – 35</td>
<td></td>
</tr>
<tr>
<td>ICU/CCU</td>
<td>30</td>
<td>35.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A &amp; E</td>
<td>20</td>
<td>23.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Medical</td>
<td>22</td>
<td>25.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgical</td>
<td>13</td>
<td>15.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in Area of Practice</td>
<td>82</td>
<td>7.8</td>
<td>1 – 20</td>
<td></td>
</tr>
<tr>
<td>RGN</td>
<td>29</td>
<td>33.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Registration</td>
<td>3</td>
<td>3.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Certificate</td>
<td>22</td>
<td>25.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree</td>
<td>8</td>
<td>9.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher Diploma</td>
<td>25</td>
<td>28.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>87</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1 presents a synopsis of demographic data of the 88 respondents who participated in the study. The data showed that the mean age of all the nurses who responded to the study was 37 years (range 25-56, SD = 7.29). The majority of the respondents in
the study (n = 62, 73%) were staff nurses, while the remaining were Clinical Nurse Manager 1 (n = 8) and Clinical Nurse Manager 2 (n = 15). The average years that the respondents were qualified as registered nurses were 14.7 and the average number of years that respondents had worked in their current area of practice was 7.8 years.

Approximately half the sample (n = 45, 51.7%) indicated that they were had extended or expanded their clinical roles. Table 2 illustrates the areas that nurses in the study had extended or expanded into and the number of respondents who performed the various extended or expanded roles in their clinical areas of practice. The most common extended or expanded duties performed were venepuncture, followed by emergency defibrillation.

**Table 2** Frequency of Respondents Performance of Extended/Expanded Roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venepuncture</td>
<td>37</td>
</tr>
<tr>
<td>IV cannulation</td>
<td>7</td>
</tr>
<tr>
<td>Defibrillation</td>
<td>21</td>
</tr>
<tr>
<td>ECG recording and reading</td>
<td>8</td>
</tr>
<tr>
<td>ABG analysis</td>
<td>1</td>
</tr>
<tr>
<td>Teaching and assessment</td>
<td>5</td>
</tr>
<tr>
<td>Applying POP</td>
<td>5</td>
</tr>
<tr>
<td>Temporary pacing</td>
<td>1</td>
</tr>
</tbody>
</table>

Crosstabulation of data indicated that there was a significant difference (p < 0.005) between the prevalence of extended and expanded roles, and respondents’ area of clinical practice. Crosstabulation of the data showed that a majority (n = 37, 86%) of those who had extended or expanded their clinical roles worked in specialist areas and a majority of those who had not worked in general wards (n = 29, 69%).

The responses to the Scope of Professional Practice Scale illustrates that a majority of the nurses (n = 80, 91%) who responded to this study indicated that they were familiar with An Bord Altranais’ guidelines for the development of their scope of practice. Nearly the same number of respondents (n = 79, 90%) felt that more in-service information on the concepts would be desirable, while 86.4% (n = 76) believed that the training provided for the extension and expansion of nursing roles were inadequate. More
than half the respondents (n = 51, 58.6%) felt that certification of competencies were appropriate for nurses who intend to extend or expand their clinical roles.

The combined responses to the Role Extension scale indicated that respondents had a generally positive attitude towards role extension. With 10 items in this scale and a total value of between 10 and 50, where 50 is an extremely positive attitude, respondents attained a mean value of 30.8, varying between 18 and 45. The mean scores for individual items on the role extension scale was obtained and ranked in order, from the highest to lowest scores (Table 3). Mean scores of below 3 indicate a high level of disagreement, whereas mean scores of above 3 indicate a high level of agreement to the individual item on the Role Extension scale. The data indicated that the highest scores, which indicated the highest level of agreement, were nurses’ mean response to the benefits of role extension such as improving the quality and continuity of patient care.

Table 3 Ranked Mean Responses to Role Extension

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve quality of care</td>
<td>3.6705</td>
<td>.95558</td>
</tr>
<tr>
<td>Increase continuity of care</td>
<td>3.6591</td>
<td>.94548</td>
</tr>
<tr>
<td>Stress from increase workload</td>
<td>3.5227</td>
<td>1.08254</td>
</tr>
<tr>
<td>Less time for nursing activities</td>
<td>3.4886</td>
<td>1.20339</td>
</tr>
<tr>
<td>Reducing doctor’s work?</td>
<td>3.3864</td>
<td>1.23579</td>
</tr>
<tr>
<td>Increases collaboration</td>
<td>3.3750</td>
<td>.96267</td>
</tr>
<tr>
<td>Meet new needs</td>
<td>3.3636</td>
<td>1.10570</td>
</tr>
<tr>
<td>Fragmentation of care?</td>
<td>3.1023</td>
<td>1.16500</td>
</tr>
<tr>
<td>Delegation of tasks</td>
<td>2.9773</td>
<td>1.31287</td>
</tr>
<tr>
<td>Money saving exercise</td>
<td>2.9545</td>
<td>1.14379</td>
</tr>
</tbody>
</table>

Rankings based on mean scores on a 5-item Likert scale identifying respondents’ degree of agreement or disagreement, with strongly disagree: 1, disagree: 2, unsure: 3, agree: 4, strongly agree: 5.

The mean value of the Role Expansion scale showed that respondents in this study had a generally positive attitude towards the concept. Table 4 illustrates the mean scores for individual items in the Role Expansion scale, which were arranged in ranked order, from the highest to lowest mean scores. Mean scores of below 3
indicate a high level of disagreement to the response of individual item on the Role Expansion scale, and mean score of above 3 indicate a high level of agreement. The highest mean scores, indicating the highest level of agreement, of nurses’ response to this scale was to item 22 on the questionnaire, where nurses believed that there should be more autonomy in the decisions and actions relating to the expanded practice.

**Table 4 Ranked Mean Responses to Role Expansion**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>More autonomy in decisions</td>
<td>4.1364</td>
<td>.55048</td>
</tr>
<tr>
<td>Promoting holistic patient care</td>
<td>3.9091</td>
<td>.82541</td>
</tr>
<tr>
<td>Patient benefit from range of skills</td>
<td>3.7614</td>
<td>.87091</td>
</tr>
<tr>
<td>More vulnerable to litigation</td>
<td>3.7273</td>
<td>1.06918</td>
</tr>
<tr>
<td>Increase job satisfaction</td>
<td>3.6023</td>
<td>.90388</td>
</tr>
<tr>
<td>Compromise quality of basic care</td>
<td>3.4091</td>
<td>1.06821</td>
</tr>
<tr>
<td>Diminish essential value of basic care</td>
<td>3.0114</td>
<td>1.15961</td>
</tr>
<tr>
<td>Care assistants assuming basic care</td>
<td>2.8409</td>
<td>.98128</td>
</tr>
</tbody>
</table>

Rankings based on mean scores on a 5-item Likert scale identifying respondents’ degree of agreement or disagreement, with strongly disagree: 1, disagree: 2, unsure: 3, agree: 4, strongly agree: 5.

Independent sample t-tests and ANOVA indicated that there were no significant relationships between staff nurses and Clinical Nurse Managers’ attitudes to Role Extension and Role Expansion. Nor were there significant relationships identified between nurses’ level of nursing academic qualification and their attitudes to these concepts. Similar findings were identified between nurses working in specialist areas and general areas to Role Expansion but there was a significant relationship (p = 0.025) isolated between nurses working in the different areas and the mean responses to Role Extension. Nurses working in specialist areas demonstrated a more positive attitude towards extending their roles than those working in general areas.

**Discussion**
Despite a majority of the respondents reported that they were familiar with the guidelines for developing their scope of professional practice, there is evidence to contradict this. The findings from this study showed that most of the respondents indicated that more in-service information on the Scope of Professional Practice and its implication to nursing practice would be useful. Also, more than half of the nurses in the study believed that the concept of certification to state that they had undertaken the necessary training and education to extend and expand their nursing roles was appropriate. This is inconsistent with the nursing board’s and the nursing profession’s recommendation that the development of nursing practice should take the form of continuing education and planned learning experiences rather than certification to verify competency in an extended role (An Bord Altranais 2000).

Respondents’ overall positive attitude toward role extension would again suggest that they were not entirely familiar with An Bord Altranais’ (2000) recommendations for the development of nursing roles. According to the Irish nursing board, developments in nursing practice should be in the form of role expansion, with an emphasis on expanded theory, knowledge and skills in the philosophy of nursing, which will enable nurses to provide holistic patient care. The concept of role extension, although not explicitly denounced, is nevertheless not recommended due to its focus on tasks rather than the patient and the lack of emphasis on performance of new skills within the boundaries of nursing and caring.

The findings also indicated that respondents had a slightly more positive attitude towards role expansion than role extension. As in numerous other studies, nurses in this study recognized the benefits that expanding their clinical roles will have on the quality of patient care in the form of holistic approach to nursing care, continuity of care and nurses possessing a wider range of skills. However, in view of their lack of understanding regarding the concept of role extension, this result may be open to discussion. Findings from this study also indicate that respondents were aware of the drawbacks of role expansion. A major obstacle to nurses assuming added roles is a resulting depleted time to carry out basic nursing duties.

No relationship was identified between the attitudes of respondents towards the expansion of their nursing roles and their area of clinical practice. However, there was a significant relationship between the area of clinical practice and nurses’ attitudes towards the extension of their nursing roles. This significant relationship would appear to corroborate with findings from other studies which indicated that nurses working in highly technical areas such as
Intensive/Coronary Care units and Accident and Emergency departments, have a tendency to focus on the extension of their nursing roles and the adoption of technical activities and tasks (Goldman 1999, Carver 1998).

A major limitation of this study is the generalizability of the findings. The low response rate and the consequential small sample size resulted in a high risk of sampling bias. In addition, generalizability of the study is limited by the selection of sample from three hospitals in one health board region, in rural areas. In addition, the research design used in this study provided a limited perspective into the attitudes of nurses towards role extension, role expansion and the Scope of Practice. To gain a broader perspective, further research using a qualitative paradigm may be valuable.

Conclusion
The nursing profession has been presented with an opportunity to develop its practice beyond the boundaries set by previous developments. With the advent of role expansion, nurses are in the position to assume authority and autonomy over their expanding clinical practice while improving the quality of patient care. To ensure that nurses are developing their roles safely and appropriately, An Bord Altranais (2000) has developed a framework to guide nurses in the determination of their scope of professional practice. The framework was developed in a manner that avoids restricting the developments of nursing practice and expansion of nursing roles.

However, in their attempt to promote independence in the determination of the scope of practice and avoiding strict regulations and protocols, there are risks of infringement of the guidelines established in the framework. Without an outright denunciation and restriction on the practice of role extension, nurses will continue to develop their nursing roles in this manner, as implied in this and numerous other studies. This can have critical implications on the standards of patient care as well as the nursing profession. In extending their nursing roles, nurses are returning to a task-focused and task-oriented approach to providing care.

Developing nursing roles without adequate knowledge of the guidelines for safe and appropriate role development can also be detrimental to the quality of patient care as well as to the nursing profession. In an era of evidence-based best practice to ensure that the best possible care is provided to patients, ad hoc and unstructured development of nursing roles is undesirable. As recommended by An Bord Altranais (2000), nursing practice need to develop to meet the current needs of the population and the health
service, and these development should take the form of expansion of nursing roles based on the fundamental philosophy of nursing, and not through the extension of roles, which is task focused.

In view of the numerous concerns brought to light in this study, more education and in-service information is required to inform nurses of An Bord Altranais’ (2000) framework for developing nursing roles. Nurses need to be made aware of its recommendations for development of nursing practice through role expansion, and not role extension.

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The lived experience of being a preceptor in evaluating undergraduate nurses’ clinical practice

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Background
The role of the preceptor in undergraduate nurse education is summarised by An Bord Altranais, (2003) as one of providing supervision, teaching, giving of feedback, as well as the clinical evaluation of student nurses’ performance. Within the Irish nursing context the evaluation of student nurses’ clinical practice is an additional dimension to the preceptorship role, since introduction of the degree programme in 2002. Internationally, the literature is strewn with findings relating not only to the complexity concerning clinical evaluation but the whole notion of clinical competence-based evaluation. However, from an Irish perspective there is a dearth of research which has explored the perspective of the preceptor involved in the process of clinical evaluation. According to An Bord Altranais, (2003) the aim of clinical learning practice is to facilitate nursing students to develop the domains of competence, and become safe, caring competent practitioners demonstrating personal and professional accountability for evidence-based practice.

Aim
The aim of this research is to explore the experience of being a preceptor in evaluating undergraduate students’ nursing practice.

Methods: A hermeneutic phenomenological approach was employed to interpret the meaning of the lived experience of the preceptor in evaluating undergraduate students’ clinical nursing practice. A purposeful sample of ten preceptors participated in the study. Semi-structured interviews were utilised to collect data. A pilot study was conducted.
Analysis and Results

Colaizzi’s, (1978) seven stage process framework was applied to guide the study from the data. One central theme, teaching and evaluating clinical competencies and four related themes merged from the data. These are knowledge and learning, questioning competence, competing demands and confidence in ability. Knowledge and learning reflects that all participants expressed positive feelings in relation to teaching and evaluating students’ clinical practice. However, there was much uncertainty regarding the theoretical dimension within the preceptorship role. The second related theme revealed by participants was that the meaning of competence was strewn throughout multiple ways of knowing (Carper, 1978). Competence was described in an integrated way, as a holistic approach in caring for the patient. The third theme, competing demands, identified that while participants recount that the patient is the foremost priority there was deep concern about the lack of time for preceptoring nursing students’. The final related theme, confidence in ability demonstrates the participants need for acknowledgement and feedback on their role as preceptor.

Conclusions: Having considered study findings in relation to pertinent literature addressing this area, implications for nurse education are explored. It is envisioned that findings will illuminate the lived experience of being a preceptor in evaluating students’ clinical practice as they reveal the potential to value the formalised role of the preceptor. The challenge to nurse education is to ensure that if this is to be realised sufficient preparation for the development of this role is a fundamental requirement. These issues shall be further explored in the presentation.
Giving Voice: Narrative Methods as Means to Transforming Understanding of Patient Lived Experience

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BACKGROUND AND CONTEXT

An Occupational Perspective
Occupational therapists work with the ongoing centrality of daily occupations in human’s lives. The occupational perspective of ‘doing, being’ and becoming’ envisages people as agentic authors of their own life narratives who literally ‘story’ the self by imbuing selected actions with meaning and purpose. Humans are perpetually engaged in ‘doing’, consciously acting on their worlds. ‘Being’ involves embracing our essence in our ‘doing’. ‘Becoming’ imbues being with a sense of purpose and future, holding out the promise of self-actualisation. These self-stories form a coherent life-plot linking past, present and future in a life configuration that simultaneously creates and communicates the essence of the self.

Ethnographic research into occupational therapy interventions reveals an ‘underground practice’ of narrative reasoning in clinical practice, where therapists think and act through storytelling with their clients. A complex process of ‘therapeutic emplotment’ emerges where these dyadic interventions create clinical narratives in clinical space to engage in a prospective intervention story that meaningfully matters to each individual client (Mattingly & Fleming, 1994).

Qualitative Paradigm
The increasing popularity of qualitative methods has opened up new vistas of opportunity to healthcare researchers. Such approaches permit insight into personal experiences of health and illness and patient interpretations of these happenings.
The subjective experience of participants must be privileged in order to understand the meaning and purpose they ascribe to their own life events. Contexts must be acknowledged. Rich, thick descriptions must be conferred with legitimacy to overcome the limitations of traditional empirical methodologies. Such approaches will fall into the qualitative paradigm. This results in “an ‘emic’ perspective and necessarily employs an inductive process of analysis requiring interpretation of data” (Hollis, Openshaw and Goble, 2002, p 3).

Molineux (2005) outlines the advantages of using qualitative research methods as facilitating “contextualised exploration”, placing a high value on subjectivity, appreciating meaning, acknowledging the researcher’s presence and the creation of rich descriptions that expand rather than contract understanding of the phenomena under investigation (p 102 – 103).

Meanings ascribed by individuals to sickness and recovery can exert profound influence on the recovery process. Through facilitation of opportunities for patients to ‘give voice’ to their experiences in their own words, dramatic insight can be gained into their perceptions, understandings and struggles in the healthcare experience.

Narrative methods permit access to this veiled world of individual embodied experience. Here, we begin to understand the unique personal meanings of health events in a way that can enhance and individualise practice.

**Narrative**

Biographical/narrative methods are particularly suitable as a means of capturing unique insights into the individual, subjective process of ‘making sense’ of the things that happen in each individual’s life.

People understand their daily experiences through narrative where selective elements of personal history are construed into meaningful structures or plots (Polkinghorne, 1988). Jonsson, Josephsson and Kielhofner (2000) propose that “narrative theory is a useful theoretical structure for understanding occupational life” (p 425).

Wicks and Whiteford (2003) explore this issue, promoting a narrative approach to occupational research for several reasons. Narrative approaches are compatible with the humanistic foundations of the occupational therapy profession. They identify strong links between occupation and stories, calling for occupational therapy research to be “occupation-based” and incorporating “the use of stories” (p 87). The placement of our stories in time and
place permits contextualisation of our individual sense of being in the world. The sharing of life stories can also be of benefit to participants.

The narrative approach is compatible with the investigation of illness experiences and is used extensively in sociological research. Frank (1995), himself a cancer survivor, describes how the telling of stories gives voice to the body even as they are told through the body. Frank concludes that those experiencing illness need to tell their stories “in order to construct new maps and new perceptions of their relationships to the world” (p 3). Chronic illness and suffering often generate a narrative loss, as well as a physical loss; the fracturing of a life story as patients restructure lives in new ways to accommodate disabled bodies (Mattingly, 1994).

Mathieson and Stam (1995) reflect on the special significance of narratives for cancer patients. They state, “in negotiating their way through regimens of treatment, changing bodies and disrupted lives, the telling of one’s own story takes on a renewed urgency. In the end, they are more than just ‘stories’ but the vehicle for making sense of not an illness, but a life” (p 284).

**Phenomenology**

Husserl developed the term phenomenology to describe a philosophical movement that dealt with the “essences of objects as they present themselves to human consciousness” (McLoughlin Gray, 1997, p 6). This leads to a belief that each person holds a unique world-view informed by their individual experiences. Whilst each subjective experience is unique, there is an essential similarity conferred through shared experience (Dawkins & May, 2002, p 129). Phenomenology concentrates on how humans experience the ‘doing’ of their activities, describing it as ‘intentional’, that is, directed at the world. Phenomenology permits better understanding and illustrates individual accounts of lived, embodied experience. Hasselkus (2002) explains that a phenomenological perspective honours our “inner sense of experience” in our lived “lifelong transformative encounters with the world”, our process of ‘becoming’ (p 68).

Cancer diagnosis and treatment presents particular challenges to both patient and practitioner. Cancer is a disease “involving the abnormal and excessive division of cells” (Barraclough, 2000, p xi). This simple definition belies the tremendous impact that this illness and its progression, and indeed its treatment, has on the individual person and their lifeworld. The description of cancer as a ‘life-threatening illness’ goes some way to conveying the devastation for those concerned and their loved ones that such a diagnosis brings.
From an occupational perspective, such an experience represents an occupational disruption, where the established activities and routines that confer purpose and meaning on an individual’s life are compromised. This disturbs the careful equilibrium (homeostasis) that the person has worked so hard to establish as an expression of selfhood and self-mastery. The loss of this competence and sense of control can exert serious ramifications on sense of well-being, with resultant impact on mental health.

Breast cancer will in almost all cases result in physical bodily changes that cause deep distress to the women concerned. Treatment regimens such as surgery, chemotherapy, radiation therapy and hormonal therapy will impose demands on time and routine, and precipitate side effects such as anorexia, weight loss or gain, insomnia, nausea, diarrhoea, fatigue, pain, vaginal dryness, hot flashes, infection, infertility or sub-fertility, menopausal symptoms or early menopause, compromised skin integrity, alopecia, oedema, lymphoedema, lowered immunity, and decreased stamina and mobility.

These in turn will exert an influence on participation in occupational routine, that is the everyday valued activities associated with normality and wellness. Young (2005, p.93) observes that “many medical professionals seem not to be sensitive to the deep identity issues that many women face with breast loss”. This may be for several reasons such as professional time pressures or perceived lack of opportunity to bring sensitive matters up for example. This means that health professionals may be working with less than the whole story. This may result in significant influential issues remaining unaddressed with associated clinical impact on issues such as compliance, recovery and in some cases, prognosis.

**AIM OF THE STUDY**

The qualitative study “Living to Tell the Tale” seeks to understand the embodied lived experiences of a group of women living with breast cancer using a phenomenological approach. Through entering their subjective worlds, the effects of deep illness on their identity, lifestyle and agency from an occupational therapy perspective are examined. This work investigates for the first time in Ireland, the occupational biographies of a group of women living with breast cancer.

**METHODOLOGY**

A naturalistic inquiry approach was adopted with strategic recruitment conducted via advertisements in a Dublin cancer support centre. All participants self-selected. Ten women have participated in in-depth interviews to date. All are Irish.
Individual recorded interviews were used to collect life histories using occupational storytelling where stories were told in the women’s own words, resulting in breadth and detail that greatly individualised accounts. Story-telling and story-making allow therapists to consider clients phenomenologically in terms of their lived, embodied experience and what it means for them from a contexted, biopsychosocial perspective.

Stories contextualise illness experiences by showing them as part of a whole occupational life story, permitting understanding of occupational histories (Molineux & Rickard, 2003)

**PARTICIPANTS**
- Women living with breast cancer
- Ten recruited and interviewed to date
- Diagnosed between Sept 2003 and October 2006
- Five on hormonal therapy
- Three receiving bone care
- One on Herceptin
- Two with recurrence/metastases
- All resident in greater Dublin Area
- Age Range 45 – 69 years with a mean of 50.5 years
- None were referred to Occupational Therapy

**DATA COLLECTION**
Initial Interviews
- Recorded one-to-one
- Occupational histories from childhood to present date
- Reflexive participation of researcher
- Co-construction of occupational narrative

**Reflexivity**
This is an increasingly important concept in Occupational Therapy research and practice

"In research terms, this can be translated as thoughtful, self-aware analysis of the intersubjective dynamics between researcher and researched.”
(Finaly & Gough, 2003, p ix)

This is of particular concern in the current study as the researcher is herself a woman living with breast cancer.

**ANALYSIS**
Occupational biographies were examined using interpretive phenomenological analysis. Following deep immersion in the data, recurrent themes were identified and categorised into broader interpretive groupings, reflecting participant experiences. This method explores in detail the participant’s perspective of the topic.

It is concerned with the individual’s personal, subjective, lived account of the phenomenon, seeking out the uniqueness of each story.

**SUMMARY OF KEY FINDINGS**

Stories reveal deep personal struggle in adjusting to living with breast cancer. Lifestyle disruption was found to exert secondary distress in curtailing expression of ‘normal’ self. Many issues were not raised in the health care setting, resulting in lost opportunities for health care providers to provide support. Themes include:

**NOT DOING = NOT NORMAL**

Inability to perform usual activities resulted in a deep sense of loss of ‘old self’ and a strong sense of present life not being ‘normal’. The women interpreted themselves as ‘sick’ when unable to perform habitual activities, particularly ADL tasks.

**OCCUPATIONAL RUPTURE**

Life-threatening illness imposes an occupational rupture where functional capacities and the valued familiar activities that are the essential signature of the self are compromised. As indicated by the use of the word ‘rupture’ this is a sudden tearing of the fabric of normal life where occupational expression is radically and abruptly changed. All participants described this phenomenon.

**FRUSTRATION AT IMPOSITION OF CANCER CALENDAR**

Many expressed frustration with the time and energy consuming practice of attending appointments. Some stated that they missed the comfort of previous routines or that these demands impeded development of new lifestyle patterns.

**IMPAIRED SENSE OF AGENCY**

Many narratives revealed an externalisation of locus of control where women felt a reduced sense of power and control over how they chose to express themselves through their ‘doing’ in the everyday.

**NARRATIVE SUSPENSE**

All stories contained a ‘narrative suspense’ where the emergent life story had become stagnated. This disruption left the women feeling
vulnerable about planning the future and lacking confidence about making plans.

- Loss of sense of future – present ‘tense’
- Grief for preferred future
- Sense of life being on hold/changed forever
- Fear of moving forward/making plans
- Fear of recurrence/death
- Loss of narrative ‘desire’
- Living with less and loss

LOWERED LIFE TONE
Many women felt that it was hard to be optimistic or to feel positive. Fear of recurrence was a strong feature in most stories. Some felt ‘cancer came first’ and dictated lifestyle choices.

LOSS OF VALUED LIFE ROLES
Many roles had been sacrificed. Those who had lost a work role felt the loss particularly strongly, especially the social aspect associated with employment.

SECRET BURDENS
Stories emerged of unshared burdens such as worries, high expressed emotion in home and relationships, struggles with poor coping strategies, sadness at contraction of social world and concerns with regard to intimacy. In some cases, the women felt that it would be unfair to burden others with such matters.

RESEARCH IMPLICATIONS
The narrative approach is a useful and viable tool to extract the deep personal experiences of women living with breast cancer.

Respondents found story-telling easy, attractive and non-intimidating.

Telling their own stories in their own words was seen to value and privilege their interpretation of life events.

Story-telling may have distinctive advantages in sensitive psycho-oncology based research.

CLINICAL IMPLICATIONS
Results to date indicate the importance of holistic and phenomenological examination of individual contexts of breast cancer patients.
Secondary influences of breast cancer diagnosis and treatment on functional capacities and lifestyle expression can create further psychological and emotional distress.

Psychosocial responses to occupational disruption appear distinct from primary reactions to the breast cancer experience and may require separate consideration.

These secondary responses to lifestyle disruption need to be integrated into assessment and treatment to achieve holistic, quality cancer care.

**CONCLUSIONS**

The narrative method is a viable, valuable healthcare research tool that can potentially enhance and transform understanding of patient lived experience.

**REFERENCES**


**Living to Tell the Tale: Narratives of Occupational Engagement, Creativity and Living with Breast Cancer**

This doctoral research is supported by:

ARC Cancer Support Centre, Eccles Street, Dublin 7
Europa Donna Ireland
Hickey’s Fabrics
Irish Cancer Society
Sony Ireland

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What level of fitness improvement occurs during Phase III cardiac rehabilitation?

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Abstract
The positive effect of increased physical activity/fitness and of participation in cardiac rehabilitation programmes has long been established. The aim of this study was to determine the level of fitness improvement following Phase III cardiac rehabilitation programmes. The study is a descriptive study of patients who participated in a 6 or 8 week Phase III cardiac rehabilitation programme. Physical fitness was ascertained by exercise stress tests using the Bruce protocol pre and post programme. The recommended guidelines for the termination of the stress test and exclusion criteria from the test were applied. The Karvoren method was used to calculate target heart rate and exercise prescription was set at a maximum of 60% of this. The results of the exercise stress test were converted to MET’s (metabolic equivalents). The sample number was 187, which was made up of 134 males and 53 females. The average age was 59.33 ± 9.58 years. The T values between MET’s level achieved pre programme and post programme was 0.035, significant at the 0.05 level. Pre programme stress test results gave a mean MET’S level of 9.02 ± 2.99 of which 63% of patients could be classified as sedentary (MET’s ≤ 10). Mean MET’s level post programme were 10.10 ± 2.66, indicating that now only 56% could be classified as sedentary. The level of fitness was also classified using AHA( American Heart Association classification of fitness taking age and gender into account. Greatest improvements occurred in the patients in the lowest fitness categories, while those in the higher fitness category had little improvements. Significant increases in fitness occurred following participation in a Phase III cardiac rehabilitation programmes, with greatest changes occurring in the least fit. However there are still a substantial number of patients classified as sedentary from a fitness point of view post Phase III cardiac rehabilitation programme.
Introduction
The ultimate aim of cardiac rehabilitation is to achieve and maintain the optimal physical and psychosocial health of the patient (Coats AJ, SIGN 2002, De Backer 2004). Traditionally cardiac rehabilitation is made up of 4 phases. Outpatient formal cardiac rehabilitation programmes occur usually 4-6 weeks cardiac post event and take the form of a formal education and exercise programme and is typically referred to as Phase III cardiac rehabilitation (Thow 2006).

The positive effect of participation in cardiac rehabilitation programmes has long been established (Thompson & Bowman 1998, Kotseva et al 2004, Joliffe et al 2006) and physical fitness has been shown to improve significantly over the course of cardiac rehabilitation programmes (Gulanick et al 2002, Dugmore et al. 1999, Shiran 1997, Lavie & Milani 2005, Turner et al 2002). There is great variation in the level of fitness of patients entering cardiac rehabilitation and initial exercise capacity has been shown in some instances to be a predictor of significant improvement in fitness (Shiran et al 1997, Pierson et al 2004, Balady et al 1996).

The objectives of this study were to determine:

- The improvements in fitness of patients over cardiac rehabilitation programmes
- If there was a difference in improvements in the different fitness categories

Methods:
This study was a single site, practice based, longitudinal observational investigation of patients before and after attending a structured cardiac rehabilitation programme. Over the time frame of the study 329 patients commenced cardiac rehabilitation. All patients who completed the full cardiac rehabilitation programme, including the exercise sessions and who completed and returned at least one SF-36 questionnaire (a parallel study) are included in this analysis, a total of 187 patients. Within this patient group data collection was still not always complete so the sample number varies within the analysis.

Cardiac rehabilitation programme: The patients attended the rehabilitation programme for up to 18 days over a 6 or 8 week period. Each day the patient had a supervised group exercise session based on individualised exercise prescription and an educational session on selected aspects of secondary prevention.

Fitness testing: Prior to entry into the programme patients underwent an exercise stress test. These tests were used for several functions; diagnostics, exercise prescription, risk assessment and for this project, fitness assessment and progress.
In this instance sub-maximal incremental work rate was measured using the Bruce protocol on patients both pre and post programme. Two protocols were enacted during the time course of the study the exercise stress test was stopped at 13 METS or 13.5METS. The recommended guidelines for the termination of the stress test and exclusion criteria for exercise were applied. Subsequently the Karvoren method was used to calculate target heart rate and exercise prescription was set at a maximum of 60% VO2 max.

Data Collection: The patient demographics and clinical details were collected from the case notes.

Analysis: SPSS version 14 was used for statistical analysis. T-tests were used to determine if there were significant improvements from pre and post VO2 max. Linear regression was used to determine the predictors of fitness and changes in fitness. Fitness as indicated by VO2 max in mg/kg/min was classified into categories using AHA (American Heart Association) categories so as to take age and gender into account (Cooper & Storer 2001).

Ethics: Permission for the study was granted by the ethics committee of the hospital concerned and conforms to the principles outlined in the Declaration of Helsinki.

Results: The sample was made up of 134 males and 53 females. From a diagnosis point of view the sample was composed of 80 myocardial infarctions (MI), 56 coronary artery bypass grafts (CABG), 34 percutaneous transluminal coronary angioplasty (PTCA), 4 other surgery patients and 13 others. The age profile of the sample ranged from 30-81 the average age being 59.33±9.58 years. The body mass index (BMI) of the patients were (n=111): 12% normal or less than normal BMI (≤ 25), 55% overweight (25-29.9 BMI) and 33% were obese or severely obese (BMI ≥30). Pre programme exercise stress test results gave a mean MET's value of 9.02±2.99 (n= 179), of which 63% could be classified as sedentary (MET’s ≤ 10 Balady et al 2000). Out of the 179 patients that did the pre programme exercise stress test a total of 16.9% reached the maximum level when the test was stopped and therefore exhibited a ceiling effect. In the post programme exercise stress test a mean of 10.10 ± 2.66 MET’s (n=122) was achieved, indicating that now only 55.7% were sedentary. Out of the 122 patients who did the post programme exercise stress test post programme 33% were stopped at the maximum level. The overall mean improvement in fitness was 1.04±2.56 MET’s.

Using the paired two tailed t test there was a significant difference between pre programme fitness and post programme fitness (n=71, t value= 0.035 significant at 0.05 level)
Fitness results were categorised into fitness categories taking age and gender into account. Table 1 shows the mean greatest improvements in fitness occurred in the lower fitness categories.

**Table 1:** Improvements in fitness following a cardiac rehabilitation programme by fitness category

<table>
<thead>
<tr>
<th>Starting fitness level</th>
<th>Mean changes in MET’s from entry to end of Phase III cardiac rehabilitation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Low</td>
<td>3.36</td>
<td>13</td>
</tr>
<tr>
<td>2 Fair</td>
<td>2.58</td>
<td>6</td>
</tr>
<tr>
<td>3 Average</td>
<td>1.37</td>
<td>8</td>
</tr>
<tr>
<td>4 Good</td>
<td>1.88</td>
<td>13</td>
</tr>
<tr>
<td>5 High</td>
<td>0.83</td>
<td>9</td>
</tr>
<tr>
<td>6 Excellent</td>
<td>-0.96</td>
<td>18</td>
</tr>
</tbody>
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When these results are examined from an individual point of view it is evident that at the lower fitness levels (levels 1, 2, 3 (low, fair and average fitness) the vast majority of patients improved their fitness level, a small proportion maintained their fitness level and none or a very small proportion showed a decline in their fitness level (see Figure 1). At starting fitness categories 4 (good) and 5 (excellent) you get a large proportion of patients maintaining their fitness. This was what was expected at these levels of fitness particularly in view that of the fact that it was a sub maximal exercise stress test and as outlined in the methodology 34% of patients achieved the maximum level of fitness measured. What was worrying was that in a small proportion of patients who commenced at fitness level stage 4 (good) and stage 5(excellent) their fitness declined over the period of the programme ( see Figure 1).

**Figure 1:** Changes in fitness level post programme categorised by pre programme fitness level
Pre programme fitness was seen to be a strong predictor of both post programme fitness (Degrees of freedom=12, $f=13.637$, level of significance =0.0000) and the improvement in fitness (Degrees of freedom=12, $f=3.942$, level of significance =0.0000).

**Discussion**

There was a significant improvement in fitness over the cardiac rehabilitation programme. Many factors may have contributed to this. The mean improvement seen here (1.04 MET’s ) is lower than some previous studies where improvements of 3.1 to 4.7 MET’s were observed (Turner et al 2002, Gulanick et al 2002). Despite the increase in fitness still 8% of patients are below the 5 MET’s level, the recommended BACR standards for a patient to be safe on a community or home based exercise programme. In this study 56% could still be categorised as sedentary – below 10 MET’s.
Pre programme level of fitness did have a significant effect on improvements in fitness both in this study and previous studies (Shiran et al 1997, Pierson et al 2004). There may be many factors contributing to fitness improvement, both patient factors and programme factors. One identified reason for this was that patients feel safer participating in exercise in a supervised programme structure and could therefore set themselves new limits (McKee et al 2007, Hammond et al 1998, Stahle et al 2000). The programme does not seem to have as good an effect on the more fit patients. We have previously shown that a substantial subgroup of patients reported that exercise was one of the aspects of the cardiac rehabilitation programme that they were least satisfied with, in these patients some of the qualitative reasons for this included “…was this fit already” (McKee et al 2007). Although the exercise is individually prescribed it may be that the level of exercise prescribed (60% VO₂ max) particularly for the already fit patients is not enough to increase fitness further. Increasing exercise to 70% VO₂ max is recommended for later stages of cardiac rehabilitation exercise programmes but usually only when telemetry monitoring of patients is available.

**Limitations**

The study population reflects the normal cardiac rehabilitation programme population and therefore contain patients that may exhibit a degree of cardiovascular limitation due to their disorder or due to their prescribed drugs and consequently these may influence their response to both the exercise test and the exercise programmes. The use of MET’s derived from a sub-maximal exercise stress test with a pre determined termination point meant that a proportion of patients attained ceiling level at both the pre and post programme exercise stress test, this prevented these patients showing the exact level of improvement above the ceiling point.

**Conclusion:** Significant increases in fitness occur following participation in the cardiac rehabilitation programme, with greater changes occurring in the least fit. However there are still a substantial number of patients classified as sedentary from a fitness point of view after the cardiac rehabilitation programme and there was a small decline in the fitness of the most fit post the rehabilitation programme. Any improvement in fitness is cardio protective to some degree, but we need to ask the question: Is this improvement enough to reduce risk or should we be setting the goals higher?
References:


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How to Enhance Critical Thinking Skills of Paediatric Critical Care Nurses in Clinical Practice

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Introduction
The health care environment is both stimulating and challenging, due to changes in advanced technology and demographics. This is particularly evident in the critical care setting, where patient acuity has intensified, presenting a multitude of complex conditions (Simpson and Courtney 2002). The critical care nurse is required to make quick judgements, use clinical reasoning skills and respond appropriately to life-threatening conditions.

Critical thinking (CT) is associated with maintaining standards of care, improvement of practice and achieving optimal patient outcomes. By encouraging critical thinking skills, the nurse learns to challenge existing therapies, recognise subtle signs of deterioration or improvement in the patient’s condition and act accordingly. To facilitate a psychomotor skill, one explains the procedure, demonstrates the activity and the learner practises under supervision. Alternatively, teaching skills from the cognitive domain remains a challenge to the clinical facilitator.

Definition of Critical Thinking
The literature states that critical thinking is an essential skill to integrate into the nursing curriculum (Daly 1998, Profetto-McGrath 2003, Brunt 2005a). Critical thinking theory is incorporated into academic programmes and the terminology is used through summative assessments.

Critical thinking is not a new concept although it remains poorly defined and difficult to determine in clinical practice. Brunt (2005b) defines CT as:

“the process of purposeful thinking and reflective reasoning where practitioners examine ideas, assumptions, principles, conclusions, beliefs, and actions in the context of nursing practice” (p.66).
Following a Delphi study, by the American Philosophical Association, Facione (1990) and more recently by Scheffer and Rubenfeld (2000), developed CT themes and attributes, see table 1.

### Critical Thinking Terms and Related Characteristics

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Analytical, Examining, Inference, Interpretation, Observant</th>
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<tr>
<td>Systematic Approach</td>
<td>Planning, Logical reasoning, Evaluation, Outcome directed</td>
</tr>
<tr>
<td>Active to Respond</td>
<td>Explaining, Proactive, Alert to Context, Assertive</td>
</tr>
<tr>
<td>Seeks Resources</td>
<td>Flexible, Creative, Open-minded, Willing to change</td>
</tr>
<tr>
<td>Seeks Information</td>
<td>Truth seeking, Inquisitive, Persistent</td>
</tr>
<tr>
<td>Confident in Position</td>
<td>CT self-confident, Applies standards, Self-regulation</td>
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These characteristics equate with Bloom’s (1956) cognitive domain, and are utilised in academic programmes and clinical practice. These attributes link Benner (1982, 1984), alongside Dreyfus and Dreyfus (1980) Model of Skill Acquisition. While the novice is concerned with clinical task performance, the advanced beginner and the competent nurse discovers ways to use their knowledge, skills and attitudes to benefit patient outcomes.

### Research

There are many quantitative studies consisting of instruments to assess ones ability to critically think (Watson and Glaser 1980, Ennis and Weir 1985, Facione and Facione 1992, 2006). The following research, included methodology triangulation and qualitative data collection.

The aim of this study was to discover ways to enhance the critical thinking skills of paediatric critical care nurses, in clinical practice. These strategies could be incorporated into facilitative and educational programmes, to encourage the learning process. Therefore, clinical reasoning skills are improved and decision-making activities.
Action Research Cycles
This collaborative study used both action research and critical ethnography to explore the nurses’ understanding and demonstration of critical thinking in clinical practice. Action research involves group participation in setting the agenda, data collection, analysis and distribution of the findings. Each cycle consists of planning a change or improvement, acting, observing the process, reflecting and re-planning. Critical ethnography addresses the culture and the distribution of power. These two approaches were combined and interchanged throughout the study.

Ethical approval was sought for the study prior to commencement. The first cycle consisted of ten participants with experience from three to twenty years, in paediatric critical care nursing. Two focus groups were held to assess the nurses understanding of critical thinking. The next cycle involved the activity of observing the demonstration of CT skills in practice. This cycle included ten sessions with five participants lasting four hours in the clinical environment. The third cycle evaluated the previous two cycles and concentrated on the feelings and experience of these five participants, through individual interviews.

Each cycle in action research is revised on completion, with collaboration and reflexivity among the participants and the researcher, prior to moving onto the next stage. Throughout the process, continuous consent and approval was sought from the participants. The researcher is indebted to the participants, as without their kindness and enthusiasm the research process would be impossible.

Results
It evolved that most of the participants had a good understanding of the term. They realised critical thinking occurs within everyday practice in the PICU, but they found it hard to put the words into context. The participants linked CT to the nursing process with step-by-step nursing activities. These processes are similar but not identical, as CT is used outside the nursing process and in situations where there is no problem to solve (Wilkinson 1996). Unfortunately, discussions on reflection lead to negative connotations. The objective is to reflect and learn from an experience or event and to use this expertise in action.

I discovered the participants practised critical thinking at a proficient level and demonstrated these skills in a variety of situations. Moreover, the participants were often unaware of their reflective and cognitive abilities. In cycle three, the researcher used vignettes as a brief synopsis to describe their analytical practise.
The participants felt their tacit knowledge validated their rationale to initiate a change in nursing management. Also, they linked clinical decision-making with CT and the activity of a ‘safe practitioner’.

Implications:
Critical thinking empowers decision-making skills, enhances job satisfaction and achieves expertise in practice (Rubenfeld and Scheffer 2006). A competent nurse is involved in continuous professional development and lifelong learning. Therefore, nurses become empowered when they have an opportunity to perform as an autonomous practitioner. Although, the patient receives holistic care from the interdisciplinary team, this should not prevent the critical care nurse from proactive participation. Nurses that practice proficiently or have expertise in their specialised field should be encouraged to utilise these skills accordingly. Additionally, strategies to enhance critical thinking for less experienced nurses, should be integrated into the learning process.

Recommendations
This study was performed to discover ways to enhance critical thinking skills of nurses, and to incorporate these strategies into educational programmes, at a theoretical and a practical level. The terminology of critical thinking should be clarified within a framework of learning in clinical practice, with an opportunity to use these skills through structured experiences. Critical thinking can be facilitated in clinical practice, through clinical supervision tailored to meet the individual’s tacit knowledge and preferred learning style.

Metacognition, thinking about ones thinking and reflection can be facilitated during clinical activities with ‘think aloud’ protocols, where the nurse demonstrates their conscious thoughts. Questioning techniques can be used within orientation programmes and preceptorship relationships. These questions should be pitched at an appropriate higher-order level. Open-ended questions are advocated, so nurses can explain the rationale behind their thinking and decisions (Brunt 2005a).

The use if vignettes capturing clinical case scenarios proved an effective educative tool and a way to introduce problem-based learning into programmes. Finally, it would be interesting to explore how to enhance critical thinking skills in novice nurses, in the paediatric critical care environment.

Conclusion
By using qualitative methods through an action research approach, I had an opportunity to explore the culture of critical care nurses,
through recognising their understanding and demonstration of critical thinking. Moreover, I gained a true picture of their valued responses and clinical activities, which would not be feasible through a written CT assessment tool.

The participants were proficient in providing holistic patient care and practised critical thinking skills, in various situations. These experienced critical care nurses are vital at the bedside and their recognition and retention is of utmost importance. Empowerment leads to increased motivation and job satisfaction which ultimately reflects in retention rates.

To enhance critical thinking for less experienced nurses involves introducing these strategies throughout their learning process. Critical thinking improves practice, contributes to optimal patient outcomes and reduces the incidents of adverse events.

References


Audit of Professional Attitudes to Pain Control

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Background and context
The key to effective pain control for patients is pain assessment. The pain assessment process should facilitate the use of nursing skills to effectively communicate with patients. Education shapes knowledge and attitudes to ensure that patients are believed. This process must be supported by systematic documentation to ensure accurate communication with the patient/client and health care professionals.

Aim of the study
The aim of the study is to evaluate the attitudes of healthcare staff towards pain and its assessment.

Methodology including research design and sampling
200 questionnaires were distributed using an attitude assessment scale with 33 variables. 167 questionnaires were returned from Nurses.

Analysis
The majority of respondents agreed with the commonly held views concerning 19 of the 33 attitude statements. These 19 statements
were all linked to the individual’s unique perception and tolerance of pain and the fact that anxiety and uncertainty of events increase pain perception. In addition because of this individuality of perception, the patient is best qualified to assess his/her own pain level as nurses frequently underestimate the severity of patients pain and cannot gauge levels of pain from their knowledge of related surgery.

Summary of key findings
Nurses require ongoing support and education to facilitate accurate assessment and management of pain for patients/clients. It is vital for nurses to communicate timely details of patients/clients pain assessment. Surgery does not necessarily mean that pain is inevitable.

Conclusions
All the nurses in this study thought assessment of pain was important and their comments have increased the scope for further research at this hospital. They also stated that there is a need for a clear and simple way to assess patient’s pain, the need for analgesia, and the effectiveness of analgesia. Many felt that pain assessment tools need to be easy for patients to use and understand.

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The Personal Nature of Breastfeeding as Experienced by Midwives in Clinical Practice

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Introduction: 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 issue relating to the personal nature of breastfeeding has 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; Schmiede et al 2001).

Methods: A purposeful 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 for the text for this study was guided by a phenomenological hermeneutic analysis method.

Results: Analysis of the interview data revealed the personal nature of breastfeeding as identified by midwives in clinical practice. The following themes were identified “You have to have your heart in it”, “Intimacy”, “It’s the ultimate”, “Be realistic”, “Breastfeeding is a process”, “Determination”

Conclusion: 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 of 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.


Nurses’ experiences of incorporating health promoting skills learnt in the classroom into their clinical practice

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Background & Context:
Duran (2003) suggests that the trans-theoretical model of behaviour change (TTM) integrated with Motivational interviewing (MI) enables nurses to better assist patients to change their behaviour.

Aim of the study
The aim of this study was to:

- Examine nurses' perceptions of a health promotion educational programme based on TTM and MI
- Reveal the extent to which nurses felt they were incorporating the health promoting skills learnt in the classroom into practice.

Methodology
A sequential mixed methods approach using focus groups to develop a 23 itemed postal questionnaire was employed. 267 nurses who had completed the health promoting training programme were surveyed. A response rate of 53% (experienced registered nurses) and 47% (undergraduate/recently qualified nurses) was obtained.

Analysis
Data from the questionnaires was analysed via SPSSV12. The Mann-Whitney U test and Chi square test were used to test for any statistical differences.

Summary of the key findings
Most respondents (64.8%, n=131) had used the skills in clinical practice and (77.1%, n=127) indicated that they had changed their practice since completing the programme.
Most (95.3%, n=130) agreed or strongly agreed that the course had provided them with in-depth knowledge. Respondents (n=129) tended to encourage choice (98.75%), exchange information (97.5%) and express empathy (95.5%) most frequently when using the skills. The two facilitating factors rated as very important, were developing a rapport and getting to know the patient (90.3%, n=124) and having the health promotion knowledge (84.6%, n=123). The two barriers rated as very important were lack of time (62.2%, n=127), and too heavy a workload (53.2%, n=126).

Conclusion
Nurses were favourably disposed to using the skills and were incorporating them into their clinical practice. Further dissemination of this programme is recommended.

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Title of Thesis: An explorative, qualitative descriptive study investigating psychiatric nurses perceptions of bed-rest in the acute inpatient mental health setting.

Research Question: What are Psychiatric Nurses’ perceptions of the use of bed-rest in the acute inpatient mental health setting?

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The aim of this study is to ascertain the perceptions of psychiatric nurses on the use of bed-rest in the inpatient acute mental health setting. For the purpose of this study bed-rest is defined as, the removal of a clients day clothes, the placement of that client into their nightclothes and the confinement of that client to the ward or hospital area. Locally it is a risk management strategy in dealing with disruptive behaviour and in preventing absconding.

The literature review explores the historical factors influencing contemporary practice. It further examines legislative issues and the concept of subtle coercion with analogies drawn to the practice of bed-rest. The practice of bed-rest needs recognition; this research brings attention to this practice and provides an insight into psychiatric nurses’ perceptions of the use of bed-rest in the acute inpatient setting.

The philosophical perspective of interpretivism underpins this explorative, qualitative descriptive study. The data collection tool of choice was semi-structured interviews. The literature review informed the interview guide. A purposive sample of ten registered psychiatric nurses from two sites in urban mental health units participated in the study. Burnard’s (1991) 14 stages of data analysis helped to manage and analyse the data following verbatim transcription.
This study identifies the defining attributes of the practice of bed-rest as; the removal of clothes, the use of night attire, curtailing freedom, prevention of absconding and increased observation. The findings of this study suggest that bed-rest does indeed sit within the realm of subtle coercion. The alternatives to bed-rest presented by the participants included more invasive interventions such as locking the ward, increasing the level of security or changing the patients’ legal status. Bed-rest, although identified as subtly coercive, does not seem as negative. This topic urgently needs further research regarding both its implications and efficacy from the clients’ perspective. This study identifies the decision making role to lie with the doctor, therefore a study researching medical opinion on bed-rest would also be of benefit.
The clinical role of lecturers in nursing in Ireland: How it is perceived by nurse lecturers.

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Background & context: Movement of schools of nursing into universities have resulted in increased concerns that the disparity between education and practice would become more evident. The clinical role of nurse lecturers has been identified as instrumental in strengthening the clinical focus of nursing and narrowing the gap between theory and its application to practice. However, the lack of a defined clinical framework for lecturers is evident: there is no available literature pertaining to situation in Ireland. As part of a larger study looking at the perceptions of key stakeholder groups on the nurse lecturer’s clinical role, the opinions of nurse lecturers on their clinical role were solicited.

Aim:
To explore the perceptions of nurse lecturers about their clinical role, examine the elements that constitute it and the issues which impact on its administration.

Methodology:
The research is part of a qualitative phase of a sequential mixed methods study and involved focus group sessions with nurse lecturers in Ireland. Purposeful sampling was employed. 13 geographically spread focus groups were carried out, average group size - 7.

Analysis: Verbatim transcriptions of audio-taped focus group sessions analysed using a content analysis framework.

Summary of key findings: There was strong agreement that the clinical role needed definition. Visibility was crucial to effective relationships with clinical staff. Activities involved in the role included: support, trouble-shooter, educational resource, research facilitation, committee participation, working with students, audits and collaborative research. Institutional emphasis was considered to be on research involvement, funding and publication to the detriment of the clinical role. There were geographical, institutional and interdisciplinary variations on the strength of these feelings.
Conclusions: Nurse Lecturers generally felt that they had unachievable expectations of themselves, and that a definition and framework of the clinical role would be instrumental in allowing them to realistically structure their workload, and achieve organisational and personal goals.
PERCEPTIONS OF STROKE SURVIVORS IN THE FIRST SIX WEEKS OF STROKE

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Background and context
Incidence of stroke is set to rise in tandem with global ageing trends. In the UK and in Ireland professional bodies have called for concerted action in terms of planning and managing stroke services that meet the needs of individuals at risk of stroke and following stroke and to more adequately support their family carers.

Aim of Study
To investigate the experiences of a sub-sample of stroke survivors moving through one regional hospital.

Methodology
The Whole System Working with Older People project (McCormack et al., 2005) examined services for older people. In one strand, the experiences of older patients (n=50) as they moved through hospital systems were captured through narrative accounts recorded in taped interviews. This presentation focuses on the secondary analysis of interview data from a convenient sub-sample of patients (n = 13) who had experienced a stroke.

Analysis
Taped interviews were transcribed verbatim and subjected to thematic analysis. Themes emerged pertaining to ‘making sense of stroke’, ‘access to rehabilitation therapy’, ‘significant relationships’ and ‘accepting the routine’.

Summary of key findings
Many patients had diagnosed their stroke prior to examination by medical staff and admission to hospital. Individual patients invested time in making sense of his/her particular stroke event and sequelia, recognising it as uniquely different from the strokes affecting others. Rehabilitation therapies were considered to be
essential for stroke recovery, and there was impatience when experiencing slower progress. Significant relationships with professionals were identified as those in which knowledge was shared and patients were enabled to work towards rehabilitation goals. Patterns of working by staff can impact on the perceived empowerment of stroke survivors.

**Conclusions**
The recommendations from this study support the need for greater understanding of the unique experience of stroke, and for the rehabilitation approaches to care to be extended over the 24-hour day.

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Counselling and Prison Based Addiction Treatment

Research Team
Gerard Moore, Muriel Redmond, Rita Glover, Chris Stevenson, Pamela Gallagher, Evelyn Gordon, Rick Lines, Linda O Driscoll, and Dermot Wallace

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Commissioned research
- The Bedford Row Family Project
- Irish Prison Service
- The H.S.E. (Mid-Western Region)

‘The degree of civilization in a society can be judged by entering its prisons.’ Fyodor Dostoevsky (1821 - 1881)

Introduction and methodology

Study Aims
- To estimate the extent of addiction treatment needs
- To estimate the extent of the affected population likely to respond to, and participate in, treatment and assistance
- To establish what constitutes best practice
- To assist the Health Service Employers (HSE), the Irish Prison Service and other relevant agencies in a collaborative planning process

Data collection method
- Literature review
- Focus Groups
- Individual Interviews
- A self – report form
Focus groups
- 6 with Prisoners
- 3 with Prison Staff
- 1 with Voluntary Groups
- 1 with Probation and Welfare Services
- 2 with Health Care Staff
- 2 with prisoners families

Substance abuse
Addiction is continued involvement with a substance or activity despite ongoing negative consequences, (Donatella 2006). Addiction occurs on a continuum where the behaviours initially provide pleasure or stability that is beyond the person’s ability to achieve otherwise. Over time it becomes necessary to engage with the substance or activity to feel normal. There are three categories under which use can be defined:

- Drug use
- Drug abuse
- Dependence

Prevalence of alcohol and drug use in Ireland
There is a relatively high rate of drug use in Ireland generally estimated at 5.6 per thousand of the population, (Moore et al 2004). In 1971 2.4% of people attending Irish Psychiatric Units and Hospitals were diagnosed with alcoholic disorders, by 2006 this figure had risen to 4.8%. During the same period of time other drug disorders had risen from 0.1% to 0.8% (Daly & Walsh 2006). The first Irish drug prevalence household study found that 3% of the adult population (aged 15-64) reported using cocaine (powder) in their lifetime. After cannabis (18%), magic mushrooms (4%), and ecstasy (4%), cocaine was the next most common used illicit drug (NACD 2003).

Substance abuse and prisons
The EMCDDA estimates that at least half of the EU’s 356,000 prison population has a drug history and many of those entering prison have a severe drug problem, this issue affects a considerable number of prisoners. In Ireland, a national census survey in 1999 reported that 52% of prisoners reported a history of opiate use and 43% reported a history of injecting drug use (Allwright at al, 1999). Imprisonment has been found to impact on an individual’s pattern of drug use (Dillon, 2001). As many as one in three drug users inject in prison, some for the first time (O’ Mahony (1997) and Allwright at al 1999).
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Imprisonment and Drug Use
- On entering prison drug use decreased
- Main reason is the lack of availability 61% reported this
- 14% were attempting to stay off drugs
- 13% of inmates reported not being able to afford drugs.
- 6% reported reduced use due to concerns about punishment.
- The act of imprisonment may encourage inmates to address their use
- Cannabis is the most widely taken substance used before and during custody
- Heroin was used by a substantial proportion (27%) (Ramsay2003)

Reasons for use in prison
- Relaxation
- Relief of boredom
- Enjoyment
- Cultural
- Be part of a group
- Calming effects
- Choices are removed
Opportunity to change in prison
Prisoners do manage to cease drug use while in prison. Prisoners use far less drugs in prison than in the community, due to reduced availability (Crowley, 1999). Injecting drugs in prison is less frequent than in the community, each episode of injecting is far more risky due to the greater scarcity of injecting equipment and the higher prevalence of syringe sharing (Dolan and al 2003). The vast majority of prisoners view time in prison as an opportunity to address problems associated with substance abuse and health professionals should not miss this opportunity ((Long et al 2004).

Models of addiction treatment
● Abstinence
● Harm Reduction

Components of an effective treatment programme
● Experienced qualified professional staff
● Flexible arrangements
● Assessment and treatment
● Engagement of concerned persons
● A broad team of health professionals
● Flexible approaches to treatment
● Encouragement and access to engage in peer support
● Quick and easy access to relapse prevention and aftercare
● Commitment to research, training and development

Findings - Themes
● Drug use in Prison
● Attitudes and beliefs
● Service provision
● Dual diagnosis
● Counselling approaches in Limerick Prison

Attitudes and beliefs
● “If we were shown a different way, you know with training and facilities, a work programme. Some people will never be rehabilitated, that’s just the way it is. But you need to invest in those that are willing to be rehabilitated” (MP).

● It’s very bad, there is nobody worried about the prisoners, to them like, we’re a bit of scum, you know. It’s like a big game” (FP).

Service provision
“People coming in and out are labelled counsellors, I don’t know what they are, I don’t know what they’re saying to people, I’ve no control or understanding of what’s going on there, I couldn’t
even tell you who’s coming in or out of this establishment at the moment” (HCS).

“I did ask for the psychologist in Limerick Prison, and it was this dude in a suit and he didn’t give a fuck, he prescribed me medication, that’s not what I wanted so I used to save it up and take it on the weekend” (FM & Ex Female Prisoner).

**Access to services**

“No, its not there, no. We have AA on a Wednesday night but they’re, a lot of the time they’re held up at the gate, at security, they have to walk them across and they might not turn up to half past six in the evening, they could be out there since half past five. The whole system is totally in disarray” (MP)

“There was a meeting on here last night with counsellors and the officers wouldn’t let them through, he said tell them to fuck off, we’re having coffee” (MP).

**Counselling approaches**

“...it’s stage appropriate intervention, there’s a lot of people who aren’t motivated, they’re pre-contemplative,.....I think a lot more could be done in terms of motivational work” (HCS).

“I often think the common dominator with drug abuse anyway is physical or sexual abuse,.....and if they really want to deal with their addiction problems you have to go back that far” (HCS)

“Total abstinence is the goal....but they still need the help and support, our aim is towards abstinence, how we get there, that part can be very different from the regular treatment centres, ...basically, we’re open to any model” (HCS).

“You can’t trust them here,.....you really need someone coming in with a blank pass, before you would start to trust them” (MP).

**Prisoner attitudes to counselling**

“They’re nice people (counsellors) and all but most of the times they’re talking out their arses, they only tell you what they think you want to hear, they don’t really want to discuss the problems that you have on your mind” (MP).

“And not filling me with all this AA crap, all this bullshit...maybe a psychoanalyst, or a proper fucking detox under medial supervision” (MP).
“Like I think there is a difference between addiction counselling and bleed’n counselling” (MP)

**Harm reduction**

“There should be more than just methadone, cause just giving people methadone is just like giving them heroin, it’s just a short-term solution. It’s not solving the problem, its just making it worse” (MP).

‘With the result that we ended up with this wing ..... originally intended to be a drug free unit is now a free drug unit’ (SPS).

**Counselling & Prison Based Treatment model**

- Model for Integrative & Collaborative Approach
- Prisoners
- Prison Staff
- Prison Health Providers
- Community Services
- Breaking the cycle

**Prison Staff**

- Clear written policy
- The appointment of a drug service co-ordinator
- Security – Drug free environment
- Recording information on drug use
- Staff education on illicit drugs
- Distinguish between drug use, abuse and dependence
- Work/Activity Programmes

**Health Service Providers – Level 1**

- A comprehensive assessment package
- Crisis intervention services
- Harm Reduction Strategy
- Psychiatric Assessment/ Dual Diagnosis
- Medical Interventions/ Methadone/Detox
- Psycho-education programmes
- Development of motivational interviewing
- Personal development groups

**Prison Health Service Providers – Level 2**

- Frequent access to 12-step group meetings needs to be increased
- Multi-model Counselling Approaches
- Regular access to addiction counselling and cognitive behavioural approaches
- Humanistic – Personal development
● Systemic Therapy / Engage concerned person and family members
● Psychoanalysis – In-depth clinical work
● Individual & Group Counselling and Psychotherapy

Coordination & Communication
● Agree a philosophy of care
● Coordinated psychotherapeutic responses
● Regular case conferences/ case allocation meetings
● Register of accredited counsellors and psychotherapists
● Therapeutic contracts
● Access to cases notes

Prisoners
● Drug free unit/ wing
● Personal motivation
● Availing of work & education opportunities
● Contracting with service providers
● Compliance with treatment programmes
● Reward system

Community Services
● The revolving door
● Intake liaision meetings between community/health services/prison staff
● Parity of prison services and community services
● Utilise community services
● Exit strategies

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Impact of an International Clinical Experience on Undergraduate Nursing Professional Development

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Background and Context: This project is relevant to the conference theme as it is expanding the research area of international health education. Findings offer suggestions for future curriculum development and identify an area of education that few schools of nursing have in their curriculum.

Canada has one of the most culturally diverse populations in the world today and having effective cultural assessment skills is an essential component of professional nursing practice.

Aim of the Study: To explore the effect of experiences in an international clinical setting on students’ perceptions of their professional nursing practice.

Methods: A two phase research project. Phase one consisted of an examination of retrospective information collected by the primary investigator over a period of seven years as part of the debriefing on students’ return to Canada. Phase two was a prospective
qualitative study using semi-structured interviews and a focus group. Participants were level 4 nursing students from McMaster University who had completed an international clinical placement in the summer of 2006. Data were analyzed using a data analysis software (NVivo) and triangulated with the research team.

Key Findings: Students described three phases of their clinical journey during the international placement. Results indicated that students’ experiences were diverse and very significant throughout this time.

Four major themes were identified: “need to understand,” “motivation for growth,” “engagement” and “awakening.” Students recognized that their experiences were challenged by a variety of events; but they were also exposed to rewarding moments as they completed their course in the international setting.

Conclusions: The themes that emerged were similar to those reported by other studies; but were also unique in their differences. These findings demonstrated the importance of exposing nursing students to experiences that would increase their cultural competence thus having a positive impact on their professional development.
An exploration of the core elements of public health nursing care

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Abstract

Background
The invisibility of public health nursing is a frequent theme in the literature (Zahner and Gredig 2005, Clarke 2004, Kelleher 2003). This research aims to contribute to documenting the work of public health nurses (PHNs) in an Irish context. This documentation is essential as more primary care teams are established and the nursing resource in the community is expanded.

Aim: To explore the core elements of public health nursing care in Ireland

The specific objectives are

- To identify core elements of public health nursing care.
- To quantify core elements of public health nursing which achieve high and low levels of agreement among the respondents.
- To compare and contrast elements that are identified as core to public health nursing with those elements which have previously been identified as core to other groups of Irish nurses.

Methodology
A survey was conducted which involved the distribution of a self-administered questionnaire to PHNs. This questionnaire was developed by Scott et al (2006) over three rounds of a Delphi
A survey conducted with general and mental health nurses. This work has informed the development of an Irish Nursing Minimum Data Set and was funded by the Health Research Board. Permission to use the questionnaire to explore the core elements of public health nursing care for this study was sought and obtained from the research programme steering group.

A convenience sample was used. The researcher attended meetings countrywide to invite public health nurses to participate. The confidential and anonymous questionnaire obtained information on respondent demographics, patient problems (physical, psychological and social), nursing interventions (physical, psychological and social), co-ordination and organisation of care and outcomes of care. PHNs were invited to provide additional qualitative data on aspects of public health nursing care that they identified as missing from the questionnaire used.

**Analysis**

Quantitative data gathered is currently being analysed using descriptive statistics with the aid of SPSS software. Percentile scores will be used to determine the importance of each item to public health nursing care.

Content analysis is being carried out with the aid of Nvivo software on the additional qualitative data provided by PHNs. This will be coded according to patient problems, nursing interventions, co-ordination and organisation of care and outcomes of care.

**Findings**

This paper will present the findings and document core elements of public health nursing care which have not previously been identified by other Irish nurses. Previous findings from other groups of Irish nurses will be compared with the findings from the public health nurses.

**References**


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The Relationship between Stress, Fatigue and Depression in Women Cancer Survivors.

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Background and Context: Cancer has been recognized as a psychosocial stressor. As a result, fatigue and depression in patients with cancer occurs commonly and can have adverse affects on each individual’s quality of life. However, cancer-related fatigue (CRF) is seldomly assessed and treated by healthcare professionals as the aetiology and treatments available for CRF remain unclear.

Aim of the Study: This study aims to examine the hypothesis that alterations in the hypothalamus-pituitary-adrenal (HPA) axis are involved in the development of feelings of fatigue and depression in cancer survivors. Consequently, the primary aim is to provide systemic research on the pathogenesis of CRF.

Methodology: A sample of women cancer survivors and an aged-matched control population are being recruited to establish the prevalence of fatigue and depression. All participants completed three questionnaires including the Multi-dimensional Fatigue Symptom Inventory- Short Form (MFSI-SF) and the Piper Fatigue scale (PFS) to analyze fatigue, while depression was assessed using the Beck Depression Inventory (BDI). Cortisol levels were measured in saliva samples collected by participants for up to one hour upon awakening on two consecutive days.
Analysis: Statistical analysis is being conducted through entry into SPSS version 13. Salivary cortisol is being analyzed using an enzyme immunoassay Elisa kit.

Summary of Key Findings: From our preliminary results it is evident that women cancer survivors are significantly more fatigued and depressed than the general population. Furthermore, our results indicate there is a significant decrease in the mean level of cortisol in CRF sufferers compared to the healthy control population.

Conclusions: The preliminary findings of this study suggest that cortisol may play a significant role in the pathophysiology of fatigue in patients who have survived cancer. It is envisaged that this study will contribute to management strategies used in clinical practice, which will inevitably aid clinicians in their recognition and assessment of these symptoms.

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What is health? An exploration of nursing students’ observations

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Abstract
There is an extensive literature in the social sciences examining concepts of what health means to lay samples. However, there seems to be a gap in the literature regarding what health care professionals consider health to be. In an effort to address this gap, this study investigates what health means to a group (52) of year 4 nursing students (comprising general, mental health & intellectual disability disciplines) within eight weeks of undertaking their final examinations. We proceeded by developing an exploratory questionnaire based on the literature review to tap into possible influences on notions of health. When the questionnaire responses were analysed similar findings to those identified by other researchers on lay samples (e.g. Blaxter 1997; Macintyre 2006) were established. These themes were then explored in a focus group constituted from the original sample. Perhaps somewhat unexpectedly nursing students on the brink of their professional career displayed similar understandings to the question ‘what does health mean’ as reported by McCluskey (1987) –that health is associated with functionality as well as the absence of illness. Possible reasons for this finding are considered and limitations of the study discussed.

Introduction
Health is an elusive concept that has attracted a lot of attention over the years (Zola 1966; Friedson 1970; Herzlich 1973; Blaxter 1982; 1992; McCluskey 1989). One of the recurring themes to emerge from the literature is that health means different things to different social groups based on a range of variables including gender, age, occupation and socio-economic status (Blaxter 1997). Developing an understanding of what health means
is of the utmost importance to a range of healthcare professionals and policy makers. However the research cited in the literature appears to be mainly concerned with lay interpretations of what health means. This study was undertaken to discover what health means to a group of 4th year pre-registration students who would shortly be working at the coal-face of the Irish healthcare service. This is an important and worthwhile endeavour in that it addresses a gap in the current state of knowledge in this area. This paper will explore what health means to pre-registration nurses based on their responses to a questionnaire survey and a focus group discussion.

**Background**

Defining what health means may appear, at first sight, to be straightforward but the fact remains that there is little or no consensus about what corresponds to what health it does mean (Weiss 1997). Developing an understanding of what health means is of perennial interest to a range of researchers in the social sciences but is of particular relevance to the disciplines of nursing, sociology and social policy. One of the earliest researchers in this area was Zola (1966) who investigated what health meant to a culturally diverse sample in New York. His work was extended by Herzlich (1973) and d’Houtant & Field (1984) working in France while more recently Mildred Blaxter (Blaxter 1983; Blaxter 1990; Blaxter 1997) has undertaken a number of studies in the UK to determine what health means to a wide range of lay people. Blaxter (1990) reports findings from the Health & Lifestyle Survey (reporting on the views of a random sample of men and women living in Great Britain). Her analyses demonstrate that personal definitions of health differ according to age, gender and perceived level of health. For example young women focus on energy, vitality and the ability to cope while for young men the emphasis is on physical strength and levels of fitness. However older men and women tended to view health as related to their functional ability as well as their state of contentment and cheerfulness. One further finding Blaxter reports is that women of all ages often include social relationships in their description whereas men rarely do so. Mildred Blaxter made use of a UK nationwide large-scale random sample (n=9003), which was repeated five years later on the same sample which was reduced to 5352 because of ‘death and not tracing’ (1997: 784). Her findings are therefore quite robust and clearly indicate that there was a high level of agreement that health depended to a large extent upon personal behaviour and circumstances.

Of particular interest for the purposes of this study was her finding that it was ‘the more advantaged [social group] who appeared to be, more aware of the structural factors – like income, work, their
The World Health Organisation has offered two definitions of health (WHO 1946; WHO 1986) both of which are problematic. For instance in its 1946 definition; ‘Health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity’ (WHO 1946; 1) no model or operational definitions were provided. While this rather utopian description has provoked much argument, the understanding inherent in this definition has clearly moved beyond a narrow disease-free view of health (Seedhouse 1986). In response to such criticisms WHO moved to broaden this definition in 1985 by publishing Health for All by 2000 and in 1986 the Ottawa Charter for Health Promotion. These documents emphasise the need to assist individual’s ability to control and improve their health and are thus broader definitions than that developed in 1946 (Thuriaux 1988). According to Bowling (2003) modern definitions of health include notions of ‘completeness’ and ‘full functioning’ of both mind and body. When these ideas are investigated they appear to include things like the ability to deal with stress, having a social support system, being integrated into a community, having high morale and being satisfied with life. Also included are feelings of psychological well being and satisfaction with levels of physical condition. Clearly health is a multi-faceted concept and any simplistic definition will struggle to encompass all possible elements that may be associated with notions of what health means.

For instance patients presenting with similar biological experiences, or events, can be understood to mean different things across time and place according to prevailing cultural norms. These social values and these disparities in interpretation may lead to different responses and actions. In terms of the conventional biomedical model, health can be seen as the absence of disease or illness and symptoms are taken as physical manifestations of malfunctioning within the body. While the biomedical model outlined above is rather simplistic having been subjected to stringent criticism from amongst others nursing models of care (Roper 1985) and sociologists (Friedson 1970; Illich 1976; Navarro 1986; Nettleton 1995; Scrambler 2002; White 2002) there is nevertheless an enduring belief in its efficacy. ‘The body is isolated from the person, the social and material causes of disease are neglected and the subjective interpretations and meanings of health and illness are deemed irrelevant’ (Nettleton 1995: 3). While irrelevant might well be overstating the case there can be no doubting the commanding
position of the biomedical approach to healthcare in general (Clarke 2003) and in Ireland in particular (Tucker 1995; Hyde 2005; O'Donnell 2005, Tovey & Share 2003).

**What is Health?**

As previously stated Mildred Blaxter is one of the most prominent researchers in this area having written extensively about her work in the UK (1982, 1983, 1990, 1997). Of particular interest here is her survey reported in 1990. She randomly sampled addresses from electoral registers in the UK and, with a response rate of over 70 per cent, assembled a final sample of 9003 respondents. For this research two home visits took place, the first one by a nurse who collected information on height, weight, blood pressure and pulse rate. The nurse also left a questionnaire to be self-completed with the respondents together with a stamped address envelope, which was to be returned by post, as soon as possible by the respondent. This questionnaire asked respondents to access their own personality and mental health status.

During the second home visit the respondents participated in a long (2 hours), open ended, structured interview about health-related behaviour. This interview investigated respondents’ behaviours like smoking, exercise, diet and how they rated their own health. The study concluded that while individuals have many different definitions of health they could be classified into four categories outlined below.

- Health is being free of symptoms of illness, for example I don’t have a headache or a backache
- Health is not having a disease/disability, for example I have no medically diagnosed condition such as a broken leg or arthritis
- Health is being physically fit, for example I am physically fit enough to play sport
- Health is psychological and social well-being, for example I feel emotionally stable and able to cope with life

Blaxter suggests that these definitions can be classified as negative or positive views of health with the first two categories outlined above being negative, and the latter two, positive. She appears to mean negative in the sense of the absence of illness or physical injury and positive in that respondents felt that they could carry out activities either physical, or to cope with whatever life happened to throw at them. Blaxter also noted that conceptions of health varied over the life course with differences based on age and gender particularly salient. For instance young men were more likely to link health to physical strength and fitness. On the other hand
while young women also identified fitness as an aspect of health they preferred ideas of energy, vitality and an ability to cope as being the significant components of health. In contrast whereas older men linked functional ability with health they also spoke of health as being linked to contentment, happiness or a state of mind even when they were suffering from a disease or disability themselves. On a general note women expanded more on the concept of health and appeared to find the whole area of health and illness research more interesting than did men with many women, but few men, including social relationships in their definition of what health means (Blaxter 1997).

Irish views of health
Desmond McCloskey (1989) investigated health beliefs and practices of a random sample of lay people (n=475; 47% Dublin city, 53% rural Dublin) in Ireland in order to reach an understanding of what meaning Irish people attached to health and to discover what strategies they would take in their pursuit of good health and to deal with illness. Like other researchers before him (Blaxter 1982, 1983, Herzlich 1973, d'Houtard & Field 1984, Calnan 1984) McCloskey’s findings confirmed that health is a multi-dimensional concept. In particular his Irish sample identified health as the absence of illness, which he described as a functional aspect that did not impede one’s ability to perform societal norms or undertake usual roles. His sample also rated being happy, an ability to cope with life, which he categorised as well-being, together with what he termed an emphasis on fitness or being physically fit, active and energetic as important components of health. In effect these findings were remarkably similar to those of Blaxter (1997: 53) on a similar type of sample.

However, where McCloskey’s findings differed from those of Blaxter was that for the Irish respondents the absence of illness was a prerequisite for being healthy. Whereas Blaxter’s Health & Lifestyles survey (1989; 1990) found that people would often respond that they were healthy despite having a disease. This was especially true of the elderly, ‘those who themselves were in poor health or suffering from chronic conditions were less likely to define health in terms of illness’ (ibid 1990: 21). However McCloskey’s Irish respondents were adamant that those with a serious illness were not healthy and this sentiment was true even of those who had experienced a major episode of illness themselves! For Irish respondents being in pain from rheumatism or bronchitis was viewed as being closely associated with being unhealthy. This was especially so if it interfered with an individual’s ability to work or perform their normal range of daily activities. While someone in a wheelchair with a heavy cold was not deemed to be unhealthy, this
view changed when their flu hampered their ability to fulfil their normal range of social roles. Also the need to access medical care was viewed as confirmation of being ill while being confined to bed was also verification that a person was ill for all respondents.

In McCloskey’s sample there was some evidence that rural residents were more likely than city inhabitants to view someone as ill when they have sought, or needed medical attention or when they were unable to perform their usual social roles. He also found that as educational levels increased so too did the reference to inability to perform normal roles as a definition of ill health. The absence of illness as a core theme of health has been found by a number of other researchers in different countries. Williams’ (1983) study of elderly people in Aberdeen revealed that the absence of illness was an important element in their definition of health. Calnan (1987) investigated the link between occupational social class and health found that for those in manual type employment the absence of illness was an important component of being healthy. Similarly Herzlich & Pierret (1987) working in France also uncovered the belief that health was strongly related to the absence of illness. More recently in the United States McKague & Berhoef (2003) discovered that the absence of illness was an important aspect in health beliefs for both patients and those working in an urban community health centre.

Wiley & Merriman (1996) investigated the level of knowledge amongst Irish women (n=2988; aged 18-60 years) regarding their health needs in a number of specific areas surrounding childbirth, sex education, parenting, nutrition and gynaecological issues. Their research, sponsored by the National Maternity Hospital, was a nationwide survey of Irish women and one of the themes they clearly identified was that absence of illness was important to their respondents. To date there has not been a national study of Irish men’s views of health. Overall then McCloskey’s finding of the link between health and physical capability are replicated elsewhere and are, therefore, robust findings in the literature and not just an Irish anomaly.

**Current areas of research interest**

Current research in the area of health beliefs appears to be concerned with the lived experience of those suffering from a range of specific illnesses and what health means to them. For instance Roose & John (2003) investigated the understanding young children (10-11) have of mental health and their views of service provision. While Bernard et. al (2004) researched Australian adolescent’s perspectives of health care provision and services and discovered that while there were some common areas of understanding there
were areas of difference which policy makers needed to address. Backett-Milburn et. al. (2006) investigating children’s (9-12 years old) understandings of health inequalities in a Scottish city established that children in this age group have a rather sophisticated understanding of the role life circumstances play in their health status. When they explored the meanings associated with body image among teenagers living in poorer socio-economic circumstances they concluded that teenage understandings are derived from adult models rather than their own. Klien et. al. (2005) also studied US adolescent’s knowledge and beliefs relating to their use of herbs and dietary supplements and ascertained that most young people are familiar with their use in the treatment of illnesses.

Chapple et. al. (2002) examined how the health views of general practitioners impacted on their patients views of health and discovered that there was a difference of opinion concerning definitions of health. Press et. al. (2006) scrutinized women’s response to the use of prophylactic mastectomy and argued that this procedure was of little interest to some women because they saw it as mimicking the illness of breast cancer. MacIntyre et. al. (2006) studied the role of socio-economic factors on health and concluded that caution should be exercised about the how socio-demographics influences actually contribute to health. Wenchi et. al (2004) sought to assess the views of Chinese American women of health and illness and found that exercise was an important component of health while language fluency played a major role in accessing health care provision.

On a more general note Shaw (2002) highlighted the difficulty of studying the health beliefs of lay people because they are inextricably linked to the pervasiveness of the bio-medical and expert model that is so closely associated with the medical rational and scientific method of health care provision. Hence the need to study the meanings that ‘soon-to-be’ nurses attach to health.

The Study

Aims
To explore year 4 nursing student’s view of health and assess how their observations on health differ from those reported in the literature by lay people.

Methodology
A questionnaire was compiled from the literature review containing 96 items structured around spiritual, physical, psychological, social and well-being. Example of items include; Health is; having a
connection to God, not being in chronic pain, health is visiting friends, health is feeling healthy. Responses were assessed by means of Likert scale (1-5) and the Cronbach’s alpha was .94, which is satisfactory for studies of this type (Oppenheim 1986). After respondents had completed the questionnaire they were asked if they would be interested in being part of a focus group to explore findings from the survey and a general interest was expressed. A focus group of eight respondents was subsequently formed lasting 65 minutes. Themes explored included spiritual, physical, psychological, social and well-being as components of health. Data from the focus group were transcribed and themes identified. Both analyses will be used in the discussion that follows below.

Participants
A purposive sample of 53 participants (age x = 24.7 yrs, sd=7.4 yrs) who attended a year 4 research class agreed to take part in the study. These participants were within 8 weeks of completing their final exams having been on clinical placement for one calendar year prior to their involvement in this research. Given that they have been exposed to almost four years of teaching from the Bord Altranis approved nursing curriculum the assumption was that they would have a more differentiated view of health than might be expected from a lay population. Respondents were asked to indicate their willingness to partake in a focus group to be arranged at a future date. Those interested were asked to write down their name on a sheet of paper (n=29) and the focus group was formed from this list of names based on availability. In this way an element of randomness was introduced, as the researchers had no method, or way of knowing who would be available on the day of either the questionnaire survey or the focus group.

Data collection
Participants were asked to take part in a study of their views of health at a time scheduled for a research class. They were told that participation was entirely voluntary though by its very nature survey research needed as large a sample as possible. They were asked to read the items in the questionnaire quickly, but to ensure that they answered all questions. They were informed that what was important in survey research was their ‘instinctive’ or ‘gut’ reaction. The problem of non-response in survey research was discussed and respondents were requested to respond to all items in the questionnaire. This resulted in an almost complete data set. Afterwards students were encouraged to ask questions about the nature of questionnaire research and its efficacy vis a vis a qualitative approach. A lively discussion then ensured which demonstrated a high level of both interest in, and knowledge of, the benefits and shortcomings of survey research. Some comments
were made on the items in the questionnaire especially that some questions were repeated in a slightly different form in different sections of the questionnaire. This discussion demonstrated that respondents had a high level of attention to, and engagement with, the research process.

The focus group took place during class time scheduled for a sociology lecture and eight students (male=3, female=5) were available for participation. Respondents were made cognizant of the consent form and ethical issues relating to confidentiality issues were agreed upon by participants and researchers in an effort to conform to best practice regarding the issue of informed consent. Subjects were once again informed that participation was voluntary and that no penalties would accrue if they wished to withdraw at this stage. Respondents were then informed of the areas that were going to be discussed, assured that all responses were confidential and that they were free to leave, or not to answer questions, at anytime. The first author acted as facilitator while the second author acted as note taker.

**Ethical consideration**
An extensive discussion occurred prior to both administration of the questionnaire and running the focus group. Issues discussed included the responsibility of the researchers to ensure the anonymity of the respondents. In particular respondents were assured that no-one would be identifiable from the information given on the questionnaire. Respondents were told that in quantitative type of surveys it was the aggregate of their responses, which was of interest to the researchers. The study was carried out with the full consent of respondents who understood that they could refuse to take part and could withdraw at any time. For the focus group research, respondents were told that the tapes and notes would be held in a secure place and that there would be no way of identifying any individual response from this material. They were assured that only the researchers would have access to the material and that no individual would be identifiable from their responses. They were asked not to discuss anything that occurred during the session with outsiders and that they should not repeat outside the group information that could identify participants. They were then given a consent form, which the researchers reviewed with them prior to tape-recording the session. After ensuring that respondents understood the nature of the task they were involved in they were then asked to sign the consent form.

**Data analysis**
Responses were imputed and analysed using SPSS (v13.5) while the notes from the focus group were transcribed and analysed for
themes. The transcript was checked against the contemporaneous notes to ensure accuracy and fidelity (Lofland & Lofland 1984). Data from the questionnaire survey will be discussed first.

The questionnaire attempted to investigate what health is by examining the level of importance respondents attached to spiritual, psychical, social and well-being these being the themes identified from the literature review. In the discussion that follows the reader’s attention is drawn to the low rate of non-responses / no answers indicating that the respondents were engaging with the questionnaire items. It is important to note that for the purposes of brevity not all of the questionnaire items are reproduced in the tables below. Table 1 below shows the responses to the items asked in relation to spiritual beliefs.

Table 1 Spiritual beliefs as a component of health.

<table>
<thead>
<tr>
<th>Health is;</th>
<th>SD</th>
<th>D</th>
<th>U</th>
<th>A</th>
<th>SA</th>
<th>N/Ans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a connection with God</td>
<td>11.3</td>
<td>22.6</td>
<td>20.8</td>
<td>41.5</td>
<td>3.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to pray</td>
<td>13.2</td>
<td>24.5</td>
<td>24.5</td>
<td>35.8</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Going to church service regularly</td>
<td>17.0</td>
<td>34.0</td>
<td>30.2</td>
<td>17.0</td>
<td>1.9</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Note; SD=Strongly Disagree, D=Disagree, U=Unsure, A=Agree, SA=Strongly Agree, N/Ans=No Answer

While having a connection to God found some level of agreement with respondents, the high rate of Unsure responses, never less than one in five of the respondents in this table, indicates a decreasing trend in concrete actions. For instance church attendance, a practical activity, attracted less positive responses than being able to pray or having a connection with God.

Table 2 below shows the responses to the items asked in relation to the role psychical aspects play in respondents’ notions of health.

Table 2 Physical aspects of health.

<table>
<thead>
<tr>
<th>Health is;</th>
<th>SD</th>
<th>D</th>
<th>U</th>
<th>A</th>
<th>SA</th>
<th>N/Ans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being able to do my physical work</td>
<td>5.7</td>
<td>9.4</td>
<td>1.9</td>
<td>58.5</td>
<td>24.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to dress myself</td>
<td>5.7</td>
<td>13.2</td>
<td>7.5</td>
<td>54.7</td>
<td>17.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Being able to walk</td>
<td>9.4</td>
<td>11.3</td>
<td>11.3</td>
<td>50.9</td>
<td>17.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to go about my work</td>
<td>1.9</td>
<td>13.2</td>
<td>5.7</td>
<td>66.0</td>
<td>13.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to shower by myself</td>
<td>7.5</td>
<td>15.1</td>
<td>7.5</td>
<td>45.3</td>
<td>24.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to physically speak</td>
<td>11.3</td>
<td>20.8</td>
<td>7.5</td>
<td>45.3</td>
<td>15.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to take part in my own sport</td>
<td>9.4</td>
<td>17.0</td>
<td>18.9</td>
<td>39.6</td>
<td>15.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Being physically able to walk</td>
<td>9.4</td>
<td>18.9</td>
<td>13.2</td>
<td>35.8</td>
<td>22.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to cut my own toenails</td>
<td>7.5</td>
<td>37.7</td>
<td>13.2</td>
<td>32.1</td>
<td>9.4</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Note; SD=Strongly Disagree, D=Disagree, U=Unsure, A=Agree, SA=Strongly Agree, N/Ans=No Answer
Table 2 clearly demonstrates the importance attached to physical activities with agreement / strong agreement only falling below one in two respondents in the final question regarding cutting one’s own toenails. The ability to ‘go about their work’ attracted a very high level of agreement as being a vital element in their concept of health. Evidently for this sample the capacity to undertake a range of what able bodied people take for granted, physical activities, is important to their concept of health.

Table 3 displays responses to items related to social aspects of health.

<table>
<thead>
<tr>
<th>Health is;</th>
<th>SD</th>
<th>D</th>
<th>U</th>
<th>A</th>
<th>SA</th>
<th>N/Ans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining contact with my family</td>
<td>1.9</td>
<td>15.1</td>
<td>1.9</td>
<td>34.0</td>
<td>47.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Having a good support network</td>
<td>1.9</td>
<td>5.7</td>
<td>11.3</td>
<td>47.2</td>
<td>34.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to socialise with my friends</td>
<td>5.7</td>
<td>9.4</td>
<td>15.1</td>
<td>60.4</td>
<td>9.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to socialise</td>
<td>3.8</td>
<td>11.3</td>
<td>15.1</td>
<td>49.1</td>
<td>20.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Having friends I can trust</td>
<td>5.7</td>
<td>13.2</td>
<td>13.2</td>
<td>49.1</td>
<td>18.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Having lots of friends</td>
<td>7.5</td>
<td>24.5</td>
<td>9.4</td>
<td>47.2</td>
<td>11.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Health is visiting friends</td>
<td>1.9</td>
<td>18.9</td>
<td>22.6</td>
<td>47.2</td>
<td>9.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Being in an intimate relationship</td>
<td>7.5</td>
<td>26.4</td>
<td>11.3</td>
<td>43.4</td>
<td>11.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Going out to the cinema</td>
<td>11.3</td>
<td>30.2</td>
<td>26.4</td>
<td>30.2</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Health is being visited often by friends</td>
<td>3.8</td>
<td>37.7</td>
<td>28.3</td>
<td>28.3</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Being able to go out to the pub</td>
<td>24.5</td>
<td>28.3</td>
<td>17.0</td>
<td>26.4</td>
<td>3.8</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Note; SD=Strongly Disagree, D=Disagree, U=Unsure, A=Agree, SA=Strongly Agree, N/Ans=No Answer

Table 3 demonstrates that social aspects play an important role in respondents’ views of health particularly the role of the family and having a good support network. While having lots of friends I can trust was deemed to be important, having lots of friends attracted some disagreement indicating the significance of having intimates perhaps rather than having lots of acquaintances. Somewhat surprisingly -given Ireland’s pub culture- being able to go out to the pub, while of importance to more than one in five of the respondents, more than half, 53.8 per cent either disagreed or strongly disagreed with this statement. This is a somewhat higher number compared to those who disagreed that going out to the cinema was an important element of social health. Nevertheless the pattern is quite clear and unmistakable that social aspects as outlined above are a vital component of what respondents think of as part of what health means. Table 4 outlines the responses to well-being as an element of health.
Table 4 Well-being and health.

<table>
<thead>
<tr>
<th>Health is</th>
<th>SD</th>
<th>D</th>
<th>U</th>
<th>A</th>
<th>SA</th>
<th>N/Ans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a balanced diet</td>
<td>1.9</td>
<td>0.0</td>
<td>5.7</td>
<td>60.4</td>
<td>32.1</td>
<td></td>
</tr>
<tr>
<td>Being able to think through things that matter</td>
<td>1.9</td>
<td>9.4</td>
<td>9.4</td>
<td>50.9</td>
<td>28.3</td>
<td></td>
</tr>
<tr>
<td>Being able to love myself</td>
<td>1.9</td>
<td>7.5</td>
<td>7.5</td>
<td>56.6</td>
<td>26.4</td>
<td></td>
</tr>
<tr>
<td>Being loved by others</td>
<td>5.7</td>
<td>11.3</td>
<td>9.4</td>
<td>35.8</td>
<td>37.7</td>
<td></td>
</tr>
<tr>
<td>Being able to love others</td>
<td>1.9</td>
<td>9.4</td>
<td>5.7</td>
<td>58.5</td>
<td>24.5</td>
<td></td>
</tr>
<tr>
<td>Being able to feel all my emotional responses</td>
<td>5.7</td>
<td>7.5</td>
<td>9.4</td>
<td>50.9</td>
<td>26.4</td>
<td></td>
</tr>
<tr>
<td>Having the ability to solve my problems</td>
<td>5.7</td>
<td>7.5</td>
<td>9.4</td>
<td>60.4</td>
<td>17.0</td>
<td></td>
</tr>
<tr>
<td>Being content with one’s lot in life</td>
<td>0.0</td>
<td>7.5</td>
<td>17.0</td>
<td>47.2</td>
<td>28.3</td>
<td></td>
</tr>
<tr>
<td>Health is being confident about life</td>
<td>3.8</td>
<td>13.2</td>
<td>11.3</td>
<td>47.2</td>
<td>24.5</td>
<td></td>
</tr>
<tr>
<td>Being able to think clearly</td>
<td>3.8</td>
<td>13.2</td>
<td>11.3</td>
<td>56.6</td>
<td>17.0</td>
<td></td>
</tr>
<tr>
<td>Being able to keep in contact with friends</td>
<td>3.8</td>
<td>13.2</td>
<td>9.4</td>
<td>58.5</td>
<td>15.1</td>
<td></td>
</tr>
<tr>
<td>Being able to express my self</td>
<td>3.8</td>
<td>11.3</td>
<td>11.3</td>
<td>54.7</td>
<td>18.9</td>
<td></td>
</tr>
<tr>
<td>Health is being excited about life</td>
<td>1.9</td>
<td>9.4</td>
<td>17.0</td>
<td>52.8</td>
<td>18.9</td>
<td></td>
</tr>
<tr>
<td>Health is what I eat</td>
<td>3.8</td>
<td>20.8</td>
<td>9.4</td>
<td>62.3</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Being able to enjoy my food</td>
<td>7.5</td>
<td>11.3</td>
<td>11.3</td>
<td>56.6</td>
<td>13.2</td>
<td></td>
</tr>
<tr>
<td>Being able to make my own decisions</td>
<td>5.7</td>
<td>7.5</td>
<td>11.3</td>
<td>45.3</td>
<td>30.2</td>
<td></td>
</tr>
<tr>
<td>Health is not feeling lonely</td>
<td>3.8</td>
<td>15.1</td>
<td>17.0</td>
<td>41.5</td>
<td>22.6</td>
<td></td>
</tr>
</tbody>
</table>

Note; SD=Strongly Disagree, D=Disagree, U=Unsure, A=Agree, SA=Strongly Agree, N/Ans=No Answer

What is clear from table 4 is the high level of agreement with items that relate to notions of well-being. The relatively low Unsure response rate indicates that the respondents were exercising critical thought and judgment when engaging with the questions. While there was, for the most part, low response rates to Strongly Disagree / Disagree support the view that these items are indeed measuring elements involved in the well-being ingredients of health. The items above clearly relate to respondents feelings and emotions about a range of issues ranging from the ability to think, through having a balanced diet to enjoying food to being confident and content to not feeling lonely.

Discussion

This discussion will be framed around the information contained in the tables in the last section and will be informed by responses from the focus group. The subject to be addressed concerns the meanings that our respondents attach to health. Our questionnaire centred on our respondents’ answers to the spiritual, physical, social and well-being questions that formed our agenda from the start. Therefore while our respondents did not have much leeway in which
to raise other issues or topics that they might have identified as more relevant they did have the opportunity in both the questionnaire and at the end of the focus group to draw the researcher’s attention to them. From the tables in the previous section, it is something of a truism to say that there is clear evidence that health is indeed a multi-faceted concept especially for students who are within weeks of undertaking their final exams.

As outlined in Table 1 above it is clear that respondents make a clear distinction between ‘having a connection with God’, almost one in two, and actual practise with slightly over one in three either ‘being able to pray’ and less than one in five physically ‘going to church service on regularly’. The rather high rates of Unsure indicate that for our respondents there may be some lack of clarity regarding the link between spirituality and health. Such a statement is borne out by some of the remarks of the focus group. There was rather general agreement when one of the male respondents (mental health) said that ‘there wouldn’t be as much emphasis on it now than there was a good while ago … my parents and …old fellows would have a big emphasis on religious beliefs affecting health … but I think now in the changing times it is not the most important thing for young people’. What is interesting here is that the link is made with organised religion, specifically the Catholic Church that was a spontaneous, though maybe natural, response to questions about the link between spirituality and health.

When probed further by the moderator there was general agreement that in times of illness people might become more religious. For instance one female (mental health) pointed out that ‘at exams we go lighting candles’ while another gave the example of an older person who was dying from cancer. She explained that a religious relic, Padre Pio’s glove, was used in the belief that it would either cure the person or ensure a peaceful death and that the family were of the opinion that it was of great value to the person who was dying. Other instances included examples from clinical practise when a person found a ‘lump’ and had to wait for a biopsy. During this waiting period the person ‘drank holy water every day for two weeks and when his biopsy was carried out the lump was gone and even the doctor couldn’t explain it at all’ (general nursing). What is apparent in this part of the discussion is that there was a clear link between religious beliefs and outcomes with all of the focus group agreeing that there was something spiritual in these examples. Of course whether religion and spirituality are one and the same thing is a contested area but for these respondents the link did indeed exist. The reasons why may have something to do with the culture and strength of the Catholic Church in Ireland in the recent past. While religion was not a variable we measured at
any time it is surely not too contentious to argue that these young people had been exposed to both their parents and grandparents beliefs throughout their young lives. The catchment area for Letterkenny Institute of Technology is, for the most part, County Donegal, which is still a largely rural community, and to speak of the demise of the Catholic Church in this area is surely somewhat premature.

Given the age of the sample utilised for this research perhaps it is only natural that physical health, in the sense of being able to ‘do’ things, would be of great significance to them. This sentiment can be clearly seen in Table 2 where being able to do my physical work found support with eight in ten of the sample. A further three quarters of the sample agreed with the statement ‘being able to go about my work’ was central to their description of health beliefs. Further significant support was given to statements that involved personal care like showering, to dress oneself and to be able to walk attracting agreement of between one half and two thirds of the sample.

One female respondent (general student) said that ‘when you can’t do what you want to do every day ... what’s a normal task every day, when you have physical problems that stop you from doing what you want ... when you have to be dependent on other people and that’s when it impinges on your life generally that’s when you’re not healthy.’ However this view was challenged by an intellectual disability nursing student ‘well, physical aspects is that clients with intellectual disability do have physical disability and have difficulty getting dressed, if they have cerebral palsy then they won’t be able to do that and they’ll need someone else to help them. But while they are very dependent they can be healthy and it depends on the individual’.

What is evident here is perhaps the different viewpoints of the different disciplines of nursing taking part in this research (general, mental health & intellectual disability) with their often very different approaches to the question of what health is. For general nurses perhaps the emphasis is on moving people out of the ward which is possibly also, although to a lesser extent, the aim of mental health nursing. While for intellectual disability nursing the emphasis might probably be more on quality of life approach given the fact that many of their clients or patients have no realistic opportunity of exercising a ‘normal’ range of physical behaviours.

The social aspects of health were clearly of some importance to the respondents. In particular the role of the family, having a social support network and being able to socialise with friends were
identified as beneficial to health. Similarly having friends and being in an intimate relationship resonated with the sample especially in regard to mental health as the following demonstrates;

‘… I think that what we see is a lot of people isolating themselves, they don’t have any social network at all and then they would be coming to the services with depression or a whole range of things wrong with them because they have no support … and I think its more their outlook, that they’re actually getting out there and socialising and you have the support of friends and family that’s so important –probably more important than medication can ever be. Because without your social support you’re just left on your own and left to your own device’ (general nurse). There is a telling phrase here ‘… more important than medication can ever be’ which underscores the importance of the social element of what actually constitutes health.

At a later stage of the discussion the same student mentioned the importance of income as being part of the social aspect of health when she said; ‘… if you don’t have enough money you’re going to be stressed if you’re constantly worrying about finances and wondering you’re going to make it through the week –it’s going to impact on your health, both physical and mental health. Because if you’re constantly worrying you’re going to end up picking up infections easier if you’re constantly stressed and worrying at the end of the day it definitely has some impact’.

The importance of family and their ability to come to the rescue is vividly recounted in the next quote which discusses how the family unit can make a real and significant difference to living conditions. ‘… I was out with the public health nurse I saw a man living in a house that you wouldn’t put a dog in –the water was pouring in on top of him and everything was wet. His family were construction workers so we just had to get on to them then and they bought him a decent house, but his health was affected big time … he got pneumonia and everything –understandable with the water pouring in on top of him’. This quote supports the idea that social networks and the family in particular have important functions to play in both living conditions and health outcomes, although perhaps it should be noted that not all families could afford such a generous gesture as remarked upon in this example. Of course this example also includes notions of well-being and is a concrete expression of being loved by others which more than eight in ten of the sample thought was an important aspect of what health means.

When discussing this aspect of health one respondent mentioned that coping skills were important. The discussion at this time was
focussed on issues of mental health and how people manage to deal with life issues ‘coping strategies can come into it. Some people just can’t cry and they cut themselves … and they can go through that for many years without anybody knowing even’ (female mental health).

Towards the end of the session when respondents were asked to sum up their responses to health, one female student commented ‘… people are losing coping skills; they’re losing everything else, they’re just reaching out for therapy as their first solution. They’re not trying to adapt and cope by themselves; they’re just going to the psychiatrist first and they’re not trying any more’ (female general). While for another female respondent ill health was ‘when they can’t cope with their illness any more, … if they have the coping skills to overcome it … you can’t really say that person in not healthy … and if you haven’t got a lot of coping skills that will impinge on your health and how you cope with it’ (mental health). Happiness was something that our respondents thought would be an important element in health with one respondent suggesting ‘having a happy life – that’s my definition of a healthy man’ (male mental health). From this statement general agreement ensued and the sample were then spontaneously given the following example and asked for their comments.

Researcher; Do you think, for example, to give an extreme example – someone you would see in an inner city, lying in a side street drinking out of a bottle of cheap cider maybe, and maybe fairly unkempt, but he’s there and he seems pretty happy with his situation – would you say he’s healthy?

Animated discussion occurred but the general agreement was that ‘if he’s happy within himself, he might have no worries or anything, he might enjoy that life if he’s happy within himself’ (female general nursing), while a male retorted ‘[that] if he’s causing no bother and he’s there, maybe if he’s happy that way. That’s his own life and we can’t stop him, it will affect him in the long term physically but at the moment …’ (mental health). Another comment related to notions of norms of behaviour as linked to health ‘Well, if I went out and done something extreme but it was what I wanted to do – someone would say, ‘She’s mad in the head for doing that there’ – I might think I was happy’ (female general nursing). Overall there are a number of themes emerging from the foregoing discussion. While happiness is viewed as an important element of well-being there were concerns for how present activities, which may seem rather more or less harmless in the present tense, could have long term consequences. The sample was very clear that the individual’s reasons behind these types of actions, street drinking, were an
important ingredient in determining whether someone is healthy or not.

**Conclusion**

The research reported here extends our knowledge of what health means to a sample of almost completed undergraduate BSc (Hons) nursing students. Perhaps their views as expressed here as to what health means are, as much as anything else, really a function of their nursing training. What we mean is that one of the core functions of nursing is to move people through the hospital system (Latimer 2000). Therefore the views expressed here by our student respondents reflects the wider public concern with the health service as one which exists to make people ‘well’. The important influence of the bio-medical model is evident although there is a clear understanding that medicine and medication are not a panacea for health. Limitations of this research include the fact that the questionnaire did not include more items relating to the spiritual impact on health. For instance there are reports in the literature of the power of prayer (Maltby & Lewis 1997) and this aspect may deserve more attention. Similarly with the focus group itself, given the nature of the dynamics between lecturers and students it may have taken some time for the group to ‘settle’ into the setting. Of more salience perhaps is that we may have simply tried to cover too broad an area and future research on similar type of samples might consider having groups explore each aspect as a separate and focal issue.

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Day by Day
Patients experiences of Hospice Day Care.

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The trend worldwide is towards longer life and the ageing of
populations. Our society is experiencing an increase in numbers of
older people. There will be a significant increase in the number of
people aged over 65 in Ireland over the next ten years (Central
Statistics Office (2006).  Currently, 11% of the population is over
65 years but by 2016 this figure is expected to be 15% and by 2050
it is estimated to be 25%. Dying can involve a lengthy preceding
illness, considerable suffering and dependency, and awareness on
the part of the dying person of the terminal nature of their disease:
alternatively it can be quick and relatively pain free occurring with
no foreknowledge. In this society death is largely confined to old
age. This has consequences for the experience of dying as it
becomes merged with old age.

Almost 30,000 people die annually in Ireland and over 6,000 people
use hospice services each year. Ireland has a rich culture of
hospice and palliative care organisations involved in end of life care.
The goal of palliative care is a good quality of life, as defined by the
patient, by maintaining dignity and controlling symptoms (Ferrell
and Borneman, 2002). It is widely agreed that the majority of
patients, given the choice would choose to die at home. There has
been an increase in demand and a change in the patient population
that are presenting to the palliative care services. There are a
larger number of patients referred to the service with more complex
symptoms and psychosocial problems with and more patients are
being referred at an earlier stage of their illness.
More recently hospice care has expanded to include specialist palliative day care. In general, these services provide facilities for medical and nursing assessment and care, coupled with social and therapeutic interventions provided by a multidisciplinary team (Goodwin et al, 2002). Whilst good symptom control and psychological support can be provided by primary care teams supported by palliative care teams in the community, there is a recognised need for peer group support. Patients faced with a life threatening illness have to make major lifestyle adjustments as they lose independence. However, we know little about the impact of hospice day care services and how effective they are at helping individuals manage what is happening to them. Lawton (2000) asserts that palliative day care allows patients to receive physical, psychological and social care allowing them to remain in their home environment. Thompson (1990) also suggests that palliative day care increases the continuity between in-patient and home care and can ease the burden of responsibility on carers. While the National Advisory Committee Report on Palliative Care (Department of Health and Children, 2001) and A Baseline Study of the Provisions of Hospice/Specialist Palliative Care Services in Ireland (Irish Hospice Foundation 2006) highlight the crucial role which Hospice Day care provides to patients with terminal illness, there is a lack of empirical work which explores this role.

Aim of the Study.
To examine the role of Hospice Day Care in the care of patients with life limiting illness.

Full ethical approval was obtained to conduct this study.

Methodology Methods: Using an ethnographic approach various tools of data collection, namely participant observation, informal interviews and in-depth interviews with 15 patients were used to collect data in this study.

Findings suggest that patients experienced layers of activity in hospice day care depending on their individual needs. Patients experienced a base layer of physical, emotional and social care and then an additional layer of medical and creative therapies.

Conclusion: Hospice day care is a complex service that attempts to address the physical, psychological, social and spiritual needs of individual patients and their families within an environment that promotes their uniqueness.


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Caring in three worlds- What mothers say it’s like to care for a child with complex needs.

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The focus of this presentation is on the outcomes from a qualitative phenomenological study, undertaken in Ireland in which mothers’ experiences of caring for children with complex needs were explored.

The aim of this Doctoral work was explore mothers’ experiences of caring for children with a diverse range of complex needs at a time when service delivery in community, respite and palliative care is under review and development.

Using a hermeneutic phenomenological approach, based on the approaches of Heidegger and Gadamer, data was collected by multiple interviews and diary recordings from a group of seventeen mothers. The mothers had children who had had rare, congenital and genetic disorders, some of which were progressive and life-limiting. Data were analysed using manual coding and using an adaptation of Koch’s (1995) and Smith’s (1997) models of analysis and NVivo for data management.

Mothers in this study provided care for their children in three worlds; an inside world of the home, an outside world and a going between world. In each of these worlds the mother was involved in highly technical care giving in an unstable world where support may be limited. The mothers’ ‘knowingness’ and the ‘unknowingness’ of others impacted on the mothers’ experiences. Experiences are bounded by constant observation and constant connectedness. Constant communication is also part of this experience. Technical care-giving is one dimension of many of the mothers experiences and involves the delivery of highly technical care and pre-emptive care in each of these three worlds.

Mothers were involved in a no choice situation in providing care in an unstable situation in which the children require individualised and technical care. Paperwork and administration add significantly to the complexity of caring.
The mothers in the study provided a wide range of activities for their children including the normal activities of feeding, bathing, washing, communication, dressing and clothing, eating, mobilising, pain, play, sleeping and assisting with toilet needs. However, mothers reported on the highly technical aspects of care that their children required including managing various types of tubes, dressings, shunts, medications and airway management. Highly complex skills of medication, pain and seizure management are undertaken. This involves highly technical assessment and observation skills as well as high level problem solving and decision making.

Additionally mothers reported on the specific, individualised needs of their children in relation to particular symptoms that were displayed. These ranged from constant, unexplained, incessant crying, hypersensitivity to touch and cold, abnormal startle reflexes and finger chewing. The need for constant observation to maintain safety and comfort was reported.

Finally mothers also outlined the fragility in their children’s conditions and the unstable nature of the children’s needs during episodes of aspiration, chest infections, unexplained episodes of deterioration, possible “near death” and progressive deterioration. The instability of the children’s conditions also required the mothers to monitor their children constantly for signs of deterioration, changes in normal behaviours or patterns, the onset of illness and to manage these situations, often without help.

The data collected provides for a greater understanding of the mothers’ experiences in caring for a child with complex needs. In order to ensure that health professionals are able to provide adequate and appropriate support for mothers in this technical caregiving role they need to better understand this aspect of the mothers’ experiences.

References
Available on request
An evaluation of the impact of the move to a new mental health inpatient facility on staff and patient outcomes.

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Background: Despite increased interest in the development of community care over the past 30 years, inpatient services continues to receive over 50% of the mental health funding in the UK. Concerns about the standard of inpatient care have been expressed, particularly over the past decade. This has led to initiatives to improve services, but there is little evidence as to their effectiveness.

Aim: To investigate whether the move to a new inpatient premises in central London was successful in terms of improving staff and patient outcomes.

Methods: A natural ‘before and after’ design was used, and all wards which were affected by the move were included. The staff experience was investigated using the Ward Atmosphere Scale (WAS) and the Maslach Burnout Inventory. We investigated that of patients using the WAS, the Client Satisfaction Questionnaire (CSQ) and the ‘Your treatment and Care’ questionnaire. 158 patients were included in the first stage, and 145 in the second, with response rates of 80% and 75% respectively. Staff figures were 182 (RR= 80%), and 197 (RR= 74%) respectively.

Findings: Results for patients showed statistically significant changes in CSQ scores, and in almost all items in the ‘Your Treatment and Care’ measure. Levels of staff burnout appeared unchanged, expect in rehabilitation wards. Among the WAS findings were higher levels of staff control as perceived by patients, and lower levels of anger and aggression.
Service level data on untoward incidents demonstrated a significant improvement in the year following the move, but this was not maintained over longer periods.

38 qualitative interviews were conducted with patients before (20) and after (18) the move. Themes extracted from these interviews serve to enrich the findings from the quantitative data.

Conclusions: The study sample demonstrated improved patient satisfaction following the move, lower ward incident rates, and similar levels of staff burnout.

A planned third phase of the study will be conducted in 2008, and will repeat the measures from the previous two. We will also attempt to capture the impact of changes in organizational structure during this stage.

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A molecular study of *Listeria* species isolated from food of animal origin in Ireland.

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Background  
*Listeria monocytogenes* is an opportunistic food-borne pathogen that causes listeriosis in humans. Clinical manifestations are usually severe and include abortion, sepsis and meningo-encephalitis. In Ireland between 2000 and 2003 there was an average of 6.5 cases of human listeriosis per annum. There is no known data of *Listeria* species in the ready to eat (RTE) food industry in Ireland.

Aim of Study  
To enhance the information pertaining to the incidence and epidemiology of *Listeria* strains, in Ireland. On a molecular level identify any specific traits/genes in all detected *Listeria* spp. including *L. monocytogenes* and to carry out an investigation into molecular typing methods available today. In addition carry out the necessary alterations which will transfer these specialised methods into high-throughput techniques for industry that are effective, simple to use and inexpensive.

Methodology  
A collection of four hundred samples is currently being compiled at the Central Veterinary Research Laboratory (CVRL) at the Department of Agriculture, Fisheries and Food (DAFF) from industry and private laboratories. Rapid identification of *Listeria* spp is being
carried out through species-specific markers on conventional polymerase chain reaction (PCR). Work is ongoing on the Real-time PCR to develop a multiplex assay that can discriminate individual strains of *Listeria* along with an in-house positive control at Waterford Institute of Technology.

**Key Findings**

Preliminary analysis of this collection indicated that forty percent of the strains possibly were *Listeria monocytogenes* and the CVRL is currently conducting a survey of food processing environments at RTE food suppliers regulated by DAF.

**Conclusion**

The bacterium *L. monocytogenes* and listeriosis have grave implications for consumer, the food manufacturer and the food industry, rapid but accurate molecular techniques hold the key to preventing the entry of this hazardous pathogen into the food chain.
BREASTFEEDING: WHAT ARE FATHERS BEING TAUGHT?

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Background and context: Irish breastfeeding initiation rates while increasing over the last few years are most recently reported as just 41.25%. This identifies a public health concern as this rate falls short of the ideal stated by the World Health Organisation. Numerous factors inhibit breastfeeding initiation and attitudes are included in these factors. While women’s attitudes to breastfeeding have been identified as a key factor in the initiation of breastfeeding, several researcher’s have suggested that partner’s attitudes are influential in women’s decisions to breastfeed or not to breastfed their baby.

Aim of study: To determine the attitudes of first time expectant fathers regarding breastfeeding

Methodology: A quantitative descriptive approach was used. The Iowa Infant Feeding Attitude Questionnaire was administered to all first time expectant fathers present at the first class in a series of antenatal classes and to those present for their first visit to the antenatal clinic on selected days.

Analysis: Data was analysed using SPSS, with descriptive and inferential statistics.

Summary of key findings: The lack of knowledge among these fathers regarding the benefits and composition of breast milk was evident and agreement was immense with the statement that women should not breastfeed in public places.

Conclusion: Healthcare professionals must find ways of dispersing knowledge surrounding breastfeeding to expectant fathers and society at large. Fathers as a population need to be educated to help increase breastfeeding rates. Father’s opinions are a key factor to their partners in supporting their decision to breastfeed and this role must be recognised. Recommendations to achieve this may involve the implementation of a father’s only antenatal classes and the establishment of classes or seminars in schools with regard to teaching teenagers about breastfeeding, especially on educating male teenagers on how to enable them to support breastfeeding successfully.
Smoking Prevalence amongst Qualified Nurses and their Role in Smoking Cessation

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Background and context
Tobacco use is a major cause of morbidity and mortality. Admission to hospital provides an opportunity to help people stop smoking. Nurses’ role and wide availability puts them in a prime position to encourage people to quit smoking.

Aim of the study
To examine the smoking prevalence amongst qualified nurses at a large university teaching hospital and their role in smoking cessation.

Research methodology
Quantitative study using a random sample of 430 qualified nurses (70% response rate). A structured questionnaire was used.

Analysis
Data from the completed questionnaires was entered onto a database (Epidata) and analysed using a Statistical Package for the Social Sciences. Differences between groups were tested using Pearson chi-square test. Where data was not normally distributed median and inter-quartile range was used.

Key findings
- 21% of nurses were Smokers, 23% were Ex-smokers and 56% were Non-smokers.
- Psychiatric nurses (47%) and Coronary Care nurses (33%) had the highest smoking prevalence.
- Lack of time (78%) and lack of training (67.8%) were the two main reasons given by nurses for not giving smoking cessation advice to patients.
- Only 14% of the nurses surveyed had received training in smoking cessation.
- 90% of Non-smoking nurses strongly agreed that cigarette smoke represents a major risk to health in comparison to only 65% of Smoking nurses.
Conclusions
The study highlighted that there are significant differences between the attitudes of Smoking and Non-smoking nurses; this is very disturbing particularly in relation to their own health and their health promotion role and responsibilities. Nurses’ potential in preventive health care has been largely under-utilised, lack of time and training are major factors inhibiting nurses role in smoking cessation.
Calculations for Nursing; an educational initiative using WebCT

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Background
Literature and research support a view that mathematics is essential in nursing and that numeracy amongst nurses is poor and lacking in skill and confidence (1). Mathematics is fundamental to nursing, however studies present a picture of lack of proficiency within both the student population and amongst registered nurses (2). The administration of medicines is an important aspect of professional practice...not solely a mechanistic task to be performed in strict compliance...but requires thought and exercise of professional judgment (3). Errors occur too frequently and are avoidable (4) and there is an estimated 10-22% of all reported adverse events are drug errors (5) where 9% of all incidents reported to the NPSA are drug errors (4).

Nurses have a vital role in medication management and safe drug administration. Incorrect calculations can lead to drug errors (5, 6), often leading to patient injury or death, and emotional trauma and suffering for those involved. The estimated cost to the NHS is between £200-400 million per year (5).

Nurses need to be able to perform calculations accurately and safely.

To be numerate means to be competent, confident and comfortable with one’s judgments (7). Safe and meaningful checks, ensuring effective mechanisms are in place to prevent errors, and demonstrating competence is key to safe medicine management.

Structure

**Calculations for nursing** is a curriculum requirement and fundamental to preparation for practice. It has been piloted in the Common Foundation Programme (CFP), where students must achieve 100% on an electronic summative assessment as a progression point for each year of study. Various learning and teaching strategies include group work, reflection, guided practice questions, and self directed learning. The assessments consist of formatives and a pre test, all accessed electronically and in a similar format.

Content

Basic rudimentary maths skills and their application to drug calculations is the main focus, where students are encourage to gain confidence in solving maths problems without relying on a calculator. The workbook and electronic resources focussed on the following;

- Formative one- addition, subtraction, multiplication and division of whole numbers, decimal fractions and fractions
- Formative two- metric conversions
- Formative three- problem solving and calculating drug dosages

**Electronic component- WebCT**

In a supervised PAWS lab, a host of resources and links within the Virtual Learning Environment (VLE) are accessed. The formatives and pre-test are accessed in WebCT at the students own pace, as often as they wish. The results and scores are accessible. Under examination conditions the students complete the summative assessment (10 multiple choice questions) in 30 minutes. Students who failed to achieve 100% receive tutorial support, practice questions and access to electronic resources. Re-takes are offered monthly.

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6 (O'Shea 1999), 7 (Coben,2000)
Results
The results are based upon the pilot on a full cohort of first year nursing students (n=411).

<table>
<thead>
<tr>
<th>Overall</th>
<th>Passed n= 377 (91.7%)</th>
<th>Failed n= 34 (8.2%)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>1st Attempt n=180 (43.7%)</td>
<td></td>
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<tr>
<td></td>
<td>2nd Attempt n= 79 (19.2%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3rd Attempt n=27 (6.5%)</td>
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</tbody>
</table>

Breakdown in cohorts

<table>
<thead>
<tr>
<th>Accelerated programme (total N=65)</th>
<th>Adult nursing</th>
<th>Mental Health Nursing</th>
<th>Child health nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>passed n=37 (94.8%) failed n= 2 (5.1%)</td>
<td>passed n=21 (95.4%) failed n= 1 (4.5%)</td>
<td>passed n= 4 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Degree Programme (total N= 113)</th>
<th>passed n= 76 (95%) failed n= 4 (5%)</th>
<th>passed n=17 (94.4%) failed n=1 (5.5%)</th>
<th>passed n=14 (93.3%) failed n= 1 (6.7%)</th>
</tr>
</thead>
</table>

| Diploma Programme (total N= 233) | passed n=149 (87.6%) failed n= 21 (12.3%) | passed n=39 (95.1%) failed n= 2 (4.8%) | passed n=20 (91%) failed n= 2(9%) |

Findings
As this is only the pilot, the above table shows the initial raw data that has been analysed crudely. The second stage will involve manipulation at a greater depth in order to draw themes from the performance of the individual student on each calculation.

Recommendations
It is not possible to determine the outcomes in relation to nursing practice at this early stage. However, over the next two years further data will be collected and analysed. Perhaps this will provide some insight in relation to academic and clinical performance. In addition, the data may show some correlation to interviewing and selection criteria which also includes a maths test. The pilot is currently being developed for year two and year three.

Conclusions
Calculations for Nursing is a fundamental aspect of nursing education. The aim is to encourage safe practice, diminish error
incidence and improve the safety of patients and nurses. Future research and further study in this area is necessary in order to monitor and measure the improvement of numeracy skills amongst student nurses.

**Key References**


Introduction
Learning to be a midwife takes place in both academic and clinical environment. There is therefore the need for appropriate teaching strategies in both areas (Bewley 1995, Begley 1999, Hindley 1999). Clinical education is central to midwifery/nursing curricula and the provision of high quality practice placement remains vital for the development of sound midwifery and nursing knowledge which will ultimately lead to the development of competent practitioners (Wilson-Barnett et al 1995, An Bord Altranais 2001, Williamson and Webb 2001, Lee et al 2002, Chapple and Aston 2004, Dalton 2005, Hutchings et al 2005, Mannix et al 2006). A review of the midwifery literature reveals paucity of research examining the clinical support for midwifery students. Nevertheless, in line with major changes recently taking place in midwifery education in Ireland, the National Council for the Professional Development of Nursing and Midwifery (2005) has identified, among other research priorities, the need to provide educational support for student midwives in the clinical area.

Aim of the study
The aim of the study was to explore, describe and understand student midwives’ expectations and experiences of support for learning in the clinical area.

Methodology
A qualitative phenomenological research underpinned by the philosophy of Edmund Husserl guided the study. Participants consisted of six student midwives who met the inclusion criteria and agreed to take part in the study. The ethics committee granted the permission for the study to be conducted and access to the participant was gained through the principal midwife tutor. Written informed consent was obtained from the participants. Individual tape-recorded interviews formed the data collection method.
Analysis
Data was analysed using Colaizzi (1978) 7-step data analysis process. To achieve rigour in the study, credibility, auditability and fittingness were addressed.

Findings and discussion
The findings revealed that both the academic and clinical staff do not achieve the required level in terms of supporting students learning in the clinical area. Six major themes which reflected the students’ expectations as well as their experiences emerged: a need for support, the learning environment, worker status, support strategies, ways of learning and theory-practice integration. The participants in the study perceived themselves more in the role of workers than learners. They described the senior students, particularly those with six months ahead of them in the training, and the newly qualified staff as more supportive. Staff shortage, increased workload and lack of time were identified as the factors that influence the support of students.

A Need for support
The need for support during the first year particularly in the first clinical placement was strongly emphasised by all the participants of the study. This was a principal element of the discussion in regard to their expectations especially when compared with the participants’ experiences of their general nursing training. Inevitably the type as well as the quality of support experienced by the participants’ of this study was influenced by many factors. Broadly speaking, the findings suggest that participants’ experiences were more unsupportive during their clinical placement. The prime message from the participants’ was a need for support and from their perspective support implies to be taught how to perform the midwifery skills during their clinical placement, to be supervised and assisted while performing those skills, particularly within the first six months of the course, which requires midwifery tutors to visit the clinical area more often. In fact the need to assist students in their clinical experience whether from the clinical staff, the educators or other student colleagues is crucial and has been highlighted in the literature by several midwifery (Chamberlain 1997, Begley 1999a, 1999b) and nursing (Wilson-Barnett et al 1995, Aston and Molassiotis 2003, Hutchings et al 2005) authors.

The clinical environment
The reality of the clinical area is far from the ideal. In general there is lack of recognition placed on the students’ educational objectives and support for learning in the clinical area. This theme suggests that in a good environment, meeting the students’ learning need is a priority and opportunities are provided for students to ask
questions. It demonstrates that overall the clinical environment can in many ways enhance as well as be a barrier to students’ learning. The number of statements from the participants expressing inhibition exceeds those indicating facilitation. This shows that the environment was more unsupportive than supportive. This was more evident in the first six months of the course when the participants were trying to adapt to the routine. A number of authors (Gray and Smith 1999, Brown et al 1998) argued that coping with clinical practice can be anxiety provoking and stressful.

**Worker status**
The participants of this study reported that they were seen as qualified nurses and consequently as part of the workforce rather than learners. In general this theme indicates that the participants were only given recognition as students while in the classroom which impacted on the learning opportunities available to them in the clinical area. In addition, the participants felt that being a registered nurse prior to commencing the midwifery programme was a disadvantage to them given that they were regarded as part of the workforce and much expected of them. This worker status was part of the findings of other Irish (Begley 1999a, Lloyd 2001) and UK (Bewley 1995, Chamberlain 1997) studies of student midwives.

**Support strategies**
This theme describes the participants’ views regarding the type of support that should be available to them in the clinical area and who is in the best position to fulfil this role. They used the terms mentor, preceptor, clinical placement coordinator and clinical placement facilitator synonymously to describe the staff that perform or should be responsible for providing learning support for students in the clinical area. The need for or the role of the support person varies among participants. On the whole the participants prefer to work alongside a named preceptor or mentor. Only in this way will they obtain accurate or objective assessment of their performance in any given clinical area. There was also recognition by the participants that support for learning in the clinical area could be better provided by people who are more aware of the students’ needs. It suggests that the support persons should be clearly identified and should have frequent contact with students. This mirrors the findings of the studies of student nurses (Wilson-Barnett et al 1995, Dunn and Hansford 1997, Neary 2000, Jackson et al 2001).

**Ways of learning**
This theme explains the different methods through which the participants obtain information and acquire skills while on the
clinical placement and whom they learn most from. It varies among the participants and also depends on the clinical area. Traditional ways of learning, such as trial and error, still exist in midwifery practice and the participants were not satisfied with these methods of learning.

They identified their student colleagues particularly those six months ahead of them and the newly qualified staff midwives as their major source of support in the clinical area. Studies by Begley (1999a) and Lloyd (2001) generated similar findings.

Theory practice integration
The ability to link theory and practice was particularly important for the participants. However, it was not easy for them as the views expressed in the classroom by the midwifery tutors were very different from the reality of the clinical environment. This was particularly difficult for them in the first year of their training given that from a theoretical perspective they had covered normal pregnancy while in the clinical area, they were confronted with complicated pregnancies. This demonstrates that the clinical area does very little in terms of enhancing the participants’ ability to link theory and practice. Cavanagh and Snape (1997) examined the sources of stress in midwifery students. The study demonstrates that students find the disparity between the lectures and their placement area as a very stressful experience which had a long-term effect on them and was a major source of frustration.

Conclusions and recommendations
The clinical practice experience is central to the development of midwifery practice skills and the quality of midwifery care delivery is dependent, to a certain extent, on the quality of students’ clinical preparation. Clinical placements help the students translate their theoretical knowledge and at the same time integrate it into practice. Since the midwifery students will be the future functioning midwives, acquisition of clinical skills is fundamental and will facilitate their smooth and sound transition into the workforce. Consequently, the importance of supporting them to achieve this crucial goal cannot be overestimated. One of the main suggestions emerging from this study is further development of the support roles in the clinical area. However, collaboration between the key stakeholders needs to be seriously considered if this establishment of support strategies is to be achieved. This will require some organisational changes to involve both the academic and clinical setting. While the academic staff needs to update their skills, clinical staff need to be educated so that they will be well prepared to undertake this role.
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Nurses use of research information in decision-making: Findings from a mixed-methods study undertaken in the Health Services Executive (South) Region.

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Background: The use of research information by nurses is an integral part of evidence based nursing. Investigations into the extent of nurses’ uptake of research have been overly dependent on identification of barriers while the factors that influence nurses’ tendency to choose one source of information over another have been largely ignored. Additionally, the situation in Ireland has not been explored in much detail.

Aim: This study, commissioned by the NMPDU (Health Services Executive (South)) (HSE(S)) was undertaken to evaluate how nurses in the region use research based information to inform their decision making in practice.

Methodology: A multi-site, mixed methods approach was taken. Data were collected in two phases, an exploratory, qualitative phase and a validatory, quantitative phase. During the qualitative phase, nurses (n= 29) were selected from across the nursing spectrum using a quota sampling method. Nurses were interviewed using a semi-structured interview technique to elicit their views on the extent of their use of research information in clinical practice and their perception of the barriers and facilitators that exist. During the quantitative phase of the study, a questionnaire was distributed to a stratified random sample of 1356 nurses in Cork and Kerry exploring further some of the issues raised in the qualitative phase of the study. The response rate was 29%.
**Analysis:** Qualitative data were transcribed and analysed using nVIVO software. SPSS software was employed to analyse quantitative data.

**Findings:** The results indicated that the use of research has increased over the past five years. Nevertheless, a large number of respondents (49%) felt that less than half of their practice was research based.

Despite the favourable views of participants towards research information and evidence based practice, they relied heavily on their own experience and that of their nursing colleagues and were far more likely to access those sources than all others. When accessing research based information in particular, they were more likely to use research that was channelled to them through for example, study days, clinical nurse specialists and practice development co-coordinators, than that which they sourced and evaluated themselves directly. The reasons were complex involved the characteristics of information sources which were related to the availability of the source, the skills required for use, support in the local environment and at organisational level, and the value assigned by an individual nurse to the source. Other important themes emerged in relation to the feasibility of integrating information from a source into nursing practice which was dependent on the power of nurses’ to initiate change and their desire to do so.

**Conclusions:** For research information to be an integral part of nursing practice, an environment has to exist where there is an expectation that research information should be used and there are facilities and support to do so. Additionally, nurses should have the skills and autonomy required. A challenge exists to introduce research findings into the nursing workplace in a form that is easily accessible and utilisable. Dissemination of changes should be active and multifaceted with input from practitioners.
RESOLUTION OF METHODOLOGICAL ISSUES IN A NURSING INTERVENTION STUDY

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This paper addresses the resolution of methodological issues that arose as a collaborative research team developed and implemented a clinical study. This federally funded study entitled: “Efficacy of Nurse Coaching to Aid Ambulatory Surgery Patients” (#R15NR05174-01A1) with Dorothy Jones as principal investigator was completed in 2006. The broad purpose of this research was to conduct a randomized clinical trial to evaluate the effectiveness of a Nurse-Coached Intervention delivered by telephone beginning on the first surgical evening and at 24 hours, 48 hours and 72 hours following arthroscopic ambulatory surgery. The intervention was planned to be effective in:

1. Promoting cognitive and emotional processing
2. Relieving symptom distress
3. Improving overall functional health status during the recovery process.

The research team members came from two institutions: perioperative nurses from Massachusetts General Hospital (MGH),
Boston, Massachusetts, USA and faculty and students from the William F. Connell School of Nursing (CSON) at Boston College located in a suburb of Boston. Massachusetts General Hospital is a major urban teaching hospital with a busy ambulatory surgical unit. The William F. Connell School of Nursing at Boston College provides education at the baccalaureate, masters, and doctoral level as well as an extensive continuing education program.

The hospital based ambulatory surgical nurses comprised about 50% of the research team. The ambulatory surgical nursing staff included the nurse manager of the operating suite and ambulatory surgical nurses. The principal investigator was a Professor in the School of Nursing as well as a Nurse Scientist at the hospital. The project manager was a PhD graduate from the school of nursing and in charge of the preadmission unit at the hospital’s ambulatory surgery suite. Four faculty co-investigators conducted the orientation to data collection and nurse coaching. They also collected data at one-week after surgery. The graduate research assistants did data collection and nurse coaching at 72 hours. One graduate student was assigned to do data entry. An undergraduate research assistant prepared subject packages and filed materials. The Nurse Faculty Director of the Research Center at the school of nursing was a consultant on our project. The ambulatory surgery nurses and the students received stipends. Faculty donated their time.

This paper is divided into three phases: first is the methodological problems of the planning phase of our research grant, second the concerns during the implementation phase and finally the dissemination of the results of the study.

**Methodological Problems: Planning Phase**

The impetus for this study was the restructuring of the health care delivery system within the United States. Advances in technology, improvements in anesthesia administration, and a move toward less invasive surgery have all helped to decrease the impact of surgery on an individual’s lifestyle and to foster recovery outside of the hospital environment. Both the literature and previous studies led by Dorothy Jones (1996, 1997) document the fact that patients increasingly are being admitted, undergoing a surgical procedure and being discharged to home the same day. The same studies consistently describe problems that patients experience at home.

The study aimed both to improve patient care and to test the theoretical bases for this intervention study. Therefore several data collection instruments were included. These tools were:
1. Cognitive Adaptation Processing Scale (CAPS) a 48 item scale that reflects coping strategies. Sister Callista Roy, of the Boston College nursing faculty was a co-investigator. The CAPS is based on the Roy Adaptation Model focusing on cognitive adaptation processing (Roy and Andrew, 1999). The CAPS has 3 classes of stimuli: focal (immediately confronting the person), contextual, (all other stimuli present) and residual (non specific stimuli, such as beliefs or attitudes).

2. Profile of Mood States (POMS) a 30-item checklist to describe six different aspects of emotional processing, that is, tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia, and confusion-bewilderment. This psychological instrument has been used in many nursing studies. (McNair, Lorr, & Droppleman1989)

3. Functional Health Status (SF -36) a 36-item instrument that measures a broad range of physical and mental health concepts and health states. There are eight subscales: physical functioning, role physical, bodily pain, mental health, role emotional, social functioning, and vitality and general health perceptions. (Ware, 1993)

4. Symptom Distress Scale (SDS) a listing of 15 symptoms with a rating scale for presence and intensity. Symptoms include: nausea, appetite, insomnia, pain, fatigue, urinary and bowel patterns, concentration, breathing and cough, mobility, appearance, and outlook. Dr. Ruth McCorkle (1987) the nurse researcher who developed this scale approved a revision of its rating scale. She had developed this instrument for cancer patients and changes were needed to reflect a healthier population. A zero rating was added to the 1-10 scale to reflect absence of symptom.

5. Open Ended Interview Questions. These questions expanded upon the quantitative data. Examples include: How would you describe your overall hospital experience? What did you find to be most helpful during this week?

The number and length of the instruments required attention to the time it took subjects to respond, how easily they understood the interview questions and the most effective order in which to present the instruments. These authors (O'Neil, Olivieri & Fairchild, 2000) conducted a pilot study, funded by Boston College entitled “Evaluation of Data Collection Methods For Ambulatory Surgical Patients”. This study determined the time for each patient interview to be approximately 50 minutes and the most effective order of presentation of the instruments to be SDS; POMS; CAPS; SF36 and open ended interview questions.
The literature supported the use of appropriately timed and planned phone contacts as a cost effective means of providing a continuum of nurse-patient contact (Hawkshaw, 1994). In this pilot study the authors tested the telephone method not only for data collection but also for delivering the Nurse-Coached Intervention. All subjects responded positively to the phone call (O’Neil et al, 2000).

A series of studies by members of our research team identified the following symptoms as most frequently causing distress: pain, nausea/vomiting, constipation, immobility, fatigue and sleep pattern disturbances (O’Neil & Fairchild, 1995). Since this study involved several nurses providing the coaching intervention, it was necessary to develop guidelines to assure consistency and reliability. For each of these symptoms, the authors developed symptom management guidelines. (Figure 1. Symptom Management Guideline: Pain) Each guideline addressed: assessment, method of current management, evaluation of adequacy of current management, specific interventions and instructions and reported outcomes.

In addition the authors wrote and produced a training video demonstrating a coaching intervention using the pain symptom management guideline (Fairchild, Olivieri, & O’Neil 2001). This video was used in orientation of the hospital nursing staff, students and faculty.
SYMPTOM MANAGEMENT PROTOCOL FOR PAIN

I. ASSESSMENT (self report)
   - Location
   - Intensity (rating scale 0-10) What level of pain relief do you expect?
   - Quality
   - Onset/Duration
   - Precipitating factors

II. CURRENT MANAGEMENT
   - What are you doing to relieve the pain?
   - Pharmacological: Medication, timing (relief: scale 0-10).
   - Non-Pharmacological Measures. List specific?

III. EVALUATION OF ADEQUACY
   - Misconceptions: For example unrealistic expectations of pain relief and medication effect.
   - Did relief meet expectations?
   - Interventions for pain management

IV. INTERVENTIONS
   - Teach pain management strategies
   - Teach correct method of taking medications i.e. timing, amount, etc.
   - If pain relief not adequate or side effects present- call MD
   - Teach to rate relief obtained and record every 2 hours.

   Non-pharmacologically
   - Teach cognitive and behavioral strategies i.e., breathing techniques, relaxation, imagery, TV, music

V. OUTCOMES
   - Self-report, rating scale should indicate a decrease in pain.
   - Use pharmacological and non-pharmacological interventions appropriately to decrease pain.

Bibliography
Methodological Problems: Implementation Phase

Research team recruitment and training was a complex and time-consuming task. Ambulatory Surgery Nurses were invited to attend a comprehensive orientation meeting to provide an overview of the study. Each received an orientation manual containing general information about the study, relevant articles, Institutional Review Board (IRB) requirements for both the hospital and the university, information about informed consent, and example packets of data collection instruments. The orientation sessions were held on two mornings to allow attendance for all interested staff. The Operating Suite Nurse Manager was supportive of the study and provided encouragement and time for perioperative nurses to participate in a nursing research project. Although many perioperative nurses were interested some were unable to commit the time.

Two teams with two to three staff nurse members, 1 graduate research assistant and 2 faculty co-investigators were formed to carry out the research. The hospital based and graduate student Nurse Coaches attended training sessions where there was a review and explanation of all the instruments and presentation of the teaching video to demonstrate data collection and coaching. The faculty and perioperative nurses role-played vignettes that centered on the symptom management guidelines. This resulted in valuable revisions. This is an early example of academic-clinical collaboration.

In addition, all research staff members were required to complete an on-line program on Human Subjects Protection before they could be certified by the Massachusetts General Hospital Institutional Review Board. The Faculty researchers were also required to complete the Boston College Human Subject Protection course. Inevitable attrition of nurse coaches caused delays in implementation while new research staff completed the requirements. Additionally, the study needed to be resubmitted to the hospital Institutional Review Board repeatedly due to organizational changes. Originally, the researchers considered a multi-site and multi-surgery study. Finally, the study focused on one site and one surgical procedure due to the many variables including patient recruitment, staffing, and institutional requirements.

The hospital ambulatory surgery nurses were responsible for initial recruitment and data collection. Concerns that emerged from recruiting subjects centered on conflict between the operating room schedule and the time it took to explain the study, gain consent and administer the research instruments. Initially, the ambulatory
surgery nurses tried to recruit patients that had an early operating room time but were unable to complete all the data collection. The ambulatory surgery nurses were more successful in recruiting patients who were scheduled later in the day. On occasion, a subject who had been recruited to the study required hospital admission, and therefore was no longer eligible.

The ambulatory surgery nurses were responsible for phone contact the evening of surgery, 24 and 48 hours after surgery. They transferred responsibility to the graduate student research assistants for the 72-hour call, who in turn contacted the faculty co-investigator for the one-week call (Table 1.). Communication by email proved helpful for the transference of information from person to person making the phone calls. Each nurse could inform the next nurse of any problems identified, coaching offered and any special concerns. For example, time and place to call the research subject. A log kept in the Ambulatory Surgery Suite assured preservation of data. However, the transfer from nurse to nurse was not always successful especially when new research staff was added. This was common with graduating students who had to be replaced. This resulted in midweek drop out of research subjects.

In addition, some patients did not receive or misplaced the packet that contained the instruments for the one-week follow up. In this case it required more effort and time for the one-week interviewer and the subject to collect the data. Amazingly most subjects were most cooperative and did complete the data collection. A few of the subjects could not be reached by repeated phone calls and the team discussed how many times a subject should be called and what time frame would keep the data reliable. Research staff meetings continued throughout the length of the grant to identify and remedy these and any other concerns. Telephone contact proved to be an effective method for collecting data and delivering a coaching intervention. The subjects expressed appreciation for the timing of the contacts, especially early on in recovery.
Table 1. Instrumentation and Data Collection for Control and Treatment Group

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<thead>
<tr>
<th>Instrument</th>
<th>Control</th>
<th>Treatment</th>
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<tr>
<td>CAPS</td>
<td>Pre op and 1 week post surgery</td>
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<td>POMS</td>
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<td>SF-36</td>
<td>Pre op and 1 week post surgery</td>
<td>Pre op and 1 week post surgery</td>
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<tr>
<td>Symptom Distress</td>
<td>Pre op , at 72 hours and 1 week post surgery</td>
<td>All 6 time periods for Treatment group</td>
</tr>
<tr>
<td>Telephone Interview Schedules/</td>
<td></td>
<td>The evening of Surgery, at 24, 48 and 72 hours post surgery</td>
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<tr>
<td>Qualitative Data Collection</td>
<td>Pre op and 1 week post surgery</td>
<td>Pre op and 1 week post surgery in addition to responses on Telephone Interview Schedules/ The evening of surgery, at 24, 48 and 72 hours post surgery</td>
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<tr>
<td>Coaching Intervention</td>
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<td>The evening of Surgery, at 24, 48 and 72 hours post surgery</td>
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Methodological Problems: Dissemination Phase
The study of Efficacy of Nursing Coaching to Aid Ambulatory Surgery Patients was completed in 2006 with a total subject population of 102 subjects. The group who received the telephone mediated Nurse-Coached Intervention numbered 52; the control group called Usual Practice group numbered 50. The Nurse-Coached Intervention was based upon assessment data from the Symptom Distress Scale administered at 72 hours postoperatively. (Subjects were also compared on this scale preoperatively and one week postoperatively.) The Usual Practice is a nurse’s phoned general query about postoperative status within 24 hours of surgery. Usual Practice nursing advice or referral might follow but there were no guidelines or plans for intervention. The number of subjects was adequate but far fewer than initially planned. The number reflects all the hurdles of an academic-clinical research study: recruitment and attrition of subjects, resubmissions to institutional review boards, replacement of academic research assistants due graduations and human subject certification of these team members, conflict between employment status and time designated to the study for clinical researchers.

A special methodological hurdle for the nurse researchers making calls to both intervention and control group subjects was to maintain the researcher role. If a control group patient reported distress, the research team member could refer the person for assistance but could not deliver a Nurse-Coached Intervention in response to the symptom. Team meetings over the course of the grant frequently featured this concern and support for the importance of maintaining the researcher role in order not to contaminate the findings.

Statistics described the groups to be similar in age averaging 46; co-morbidities 0.85; gender: male 31, female 20; marital status: married 32 to single 19; education: mainly post secondary education. These similarities probably arose from the urban medical center location and the type of surgery – joint arthroscopy.

Three hypotheses based on the study aims guided data analysis. Data analysis for each of the following hypotheses used repeated measures multivariate analysis of variance (R-MANOVA).

Hypothesis 1 addressed the aim of the study to determine the efficacy of a telephone mediated Nurse-Coached Intervention (NCI) in promoting cognitive and emotional processing. Hypothesis 1 stated that at one-week post surgery, patients who received telephone-mediated Nurse Coached Intervention (NCI), when compared to a Usual Practice (UP) group, will have:
1. Significantly higher clear Focus, Perspective Focus and Method subscale scores of the CAPS.
2. Significantly lower Internal Diffuse and Fixed Focus subscale scores of the CAPS and a
3. Significantly lower POMS total score.

The CAPS and POMS were administered in person preoperatively and by phone one week later. The 48 item length of the CAPS and the 30 item length of the POMS plus the repetition of content in the subsequent SF-36 led to the earlier described revision of subject recruitment timing and to the need for one-week phone callers to encourage and even cajole subjects to complete the responses. With support, most subjects did complete responses to all instruments.

There was one between subjects factor with two levels (Nurse-Coached Intervention group and Usual Practice group), three within-subjects factors (two subscales of the CAPS and the total POMS score) each of which had two levels: preoperative and one-week post operative. The data analysis thus far supports the hypothesis.

The second hypothesis was divided into two parts to address the study aim of relieving symptom distress. This hypothesis stated that the patients who received the telephone-mediated Nurse-Coached Intervention (NCI), when compared to a Usual Practice (UP) Group, will have:
1. Significantly lower Symptom Distress scores at 72 hours post surgery and at one-week post surgery.
2. Symptom Distress scores that will significantly differ across the three time periods: Baseline (preoperatively), 72 hours and one-week post surgery.

What might be perceived as a problem in administering this scale was the pertinence of each symptom to this particular population. Analysis of responses that is in progress will be a contribution to ability to recommend this instrument for populations other than the patients with cancer for whom the tool was developed.

There was one between subjects factor with two levels (Nurse-Coached Intervention and Usual Practice group); one within subjects factor (Symptom Distress Total Score) with three levels: preoperative, 72 hours and one-week postoperative. Data analysis is in progress.

Finally, the aim of the study to improve overall functional health status was expressed in Hypothesis 3. This hypothesis stated that at one-week post surgery, patients who received the telephone-
mediated Nurse-Coached Intervention (NCI) when compared to a Usual Practice (UP) group, will score:

Significantly higher on the physical functioning, physical role, mental health, emotional health, emotional role, social functioning, vitality, and general health scales of the SF-36: and Significantly lower on the SF-36 Bodily Pain subscale.

In relation to methodology, the instrument was developed for general health surveys and it has many questions beginning “During the past four weeks ...” Also, it contains many items that are repetitive of content of the CAPS and POMS. The CAPS and POMS are administered before the SF-36. Interviewers used reassurance to help subjects complete this instrument.

There was one between subjects factor with two levels (nurse coached intervention and control groups), eight within-subjects factors (8 subscales of the SF-36), each of which has two levels; Preoperative and one-week postoperative measures. Data analysis is in progress.

Qualitative data obtained from open-ended questions enriched understanding of the person’s experience during the surgical and recovery phases of the ambulatory surgery experience. Some subjects suggested system changes such as pharmacy hours for filling postoperative prescriptions but most were very positive about the overall surgical experience. Many were able to elaborate upon symptom distress experience during recovery and the means used to relieve distress. Methodologically, this aspect of the study was dependent on the quality of documentation by the interviewer. This aspect requires continuous emphasis and direction for team members.

The current purpose of the research team is to disseminate the results of this research and to encourage application of the Nurse-Coached Intervention with other surgical populations treated in Ambulatory Surgery. Means used to achieve this purpose thus far have included mailed results to all subjects who expressed interest, presentations via illustrated lecture to the entire research team, to the entire operating suite nursing staff, to institutional review board members and collaborating physicians. The principal investigator prepared a poster with names of all research team members for presentation at these meetings and at professional meetings.

A post-study methodology concern is the inclusion of all team members as a basic principle for dividing assignments to publication and presentation opportunities. All are involved in planning meetings. Some will present overviews of the entire process; others
will focus on particular instruments, phases of the experience or symptoms. Authorship credits will go to the person(s) preparing a report. Team members will be acknowledged.

In summary, this presentation discussed methodological problems in the planning, implementation and dissemination phases of a complex clinical study. The problems and their resolution included:

**Planning Phase:**
- Melding academic-clinical researchers into an effective, smoothly functioning team.
- Giving equal attention to the experience and expertise of academicians and clinicians.
- Aiming both to improve patient care and to test theoretical bases for the intervention.
- Sequencing and ordering several multi-item research instruments
- Producing training materials

**Implementation Phase:**
- Recruiting and training (and replacing, training) research team members including certification in human subjects protection
- Recruiting and retaining research subjects
- Differentiating control/intervention groups
- Collecting, communicating, storing data
- Intra-team communications
- Researcher-subject communications

**Post-completion Phase:**
- Data analysis
- Interpretation of results in view of study aims
- Communication of study results
- Inclusion of research team members in dissemination of study results.

The identification and resolution of methodological problems is necessary for the continuation and improvement of clinical nursing research to improve patient care outcomes.
References and Bibliography


Development and Evaluation of a Professional Development Module on Caring for Children with a Neurological Disorder.

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Abstract

The aim of this poster is to outline the development and evaluation of a professional development module. The module entitled “Nursing Care of Children with a Neurological Disorder”, which is the first of its kind in Ireland, was developed by the Children’s University Hospital, Dublin in partnership with Dublin City University. This new and innovative module was developed in response to a need for specially trained nurses in the field of paediatric neurology and aims to address the education needs of nurses caring for children with a neurological disorder and their families. It enables nurses to enhance, develop and extend their knowledge and clinical experience in the area of Paediatric Neurological Disorders. The module provides participants with a theoretical foundation of the context and concepts of care for patients with a Neurological Disorder and enables the acquisition of the knowledge base necessary to prepare for advancement in Paediatric Neurology Nursing.

A Likert scale questionnaire was used to assess the module content, programme delivery and learning environment. This quantitative data was analysed using descriptive statistics. The results indicated that there was a high degree of student satisfaction with the module and students reported benefits from undertaking the course in terms of increased knowledge and confidence in the care of a child with a neurological disorder.
Introduction:
Stressors and coping strategies experienced by Bachelor of Science (BSc.) undergraduate nursing students was explored following the recent curriculum changes in nurse education in Ireland, from apprenticeship to diploma and more recently to a four year degree level training (BSc.). Recent changes in nurse education in Ireland has prompted the examination of stress and coping as experienced by undergraduate students. This study examined stressors and coping strategies among 1st and 2nd year students, to gain an understanding of the phenomenon of stress experienced during training.

Aims:
The purpose of this study was to address the following research question: what are the stressors experienced and coping strategies sourced by the first cohort of undergraduate nursing students undertaking the BSc. degree training programme? The aim was to identify the most common stressors experienced and the coping strategies used by these students. The objectives included:

a) To gain an understanding of the stressors experienced by BSc. nursing students
b) To identify coping strategies sourced by BSc. nursing students
c) To compare the variables (gender, branch of training, year of training) among 1st and 2nd year nursing students
d) To provide data that would be of future value to both clinical and academic staff in supporting nursing students

Sampling:
Convenience sampling was employed which involved a large teaching university in an urban area in the Republic of Ireland. The target population for the study was all nursing students registered on year one and two of the BSc. undergraduate nurse training programme which consisted of 364 students. At the time of undertaken this study, the BSc. programme was in its second year of implementation. First years (n = 201) and second years (n = 163) were available for recruitment. Students from all branches of nurse training, General, Intellectual Disability and Psychiatry (Mental Health) were invited to participate in the study. The
students who were present in class when the researcher visited the university, were invited to complete the questionnaires.

**Ethical considerations:**
Ethical approval was granted by the university research ethics committee. The students were informed regarding the study and had permission to leave the study setting, if they chose not to participate. The voluntary nature emphasised that the students could refuse without penalty if they chose not to participate. The students were informed of the aim of the study and were provided with a written consent. The questionnaires were distributed by the researcher to the students in the class setting. Questionnaires remained anonymous. The researcher was an independent person who was not employed in the university or known to the students.

**Design:**
A descriptive survey design was employed to address the research question. A modified questionnaire using the Student Nurse Stress Index (SNSI) (Jones & Johnston, 1997) and the Ways of Coping questionnaire (Parkes, 1984) were used to investigate stress and coping respectively. The 36-item questionnaire was distributed to the students (n=129) from within the three branches of nurse training (General, Intellectual Disability and Psychiatry (Mental Health). There was a 35% response rate however this is based on the total number of students registered on the programme, not the actual amount of students who attended class, which was observed to be considerably low, when the researcher visited the students in the university setting.

**Data Analysis:**
The statistical software package for social sciences (SPSS) was employed to analyse data with descriptive and inferential statistics. The highest noted stressors and ‘ways of coping’ were identified among both cohorts. The demographic profile (including branch of training, gender, age group and year of training) were compared with the highest noted stressors among both cohorts. The highest noted ways of coping were similarly compared with the demographic profile. Non-parametric testing including the Mann–Whitney U test and the Kruskal - Wallis test was used.

**Findings / Discussion:**
Findings illustrated that similar stressors were experienced in 1st and 2nd year of training. The key stressors were ‘examinations’, ‘fear of failing the course’, ‘amount of classwork to be learned’ and ‘difficulty of classwork to be learned’ which are in keeping with the literature (Beck & Srivastava, 1991, Lindop, 1991, Hamill, 1995, Jones & Johnston, 1997). The levels of stress experienced were
significantly higher in 2\textsuperscript{nd} year, among mature students and within the Intellectual Disability branches. These findings are important considering the lack of other studies similarly comparing stress among the different branches of training, as well as exploring the impact of undertaking training as a mature student.

Although the key stressors noted among 2\textsuperscript{nd} year students were similar to 1\textsuperscript{st} year students, it is important to consider if ‘specialist’ clinical placements (e.g. theatre, emergency department) impacted on stress levels. Students usually commence their specialist placements in 2\textsuperscript{nd} year, therefore it is recommended that these clinical placements are also examined to determine if students experience increased stress in specialist areas, as ‘relations with staff in the clinical area’ was statistically significant in 2\textsuperscript{nd} year of training ($p = .000$).

‘Problem-focused’ coping was the most common coping strategy sourced which included ‘asked someone you respected for advice and followed it’ and ‘came up with a couple of different of solutions to the problem’. The coping strategies used must be appropriate where support structures are accessible to empower students to effectively cope with unavoidable stress (Lee & Kirkland, 1998). This is of particular relevance to the new course structure in the Irish context, where curriculum developers and educators play a pivotal role in establishing support networks. A student counseling service was available in the university for all students in this study, however it is not known whether accessed this facility, which is an area that needs to be explored further. The implications of these findings have an impact on academic staff, including the role of the personal tutor, link lecturer, to draw on their resources to provide optimal support to students. Equally, it is important that the role of support staff is also explored regarding the student’s expectations of these roles, and indeed whether students access the support services available to them.

**Conclusion:**
In conclusion, the findings of this study provide a unique contribution to the understanding of stress and coping strategies employed by BSc. undergraduate nursing students in the Irish context. The level of stress was identified to increase as training progressed; in particular the student’s perceived stress in relation to ‘academic load’, which has implications for nursing education. Due to the new course structure in Ireland, curriculum developers and nurse educators have a pivotal role in developing strategies to minimise stress thus preventing ‘burnout’ among students. Clinical practitioners equally have a collaborative role in supporting students, where stress can be minimised in the clinical environment.
by facilitating an effective student / staff relationship. This study therefore has implications to nursing education, clinical practice and research where a longitudinal study using a larger sample size is recommended to further validate these research findings in a similar setting.

**Acknowledgements:**
The researcher wishes to thank all the nursing students who participated in the research study.

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Exploitation, Neglect and Abuse of Older People: A Review of the Literature

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Aim
The aim of this study was to undertake a literature review on elder abuse and provide clarity on a definition, identify the scale of the problem, examine issues in relation to settings where abuse takes place and determine any correlations between training and reporting abuse

Methodology
A search of academic literature from 1996-2007 was conducted utilising texts, journals, on-line source material and the Social Care Institute for Excellence framework was used as a basis for evaluating this research. Sources included electronic databases, reference lists from relevant primary literature and review articles, professional journals and concise searching of the internet using search engines such as “Google”

Key findings
The main messages from the analysis are that research is needed to consider how consensus over the definition of elder abuse may be achieved, at the same time reflecting older people’s perceptions and the legal framework. Agreement is needed about how to establish more accurate figures on the prevalence of abuse. Perpetrators of abuse are diverse and exist in a range of settings and relationships according to perceptions of professionals and others. The effectiveness of training initiatives should be examined as, despite an increase in provision, there are gaps in the knowledge of staff as to what constitutes abuse
Conclusions
The analysis provided a clearer understanding of issues in relation to reaching a consensus on definition; further research would help establish an operational definition for policy makers, practitioners and researchers. Lack of research, and the difficulties the public and staff have in whether to report abuse, compound the problems in determining the scale of the problem. Evaluation of training is urgent to examine correlations between training and reporting of abuse. It must be recognised that elder abuse is not a single problem but a complexity of issues relating to policy and practice and these issues must be investigated or the needs of the older person will remain unaddressed.

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Evaluating the use of Podcasts and Multimedia technology to facilitate student learning of Pathophysiology in Undergraduate Nurse Education

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**Background and Context**

Nurses require an understanding of pathophysiological processes to support safe clinical practice. A review of the literature indicates that nursing students have traditionally found this to be a challenging element of the course. Furthermore studies suggest that students find blended learning strategies that combine traditional teaching with more innovative methods particularly beneficial. In view of this, lecturers developed multimedia resources to incorporate into the module. It was considered that this would cater for a broader range of learning styles and enhance student learning.
Aims and objectives of the study
The aim of the study was to evaluate nursing students’ views on the use of a variety of learning resources to facilitate understanding of pathophysiology. The objectives were to determine whether the introduction of multimedia resources facilitated learning in comparison to more traditional approaches.

Methodology
Two lectures were selected from the module and made available to students using both online and mobile technology. The remaining lectures followed a more traditional lecture format. A convenience sample of a cohort of third year nursing students undertaking the module was accessed. A questionnaire was developed to capture both quantitative and qualitative data.

Analysis
Quantitative data was analysed using SPSS. Qualitative information required content analysis which analysed the material for recurring themes.

Summary of key findings
The majority of students positively evaluated the use of alternative learning opportunities. The main benefits included greater flexibility to work at their own pace and revisit material thereby facilitating individual learning requirements.

Conclusion
The study indicated that the majority of students would welcome the incorporation of alternative teaching approaches into the undergraduate nursing programme as part of a blended learning strategy to enhance their understanding of pathophysiology.

References

The Journey from Despair to Hope:
An Exploration of the Phenomenon of Psychological Distress in Women Residing in Secure Mental Health Services.

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This presentation will describe the research study I have recently successfully completed for my PhD. While working with the female patients detained on the wards, it became apparent that they were invariably diagnosed with a ‘personality disorder’ and tended to self-harm. Many of them had also been subjected to extensive trauma and abuse throughout their lives. On closer observation, a number of these individuals did appear to express their deep emotional hurt and pain through extreme acts of self-harm. It was interest in this phenomenon, which has formed the basis of this research. The aim of the study has therefore been to explore the phenomenon of ‘psychological distress’, and how it is expressed in female patients currently residing within secure psychiatric services.

A scientific approach to descriptive phenomenological research developed by Giorgi (1985: 2000a: 2000b) was used as the theoretical framework for completing the investigation. The study was conducted with 11 patients drawn from a high secure hospital (A) and an independent medium secure hospital, who were asked to describe their ‘lived experiences’ of being ‘psychologically distressed’. The interviews were subsequently transcribed and thematically analysed. Having uncovered the ‘essential structures’ of ‘psychological distress,’ the general description of this structure is presented.

Finally, the key outcome of the study is a new model of care for practitioners working in practice with this emotionally vulnerable group of women. The ‘Humanistic Conceptual Framework for Care’, based on Maslow’s ‘Hierarchy of Needs’ (1954), has been specifically designed and developed to both inform and help to organise the delivery of care to this unique group of ‘psychologically distressed’ female patients. It is hoped that this novel and insightful
approach will begin to equip practitioners with increased knowledge and understanding of the specific and unique care needs of this troubled and vulnerable group of patients

References


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First year Nursing students access and use of biological sciences e-learning materials

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Introduction
Mature students have always made up a significant proportion of students entering nursing courses. The students study biology on the B.Sc degree course over four years. Most of the biology is studied in years one and two, with less in years three and four. Biology lecturers on the nursing degree course attempted to meet the learning needs of these students by developing a self-directed e-learning component. The online material supplements year one and also provides a foundation for study in year two. The aim of the course is to establish or revise basic scientific knowledge to ensure the students have an equal foundation level of knowledge before commencing on the formal course. The course title is “Introduction to the Life Sciences”. The course is not graded, there are no formal teaching sessions or time limits, but it is recommended that the students complete the relevant section before the associated class lectures and tutorials. The students can access the course outside the college using their student login and password.

Structure of the course
The course is multi-author. As would happen in the classroom, different teachers have adopted different styles of presenting their material. The learning material is hosted on webCT, an online virtual learning environment. The content is divided into the “cell as a unit of life” and “the multicellular organism”. The cell biology section covers the chemical organisation of the cell, the cell membrane, and basic energy processes in the cell. The multicellular organism section illustrates how the cells of the body are grouped into tissues and organs. This organisation produces the systems of the body: respiratory, cardiovascular, digestive, urinary, reproductive, nervous, immune, blood, reproductive. The course material contains text, images, rollover buttons, animations, quizzes, and links to relevant Internet sites. Each subject area is divided into learning objectives, the content itself, and a self assessment quiz at the end. The quiz format includes multiple choice questions and fill in the blanks. The self assessment MCQ quizzes follow the same format as the end of year
MCQ exam. In addition to the learning material, the students can use a number of course tools. These include a glossary of biology words, chat rooms, and a calendar.

Assessment
At the end of the first and third term, the first year students are examined in biological sciences using multiple choice question (MCQ) format with no negative marking, and short answer written format. Both exams comprise knowledge based questions (not case histories or problem solving). The students are examined on the lecture, tutorial and relevant online learning material. The students must pass the first year biology course to progress to year two.

Aim of Study
This study aimed to evaluate the utilisation of this directed self-learning online component and to determine if the use of the e-learning component improved results.

Methodology: There were two methods used in the collection of the data. Student results and utilisation of the e-learning component were collated from the school database. This data was analysed using SPSS version 14. An anonymous questionnaire was also developed. Through the use of closed questions the questionnaire recorded student mode of entry, speciality, use of the course material, computer skills and reasons for poor usage of the e-learning component. At the end of the questionnaire there was an open question inviting further comments on reasons for poor usage. Of a class size of 202 there was a 50% response rate. The open questions were manually thematically collated and analysed.

Results and discussion: Findings from the questionnaire showed that the majority of students reported usage levels below those recommended by lecturers for the course. Qualitative analysis of the survey highlighted lack of time as a major factor, together with access issues and a preference for other study materials. Usage of the e-learning component when correlated against exam results was found to be significant at the 0.01 level.

Conclusion: This study showed that the use of the e-learning component was a factor that significantly influenced student results. To maximise the effectiveness of this teaching tool, there is a need to address the barriers students have to its usage.

We would like to thank the First year nursing students for their participation in this study
Experiences of Post-Operative Pain by Adult Patients Following a Total Hip Replacement

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Abstract
For patients, pain management is both a right and an expectation. For nurses it is a fundamental aspect of patient care. Post-operative pain remains one of the greatest concerns for surgical patients and presents a considerable challenge in assuring quality. It has been reported that up to 75% of all surgical patients experience moderate to severe pain while in hospital (Klopfenstein et al., 2000). Only three studies exist which have used qualitative designs to explore post-operative pain from the patients’ perspective (Carr, 1997, Zalon, 1997 & Santy, 2001). There is no Irish study that investigated post-operative pain experiences by adult patients following a total hip replacement. The aim of this study was to gain an understanding of the meaning of post-operative pain experiences of adult patients following a total hip replacement. A qualitative phenomenological approach was used with semi-structured interviews employed to gather data. The purposive sample consisted of both male and female patients (n=6) aged 50-70 years and who recently had a total hip replacement. Collaizzi’s, (1978) framework was used to analyze the data. Six themes emerged from the analysis of data (i) Severity of Pain, (ii) Movement and Pain, (iii) Expectations & Experiences of Pain, (iv) Satisfaction with Information, (v) Security and Comfort (Emotional Support & ‘Presencing’) and (vi) Non-Pharmacological Strategies used (Heat & Distraction). Strategies for effective pain management of surgical patients are Recommended.
Respite care services for older people: an Irish perspective

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Background and Context
Population ageing is an international phenomenon without historical precedent. With the increasing rise in the elderly population across the world, predicted at 25% in Ireland (over 65) by 2026 and 37% in Europe (CSO, 2007) both formal and informal care needs are expected to increase while the resources to provide it steadily decreases (Stoltz, Uden and Willman, 2004). Government policy not just in Ireland, but throughout Europe and beyond is to maintain elderly people in their own homes for as long as possible (DOC, 1988; Ashworth and Baker, 2000; DOHC, 2001). Research suggests that this is the preferred option for older people themselves (Garavan, Winder and McGee, 2001). However, according to Fine and Thompson, (1995) formal services seldom maintain a person at home without additional support and assistance from informal carers. Respite care is a service that has evolved to meet the needs of carers, to provide support for them and enable older people to remain living at home for longer. The provision of respite care is based on the assumption that temporary relief from care-giving will relieve caregiver stress and may extend the duration of homecare (Gilmore, 2002; Winslow, 2003). Indeed, research has shown respite care as one of the most important unmet needs of carers (Garavan, Winder and Mcgee, 2001; Stoltz, Uden and Willman, 2004).

However while the importance of respite care is well documented, there is a general lack of evidence regarding substantial benefit
from respite care. Part of the difficulty implementing respite care is the ambiguity surrounding the provision of the service with researchers and policy makers having yet to identify what outcomes are most appropriate for respite evaluations (Kosloski and Montgomery, 1995). Too often, emphasis is placed on delaying nursing home placement with enhancing carer and care recipient wellbeing as merely a by product of this goal. With regard to the provision of in-hospital respite care, benefits of the service may be diminished if the needs, wishes and expectations of carers and care recipients are not addressed.

Responding to the needs of older people and their carers particularly with regard to providing opportunity for increased and sustainable health gain is essential if respite care is to remain a viable and important component of community care. This study explored how in-hospital respite care contributed to benefit or lack of benefit, depending on whether or not health promotional opportunities during respite care were captured. It is imperative to service quality that key issues important to patients and carers are reflected in client-centred respite care services.

Aim of the Study
To explore nurses’ awareness of the needs of older people and their carers and their desire for health promotional opportunities during respite care.

Methodology
For the purpose of this study a qualitative descriptive design was used using focus groups as a means of data collection. Nurses from three care of the older person settings were invited to participate in the study. Overall seventeen nurses participated. Purposive sampling was utilised as this is the preferred method of sample selection for many qualitative designs such as focus groups (Macnee, 2004).

Analysis
The data was analysed using framework analysis by Ritchie and Spencer (1994). There are five stages in the data analysis framework process; Familiarisation; Identifying a thematic framework; Indexing; Charting and Mapping and Interpretation of key objectives. A chart was formed in Microsoft Word for themes which emerged from the data, with each focus group entered on each of the charts.

Summary of key Findings
Findings from the study reveal a functional approach to providing care as opposed to actively seeking ways to expand or develop the service in a proactive way. Ambiguity surrounding appropriate outcomes for respite care at national level impacts on how care is delivered at local level. Respite was viewed more positively where it moved beyond providing functional care to providing some identifiable benefit for the care recipient.

Conclusions
While nurses are aware of many of the issues important to older people and their carers, their ability to engage with these issues tended to vary. Environmental, organisational and cultural issues impacted on how these needs were addressed. A recommendation of the study is that rather than providing respite care solely in response to family stress or crises, the educational and health promotional potential of respite care should be harnessed. This requires reconceptualisation of respite care from that of a reactive service to a proactive service which provides the necessary supports and resources to adapt care-giving practices that more effectively meet the needs of older people and their carers.

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Implementing a problem based learning module – facilitation experiences

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Problem based learning is well established in health education. PBL is a pedagogical strategy of active learning. It is characterised by students engaging in small collaborative groups, learning is driven by challenging and realistic clinical problems (“triggers”) and lecturers take on a facilitative role. It is, therefore, a shift from a teaching paradigm to a learning paradigm. The learning environment in PBL is largely dependent on lecturer facilitation of the process.

The aim of this poster is to outline the experiences of university lecturers during the facilitation of a problem-based learning module for post-graduate students undertaking a higher diploma in children’s nursing. A reflective structure was used by facilitators to explore the challenges of implementation and facilitation. This reflective analysis will be used to guide future PBL facilitation.
A review of Blood Borne Virus transmission in Haemodialysis Units internationally.

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Background:
Haemodialysis is a therapeutic intervention used to compensate for renal failure. It involves pumping a patient’s blood through a filter containing a semi-permeable membrane, in order to remove metabolic waste, maintain physiological electrolyte levels and remove excess fluid. Without this treatment such patients would die from an accumulation of waste products such as urea and creatinine, fluid overload and electrolyte imbalance. The process is typically carried out for four hours three times a week. In order to be effective, the blood must be pumped at high speeds, typically 300ml/min or greater. To achieve such pump speeds, good vascular access is required. A large bore catheter, is inserted into a large vein, usually the internal jugular, or an arteriovenous fistula is surgically fashioned into which needles are inserted each treatment (Levy 2001). A number of patients will receive such treatment at the same time in a typical dialysis unit.

The connecting and disconnecting of patients to machines, the responding of staff to alarms and manipulation of vascular access during treatments because of poor blood flows all give rise to potential contact with large volumes of blood, and in the absence of rigorous infection control, can allow for the transmission of infections between patients. As a result, patients receiving dialysis treatment are at an increased risk of contracting a Blood Borne Virus (BBV).

The Centre for Disease Control (CDC) in Atlanta USA, recognised this risk in the 1970’s, and issued very specific guidelines on the management of BBV’s in haemodialysis settings. Since that time the CDC has set the bench mark for best practice in this area, and the most recent CDC guidelines (CDC 2001) are referenced in many local guidelines, (Department of Health 2002, Department of Human
Services 2006) including the recent Irish guidelines on the prevention of blood borne viruses in healthcare settings (Department of Health and Children, DoHC 2005). Despite these guidelines the prevalence of both Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) in this patient population has been consistently shown to be greater than that of the general population. Cristina et al (1997) found the prevalence of HCV in their region of Italy to be 2.9%, but found it to be almost ten times greater in their haemodialysis population at 22.6%. Katsoulidou et al (1999) describe a prevalence of HCV of 22.5% in their dialysis population in Greece compared with a general population prevalence of only 1%. In a study of almost 3000 patients across 43 dialysis centres in Germany, the prevalence of HCV was 7% in the dialysis population, compared with a general population rate of between .42% and .84% (Hinrichsen et al 2002).

**Aim of the review:**
The aim of this review was to explore the literature surrounding the transmission of blood borne viruses in Haemodialysis Units internationally.

This review:
- elucidated the possible causes of transmission recurrent in the literature
- gave insight into practices which increase risk
- indicated areas for future research.

**Search and review methodology:**
A search of online databases was undertaken to ascertain current research on this topic. Keywords included “Hepatitis”, “Infection Control”, “Blood Borne Viruses”, “Haemodialysis & Dialysis” and “Hepatitis B & C”. The databases included the Cumulative Index of Nursing and Allied Health Literature (CINHAL) 1982 to date, Medline and Ovid 1966 to present. A general search of GOOGLE (scholar) was also undertaken. Manual searches were also carried out in libraries of HSE and Non HSE sites, third level institutions and professional bodies (these searches were typically for primary source material not available on the internet, e.g. European Dialysis Transplant and Nephrology Nurses Association Journal.) The majority of papers were sourced in Nursing, allied health care professionals and scientific journals, with the scientific journals providing much of the data.

The strategies employed in healthcare facilities to prevent transmission (e.g. Standard & Universal Precautions, CDC guidelines
for Haemodialysis Facilities) were consulted in order to establish international best practice standards.

This provided a broad interdisciplinary knowledge base and expanded the author’s knowledge on the topic on which to build the review.

Abstracts were then reviewed, and those articles appearing to be of further interest were read in full. A review of blood borne virus epidemiology and transmission was first undertaken. This led to an in-depth exploration of research into transmissions in haemodialysis environments, possible causes, and the standards of prevention mechanisms applied in this environment.

**Analysis:**
Research examining the causes of transmission, infection control practice and variables surrounding such transmissions were reviewed in detail. Seminal papers examining large cohorts of patients were included e.g. (Jadoul et al 1998, Petrosillo et al 2000, Schneeberger et al 2000, Hinrichsen et al 2002, Fissell et al 2004). This allowed for the emergence of recurrent variables of statistical association or significance.
A number of smaller studies of specific outbreaks were also examined e.g. (Cristina et al 1997, Mclaughlin et al 1997, Norder et al 1998, Furusyo et al 2004, Savey et al 2005). These papers demonstrated possible failures of practice or policy which resulted in HCV transmission, and highlighted the potential for nosocomial transmission of BBV’s in this environment.

**Summary of Key Findings:**
The development of phylogenetics (the analysis of RNA structures of viruses) has allowed researchers to identify the particular viral genotypes of each infected patient and compare it with others in an outbreak.

This information allows the identification of:
- the source of the infection
- the most likely mode of transmission
- the sequence of multiple infections.

It emerged from such analysis that the adherence to CDC guidelines to prevent the transmission of Hepatitis B, appear to be effective when implemented (CDC 1996, CDC 2001). The introduction of those guidelines resulted in an 80% reduction in transmissions, and the results of CDC investigations into more recent outbreaks have shown failures in the implementation of the guidelines as the causes of transmission of the virus (CDC 1996, CDC 2001).
The CDC reported no instances of H.I.V. being transmitted as a result of Haemodialysis procedures (CDC 2001)

Therefore, the reviewer focused on the transmission of Hepatitis C, as transmission is not uncommon, and considerable debate still exists on the best mechanisms for prevention.

Three main issues emerged from the literature.

1) A number of authors consider haemodialysis machines to be a potential source of infection. (Delarocque-Astagneau 2002, Sartor et al. 2004, Savey et al. 2005). As a result, some authors suggest that the CDC guidelines for Hepatitis C management in insufficient. Saxena et al. (2003) isolated patients, staff and haemodialysis machines (the normal protocol for Hep B management) in an effort to reduce seroconversion rates. Shamshiraz (2004) examined isolated versus non isolated haemodialysis machines, with improved results for those on isolated machines. However, a dichotomy exists within the literature around this very point i.e isolation versus non-isolation. Ireland’s recently published guidelines recommend the isolation of machines for HBV, HCV and HIV (DoHC 2005), however some contend that strict adherence to good infection control practice is adequate (Jadoul et al. 1998, Petrosillo et al. 2001).

2) A number of factors are statistically significant or statistically associated with Hepatitis C transmission in haemodialysis. Holiday dialysis (where a patient receives a treatment, or a number of treatments in a different dialysis unit) had a statistical association with HCV seroconversion (Schneeberger et al. 2000, Carneiro et al. 2005). The use of multi-dose drug vials has been identified as a possible source of transmission in multiple instances (Covic et al. 1999, Krause et al. 2003, Furusyo et al. 2004). Staff patient ratios and staff experience (Petrosillo et al. 2000, Saxena & Panhotra 2004) and the prevalence of HCV (Pujol et al. 1996, Petrosillo et al. 2000, Fissell et al. 2004) have both been identified as statistically significant. The only factor repeatedly found to be an independent risk factor for HCV is length of time on haemodialysis. It has been suggested that even minor breaches in infection control, multiplied over time, present the single largest risk to patients. (Huang et al. 1993, Sivapalasingam et al. 2002, Hinrichsen et al. 2002)
3) The majority of smaller studies of specific outbreaks suggest that the primary means of patient infection is nosocomial transmission (transmission in the hospital environment). Two primary types of transmission are described, Vertical (transmission between two patients who have used the same machine at different times) and Horizontal (transmission between patients having treatment at the same time, but on different machines). Horizontal transmission appears to be more common. This would generally indicate a failure of infection control practice, with the virus being transmitted either by the staff of the unit, or by the environmental surfaces. (McLaughlin et al 1997, Norder et al 1998, Sivapalasingam et al 2002, Arenas et al 2005).

Conclusion
The literature suggests that poor infection control policy or practice is the overriding cause of HCV transmission in haemodialysis units internationally.

There is a dearth of research in this area in Ireland, and following this review, the author is currently submitting a proposal for ethical approval to undertake a study in the Irish context. The author plans to examine Infection Control policy to prevent the transmission of blood borne viruses in Irish Haemodialysis Units, with particular emphasis on the following:

- Those practices identified in the literature as causing potential risks for BBV transmission.
- The specific strategies for managing each BBV, e.g. establish if it is the policy of units to isolate patients with HCV & HIV, and what other protocols are in place for the management of such diseases.
- The availability of infrastructures to support such policies, e.g. suitable isolation facilities.
- How and where dialysis units deviate from the Irish recommendations on BBV management (DoHC 2005), including screening protocols, physical infrastructures, and practice recommendations on BBV management.

This research should establish the current policies in Irish haemodialysis units for managing BBV’s, identify areas of concern, and establish the resource deficits in meeting the new Irish Guidelines in this area.
References


Emergent ethical dilemmas confronting pregnant women with regard to antenatal screening for Down syndrome.

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Background: In the United Kingdom there is an increasing policy trend towards universal antenatal screening for Down syndrome. The National Institute for Clinical Excellence (2003) has proposed that, by 2007, all pregnant women should be offered screening. In Northern Ireland, it has been proposed that all pregnant women should be offered second trimester screening (National Screening Committee 2006).

The momentum towards universal screening is primarily driven by initiatives from government, sectors of the medical profession and the medical supply industry. Yet the interests of pregnant women have been largely disregarded despite the potential for ethical dilemmas to emerge as a direct result of the premature universalisation of screening.

Aim of review: This paper presents a systematic literature review aimed at identifying some of emergent ethical dilemmas confronting pregnant women with regard to screening.

Review methodology: Thirteen databases were searched with the medical subject heading (MeSH) keywords ‘ethical dilemmas/ethics’ combined with ‘antenatal/prenatal screening/testing’ and ‘pregnant women/women’.
Analysis: The retrieved papers were synthesised using the classification of evidence framework from the Department of Health in the National Service Frameworks.

Key findings: Eight main dilemmas were identified: ‘optional’ versus ‘routine’ screening; dependence on risk and probability-based information; merits of first versus second trimester screening; influence of developments in fetal medicine; influence of moral, religious and socio-cultural beliefs about termination of pregnancy; perceptions and knowledge of Down syndrome; significance of screening results and the potential for having to make decisions about the standards for entry into the human community.

Conclusions: It is concluded that there needs to be further debate and research with pregnant women, healthcare professionals and policy makers about the potential ethical dilemmas which may arise from antenatal screening for Down syndrome and supportive responses required by women, before, rather than following, the introduction of universal screening.
A group model of prenatal care: CenteringPregnancy©: Results of a Randomized clinical trial (RCT)

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CenteringPregnancy®, a model of group prenatal care was developed in 1993-94 by Sharon Rising, CNM, MSN, a nurse-midwife and educator in Connecticut. The Centering® model provides prenatal care to 8-12 women with similar gestational age in a group context, and includes 10 prenatal/postpartum sessions. Each two-hour session reflect the schedule of routine prenatal care and includes content related to: Nutrition & Fetal Development; Common Discomforts; Relaxation & Labor; Family & Parenting Issues; Birth Experience & Tour Birthing Unit; Labor & Decisions of Pregnancy; New Baby Care & Infant Feeding; Post-Partum Adjustment; Baby Care; Baby/Mother Care & Birth Control. The women are taught to do self-care activities and each has a brief time for individual prenatal exam with the health provider within the group space. The model uses a facilitative leadership style, skills building activities, allows for flexibility in group discussions, and provides opportunities for women to socialize and form community.

The RCT was undertaken following promising data from a cohort study done on this model.1 A two-site RCT was conducted at two university-affiliated hospital prenatal clinics. Pregnant women aged 14–25 years (n=1,047) were randomly assigned to either standard or group care. Group participants received care in a group setting with women having the same expected delivery month. Structured interviews were conducted at study entry, during the third trimester, and in the postpartum period.

RESULTS: Using intent-to-treat analyses, women who were assigned to group care were significantly less likely to have preterm births compared to those receiving individual care: 9.8% compared...
with 13.8%. No differences were seen in age, parity, education, or income between the women in individual or group care. This represents a 33% (odds ratio 0.67, 95% confidence interval 0.44–0.99, P = 0.045), or 40 per 1,000 births. For African-American women: 10.0% compared with 15.8% (odds ratio 0.59, 95% confidence interval 0.38–0.92, P = 0.02). Women in group sessions were less likely to have suboptimal prenatal care (P < 0.01), had significantly better prenatal knowledge (P < 0.001), felt more ready for labor and delivery (P < 0.001), and had greater satisfaction with care (P < 0.001). Group care patients initiated breastfeeding at a higher rate: 66.5% compared with 54.6%, P < 0.001. The costs associated with group care were equivalent to individual care costs. These results have implications for design of sustainable prenatal services that might contribute to reduction of racial disparities in decreasing adverse perinatal outcomes.

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The role of one-to-one volunteer support in helping bereaved families: clients’ views

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Background: The rapid development of hospice-based bereavement support services reflects a growing need to provide appropriate support for bereaved family members. The nature and extent of bereavement services offered to the bereaved vary widely, but may range from written information and memorial services to social activities and dedicated one-to-one support. The National Institute of Clinical Excellence (NICE) recommends that service providers should offer three levels of service support across a spectrum of low, medium and high level care, but few studies have been undertaken to evaluate the effectiveness of such services.

The bereavement service provided by the hospice in this study comprises five main elements: (1) a bereavement follow-up contact made to a family member by hospice staff shortly after the death; (2) a Monthly Memorial Ceremony; (3) a Bereavement Information Evening (BIE), a presentation by the hospice social worker on the bereavement process and the hospice bereavement services; (4) a Volunteer Bereavement Support Service (VBSS), a listening service provided by trained volunteers under the supervision of the hospice social work team; and (5) two annual events – an Annual Remembrance Service and the Christmas ‘Tree of Life’ Ceremony.

Aims: This study was designed to evaluate all elements of an adult bereavement support service provided in a large hospice in Dublin. The Volunteer Bereavement Support Service is the focus of this paper which formed part of the first stage of the study.

Method: Participants who were invited to attend one or more of the bereavement services (including the VBSS) during the previous 12 months (n=529) were sent a Bereavement Service Questionnaire (BSQ). The BSQ was designed for purposes of the study in order to elicit a wide range of background information on all respondents.
including, in particular, their utilisation and views of each of the above support services.

Two instruments were also administered with the BSQ. Firstly, the *Texas Revised Inventory of Grief* (TRIG)\(^6\) is a brief, widely used and psychometrically robust measure of the intensity and nature of an individual’s grief response. The scale comprises 26 items with three subscales. Part one, which measures ‘past behaviour’, is an 8-item measure which concerns the feelings and actions at the time of the death, such as, the extent to which the death affected one’s emotions, activities and relationships. Part two, ‘present feelings’, is a 13-item measure which focuses on present feelings, such as, the continuing emotional distress, lack of acceptance, rumination and painful memories; part three consists of a number of unscaled items related to facts about the death, such as, the nature of the relationship (spouse/friend), perceived closeness to the deceased, length of time since death, and other related facts (funeral attendance, anniversary reactions). Only parts one and two were used in the current study to explore any differences in grief response between service attenders and non-attenders. Secondly, the *Santa Clara Strength of Religious Faith* (SCSORF)\(^7\) is a 10-item instrument which assesses strength of religious faith irrespective of religious denomination or affiliation, with higher scores reflecting stronger levels of ‘religious faith’\(^7\). The SCSORF was only administered to those who were invited to attend the monthly liturgical ceremony in order to ascertain whether attenders and non-attenders of this service differed in their overall levels of religiosity.

One-to-one interviews were also conducted with a small sub-sample of service attenders and non-attenders (n=22).

**Analysis:** The quantitative data were analysed using SPSS to generate descriptives and to explore differences between attenders and non-attenders. The qualitative data were transcribed and subjected to a thematic analysis in order to identify key themes and messages.

**Key findings:** A total of 246 people (47% response rate) returned completed questionnaires, 31% (76/246) of whom had attended the Volunteer Bereavement Support Service (VBSS).

Nearly one-quarter (35/159) of those who did not access the VBSS were unaware of the service. Of those who reported that they knew of the service, almost half had heard about it first prior to, or on, the death of their relative or friend. There were mixed views about attending the VBSS session at the hospice. Some had been to the hospice before during the care of the relative/friend, whereas others
had not. One-third found it difficult to attend their sessions at the hospice, whilst almost half found it a more positive experience with the remaining respondents (18%) reporting mixed feelings.

The reasons for using the service varied. Some wished to talk to someone outside their family whilst others felt that they could not cope on their own or had no one else to talk to. Others were persuaded to attend by their family and friends. The reasons for not accessing the service also varied. Some respondents felt that they were coping ‘ok’ whilst others stated that they were already receiving sufficient support from family and friends, one in ten were not aware of the service and others reported that they were too emotional to access the service.

Service users generally accessed the service approximately six months after the death of their relative/friend and attended for an average of five sessions, although this ranged from 1 to 30 sessions. The majority of service users met with the same volunteer for all of their sessions. Most considered the ability of the volunteer to listen, understand and have knowledge of the bereavement process to be very important.

People who attended the service generally reported a number of benefits, such as: being listened to and feeling that they were not being judged; being allowed to feel that their loss was not being compared to other people’s loss; the opportunity ‘to unwind and pour your heart out; to be assured that they were neither “stupid” nor “mad”’; being given the opportunity to discuss the person who had died with someone who did not know them and who was independent of family and friends; and the opportunity to have a ‘safe space’ to grieve. However, some attenders also reported some negative aspects of their experience. For example, some reported feeling vulnerable and losing control during the sessions. Others did not like being asked questions about their past or discussing issues for which they were unprepared. Some also stated they felt a lack of rapport with the volunteer who was assigned to them whilst a few also had some questions around the qualifications of the volunteers.

The majority of this group were satisfied with the service, although a number of suggested improvements were highlighted. For example, it may be beneficial to increase awareness of the service amongst all of the bereaved relatives and friends. At present, there are a number of points at which the bereaved are informed about the VBSS, but a significant proportion of people remain unaware of the service. The service providers may also wish to consider allowing clients the opportunity to change the volunteer whom they
see initially, whilst also considering offering other services, such as, bereavement support groups. The introduction of a process of continuous evaluation into the VBSS (and other parts of the service) might help to monitor changes over time and ensure that clients’ needs are met in the most sensitive and effective way.

Several statistically significant differences (p<0.05) between those who attended the service and those who did not, emerged with respect to grief reaction. Those who used the service scored higher on the TRIG-part 2 than those who did not, indicating that the service users were more distressed at the time they completed the questionnaire than the non-service users. Those who felt they did not have anybody to talk to or did not have enough practical support at the time of the death, also scored higher on the TRIG-part 1. Those respondents whose relative died at home or in hospital, obtained the two highest scores respectively on the TRIG-part 1; notably, those whose relative died in the hospice obtained the lowest scores of all.

Conclusions: This is the first comprehensive study of its kind to describe and appraise the effectiveness of a bereavement support service in Ireland. The findings from this first stage of the evaluation underpin the important role of volunteer support in the bereavement process and provide some useful lessons for the development and effective functioning of such services. These findings will be supplemented by those emanating from the second phase of the study, which is currently underway. This phase involves a prospective, six-month follow-up study of all clients who use the Volunteer Bereavement Support Service. Participants are asked to take part in interviews during which a battery of measures is administered. A sample of people who have chosen not to access the service are also included as a comparison group.

Acknowledgements
A. Roberts carried out the study as part of her PhD thesis under the supervision of Dr. S. McGilloway. The study was funded by the Irish Hospice Foundation under the Therese Brady Scholarship. We would like to thank the Irish Hospice foundation and the staff and families at St. Francis Hospice for their continued help and support in conducting this research.

References


Children’s Appraisals of Interparental Conflict and Parenting

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Background and Context: One of the important ways in which a family can affect the development in children is the Emotional climate of the family. Parents play a major role in determining the emotional climate within the family, through the nature of marital relations and parenting style. Marital relations characterized by conflict and anger create a negative emotional climate that can lead to more emotional problems for children. Family emotional climate is also affected by the attitudes and behaviours of parents as they respond to the physical and emotional needs of their children. Children who are emotionally well-adjusted with few behavioural problems are more likely to have experienced a parenting style characterized by high acceptance, warmth and support, rather than a hostile, over controlling parenting style.

Parental Style is a set of attitudes, goals and parenting practices that create an emotional environment through which the parent and child interact (Darling & Steinberg, 1993). Acceptance consisted of parenting characterized at the positive pole by sharing, expression of affection, positive evaluation, and at the negative pole by ignoring, neglect and rejection. Psychological Control is characterized by intrusiveness, parental direction, and control through guilt, with the possessiveness, protectiveness, nagging, negative evaluation, strictness and punishment.

The family systems perspective understands psychopathology as a reflection of family process. According to family systems theory, interparental conflict is a risk factor for children because parent child relationship are accompanied by an intensification of either intimacy, rejection, or both, which also are accompanied by symptomatic behaviours in the child. The parent child relationship is the primary feature of the context, as a risk factor, as a protector variable in the parental conflict.

The expression “parental conflict” refers to the type and victim, that is, the child witnesses the violence and/or the conflict between two next of kin emotionally attached and with whom is shared the space.
The cognitive-contextual framework (Grych & Fincham, 1990) proposes that children’s appraisals of interparental conflict shape the impact of conflict on their adjustment. The interparental conflict influences the relationship between parents and child, which can lead to a deterioration of the affective and physical disposability of parents (Grych & Fincham, 1990).

**Aims of the study:** The study aims to identify the child’s perception of the parental conflict and to analyse the influence of the relation between parents and child and the perception of the parental conflict.


**Participants:** 2280 children aged between 8 and 11 attending schools in Madeira Island (simple random probabilistic sample).

**Summary and Key findings:** The age average of the children is 9.51 years, (SD= 1.03). 34.2% have ten years olds. Most (52.1%) of the total were boys. The majority (77.9%) of the children never failed. 82% were living with both biological parents. The predominant (75.8%) type of family is nuclear. 86.5% of the children had daily contact with father and 96.4% with mother. 38.3% of the children are the younger brother and 29.7% are the eldest.

More than half of the mothers (55%) were between 30 e 40 years old and 45.7% of the fathers were between 40 and 50 years old. Most of the parents were married or live together (86.7% fathers and 88.2% mothers).

44.1% of the fathers and 39% of the mothers has the 1st education level.

**Conclusions:** Correlations shows that Acceptance is negatively associated with interparental conflict, however Psychological Control is positively associated with interparental conflict.

Children that had a relationship of acceptance with their mother perceived lower levels of interparental conflict.

Children that had more Psychological Control of the mother perceived higher levels of interparental conflict.

Nursing assumes a nucleus role to be a profession able to detect cases of imbalance within the family, involving simultaneously...
strategies that aim the harmony and the development of the familiar health.

Well-being and the “treatment” of the families can assume a dimension of public health in the way it fortifies the family as a social system, promoting the resilience of all individuals, especially children.

References


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Implementation of recommendations from a Nursing Workforce Planning Project in a large Dublin Academic Teaching Hospital. Workforce planning project in Two Dublin Academic Teaching Hospitals

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Aim: This purpose of this project was to ascertain nursing workforce requirements in conjunction to patient dependency and demand for care within the Irish context. The aim of the study was ultimately to determine a method of measuring nursing workload in conjunction with other factors including patient dependency, nursing activity levels, quality indicators and staffing establishments. In analysing the data collected a number of areas for process improvement were identified.

Background
A nursing workforce planning project was jointly undertaken by The Adelaide and Meath Hospitals, Incorporating the National Children's Hospital, Tallaght and Beaumont Hospital in 2006. The guiding force of this project was to ascertain a method of determining nursing workforce requirements in response to changing patient requirements for care.

Method
This project firstly involved a review of the current literature in order to determine the most appropriate method of nursing workforce measurement. Subsequently, the chosen method consisted of four measurements including; patient dependency measurement, nursing activity analysis, nursing quality audit and staffing establishments. Each of these measures were instituted in three clinical areas in each of the hospitals involved in the project. As part of this project the project team consulted with a Workforce Planner in the United Kingdom, Professor Keith Hurst. The data was collected over a period of a month and then sent for analysis.

Analysis
All of the data collected was transferred into electronic format into excel files, facilitating the extrapolation of key findings and recommendations. This data was analysed by Professor Keith Hurst.
Summary of key findings
The key findings in this project are two-fold: recommendations on staffing establishments and recommendations on key areas for process improvements in the clinical area. The presentation will expand and examine the key recommendations and areas for process improvements as a result of this project. In addition the presentation will outline the implementation of these findings and recommendations in practice.

Conclusions
The completion of a nursing workforce planning project is a very worthwhile venture in order to examine the current processes of nursing activity, which leads to the identification of areas of process improvements. Encouragingly, this project revealed the value in examining how nurses work in order to uncover areas for improvement which can be easily implemented to facilitate improved patient care and efficient use of resources.
Critical Incident Technique Utilization in Research on Holistic Nurses

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Acknowledgement:
The author would like to acknowledge the nurses who participated in each of these studies used in this article.

Abstract
This article describes the Critical Incident Technique (CIT) as it informs holistic nursing. The CIT is a qualitative, systematic, open-ended technique for eliciting descriptive data from participants. It is an effective naturalistic tool for focusing participants’ on a specific event. The CIT is a user-friendly instrument that can foster reflection and promote personal expression. Holistic nursing is a personal and professional commitment to the healing process of self and others. The competency of holistic nurses revolves around their ability to incorporate the concepts and standards of the philosophy of holistic nursing into their life and practice.

This article explores the use of the CIT in two separate studies on holistic nurses. Both studies utilized the CIT as a secondary source of data collection. All participants in both studies were members of the American Holistic Nurses’ Association (AHNA). One study explored how experienced certified holistic nurses (HNCs) learned to become competent practitioners while the other study focused on holistic nurses’ experience with modalities, the perceived benefits to self and client.

Key Words: Critical Incident Technique, qualitative research, story-telling, research methodology, descriptive data collection, reflection, holistic nursing

INTRODUCTION
The Critical Incident Technique (CIT) has assisted qualitative researchers’ to capture a retrospective story of an actual event in a participants’ life. The CIT is a systematic, inductive, open-ended procedure for eliciting verbal or written information from participants (1: Norman, Redfern, Tomalin & Oliver, 1992). It is an effective naturalistic tool for focusing participants’ on a specific
event. This technique enables researchers to capture the reality of contemporary nursing practice, and nurses’ experience of that practice (2: Keatinge, 2002). This inductive approach allows for ‘freedom of expression’ with a reference framed by the research question (3: Cox, Bergen, Normal, 1993). It is a “brief written or spoken depictions of vividly remembered events” (4: Brookfield, 1990a, p. 84).

This paper will describe the CIT as it informs holistic nursing. Following a brief description of the CIT and holistic nursing, a discussion on the inclusion of the CIT in two separate studies on holistic nurses will conclude this article.

It is the intended meaning of the participant that the researcher hopes to glean from the CIT. Understanding that meaning, and being able to adequately articulate it is the researcher’s goal and intention. The CIT is a route for the participant, if they wish to, to make meaning of their experience. To make meaning of one’s experience refers to understanding the meaning behind the experience, to make an interpretation of it (4). The premise is twofold: the participant might gain a deeper understanding of the event and own its’ meaning while the researcher attempts to make meaning and an interpretation based on the participants’ singular story.

CRITICAL INCIDENT TECHNIQUE

The critical incident technique was originally developed by Flanagan and members of the Aviation Psychology Team during World War II (5: Mezirow, 2000). In his seminal work, Flanagan detailed how he and others first utilized this method to identify critical incidents of pilots. Flanagan describes the CIT as a flexible set of procedures for “collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems” (6: Flanagan, 1954, pg. 327). To be critical, Flanagan states that an “incident must occur as a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects (6, p. 327). By the term incident, Flanagan refers to “any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act” (6: p. 327). He developed a feasible and proficient method of rigorous interviewing aimed at specifying facts and identifying critical behaviors. The basic principles of the CIT are that factual reports of behavior are preferable to general opinions and impressions and only those behaviors that make a significant contribution to the general aim of the study should be considered (7: Woosley, 1986).

There is a two-fold assumption behind this technique (1). First, observers make references about the person’s competence on
the basis of his or her observed performance in specific situations, and second, they make definite judgments that the behavior observed makes a significant contribution, either positively or negatively (1). As a means of probing participants’ assumptive worlds, the CIT is rooted in the phenomenological research tradition and presumes that participants’ general assumptions are embedded in, and can be inferred from, their specific descriptions of particular events (8: Brookfield, 1990b). The CIT is a tool that can be easily adapted to any qualitative inquiry as it attempts to glean participants’ real life experience.

CITs’ differ from other forms of qualitative inquiry. Even though qualitative inquiry addresses human affairs, the action behind the method employed varies. CITs’ are short, retrospective excerpts of an event in a participants’ life. Interviews are always verbal reports, with probing to elicit an expanded response from participants. Focus groups are composed of several individuals who are being ‘interviewed’ within a group interaction. CITs’ are individually completed with no probing from the researcher. CITs’ should be considered a methodological data instrument that can be utilized in any qualitative inquiry to elicit data. Additionally, CITs’ should be analyzed according to the specific type of qualitative study being conducted, be it phenomenological, naturalistic, case study, descriptive or ethnographic. There is no difference in the analysis of data obtained from a CIT in any form of qualitative inquiry.

Advantages and Limitations
The account is usually a description, rich in emotional color and with details of associations that are not strictly relevant to the action being retold (9: Urquhart, et al). The design allows information to be obtained quickly, requiring only simple types of judgments and responses from participants, usually in only 15-20 minutes; it is a flexible tool and can be easily adapted to meet the requirements of individual research studies; and the CIT can be collected via a variety of methods (including face-to-face interviews, telephone interviews, workshops, group interviews, systematic record-keeping and direct observation (10: Kemppainen, 2000) as well as a self-administered e-mail attachment. Given the various forms of administration, CITs’ can be considered very versatile. The researcher can read the CIT to participants; hand out copies of the CIT to participants and have participants write their responses; make observations based on the CIT question and record their own observations or send a copy of the CIT via email attachment and ask participants to respond via computer email.

It is a form of story-telling, as the participant is sharing their singular experience as a story to the researcher. It ensures that all participants focus upon the same issues, given the general aim of
the study. The advantage of focusing on specific incidents is that, in addition to facilitating recall, participants can identify and clarify feelings and meanings which they may attach to these, but otherwise be unable to articulate (3). It can provide a powerful vehicle for stimulating transformative learning because they are so closely connected to the personal experience (11: Cranton, 1994). Finally, it can provide a unique and effective means of leading participants from the “specific to the general in understanding their underlying assumptions and beliefs” (11: p. 189). The value for fostering critically transformative learning is twofold: CITs’ are accounts written by people about actions in their own lives and they are undeniable sources of data representing participants’ existential realities, thus providing primary data that gives insight into the participants’ assumptive worlds in expressions that are specific for that individual (8).

In a CIT study, sample size is not determined by the number of people but by the number of incidents collected. The number of incidents needed cannot be predefined (1) with each participant usually contributing one or two incidents (9). As with most qualitative studies, sample size is usually small, thus the critical incident technique utilized must be written very concisely to allow the participants’ to answer it as descriptively and clearly as possible.

However, all forms of methodology must declare their limitations. Even though the CIT is a versatile tool, it is dependent on the “memories of participants and their ability to recollect specific examples of the concepts in question” (12: Care, 1996, p. 28). The issue of reflection in the CIT has raised both positive and negative comments. This can be viewed as a limitation whereby it is dependent on participants’ ability to accurately provide a detailed account of an event. Though researchers’ should be confident in their participant’s ability to ‘tell their story’, there is always the element that embellishment might occur. In spite of this, CITs have the capability of assisting participants to reflect upon their experience and expand on personal insight into their personhood. Transforming one’s frames of reference through critical reflection on assumptions supporting the content and/or process of problem-solving, and transforming one’s habits of mind by becoming critically reflective of the premises defining the problem (13: Brookfield, 2000) can lead to a transformative learning experience where the participant can gain a more comprehensive awareness of the experience and their actions. CITs’ guide participants through a factual description, as well as reflection, of the event (14: Rosenal, 1995).

Finally, the CIT is “less equipped to explore those situations in which there was no decision or act, or where the user was unaware of the information need or suppressing (consciously or
unconsciously) the perception of the information need” (9: pg. 71). If there was no definitive act within the event, the ‘purpose’ or ‘intent’ of the event may be absent. Thus, the ‘critical’ element, per Flanagan’s definition of critical, is not present and the account cannot be considered ‘critical’. Additionally, it might be difficult for some researchers to separate the story of one incident when there is a choice of multiple stories or experiences written within the same event (9). In other words, the participants’ story might have more than one experience within the description, thus, the researcher might have difficulty in unraveling the event. Finally, subtle changes in the wording of the critical incident question itself might produce differences with participants’ responses. Thus, the same exact language is necessary to minimize this potential limitation.

Reliability and Validity
The recounting of incidents/happenings depends on the participants’ ability to recall events, the authenticity of which is difficult to verify (3). Validity of data gleaned is partially ensured by the fact that all participants focus on the same issues. Inter-rater reliability can be used to make the categorization process less subjective. Triangulation can increase credibility. CITs’ can be used for triangulation purposes or utilized in juxtaposition with other data gathering techniques. For triangulation purposes, CITs’ can be incorporated as a complement to different data gathering amalgamation. By using the CIT to validate and verify data, by double-checking interpretations and findings and using multiple sources of data collection, the researcher can construct triangulation. CITs’ can be used as an additional source of data collection to provide a format to validate and double-check the researchers’ interpretations and findings.

The CIT can be used a primary source of data collection or as an evaluation technique, to supplement the interview or questionnaire questions (9). CITs can be used to refine and/or revise a primary instrument, such as an open-ended interview guide, as well as being used as a secondary source of data collection. A researcher can pilot the CIT to determine if he/she is asking the right research questions and revise the CIT and other instruments accordingly.

Studies incorporating the CIT
Since its development as a research instrument, CITs’ have been popular in many areas of research. The CIT has been developed and adapted to suit many diverse studies with respect to “effectiveness, value and impact of service provisions” (9, pg. 71). Both small and large participant studies can easily adapt and utilized CITs’ effectively. Some larger-scale studies include a

**Conclusion on the CIT**

It is apparent that the CIT is a useful tool to utilize in qualitative research. It has been utilized with a multifarious group of participants and academic settings. CITs’ are a powerful methodological instrument that can foster reflection and promote personal expression. It is obviously a useful technique to expand nursing knowledge and understanding on a suntody of multilayered levels. Some potential ways in which nurses can use CITs in educational practice is to foster self-reflection; to inform educators of the reality and impact of nurses’ experiences; to conduct learning needs assessments and to acquire exemplars useful in teaching (14). Furthermore, CITs’ can be used to gain a meaningful understanding of nurses’ perceptions on various issues. Finally, CITs’ can be used to assist nurses and healthcare professionals to gain a deeper and more personal understanding of clients, acquiring their perspectives and concerns; as well as a more personal awareness of one self.

**HOLISTIC NURSING**

Holistic nursing is a personal and professional commitment to the healing process of self and others. The recognition by holistic nurses of the interrelationships of the bio-psycho-social-spiritual-cultural elements will impact how the client perceives the holistic nurses’ involvement. The significant 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. The competency of holistic nurse practitioners revolves around their ability to incorporate the concepts and standards of the philosophy of holistic nursing into their life and practice. Holistic nursing is not just a profession; it is a way of being. A holistic nurse recognizes the importance of understanding and honoring the
belief systems of self and others, thereby increasing awareness of the interconnectedness of all individuals and their relationships to each other and the global community (30: Sharoff, 1997).

Holistic nursing weaves a tapestry of the bio-psycho-social-spiritual-cultural elements to assist in the healing process of self and others. The healing process is a continual journey of changing and evolving of one’s self through life, as well as the awareness of patterns that support or are challenges/barriers to health and healing (31: Dossey & Guzzetta, 2005).

Critical Incident Technique Methodology Utilization in Research on Holistic Nurses

The author used the CIT in two separate studies on holistic nurses. Both studies utilized the CIT as a secondary source of data collection, with semi-structured open-ended interviews being the primary source (conducted via telephone and audio-taped). The CIT was used to help refine and revise the interview questions and as part of triangulation. Finally, all participants were initially contacted via e-mail with a general description of the purpose of the study, participant eligibility, and participant involvement. Purposeful sampling occurred when the researcher reviewed the AHNA Member Directory, which was available to all members. E-mail addresses were obtained through the AHNA’s Member Directory. Once a participant agreed to be in either study, and eligibility was confirmed, an introduction letter, critical incident, and demographic inventory were sent via e-mail attachment. This data was then sent back to the researcher via e-mail attachment.

Both studies received Institutional Review Board (IRB) approval for the protection of human participants’ rights.

To corroborate the researcher’s perception of theme and category coding, review of data was confirmed through inter-rater reliability checks and all participants were asked to review the interview for accuracy. The coding scheme was developed for each study’s research questions. Descriptors were formulated from the critical literature review with additional descriptors constructed after analyzing the interviews and critical incidents. Analysis of the CIT used the same coding scheme/descriptors developed for the primary data source (semi-structured interviews).

Study # 1: How Experienced HNCs Learn to Become Competent Practitioners

Purpose

The purpose of this naturalistic qualitative study was to explore how experienced certified holistic nurses (HNCs) learn to become competent practitioners (32: Sharoff, 2006). The study focused on a sample of 10 volunteer HNCs who have been practicing as holistic nurses for more than three years and have incorporated the
philosophy of holistic nursing into their life and practice. The initial criteria for inclusion in this study were being a certified holistic nurse and the time frame of the practicing HNC. With analysis of eight volunteer participants’ interviews, theoretical saturation was evident. To confirm saturation, two additional volunteers were interviewed.

**Research Questions**

The inquiry for this study was driven by four central questions: (1) What motivates a professional registered nurse to become an HNC? (2) What knowledge, skills and attitudes do experienced HNCs perceive they needed in order to become competent as holistic nurse practitioners? (3) How did those practitioners acquire the knowledge, skills and attitudes they perceived they needed? and (4) What factors facilitated and/or impeded their ability to become competent practitioners?

**Participants**

The participants in this study were primarily Caucasian (10% Asian), female, age range of 40-54 (mean 51.6 years). Highest degree obtained by a majority of the participants was a baccalaureate degree (50%), MSN (30%) and doctoral degree (20%). The mean number of years in nursing was 26.7, and range of years as an HNC was 3-5.8.

An analysis of the demographic inventory indicated that the participants were representative of the AHNA’s membership, as well as representative of professional registered nurses’ who hold certification in a specialty area. In addition to the interview and CIT, a summative focus group was also utilized for triangulation to validate conclusions.

**Critical Incident Technique**

A critical incident was used to obtain a real life experience that pertained to research questions # 3 and # 4. After 8 of the 10 participants completed the original critical incident and analyses of those 8 critical incidents were completed, a more precise and brief critical incident was developed. The initial CIT utilized in this study was rather long and arduous, following more of Brookfield and Cranton’s version of including questions of when, how and who (see Table 1). The researcher realized that the data gleaned was not detailed enough and provided non-essential data to the research questions. The revised critical incident instrument was more to the point of the general aim of the study, it was succinct and brief (see Table 2). This CIT provided a crisp story of participants’ experience and reflection upon that event. The decision to develop a new CIT was based on the researchers’ interpretation that the initial data gleaned was not sufficient for triangulation and this was agreed
upon by the researchers’ dissertation committee. Thus, a revised CIT was developed for the last two participants in this study.

**Key Findings**

The key findings from analysis of data from the semi-structured interview with the CIT data used as triangulation data gleaned the following results. All participants described (1) some form of disjuncture between the structure of traditional nursing and their own personal and professional growth and development, (2) needing credibility as key to their becoming competent as practicing holistic nurses, (3) using informal learning strategies to assist the holistic nurse to achieve competency and (4) challenges they had to overcome as they transitioned from traditional nursing and in their practice as HNCs facilitated their ability to become competent (32)

**Statements by participants from CITs**

One participant, a registered nurse for thirty-three years and seven years as an HNC, commented in her CIT on how holistic nurses are true champions of patient advocacy. She stated:

> We, as holistic nurses, are true champions of patient advocacy...nurturing to ourselves as well as those in need...the hearts that speaks out to this misnomered ‘health care’ system which is unbalanced...out of harmony with the very nature of those it wishes to assist.

One participant, who works in a home health care facility in California, shared an experience of her discussion with a clients’ family about end of life issues and how that conversation and connection brought about a new level of her own personal understanding of this issue. She wrote:

> This experience...added to my level of competency...found the right words that this family needed to hear...will allow me in the future to be...sensitive to others in their own exploration of end of life...the level to which this conversation arose to, the depth...intensity...valuable learning experience.

One participant, who has been an HNC for over seven years, shared an experience of hearing her inner voice telling her of the need for self-care and change. She wrote:

> (I) clearly heard my inner voice/wisdom convey...profound need for change, increased awareness and eventual change.

Another participant, an HNC for over three years, described an experience where she realized, through self-awareness, how she
challenged her beliefs and learned how to behave differently in certain situations. She wrote:

This experience helped me face my insecurities...challenged my own thoughts and beliefs...of what I might have done differently...concluded I would have done things differently as a manager but my actions as a leader would not have changed.

One participant who works in a hospital critical care setting stated:
(I) feel blessed from all my experiences...which have been enhanced because of my acquired HNC...(I) believe by furthering my knowledge by pursuing my HNC...I opened pathways from within myself.

Finally, another participant, who practices in an educational setting, described how she believes that holistic nursing is the key to health care for the 21st century. She wrote:

Holistic nurses...the philosophy, ethics, principles and practice which we hold so dear...key to the change and reclamation of health care for the 21st century.

Study # 2: Holistic Nurses’ Experience With Modalities: Perceived Benefits to Self and Client

Purpose
The purpose of this naturalistic study was to describe the experience that holistic nurses have in incorporating holistic modalities as they participate in the care of their clients; gain a deeper understanding of holistic nurses and the perceived benefit of utilizing a holistic modality with their clients and themselves concurrently as providers of the modality. The study focused on a sample of 10 volunteer holistic nurses who incorporate a holistic modality (healing touch, reflexology, integrative therapies, mind balancing, and aromatherapy) into their practice. The inquiry for this study was driven by three central questions: (1) What motivated you (the nurse) to incorporate a modality into the healing-caring process? (2) How does using the modality benefit your clients? and (3) What are the benefits that you (the nurse) received by using this modality?

Participants
The participants in this study were Caucasian females, age 44-71 with a mean of 55.9 years. Years in nursing ranged from 15-49 with a mean of 29.8 years. Highest degree held was a PhD (10%), with MSN 30%, MS 20% and BSN 40%. Modalities discussed were
primarily Healing Touch/Energy Healing (70%), Reflexology (10%), Brain Balancing (10%) and Integrative Therapies (10%, consisting of Reiki, Hypnotherapy, Therapeutic Touch, Aromatherapy, and Acutonics). All participants who utilized Healing Touch/Energy Therapy were certified in this modality. Only one participant was not certified in the modality discussed (Brain Balancing). Many of the participants held certification in other modalities and incorporated the use of various modalities in their practice and life (50%). Additionally, several participants were also certified as holistic nurses (30%).

The researcher conducted a pilot study with 3 participants utilizing the same instruments (critical incident, semi-structured open-ended interview and demographic inventory). This was conducted as a means of refining and revising these instruments. The pilot study established appropriate data collecting methods, thus no changes were made in the instruments. Since the tools were not revised and the data gleaned was descriptive and deemed pertinent, it was included as part of the study’s overall interpretations and findings. Pilot study participants demographics were reflective of study participants as well.

Modalities are different techniques that can be included in the healing-caring process to assist the nurse and client in achieving maximum health potential. 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. There is an energy flow in the body and keeping the body’s energy in a balanced state is necessary to maintaining health.

Key Findings
The key findings from analysis of data from the semi-structured interviews with the CIT data used as triangulation data gleaned the following results. All participants 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 inclusion of a modality into the healing-caring process.

Critical Incident Technique
CRITICAL INCIDENT DESCRIBING THE HOLISTIC NURSES’ PERSPECTIVE ON THE INCLUSION OF MODALITIES INTO HIS/HER PRACTICE
Please think of an important event in your practice where you utilized a modality. Please reflect on how this experience affected you in your practice as a holistic nurse. Please briefly describe this incident.
How would you describe the benefits you received from utilizing this modality?

How would you describe the benefits your client received from utilizing this modality?

Upon retrospect, the researcher realizes that this CIT might be leading the participants’ to reflect only on positive benefits, since it is asking for ‘benefits’. Even though the research questions themselves are not asking for ‘positive’ benefits only, they do not differentiate from positive and negative benefits. Thus, this might be considered a limitation as it may be perceived as ‘leading’ the participant.

**Statements by participants from CIT**

One participant, who was certified in reflexology, discussed how she felt when she was able to offer comfort to someone in distress. She wrote:

I was ecstatic that I had the means to offer comfort and pain relief to someone who was in such distress.

Another participant, who was certified in Healing Touch, also discussed how gratifying it was to be able to offer support to another. She wrote:

Gratifying...to be able to help...without this modality...would have had.....{to} just sit there...offer understanding...support (not to belittle that)...just send her home...gratifying...could do this work in...setting.

She continued to share how the benefits she personally received from using healing touch validated her abilities to help others. She wrote:

Benefits...received...personal validation about...abilities...personal gratification...being able to help someone.

One participant, certified in Healing Touch and Hypnosis and with 32 years of nursing experience, shared how using healing touch provided an opportunity to be present with a client and family. She wrote:

As nurses, we are often placed in situations when “there is nothing that can be done”...can be very draining...with healing touch...ability to simply be present with a patient and family...there is an acceptance that you are being “worked through”, instead of energy being “pulled from”...instead of being drained by this
emotional situation, by using healing touch…it was an uplifting and gratifying experience (yet again).

This same participant discussed how she used this modality during the dying process with a client. She wrote:

Geriatric patient in active dying process drifting in and out of terminal restlessness remained at bedside doing healing touch rested comfortably did not need Ativan not responsive could hear everything daughter arrived able to speak to her about how gentle dying process is spoke over bed of joyous times did wonderful life review explained energy field daughter participated in doing ‘chakra spread’ preparing mother for transition SHE OPENED HER EYES clearly said “I want you to go and get some rest. I am fine” her eyes radiated with love and peace she died peacefully two hours after left bedside.

Another participant, who utilizes a variety of integrative therapies, also shared her experience with a client during the dying process. She wrote:

Had patient at end of life wanted badly to make his transition was in small house chaotic kids dogs running wild patient in a prominent position in hospital bed in living room caregivers in conflict sat down with them in presence of very agitated but conscious patient. Did imagery focus on heart center love for patient themselves with each other look deeper into heart see exactly what each needed after each one shared patient calm they better understand patient’s inability to relax was directly related to their conflict patient passed on peacefully within 48 hours.

This same participant continued to share how empowering it was for her and the families she works with during the dying process. She wrote:

Working with families sometimes more important than working with patient when end is imminent needed someone to intervene make environment more conducive to moving forward on journey empowering experience for all of us.

Comparison of Studies
Participants in both studies were similar with respect to age gender (all female) years in nursing and degrees obtained. All participants were representative of AHNA membership. CITs were written in the same style with participants’ statements being crisp and succinct.
Participants addressed the general aim of the CIT scope with highly descriptive and emotional statements. The CIT allowed for a secondary source of highly colorful singular stories by the participants. In each study, participants’ explored a specific critical event with detailed information and specifics. The CIT purposely asked participants’ to ‘reflect’ on an experience which provided an opportunity for retrospective reflection. Additionally, the researchers’ analysis of the CITs validated the interpretations and findings of both studies.

**Conclusion**

The CIT is a straightforward instrument to design, user-friendly and uncomplicated for both researcher and participants. The development of the CIT to generate indicators of specific happenings relative to research questions demonstrates the technique’s suppleness and emphasizes the capability of this methodology in nursing research. As demonstrated by its’ inclusion in two separate studies, CITs provided rich data from participants’ singular happenings. If carefully applied, the CIT seems capable of capitalizing on the participants’ own stories and avoids the loss of information which occurs when complex narratives are reduced to simple descriptive categories. As nurses learn more about this methodology and its application to the study of nurses and nursing care, they will begin to comprehend how simple and effortless this technique is to use. The CIT can be developed to conform to any area of nursing and provide a more comprehensive awareness of what nurses do and the needs of our clients.

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Table 1. Initial CIT Describing Learning from Experience of the Certified Holistic Nurse (Study #1)

Your critical incident will be a part of a study that is exploring learning from experience of the HNC. Of particular interest are experiences that were particularly memorable or outstanding with regards to learning from experience. Please reflect on an experience that impacted the way you practice as an HNC.

1) Think back over your career as an HNC. Describe a memorable experience where you were surprised at your ability (know how) to deal with a challenge of practice. How did you feel prepared to deal with this challenge based on your experience? Where does the ‘surprise’ of your ability to meet the challenge of practice emanate from? Perhaps you reflected “I am surprised that I had known what to do during the situation”. Or perhaps you reflected “Where and how did I learn what I needed to know to meet the challenge of practice?

- When did the experience occur?
- How long had you been practicing as an HNC?
- Who was involved in the experience (titles, not names please)?
- Where did the experience occur (in a clinical setting, learning on your own, in a formal educational setting)?
- How did this experience influence your level of competency as a practicing HNC? How did it impact the way in which you practice?
- How have you incorporated this knowing into your practice?
- How has this experience been an experience of learning?

Please be specific and detailed in your description of the learning from experience including your feelings and thoughts about it at the time and later. Please address how this learning from experience influenced your level of competency as a HNC, how do you think, feel, act as a result of this experience? How has this experience impacted your practice?

Table 2. Revised CIT Describing Learning from Experience of the Certified Holistic Nurse (Study #1)

Please think of an important event in your career. Please reflect on how this experience affected you in your practice as an HNC. Please describe this incident.

How would you describe the key lessons you learned from this experience?

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Completion of nursing degree programmes – does the gain exceed the pain?

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Background and context
Nursing is central to effective health service delivery and nurses must be prepared through education to meet societies changing needs and enable people to achieve an optimum state of health. The acquisition of increased knowledge, skills and attitudinal change as a result of undertaking nursing degree studies and their subsequent translation into practice cannot be assumed (Francke et al, 1995). A literature review suggests that nursing practice is positively affected by nurses completion of degree studies (Spencer, 2006; Wildman et al, 1999). Higher education in nursing is associated with improved patient care, enhanced critical thinking and increased autonomy in practice. However there is a lack of consistency between studies with some studies identifying barriers to the incorporation of learning into practice and negative impacts of higher education. The impact of degrees for nurses, merits examination in view of nurses’ increasingly demanding roles, the recent establishment of nursing in Ireland as a degree-based profession and the recent growth in post-registration degrees for registered nurses. Furthermore, there is as a paucity of research exploring the impact of higher education on nurses and nursing in the Irish context.

Aim
This research study was conducted to determine nurses’ attitudes on the personal and professional impact of having attained a degree in a nursing related discipline.

Methodology
The research design was a descriptive quantitative survey using a self-report questionnaire which was adapted from that used by Whyte et al (2000). A convenience sample was recruited which consisted of 88 clinical and non clinical nurses who worked in different specialities in two hospitals. The response rate was 63%.
Each study participant had successfully completed a degree at level 8 or 9 of the national qualification framework (National Qualification Authority of Ireland, 2003).

**Analysis**
Data was analysed employing descriptive and inferential statistics using SPSS.

**Findings**
This study supports the value and function of degree studies in the empowerment of nurses’ careers, preparation of nurses for practice, the procurement of promotion and the improvement of practice and enhancement of patient care. This study also identified barriers to nurses’ pursuit of degree studies and nurses translation of new knowledge, skills and attitudes into practice.
A Comparative Study Exploring The Attitudes Of Doctors And Nurses Towards Hand-Hygiene And Alcohol-Based Hand-Rubs

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Background and Context:
Hospital-acquired infections place an enormous burden on the health service. Hands readily transmit cross-infection. Hand-hygiene substantially reduces the risk of cross-infection within the health-service. Attitudes, behaviours, poor compliance and barriers exist towards hand-hygiene. Alcohol-based hand-rubs, however, counteract this problem. They are quick, effective and user-friendly.

Aim:
The aim of this comparative-study is to explore and compare compliance, perceived-behaviours and attitudes and barriers towards hand-hygiene and Alcohol-Based Hand-Rubs between doctors and nurses.

Methodology and analysis:
A quantitative positivist methodology, utilising a cross-sectional design was used. Ethical approval was granted from the participating hospital. Data collection consisted of a validated attitudinal survey comprising of a five-point Likert-scale. This study was conducted in a large, Acute, Irish Teaching hospital. A stratified random sample (N=423) achieved representation of doctors and nurses. Data were analysed descriptively and crosstabulated. Chi-square (Pearson’s) and Mann-Whitney-U statistical tests, using SPSS version 14.0 were conducted.

Outcome:
Several statistically significant differences between doctors and nurses attitudes, behaviours, self-reported compliance and barriers towards hand-hygiene and ABHRs were identified, (p < .05).
Results demonstrated several statistically significant differences, (p<. 05) between doctors and nurses self-reported compliance, perceived-behaviours and attitudes and barriers towards hand-hygiene and Alcohol-Based Hand-Rubs.

**Discussion and Summary of key findings:**
These research findings conflict published hand-hygiene research as several barriers towards using Alcohol-Based Hand-Rubs including dermal tolerance and time factors were evident among Irish Healthcare-professionals. Despite their advantages, only 47% of participants reportedly use Alcohol-Based Hand-Rubs >90% of the time, with noteworthy differences between the professions (p<. 05). Lack of awareness of local, national and international guidelines was especially apparent among doctors. This study suggests that the level of acceptance of Alcohol-Based Hand-Rubs among healthcare-professionals may be a barrier towards the implementation of hand-hygiene recommendations.

**Recommendations:**
To date, there is a paucity of Irish hand-hygiene studies. Internationally there is a dearth of studies, which specifically explore attitudes towards Alcohol-Based Hand-Rubs. The researcher envisages that these research findings will provide a valuable contribution to the existing hand-hygiene evidence base. Further studies are necessary to determine if these findings are evident in other healthcare settings.
Practices for Predicting and Preventing Preterm Birth; A National Survey.

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Introduction: Preterm birth, defined as birth before 37 completed week’s gestation, is a major cause of neonatal mortality and morbidity and continues to pose a major challenge in current maternity care.

Objectives: To describe and critically analyse practices for predicting and preventing preterm birth in Ireland and to compare these practices with the empirical evidence base, international practices and best practice recommendations.

Design: A quantitative descriptive survey design.

Participants: All consultant obstetricians practising obstetrics in Ireland at the time of the survey.

Results: The overall response rate to the survey was 68% \((n = 68/100)\). Results were categorised into two groups; women symptomatic for preterm birth and women asymptomatic for preterm birth. For predicting preterm birth; 97% and 97% of respondents did not use fetal fibronectin testing, 71% and 29% carried out routine 2\(^{nd}\) and 3\(^{rd}\) trimester cervical assessments, and 75% and 44% routinely screened for genital tract infection. For preventing preterm birth; 62% and 1% prescribed bed rest and 24% and 1% prescribed antibiotics. In women with a history of one or more mid-trimester miscarriages (15-22 weeks gestation) 14% of respondents routinely inserted a cervical cerclage. Tocolytic therapy was routinely used by 61% of respondents for preventing preterm birth in women symptomatic for preterm birth. The most common tocolytic agent administered was atosiban (35%).

Conclusions: The findings of this survey, for the most part, reflect the empirical evidence-base, international practices and best practice recommendations. There are, however, a number of practices that do not reflect the empirical evidence base and these
require review. To effectively manage the ongoing problem of preterm birth consultant obstetricians in Ireland must keep abreast of research based evidence and best practice recommendations.
Ties of Affection

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ABSTRACT

Key Words - Affection; Bonding; Mother; Fectus

Introduction

Lately, a considerable change happened in the way we face the abilities of the newborn: from a vulnerable being to the environmental conditions, immature and defenseless in all aspects, he turns to be seen as able of having behavioural competencies that allows him to have an active interaction inside and outside the uterine body.

The conception and the pregnancy unchain in the future mother an authentic psychosomatic "revolution": as much as in her body as in her psychic functioning suffers deep modifications and adaptations, all of them necessary to accept the baby and promote his development.
Aims

- To promote the optimization in fetus development;
- To develop the abilities of the fetus/new born;
- To provide a better quality of life and wellbeing in the Uterus;
- To sensitize the health professionals for the advantages of the early relationship in pregnancy.

BRAZELTON and CRAMER (1989; p: 24-30) enhance that, for the woman, the desire to have a child is based on several presumptions:

- Identification – that comes from the fact that all women lived the experience of having a mother and as much as they develop their autonomy, they assume maternal views, through modeling similar to the women who are close to them.

- The desire of being complete and omnipotent – that is part of a narcissistic desire and that is expressed in the psychic life through fantasies. Thus, the desire of the woman to become complete, to feel her productive and powerful body, annulling any concern about body imperfection. As BRAZELTON (1986, p: 26) states "the narcissistic desire of completing ourselves through a child is more differentiated: the mother starts facing the desired child as an extension of her body, conferring her an increased image that she can exhibit with pride".

- The desire of fusion and union with the other –that consists in the fantasy of symbiosis, the union with the child and simultaneously, in the desire that the birth, the development and the maintenance of these attitudes of bonding are dependent on the ability that the woman had to regain these union fantasies with her mother.

- The desire of seeing herself in her child – being also a narcissistic dimension, attempts to love the reproduced image, with a feeling of immortality. BRAZELTON (1989, p: 26) tells us that "... this desire extends to the familiar tradition and ideals, the child represents a promise of continuity, the corporization of these values".

- Accomplishment of ideas and lost opportunities – refers to the feeling that the parents have in the sense that their child will be well succeeded precisely in the aspects in which they failed or they had not obtained successes. There is a chance of modifying the situations, since the child represents the ideal of perfection. The future child, besides being an extension of the mother’s body
is also an extension of the grandiose image that the mother posses of herself. The child, fruit of her fantasy, has to be perfect and realize all the underlying desires of the parents.

- The desire to renew old relationships – therefore the child is seen as a potential, able to renew lost ties and affection of infancy, what happens when a child seems to substitute a brother, a father or an already deceased friend. Thus, this child seems to have magical powers, in the sense that faces the power of remaking old relationships, to deny the passage of time and the pain provoked by death and disappearance. It seems like transference of feelings and unconscious relationships from the parents to the child.

**Conclusions**

The mother possesses communicative abilities that allow her to answer adequately to her baby, and it is undeniable that the newborn possesses, also, a precocious ability to actively relate with the environment, controlling his own behaviour and the one of his mother. These "abilities" are complementary, establishing between them a transactional and evaluative dialectics being specific of each diade.

More and more, the father has an active role being requested to emotionally support his mate in the pregnancy and after childbirth, and, today, the beneficial effect of this afecional support to the mother and the fetus are recognized, as well as the increasing acceptance of the pregnancy and the baby, more positive experiences of the childbirth and greater availability for the maternal breast-feeding. The father must be present in the pre and pos natal appointments.

The consistency and the constancy of parental care to the child, the adjusted interaction parent-child and the safe bonding of the child to the parents are crucial factors for the psychic and social development of the child, with repercussions through all her life cycle.

When a baby is born, a mother and a father are also born.

The health professionals, through the knowledge they withhold, constitute a pillar of reference to the parents who look for help in the process of adaptation to their real child. Their capacity to involve the parents in the nursing care during pregnancy, in conjunction with the inherent abilities due to their profession, are an added value to help the parents to establish the bonding process.
References


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Simulated practice learning: to do or not to do: that is the question

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Introduction
The demand for clinical placements for nursing students is increasing exponentially. At the same time the rapid turnover of qualified staff within the NHS continues to gather pace which has the potential to diminish the quality of mentorship and supervision of students in practice. The effects of these phenomena have led to a debate surrounding the efficacy and effectiveness of simulated practice learning, driven in part by Higher Education Institutions (HEIs) providing undergraduate nursing programmes and by providers of clinical placements in both primary and secondary care settings. In light of this the Nursing and Midwifery Council (NMC) called on Schools of Nursing and Midwifery to bid for pilot projects with a view to developing standards for the use of simulation for up to 10% of programme practice hours. The standards were to be piloted across a number of programme providers, with the Council of Deans and other stakeholders involved with the NMC in developing and piloting the standards. This paper describes the
implementation and evaluation of one NMC simulated practice learning project undertaken with a cohort of first year Diploma in Higher Education (Dip HE) nursing students.

**Background**

In July 2006 the NMC, UK regulator for 682,000 nurses, midwives and specialist public health nursing working in the UK, announced a pilot project aimed at identifying a UK wide baseline standard for simulated learning as part of practice learning. In order to inform new standards for skills laboratories and other forms of simulated learning thirteen pilot sites drawn from NMC approved universities and HEIs in the UK were charged with the task of organising and delivering teaching through simulation using up to seven days of practice time taken out of current pre-registration curriculum. The express intention was to collect data regarding what needs to be in place to ensure simulation enhances practice learning with particular emphasis on safe and effective practice. Pilot Projects, were chosen to capture a broad range of simulation approaches from those using well equipped skills facilities replicating practice settings to those using less sophisticated approaches using role play, commenced in September 2006 for a period of three months and was reported to the NMC in June 2007. The NMC are currently collating the reports and deliberating the response, but at a feedback session in September this year reported that the "Findings are overwhelmingly positive and suggest strongly that simulated learning offers students opportunities which are not possible in the clinical setting and helps students achieve clinical learning outcomes” (NMC, 2007)

**Methodology**

The students were located in the first year Common Foundation Programme (CFP) and as such were taught together for the first two semesters of the course irrespective of chosen pathway of nursing, i.e. adult, children’s, learning disability, and mental health. The project, which commenced in semester three, consisted of an introductory day, followed by a series of activity days in which the cohort of 160 students were divided into mixed pathway groups. A final group evaluation day completed the project. Each activity day consisted of scenario-based activities utilizing patient simulators and academic and clinical practitioners as facilitators. Experienced patient simulators were used and all facilitators attended a workshop designed to support the use of simulation as a learning tool for use with nursing students. The scenarios covered aspects of nursing care required by adults, children, clients with learning disabilities, and clients with mental health issues. All students, irrespective of their chosen branch of nursing would, by the end of
the project, have had an opportunity to experience each case scenario, to engage with role play, observe and participate in relevant clinical skills, engage with discussion centered on the scenario, and receive feedback on their performance.

Central to the project was a philosophy of supporting the student’s learning within a controlled and safe environment. With respect to the importance of respecting the student’s view on engaging with simulation activities, whether positive or negative, students were advised that should they wish to abstain from engagement in simulated activities, they could do so without compromising learning. However, it was deemed important to engage students as far as possible in all aspects of the experience on offer, in order that first, students could receive maximum benefit from each activity day, and second, in order to ensure validity within project evaluation.

The evaluation strategy consisted of a pre-project questionnaire, which aimed to capture the students’ initial thoughts regarding the concept of simulated practice learning. Students completed this questionnaire immediately after the launch day presentation in which the background to and aims of the NMC project were explained, followed by explanation of the project in our School. It is possible that students began to form their opinions based on the launch day information and therefore the validity of the data is open to question in that all project information was presented in a positive fashion. However, it was felt important that students had at least a rudimentary understanding of the concept of simulated practice learning and that not do so would have rendered any data unreliable given the fact that students may have misunderstood or misinterpreted the concept. The initial questionnaire was replicated and administered to the students at the end of the final evaluation day in order to complete the capture of pre and post project data. Students were asked to identify themselves by personal number (p number) in order to match the pre and post questionnaire as a means of evaluating any attitudinal shift, whether positive or negative, in a student’s feelings regarding simulated practice learning. An additional questionnaire was administered to all students at the end of each activity day. By wording the questions specifically to the activities undertaken and how they enable the achievement of programme outcomes it is possible to attribute any attitudinal shift regarding simulated practice learning to the experiences undertaken during the project.

It is important to recognize the value and place within evaluation, of qualitative data. To this end, a final evaluation exercise was undertaken with the students using nominal group technique (Macphail, 2001) in order to capture qualitative data from a large
number of students (n=163). Focus group interviews are planned with patient simulators, facilitators, and practice colleagues to complete the qualitative data set.

**Nominal Group Technique**

All 145 students in the cohort were invited to an evaluation day, which included an overall summary of the project, the perspective of the Simulated Patient Unit (SPU) and a modified version of a nominal group technique (NGT). NGT is a method of collecting large amounts of data in a relatively short period of time, and has been utilised for educational purposes previously (Macphail, 2001). The evaluation day commenced in a lecture theatre with the entire cohort together, and following this smaller rooms were made available for students to remain in the mixed-discipline groups that had completed the project to undertake the first part of the NGT.

Facilitators of the NGT met before the event to ensure that a uniform approach was maintained, and that all materials used were constant. Eight mixed groups, of approximately 18 students, worked simultaneously in different rooms on the campus. Each student was asked to pick a seat of their own choice and to work independently for the period of the NGT. Students were all given a pre-printed A4 sheet with the following statement:

> “The NMC are considering whether to replace up to 10% of practice learning with simulated practice.”

The following instructions were additionally printed on these sheets:
- Please write all your responses to this statement below.
- Please do not discuss this statement with your colleagues. We are interested in your individual response.

Once students had written all of their responses to the NMC statement, they were asked to identify their own top five priorities and rank them from 1 to 5, with 1 being the most important. Each student was then given five Post-It notes and asked to write one of their priorities on each Post-It and to number them according to their rank priority. Flip chart paper was made available in each room, separately numbered from 1 to 5. Students were then asked to post their Post-Its’ onto the corresponding sheet of flip chart paper.

All responses were then collated according to the ranking that students had identified. All rank 1 response flip charts were collected together and typed-up onto a single Word file. Simultaneously, all other ranked responses were collected together and quickly typed-up. The resulting five files were amalgamated.
into one *Word* document, which clearly identified which rank the responses corresponded to. The final document was a fourteen page file, which was then photocopied for each student in the cohort. This activity, of collating, typing and eventually photocopying all student responses occurred during the lunch-break of the evaluation day.

Students reassembled in lecture theatre and were given a copy of the final document. Working independently, students were asked to choose their top five most important responses from each set of responses. So, for all of the responses within response 1, they were asked to identify the five most important features and rank from 1 to 5, with 1 being the most important, and 5 being the least important. The final documents were collected for analysis. These data were analysed from a qualitative perspective, using content analysis and quantitatively by ranking. The results of quantitative analysis are presented below.

**Findings**

**Quantitative data**

From the first phase, within small groups, the following numbers of responses were obtained for each category:

- Rank 1 responses: 46
- Rank 2 responses: 129
- Rank 3 responses: 144
- Rank 4 responses: 138
- Rank 5 responses: 56

From the second phase, where all students re-grouped in the lecture theatre, 129 response sheets were completed. There are some anomalies in the quantitative data: the number of responses in each category which is not uniform, and the number of students who participated in the morning session is greater than the number that completed the final NGT document. The former is because the typing of the first-phase responses from *Post-It* notes was undertaken by different members of staff, some of whom merged responses thematically, while some did not; the letter is because there was some attrition between the morning and afternoon sessions.

Although there was a large spread of responses within each category, the top ten ranked items (within each category) have been selected for presentation here.

**Rank 1 responses (n = 46)**
The table below shows the top responses from the category 1 responses. The column on the left shows the overall rank of the statement within the category, the middle column shows the both the student response (text) and the numbers reflect how individual students ranked that statement. The right-hand column illustrates the number of students who ranked that statement. Data for all categories are presented in this format.

Table 1: Rank 1 responses

<table>
<thead>
<tr>
<th>Rank</th>
<th>Statement</th>
<th>No of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Useful to learn about some clinical skills that many people had not had the opportunity to practice</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>Allows you to evaluate correct and improve your faults before practicing on the patient</td>
<td>28</td>
</tr>
<tr>
<td>3</td>
<td>Think it would be better during rotations not instead of practice</td>
<td>27</td>
</tr>
<tr>
<td>4</td>
<td>Good project as it gives students a safe environment for clinical practice skills</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>Its good to develop your confidence e.g. urine sampling, BMs, vital signs</td>
<td>24</td>
</tr>
<tr>
<td>6</td>
<td>Develops communication skills in a safe environment</td>
<td>23</td>
</tr>
<tr>
<td>7</td>
<td>Simulation is a good and safe way to learn new skills, communication and interventions</td>
<td>23</td>
</tr>
<tr>
<td>8</td>
<td>Smaller groups would have been better, people were too nervous to speak and take part in the group the size it was</td>
<td>22</td>
</tr>
<tr>
<td>9</td>
<td>Beneficial if at start of course</td>
<td>22</td>
</tr>
<tr>
<td>10</td>
<td>Confidence for students prior to placement</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 1 therefore represents the most important responses from students. The spread of students highlighting individual responses was from 32 to 0, with only one response not being marked by any students, and only one response marked by one student. Overwhelmingly, the responses in the top ten ranks of this category are very positive; ranks 3 and 8 are not negative, but reflect
comments that were consistently heard from students that the project would have been more helpful earlier in their training and before the alternative experiences in other branch placements. Interestingly, of the 32 students who ranked the statement about clinical skill, nearly half of them (14) additionally ranked this statement as number 1. Indeed, the benefits of learning clinical skills in this manner are highlighted in statements ranked 1, 4, 5, 6 and 7. Furthermore, for all of these statements relatively high numbers of students have allocated high rankings to them.

**Rank 2 responses (n = 129)**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Statement</th>
<th>No of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The simulation can give you ideas and how to start conversations with patients or how to put patients at ease or how to explain procedures to patients</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>1 2 1 4 2 1 1 1 2 1 2 3 1 2 1 2 4 3 2 3 1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Chance to ask questions, talk about concerns, reflect on your own practice safely without being judged</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>2 2 2 1 4 1 1 3 2 3 1 5 2 4 3 2 4 3 2 2 1 1 3 5 3</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Good learning experience, when mistakes can be made and lessons learnt on how to improve these mistakes</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>1 4 5 5 1 4 1 5 2 2 4 2 4 5 1 2 2 4 2 4 3 1 3 4 3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Prefer to learn from real experience</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>1 2 1 5 1 1 2 1 2 3 4 1 1 2 1 4 1 1 2 3 2 1</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A great way to learn how other students would tackle a certain situation in a simulated clinical setting</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>3 3 4 2 3 2 3 3 2 3 5 3 4 3 5 1 4</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Practice simulation could be a good idea especially for those students with no previous experience</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>3 1 1 2 4 2 3 3 1 1 1 4 2 5 1 4 1 1</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I think simulated practice has its limitations as I found it impossible to act the same in simulations as I would do in real practice</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>1 3 1 3 3 3 2 4 1 3 4 3 2 4 1 4</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Simulators are not ill patients so it is difficult to interact with them</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>1 1 5 3 3 5 2 2 4 1 2 1 1</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>More beneficial than workbooks</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>3 5 5 3 5 4 4 3 5 1 3 3 4</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>It was beneficial as you were able to observe how others interacted with a simulator</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>2 2 2 4 4 3 1 2 3 2 4 2</td>
<td></td>
</tr>
</tbody>
</table>

For category 2 responses, there was a greater spread, ranging from 25 responses to 0, with twelve responses not being highlighted by any students, and twenty-four responses being marked by singular
students. Many of the highest ranking statements were also positive. Table 2 shows the top ten statements, seven of which are clearly positive. Statements ranked 4, 7 and 8 do have a negative tone, but really emphasise the difference between simulated learning and practice experiences, with the benefits of practice and “real patients” being made clear. However, all other top responses were very positive in terms of communication skills (rank 1) and reflecting on one’s own development (rank 2, 3, 5, 10). As with category 1, of the 25 students who identified the highest ranking statement (starting conversations) nearly half (12) had additionally identified this as their most important statement within the category.

**Rank 3 responses (n =144)**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Statement</th>
<th>No of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Practice simulation teaches you importance of using effective communication skills when nursing adult, child, mental health and learning disabilities, which is beneficial to all branch areas</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>A good way of interacting with other students on the same level and getting to know that you are not alone</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>Gain confidence in going out onto the wards and know what to expect</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>I did enjoy the practical side of the simulation, problem solving and team working was the best key to enjoying the activities</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>Doing care planning, basic obs was a positive learning experience</td>
<td>14</td>
</tr>
<tr>
<td>6</td>
<td>Unrealistic to the actual working environment</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>The simulation can help you to be critical of your actions. Its easier to see where you go wrong and where you can improve</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>The different scenarios are a good idea, as it will help people when they come into contact with different client groups</td>
<td>13</td>
</tr>
<tr>
<td>9</td>
<td>Simulation was sometimes irrelevant to my branch programme and so certain parts were quite boring</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>It would have been of some use before the rotations as we would have had some experience of other branches first</td>
<td>12</td>
</tr>
</tbody>
</table>
With the largest number of responses, category 3 inevitably had the greatest spread, ranging from 24 to 0 students, with sixteen responses not being marked by any students, and twenty-seven responses being only marked by individual students. The majority (of the highest ranking) category 3 responses were positive, with only statements ranked 6 and 8 being negative. Surprisingly, for the category with the largest number of responses (144), the statement ranked highest (benefit to all branches) was ranked by 24 students, with 8 ranking it highest in the category. The variety of activities, and the fact that simulations representing all branches were incorporated into the project, (ranks 1, 2, 4, 8) featured highly within this category, although this appeared of little relevance to twelve students (rank 9), where this was rated most important for his category.

### Rank 4 responses (n = 138)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Statement</th>
<th>No of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Allowed for opportunities for skills practice that might not be available whilst on placement 5 1 1 2 2 1 2 5 2 1 2 1 1 4 1 1</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>Takes you away from your placement which means you would be missing vital patient care with your patients 2 1 2 2 1 2 2 4 5 3 4 2 2 4 5</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>Would probably benefit students in first year that haven't been on placement / done workbooks 3 1 2 1 1 3 3 1 3 3 5 2 4 1 2</td>
<td>16</td>
</tr>
<tr>
<td>4</td>
<td>I think simulation provides a good opportunity to learn from others 1 3 3 1 1 1 1 1 4 1 5 1 1 1 1</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>Helped give more confidence when dealing with real patients and relatives 2 2 1 3 2 1 2 5 2 2 3 2 2 2 3</td>
<td>15</td>
</tr>
<tr>
<td>6</td>
<td>Could make students feel a little more confident about different nursing situations 3 1 1 4 3 1 4 5 5 5 1 3 1</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>Real life experiences are more beneficial than role playing and staged scenarios 1 1 1 1 1 1 2 1 2 1 3 1 1</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>Should have done the simulation before our short placements we did 5 4 3 4 4 2 3 5 3 4 1 2 2</td>
<td>13</td>
</tr>
<tr>
<td>9</td>
<td>I feel that there is only so much you can practice on a simulated ward whereas what you could learn on the ward (as most of us did on these NMC days were things we did everyday on the ward) 4 4 4 2 2 5 5 3 3 2 3 5</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>It should be done before the rotations 2 3 3 3 1 4 2 2 4 3 1 2</td>
<td>12</td>
</tr>
</tbody>
</table>
The range of student responses to the statements in category 4 was from seventeen to zero, with twenty-two students not responding to certain statements, and fourteen responses being highlighting by individual students. A number of negative responses were noted in this category, particularly relating to time away from clinical placements (ranks 2, 7 and 9) that simulation activity involved. This is most readily identified in response rank 2, where sixteen students agreed that the activity “...you would miss vital patient care...”, or response 7, where thirteen students agreed that “real life experiences are more beneficial...”. However, there were also some very positive responses, e.g. rank 1, where seventeen students acknowledged that simulation allowed “... opportunities for skills practice...” or ranks 5 and 6 students highlight that the project increased their confidence in situations.

### Rank 5 responses (n = 56)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Statement</th>
<th>No of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Students should be given the choice to attend simulation or practice</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>2 4 1 1 5 2 1 2 3 3 1 4 1 1 1 1 3 3 1 1 1 1 2 2 1 3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Good for students starting the course</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>5 5 1 1 4 5 1 1 2 5 4 4 1 5 5 1 5 1 1 3 1 5 1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Opportunities to ask mentors and staff anything you are unsure about</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>5 4 4 5 5 5 4 5 4 3 5 3 5 5 2 3 5 5 3 5 4 2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Students need more hours not less in the clinical situation</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>5 2 4 1 5 5 2 1 5 4 4 1 4 5 5 4 4 5 1 5</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Gave a chance to learn from other people</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>1 1 1 5 4 2 3 1 3 1 2 3 1 5 5 5 1 4 3</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Clinical skills experience was good</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>3 5 2 2 2 2 1 2 3 1 2 3 5 2 2 2 3 3 3</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Too late in the year, earlier i.e. first three months would have been</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>better</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 2 2 1 5 2 1 1 1 4 4 3 2 5 2 1 2</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I would prefer to be on a placement</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>3 2 2 3 1 4 3 4 5 3 5 1 5 5 3 4</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Some people felt uncomfortable with role play</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>5 4 2 2 3 2 1 3 2 1 3 3 3 2 4</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Simulations got better the more familiar we were with colleagues</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>4 3 4 3 4 5 3 2 2 3 3 4 2 4 4</td>
<td></td>
</tr>
</tbody>
</table>

The final category had a limited range of responses from twenty-seven to zero, with only one response not being highlighted by any students, and no responses being marked by individual students. Two students highlighted one response, and three students ranked three separate responses, therefore giving a much more compacted
spread than other categories. The majority of responses in this category were negative (responses ranked 1, 4, 7, 8, 9). However, this can be viewed from a number of perspectives; students appeared uncomfortable with simulation (rank 9), that they felt this should be optional (rank 1), or that they would prefer to be in clinical practice (ranks 4 and 8). Interestingly, of the 27 students (rank 1) who highlighted that this should be optional, thirteen ranked this as their most important priority within this category. The timing of the simulated activity additionally seems important; seventeen students (rank 7) highlight that the project should have been in the first three months of their nurse education. Of the more positive responses within this category, twenty-two (rank 3) acknowledged that this was a good opportunity to explore with staff/mentors issues that they were unsure about, and nineteen (rank 6) highlighted the importance of the clinical skills experience.

Discussion
The nominal group data presented here represents only one component of the evaluation strategy of the NMC Simulation in Practice Project at the School of Nursing and Midwifery at DMU. As a methodological tool this has proved extremely valuable for collecting a large amount of qualitative data in a short period of time, which would have proved difficult using other methods within this timeframe. In so doing, key issues surrounding the application of simulated learning in nurse education were identified. The experience of our CFP students broadly reflects the findings of other HEIs undertaking simultaneous pilot projects (NMC, 2007). The NMC will give further guidance in due course about the development of simulated learning within nursing curricula, but this project would seem to indicate that simulated learning can play an important role in helping students to achieve practice outcomes. Certainly many of the students in our project were able to identify the benefits of simulated practice in providing a safe environment to practice clinical skills.

Acknowledgements
We would like to thank our practice and educational colleagues who helped to make this project successful.

References:

A Survey of Nurses’ Knowledge and Attitudes Regarding Paediatric Pain Assessment and Management: An Irish Perspective.

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Aim  
The aim of this research study was to explore registered nurses knowledge and attitudes regarding paediatric pain assessment and management.

Design and Methods  
A quantitative descriptive survey was employed. Using a simple random sample strategy, 292 registered nurses, from a variety of units in a children’s hospital in the Republic of Ireland were invited to participate in this study. Ethical approval was granted from The Faculty of Health Sciences, Trinity College Dublin and from the participating hospital. The Paediatric Nurses Knowledge and Attitude Survey (PNKAS) regarding pain, a self report questionnaire was utilised to collect data. Tool is a statistically reliable: Test-retest $r = 0.859$ and Cronbach alpha 0.708. A response rate of 60% ($n = 174$) was achieved.

Data Analysis  
The Statistical Package for Social Sciences (SPSS) version 12 was employed to analysis quantitative and open questions were analysed by thematic content analysis. Descriptive and inferential statistics i.e. Chi-square, Independent Sample t-test, Analysis of Variance (ANOVA) and Kruskal-Wallis tests were performed to examine differences between groups.

Results  
Total mean score on the PNKAS scale was 62%. Majority of nurses scored < 80%, which has been identified as a satisfactory level for practice standards. Nurses had knowledge deficits particularly in regard to pharmacology pharmacokinetics and non-pharmacological interventions and especially opiates i.e. the incidence of respiratory depression and risk of addiction. No differences were demonstrated
between nurses’ age, nursing experience, years of paediatric experience, nursing grade and having pain education during hospital orientation on the mean PNKAS score. A statistically significant difference ($p<=$0.001) of moderate to large effect was demonstrated between nurses whose main qualification was RCN compared to RGN on the mean PNKAS score. Also between nurses who worked in different specialities on the mean PNKAS score ($p=0.003$). Nurses who had received pain education within the previous two years demonstrated a positive difference ($p=0.003$) on the total PNKAS scale.

**Implications for Practice**

Findings support concerns regarding unsatisfactory pain management attitudes and knowledge in nurses. RCN qualification and continuing education, including nurses area of expertise had a positive influence on nurses’ knowledge. There is a need for intensive continuing education for nurses regarding pain management and special consideration in relation to non paediatric qualified nurses. Education is needed in: pain assessment, including self report; pharmacology and pharmacokinetics of analgesia especially in relation to opiates to dispel fears and non-pharmacological interventions. Educational strategies i.e. problem based learning and reflection should also be considered.

**References**


Multicultural Ireland: Lessons to be learned from the experience of the Irish in Britain.

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Ireland has changed from a society of mass emigration to one with significant immigration from different parts of the world. While there are valiant attempts to address this challenge, health authorities geared towards a predominantly homogeneous population struggle to provide for people from diverse religious and cultural backgrounds. There are many lessons which can be learned from the experience of Irish migrants in Britain. Drawing upon theories of acculturation, relative deprivation and psychosocial stress, highlights the relationship between migration, discrimination, deprivation and health (Tilki 2003). These lessons are highly applicable to new communities in Ireland, illuminating the justification for damaging health behaviours, coping strategies and barriers to health care. As such they have implications for policy, practice and health promotion in an increasingly multicultural society.

While the Irish in Britain experience considerable health and social disadvantage, they also constitute a highly resilient, resourceful and self-reliant community. The self-reliance of Irish (and other disadvantaged groups) reflects inadequate, inaccessible or insensitive services, but is also an expedient, dignified approach to managing in an uncertain environment (Tilki 2003). It is easy to problematise migrants or refugees and neglect their capabilities, tenacity and determination. Notwithstanding the problems that exist, it is health –promoting in itself to capture abilities, energies and strengths, to harness and nurture them in empowering ways.

There are many similarities between the experience of Irish migrants in Britain and new migrants to Ireland. Significant opportunities exist to reinforce the skills, expertise and determination of new communities, engaging them and affording integration for the good of the whole community. The relationship
between smoking, alcohol and substance use in a new and strange environment must be considered. The relevance of religious beliefs and practices in maintaining wellbeing and health and recovering from illness and their relationship to social integration cannot be underestimated. Maintaining a positive ethnic identity through links with home and Irish culture has enabled Irish migrants deal with the harshness of their lives in Britain over many decades. It is equally important that contemporary migrants to Ireland feel able to value and maintain their own heritage while learning the culture of the wider Irish community.

Childbirth in Exile: Refugee and Asylum Seeking Women’s Experience of Childbirth in Ireland

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Focus of Presentation:
Draws from the research findings and the reflexivity of the researcher to highlight the vulnerabilities of the participants as they struggle to articulate and present their experience of childbirth within a foreign culture.

Background and literature
The experience of giving birth is greatly affected and predetermined by the culture in which a woman has been socialised (Steinberg 1996). For women, displaced from their country and culture, it is even more crucial that they experience care during childbirth that is sensitive to their needs. Immigration and asylum seeking have become important social phenomena in Ireland since the mid 1990s. Whilst a number of research studies have been commissioned to investigate the needs of refugees and asylum seekers in Ireland (Begley, et al. 1991; Fanning, et al. 2000; Kennedy and Murphy-Lawless, 2003; Visser and O’Connor, 2004), much of the focus of these studies tended to be on practical needs such as accommodation, housing and lack of income. More importantly, the voice of the women themselves is largely absent from the published reports.

Aims:
To explore the physical, emotional and social experiences of refugee and asylum seeking women during pregnancy and childbirth in Ireland.
To make these experiences visible through the inclusion of the voice of refugee and asylum seeking women.

Methodology
A qualitative descriptive approach drawing from a feminist paradigm, allowed for the inclusion of the women’s voice. Participants were drawn from women attending two maternity hospitals in Ireland. Women participated in an exploratory workshop prior to data collection to ensure collaboration in the proposed study design and data collection methods. Data were collected through in-depth semi-structured interviews. Data analysis utilised manual data analysis and the use of NUDIST computer software.
Ethical approval
Granted by Trinity College, Dublin, The Rotunda Hospital Dublin and the North Eastern Health Service Executive.

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Translating Best Practices in Non-Drug Enhancements for Postoperative Pain Management in a Magnet Community Hospital

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ABSTRACT

The Agency for Healthcare Quality Research (AHRQ) cites the under-use of non-drug methods for pain management as among the top twenty-five issues in patient safety in acute care hospitals in the United States. Using a six-step collaborative research utilization model conceived by Dr. Marlene Dufault, this pilot project sought to determine the efficacy of complementary non-drug methods in reducing postoperative pain in older patients. The primary purposes of the study were twofold: a) to explore changes in subjects’ knowledge, attitudes, and abilities to use a tailored teaching intervention on three best practice protocols for music, massage, and self-guided imagery for postoperative pain management, and b) to determine how frequently subjects’ used these non-drug measures over the day of surgery and the first three days of their postoperative stay. A secondary purpose was to describe subjects’ level of satisfaction with using the non-drug measures as part of their overall pain management plan. The Collaborative Research Utilization Model, built on Roger’s Theory of the Diffusion of Innovation, framed the study. Additional theories related to pain management, information coping, reasoning, and planned behavior supported the study.

The data collection site was a 148-bed urban community Magnet hospital in a coastal Northeast town in the United States. A 2-group, quasi-experimental, pre-test-post-test design was used with a convenience sample of 137 adults, aged 50 and older, and undergoing joint replacement surgery requiring a minimum 3-day postoperative hospital stay. Data were collected using several instruments, including the Miller Behavioral Style Scale, the Non-Drug Complementary Pain Interventions Survey, the Use of Non-Drug Complementary Pain Interventions Form, a modified version of the Brief Pain Inventory and the Complementary Chart Audit instrument. Descriptive statistics and ANCOVA were applied to analyze the data. Results showed significant changes in subjects’ pain intensity across their hospital stay, a decrease in the effect of
pain on functional abilities, significant changes in subjects’ knowledge and attitudes following use of the teaching intervention, and increased frequency of use of non-drug measures over the four-day acute care hospital stay. Subjects also reflected that they were satisfied with the non-drug methods they chose as part of their pain management plan. The pilot suggests the CRU model is a useful model for translating research findings into practice, tailored teaching interventions may positively change patient’s knowledge, attitudes, and behaviors related to the use of non-drug measures for postoperative pain control, and the use of complementary pain enhancements was satisfying to this cohort of patients. Further experimental research with other cohorts, in the form of randomized controlled studies, is warranted to determine the true value of integrating these non-drug enhancements into everyday nursing practice.

Interested parties may access the citation below to read a fuller account of and reference list for the research:


Also, feel free to contact me with any questions or interest you may have in collaborating in a trial of this research in your institution. Thank you.
Staff Nurses Experience of Providing Palliative Care for Elderly Patients in Hospital.

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Introduction/Background
The provision of effective terminal care in hospital has been compounded by a number of demographic and health related trends. An increase in the older population, advancements in medical and pharmaceutical technology, socio-economic changes and the dispersing disintegrating family along with a higher percentage of chronic diseases have contributed to an increased proportion of elderly dying in hospital (Institute of Public Health In Ireland, 2001).

Given the increasing older population and a growing recognition that non-malignant diseases require periods of palliation, it is envisioned there will be rising numbers of patients in hospital wards in need of palliative care.

Mc Donnell et al, (2002) claim nurses are the healthcare professionals dying patients have the most contact with. However, a number of studies conducted outside of Ireland reveal there are a number of challenges facing nurses when caring for dying patients in hospital that consequently contribute to an insufficient level of care being provided.

There have been no research studies conducted within the Irish HSE that can support or rebuke the above statement. This has prompted the need for this research to be undertaken.

AIM:
The aim of the study is to gain a deeper understanding of the nurse's experience in providing palliative care to elderly patients in an Irish Hospital.

Study Design:
A qualitative design using the phenomenological approach of Husserl (1931) was chosen to enable the exploration of nurses experience in providing palliative care to elderly patients and to give meaning and insight into those experiences.

Methodology:
Individual, unstructured, tape recorded interviews with N=6 nurses, who had experience of working with dying older people in an acute hospital. The interviews were tape recorded and data analysis was conducted using Colaizzi (1978)
Findings:
Findings revealed some similarities to previous studies:
Several nurses felt ill equipped to fully provide palliative care in hospital due to
1. lack of time and resources
2. Lack of specialist knowledge and education
3. Insufficient medical team support
4. Nurses communicating poorly with the patient and poor communication between members of the multidisciplinary team in relation to diagnosis.

New findings from this study:
Nurses felt that:
1. There is a need for palliative care teams to be more involved in the care of patients with non-malignant, chronic conditions.
2. Families should be listened to and included (if they wish) in the dying process.
3. There is a lack of support in the community care services for patients who wish to die at home.
4. Although religion and spiritual care is a vital factor they were not confident in providing spiritual care for patients who were non-catholic.

Limitations & Strengths:
A limitation was that the experiences highlighted were from Irish catholic female nurses. No men or individuals of a different culture were present in the study.
The main strength of the study is in having given an opportunity for nurses to describe their experiences when caring for elderly dying patients in hospital.

Recommendations for Practice, Education & future Research:
Nurse Educators, Curriculum developers, Heads of department; Clinical Managers and Practitioners must acknowledge and take heed of the above experiences when planning future care for dying elderly patients in hospital and when deciding the educational needs of nurses so that a high standard of palliative care can be delivered. Future research needs to include male nurse’s experiences and those nurses of a different religious background. A review of the current nursing educational curriculum needs to address the issue on whether there is adequate provision given to palliative education pre and post nurse registration.

Conclusion.
Patient and families have most sustained contact during the dying process with nurses. In this study nurses outline several challenges
in caring for dying patients in hospital. The need for education in palliative care and improved clinical support are stressed if the recommended level of palliative care is to be provided to elderly patients in the hospital environment.

This study has added to our knowledge on the provision of palliative care in Ireland and will assist the future direction of education, research and practice in palliative care.

**References:**


Nursing people of a different culture in Ireland

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Background: Over the last 10-15 years there has been a dramatic change in the population of Ireland. Due to strong economic growth, a buoyant economy and universal population migration, Ireland has moved from a monoculture to a multicultural society over a relatively short period of time. Nursing in Ireland has limited experience of caring for people of a different culture.

Aim: The aim of this paper is to discuss the experiences of registered nurses in Ireland, who have nursed patients from different cultures.

Methodology
This research study purposively sampled registered nurses who had nursed people of a different culture within the previous six months. Invitation to participate in the study was through information sessions and fliers. During the semi-structured interviews data were recorded using both audio-tapes and field notes.

Analysis
The data were thematically analysed. Tapes of the individual interview and focus group discussion were listened to by each researcher and then transcribed verbatim, allowing immersion in data. Initially, independent thematic analysis was undertaken by all researchers. Subsequent discussion and reflection on the initial
themes lead to consensus and three themes emerged from the findings.

**Summary of key finding**
The main themes to emerge from the focus group interviews are: dealing with cultural issues at the “coal face”; how to access and use the interpreter service and finally, planning and taking action to improve nursing care for patients from a different culture.

**Conclusions**
A number of recommendations for improving nursing people of different cultures are proposed, namely: promote an ethos of providing culturally competent and culturally safe nursing to patients of another culture; to improve the resources available to nurses; the provision of easier access to formal interpreter services with continuity of interpreters for patients and finally an increase in transcultural nursing education.
Practice Issues for Midwifery Education

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Background and context: The practice issues for midwifery education are fundamental to any midwifery programme. Clinical practice experience is an important part of the development of newly qualified midwives which can be fraught with difficulties. Because of the increased medicalisation of childbirth (Murphy-Lawless 1998, Begley and Devane, 2003), the heavier workload, increased expectations by consumers, the perceived theory practice gap and the increasing climate of litigation in obstetrics in Ireland, clinical practice puts many demands on midwives.

Aim of the Study: The purpose of my study was to explore newly qualified midwives’ lived experience of clinical practice with a view to gaining a deeper understanding of their individual experiences and as a result, to highlight the practice issues which need to be addressed by midwifery educators.

Methodology: The study took place in the maternity department of a large regional university college teaching hospital. A purposive sample of six newly qualified midwives who were willing to share their experiences was selected. A qualitative approach using Heideggerian phenomenology was chosen for this study. Data were collected using formal semi-structured interviews.

Analysis: Analysis and interpretation of the data were achieved using Colaizzi's Analysis Framework.

Summary of Key Findings: The main findings revealed six themes that describe the meaning of clinical practice for newly qualified midwives. These themes were as follows; the importance of good clinical support and mentorship, living up to expectations, dealing with the theory practice gap, need for continuous education, feeling prepared and the reality shock of now being qualified.

Conclusion: This study is very useful in view of the recent changes in midwifery education and highlights the practice issues for newly qualified midwives in clinical practice. Midwifery educators need to address these issues when preparing student midwives for transition to practice.
A Descriptive Survey of Observation Policies within Irish Mental Health Services

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Abstract

Although increased observation is the standard practice for the treatment and management of self-harming and suicidal behavior in in-patient psychiatric facilities, a literature review reveals a dearth of published research regarding the content, use or implementation of observation policies in mental health services. Also implicated in the literature is the impression of observations as an overused, under-researched, under-resourced, poorly implemented, staff-intensive intervention that has no clear correlation with the reduction of risk, their practice is based on custom and tradition rather than research-based evidence. Without research-based evidence on which to base the policies that guide the practice and process of increased observations their content has been found to vary considerably (Bowers et al, 2000). Such information about the content of Irish observation policies is not currently available. Obtaining this information provide the first step towards making suggestions and recommendations for sound evidence-based policy on which training, practice, management and audit of increased observations can be based.

This survey asked if policies relating to the practice of increased observations exist in Irish Mental Health Services, and if so, do the commonalities and variations in the content of these policies give rise to confusion regarding the role and responsibilities of the nurse? To answer this question a self-administered postal questionnaire designed specifically to investigate the content of increased observation policies in the UK (Bowers et al, 2000) was adapted and distributed to 51 Directors of Nursing in Irish mental health services.

This study reports a lower response rate than the original study, however, the overall proportion of total population representation in both studies is equal. Analysis of the characteristics of respondents and non-respondents indicate that the findings of this study can be generalized only to mainstream mental health services. They can
not be applied to the practices and processes of increased observation within the context of Intellectual Disability services or nursing home services.

The findings of this study clearly indicate wide variations and inconsistencies in the local increased observation policies of Irish mental health services. These variations are reflected in practice with little consensus on defining the intervention, the procedures and processes relating to the initiating, modifying and discontinuing increased levels of observation that may contribute to confusion regarding the role and responsibility of nursing staff, and clinical and statistical recording systems. These variations and inconsistencies have serious implications for mental health services users, staff and managers.

The findings of this survey indicate that standardised guidelines are necessary to address inconsistencies in policies and practice, and ultimately to improve patient care and safety.

The Silent Epidemic: Oral Disease in Children

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Oral disease in children continues to be the most prevalent infectious and untreated disease in children in the US and Canada. In the US, 25% of the school-age children suffer 75% of the nation’s tooth decay resulting in approximately 50 million school hours lost per year. These children are typically from economically or socially disadvantaged families or have a disabling condition. Compared to the US, Pennsylvania statistics are worse with only 21% of the children receiving dental services in the year 2000. In addition, children from the poorest families had twice as many dental carries than children from financially stable families. As a nation, the long-range health care implications for poor oral health is concerning. Studies have not only shown a relationship between periodontal disease and systemic conditions such as cardiovascular disease and diabetes mellitus but also an increased risk for very preterm deliveries in mothers with dental disease. The purpose of this study was to improve the dental health in the over 600 children, aged 3 to 5 years of age in low-income families enrolled in the Head Start Program in Westmoreland County, Pennsylvania, USA. Measures for conducting an oral health risk assessment and establishing the “dental home” through anticipatory guidance and education were implemented. For the academic year 2003-2004, 67% of the enrolled children had dental exams with 25% of those children receiving treatment. By the academic year 2005-2006, 83% of the enrolled children received dental exams with 30% of those children receiving further treatment. The project continues with financial support from the American Dental Association in order to provide all members in the household with toothbrushes and dental floss. Ongoing education on proper oral care and the importance of good dental health will be extended to all family members in the forthcoming year.
Community Mental Health Nurse Prescribing: The Results of a Preliminary Study

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Martina Gooney, PhD, BSc(Hons)

Background

An Bord Altranais and the National Council published a final report in 2005 that recommended further use of medication protocols and extension of prescribing authority to nurses. This was followed by the passage of the Irish Medicines Board Act (2006), which gives limited powers of prescribing to nurses who have undergone specialist post-registered training.

Doctors and nurses in mental health services have been criticised for inflexibility in relation to adherence to rigid role boundaries that impede rapid response to patient crises, especially as it affects control of psychotic arousal. A Vision for Change (2006) emphasises a person centred recovery model to operate within the CMHT but has little to say about the breaking down of boundaries. Prescribing authority has the potential to be a source of tension within the CMHT, particularly as this relates to professional boundaries. This paper reports the first stage results of a study of community mental health nurses and issues of team boundaries within a new prescribing context

Aim of the study:

To describe the views of community mental health nurses in Ireland on prescribing authority as this relates to clinical supervision and professional boundaries.

Methodology

A 13 item questionnaire adapted from work by Nolan (2005) was administered to 120 community mental health nurses, with a response 89%. Questions included both closed and open-ended items which were analysed through SPSS v14 using descriptive statistics and category analysis respectively. Qualitative data was analysed for recurring themes and categorized accordingly.

Summary

Analysis of the data identified that whilst many nurses agreed that their knowledge base was sufficient to engage with a prescribing role concerns were expressed about the potential for conflict in relation to communicating prescribing decisions.
**Conclusion**

These preliminary results indicate the need for further exploration within the context of community mental health care in Ireland.
AN INVESTIGATION OF PATTERN MANIFESTATIONS IN SUBSTANCE ABUSE IMPAIRED NURSES

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Substance abuse impairment is a problem in nursing which affects both the profession and society. Many nurses who become impaired are not identified until symptoms are very apparent and patients are at risk. The purposes of this study are to investigate early risk factors that lead to substance abuse impairment, and to predict group membership between impaired (SI) and non-impaired (NSI) registered nurses based on those identified risk factors.

The theoretical framework for this study is a synthesis of Donovan’s multifactorial model of impairment, and Rogers’ Science of Unitary Human Beings. Donovan’s model explains varying patterns of impairment development. Although individuals may have common characteristics, they vary in development, progression, and severity of impairment. There is a dynamic relationship among the many dimensions and manifestations of impairment. Rogers’ model explains concepts of wholeness, patterning, human and environmental fields, and mutual process that occur with individuals as different manifestation patterns emerge. Once pattern manifestations are identified and understood, the focus can be on changing the pattern of the field toward health and healing.

Data was gathered from 100 previously impaired and 100 non-impaired nurses. Nurses were found from on-line nursing chat rooms and listserves. Mailing addresses were received from nurses who would like to participate and questionnaires were mailed to their addresses. Three questionnaires were used in the study: the Zuckerman Sensation Seeking Scale, the Efinger Alcohol Risk Survey, and the Children of Alcoholics Screening Test. The CAGE questionnaire was used for the non-impaired nurses as a screening tool to evaluate whether they are non-impaired, as defined in the study.
Data analysis was done using SPSS-PC. Demographic data was evaluated using descriptive statistics including frequencies and percentages. The SI nurses were 87% female with a mean age of 45. The NSI nurses were 93% female with a mean age of 41.7. The SI nurses had a higher percentage of those with a German, Irish, and English ethnic background. There was little difference between racial backgrounds with the highest percentage in both groups being Caucasian (SI = 95%, NSI = 94%). There were a higher number of SI nurses who were divorced (SI = 37%, NSI = 13%). More SI nurses were left-handed than SI nurses (SI = 19%, NSI = 6%). More SI nurses also smoked in comparison to NSI nurses (SI = 40%, NSI = 9%). The NSI nurses had more educational preparation with a higher percentage of BSN’s (NSI = 41%, SI = 27%) and MSN’s (NSI = 23%, SI = 7%). There were a higher number of diploma (SI = 40%, NSI = 26%) and associate degrees (SI = 15%, NSI = 6%) within the SI nurses. As expected, more of the NSI nurses (96%) were presently employed in nursing compared to the SI nurses (75%). There were no significant differences in clinical areas where nurses worked. Amount of continuing education on addiction/alcoholism was low for both groups (SI = 45%, NSI = 38%), with the SI nurses having more hours (15% of the SI nurses had 36 - 40 hours). There were no major differences between groups in religious affiliation and attendance at services. As would be expected, the SI nurses knew more impaired nurses than the NSI nurses.

Inferential statistics were used to analyze data for the research questions. Pearson’s Correlations demonstrated a significant relationship between the EARS and Sensation Seeking Scale (r = .37, p = .01), and the EARS and CAST (r = .51, p = .01) for the impaired nurses. For the non-impaired nurses, the Pearson’s Correlations demonstrated a significant relationship only between the EARS and CAST instruments (r = .31, p = .01). Independent t-test scores demonstrated the impaired and non-impaired groups differed on all three of the instrument total scores (SSS: t = 8.30, df = 181.6, p = .001) (EARS: t = 18.71, df = 182.1, p = .001) (CAST: t = 7.91, df = 185.7, p = .001). Discriminant analysis strongly supported the significance of the three variables as predictors of the impaired and non-impaired nurses. Classification results indicated a correct prediction of SI membership in 87% of the cases and correct NSI membership in 95% of the cases with an overall percent of 91% for grouped cases correctly classified. Scores on the EARS had the largest correlation and was the strongest predictor (.99) followed by scores from SSS (.44) and scores from CAST (.42).
The results indicate that the three variables studied (sensation seeking, early risk factors, and family history) can be used to identify early risk indicators for substance abuse impairment in nurses. Although substance abuse impairment is a complex and continuous process, impaired nurses share some common characteristics and patterns. As patterns are identified and understood, the focus of nursing intervention can be on changing the patterns toward health and healing.

Identification of those at risk for impairment will allow for earlier intervention and possible prevention of becoming impaired. This knowledge can lead to an increased understanding of when to intervene through counseling and education. Methods to reduce the number of risk factors could be implemented. Continuing education as well as nursing school curricula should be adapted to include more content on early identification and prevention of substance abuse impairment.
Women’s expectation and experience of their first ultrasound scan at the first antenatal booking visit

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Background to Study
Maternity services in Ireland are predominantly hospital based. In Dublin there are three public maternity hospitals each catering for in excess of six thousand eight hundred deliveries per annum. A potential twenty, first booking visits per day are conducted alongside additional antenatal clinics. This would appear a relatively short time in which to conduct the booking visit and discuss the plethora of associated issues at the meeting the literature regards as the most important between the pregnant woman and the midwife (Methven, 1989, Shepard, Rowan, Powell, 2004).

The National Health Promotion Strategy, a recent Government policy in Ireland (Department of Health and Children (DoHC), 2000) places emphasis on developing maternity services, which are responsive to women’s needs while in the past decade policy has expressed that women’s needs, requirements and choice in maternity care should be established (DoHC, 1994; DoHC, 1995; DoHC, 1997). With the exception of an unpublished PhD thesis “Public Patient Antenatal Care and Childbirth in Dublin: Views of Service Providers and Users” (Collins, 2002), there is no empirical literature on women’s views of maternity services in Ireland.

Women’s views and opinions are vital if midwives are to provide and develop women centred maternity services.

Aim of Study
The aim of the study was to explore women’s expectation and experience of the first antenatal booking visit as they experienced it in a large maternity hospital setting in Ireland.

Literature Review
The literature review sought to identify women’s expectation and experience of their first contact with the maternity care providers
and their opinion of the content, structure and process of the booking visit. An extensive search revealed a paucity of research on the booking visit from the woman’s perspective and highlights a gap in midwifery knowledge of women’s expectation and experience of the first antenatal booking visit.

Irish and international anecdotal and empirical evidence reviewed surrounding the antenatal booking visit and satisfaction with early antenatal care does not focus on or emphasise the obstetric ultrasound scan. However Sanders (2000) and Collins (2002) reveal the ultrasound scan is an area of importance for women. Sanders (2000) found that women in the United Kingdom at a mean gestation of eight weeks rely on the scan to confirm their pregnancy and to reassure them of an ongoing pregnancy.

While Collins (2002) reveals that women expect an ultrasound scan at the booking visit (mean gestation 15 weeks) and that the number of scans in pregnancy contributes to satisfaction with antenatal care.

It is important to note maternity services, in particular the timing, place and content of the first booking visit are not comparable in Ireland, the United Kingdom, Europe or Australia.

**Methodology**

A qualitative descriptive approach underpinned by feminist principles was chosen to explore the subjective nature of women’s expectation and experience of the first visit. Seeking to explore women’s experiences and make them visible with intention to implement change is supported by the application of feminist principles

A purposeful sample was recruited at the first antenatal booking visit.

Focus group discussions were the chosen data collection method as the purposeful interaction between participants may reveal information that would be difficult to obtain in an individual interview (Morgan, 1998; Kamberelis and Dimitriadis, 2005). Focus group discussion generally obtains a broad, rich range of information (Sandelowski, 2000; Lane et al., 2001; Mc Lafferty, 2004; Denzin and Lincoln, 2005).

Though the inherent difficulties with focus groups were encountered they were an appropriate means to capture women’s experience of the first antenatal booking visit.

Eleven women participated in the focus group discussions.
Thematic content analysis of the data was conducted and five themes emerged that encompass the phenomenon of the first antenatal booking visit from the woman’s perspective and in the woman’s own terms.

Findings

The study was new and unique in Ireland. The findings are specific to the Irish maternity services however due to the qualitative nature of the study, the findings cannot represent the expectations and experiences of all women attending for a first antenatal booking visit.

During the focus groups the women freely discussed their expectation of and their experience of the first antenatal booking visit. They gave detailed descriptions of how the conduct, structure and content of the first visit impacted their experience and differed from their expectation.

The study findings are outlined in five themes using excerpts from the women, however the focus of this presentation is women’s expectation and experience of their first ultrasound scan at the first antenatal booking visit.

The Scan

“ I think its all about the scan, the first is all about the scan”
“you don’t know until you’ve had the scan is everything OK or not”
“I was sitting there holding on for hours”
“They did a scan and she said everything was normal”
“I could see something with one eye”

Information Seeking

“at the time I was desperate for information”
“you need to have the information....then you’re armed with power...”
“you need to be prepared”

Conduct, Structure and Content

“I didn’t expect all the different parts or to see so many different people”
“One stop shop”
Women’s Individual Needs

“it’s a special day and you just want to feel that you have some value”
“it would be nice to have a choice”
“I know you have a job to do but you know as an expectant mother I have a job to do as well”

Follow Up Plan of Care

“but seriously the baby could be born before my next visit”
“there is no plan that I’m involved in anyway”

Women’s expectation and experience of their first ultrasound scan at the first antenatal booking visit

The ultrasound scan was a dominant topic of discussion amongst all the women during the focus groups. The scan emerged as a significant expectation, event and experience for all the women at the first antenatal booking visit. Without exception the women’s focus on this technological aspect of the first visit was profound. The value placed on the scan outweighed the meeting between the woman and the midwife

“I think its all about the scan, the first is all about the scan”
Women felt the scan “when you actually see the little head and body moving around, its brilliant”, the highlight of the first visit and what they expect from the first visit.
Some women describe the waiting period for the visit and the scan as an anxious and doubt filled time wondering, “how soon I can get scanned ...and is there a heartbeat”.

“you don’t know until you’ve had the scan is everything OK or not”
Descriptions of the first antenatal ultrasound scans in this study are “the scan is great, the scan is brilliant”. Expectations are that the scan “makes it all real” and confirms the pregnancy, reassures that “everything is OK” and that a good picture of the baby will be seen.

“they did a scan and she said everything was normal”
“When I had the scan I was so relieved and so happy” highlights the reassurance and positive feelings women in this study had as a result of the scan.

Many women were uncertain of their pregnancy diagnosis until they had an ultrasound scan, “its an amazing thing, it hits you like a ton of bricks, you’re definitely pregnant then”. This uncertainty was
common despite the known accuracy of positive pregnancy tests and experience of early pregnancy physiological changes as depicted by this woman “until the moment you see that scan I think that’s when its reality, you’re not just pregnant because you have done a test,...or you have been falling asleep. and in that moment the whole thing becomes real”.

One woman questioned “is it a bit too early at a 12 weeks booking visit scan to tell a woman her baby is healthy”, while one woman mentioned the potential of the scan to determine “if an abnormality in the baby is found the doctor will tell after”.

The clarity of the scan amazed women “I couldn’t believe how clear the image was...there was a perfectly formed head, bum, legs, hands moving like mad...”.

“I was sitting there holding on for hours”
Some women felt the full bladder sensation while waiting for the scan was uncomfortable and distracting. “like to drink and hold on to it for a long while and you’re waiting around and there’s three or four in front of you and you’re like oh God this is too much”

“I could see something with one eye”
The conduct of the scan proved to be either a good experience or very disappointing for some women who felt “it was so quick, I could see with one eye only...”, Women felt there was not adequate time available for the scan or for the ultrasonographer to address their concerns and worries.

Conversely woman felt “the woman doing the scan was really good, she was really reassuring like the way she moved it around so you could see, she showed us like in 3D its a lot easier to read than in a picture, so it was really good”.

Conclusion
The study findings highlight the enormous focus women place on technology and the scan at the first booking visit thus impacting their experience of the first antenatal booking visit.

Recommendations
The study findings highlight the need for a national study of women’s experience of the first antenatal ultrasound scan and their understanding of the purpose and capability of the scan.
References


Full Reference List Available on Request.

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Creating Life Story Books for Older People with the Support of Family Carers in a Community Setting.

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Background
Life story books and personal portfolios involve collecting and recording aspects of a person life both past and present and consist of photographs and materials relating to a person’s life and a life history. The process of completing life storybooks provides a holistic view of the older adult. It is a useful foundation for working with families and offers the potential to promote and enhance person-centered care. Life story books can improve assessment, be as basis for individualised care and may help to challenge ageist stereotypes about older people.

Aim
The aim of the study was to explore the value and benefits of engaging family carers in developing life story books of their family member in a community setting. A further aim was to gain insight into the benefits of having the life story books from the perspective of the health care professionals.
Research Methodology
A descriptive qualitative exploratory design was utilized for the study. A convenience sample of family carers (n=8) participated in focus groups and individual interviews were conducted with health care professionals (n=3). These were tape recorded, transcribed and thematically analyzed.

Findings
Several key themes emerged from the qualitative data. These were therapeutic value of the intervention for family carers, the uniqueness of the individual and the building of family relationships. The life story books allowed the health care professionals to see the 'person behind the illness'.

Conclusion:
This study demonstrated that life story books helped family carers to value the important knowledge and information they have about the person they are caring for. The creation of the life story books enhanced the relationships between family carers, the person they are caring for and the health care professionals.

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Identification and management of neonatal nosocomial infection: a quantitative study.

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Due to advances in science, technology and pharmacology increasing numbers of premature, sick newborn infants survive. Despite these advances, infection continues to be a major cause of morbidity and mortality. Identification and subsequent management of septic infants is fraught with difficulty due to the non-specific, subtle nature of clinical presentation, the variety of possible differential diagnoses and the unavailability of specific, sensitive and definitive diagnostic tests.

The aim of this study was to determine the current state of practice regarding identification and management of nosocomial infection in a large Irish neonatal unit.

A quantitative descriptive approach was adopted with information collected from a non-probability sample using a questionnaire developed for this purpose. An initial pilot study was conducted.

Data was analysed using SPSS Version 11.

Results identified very preterm, low birth weight infants as those at risk, with 50% of cases <27 weeks gestation and 86% <1,500g birth weight. Median age of onset of infection was thirteen days of life, earlier than similar studies reported in the literature. Peripherally inserted central catheters and total parenteral nutrition were found to be statistically significant risk factors. Coagulase negative staphylococcus accounted for the majority of infecting organisms, with gentamicin and flucloxacillin being the treatment drugs of choice.

Accurate detection results in appropriate antimicrobial therapy, reduction in antibiotic resistance and reduced healthcare costs. This study provided an opportunity for the Advanced Nurse Practitioner (Neonatology) to identify an area of nursing that can be developed beyond the current scope of practice and promotes interdisciplinary teamwork in the interest of infants with suspected nosocomial infection.
The illness experiences of patients following surgery for colorectal cancer – a phenomenological investigation.

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‘The real voyage of discovery consists not in seeing new landscapes, but in having new eyes’
(Marcel Proust)

Background and Context
Colorectal Cancer is the 4th most common cancer throughout world (WHO, 2003). The incidence of and deaths from this cancer are generally increasing most of all in the developed world and urban areas of the developed world (World Cancer Research Fund, 2003). It is a common tumour in both sexes and is closely associated with advancing age. There are over 30,000 new cases diagnosed each year (WCRF, 2003), this means on average 650 patients are told every week they have bowel cancer. Consequently many health care professionals will have contact with individuals suffering from this disease.

Cancer is a disease, which can be addressed in terms of pathogenesis, pathology and responsiveness to forms of intervention. It is also a series of experiences that profoundly affect the person who has the cancer and those who share the illness experience (Carnevali and Reiner, 1990). In the twentieth century, health care in the developed world has changed dramatically. Rapidly growing basic medical sciences have provided an ever more complex understanding of the body in health and illness. At the same time increasingly sophisticated diagnostic and therapeutic facilities have become available. Knowledge and technique have combined to transform medicine to the status of a technological science. However, according to Little, Jordons, Paul and Montgomery (1998), because of its reductionist tendency, conventional medical understanding typically fails to capture the embodied experience of illness.
By construing body and illness only in terms of cells, organs and systems, it tends to arrive at an understanding of the disease processes, without necessarily achieving an understanding of illness as the experience of an embodied, suffering subject. Corner (1996) recommended a counter culture to the dominating biomedical construction of cancer care in which survival rates, levels of toxicity for any given treatment and prognosis in terms of response rate are the dominant constructs of treatment and care. She argued for a culture which is centred on the individuals’ everyday experience of living with cancer, through and after cancer treatment.

Given that there have to be ways to make the subjective experience of illness more intelligible to stakeholders, one could argue that the first step to achieving this goal is the identification of such experiences for it is only after they have been identified that the issue of sustainment can be addressed. The study of illness experience can, therefore, significantly contribute to the body of knowledge by focussing on the interrelations between biology, emotions and the body (Pierret, 2003). Often the role of the healthcare professional is to help people live a life that is as good as possible. To fulfil this goal they need information about the lived experience to enable them to offer support and caring that has meaning to affected patients.

The profile of cancer has been raised recently both through the media and the publication of reports and Government policies. Although many patients report positively on their experience of cancer care, there are still too many who claim they did not receive the information and support they needed. The first National Cancer Patient Survey (2002) showed wide variations in the quality of care delivered across the country. Recently NICE (2004) have recommended that research funders should invest in longitudinal studies of patient and carer experiences and expectations of illness and health and social care, to describe changes in perspectives as illness evolves and the best ways of meeting needs at different points in time.

The trend of shortened hospital stay has moved the focus of care from the hospital to the community, with colorectal patients returning home following major abdominal surgery after six to seven days. Several studies have indicated that some patients with cancer felt abandoned by healthcare professionals upon completion of this stage of their treatment (Kjeldson, Thorson, Whalley and Kronberg, 1999; Olsson, Bergbom and Bosaeus, 2002). Therefore how much regard is given to the physical and psychosocial impact of colorectal cancer and specifically patient’s experiences when
surgical treatment is completed? Are they entering a ‘black hole’? This research was undertaken in response to these facts and questions with the purpose of describing the patient’s perspective of their experience from their illness.

The purpose of the study
The aim was to build nursing knowledge through research that leads to description and comprehension (rather than prediction) of this complex human phenomenon by providing an understanding of individual perceptions and experiences of illness following surgery for colorectal cancer.

Through knowledge gained a subjective knowing and greater understanding of an individual’s experience can occur which may serve to determine the care needs of these patients. It may also promote the health professional’s empathy and substantiate and direct their style of care and develop initiatives to improve the future care of others in similar situations.

Methodology
This study was carried out using a qualitative approach based on a view that is both holistic and contextual and has the beliefs that there is not a single reality and what we know has meaning only within a given situation or context (O’Brien, 1998). That is, the holistic philosophy that knowledge cannot be dissected from life experience.

Within this interpretive paradigm a Giorgian phenomenological approach, which in turn follows a Husserlian tradition, was adopted. Phenomenological enquiry strives to bring to language the perceptions of human experience and allowed for an in-depth exploration of the individual patient’s perceptions of their illness experiences. Since professional nursing practice is enmeshed in the life experience of people, the phenomenological research method is well suited to the investigation of phenomena important to nursing (Streubert and Carpenter, 1995).

Data was collected from a purposeful sample of twenty subjects utilising an in an in-depth semi-structured interview in a style based around a topic guide and prompt questions, acknowledging the methodological preference for gentle guidance rather than firm control (Rose, 1994; Lincoln and Guba, 1985; Smith, 2003). The questions were broad and open-ended, the use of closed or leading questions was avoided, as the intention was to let the subjects speak for themselves and to avoid influencing their answers in any way. In anticipation that additional information may be required several of the questions were prepared with probes designed to obtain greater depth of understanding into their feelings and
reactions. All subjects were interviewed in their own homes. A target was to interview within 4-6 weeks of discharge from hospital and prior to the commencement of any adjuvant therapy. All interviews were recorded using an audiotape and transcribed verbatim.

The transcripts were analysed using Giorgi’s (1975) method of phenomenological analysis resulting in descriptive statements representing the participants’ illness experiences. These include statements common to most participants and others unique to individuals. In order to determine if the data was demonstrating if or how the experience changed over time this, thematic analysis was combined with a phase analysis. Therefore each theme identified has been placed within a time band, thus indicating whether it occurs at a specific point or throughout the experience, in which case it should be possible to demonstrate if or how it has changed. Three time bands were created for this purpose, pre-operative, post-operative and post-discharge. The pre-operative phase covers the time span from diagnosis to surgery; the post-operative phase covers the period of hospitalisation after surgery and the post discharge phase from the point of discharge until the time of the interview approximately 4 weeks later. For the purposes of this presentation only the post-discharge phase will be considered.

**Results – Post-discharge findings**

To facilitate the presentation of the results, both the common and unique descriptive statements have been grouped together in categories that best capture the structure of the phenomenon of having colorectal cancer and undergoing a bowel resection. Within these categories themes have been identified as emerging from the data to describe the illness experience and incorporate both the common and unique statements (table 1). The identified themes form a web of interconnections of experiences rather than a chronological series of events.
Table 1

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Returning Home</td>
<td>New Normality</td>
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<tr>
<td>The Disease</td>
<td>Physical restoration</td>
</tr>
<tr>
<td>Communication/Information</td>
<td>Mortality</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Uncertainty</td>
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<tr>
<td>Elimination</td>
<td>Isolation</td>
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<tr>
<td>Nutritional Issues</td>
<td>Fear/Anxiety</td>
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<tr>
<td>Rest and Sleep</td>
<td>Cancer Identity</td>
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<tr>
<td>Family Issues</td>
<td></td>
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<tr>
<td>Ongoing problems</td>
<td></td>
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<tr>
<td>Professional Issues</td>
<td></td>
</tr>
<tr>
<td>The Future</td>
<td></td>
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</tbody>
</table>

Discussion
The findings of this study confirmed Guex’s (1994) statement that for these participants the journey back from the land of the ill to the land of the well was a much slower one than the sudden trip that took the patient to the land of the ill originally as illustrated by the comment below.

'I have a very good appetite. But I was eating very well before surgery. I felt well before I had the surgery. I felt ill in hospital and I felt ill when I came home which just seemed strange that you actually go into hospital feeling 100% although I know I had a major problem but I felt well. And I came out of hospital feeling ill with pains and not being able to walk and I thought this is very strange, you are supposed to come out of hospital feeling better’ (15).

The trend of a shortened hospital stay after cancer surgery has moved the focus of care from hospital to the community and home, making this post-discharge phase of the illness trajectory very important. Throughout the treatment phase, the participants and their families were encountering nurses, doctors and other healthcare providers who were concerned about their welfare and helped them to manage. Following discharge, these people were no longer available on a day-to-day basis and any problems all had to be managed in the home setting. The external source of professional services had been abruptly reduced even though the physical and emotional problems had not necessarily diminished and in some cases had actually increased following the transfer to the home environment.

The post-discharge phase was an emotional time characterised by social isolation imposed by excessive fatigue, erratic elimination and fear of incontinence, a significant weight loss often combined...
with a poor appetite and reduced energy levels. Uncertainty was repeatedly expressed about what could now be viewed as normal with respect to many aspects of their recovery. Awareness of mortality and uncertainty about the future were prominent. For some this increased feelings of isolation as they realised they could never completely share the horror of the experience they had endured.

For the purpose of this presentation two of the post-discharge categories will be considered, communication and information and elimination as well as the themes incorporated within them. Sections of the participants’ transcripts have been used to clarify and enhance the discussion.

**Communication and Information**

Each individual’s physical condition, disease state, emotional state and social circumstances was inextricably linked with their need for information. Most of the participants had been given a leaflet providing basic information on day-to-day activities, feelings and emotions, diet and bowel activity, sexual activity and follow up. It also provided the contact information for such organisations as Cancer BACUP, Cancerlink and Colon Cancer Concern. For some, returning home was a particularly anxious time because they felt that they had received insufficient information prior to discharge to be able to understand the ‘new normality’ particularly in respect to bowel function. Others felt that whilst the information valuable to a degree it was too general, lacking in clarity, detail and specificity to their individual needs.

‘Once you get home, there is no one to answer questions or fears. How long will it take for my tummy not to go tender, weeks, months? At night I want to pass urine, every one and a half hours, no sleep or very little. When will this settle? I open my bowels slightly every day, about four times a day, only a little. But what if I feel constipated, what do I do? Do I take anything? Nurses from your surgery have no real knowledge of your condition and they’re only able to change dressings’ (8).

‘And I don’t know how much I can do, because they say no heavy lifting for six weeks, but what is heavy lifting? If you lift a kettle of water, you tend to feel it pulling’ (17).

The importance of information pertaining to resuming self-care after colorectal cancer surgery has been previously reported (Galloway and Graydon, 1996; Saegrov and Harding, 2004; Simpson and Whyte, 2006). The findings of this study concur in that they highlight the need for more detailed, personalised
information to increase the ability to interpret and manage symptoms that were previously unknown to them or have changed in character as well as providing details as to when to resume normal activities. The findings suggest that, because the physical impact of the cancer and the surgery is still significant in the post-discharge phase, information related to these aspects of the illness experience appear to take priority over information about what is available in the community and how to handle feelings about the illness.

The CNS, who visited most of the participants at home, was the most valued source of information in this post-discharge period, recognising the physical and emotional vulnerability experienced in the first weeks following discharge, working outside the requirements of her contract she chose to visit the participants to convey and explain the implications of the histology results in terms of future treatment and prognosis and discuss any personal issues or concerns.

'Oh it has been fantastic, because until I knew that she (CNS) was involved in it you think well, if I have got any problems who do I get hold of. I mean Mr J (consultant) isn’t going to be interested. Dr G (GP) won’t know enough about what has been going on because all he has had is a letter saying I have had this and that done and that is it basically. So how far his knowledge would go to helping me if I have got any specific problems I don’t know. But she (CNS) has expertise’ (1).

She was responding to the fact that this period is often the first opportunity that individuals, who have previously been caught up in the world of investigations, hospitalisation and surgery, have to absorb and think about the implications of the fact they have cancer. There was also recognition that visiting a patient at home moves the balance to one where the participants, and not the healthcare professionals, are in charge, they are no longer in the patient role and are therefore, much more empowered. She reported that they and their family members were much more open and relaxed and willing to talk in their own environment. They can cry, they can be distraught and they do not need to walk through an out-patient department afterwards and go home in a distressed state. For these reasons, the CNS places great importance on home visits at this point in an individual’s cancer journey; this was clearly valued by the participants. The participants not visited by the CNS did not receive any such information until their follow up out-patient appointment approximately four weeks after discharge.
This study, like that of Knowles, Tierney, Jodrell and Cull (1999), has demonstrated that clear communication of appropriate information and explanation is important throughout the care pathway for bowel cancer patients and that individual information needs change as they progress through their cancer journey. This is not surprising because, as has been shown, the participants’ condition changes as they recover from surgery; information provision should, therefore, be a dynamic process over the entire illness trajectory, spanning across the primary-secondary interface (Knowles et al, 1999). However, this was not achieved for all participants and shortcomings were exposed.

’No, they were saying all along that it would be 8 days before the histology results came through. Then that slipped a bit and they were saying that they had, I think they call them a multidisciplinary meetings on a Thursday so they were then saying that they hoped that they would get the result by Thursday which would have been the 25th of November. Well the 25th of November came and went and nothing was said as to whether they had the results then or not. My definitive knowledge to date is that I have had a section of bowel removed. They (clinicians) certainly inferred that is what it was but I don’t think anybody has ever used the word ‘cancer’ or anything, no. I am putting 2 and 2 together after receiving the letter from the oncologist’ (18).

Two participants suffered from severe swelling of their lower body as a complication of their epidural anaesthesia; this was not addressed and no subsequent management was explained to them and they returned home without adequate information and high levels of uncertainty, making the transition stressful.

’Well I got more trouble from my knees and my legs through the water, through the epidural thing. That worried me and upset me more than anything, because while I was still in bed, I lost the use of my right leg and I had no control at all, and I couldn’t stand on it or do anything. They took out the epidural and it was an improvement for a day or so, but I thought that it ought to have cleared quicker. According to the leaflets they gave me saying, this will clear almost immediately. But it did not. My legs, feet and toes were completely blown up. I couldn’t get my shoes on and it was very, very painful and I didn’t have a lot of control and that worried me more than the operation. I had to keep my feet up all the time and they were very bad indeed and painful. And was it a problem getting stuff on? I came home in my pyjamas, dressing gown and slippers. I couldn’t get my shoes on. My feet were swollen so much. It was quite frightening the swelling. It caused me more trouble than the operation’ (10).
One of the best ways the clinicians can support their patient through this illness experience is by the provision of information. Being well informed is one way of enabling individuals to retain or regain control of their lives. The study has identified discrepancies in the amount and quality of information received, highlighting the importance of assessing the quality and content of communication of information at various stages in the illness. The participant has a right, not a duty to hear bad news (Buckman, 1992) and it is, therefore, essential to assess the patient to identify the extent of information required.

Elimination
Given the diagnosis of colorectal cancer and the nature of the surgery performed, elimination issues were understandably one of the main physical symptoms to dominate this post-discharge period. For some they imposed physical restrictions and isolation, whilst other participants were struggling to come to terms with a 'new normality'.

'I came out (of hospital) on the Tuesday and on Wednesday I still hadn’t been, and the Thursday and I was beginning to feel oh golly, you know, what if it has fallen apart, how do I know if it has fallen apart? I have no idea how to tell whether it is working or not. And I was really getting anxious at one stage and thought I wonder if I ought to phone somebody and say, you know, I haven’t done anything yet, and it was about that time that I suddenly shot out into the loo and discovered that it all worked. And the relief was immense‘ (2).

It is getting a lot better and today, it was ok, I have had a motion. I don’t, except on two or three occasions when I have quite a significant movement, I don’t ever feel as though I have eliminated, as though I have cleared my bowel, so I hope we get to that stage’ (13).

'What they did, when they discharged me, they gave me paracetamol and codeine, which will constipate. And that’s exactly, what happened. So when I came out of hospital I was constipated. Now my engineering background tells me, that if I put stress on a joint, especially if it’s a new joint and realising if you’ve got a ball of faeces going through this point, I would be double worried, a because things weren’t settling down. And B realising that there’s going to be stress on this joint’ (4).

For some individuals coping with elimination issues was a struggle, not least because they found it very embarrassing to discuss such a personal issue as bowels.
'If you have a breast operation, you can say breast. It’s a nice word isn’t it? And bowels are something everybody has, and yet nobody wants to talk about bowels so much’ (17).

In the post-discharge phase isolation was discussed in both a social and physical context driven by the fear of faecal incontinence. Participants in these first weeks after surgery did not display sufficient confidence in their bowel function to stray far from their home environment. Thome, Dyskes, Gunnars and Hallberg (2004) described such restrictions, in relation to cancer generally, as a constriction of available ‘lived space’ by limited bodily capacities, and the loss of such space that had formerly been taken for granted sometimes became difficult to handle. Whilst accepting that this was a consequence of bowel resection, it was also source of frustration for many of the participants, given that, at this stage, they did not know how long their erratic bowel patterns and impaired sensation would persist.

Another aspect for many of the participants was the physical loss of complete control of bowel function in the post-operative and post-discharge phases. The loss of control of such bodily functions is intensely personal but the significance attached to such physical experiences of the body is informed by the social categories through which it is known (Rozmovits and Ziebland, 2004). Hence the experience was perceived as being socially unacceptable, distressing, humiliating, undignified and intensely embarrassing.

You do spend a lot of time in the toilet because you are not sure if you’re going to have your bowels open or pass wind. If I feel that way inclined I will go to the toilet just in case. I have had one little accident since I have been home and that was that feeling. I was in the kitchen doing the washing up. My husband had popped out to do some shopping and I thought I would just do this and so the feeling came and I let the wind go. Unfortunately a little bit more came away and I thought oh my good gracious, I thought, thank goodness my husband is not here. And that is the only accident I have had, so as you say, it was best sort of popping to the toilet just in case’ (15).

The findings highlight the sensitive nature of this form of cancer over less personal forms of the disease. Elimination issues were very much an area of concern for all participants and at times a cause of great anxiety and embarrassment associated with the fear of loss of personal dignity

Conclusions
This study highlighted both the common and unique aspects of the experience but most importantly reveals that even the common aspects are experienced in a unique way. A strong feature of the
narratives was the particularly incapacitating nature of the surgical intervention both in the short term and longer term which had both physical and emotional consequences.

So, is there a ‘black hole?’ The answer to this question is that, for some of the participants who were not cared for by the CNS, a black hole did exist. The general practitioner and district nurses were not routinely or actively involved in their care and they ‘muddled on’ with the support of family or friends. There was a distinct level of dissatisfaction expressed with the information received prior to discharge with participants objecting to a ‘one size fits all’ approach. There is a requirement for detailed information prior to leaving hospital tailored to individual needs, especially for individuals with symptoms incongruent with clinical expectations. An information package needs to include information related to the actions to take if complications occur and taking into account elimination patterns and activity, management of existing symptoms. The information given needs to be of a level that would help an individual formulate a realistic picture of events that might occur in the early recovery period at home. Having more individually tailored information about bowel function would hopefully remove some of the associated anxiety.

Whilst many healthcare professionals have ‘knowledge’ about the various forms of illness, they may not always recognise the experiential values of pain, fear, uncertainty, isolation, incontinence and other conditions of the body and mind displayed by these patients. Illness is a multifaceted experience; therefore; central to its understanding is the requirement that the entire experience be considered from the patient’s perspective. People whose lives are affected by cancer can be viewed as experts on living with its consequences. Drawing on their experiences can hopefully make a significant contribution to the planning and delivery of care.

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Interdisciplinary Education: Evidence Based Simulation Training in Neonatal Resuscitation for Neonatal Nurse Practitioner (NNP) Students

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Aim of Review: Evidence Based Simulation Training in Neonatal Resuscitation for NNP students utilizing simulation technology for advanced clinical procedural skills for NNP students was developed at Jefferson School of Nursing in response to the need for an increasing array of interdisciplinary skills in a neonatal intensive care environment. The advanced neonatal resuscitation skills needed by the NNPs in an interdisciplinary practice format are not taught in many NNP programs. The Interdisciplinary Neonatal Resuscitation Education (INRE) model described here was based on evidence based practices and standards from the American Academy of Pediatrics.

Search and Review Methodology: An interdisciplinary model utilizing “Change Theory” was implemented. This model analyzed the need (systems), Structures (availability of education for advanced interdisciplinary clinical skills), Processes (Neonatal skills).

Analysis: Implementation of this interdisciplinary INRE educational model developed out of external influences: need for clinical resuscitation skills currently used in NNP practice. Internal Influences driving this innovation were: leadership and changing
value systems in the neonatal care setting. Educational leadership and interdisciplinary faculty were crucial in implementing this innovative model. Change in health outcomes of neonatal patients resulted from interdisciplinary education.

Summary of key findings: This model is the first collaboration in NNP student education for advanced procedural skills for NNP students in a tri-state area. The model will maximize medical and nursing faculty resources, increase numbers of NNPs who will be prepared in neonatal resuscitation skills where advanced interdisciplinary skills education was unavailable to NNP students.

Conclusions: This model will improve marketability of the NNP graduates, prevent complications in the neonatal care setting, improve patient outcomes, and enhance the skill set of new graduate NNPs. Additionally, interdisciplinary skills’ teaching maximizes resources for clinical education.

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