

**AN EVALUATION STUDY OF THE REGULATORY APPROACH
TO GENERAL NURSE EDUCATION 2001 – 2004 IN IRELAND**

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Volume 1 of 3

DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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This work is inspired by a quotation of the day, "Start by doing what's necessary, then do what's possible, and suddenly you are doing the impossible" (attributed to St Francis of Assisi (1182-1226))

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Abstract

Ryan, Anne-Marie

*An Evaluation Study of the Regulatory Approach to General Nurse Education
2001-2004 in Ireland*

This study explored the regulatory approach to general nurse education programmes operationalised by the Irish regulatory body for nurses and midwives during a period when all nurse education moved to the higher education sector. The underpinning theoretical framework of regulation (Department of An Taoiseach 2004) focused the exploration of educational Requirements and Standards (An Bord Altranais 2000) of all the general nurse education programmes. The literature associated with regulation, learning nursing and evaluation informed the conduct and findings of the study. The study method rooted in evaluation research approaches, was conducted in two phases to describe and illuminate the regulatory process of ensuring safe standards of preparation of general nurses. The methodology used in phase one of the study was designed to capture how existing programmes met regulatory requirements and was guided by Stakes' (1985) five stages to generate data in evaluation. This first phase of the research reflects "descriptive evaluation" as described by Quinn Patton (1987) which utilised a large quantity of documentary evidence supporting the thirteen general nurse registration/degree programmes between 2001 and 2004. A grounded theory approach (Miles and Huberman 2004 and Dey 2004) was used to analyse data with further analysis achieved through the assistance of an expert group. The purpose of the first-phase was to acquire insights, not by establishing causality, but to develop an understanding of how current systems of general nurse education operate and whether they meet regulatory expectations (ABA 2000) and criteria. Judgements of compliance with current regulatory standards are posed. The methodology utilised in the second phase of the study was underpinned by the principles of concept development and used key stakeholder focus group discussion to suggest a process for effective regulatory function. Principles for regulatory governance of education programmes are also described. The proposed regulatory framework is based on the emergent core categories of governance, quality in education and knowledge for practice to capture the essence of issues in professional general nurse education to ensure the protection of the public.

GLOSSARY

ABA	An Bord Altranais (Irish Nursing Board)
CAUSN	Canadian Association of University Schools of Nursing
CCNE	Commission on Collegiate Nursing Education
CINAHL	Cumulated Index of Nursing and Allied Health Literature
CIPP	Context Input Process Product (Stufflebeam 1997)
CNE	Centre of Nurse Education
CNM	Clinical Nurse Manager
CPC	Clinical Placement Coordinator
DCU	Dublin City University
DoHC (Irl)	Department of Health and Children (Ireland)
DoH (UK)	Department of Health (UK)
EU	European Union
HEI	Higher Education Institution
HETAC	Higher Educational Training Awards Council
ICN	International Council of Nurses
MCQ	Multiple Choice Questionnaire
NCBSN	National Council of State Boards of Nursing
NEATE	Nurse Education and Training Evaluation in Ireland
NHS	National Health Service (UK)
NLN	National League of Nursing
NQAI	National Qualification Authority of Ireland
OECD	Organisation for Economic Co-operation and Development
QA	Quality Assurance
QAQI	Quality Assurance Quality Indicator
PERC	Practice, Education and Regulation Congruence Task Force of National Council of State Boards of Nursing (US)
SDL	Self-directed learning
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WHO	World Health Organisation

CHAPTER ONE - INTRODUCTION

This thesis is entitled “*An Evaluation study of the regulatory approach to General Nurse Education 2001-2004 in Ireland*” It aims, through evaluation research and grounded theory approaches, to develop a culturally relevant framework for general nursing programmes that embraces the concerns and mission of the regulatory body of nursing in Ireland

This chapter provides an overall introduction to the impetus, context, underpinning rationale, and background justification for undertaking a study of the registration/degree general nursing programme from the perspective of regulatory obligation. This study commenced to inform the regulator of nursing in Ireland of the evaluation process necessary “to promote high standards of professional education and training [to] fulfil the functions assigned to it” (Nurses Act 1985, 6(1)) by the Nurses Act 1985

This study

- Examined the “provision for courses of training and examination to be taken by candidates for registration” (Nurses Act 1985, 31) currently operating and
- Captured how the “Requirements and Standards” (ABA, 2000) meet the obligation to “specify conditions of suitability for hospitals and institutions’ (Nurses Act 34 (2), 36 (1, a)), “the standards of theoretical and practical knowledge required for examinations,” and “the clinical training and experience provided in any training programme organised by a hospital or institution approved of by the Board” (Nurses Act 36 (b), (c))
- And proposes a framework of accountable nurse regulation to “promote high standards of professional education and training” fulfilling the functions of An Bord Altranais (ABA) assigned to it by the Nurses Act (1985)

The outcome of the study is to formulate a systematic, structured regulatory evaluation approach for general nursing education programmes capable of supporting the development of meaningful professional nurse regulation

OVERVIEW OF THE REPORT

Chapter one details the current context of nurse education and practice within the regulatory framework of ABA. The development of regulatory responsibility for ensuring standards of educational preparation is outlined along with the issues that influenced the maturation process of contemporary general nursing in Ireland. It explores issues related to changes associated with autonomy, responsibility, education and organisation of care, while acknowledging the significant issues that have shaped the current professional position of general nursing education. Appreciating the context of care and the preparation of nurses to provide professional nursing care is important to developing an understanding of the current nurse in practice and education, and the influence of policy in health care in shaping the current nurse educational programme.

Chapter two presents a general literature review, which was conducted to focus the investigation and explore the theoretical constructs of the issues under study. The review though quite diverse in its breadth of subject area used network theory (O'Connor 1992) to assist in developing the focus contained in this report to ensure depth to the issues under consideration and was divided into separate sub-sections of regulation, learning nursing and evaluation.

Section one examines the concept of regulation, self-regulation, quality systems and the role of the regulator as an agent of a quality system. The regulation of nursing both in Europe and Ireland is explored with reference to international experiences. The harmonisation of systems within Europe, to facilitate exchange and movement of services and professionals providing services, is explored in relation to professional regulation (Lisbon Agreement 2000). It is argued that the role of professional evaluation mechanisms in approved educational mechanisms needs to effectively and efficiently produce an added value for all participants and should not end up being a further bureaucratic burden (Gragnola 1997) to academics, practitioners and administrators of systems. Since the 1980's there has been an expectation that universities worldwide but particularly in Europe would develop:

effective internal and collaborative evaluation systems so that the confidence of government could be achieved, the public could be assured about quality

and the return on their investment and, ideally, so that mechanisms could exist to improve the programmes and services in the institutions concerned

(Kells 1992, p.11)

In respect of professional education the Pew Commission (1997) determined links between professional regulation and quality education and support the professional role in quality systems. They suggest that the professional is not only appropriate but they are the best entity to determine “professional standards of education requirements” and “scopes of practice” as only they “have the appropriate understanding and knowledge of the intricacies of the profession” (Gagnola and Stone 1997 p.30). The concept of the profession as the determinant of adequacy and suitability of a programme is explored as a knowledgeable quality factor to protect the public interest.

The nature of quality assurance schemes is examined with an emphasis on self-regulation and the components of some systems currently operationalised. The Nurses’ Act 1985 saw significant reform for Irish nurses with the concept of self-regulation being embraced for and by the profession. Regulation and particularly self-regulation is embraced for nursing in many countries and is associated with professional development of nursing within that country (Percival 2001). Self-regulation as a concept however is under scrutiny in many countries and developing a professional framework on the principles of flexibility, accountability, transparency, public participation, equality and balance and disciplinary power are the challenge for regulators (Department of the Taoiseach 2001, Percival 2001). Matching the regulatory mechanisms and developing common principles and understandings of the unique contribution and relevance of the professional’s role in approval structures is the challenge for the changed milieu of education for practice disciplines.

Section two examines the knowledge base of nursing and the development of a curriculum to support professional nursing education in an era of unprecedented change both in healthcare provision and public expectation. The nature of knowledge within a professional context is reviewed with some support being given to the constructivist paradigm. The variety of types of knowledge that inform ways of knowing including, propositional, experiential, tacit and personal knowledge are

examined for a practice-based profession such as nursing. The nurse theorists associated with each of these types of knowledge are examined and the notion of learning from practice is explored in depth. This exploration clarifies the construct of the overall aim of the education programme for entry of a name to the Register of Nurses held by the regulatory body. Understanding what needs to be taught in general nurse education programmes emerges from an understanding of the theoretical underpinnings of the discipline and the application of this theory to the educational curriculum and the practice of a practice-based discipline such as nursing.

It is acknowledged however, as suggested by Greaves (1988, p 4), that “in the final analysis knowledge cannot realistically be called either practical or theoretical and for curricula nursing content must be concerned with describing, explaining and controlling the phenomenon of nursing patients.” Knowledge in nursing therefore must be viewed as arising from realities in practice and directed towards present and future problem solving. There should be no distinct separation of theory and practice in learning about nursing. Learning the practice of nursing is an integral part of the general nurse education programme.

Section three examined the concept of evaluation research and reviews a number of common models and approaches to evaluation research that has influenced nursing in particular. Evaluation research embracing a theoretical construct, although described since the 1940's (Tyler 1942) is examined and approaches to its implementation are explored particularly in nursing. A number of studies that incorporate evaluation research methodologies are critiqued in respect of nursing education programmes (Singh 2004, Heath 2002, Simons et al 1998, Bartlett et al 1998, Crotty and Bignell 1998, Luker et al 1996, Phillips et al 1996, While et al 1995). The theoretical arguments, as advanced by Quinn Patton (1997 p 24), who suggests that the difference between research and evaluation is between conclusion-oriented and decision-oriented inquiry is argued. This, however, is more fundamentally placed in the arguments associated with the perspectives of social inquiry and scientific inquiry. The roots of social inquiry and evaluation are explored in further detail.

The elements of evaluation research that usually are conducted as continual processes of evaluating a programme, or programmes, are described as both formative

evaluation (ongoing) and summative evaluation (outcome) (Shadish, Cook and Leviton, 1991) A number of studies are explored that used evaluative research methods and these are critiqued with a view to informing a theoretical and methodological approach for conducting this study as well as comparing and contrasting this study with reported other studies (Singh 2004, Stufflebeam 2000, Simons 1997, Allen 1977) The results of this review of evaluation aim to illuminate the approaches undertaken within this study as well as the processes by which knowledge for nursing practice can be generated and supported The information gleaned will assist with understanding long-range planning and ensuring appropriate regulatory governance In this respect the term evaluation research is utilised throughout this study to describe and analyse the implementation of the general nursing programme at a national level, interpret this data in the context of the programme to determine meaning and tease out substantive significance in order to judge the divergence and convergence of the programme The evaluation research process usually includes defining the client, determining the purpose of the evaluation including the accountability issues, improvement issues, and development of knowledge (Stufflebeam 2002) A number of theorists were examined to identify a perspective for focussing the evaluation (Keating 2005, Alkin 2004, Fetterman 2004, Rossi 2004, Stufflebeam 2000, Quinn Patton 1997, Rutman 1984, Allen 1977)

In focussing the methodological concerns through the literature the evaluation framework suggested by Stufflebeam (2003) emerged as an initial template Methodological concerns for this evaluation researcher are to ensure that the study is relevant and credible as a contribution to evaluation research theory and a theoretical framework of regulation that addresses the regulatory concerns for the profession

Chapter three presents the methodological debate This study rooted in evaluation research approaches describes and illuminates issues that will inform the regulatory body of a process of ensuring safe standards of preparation of general nurses The fundamental purpose of this study is to support, inform and influence future choices and actions for the regulator to meet its governance agenda of accountability and social inquiry (Alkin 2004, Department of An Taoiseach 2001) Accountability elements in evaluation are usually focussed on the outcomes produced from any programme (Quinn Patton 1997) In respect of nursing regulation the general nurse

education programmes throughout the country, the outcomes for the programme have been stipulated (ABA 2000). Identifying, therefore, the methodologies of how the programmes achieve the specified outcomes at a national level emerged from this study. Social inquiry theory and methods are explored within the post-modernist paradigm (Alkin 2004, Bensimon et al 2004, Riessman 1993, Polkinghorne 1992). In exploring these methodologies and paradigms, a framework for practical decisions in relation to the practices of implementing programmes is explored and developed.

This evaluation study was conducted in two phases. A two-phase approach to the development of the proposed regulatory framework for the regulation of general nursing programmes is outlined. The methodology used in phase one of the study was designed to capture the extent to which existing programmes meet regulatory requirements. The chapter details how a tool was developed to systematically collect information about the operations and outcomes of general nurse education programmes, to make judgements about the requirements and standards (ABA 2000), improve their effectiveness and inform decisions about their future. This was guided by Stakes' (1985) five stages to generate data in evaluation. This first phase of the research reflects "descriptive evaluation" as described by Quinn Patton (1987) which utilised a large quantity of documentary evidence supporting the thirteen general nurse registration/degree programmes between 2001 and 2004 utilising a grounded theory approach to analysing data. The purpose of the qualitative research methodology, rooted in grounded theory, as used in this study, was to acquire insights not by establishing causality, but through developing an understanding of how current systems of general nurse education are operating and meeting regulatory expectations. The methodology utilised in the second phase of data generation was underpinned by the principles of concept development described by Schwartz-Barcott and Kim (2000). Data to suggest a process for regulatory governance was obtained using key stakeholder focus group discussion. The analytical method is described in detail, as are the ethical considerations of conducting a national evaluation study of the general nurse registration/degree programme 2001-2004 from a regulatory perspective.

FINDINGS AND DISCUSSION

The findings and discussion chapter of phase one narrates the national picture of general nurse education by providing a description from documentary analysis against requirements, standards and criteria (ABA 2000) Polkinghorne's (1988 p 142) concept of narrative action underpins the emergent story where "purposeful action is the result of a means-end calculation to achieve personal ends, action is the enactment of transcendent and logically ordered rules, and, action is behaviour conforming to socially agreed upon rules" This composite story applied the principles of utility, propriety, feasibility, and accuracy to fulfil the standards required of all evaluation reports (Sanders 1994) The analysis of the data was achieved through the assistance of an expert group, which verified and identified the broad categories that emerged from the data and gave rise to the overall findings that were linked to the literature A national picture of how the requirements and standards are being met is narrated and linked to the literature where appropriate Judgements of compliance with current regulatory standards are posed

Phase two of the study saw a key stakeholder focus group convened to discuss processes for effective regulatory function to determine a regulatory framework for general nurse education The principles to be adhered to by the regulator for a regulatory approval framework were identified by the key stakeholder focus group This framework is underpinned by the core categories of governance, quality in education and knowledge for practice

CONCLUSION

The chapter builds on the core category findings and discussion and develops the themes within the core research questions to illuminate judgments of the current regulatory system A proposal for a framework of regulatory processes that builds on current policy initiatives within regulation and quality systems is presented The limitations of the study design are presented, as are recommendations for future research, practice and education

CHAPTER TWO - CONTEXT

INTRODUCTION

This chapter outlines the context in which the study commenced and was conducted. The role and responsibilities of ABA in relation to its education and training function are explored and the processes used to conduct its affairs are explained.

IMPETUS FOR THE STUDY

The internal workings of regulatory bodies have been challenged to keep abreast of societal expectations and policy development (Department of the Taoiseach 2004). This challenge emerges from the processes and rules under which regulatory bodies operate and in many circumstances the legislation pre-dates these developments. The methodological emphasis for this study was on a qualitative analysis of the processes that the Board had engaged in to effect its statutory responsibility. This responsibility emerged from the Nurses Act 1985 (36 (1)), which states

The Board shall, from time to time as occasion may require but in any event not less than every five years, satisfy itself as to the suitability of the education and training of nurses provided by any hospital or institution approved of by the Board pursuant to section 34 of this Act, the standards of theoretical and practical knowledge required for examinations, (c) the clinical training and experience provided in any training programme organised by a hospital or institution approved of by the Board pursuant to section 24 of this Act,

The nursing profession in Ireland has not been the subject of much study (Cowman, 1994) and this applies in particular to the regulation of nursing. The Board of Nursing in Ireland (ABA), is required by the Nurses Act 1985 (36) to set standards of education and monitor the quality of education programmes. Further the Board is provided for by the Nurses Act 1985 (36 (2)) to “engage in research into education and training of nurses, including the formulation of experimental curricula and the evaluation of existing programmes and examination and assessment procedures”. In this capacity the Board conduct on-site visits with the thirteen Higher Education Institutions and the associated health care institutions offering the registration/degree programmes in general nursing. It became evident to the researcher that she needed to develop a system to evaluate the current systems used by the regulatory body to fulfil the statutory obligation. This was necessary in respect of the changes that had

occurred in the provision of general nurse education and in particular, to include new relationships and partners in the educational experience of students. The evaluation research report that ensues will therefore provide to the Board an overview of the accountability and social inquiry issues of the current regulation of nurse education and help it to meet its statutory responsibilities.

CONTEXT OF THE REGULATION OF GENERAL NURSING IN IRELAND

The Nurses' Act 1985 provides the statutory framework for nursing in Ireland through which ABA sets standards for the education and training of nurses and the continuing education of registered nurses. Through rules it provides for the approval of higher education institutions and of hospitals and health care institutions providing training to ensure that appropriate clinical and theoretical experience is offered. Under Section 34 of the Nurses Act, 1985 the Board is required to satisfy itself as to the adequacy and suitability of hospitals and institutions for nurse education and training at least once every five years. This process includes curricular review. Nurse education and training programmes have been legislated for in the state since 1919. Legislative review for nurses and midwives subsequently occurred in 1950 and 1985. The Nurses' Act 1985 saw significant reform for nurses with the concept of self-regulation being embraced for and by the profession.

Nurse education in Ireland has undergone significant reform since 1994 when the first academically accredited Registration/Diploma in nursing programme was commenced. An independent external evaluation using a case study approach was undertaken to evaluate the initial change to the Registration/Diploma programme (Simmons et al 1998). Since that time further developments emanating from the Report of the Commission on Nursing (1998) have included the implementation on an all country basis of a Registration/Degree nursing programme in conjunction with thirteen Higher Education Institutions in September 2002. ABA published Requirements and Standards for Nurse Education Programmes (2000, 1999) that also identified the outcomes that the programmes of preparation should achieve for each student. The curriculum must represent the realities of the world of nursing and take

account of major problems and issues of current practice while appreciating the needs of future practice requirements and skills³ sets

Learning the practice of nursing is an integral part of the nursing curriculum. The need to prepare clinical staff to assume a teaching role in relation to student nurses was identified by a number of reports (Nurse Education Forum 2000, Simmons et al 1998, Commission on Nursing 1998). Understanding how existing practitioners may achieve this poses a number of practical considerations for the clinical area where students learn the practice of nursing with Registered Nurses' as their mentors. These changes in expected outcomes of a registration programme and the support structures to implement the programme posed some challenges for regulatory management and required an overhaul of regulatory mechanisms. The regulatory management challenges also emerged as a shift in ideology from one of prescription and control to one of an all-embracing philosophy associated with the post-modernist paradigm and supporting systems. This shift required the regulator, ABA, to set standards for the curriculum, the third-level institution, the clinical experience, the assessment process and the external examiner (ABA 2000). The implication of this was a need to trust the authorities of the stakeholders to identify achievement of competencies at the completion of a course. This confers eligibility on candidates to apply to enter a name on the Register of Nurses following completion of an approved course and the elimination of the traditional ABA State Exam for registration purposes.

HEALTH POLICY CONTEXT OF THE STUDY

This study was commenced in the context of major reform of nurse education in Ireland and at a time when regulatory structures and practices were being examined. The reform of the structure and accreditation of programmes and the mechanism of delivery of nurse education programmes were explored in the context of the reform of the health services and associated reports (Department of Health and Children 2001, Department of An Taoiseach 2001) and the education sector as it impacted on the provision of professional education in a culture of quality and accountability (Education and Training Act 1999, Universities Act 1997).

The Irish health service has recently been the subject of restructuring and reform ‘Quality and Fairness A Health System for You’ (DoHC, 2001) signalled the policy which advocates a quality health service underpinned by value for money. This overarching policy was supported by a number of complementary reports but the most important of these was “Primary Care A New Direction” which signalled a strategy for services based in and for the community with the objectives of multidisciplinary teamwork, access of all to primary care services, improved relations between primary and secondary care services and providers, and recognition of the significance of health promotion and disease prevention (DoHC 2001b). “The Report of the Commission on Financial Management and Control Systems in the Health Service”, otherwise known as the Brennan Report (Government of Ireland, 2003) concluded that there was extensive fragmentation of service provision in the health services and that accountability for health provision likewise was not working to capacity or efficiency of cost management. As a consequence of this policy and other related policies a unitary management system of the health services was established in January 2005 in the form of the Health Services Executive (HSE) abolishing the health Board structure that was in place since 1970 (Health Bill 2004). “The Audit of Structures and Functions in the Health System” (DoHC 2003b) (Prospectus Report) examined the health system reform and identified the need for changes in legislation and supporting processes in order to implement the health strategy. Significantly this report stressed the responsibility of professionals to contribute to the efficient and integrated service delivery of health care including nurses’ contribution. The reform of the acute hospital system is influenced by EU directives for the reduction of medical practitioner working hours, which was the subject of a further report called “Report of the National Task Force on Medical Staffing” (DoHC June 2003c), otherwise known as the Hanley Report. This report highlighted a need to examine the current health care professionals’ roles. The Department of Health and Children (DoHC 2003d) produced a Discussion Paper “The Challenge for Nursing and Midwifery”, which based on two pilot site studies, suggested the implementation of midwifery-led and nurse-led clinics. This paper also argues for the continued advancement of the nursing and midwifery professions in a manner that builds on the new four-year degree programme and the growing numbers of nurses in clinical nurse specialist and advanced nurse practitioner positions. In summary the traditional domains of practice and historical boundaries of health care professions are being

evaluated in relation to determining appropriate roles and responsibilities of practitioners to advance interdisciplinary efforts in providing and promoting quality health care in all settings. The question of how to best utilise the knowledge, skills and competency of individual nurses and midwives is being addressed in many areas and circumstances within the system.

CURRENT STANDARDS AND APPROVAL MECHANISMS

Currently the regulatory board for nursing operates an approval system of pre-registration programmes that requires the higher education institution (HEI) to submit a curriculum to the regulatory body based on the published Requirements and Standards (ABA 2000).

The Requirements and Standards for Nurse Registration Education Programmes (ABA 2000) contain the standards of the Irish Nursing Board for nurse education programmes. It is deemed that the programmes, policies and practices of the third level institutions and the health care institutions shall meet the requirements and standards of ABA documents in order to receive ABA approval for a course. Section three of these documents provides a statement of the standards that must be met by the third level and health care institutions. These standards are applicable to educational programmes that lead to nurse registration and embrace both the EU directives and essential requirements to be met in a programme.

Standards are the statements of a defined level of quality that is expected in a given set of circumstances (World Health Organisation (WHO) 1999). The standard statements identify and define the criteria which influence the quality or competence of the third level institution/health care institution, the curriculum, the clinical practice experience and the assessment processes as related to nursing education, nursing practice (ABA 2000) and the clinical learning environment. The standards identify what is expected in terms of structures, processes, and outcomes. The WHO, (1999) have recommended that a structure, process outcome approach must be utilised for both the theoretical and practice components of nurse education programmes. It is

contended that clinical placements must be audited to agreed acceptable standards as learning environments (ABA 2003)

The development of the requirements and standards documents has been informed by the responsibilities of ABA under the provision of the Nurses Act, 1985, the Nurses Rules 1988 (Amended), 1988 and 1999 and by a systematic review of the international policy and research based literature. These standards form the basis for the measurement of the quality of nurse education provision within the developing theoretical and clinical education partnership. The Higher Education Institute and Health Care partnership are required to submit a self-assessment audit of compliance with the requirements and standards to ABA. An approval sub-committee of the Education and Training Committee undertakes initial assessment of the submitted curricula and self-audit documentation. The recommendations of this sub-committee are brought to the Education and Training Committee and then brought to the Board of ABA. Approval may be granted with recommendations, conditions and/or agreed action plans by ABA to the partnerships providing the nurse education programmes.

The education and training agenda is prioritised within the structure and functioning of ABA. Section 34 of the Nurses Act, 1985 empowers ABA with the development of rules specifying conditions of suitability for hospitals and institutions and the approval of hospitals and institutions suitable for training purposes. Section 36 of the Nurses' Act, 1985 empowers ABA to satisfy itself regarding the standards of theoretical and clinical experiences within courses. The requirements and standards for nurse education and training (ABA 2000) were developed to provide guidance "for the development of flexible, innovative, practice orientated registration programmes to third level institutions and health care institutions involved in the education and training of nurses" (p 5). Section three of the Requirements and Standards provide a statement of the standards that must be met by the third level and health care institutions (ABA 2000). These standards are applicable to specific educational programmes and they enable both the EU directives and the ABA requirements to be met. The site visit audit provides ABA with the opportunity to audit and evaluate the requirements and standards from an operational perspective.

THE SITE VISIT

This site visit process conducted from September 2001 to May 2002 provided an opportunity for the Board to test the requirements and standards (ABA 2000) and the revised site visit process was designed based on these standards. The site visit process was designed to maintain standards for nurse education through the use of a systematic approach to assuring the quality of programmes. This provided the Board with the opportunity to review its requirements and standards and the site visit structures and processes. In all thirteen Higher Education Institutions and their partner Health Care Institutions were captured within the study process. The site visit process was informed by documentary analysis of self-assessment audits of compliance and submitted documentation received by the Board prior to individual site visits. Self-evaluation/audits of compliance are submitted by the HEI/Health Care partnership and the Education Department and the Education and Training committee of ABA conduct an analysis of these curricula, and other documentation pertaining to the programme. Action plans are identified in partnership with the Board. These action plans and feedback/responses in relation to them were addressed at the commencement of the site visit. Additional documentation was also utilised to inform the initial meetings of the site visit. The audit tool developed by ABA was in the form of an open format questionnaire. It was distributed to the HEI/Health Care partners well in advance of the commencement of the visit. This was used by many partnerships to self-assess prior to the site visit. It should be noted that no specific indicators of standards were identified in the audit tool.

The completed audit tool was sent to the Board on occasions, or in some instances provided for the team on its arrival at the site. Other documentation such as the college prospectus, annual reports, curricula, local clinical/educational audit documents and results, student attendance details, internal evaluation data and external examiner feedback was also provided for review. The site visit teams consisted of Board members with the relevant academic or clinical experience and members of the executive from the relevant division(s) of the register. The site visit team could contain as many as nine members, however the team split into smaller teams dealing with specific programmes in terms of the clinical dimension. The site visits were conducted in the light of the requirements and standards documents (ABA

2000) for the General Nursing programmes. The Education and Training committee of ABA provided the primary steering structure for the site visit process.

SUMMARY

This chapter has presented an introduction to the overall investigation by providing an overview of the background to and impetus for conducting the study. The context for the investigation has been briefly outlined as well as the current policies that underpin current regulation of general nurse education programmes.

This evaluative study commenced during a period of unprecedented major reform of nurse education in the Republic of Ireland. During this time there was extensive examination of the regulatory structures and practices that heretofore supported professional nursing practice. The manner in which nursing programmes were delivered and accredited came under scrutiny within the overall context of a general review and reform of the health services as evidenced in Government reports published by the Department of Health and Children (2001) and the Department of An Taoiseach (2001). Additionally the education sector seeing an opportunity to welcome undergraduate and post-graduate nursing education into the third level sector explored how professional education could be delivered within a culture of quality and accountability. The changes proposed as a result of the reports and documents posed challenges for the regulatory management of nursing programmes within ABA. ABA, as the regulator of the profession, set broad standards in the form of competencies for all elements of the educational processes associated with nurse education including

- the content and processes involved during the period of undergraduate education as reflected in the educational curriculum,
- the place where academic nurse education would take place namely the third-level institution,
- the locations where clinical practice is undertaken referred to as the clinical experience,
- the method in which nurse education was assessed and
- the manner in which local educational establishments utilised an external examiner (*ABA 2000*)

A significant number of stakeholders are involved in the education of nurses. It was necessary for each of them to demonstrate in writing how the graduate would achieve these broad competencies that were indicated by ABA on completion of a course of studies. The implication of this was a need to trust the stakeholders to identify achievement of competencies at the completion of a course. When the student nurse in each third level institution and affiliated health care institution demonstrated that they had successfully achieved these competencies they met the criteria for eligibility to the nursing register. As a result he or she could apply to enter their name on the Register of Nurses as maintained by legislation under the Nurses Act (1985) by ABA.

CONCLUSION

In explaining the context of current systems operated by the regulator to approve and monitor programmes of education and training and the health policy context in which the education and training occurs the impetus for the study can be understood. All research is context bound in one-way or another and especially within the realm of policy implementation and review (Pestieau 2004). The following literature review adds to the context section of the study to illuminate, compare and contrast and critique the literature in respect of the issues under study.

CHAPTER THREE - LITERATURE REVIEW

INTRODUCTION

In order to portray an accurate picture of what has previously occurred and what is the present position related to the cultural context of nursing and the performance of nursing, a framework (O'Connor 1992) for conducting a review of the literature was employed. The review is more than a summary of the findings of empirical and theoretical literature, it strove to be a comprehensive examination of professional regulation and knowledge for practice of nurses. The reviewer immersed herself within the literature using as much up-to-date work as was practically possible. The pertinence and originality of the review is to provide a discussion document within which to contextualise regulation, and evaluation in relation to nursing and particularly general nurse education in Ireland.

The use of a systematic method for reviewing the literature as proposed in an article by O'Connor (1992) was employed to aid in the achievement of a comprehensive review. The use of "Network Theory" (O'Connor 1992) particularly assisted in making sense of the articles, reports and magazines reviewed. The review was conducted using a range of sources covering the fields of health, health services management, education, social science and academic research. "Network theory" (O'Connor 1992) is a practical tool for the systematic construction of literature reviews. It requires the reviewer to identify key current articles and work backwards with the references and journals pertinent to the area. A graph is drawn with time usually on the 'X' axis and the articles on the 'Y'. The articles retrieved are then plotted on the graph to achieve a chart. The chart demonstrating the relationship of articles assists in establishing discernable patterns and central ideas. Given a wide body of literature it becomes possible to discern ideas, concepts, debates or historical developments backwards through time. The backward charting of articles enables the forward development of ideas (O'Connor 1992). This systematic charting of articles was also assisted by means of a coding system to indicate the nature of the article both from a research and topic perspective.

The databases that were accessed included CINAHL, Medline, British Nursing Index, ERIC, Biomed OVID, and Cochrane. The search also embraced the Internet, Department of Health and Children, EU Offices, Nurse Regulatory body websites, a personalised weekly literature review service of Sigma Theta Tau and a search of the library of the ABA. The issue when looking in the databases for Irish studies in relation to nurse education became evident through the paucity of reported studies. Consequently personal contacts and access to pertinent reports through archival material became important. It is acknowledged however that our nurse colleagues in the United Kingdom were also grappling with changes in nurse education and therefore using their reports that ultimately impacted and effected policy decisions in Ireland are used and referred to within the review as appropriate.

The initial key words included 'registered nurses' role, professional skills of nurses, evaluation, evaluation of nursing curricula, nurse regulation, using the AND & OR functions. The key words in CINAHL, Medline and British Nursing Index for the period 1986 to 2004 yielded 114018 citations to registered nurses role which when merged with education (n=161015) yielded 37471 citations in English. The fields were further narrowed by journal type and narrative analysis and yielded 75 citations all of which were reviewed for relevance. Evaluation as a concept is an area of study shared by many disciplines. The term 'evaluation' when inserted into the education ERIC database for the period 1966 to 2004 yielded 258,838 citations. The field was narrowed using Boolean AND OR options with 'nursing regulation' and other permutations of the fields searched were 'evaluation' AND 'regulation' AND 'governance' all citations in English, research reports were reviewed. Other sources of data were the World Wide Web, evaluation websites (n=9), books from the library of DCU and ABA. This chapter presents a general literature review related to the research question, which was conducted to focus the investigation and explore the theoretical constructs of the issues under study. The review though quite diverse in its breadth of subject area used network theory (O'Connor, 1992) to assist in developing the focus contained in this report to ensure depth to the issues under consideration. It was divided into separate sub-sections of regulation, learning nursing and evaluation as the emergent themes to understand what should a nurse regulation system consider as an appropriate programme of professional preparation and how does it know if this is achieved.

REGULATION

Introduction

This section of the review examines the concepts of regulation, quality systems and the role of the regulator as an agent of a quality system. The regulation of nursing in Ireland, Europe and internationally is examined to articulate the meaning of professional regulation within a quality system. This examination of the literature and current policy initiatives is designed to illuminate issues around the values and basis guiding the regulation of professional learning and mechanisms of regulating professional learning. In examining these questions the issues associated with regulatory reform and self-regulation are explored with a view to determining a theoretical framework for this study. The literature to support this analysis was obtained from a CINAHL search, from an examination of WHO and EU policy documents, regulatory websites, governmental websites and a search of the ERIC database.

Definition of Regulation

Regulation as a concept is associated with the terms 'control,' 'evaluation,' and 'quality' or examining a performance against criteria and making a judgement (Kells 1992). Coglianesse, Nash and Olmstead (2004 p 706) contend, "regulation is designed to improve the performance of individual and organisational behaviour in ways that reduce social harms, whether by improving industry's environmental performance, increasing the safety of transportation systems, or reducing workplace risk." The term however can be interpreted to a much narrower function usually associated with legislation otherwise known as hard regulation, and governmental initiatives such as clinical governance and complaints systems termed soft regulation (Tingle 2004). Although a current popular concept, governance is associated with local control, conduct, responsibility, regulation and participative management (Castledine 1999) where regulation is associated with rules telling individuals and businesses what they can and cannot do (Coglianesse et al 2004). Regulation is defined by the Department of the Taoiseach (2004 p 4) "to mean primary legislation enacted by the Oireachtas depending on the context, it can also mean "to regulate" in the economic and social sense of the word." Nursing in Ireland is subject to 'hard' regulation in that primary legislation has guided its processes for most of the last century through the Nurses'

Registration (Ireland) Act 1919, Nurses Act 1950 and currently the Nurses Act 1985 (O'Morain 2004)

Professional Regulation

The U K has eight regulatory bodies established under statute for health professions (Caulfield 2004) whereas Ireland has five bodies namely the Irish Medical Council, the Dental Council, the Opticians Board, the Pharmaceutical Society and ABA. These bodies are established on the principle of self-regulation and in common with each other have powers (1) to set standards of education and entry to the profession, (2) set standards of behaviour for members and can investigate complaints, and (3) maintain a register of names of the professionals who are able to practise in the profession who usually pay for the services of the professional regulatory body (Caulfield 2004). The regulation of individuals through legislation is therefore confined to select groups in the health services considering the numbers of people employed by the health services. Across Europe there is no universal mechanism or understanding of how the process should operate from country to country (OJ No L 176/1, 15 7 1977). In respect of each profession above European Union sectoral directives, that require transposition in legislation in each country, cover only some of the groups of health care workers such as doctors, nurses responsible for general care, midwives, pharmacists and dentists.

In calling for the modernisation of regulation the Department of Health (UK) (2000) suggested that to be effective, professional regulation needs to be open, responsive and accountable, focussed on protecting patients and the public rather than solely on professional staff and also needs to be flexible enough to support a changing work environment.

Regulation under Review

The current scrutiny that regulation is experiencing in relation to government reappraisal of systems (Department of An Taoiseach 2001) is occurring against a backdrop of rapid change in professional roles, altering consumer expectations, technological and scientific developments, and healthcare structural reform (Percival 2001). Governments in addressing this challenge have embraced a new theory to achieve healthcare reform termed "New Public Management" which builds on

academic thinking about the relative merits of the current monopolistic approach (Caulfield 2004 p 23) The central tenet of this theory provides for a central provision for policy development that is implemented by agencies of the state that own, provide and manage the service allowing the state to take an overall administrator function Caulfield (2004 p 240) further contends, “the government is actively decreasing the power of individual health professional regulators, while actively increasing regulation by the employer in direct relationship with the government” The overall effect of this strategy is to reduce the administrative burden of regulation and thereby improve the efficiency of systems that provide services and the responsiveness of the service providers to users Coglianesse et al (2004 p 706) suggest regulators usually direct those they govern in two ways to improve their performance These ways they describe as “prescribe exactly what actions regulated entities must take to improve their performance or they can incorporate the regulation’s goal into the language of the rule, specifying the desired level of performance and allowing the targets of regulation to decide how to achieve that level” While the regulation of healthcare has been considered in the U K (Caulfield 2004, Tingle 2004) regulatory reform touches on all aspects of government (Department of An Taoiseach 2001)

It is argued by the OECD (2001) that regulatory reform in Ireland began later than in many countries, but is now moving ahead on a broad front Following Ireland’s remarkable economic performance in the 1990s, regulatory reform is helping to manage the consequences of fast growth and to sustain growth into the future (Department of the Taoiseach 2004) The report of the Department of the Taoiseach (2004) calls for a more coherent and determined approach to regulatory reform Ireland is among several OECD countries that requested a broad review by the OECD of its national regulatory practices and domestic regulatory reforms This review presented an integrated proposal for regulatory reform in framework areas such as the quality of the public sector, competition policy and enforcement, and market openness (OECD 2001) These values are also proposed by the European Union in the Lisbon Agreement (2000) The policy recommendations present a balanced plan of action for both the short and longer term based on best international regulatory practices and were a precursor for the Taoiseach to commission a review of Irish systems (Department of the Taoiseach 2001)

Regulatory reform, which was initiated by the Taoiseach, was required as a consequence of the impact of the Lisbon Agreement (2000). These reforms, it could be argued, stemmed from another OECD report (1996 p 7), which sought to “maximise performance and well-being in ‘knowledge based economies’”. Regulatory reform describes, “changes that improve regulatory quality i.e. enhance the performance, cost effectiveness or legal quality of regulations and related government formalities” (OECD Regulatory Reform in Ireland 2001, cited in Department the Taoiseach 2004 p 5). There are over 500 public agencies/bodies in Ireland many of which have regulatory functions either as a rule maker or rule enforcer (Department the Taoiseach 2004 p 14). A key consideration in evaluating the effectiveness of a regulation is the extent to which it is complied with but this report warns that the thrust is to “achieve compliance without excessive enforcement procedures” (Department the Taoiseach 2004 p 170). Regulatory management and better regulation are terms being used to convey the concept of an ongoing commitment by governments to improving regulation and the quality of services (Department the Taoiseach 2004).

In the UK this issue was addressed in the mid 1980’s and the development of clinical governance was associated with “a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” (NHS 1988 p 33). The NHS following extensive consultation outlined principles for professional regulation in the health field that included clarity on standards, maintaining public confidence, transparency and fairness of procedures, responsiveness to, and protection of the public (NHS, 2001). According to Haynes (2004) the National Health Service (NHS) embraced quality and performance issues as a consequence of the Health Act 1999 (s 18) as it stated that each health authority was required to put in place systems to monitor and improve quality of health care that it provided to individuals.

Regulating Better A Theoretical Framework

In Ireland, in delivering on a commitment towards ensuring a competitive and open economy, the Department of the Taoiseach (2004) following on extensive consultation in 2001 set out the core principles for Government in regulation and

outlined a number of steps to put the principles into place (Department of the Taoiseach 2004). The approach was designed to frame the introduction and enforcement of regulation in existing and new areas (Department of the Taoiseach 2002). This framework is not too dissimilar to others (DoH (UK) 2001) but it is culturally developed within an Irish context. The Taoiseach in the forward to the document states, “good quality regulation contributes to establishing and maintaining individual freedom and social cohesion, not least through articulation and protection of citizens’ and consumers’ rights” (Department of the Taoiseach 2004 p 1). Improving the regulatory environment was at the core of the document in the principles that are articulated as necessity, effectiveness, proportionality, transparency, accountability and consistency (Department of the Taoiseach 2004, p 6). It is further suggested the key to better regulation is clarity and accessibility of regulations with the “publishing of explanatory guides” (Department of the Taoiseach 2004 p 3). These principles in themselves are reflective of the cultural context of developing and reviewing current regulatory systems. In acknowledging processes for effective regulatory accountability sectoral regulators are challenged to develop mechanisms that give “full account for the discharge of their duties and that their regulatory independence is not being compromised in the process” (Department of the Taoiseach 2004 p 31). In examining the principles particular relevance was attributed to issues reflecting sectoral regulators, such as the nursing board, which is provided for in primary legislation related to education, registration, fitness to practice and guidance to nurses (Nurses Act 1985). These principles were examined with a view to representing the culturally relevant issues associated with nurse regulation. In this respect ABA discharges its responsibilities for “full account” in publishing an annual report. It is argued examining regulatory principles could enhance the regulatory independence for the discharge of its duties. In examining the identified principles of “better regulation” in Ireland (Department of the Taoiseach, 2004), as they apply to sectoral regulation of nursing, it is worth exploring this as a theoretical framework for nursing regulation.

The emphasis of the tenets within the document “Regulating Better” is the notion of appropriate regulation (Department of the Taoiseach 2004). This notion is further developed in the principle of necessity and around the question as to whether the regulation was necessary. In reflecting this in respect of the case of nurse regulation

in Ireland the question arises as to the extent to which the requirements and standards of ABA (2000) demonstrably benefit the public by assuring the quality of the education programme and therefore the quality of graduate nurses from the programme (adapted from the Department of the Taoiseach 2004) The notion of needing an additional regulator to that used by mainstream educational programmes is one worth exploring in this study

The next principle identified is that “effective regulation requires clear, achievable objectives the stated objective must also be clear” (Department of the Taoiseach 2004 p 16) A key related consideration in judging the effectiveness of a regulation is the extent to which compliance is achieved The Department of the Taoiseach acknowledge that up to this, the success of regulation has not been based on “compliance and enforcement indicators” (2004 p 17) In this study the researcher identifies the issues for ABA relating to effectiveness are the extent to which the requirements and standards are clear and achievable and the extent to which they are complied with (Department of the Taoiseach 2004) Compliance Questions that should also be considered by ABA are taken directly from “Regulating Better”

Has the issue of compliance with the regulation been fully considered?
 What are the compliance costs and who is most affected by them?
 How can these costs be minimised?
 Has consideration been given to how enforcement can be improved?
 What criteria for success will be put in place?
 What methods of enforcement will be or are being applied?
 Is it obvious where full compliance has been achieved?
 Are there enforcement costs involved and who will bear them?
 Has attention been given to enforcement issues with respect to technological advances?”

(Department of the Taoiseach 2004 p 18)

The current Nurses Act 1985 while conferring authority to ABA to conduct its business also requires that a number of decisions of the Board including withdrawal of approval of a hospital or institution for training purposes to be approved by the Minister of Health and Children (Nurses Act, 1985 34 (4)) The Act further states, “a hospital, or institution, which the Board has refused to approve may apply to the Minister to direct the Board to approve of it and if the Minister, after consideration of the facts of the case, gives the direction, the Board shall approve of the hospital or

institution' (Nurses Act, 1985 34 (5)) In this respect the ability of ABA to enforce compliance is a negotiated one and further reflects the issues of participatory versus prescriptive regulatory processes. However, in examining the implementation of the Regulation/Degree general nursing programme compliance with ABA (2000) requirements and standards will be explored and thus the principle for regulation of general nurse education programmes

The third principle of regulation refers to proportionality that is the extent to which there is a balance between the advantages the approval system provides against the constraints it imposes (Department of the Taoiseach 2004). An efficient and well-founded regulatory system is regarded as a feature of "good governance and gives strength and certainty to society and the economy" (Department of the Taoiseach 2004 p 20). It is further suggested that "it is important to assess the costs and benefits of a traditional 'command and control' type regulation but also to evaluate whether it would be more sensible to use an instrument other than regulation" to achieve the policy goal (Department of the Taoiseach 2004 p 20). In this incidence the approval systems of ABA should be valued as advantageous to the stakeholders of nurse regulation. In making a judgment the systems require periodic review and evaluation. The implementation of regulation is one that has posed challenges to researchers in determining the added value from an outcomes perspective of enforcement type regulation. Thus it is necessary to determine if local systems of devolved authority to providers of education, demonstrate that ABA approval systems are unnecessary in the presence of HEI systems.

The fourth principle "transparency" is seen as a contributor to the quality of regulations, the increased likelihood of compliance and the reduction in bias towards special interests. The principle seeks to achieve maximum clarity and openness in the operations of public administration (Department of the Taoiseach, 2004). This study in examining regulatory principles of transparency seeks to explore the extent to which the standards support clarity and openness in the operation of an approval system that supports the safety of the public in relation to the graduates of the programme. The documentation it is advised should be "written in a style that is unambiguous provides clarity, simplicity and accuracy" (Department of the

Taoiseach, 2004 p 28) The standards and requirements of ABA (2000) therefore will be reviewed with this consideration

The principle of “accountability” is ‘fundamental because of the complexity of the regulatory process and the range of participants involved’ (Department of the Taoiseach 2004 p 30) The issue for many in respect of regulatory accountability is the question “who regulates the regulator?” (Department of the Taoiseach 2004 p 30) The Nurses Act 1985 and the document “Regulating Better” instigate a four stage process of accountability for sectoral regulators i.e. to government in selection, financial audit and policy frameworks, the Oireachtas through annual reports and Oireachtas committees, the Courts through judicial review of decisions, and the public generally through the publication of information about decisions and work (Department of the Taoiseach 2004 p 31) For the purposes of this study consideration needs to be taken of the extent to which the requirements and standards (ABA 2000) support fair, open, efficient and effective processes including appeals procedures (Department of the Taoiseach 2004)

The final principle “consistency” in the regulatory process relates to the degree of predictability and legal certainty to individuals and groups. The essence of the principle is the extent to which the standards support structural consistency i.e. the same approach in relation to production of reports and requirements apply to all parties. The issue for this study is that all issues emerging from the regulation of programmes are addressed consistently to ensure greater confidence in the system, greater transparency in decision-making and promote greater efficiency between the function of ABA and the educational accreditation authorities (Department of the Taoiseach 2004) This study will, therefore, illuminate the extent to which current processes support, or not, this principle. This theoretical framework for regulation, being a policy statement for regulation, warrants explanation for applicability within the sectoral area of nursing regulation. It is for this reason that the principles contained underpin this study.

Regulation in Health Care

The UK Government was concerned that regulatory bodies should build and manage a new framework for self-regulation which was explicit in putting patients first, was

open and transparent allowing for public scrutiny, was responsive to change, provided for better integration between regulatory bodies to ensure better conformity of good regulation and was consistent in its approaches (DOH 2001) In this open accountability to the public and the professions was identified as the key to effective reform of regulation (NHS 2001) In essence as Kerrison suggests (2004 p 79) “the independence of regulatory agencies from government is one of the central issues which determines whether a regulator can decide its own policies and consequently, be responsive to the voice of users” This reform was set against a background where there was a perception that regulatory bodies had not kept pace with the changes taking place across the NHS and predominantly the issue of professional self-interest came before the interests of patients (DOH 2001)

It could however be argued that the Pew Commission (1997) in a consultation exercise which received 76 submissions related to health professions boards commenced an analysis of the regulation issues for health care professions The Taskforce which initially was set up in 1989 with a broad remit in respect to regulation set itself a task in 1994 to “identify and explore how regulation protects the public’s health and to propose new approaches to health care workforce regulation to better serve the public interest” (Graghola and Stone 1997 p 4) The vision of the Taskforce was for state regulation that was SAFE, or standardised, where appropriate, accountable to the public, flexible to support optimal access to a safe and competent health care workforce and effective and efficient in protecting and promoting the public’s health, safety and welfare Its main recommendation in respect of evaluating regulatory effectiveness that ensures health professions regulation protects and promotes the public interest stated “States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies in order to best protect and promote the public’s health” (Graghola and Stone 1997 p 28) While it is true that only 62% of the sample responded to this question of the 85% who supported this recommendation they identified barriers to achieving it The barriers relate to the political and limited nature of sunset reviews and the bureaucratic nature of external reviews The report suggests a three-phase approach that includes Boards to institute time-limiting periods of self-assessment against established outcome measures, and an overseeing interdisciplinary review board with public members, with a state Attorney General overseeing the board assessments In respect

of professional education they state that not only is the professional appropriate but they are the best entity to determine professional standards of education requirements and scopes of practice as only they “have the appropriate understanding and knowledge of the intricacies of the profession” (Gragnola and Stone 1997 p 30)

Regulation of service provision and settings has also impacted within the education sector. More widespread is regulation of settings and regulation by employers (Caulfield, 2004). Since the 1980’s there has been an expectation that universities worldwide but particularly in Europe would develop

effective internal and collaborative evaluation systems so that the confidence of government could be achieved, the public could be assured about quality and the return on their investment and, ideally, so that mechanisms could exist to improve the programmes and services in the institutions concerned

(Kells 1992 p 11)

A number of functions are attributed to the regulatory process and as such based on conceptual models for regulation, evaluation and self-assessment, Kells (1992), culminated her thoughts over 20 years experience concerning the nature of continuing and evolving struggle to regulate universities themselves. Regulation, she defines as

the informed and periodic process through which a system, institution, programme or procedure is attuned over time to expectations (intentions, standards, norms) through choices and actions judged by the regulator(s) to be needed as a result of formative or summative evaluation

(Kells 1992 p 17)

She further contends that there are three major constituent sub-functions of the process namely “quality assurance, quality assessment (evaluation), and quality control” (Kells 1992 p 17) that universities have the choice to embrace lest governments do it for them in other ways. While this illuminates the potential for regulation and regulators the themes imply a cold dissociation of regulators from those being regulated. It can be argued that perspective and context informs approaches to regulation, with professionals and researchers looking for different outcomes for regulation in that the professional seeks new solutions to operational matters while traditionally in university the researcher seeks new knowledge.

Context of Regulation

Regulation is under scrutiny in many countries and old ways of operating are being questioned. In light of the issues raised associated with increased accountability of regulators ABA as the Irish State identified regulator of nursing and midwifery needs to ensure effective governance if it is to achieve the aspiration of government of “rules, processes and behaviour that affect the way in which powers are exercised particularly as regards openness, participation, accountability, effectiveness and coherence” (European Commission, European Governance – A White Paper, 2001 cited in Department of the Taoiseach, *Regulating Better*, 2004, p 4). ABA carries out its function of protecting the public by ensuring standards of education and training and practice of nurses and midwives by approving programmes of education and training and institutions and for the education and practice of nursing (Nurses Act 1985). This mechanism of professional authority where the link between educational preparation, scope of practice of the individual nurses and midwives and the accountability for practice are central to the concept of professional regulation. Professional regulation within a self-regulatory framework has many sceptics (Caulfield 2004, Finocchio and Dower 1995, Kells 1992). The scepticism is associated with self-interest and self-protection being of paramount importance rather than protection of the public interest. Understanding the systems whereby government leads regulation and self-regulation overlaps and fulfils expectations needs further explanation.

Professional Self-Regulation

Walshe (2003) identifies the key general characteristics of regulation as the existence of a central authority in which is vested formal responsibility to regulate and which is responsible to protect and act in the best interest of the society at-large, and which has a framework for control and accountability. The principles underpinning regulation of a profession are the setting, promotion, control and maintenance of standards. In relation to nursing, the UK Royal College of Nursing (RCN) (2004a) categorises the functions of regulation as professional self-regulation, public protection, education, safety of individuals, competence, performance management, quality assurance, and setting standards.

In most economically developed Western countries the nursing and midwifery professions are self-regulated by professional statutory bodies created by Government legislation, either at a national level in smaller countries such as Ireland and the UK, or at a state and federal level in larger countries such as the USA, Germany and Australia (Quinn 1979). In the USA, Australia and the UK the degree of complexity of regulation has increased generally because of restructuring of health care systems, technological advances and changes in expectations of health care consumers (RCN 2004a, Pearson et al 2002, Hutcherson & Williamson 1999). However, while the extent of regulation within the nursing and midwifery professions differs somewhat from country to country, and in large countries from state to state, the key characteristics and goals are generally similar.

The combination of self-regulation with the authority of the state has generated concern (DOH (UK), 2001). The considerable autonomy and independence with which professional boards regulate their respective professions has led to criticism that professional self-interest and conflict of interest are inherent in self-regulation (Finocchio and Dower 1995). The Pew Commission Taskforce further warns against self-regulatory systems that “treats practice acts as rewards for the professions rather than as rational mechanisms for cost-effective, high quality and accessible service delivery by competent providers” (Finocchio and Dower 1995 p 12). In this respect Kells (1992) suggests a successful self-regulation system depends on the extent to which the managerial and academic elements of institutions are prepared to create a culture of self-regulation and whether they can design a system of quality assessment that can effectively serve the regulation scheme. The possible regulatory activities in education are articulated by Kells (1992 p 31-34) where she identifies activity and five levels of regulation, government level, collaborative university or guild organisation (e.g. Nursing Board), institutional level (Board of Control or Executive Activity), Programme, discipline or Departmental level, and individual level. The activities attributed to a board or guild, such as ABA, would include 10 elements.

Possible Regulatory Activities in Higher Education by Guild Organisation	
1	The establishment of standards of good or expected practice
2	Peer review of programmes and or institutions
3	Linking of the results of peer review to access to certain funds, possibly in collaboration with government
4	Provision of consultants to review and recommend changes in programmes
5	Designation of those successfully reviewed with and accredited or other status, withheld unless problems addressed
6	Peer review of the internal, institutional quality control processes (meta-evaluation)
7	Guild approval to award certain degree levels or to offer particular programmes
8	Peer approval (or the approval by one official or senior institution) of the license, charter or degree granting status of new institutions
9	Collaborative peer external examination of students, grading levels and level of any differentially graded degrees
10	Separation of instruction and grading by use of an inter-institutional grading scheme

Table 3 1 Possible Regulatory Activities in Higher Education by Guild Organisation (from Kells 1992 p 32)

Notably absent from this framework as described by Kells (1992) is the involvement of the public in the review exercise. Also absent is the involvement of students on the programme to provide feedback for the review and match this to the expectation of the practitioners of the programme to achieve the required standards in respect of the guild. In summary the loop of the programme goes from setting standards, to assessing the plan for their implementation, to checking if implemented, to assessing the appropriateness of the standards in practice and eventually the relevance and effectiveness of the standards in the first instance. The regulation of nursing in the higher education sector as a practice-based discipline requires further exploration.

Self-regulation of the university sector is acknowledged by Kells (1992) to experience periodic difficulties to respond to demands of the public and external demands. However in supporting the construct she outlines the advantages of a self-regulatory system to the knowledge a system gains about itself, the strengths and challenges through the validation and peer review process it contains through to building further capacity thus strengthening the programme. Conversely she argues that

A university primarily regulated by government has less control in relation to inputs, environment and markets, less involvement with its peers and less sense of its intentions (purposes and goals) and the workings of its faculties and services than does the self-regulated university

(Kells 1992 p 39)

In outlining the advantages and disadvantages of both systems that include a guild perspective, a successful self-regulation system depends heavily on the leaders, both academic and administrative, in creating a culture that can effectively support the regulation system based on quality goals. The issue of self-regulation is reflected in the notion that “the ordinary good citizen is as a matter of fact subject to a great deal of social control and that a considerable part of this control is not felt to involve restriction of personal freedom” (Dewey 1963 p 52)

Regulation of Nursing

Regulation according to the International Council of Nurses is

All those legitimate and appropriate means - governmental, professional, private, and individual - whereby order, identity, consistency, and control are brought to the profession. The profession and its members are defined, the scope of practice is determined, standards of education and of ethical and competent practice are set, and systems of accountability are established through these means

(ICN 1992, p 45)

The most important construct within this definition is the association of standards of education with competent practice. This association is at the root of a professional regulatory mechanism where the purpose is to protect the public and thereby ensure the quality of services provided by the practitioners or graduates of the nurse education programme. The Irish mechanism for nurse regulation is currently *The Nurses' Act 1985*. The Act requires ABA to implement European Union Directives for nursing (Nurses Act 1985, 37) and the act is operationalised through *The Nurses' Rules 1988* and subsequent Amendments. Dewey (1963, p 53) the educational philosopher suggests that

“control of individual actions is effected by the whole situation in which individuals are involved, in which they share and of which they are co-operative or interacting parts”

The notion, therefore, of regulation within a professional context is explored to examine the impact of regulation in a local, national, European and the international context

The inception of regulation for nursing according to International Council of Nurses (ICN) was established in 1899 from a concern to ensure that the public had access to quality nursing services caused much debate in the nursing fraternity (Scanlan 1991). The founders of ICN believed that having a recognised system of education for nurses promoted standards for the professional identity of nursing. The concept of universal standards was also a concern internationally (Quinn 1989 p 1-2). Quinn (1989) further suggests that the World Health Organization (WHO), at its first World Health Assembly (WHA), recognised the importance of nursing care as a key medium to achieve health for all and has promoted the strategy of strengthening nursing through appropriate regulation. WHA resolutions over the past two decades have consistently called on governments to provide for adequate and relevant regulation of nurses and nursing (WHO 1977, 1986).

However, the goal of WHO to realise the effective use of nurses in implementing primary health care (PHC) was as suggested by Quinn (1989) impeded by regulatory diversity throughout Europe and the world. Quinn further suggested that to meet PHC goals, nurses' role and contributions to health care needed to evolve beyond the areas traditionally assigned to them. However, the WHO identified that in some jurisdictions outdated, inflexible and inappropriate regulatory policies and practices, especially those restricting the scope of nursing education and practice, were obstructing such changes (WHO 1986) and such diversity still exists even within Europe (ABA 2003).

Regulation is associated with forming the identity, structure and type of services a professional can offer. An international study of nursing was commissioned by ICN (1986) on regulation, and this was followed by further reports in 1995 and 1997. ICN's 1986 report on regulation concluded that, to maintain congruence between global health, human resources objectives and nursing development, ICN and WHO must work jointly to influence health policy and the contribution of nursing to healthcare, periodically reviewing nursing's progress and suggesting future directions (ICN 1986). WHO further extended this collaborative work into the field of nursing regulation in its 2002 document setting out strategic directions for strengthening nursing and midwifery services. This report noted the following

The provision of health care has changed markedly over the past decade. Many countries are engaged in health sector reform. Strategies such as decentralisation and privatisation are forcing changes to traditional work patterns, health system governance and financing. Globalisation and technological advances create new opportunities on the one hand, but also engender tensions that could significantly impact on the location and regulation of health care services (WHO 2002 p 2)

Further the report suggests that a high-level of interest of government, public and profession in regulation and an emphasis on continued competence has increased pressure on regulatory systems to pay more attention to developing effective and accountable quality and safety concerns. Globalisation and the emergence of global and regional trade agreements have caused increasing mobility of services and health care workers including nurses. This has stimulated more demand for harmonization and recognition of standards and regulatory processes (EU Services Directive 2002)

The challenge for regulatory frameworks therefore is a need to make explicit ethical, professional and legal accountability of the individual practitioner and the regulatory system itself. There are two aspects of accountability. Nurses, as healthcare professionals, are accountable for the actions they take in the provision of all aspects of health care they provide and regulatory frameworks need to clearly define what a health professional is answerable for, and to whom. Scope of practice statements, code of ethics, and practice guidelines are some of the tools used to define and clarify accountability issues. In addition, those involved in setting policy and applying the provisions of the regulatory system are accountable with respect to assuring that policies, processes and procedures meet and continue to meet the system's stated goals (e.g. public protection, contributing to quality improvement) and values (e.g. fairness, transparency, collaboration). Therefore the systems the regulator uses need to be subject to accountability and social inquiry. The effectiveness of the regulatory system to achieve their stated goals or purposes that will assure the safe and competent practice, the policies, processes and procedures applied should accomplish this desired result.

Regulation of Nursing in Ireland ABA

ABA is the statutory regulatory body for nursing and midwifery in Ireland. The provisions of the Nurses Act, 1985, define the responsibilities and duties of ABA. Part

IV of the Act authorises the Board to 'prescribe the manner in which and the conditions under which training shall be provided' (31) Under the Act and the Nurses Rules 1988 (Amendment) Rules, 1998 and 1999 the Board is authorised to "specify the conditions of suitability for hospitals and institutions" (34 2) ABA sets Requirements and Standards for Nurse and Midwifery education in 1999 and a second edition in 2000 These requirements and standards cover areas such as competence for registration, essential requirements in terms of theoretical and clinical instruction, syllabi/indicative content for the programmes, standards in terms of the Higher Education and Health Care institutions, curriculum design, clinical experience, the assessment process and external examiners to the programmes This is in keeping with the Nurses Act 1985 section 36 1 As part of an ongoing approval and monitoring process ABA validate education programmes submitted by the Third level Institution and the health care institution partnerships providing such programmes ABA conducts an audit of these programmes at least once every five years in line with the Nurses Act, 1985 section 36 1 ABA supports the principles that curricula should be flexible, adaptable, innovative, underpinned by the quality agenda and continuously evolving in response to on-going curriculum evaluation (ABA 2002)

The general concern of ABA is the promotion of high standards of professional education, training and practice and professional conduct among nurses and midwives thus ensuring the protection of the public (ABA 2001) The developments in nurse education, for the introduction of a graduate profession from 2002, enhanced the commitment of ABA to being proactive, guiding, supportive and responsive to the changing educational structures and processes, which support the registration/degree in nursing

ABA embraces opportunities to develop, extend and strengthen the principle of partnership with all parties to the educational experience while maintaining statutory independence (ABA 2002) The Board stated that partnership supports the principle of self-regulation being a privilege to the profession and is fundamental to developing a quality nursing/midwifery service to the public (ABA 2001) Quality is one of the main principles underpinning the health strategy since 1994 and as expressed in the recent Health Strategy (2001 p 19) "setting and meeting standards is not enough" it is

about creating a “culture of quality”. The concern of ABA in the protection of the public acknowledges the issue of quality, in education, actual practice of nurses and midwives and the need for practice to be grounded in appropriate current evidence (ABA 2001). Quality and the governance of the initiatives to support a quality culture in the clinical environment are about developing frameworks for improving quality and creating environments in which excellence in clinical care will flourish.

The regulatory requirements to support such developments and to ensure competence of nurses to apply to have a name entered on the Register of Nurses is contained in the Nurses Act 1985 and Nurses Rules 1988 and Amendments. The education and certification functions are summarised in table 3.2. These functions articulate the overall context of educational governance since the enactment of this self-regulation structure for nurses and midwives.

EDUCATION
<ul style="list-style-type: none"> • Approve hospitals and institutions suitable for training purposes and the inspection of these at least once every five years to ensure the suitability of the education and training for nurses which is being provided, • Determination of the minimum education requirements necessary for entry to nurse training, • Establishment of a central applications bureau to process applications from persons wishing to undertake training as a nurse, • Providing or making provision for the courses of training to be taken by candidates for registration in the Register of Nurses, • Providing or making provision for the examinations to be taken by candidates for registration in the Register of Nurses, • Providing or making provision for courses of training and examinations for nurses and for the granting to nurses taking such courses and passing such examinations of certificates or diplomas, • Satisfy itself as to the adequacy and suitability of post-registration training courses for nurses provided by bodies recognised by the Board for that purpose

Table 3.2 Abridged Education and Certification Functions of ABA (The Nurses Act 1985) (Nurses include Midwives)

The General Division of the Register of Nurses

In Ireland it therefore becomes important to examine the regulation of Irish general nursing. The general division of the Register of Nurses' is numerically the largest and most dominant branch of the profession in Ireland (Ryan 2000, Savage 1998, Condell 1998, ABA 1994). The present system of general nursing in Ireland has a long tradition (ABA 1994, par, 2.2) and is rooted in an established pattern of caring for the physically ill in hospital. The Working Party on General Nursing (1980 par 1.1) records that the plans for the instruction of general nurses were outlined as early as 1817. An early effort toward the systematic training of nurses failed until the 1890's when the value of the formal training of a large numbers of student nurses from a service perspective were realised. This was the genesis of a model of service delivery that depended heavily on student nurse labour, which existed for many decades (Department of Health 1980). The regulation of general nursing was established through the Nurses Registration Act, 1919.

Currently there are 50,637 recorded qualifications on the active file of the general division of the Nurses' Register of ABA (ABA 2005). The claim by Ryan, (2000) and Condell, (1998) that the majority of Irish nurses first encounter nursing through the general division is supported by the statistics of applicant trends. The numbers of training places for nurses available have fundamentally respected the local need to train staff for nursing positions and a review of the statistics show a remarkable peak and trough of these figures through the years (Department of Health and Children 2001). The highest support for nurse training places was the approval of 1640 places for funding by the Department of Health and Children with the introduction of the registration/degree programme in 2002.

Savage, (1998) argues that the hospital setting remains the predominant place of work for the general nurse. This argument is substantiated on the basis of the dominance of the medical model, which has elevated hospital medicine to the central position in the health care arena (Boschma 1994, Baly 1980). A report of ABA entitled the Future of Nurse Education and Training in Ireland (1994, par, 2.2) indicated that changing health patterns and health service activities had paralleled the historical developments in general nursing. The continuance of this pattern of reciprocity is predicted and

Ryan (2000), argues that general nursing must grapple with immense and complex change to retain its viability Birchenall (2000) affirms the complex nature of change and draws attention to the correlation between developments in nursing practice and change in the politico/socio/economic landscape

In 1973, Ireland joined the European Union and the health-related debates of the European Commission as well as the policies of the World Health Organization, particularly the emphasis on disease prevention and primary care, began to influence health policy ideas Nonetheless, events continued to be directed by an illness perspective Condell (1998) implicates the European Union Nursing Directives, (77/452/EEC and 77/453/EEC) as a significant precursor of change in general nursing Implemented initially in accordance with Article 57 of the Treaty of Rome, its purpose was to facilitate the free movement of nursing labour throughout member countries This predicated the need to develop an agreed minimum standard of nurse education and training that was acceptable throughout all Member States of the European Union the contentious issue of "student status" for the student nurse

In the period prior to 1994, general nurse training in Ireland was akin to an apprenticeship (Quinn 1979) In addition, an Advisory Committee on Training in Nursing was established to offer guidance and advice to the European Commission on issues related to nurse education and training across the member states The published guidelines (111/D/5044/1/89EN) are cited by Condell (1998) as important in highlighting the theory practice gap in general nursing and student nurse occupying a dual role as learner and employee Ryan (2000) observed that the published Syllabus of Course Instructions (1956) from ABA had remained unchanged until 1979 It can therefore be inferred that nurse education in Ireland, like a number of social policy issues, was a key beneficiary of Irelands joining the European Union The Sectoral Directives 77/452/EEC and 77/453/EEC were transposed into Irish legislation in 1980 (SI No 237/1980) Further developments in respect of the European Community directives occurred with General Systems Directive 89/594/EEC During these decades and those that followed health services were mainly related to illness and disability, and there was little opportunity for development

Nurse education has witnessed much change in the manner of course delivery since the transposition of European Directives 77/453/EEC and 77/452/EEC in 1980 and subsequent Directives 89/594/EEC. This saw the education provision of programmes move from requiring 26 weeks of theoretical instruction within a programme to 40 weeks and subsequently the move of nurse education from an apprentice type model of training to an accredited programme with higher education institutions offering a three-year diploma in nursing studies (Simmons et al 1998). The requirement for students to provide service to the hospital while students was dropped for the diploma programme but reintroduced for the degree programme where the students were required to provide 47 weeks rostered service (Simmons et al 1998, Para 5.22).

The issue of full student status for student nurses was not new and can be traced to the UK and the recommendation of the post-war Wood's Committee Report (1947). Unfortunately many of its forward thinking recommendations including "full student status" were not implemented even after it was recommended by the Working Party on General Nursing (1980) because it did not coincide with the views of nurse leaders of the day nor the service provision needs of the hospitals. In 1994, significant educational reform and restructuring of the general nursing programme occurred (Simmons et al, 1998). This represented an attempt to develop a more academically credible nursing programme where the student nurse would be supernumerary to service requirements. It can be argued that the essential catalytic ingredients of context, convergence, and contingency were present to ignite this change in policy (Traynor and Rafferty 1999).

The context was receptive, with pressure for change informed by international and national opinion (Commission on Nursing 1998, WHO 1994, ABA 1994). There was the unexpected convergence of professional and governmental agendas in relation to nurse education. Consequently, the curriculum for general nursing required revision to subsume the additional educational and accreditation requirements of the partnership arrangement in providing nurse education programmes between health care institutions and higher education providers. The new programme, the "Galway Model" granted supernumerary status to the student nurse and developed strong links with the third level education sector. This was the beginning of a radical change to the system of nurse education and training in Ireland (Ryan 2000). However, an

imperative prerequisite for curriculum innovation is utility and relevance of the educational programme to health care priorities. The WHO (1999 para 1.3) warn that “nurses education now will be productive for 3 to 30 years and that education must produce nurses who are valuable at once and who can retain value in the future” in respect of the changing pattern of health care and the drive for more integrated services.

Regulation of Nursing in Europe

In examining the professional context of nursing it may prove useful to note Naisbitt and Aburdenes (1990) observation that events rarely if ever occur in a vacuum but rather in a social, political, cultural and economic context. What any profession or division of a profession is arises from history, its place in the system, the interplay of social forces which shape its development together with the power play of different groups that have a vested interest in its advancement. The issues surrounding claims to professional status are often highly contentious, not surprisingly various interest groups either welcome or reject attempts to examine the claim from different perspectives (costs, outcomes and quality of nursing care).

As discussed in 1977 following consultation with the International Council of Nurses and An Advisory Committee on nursing from member states the European Union issued Sectoral Directives for general care nursing in accordance with Article 57 of the Treaty of Rome, which required the free movement of labour throughout Member States (Keighley 1994). It was recognised that special provision required to be made to enable the automatic professional recognition of the “title” nurse or midwife throughout Europe and the development of harmonisation criteria that would allow movement of nationals from one country to practice in another in the spirit of the Treaty (Quinn 1979). Keighley (1994) succinctly describes the shift in Europe from the old system of harmonisation to the newer model of recognition. An example of how harmonisation was pursued was through the nursing directives that harmonised the system of preparation of nurses across Europe by ensuring particular subjects were studied for a specified length of time. Recognition seeks to recognise levels of development. Currently the Directives support a straightforward procedure for nurses within the EU and the European Economic Area (EEA) wishing to register to work in a Member State. Under EU Sectoral Directives governing the mutual recognition of

qualifications, the regulatory body in the Host State is notified by the regulatory body in the applicant's country of origin, that the education programme undertaken by the applicant and leading to registration meets existing EU Sectoral Directives governing nursing education programmes. Eligibility for registration with the regulatory body in the Host State becomes automatic if this verification is supplied. Alternatively, if the qualification gained does not satisfy the minimum training requirements, under the Sectoral Directives the Host State can accept verification from the regulatory body in the country of origin in which the nurse or midwife is registered, accompanied by a certificate stating that the nurse or midwife has practised for three of the previous five years. However, it is apparent from the profiles on nursing and midwifery (Table 3.3) in the new Member States that not all countries operate the same compliance with EU Directives.

The configuration of the programme and duration of training was stipulated in the Directives. This entailed a programme of three years duration or a programme incorporating 4600 hours of theoretical and clinical instruction with the former representing at least one third of the programme and the latter at least one half of the minimum duration of training for general care nursing. The table below (3.3) represents an overview of comparable information from the Member States relevant to general care nursing compliant with the minimum standards as laid down by EU Directive 77/453/EEC.

The table contains valuable information regarding the overall structure of pre-registration nurse education inputs throughout the European Member States. There is variation between the Member State requirements and divergence from the minimum training standards as expressed in EU Directive 77/453/EEC. In some Member States (Netherlands, UK, Italy, Greece, Belgium, Finland) there are different levels of educational award available for entry to practice (Certificate, Diploma, and Degree). The discrepancies that emerge reflect a growing divergence in the comparability of education and training programmes for nurses throughout the Member States. While it can be argued that the adoption of the EU Directives has impacted positively upon general care nursing it can be argued from the evidence presented that there is a need to draft new training standards to ensure compatibility of education and training and a greater freedom of movement for general care nurses. In addition, it can be argued

that while registered general nurses have the right to practice in any Member State it is becoming increasingly important to plan nursing resource requirements at a European level. Nursing in Europe does not take place in a political or socio-economic vacuum. In 1997 the WHO Expert Committee on Nursing Practice intimated that the existing divisions in knowledge, skills and roles of health care providers would need to change. It identified the rigid boundaries between and within professions and inadequate educational preparation as contributing to restricted practices. It suggested that in order to deploy nursing services efficiently and effectively, managers must have a clear description of the educational preparation and practice competencies of all nursing personnel. This will become even more evident with the challenges that are imminent in the implementation of the Bologna (1999) and Lisbon Agreements (2000) for 2010 when the realisation of a knowledge based economy for Europe becomes a reality. In this respect the regulatory challenge of recognition of other education systems and outcomes from programmes are associated with how regulation will be evaluated.

Regulation of Nursing from an International Perspective

Regulation of nursing internationally as discussed has been well established (ICN 1994). The notion of a single perspective however is not tenable in looking at the European perspective. In North America a trilateral initiative with the cooperation of Canada, Mexico and the United States was formed in 1994 with the long-term goal of developing mutually acceptable standards for nursing so that ultimately health care is improved in the three countries (Maroun 1995). The diversity of regulation was seen in this document from the three countries emerged and in Canada there are 10 boards of nursing (Earle et al 1995 p 14), Mexico there is General Law on Professions (1945) that includes nurses but there is "no approval councils formed by nurses to approve curricula and educational programmes" (Munoz et al 1995 p 83) and in the United States there are fifty boards of nursing (Bosma et al 1995 p 159). Of significance in examining monographs from each of the countries was the establishment in 1984 of a Board of Accreditation in Canada. The processes adopted by The Canadian Association of University Schools of Nursing (CAUSN) for accreditation were revised in 1995 with a view to quality assurance in nursing education (McBride and Dye 1995) as opposed to regulatory harmonization as seen in the objective of the EU

CURRENT EDUCATION AND TRAINING OF GENERAL CARE NURSES IN THE EU			
Countries	Qualification	Course Duration	Theory (T) / Practice (P)
Netherlands	Diploma	4 years	T 3897 hrs / P 2823 hrs
	Degree	4 years	T 2706 hrs / P 3384 hrs
Sweden	Degree	3 years	T 2400 hrs / P 2400 hrs
Luxembourg	Diploma	3 years	T 1600 hrs / P 3000 hrs
United Kingdom	Diploma	3 years	T variable / P variable
	Degree	3 years	T variable / P variable
Finland	Diploma	3 5 years	T 2682 hrs / P 1973 hrs
	Degree	3 5 years	T 3600 hrs / P 2000 hrs
Belgium	Certificate	3 years	T 2080 hrs / P 2240hrs
	Diploma	3 years	T 1440 hrs / P 1800hrs
Germany	Diploma	3 years	T 1000-12000hrs / P 2400-3600 hrs
Austria	Diploma	3 years	T 2400 hrs / P 2800 hrs
Denmark	Diploma	3 5years	T 2000 hrs / P 2600
Spain	Diploma	3 years	T and P 3900 hrs
France	Diploma	3 years	T 2485 hrs / P 2275 hrs
Ireland	Diploma	3 years	T 1533 hrs / P 2300 hrs
Portugal	Degree	3 years	T 1400 hrs / P 3200 hrs
Greece	Diploma	4 years	T 2260 hrs / P 2220 hrs
	Degree	4 years	T 2876 hrs / P 2160 hrs
Italy	Diploma (University)	3 years	T 1400 hrs / P 3200 hrs
	Diploma (Professional)	3 years	T 1750 hrs / P 2850 hrs

Table 3 3 Current Education and Training of General Care Nurses in the EU Source European Commission /Advisory Committee on Training in Nursing Oct 1997 XV/E9432/7/96-EN

Directives The accreditation system in Canada was based on the four key criteria of Allen (1977), which CAUSN adapted to include “relevance, accountability, relatedness and uniqueness” (McBride and Dey 1995 p 68) The tenet behind this move was to promote activities on evaluation with the four key criteria of CAUSN (1995) being the stages of the process The system, which commenced with seventy-

five behavioural indicators, has been revised down to forty behavioural indicators within the criteria. The criteria read:

Relevance - the extent to which the mission and goals of a programme reflect a response to the major trends in society that impact on the health needs, present and future of the larger community,

Accountability – the extent to which the programme teaches the student that the primary responsibility in nursing is to the client, that is community, group, family, person,

Relatedness - the extent to which the components of a programme support and build on other parts, thereby promoting or negating the achievement of goals

The components are 1) curriculum, 2) the teaching of nursing, 3) research, clinical practice and professional activities and 4) administration. This criterion is a measure of internal consistency,

Uniqueness – the extent to which a programme capitalises on unique characteristics of its resources (faculty, community values, financial support) within its particular setting

(CAUSN 1995, cited in McBride and Dye 1995 p 70)

These criteria though utilised on a voluntary basis by some of the provinces were seen as the mechanism that could cohere two regulatory systems that operate in Canada between the ten provinces. This mechanism was the conduit for standard implementation of the education programme that is monitored through the approval/accreditation process (Earle et al 1995 p 15)

The debate as to who should have overall responsibility or accountability for the quality of nursing programmes is one that reflected in four models of approval that are available worldwide. The National Council of State Boards of Nursing (NCSBN) identified the four models in a study in 1998 from 560 nurse education programmes reviewed. The first of these models was suggested from a review that identified 80% of the programmes in the USA operate a separate and distinct model of initial and continuous approval based on the Boards' separate and distinct view of nurse education programmes. The next most favoured option was for a system of

accreditation recognition mechanism where the Board to a programme grants initial approval but the Board then recognises continued national approval systems. The next system of non-involvement by the Board in approval system was used only in two states and this system was operated by education systems in the country without the involvement of nurses or Boards of nursing. The other system was not specified but did not have Board approval. Of the systems used 89% of those surveyed believed that the model they operated safeguarded the public in changing healthcare environment and demonstrated accountability.

The practice, education and regulation congruence task force (PERC) of the National Council of State Boards of Nursing (2004) in the US identified that there are times when regulation should operate in isolation and others when regulators, education and practice should act together. The study conducted by the PERC taskforce invited comment from 200 nursing, governmental and regulatory organizations by mail and website followed by a meeting with 14 stakeholders. The congruencies identified were that regulators and educators both value high quality nurse education and most boards collaborate with educators. A burden was identified in accreditation requirements of boards of nursing and other accreditation bodies that require different documentation. Public health nursing was reported as inadequately addressed in curricula and there was seen to be a similarity in curricula from 20 years ago to current offerings albeit with additions instead of responsive futures oriented curricula that embraced the acuity of current patient populations and technological advances. One of the other main findings of the study was incongruence when practice, education and the regulator have values other than public protection.

Crawford (2004) further reports on a recent study with responses from 34 of the possible 61 boards of nursing in the United States and its territories. In measuring the outcomes of board activities from internal and external sources that included 378 nursing programmes reported, they viewed "regulation as adequate in areas of practice, resolution, and licensure" (p 224). They also reported there was too much regulation in the area of education programme approval. The responses of the study saw regulation as effective in protecting the health and safety of the public and providing highly satisfactory services and assistance to nursing programme. However they viewed regulation as "only fairly effective in promoting quality in education,

responding to health care changes, and responding to innovation in education” (Crawford 2004 p 224) In summary the regulation of nursing around the world is varied in approach from one of being associated with structures (EU) to accreditation models (Canada) and outcomes focused models (US) Understanding these approaches gives insight into the perspectives operated and affords opportunities to recognize and respect the value of each approach

Quality, Standards and Higher Education

The effectiveness of standards and outcomes of education to key stakeholders such as students, nurse educators and others involved in the delivery of healthcare can be provided through evidence in evaluation research (Ornstein & Hunkins 1998) Nurse education programmes must be evaluated with an understanding of the wider context of evaluation in the third-level sector Evaluation of higher education programmes is now being influenced by a number of factors including the expansion and diversification of the university sector, the need to measure the adequacy of the preparation that students receive for the world of work, the increased costs both to governments and students of higher education and, European and national policy directives (Skilbeck 2001, Higher Education Quality Council 1997) A number of policy directives published over the last decade such as the Bologna Declaration, the Universities Act (1997) and the Organisation for Economic Co-operation and Development review of higher education in Ireland report (OECD 2004) have called for an increase in evaluation studies as evidence of the impact and outcomes of educational programmes To understand the evaluation of any programme in the third-level sector and to place this research in the context of current thought on evaluation theory it is necessary to examine these national and European policy directives Therefore, this section of this chapter will explore the policy directives that have been published over the last decade that pertain to higher education

The growth in educational evaluation over the last decade is reflected in the number of declarations, governmental acts and reports that have been published at international, national and EU level on the role and function of higher education systems (Universities Act 1997, Qualification (Education and Training) Act 1999, Bologna Declaration 1998, OECD, 1996, 2004) Although they deal with a number of diverse issues such as international transparency of qualifications and learning,

international recognition of learning, international mobility of citizens, governance of universities and increasing competitiveness, a central theme in the reports is the centrality and importance of ensuring the standards and quality of educational programmes. In the more recent reports the assurance of quality and standards has been given increasing prominence with a recommendation that students become involved in the evaluation of their education programme (Universities Act 1997, Qualification (Education and Training) Act 1999)

The increasing importance of quality and evaluation in the higher education sector has also been highlighted in a number of EU initiatives and declarations published between 1998 and 2003. The initial purpose of these declarations was to begin a process of standardising, integrating and converging higher education systems across the states of the EU by the year 2010 to achieve a knowledge economy for Europe (Lisbon 1997). However recent declarations, most notably Prague in 2001 and Berlin in 2003, have extended this process by placing increasing emphasis on the quality of outcomes of educational programmes.

Quality and the EU

The process of standardising higher education began with the Sorbonne Joint Declaration (1998), which made recommendations on the introduction of flexibility and transferability of educational pathways across the member states of the EU. The Bologna Declaration (1999) developed this conviction to ensure that the European higher education system remained competitive in the international higher education arena. The thrust of these declarations was for the integration and development of the European higher education systems around five central themes. These included the adoption of transferable and comparable degrees, a two-cycle undergraduate-graduate system, the introduction of transferable credits, and the promotion of mobility for students and researchers/lecturers, the promotion of a European dimension in higher education, and the development of methodologically comparable evaluation and quality assurance systems. The rationale for comparable evaluation systems was intended to allow for the Europe-wide recognition of the value and standards of educational programmes (Maguire 2005).

An update on the progress made following the signing of the Bologna Declaration was held in Prague in 2001 (Prague Declaration 2001). This declaration again broadly identified the importance of quality assurance to the higher education systems in the European Union. One recommendation was for the Europe-wide dissemination of examples of best practice in the evaluation of educational programmes. A criticism of the Bologna Declaration is the scientific and competitive hegemony of the report, this was addressed to an extent in Prague by including the social dimension of higher education and the need to stress “the importance of students as partners in European higher education” (Wachter 2004, p. 266).

The most recent update on the Bologna process was given in Berlin in 2003 (Berlin Declaration 2003). The centrality given to competitiveness in the Bologna Declaration was tempered somewhat in the Berlin communique by the recognition that higher education also has an important role in strengthening social cohesion and reducing social inequalities. The report went on to adopt the declaration made in Lisbon (2000) that consideration be given to making Europe

the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth with more and better jobs and greater social cohesion (p. 2)

However, quality assurance was also given prominence to counterbalance the emphasis on competitiveness outlined so strongly in the Bologna Process (Wachter 2004). The recommendations from the Berlin Declaration (2003) that are of concern to this study relate to issues surrounding the quality of higher education. Again, as in previous declarations, the need to develop mutually shared criteria and methodologies on quality assurance was stressed. Central to this process of quality assurance was a recommendation that by 2005 national quality assurance systems should include “evaluation of programmes or institutions, including internal assessment, external review, and participation of students and publication of results” (p. 3). The European Network for Quality Assurance in Higher Education (ENQA) recently published an overarching framework for quality as the “Standards and Guidelines for Quality Assurance in European Higher Education Area” (ENQA 2005). This report outlines “an agreed set of standards, procedures and guidelines on quality assurance” and “explores ways of ensuring an adequate peer review system for quality assurance and or accreditation agencies or bodies” (ENQA 2005 p. 3). The collaboration of

European Ministers of Education, for whom the report is directed toward, is acknowledged as a first step toward a 'widely shared set of underpinning values, expectations and good practice in relation to quality and its assurance, by institutions and agencies across the European Higher Education Area (ENQA 2005 p 3). The prominence given to quality assurance now matches or in some cases surpasses the prominence given to compatibility and comparability of degrees that was outlined in the Bologna Declaration (Wachter 2004). Furthermore, there is some evidence in the convergence of quality assurance protocols among EU states with the Berlin communique. This is particularly necessary if the aspiration of Europe as the "most dynamic and knowledge-based economy in the world" (Lisbon 2000) is to be realised a mechanism of ensuring, assuring and demonstrating that quality is fundamental.

Although the Berlin communique calls for an agreed system of quality assurance, no national quality assurance system for higher education currently has national agreement in Ireland. However, as part of the process following the Bologna Declaration the Irish Higher Education Quality Network (IHEQN) was initiated to provide a forum to discuss quality in a national context, with a view to working towards the development of a common national position on key quality assurance issues, in order to inform the debate on those same issues at the European level. The guiding principles of assuring quality assurance outlined by the IHEQN include the importance of continuing evaluation and the publication of the outcomes of evaluation. These recommendations concur with those in The Universities Act 1997 and the Qualifications (Education & Training) Act 1999 both of which identify that evaluation should be undertaken on the quality of teaching and research and these should be assessed by students availing of the teaching and research. The Qualifications (Education and Training) Act (1999) is the first official government publication that identifies the role of the learner in the evaluation of their programme of study. However, no government report identifies what should be evaluated and debate on outcomes of higher education at any level is scarce. Duff, Hegarty and Hussey (2000) identified this need and developed guidelines for "Academic Quality Assurance in Irish Higher Education" based on international and European trends. The application of the principles and frameworks contained in the handbook illuminate the areas of responsibility for the higher education sector in times where

accountability for both funding and services provided is needed (Duff, Hegarty and Hussey, 2000)

Unfortunately the trends of the Sorbonne/Bologna/Prague/Berlin communique's call for standardised forms of evaluation based on purely structural and input issues such as the number of hours per module, or the reading material available to students. This is further supported by the advantages argument for a national credit system that complements the European systems. The national qualifications framework (NQAI 2004) would provide a common credit language based on learning outcomes and student workload for describing and locating diverse national qualifications. This shift in approach gives little recognition that comprehensive evaluation needs to examine the outcomes of a programme as well as the inputs. Zabalegui et al (2006) argues that evaluation should not concentrate on inputs but needs to identify the outcomes and competencies that have been developed as a result of the course of study. In the majority of declarations and directives published at a European level qualifications were generally described in terms of entry level, the content and duration of the programme, very little attempt was made to describe programmes in terms of learning outcomes or impacts (Zabalegui et al 2006). To address the imbalance between inputs and outcomes the Tuning project (González & Wagenaar 2003) was initiated to identify and develop learning outcomes at both undergraduate and postgraduate levels.

The Tuning Project

The Tuning project builds on Sorbonne/Bologna/Prague/Berlin by attempting to introduce a system of easily readable and comparable degrees, the adoption of a system based on two cycles (Bachelor's and Master's) and the establishment of a system of credits. Specifically, the project aims at identifying points of reference for generic and subject-specific competences of first and second cycle graduates in a number of subject areas including Business Administration, Education, Geology, History, Mathematics, Physics and Chemistry. A nursing group was recently established with members from thirteen countries, including Ireland (personal communication with Claire Walshe, December 2004). The aim of the group is to identify what is common to the different countries' nursing curricula for first and second cycle nursing degrees. The nursing group is currently involved in development

of level descriptors for nursing education programmes (first and second cycle degrees), application of competences in practice and ECTS as a credit accumulation system (National Council for the Professional Development of Nursing and Midwifery 2004)

Competencies describe learning outcomes, basically what the learner knows or is able to demonstrate after the completion of a learning process. These outcomes concern both subject specific competences and generic competences, for example communication skills and leadership ability. In the Tuning project outcomes are described as points of reference for evaluation. However, there is a degree of flexibility in the identification of outcomes. Learning outcomes are defined as “the set of competencies including knowledge, understanding, and skills a learner is expected to know/understand/demonstrate after the completion of a process of learning” (González & Wagenaar 2003 p 24)

As a result of the Bologna process and the Tuning project the challenge for educators involved in nursing education is to identify and evaluate those outcomes that are specific to nursing programmes. ABA identified five domains of competencies for the registration /degree programme in nursing in 2000. The outcomes of the programme require that students acquire the skills of

- Critical analysis
- Problem solving
- Decision-making
- Reflective skills
- Abilities essential to the art and science of nursing

(ABA 2000, p 14)

It is evident that reports at EU level identify the importance of determining standards of education to the overall higher education sector and in our case apply this to nursing. It is also evident that there is an ongoing debate on determining the level and outcomes that occur as a consequence of undertaking study.

Conclusion

Regulation as a methodology for establishing accountable practices was explored and in particular the current trend toward better regulation of the professions. The

principles of regulation as a framework for ensuring quality of education programmes were explored (Department of the Taoiseach 2004 and CAUSN 1995) though evidence of their efficacy and applicability is limited in the research literature. The policy of regulation was explored as a framework to underpin this study. The regulation of nursing in Ireland and Europe is explored in relation to EU Directives. The perspectives of regulation from North American systems were explored along with the concepts of structures models, outcomes focused models and accreditation models of supporting regulation. A number of reports and policy directives, supported by national legislation, have been published over the last ten years at EU and national level and have identified the growing importance of identifying and evaluating the outcomes that have occurred as a result of completing a higher education programme. The Bologna declaration has been successful in the initiation of a debate on the introduction of standardised evaluation systems and the articulation of generic and specific outcomes of education through the Tuning project and for quality assurance through the ENQA report. There is a need to equate evaluation with the outcomes of an educational programme as well as the inputs and processes.

There is also a growing recognition of the importance of the role of the student in the evaluation process. In Ireland this has been recognised with the inclusion of student involvement in evaluation in two recent pieces of government legislation. The Universities Act 1997 and the Qualifications (Education & Training) Act 1999 as well as highlighting the importance of promoting the highest standards in, and quality of, teaching and research also identify that students should be involved in the process of evaluating the quality of their experience of higher education.

The procedures shall include assessment by those, including students, availing of the teaching, research and other services provided by the university (VII, 35, 2b)

It is evident that there is a growth in identifying and evaluating the outcomes from higher education at EU wide level. However, the challenge remains to identify those outcomes and use models and methodologies that can accurately and comprehensively evaluate those outcomes and requirements of regulators of professions. In summary performance standards are appropriate in some contexts and as Coglianese et al (2004 p 723) contend a combination of performance standards with design standards although not reducing the amount of uncertainty “calls for all the available evidence

as well as effective communication of this evidence to decision-makers and the various affected parties” This researcher contends that an overall framework of regulation provides the basis for ‘design standards’ and the ‘performance standards’ are those from which comparisons and accountability can be evidenced to affect judgment for the key stakeholders in nurse education. It therefore, becomes necessary to examine what it is nurses should be learning on a general nurse education programme.

LEARNING NURSING**Introduction**

This section of the chapter sets out to examine the knowledge base of nursing and the development of a curriculum to support professional nursing education in an era of unprecedented change both in healthcare provision and public expectation. The nature of knowledge within a professional context is reviewed with some support being given to the constructivist paradigm. The variety of types of knowledge that inform ways of knowing including, propositional, experiential, tacit and personal knowledge are examined for a practice-based profession such as nursing. The nurse theorists associated with each of these types of knowledge are examined and the notion of learning from practice is explored in depth. This exploration develops the construct of the overall aim of the education programme for entry to the Register held by the regulatory body. The aim of the registration/degree programme is to ensure that students acquire the skills of 'critical analysis,' 'problem solving,' 'decision-making,' 'reflective skills' and 'abilities essential to the art and science of nursing' (ABA 2000 p 14). Understanding what needs to be taught in general nurse education programmes emerges from an understanding of the theoretical underpinnings of the discipline and the application of this theory to the educational curriculum and the practice of a practice-based discipline such as nursing.

It is acknowledged by Greaves (1989 p 4) that "in the final analysis, knowledge cannot realistically be called either practical or theoretical and for curricula purposes nursing content must be concerned with describing, explaining and controlling the phenomenon of nursing patients." Knowledge in nursing therefore must be viewed as arising from realities in practice and directed towards present and future problem solving. In this respect the origins of the Requirements and Standards (ABA 2000) for the current general nurse education programme are explored, as are the competencies to be attained on completion of the programme. There should be no distinct separation of theory and practice in learning about nursing. Learning the practice of nursing is an integral part of the general nurse education programme.

Origins of Nursing Knowledge

The origins of knowledge in nursing curricula, as identified in this review, are firmly rooted in the medical tradition. The development of nurse education has mirrored medical care systems, as a result of this nursing's own philosophical values and theories may have become obscured. Salmon (1982) argues there exists today an unprecedented need for clarification regarding the uniqueness of nursing. Otherwise overriding forces in contemporary society may lead to the disintegration of nursing as a distinct profession. One hallmark of a profession is the claim to a unique body of knowledge. The quest for a science of nursing has been a long-standing preoccupation of the nursing profession as shown in critical review articles published by Bixler and Bixler in 1945 and again in 1959. Walker (1997) claims that the quest for a science of nursing is legitimate for a number of reasons. Initially development of nursing knowledge was spurred by the desire to legitimise nursing as an occupation of a professional stature. More recently the motivation has shifted to knowledge development as a vehicle for improving and achieving outcomes for patients and families. With this shift comes a fundamental reorientation away from knowledge in the service of the nursing profession to knowledge in the service of nursing patients and families. Both Kim (1997 p 1-12) and Winstead-Fry (1997 p 38) agree with this position and argue that nursing's central concern is human living centering around health with implicit connections to disease, illness, sickness, disability and dying and with the fact that nursing is a human practice discipline in which a social mandate is a necessary part (Henderson 1995, Roper, Logan and Tierney, 1984).

In an attempt to articulate the separateness of nursing knowledge, nurse theorists have started to examine the assumptions and constructs upon which nursing interactions are formed. Carper (1978) argues that the conceptualisation of a field of inquiry determines the type of knowledge sought and organisation, testing and application of that knowledge. Inherent in Carper's contention, is the notion that being and knowing are not necessarily separate human concerns. In her view epistemology if taken to mean methods and ways of knowing both drives and restricts ontology, i.e. how phenomena are understood. Related to this position is De Silva and Sorrell's (1995) point that the validity of all knowledge claims are judged by standards of evidence and tests of truth consistent with the nature of the question asked and the form of inquiry used.

Nursing / Medicine Curriculum Debate

Usher et al (1997) suggest that the conventional argument about disciplines is that they constitute a knowledge base or foundation that supports a superstructure of practice. In this sense, therefore, foundation disciplines provide the necessary theory part of the theory practice relationship but do so at the cost of a radical separation between theory and practice. While this possibly holds true for nursing, the discipline itself is struggling with an identity that is rooted in practice and has not yet constructed a cohesive body of scientific knowledge.

Hirst (1974) drew a distinction between forms of knowledge (equitable to disciplines) and fields of knowledge constructed as integrated composites from the forms. Fields of knowledge are distinguishable in terms of their theoretical or practical orientation. Nursing could at one level be considered to be a field drawing from the disciplines in a manner appropriate to its practical orientation. Usher et al (1997) clarify the position (not in relation to nursing) by suggesting that the argument is that disciplines tell us the way the world is. Therefore nursing as a practical activity is concerned with acting in, rather than knowing, the world although in order to act, knowledge of the world knowledge provided by the disciplines is needed. In a field of knowledge, the knowledge itself originates from outside the field in relevant foundation disciplines. These disciplines are then organized and integrated in a way appropriate to the nature of the field. In particular according to its theoretical or practical orientation it could be argued that some problems in the application of this thinking to nursing arise particularly when one considers the relationship between science, nursing and medicine. The questions for curriculum developers have been around the issues of deciding foundational studies, the weighting given to the sciences, differentiation issues between practical and theoretical knowledge and the ownership of this knowledge.

Much technical nursing knowledge has emanated from the empirical view of science, which places significant value on rationality, objectivity and control. Akinsanya (1987) describes how traditionally the knowledge base for nurses was a 'watered down' version of the life sciences that comprised medicine. This scientific paradigm, which has permeated society, has also contributed to the structure of nursing value systems. In adopting this scientific view a value system is accepted which frequently

challenges other approaches to the generation of knowledge that emerges from the experiential domain of the practice world of nursing. The challenge for curriculum planners therefore comes in placing a value on other forms of knowledge needed to inform the practice of nursing.

Liaschenko (1997) has suggested that nursing as a boundary discipline operates within and at the margins of a number of disciplines, each of which has its own knowledge base. The process of developing a body of nursing knowledge draws upon the knowledge of other sciences, specifically biological and natural sciences. Obviously a major portion of nursing work shares the knowledge of scientific medicine. While contemporary attempts to define nursing may have been fired by a drive to assert nursing's unique contribution to healing they have also been motivated by a desire to challenge assumptions regarding nursing's subordination to medicine and propose the idea of replacing a bureaucratic occupation with a profession. The occupation versus profession debate relies on the notion that there are three components to professional knowledge associated with a basic underpinning discipline of knowledge; an applied science component from which day-to-day elements of knowledge are used; and a skills and attitudinal component that concerns the actual performance of services using the underpinning basic and applied knowledge (Schon 1987 p.27). Nursing education like nursing practice has carried the inheritance of its appendage to medicine. As nursing has attempted to re-orientate itself towards health and away from disease, so education must follow suit, and understand the relationship of the development of professional knowledge and challenge the dominance of the reliance on such a positivist approach to acknowledge the craft elements of knowledge production (Schon 1987 p.34)

Greenwood and King (1995) in a recent study found the implicit construction of nursing, in the reasoning of both expert and novice practitioners, was consistent with the medical model of care. The medical model of care is based on a technical rational view of the world where the body is broken into component parts to be treated accordingly and the physicality of the human being is the primary focus of understanding health, illness and cure. These findings are supported by Ekman and Segesten (1995), who analysed that oral communication between nurses was dominated by the medical paradigm, leaving nursing virtually invisible, with little

attention being paid to nursing needs and measures Higgs and Titchen (1995) suggest that the empirico-analytic paradigm provides the basis for the medical model of care In some areas of medicine particularly those dealing with biological aspects of human functioning knowledge tends to be grounded in experimental research The medical model is increasingly being regarded as inappropriate for the study of people and the provision of holistic care, which balances both biological and behavioural aspects of human functioning Practitioners have also identified a dissonance between the goals of practice and research (Manley 1991, Holmes 1990)

It would seem from these findings that nursing is still aligned by its heritage to medicine, a profession that functions from a dominant scientific view of the world The effect of this has been an unfortunate pre-occupation with disease, from which nursing has drawn its knowledge base The powerful conceptualisation of the medical model and its demonstration by nurses in their day-to-day practice has given little opportunity for recognition and exploration of the true basis of nursing on contributing to health gain Caring still seems to be dominated by a view of illness as a starting point and within society, individuals have difficulty in understanding the value of health before they have experienced illness or lack of health (Herberts and Eriksson 1995) In furthering the debate in relation to the positivist paradigm Streubert and Carpenter (1995) contend that this paradigm, which focuses on prediction and control, has gained wide acceptance because of its roots in male dominance The technical and objective discourse of medicine and the subjective and nurturing discourse of nursing can be combined with a gender argument Davies (1995) considers that gender socialisation compounds the interaction between these two competing discourses as they form distinct axes of nursing knowledge and practice The outcome of the interaction between the power and knowledge embedded in medical expertise, and the nurturing and knowledge of nursing expertise, is such that the subject 'nursing' is constituted by representations and practices, which continue the hegemony of medical science

If one places experience and intuition from a humanistic nursing framework within the previously described health care context, which emphasizes empirically defined illness related knowledge, a picture of incompatibility emerges

Nurses on the whole, it would seem, are operating in an illness and disease orientated paradigm. They have difficulty in articulating the distinct nursing knowledge base for their actions, as they draw easily upon the visible and articulated languages of science and medicine. This leads many nurses to either ignore or not recognise the 'intangible' and 'invisible' components of the more humanistic aspects of their role.

In making a similar comment along the same lines of the argument presented above it has proved impossible to build a theory that integrates the various disciplinary strands and which is also appropriate to a practical field. This brings the debate right back to the sentiments of Cervero (1992) to argue for theory as a foundation for practice is to privilege a notion of scientifically derived knowledge as not only different from but better than knowledge arising from practice. Epistemology is political. Hence as suggested by Usher et al (1997) that without a means of integrating practice and disciplines the very notion both of a foundation of practice and a disciplinary foundation becomes problematic for curriculum planners and students of the curriculum to understand the priorities of learning. As suggested by Greaves (1988 p 4) "knowing what to do and how to do it is inextricably bound up with the performance itself and knowing and doing belong to the same locus of existence and the same order of awareness."

Evidence-Base for Nursing

To explore another avenue in the development of nursing knowledge current nursing programmes argue for the development of nursing knowledge through research-based practice (ABA 2000, 1999). Clearly the integration of knowledge and practice begs a fundamental question as to what knowledge is valid in practice. The central tenant at this point is to suggest that a philosophical shift from epistemological inquiry to ontological inquiry may represent one way forward in terms of articulating the process of knowledge construction to be included in nursing curricula. The point of drawing on philosophy is that it establishes a justification and provides a basis for some consensual educational principles. Taylor (1994, p 7) argues that throughout history knowledge generation has undergone changes, which have been grouped into ways of knowing. During recent years a number of opinions concerning the development of a scientific body of nursing knowledge have been expressed (Chinn and Kramer 1991, Benner, 1984, Carper 1978). Nursing scholars and researchers

generally agree that a scientific body of nursing knowledge is an important goal. However, there is little consensus as to what this body of knowledge should consist of, what qualifies as legitimate forms of scientific knowledge, or how the knowledge should be generated. The utility of exploring ways of knowing is to present a context within which to judge the appropriateness of nursing knowledge. Gaining an insight into the process of knowing will not enlarge the body of knowledge in nursing. It will, however, serve to focus critical attention on what it means to know, and what kinds of knowledge are valid for inclusion in nursing curricula. Clearly it is only through examination of current belief structures that both practitioners and educationalists in collaboration can search for a unique body of nursing knowledge.

Profound changes in society such as a shift from a knowledge age to the information age are altering perceptions of possible realities. As the environment of nursing increases in complexity, ontological questions are emerging regarding the nature and meaning of nurses' and patients' realities. If the development of nursing knowledge is to emerge as a function of nursing itself as opposed to an expansion of medical knowledge then the character of nursing requires expansion in the broadest sense.

Knowledge of Practice

Knowing in nursing has been described by the ways in which it has been reflected in nursing definitions and by the ways in which it has been categorized by nursing scholars. Regardless of the manner in which nursing scholars present their epistemological categorizations, there is a consensus in recent writings (Liaschenko 1997, Chinn and Kramer 1991, Parse 1987, Benner 1984, Carper 1978) that alternatives to positivistic understandings exist. Another argument is provided by Polanyi (1958) who contends that logical positivism and all the current structure of science cannot save us from the fact that all knowledge is uncertain, involves risk, and is grasped and comprehended through the deep personal commitment of a disciplines search. There is also recognition that in nursing we require a mixture of approaches to find meaning in practice and to portray the relative complexity and diversity of knowledge in an action orientated discipline. As the inequalities that emerge from the contemporary social constructs of race, class and gender become inextricably linked to health needs increasing numbers of nurses are exploring the use of alternative methodologies for uncovering tacit nursing knowledge. This mirrors Winter's (1998)

position which advanced action research as a mechanism for decentralizing the production of knowledge, and removing the monopoly of universities, governments, and scientific research establishments thereby giving a voice to practitioners and community

In embracing the reform necessary to support ontological enquiry it is argued that nursing has the potential to redefine itself from within as it is nurses in practice who know most about nursing. An alternative approach to characterising the knowledge base for a profession is to ascertain the personal knowledge of working professionals. This originates from the idea that in nursing as in other practice disciplines there is a significant distinction between propositional knowledge and craft knowledge. The former depicts theoretical knowledge, which underpins professional action, and the latter describes practical or tacit knowledge, which is inherent in the nursing action itself. From this standpoint action research has recently appeared at the forefront of applied nursing research (Hart and Bond 1994, Webb 1991). Interpretative methods of this nature have the potential to invite the full expression of community voice. From a methodological perspective the key issue debated in this shift is encapsulated in Chinn's (1985) sentiment. Interpretative methods allow exploration of humans in ways that acknowledge the value of all evidence, the inevitability and worth of subjectivity, the value of a holistic view and the integration of all patterns of knowing.

From an ontological perspective the linguistic link between nursing and the act of nourishing provides a point of departure in clarifying the nature of nursing. The idea of nursing as the suckling of an infant is long been superseded by current political and societal expectations. Nursing could be considered as an integral, essential part of human life and development. Nightingale (1860 in 1969) attempted to recognise the separate nature of skilled nursing distinct from the nursing component of "every woman". Nightingale presented the essence of nursing as the provision of support to the curative properties of nature. The ensuing era in nursing argued that the nature of nursing was reflected in the observable activities performed by nurses. Orlando (1961) described nursing in terms of facilitation of the patient stimulus-response mechanism. Hall (1964) presented nursing as the provision of direction towards health goal attainment. While these definitions concur that nursing is reflected in actions, the context in which activities are performed is considered irrelevant. Allied to this the

list of disparate activities fail to reflect the reality of nursing as it is selectively applied to individual patient situations. It is this functional approach that continues to cause considerable difficulty in defining the unique nature of nursing and subsequently the corresponding body of knowledge necessary to inform nursing practice. If the education of students continues to be based on objectivity and a natural science model without embracing subjectivity, this will increasingly raise conflicts with the humanistic philosophy espoused for nursing practice. Nurse education is at a point where it needs to acknowledge this contradiction in order to move forward. More recently, several nurse-theorists have suggested that the central dominant unifying feature of nursing is caring (Leininger 1985, Watson 1985). The idea of caring as central to nursing is not new. Caution must be exercised in defining nursing as formalized caring lest it limits the development of new frameworks for the exploration of nursing. Hence, reality of practice as a formal social role as opposed to an ideal emerges, which depicts caring in practice as functional rather than altruistic (Clifford, 1995). Other nursing scholars have utilised the Heideggerian concept of 'presencing' to describe the availability of the nurse to understand the patient by a process of human relating (Benner and Wrubel 1989). These post-modernist nurses contribute to the argument espoused by the theologian Campbell (1985) who described nursing as 'skilled companionship' that entails 'sharing freely with others, sensing need, accommodating idiosyncrasies and helping onwards to recovery or death.'

Central to current ontological debate about nursing is the notion that practitioners know themselves what it is to nurse and they can be encouraged to find ways to uncover and express the sophisticated meaning of nursing interactions in context. This is in keeping with Kikuchi's (1992) argument in favour of private ways of knowing. Kikuchi (1992) warned that the failure to make the distinction between private ways of knowing and public ways of knowing has led to fuzzy thinking regarding the knowledge that nurses use in practice vis-a-vis the knowledge that lies within the body of disciplinary knowledge. The basis of Kikuchi's warning was captured years back in Donaldson and Crowley's 1978 statement that nursing as a discipline is broader than nursing science. Similarly, Schotfeldt (1992) viewed disciplinary knowledge as encompassing nursing science, nursing philosophy and nursing history. Each of these forms of knowledge is produced using different modes of inquiry and different tests of truth. In conceptualising nursing as an art, Johnson (1994) explicated

five distinct conceptualisations of nursing three of which are a form of cognitive activity occurring within the context of a particular patient-nurse encounter grasping meaning, determining a course of nursing action, and determining what constitutes moral conduct. The work of Benner (1984) and Tanner, Benner, Chesla and Gordon (1993) on knowing the patient have pointed to the roles of experience, involvement and pattern recognition in producing these understandings about meaning and advisable courses of action. Moch (1990) described personal knowing as evolving within practice and Gaddow (1990) added that personal knowledge couldn't be transferred, only evoked and demonstrated through exemplars. Yet another explanation of knowing in nursing can be found in Kim's (1997) notion of synthesis to describe the way in which a nurse brings knowledge from different spheres to bear on a singular situation using an epistemological framework that encompasses the empirical sphere, the interpretative sphere, the critical sphere and the ethical/aesthetic sphere. Kim (1997) refers to the nurse in practice as the ultimate synthesizer. Fortin (1997) suggests that such a framework could be used to guide what is viewed as nursing problems and to generate substantive questions that are both important and significant to nursing. Brown (1997) in commenting on the work of Kim refers to synthesis as the complex mix of knowledge integration that attempts to contact the realities of a particular situation. Kim's work is consistent with Carper's (1978) description of aesthetic knowing in nursing which the author characterizes as knowing which is individual, particular and unique, going beyond existing concepts, principles and theories. Smith (1992) on the other hand is critical of Carper's analysis and argues that it is only if interrelatedness, interdependency and overlapping are ignored that knowledge can in fact be categorized in this way.

A particular challenge for nursing in identifying its knowledge base relates to the absence of agreement on the exact meaning or description of nursing which includes all its activities. For instance Sarvimaki (1988) believes that the moral art, involving practical activity and communication interaction is the central essence of nursing (Hall 1980). Other authors stress the unique caring aspects of nursing (Leninger 1994, Van Maanen 1989, Roach 1987). Another perspective is that nursing is principally interested in helping others to maximize their function within the varying states of health. Others summarize nursing as a helping discipline that focuses on interpersonal relationships and a holistic approach (Chinn and Jacobs 1987). Ruddy (1998) argues

that various scholars continue to debate that nursing is both an art and a science with science meant as an intellectual activity relating to knowledge, and art as being skilful practice. Still another conceptualisation considers nursing in terms of levels of practice related to different forms of knowledge. Burnard (1987) suggests that the theory of nursing knowledge has three components: propositional knowledge which refers to text book knowledge of facts, theories and models, practical knowledge expressed by doing or application, and experiential knowledge which is personal knowledge gained through personal encounters. Benner (1984) adopted the Dreyfuss model of skills acquisition to explain the development of nursing expertise. Benner (1984) states that a nurse travels through five levels of proficiency and knowledge acquisition that can be characterized by the ways in which she operates: novice, advanced beginner, competent, proficient, and expert. The author suggests that the novice nurse has no experience upon which to rely for judgment and depends on rules to guide actions thus using propositional knowledge. The advanced beginner has some experience to apply to propositional knowledge but not enough to interlink and negotiate situations. The competent nurse has acquired enough practical knowledge to reflect on experience using propositional knowledge. The proficient nurse has made inroads on experiential knowledge and in certain situations can differentiate problems accurately. An expert nurse by contrast has a wealth of experience from which to draw. This nurse has "intuition" which allows accurate problem definition and engages the three forms of knowledge in an integrated manner.

It would thus appear that expertise in nursing exists when the nurse has developed the ability to use appropriate nursing knowledge and skilled judgment in the delivery of client care. This ability requires not only the use of technical knowledge but also the development of an intellectual capacity to contextualise and then apply this knowledge in diverse practice settings. Although this form of knowledge may not be directly observable or measurable, the skills component may be communicated e.g., active listening skills displayed in an empathetic manner. The ideals underpinning practical knowledge appear to be similar to Benner's (1984) notions of expert practice grounded in the use of intuition and Carper's (1978) explication of nursing knowledge in terms of empirical, aesthetic, moral and personal dimensions although Chinn and Kramer (1991) argue for the addition of judgement to all dimensions. Clearly the

complexities of formalising nursing knowledge multiply the deeper one descends into nursing cognition

The nature and process of nursing knowledge are a source of great debate in contemporary literature (Catalano 1996). Indeed Bevis (1988) contends that the greatest dilemma facing nurse educators is the fact that no one knows what will survive in the rapid validation and generation processes occurring with regard to nursing knowledge. While some of nursing's knowledge may be subsumed by technocracy, the nursing perspective with which the knowledge is applied in caring practice makes it uniquely nursing. Eraut (1985) considers knowledge creation and knowledge use in professional contexts and further suggests that there are traditional assumptions about the labelling and packaging of knowledge. In contrast Oakeshott (1967) makes the distinction between technical and practical knowledge. Technical knowledge is capable of written codification and practical knowledge is that which can only be expressed through practice. Behind Oakeshott's distinction between technical and practical knowledge lies an assumption that technical knowledge is used systematically and explicitly while practical knowledge is used idiosyncratically and implicitly. This is true for some kinds of knowledge but to deny other possibilities is to put unacceptable limits on the symbiotic development of theory and practice.

Ways of Knowing Nursing

Taylor (1994 p 7) argued that throughout history knowledge generation has undergone changes, which have been grouped, into ways of knowing. The utility of exploring ways of knowing is to present a context within which to judge the appropriateness of nursing knowledge. Gaining an insight into the process of knowing will not enlarge the body of knowledge in nursing. However it will serve to focus critical attention on what it means to know, and what kinds of knowledge are valid for inclusion in nursing curricula. Clearly it is only through the examination of current belief structures that both practitioners and educationalists in collaboration can search for a unique body of nursing knowledge.

In contrast to positivism, constructivist human scientists believe that knowledge is the result of a dialogical process between the self understanding person and that which is encountered, whether it is text or the meaningful expression of another person (Smith

1990) Guba and Lincoln (1994) reiterate this idea of a constructed reality as the most meaningful reality, because it embraces the notion of multiple perspectives. This idea acknowledges that there is more than one dimension to the process of knowing and that knowledge is context bound.

There are, however, inherent difficulties with the definition of human constructivism presented. The dialogical process can be understood as an attempt at encounter. While the self-understanding person can be considered as a higher system engaged in human development through the process of reflection, the dialogic process requires the learners to confer in order to reach a shared meaning or definition of a concept. By articulating and contrasting various points of view, common understandings emerge. Within the constructivist perspective, knowledge is viewed as something that the learner must construct (Blais 1985). Located within the interpretative research paradigm, human constructivism stems from the ontological position of relativism (Schon 1987). Within this perspective, individuals construct their own unique view of the world in order to understand, predict, and control their own environment. Knowledge, which is generated within the mind of the individual and cannot be transferred from one individual to another (Dewey 1974). All knowledge is a deliberate construction of human beings striving to know about nature and experience (Gowin 1981 p 27). Similarly, in the personal construct theory, there is no objective absolute truth (Blais 1985). Cohen and Mannion (1985 p 315) continue that events are only meaningful in relation to the ways that are constructed by the individual. People respond to their environment, as they perceive it to be. Constructivists believe students construct knowledge that is not "true" or "false" but instead represents their own viable understanding of experiences (Blais 1985). Thus, truth is both complex and alterable based on on-going experiences and their meaning to the person (Guba and Lincoln 1994, Lowenberg 1993). Higgs and Titchen (1995) contend that the key elements of this understanding of knowledge are that knowledge is constructed, not discovered, that individuals create unique constructions or interpretations of nature and of their own experiences, and that knowledge is the product of a dynamic and indeed difficult process of knowing or striving to understand. In such striving, the individual's depth and certainty of knowledge grows. In addition, what is being learned and the relationship between elements of such knowledge are tested and refined both

against the individual's own prior knowledge and experience and also against external knowledge (Polkinghorne 1988)

In this arena reality exists as multiple, sometimes-conflicting mental constructions of everyday life experiences that are situation and context determined. In constructing their schema of the world students frequently hold implicit theories and understandings, which can be inconsistent with disciplinary knowledge (Floden 1985). Creedy et al (1992) cogently argue that unless knowledge is addressed, the likelihood of change to, or the adoption of a more appropriate conception is reduced. The disciplines are therefore used, as Chandler (1991) suggests, not for application to practice but to question the legitimacy and effectiveness of nursing work and behaviour. Simultaneously students' and practitioners' contextual knowledge is achieved through collaborative research between educationalists and practitioners. Methodologically interaction between the educator and learner is necessary for discovering the meaning of these experiences and this process itself contributes to the construction that is created. From a methodological perspective Guba and Lincoln (1994) suggest that the process is thus reflected in the depth, richness, and authenticity of individual understanding. Gerrish (1990) states the application of humanistic thought to education appears to be concerned with maximising individual differences. Mulholland (1995) similarly critical of this position suggests it makes a prior assumption regarding the relatively harmonious nature of the manifestations of such differences. In applying both Gerrish's (1990) and Mulholland's (1995) criticisms to nurse education, it becomes apparent that humanistic analyses within this arena must attempt to address the dynamics of the practitioner - student - educator - relationships within specific socio-political contexts. In embracing humanistic values there is a need to acknowledge the interconnectedness of power and knowledge and recognise that any re-organisation of knowledge is closely linked to the social position of the carriers of that knowledge. Clearly there is a need for critical reflection on the way organisational dynamics and power relations influence the subjective understandings practitioners' make of the experiences and knowledge gained about how to embrace profession expectations. Understanding the input knowledge required for professional practice therefore needs to be discussed.

Current General Nurse Education Programme

As discussed the evolution in current standards of nursing education for practice within Europe emerged as a consequence of European Directives for nursing in 1977 (77/452/EEC and 77/453/EEC) These Directives accompanied by General Systems Directives of 1989 (89/545/EEC) have influenced the standard setting of regulatory bodies for the education and training of general care nurses The advisory Committee on Nursing in Europe devised these Directives to support the development of a nurse who was capable of implementing the World Health Organisation goal of 'Health for All by the Year 2000' where health for all continues to be a call for equity and social justice where nurses can advance the notion that global health is a local concern (Messias 2001) While Ireland transposed these directives through Statutory Instruments the nature of this vision of the nurse as agent of health has yet to be evaluated as proposed by Allen (1977) Despite the increase in the theoretical provision of the curriculum for general nurse education with the introduction of the diploma and degree level accreditation the nature of general nursing education to meet requirements of a changed health care system needs to be explored and evaluated

Curriculum

A definition of curriculum ranges from the most concise "course of study" (Oxford Dictionary 1984) to one that embraces a more holistic view of education Curriculum in a broader perception refers to all the planned learning experiences offered to learners by the educational institution, together with the experiences that learners encounter when those intentions are implemented (Print 1988) Greaves (1988 p 30) suggests that in nursing this includes "the sum of learning activities and experiences that a student has under the auspices of the school" although he also acknowledges that it is only seen as such in the last two decades in nursing as prior to this it was "the content of a syllabus and the programme of course arrangements" This was despite the Open University (1971) suggestion that "a curriculum is the offering of socially valued knowledge, attitudes and skills made available to students through a variety of learning experiences and arrangements during the time they are at school" Kerr (1968 p 16) also refers to "all the learning planned and guided by the school" and this includes the beliefs and values and methods of instruction of a school Nursing therefore struggled with its understanding of systematically planning the learning sequences and events to effect evaluation during this period in Ireland In the first

independently commissioned evaluation of nurse education in Ireland Simons et al (1998) suggests the curriculum needs a purpose, subject matter must be identified, the learning experiences to achieve this identified, along with the organisation of the learning events articulated and the assessment of the results of learning experiences outlined More recently Keating (2005 p 2) suggests, "a curriculum is the formal plan of study that provides the philosophical underpinnings, goals, and guidelines for the delivery of a specific educational programme " The curriculum therefore embraces all the planned learning opportunities of an entire programme of study that is emerged in a cultural context The planned nature of the curriculum gives rise to developing a purpose or rationale for the curriculum in the first place Curriculum rationale according to Tyler (1950 p 1-2, cited in Madaus 2004 p 75) answers the questions of

- 1) What educational purposes should the school seek to attain?
- 2) What educational experiences can be provided that are likely to attain these purposes?
- 3) How can these educational experiences be effectively organised?
- 4) How can we determine whether these purposes are being attained?

Simons (1998 p 61) acknowledges the curriculum in nursing includes "aims and philosophy, the design of the curriculum in action, teaching and learning processes, and assessment, as well as the hidden and received curriculum It also includes teaching and learning in the clinical areas " According to Greaves (1988 p 4) "in the final analysis, knowledge cannot realistically be called either practical or theoretical and for curricular purposes nursing content must be concerned with describing, explaining and controlling the phenomenon of nursing patients " Curriculum in nursing according to Quinn (1995 p 268) need to embrace number of main interpretations as it is seen as objectives (Tyler 19949), as subject matter (Bell 1973), as student experiences (Kerr 1968), as opportunities for students (Quinn 1988), as an aspect of culture (Skilbeck 1984) It occurs in a number of guises as the official curriculum or laid down policy, statutory requirements, the formal curriculum or planned learning, content & teaching, the actual curriculum as implemented, and the hidden curriculum or the transmitted attitudes and values, culture and environment by the teachers and practitioners (Quinn 1995, Bradshaw 1989, Tracey 1987) Understanding the breadth of the curriculum therefore challenges the assumptions of exerting control on all aspects of the learning experience of a nursing student The

regulatory management of a course therefore needs to acknowledge the diversity of mechanisms that contribute to how learners learn. The curriculum model chosen should be dynamic and flexible to allow for changes in nursing practice and health care delivery (ABA 2000). In nursing the nursing curriculum must have the capacity to direct the scope of nursing progress for a developing and constantly changing health environment and shape the characteristics, attitudes, knowledge and skills of neophyte nurses. Developing programmes with capacity it is argued, "is the responsibility of nurse education in collaboration with practice settings, to shape practice, not merely respond to changes in the practice environment" (AACN 1999 p 60 cited in McEwen & Wills p 416). This poses many challenges for curriculum planners as the fluidity of the health care arena and the requirements for the professional development of nursing need to acknowledge a futures orientation.

Philosophical Base for Nursing Education

The purpose of theory is to explain phenomena and assist the development of understandings. Theories are representations of reality and particularly when the constructs are of an abstract nature they assist in developing a concrete picture of that phenomenon (Pearson and Vaughan 1990). Theories have the capacity to describe, explain, predict and control relational and non-relational concepts (Quinn 1995). The operationalisation of theories is a model that provides a rationale or a blue print for decision-making. In nurse education curricularists are offered the choice of nursing theories and curriculum theories to underpin a learning experience. Quinn (1995) in critiquing four classical curriculum models (Beattie 1987, Lawton 1983, Stenhouse 1975, Tyler 1949) asserts that all with the exception of Beattie's model were developed for teaching children and as a consequence have limited applicability to a professional nursing programme. Beattie's model in fact is also criticized for not including the needs of service and employers in relation to the outputs they require of a programme to fulfil service contracts (Quinn 1995). With this criticism it could be argued that nursing theory must be the foundation of a nursing programme. A model of nursing like all models is a picture window through which the world of nursing is viewed. It provides a point of view for describing nursing. Bevis, (1989) contends it is a belief construct, a speculation about the nature and value of things. While theories and models have mutuality between them they are not interchangeable. A nursing theory according to Fawcett, (1978, p 26) is "a set of inter-related propositions and

definitions which present a systematic view of one or more of the essential concepts of nursing – person, environment, health, nursing – by specifying relations among relevant variables” It is an outgrowth of the philosophy of four inter-related elements or concepts that can be brought together in nursing. A theory is a creative and rigorous structuring of ideas that project a tentative, purposeful and systematic view of phenomena (Chinn and Kramer 1991). They provide therefore a global perspective of a discipline acting as an encapsulating unit or framework within which the more restricted structure develops. It identifies certain phenomena, which are of interest to a discipline, and explains how that discipline deals with those phenomena in a unique manner (Fawcett 1992 cited in McKenna 1998, p 2). The more restrictive structure that develops is known as the model of nursing. Many models of nursing have emerged over the years as attempts at describing nursing and in a review of models used in twelve countries of Europe (van der Bruggen 1992) only thirteen models were identified from published literature. Ireland was omitted from the study and in this respect reviewing the curricula of national programmes will illuminate a national picture for curricula, education and the practice of nursing.

The relationship of conceptual models to nursing education is in the structure provided to a curriculum through a conceptual framework that “helps faculty to identify and develop relevant concepts that serve as the knowledge base for professional practice” (King 1986 p 75). A framework organises dimensions of the course of studies and gives direction in identifying objectives, instructional design, and evaluation strategies (p 84). Integration of models and theories therefore needs to be explored through evaluation. The relationship of the focus must initially concentrate on structuring, ordering and sequencing content by seeking to unify nursing practice and nursing theory. Nursing ‘practice’ and nursing ‘theory’ relationship must be seen as aspects of knowledge that are holistic and interdependent (Greaves 1984, p 41).

Nursing theory if taken literally imposes structure on practice. Practice nurses are immersed in a reality that requires creativity. Creativity is needed to address the interpersonal and interpersonal aspects of knowing and providing care. Understanding the meta-paradigm of nursing as described by Fawcett (1992) in respect of common models of nursing is worthwhile. This represents the structural hierarchy of

knowledge of the discipline of nursing and summarises the intellectual and social missions of the discipline while placing a boundary on the subject matter of the discipline (Kim 1989 cited in Fawcett and Malinski 1996 p 111) A model of nursing, as depicted below (see Table 3.3), guides nursing practice and operationalises a theory. As can be seen the values inherent in each of the models represents perspectives and beliefs about man, nursing health and the environment which contribute to a world view of nursing. The models outlined are mainly systems based models (Henderson, Roper, Roy) although Roy (1971) develops the system base with elements of interactionism that underpins Orem's (1980) model. Utilizing these types of approaches to understanding and describing nursing for neophyte nurses challenges the assumptions of constructivism in understanding the realities of practice from practice and therefore challenges our assumptions of how nursing becomes understood. The implications of understanding these approaches will be examined in respect of the national programmes of general nurse education and the influence of a unique nursing focus within nurse education nationally.

These models (Table 3.4 over) present descriptions/understandings /worldviews of man, nursing, health and the environment that illuminate different priority considerations toward care provision as advised of the nursing meta-paradigm described by Fawcett (1992). Recent studies demonstrate that those working within nursing have a good understanding of the more traditional ways of promoting health, such as dietary advice and exercise, that is, health as behaviour, but have difficulty expressing and promoting the higher dimensions of health – health as being, characterised by a search for balance in one's inner state and health as becoming, growing towards health and becoming whole on a higher level of integration (Wallace and Appleton 1995). This would appear to be a problem, in that nursing continues to promote the external manifestations of health, but has little understanding of the multi-dimensional nature of health as a holistic concept, or indeed what nurses can do to assist people to utilise the power within as they evolve towards higher levels of consciousness (Newman 1986). The challenge for nurse educators is therefore to translate the evident awareness of nurses, at least at a superficial level, to operate within a health domain that incorporates the environment in which a person exists.

OVERVIEW OF THE COMMONLY USED MODELS OF NURSING PRESENTED AS A META-PARADIGM			
Person / man	Nursing	Health	Environment
Biological human beings with inseparable mind and body who share certain fundamental human needs (Henderson, 1966)	A profession that assists the person sick or well in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he or she would perform unaided, given the necessary strength, will or knowledge (Henderson, 1966)	The ability to function independently regarding 14 activities of daily living (Henderson, 1966)	That which may act in a positive or negative way upon the client (Henderson, 1966)
An unfragmented whole who carries out or is assisted in carrying out those activities that contribute to the process of living (Roper, et al , 1990)	A profession whose focus is to help the client to prevent, solve, alleviate or cope with problems associated with the activities he or she carries out in order to live (Roper, et al , 1990)	The optimum level of independence in each activity of living which enables the individual to function at his/her maximum potential (Roper et al , 1990)	Circumstances that may impinge upon the individual as he or she travels along the life-span and cause movement towards maximum independence (Roper et al , 1990)
A functional integrated whole with a motivation to achieve self-care (Orem, 1980)	A human service related to the clients' need and ability to undertake self-care and to help them sustain health, recover from disease and injury or cope with their effects (Orem, 1980)	A state of wholeness or integrity of the individual, his parts and his modes of functioning (Orem, 1980)	A sub-component of man, and with man forms an integrated system related to self-care (Orem, 1980)
A bio-psycho-social being who presents as an integrated whole (Roy, 1971)	A socially valued service whose goal is to promote a positive adaptation to the stimuli and stresses encountered by the client (Roy, 1971)	The adaptation of the person to stimuli on a continuous line between wellness and illness (Roy, 1971)	Both internal and external From the environment people are subject to stresses (Roy, 1971)

Table 3 4 *Overview of the commonly used Models of Nursing presented as a meta-paradigm (Fawcett1992)*

Another challenge for educators is to look at the congruence of the influence of the foundation discipline of medicine in an attempting to understand the nursing practice health role Nursing conceptual models when used in practice assist practitioners to articulate a philosophy/mission of care, identify objectives/outcomes of care, develop a meaning to support learning experiences/ opportunities available in the care experiences and a mechanism to understand the learning supports required to underpin the assessment strategies for the student nurse In essence this framework also reflects

a number of curricular models that articulate a philosophy of education, a means of identifying goal/objectives/outcomes, developing content and the sequencing of content, teaching methods, assessment strategies and evaluation strategies Nurse educationalists are challenged to marry the conceptual models that give meaning and cohesion for the student to effectively and efficiently learn and achieve competence

In matching the conceptual models the education programme outcomes of ABA (ABA 2000 p 14) are challenged to support the stated aims of the registration/degree programme The following context is provided to illuminate the transition issues tackled by educators and the regulator to achieve the current Requirements and Standards (2000)

The European Directive

Council Directive 77/453/EEC of June 1977 is concerned with the co-ordination of provisions laid down by Law, Regulation or Administrative Action in respect of the activities of nurses responsible for general care The directive sets out that the training programme comprises a three-year course or 4600 hours of theoretical and practical instruction European Union Directive 77/453/EEC refers to clinical dimensions of programmes being no less than 2300 hours The requirements of European Directive 77/453/EEC must be met by programmes leading to Registration as a General Nurse with ABA through the transposition of the Directive by the Minister for Health in 1979 This Directive applies to the General Care (General) nurse only This Directive specifies that programmes must be of 3 years or 4,600 hours of which no less than one-third (1533 hours) to be devoted to theoretical instruction and no less than one-half (2300 hours) to be devoted to clinical instruction The training leading to the award shall include theoretical and clinical instruction

In terms of clinical instruction the Annex of the Directive states that the training shall consist of two parts, A, theoretical and technical instruction and B, Clinical instruction This Directive requires that programmes provide experience in

- General and specialist medicine
- General and specialist surgery
- Childcare and paediatrics
- Maternity care
- Mental health and psychiatry
- Care of the old and geriatrics

Home nursing

The directive specifies the areas where experience must be gained, it does not specify a time frame for each clinical experience or how the education experience should be implemented

In the most recent past ABA published guidelines for the education and training of nurses. These include the "Rules and Criteria for the Education and Training of Student Nurses" December 1991, the "Rules for the Education and Training of Student Nurses" October, 1994 and "Requirements and Standards for Nurse Registration Education programmes" (July 1999 and November 2000). The first two documents pertained to hospital based certificate education programmes. These education programmes were three calendar years in duration and were apprenticeship in nature. Students were employees of the health service provider and as such were paid a salary. Each health service provider housed its own School of Nursing, which oversaw the implementation of the education programme under the leadership of the Principle Nurse Tutor with accountability for the programme remaining with the Director of Nursing.

The Commission on Nursing

The Commission on Nursing (Government of Ireland 1998) was established by the Minister for Health, Mr Michael Noonan TD, in March 1997 following a recommendation from the "Labour Court" (Recommendation No LCR 15450)

The terms of reference of the Commission were

The Commission will examine and report on the role of nurses in the health service including

The evolving role of nurses, reflecting their professional development and their role in the overall management of services,

Promotional opportunities and related difficulties,

Structural and work changes appropriate for the effective and efficient discharge of that role,

The requirements placed on nurses, both in training and the delivery of services,

Segmentation of the grade,

Training and education requirements and

The role and function of ABA generally, including, inter alia, education and professional development, regulation and protection of the citizen

(Government of Ireland 1998 p 25)

Ms Justice Mella Carroll chaired the Commission. The report was presented as a "blue print for the future". The Commission methodology was based on key stakeholder involvement, extensive consultation, regional seminars, meetings with stakeholders, a visit to Australia and the commissioning of a number of literature reviews. The report was presented in twelve chapters and chapter five specifically addressed "preparation for the profession". This chapter recommended a revised framework for the pre-registration education of nurses.

The Commission recommends that the future framework for the pre-registration education of nurses be based on a four year degree programme in each of the disciplines of general, psychiatric and mental handicap nursing, approved by the Board which will encompass clinical placements, including twelve months continuous clinical placement as a paid employee of the health service. The Commission considers it essential that nursing education continues to have a strong clinical foundation. The granting of a degree will entitle the holder to registration with the Board. The academic year should be based around the existing academic calendars for third-level institutions. Nursing students should be integrated with the general third-level student body to facilitate exposure to a greater range of disciplines and ideas outside of the health services. Focused clinical placements to ensure that learning is applied, would take place over the initial two or three year period but would be largely fitted into the academic calendar. Nursing students would be supernumerary for these initial placements. Nursing students' holiday entitlements would be broadly in line with existing third-level students on other courses. Nursing students would not be supernumerary during the twelve months continuous placement.

(Government of Ireland 1998, Para 5 22, p 80)

In summary, this recommendation of the Commission on Nursing recommended that pre-registration nursing education be based on a four year degree programme, incorporating one year of employment, with structured clinical placement in the health service and be fully integrated within the third-level education sector (1998 p 4). The twelve-month continuous clinical placement as a paid health service employee was seen as an important component of the programme (Government of Ireland 1998 para 5 23). Further in order to implement these recommendations the Commission further recommended, "that a forum be established by the Minister involving the third level institutes, schools of nursing, health service providers and the Board. The objective of the forum is to agree a strategy for the implementation of degree level pre-registration education and it should be funded by the State" (para 5 26 p 81).

The implementation of the Commission recommendation for a four-degree programme as the future framework for pre-registration nurse education, with a central twelve-month continuous clinical placement as a paid health service employee was to commence on a national basis from September 2002

The Nursing Education Forum Report

Following the recommendation of The Commission on Nursing (Government of Ireland 1998 p 81) the Minister for Health & Children established the Forum in February 1999, it comprised thirty-four representatives from various organisations active in nurse education in Ireland. It had an independent chair, Dr Laraine Joyce. The Forum report was published in October 2000 (Government of Ireland October 2000)

The terms of reference of the forum were

- To prepare a strategy for the implementation of a four-year pre-registration nursing education degree programme,
- To estimate the additional costs arising from the introduction of such a four-year degree programme as a replacement for the present three-year diploma programme,
- To consider the respective weightings that should be given to academic achievement and general suitability in the context of the transfer of the application system for entry to pre-registration nursing education to the Central Applications Office (CAO), and to furnish recommendations to the Minister for Health and Children in relation to this matter as a matter of urgency,
- To consult extensively with nurse teachers involved in the development and delivery of the registration/diploma programmes,
- To report to the Minister for Health and Children by the 30th September 2000

The forum adhered to four working principles in its approach to developing an effective and achievable strategy for the implementation of relevant recommendations outlined in the report of the Commission on Nursing. The four working principles were 'partnership,' 'consultation,' 'openness' and 'transparency' and "adherence to the spirit and letter of the report of the Commission on Nursing in relation to pre-registration nursing education in Ireland" (Government of Ireland 2000 p 22). The Forum acknowledged that it wasn't within its remit to re-examine the recommendations of the Commission on Nursing. The Forum consulted with key individuals and interest groups, held consultative meetings, formed sub-committees and task groups, received sixty four submissions, commissioned three internal

briefing papers and three specialist discussion papers, produced a newsletter and maintained a web site.

This large consultation exercise identified the aims of the educational programme and some key issues required for this to be achieved. The Forum stated that in order for nursing students to become competent, safe and effective in providing patient care, they would need considerable exposure to clinical practice during their educational programme. The link between education and practice was seen as vital to achieve these aims and in that respect the partnership between educational institutions and health care providers was considered of vital importance. The curriculum, regulation and design of the education programme were addressed in Chapter 5 of the Forum report. The first key point in this chapter was that the curriculum design for pre-registration nursing must take place within the regulatory framework of the ABA requirements and standards. The Forum report indicated that the provision of a pre-registration nursing degree would involve three stakeholders: the regulatory/professional body, 3rd level educational institutions and health service providers. The Forum report acknowledged that the primary educational responsibility of ABA was "...to ensure the establishment and maintenance of and adherence to professional standards in all courses preparing students for registration." The discharge of this responsibility required An Bord to: "establish requirements and standards for pre-registration nurse education and training" (Government of Ireland 2000 p.44). This was undertaken by the Bord and culminated in the publication of the Requirements and Standards for Nurse Registration Education Programmes (ABA 2000).

The forum acknowledged that there were service implications associated with the rostered year. It acknowledged, "a key issue facing nurse managers is one of ensuring a consistently high quality of care whilst at the same time facilitating student learning. Students on rostered placement will be paid employees of health service providers but will still require support and supervision in practice" (Government of Ireland 2000 p.52).

The Nursing Education Forum (2000 p.58) considered three types of curriculum: pre-technocratic; technocratic and post technocratic. The pre-technocratic model equates with an apprenticeship approach to teaching and learning. Technocratic curricula

consist of a threefold approach to professional preparation transmission of some systematic knowledge, the interpretation of that knowledge as it is applied to practice, and practical placements The Forum (2000) contends that the technocratic model is characterized by the location of student learning in schools associated with third level education Academic subject specialist often delivers the curriculum content Knowledge is interpreted and applied in practice Jarvis (2003 p 201) argues that the third approach, post technocratic, arose as a response to the positivist approaches contained in the second model It is built upon both the experience of practice and reflection on it so that its focus is upon professional competence and the practical experiences becomes the centre of the professional preparation In explaining the post technocratic model the Forum (2000) says that emphasis is placed on the acquisition of professional competencies that are primarily developed through experience of and reflection on practice in a practice setting where students have access to a skilled practitioner The Forum suggests that the post-technocratic model with elements of the technocratic model is the most appropriate model for pre-registration nursing education The Forum (2000) emphasised that the concept of a competency-based curriculum has limitations in that it is not sufficiently dynamic and holistic and therefore concluded that that it is incongruent with the approach and ideals advocated by third level education (p 62) In a similar vein ABA have identified domains of competence as a requirement to enter ABA's register, however, the Board also emphasised that it was not advocating a competency-based curriculum This became the impetus and background for the development the Requirements and Standards 2000

The Requirements and Standards for Nurse Registration Education Programmes (ABA, July 1999 and November 2000)

The first edition of the Requirements and Standards for nurse registration education programmes published by ABA in July 1999 applied to the Registration/Diploma programme (ABA 1999) This programme was heralded as a partnership programme offered by the health care providers and its affiliated Higher Education Institution The Registration/Diploma was a three calendar year programme, where students were supernumerary for most of the clinical experience except for fourteen weeks in the third year of the programme, which was completed as a rostered placement Students completed this fourteen-week period as an employee "to experience the 24 hour cycle

of patient care” (ABA 1999 para 3 2 3 9) ABA produced the second edition of Requirements and Standards in November 2000. The basic template for the revised set of requirements and standards was largely unchanged from the first edition. The most notable exception to this was section 2.2 which presented the concept of competence and provided the profession with the domains of competence, “the broad enabling framework” for the Registration/Degree “to facilitate the assessment of pre-registration student nurses’ clinical practice” (ABA 2000 p 14). The document was prefaced within a changing environment (p 3). It refers to the report of the Commission on Nursing - A Blueprint for the Future, 1998 and the plan for a four-year degree programme to commence at the beginning of the academic year of 2002. The preface to the document states that a “Nurse Education Forum has been set up to plan the transition from the diploma to the degree” (ABA 2000 p 3). These Requirements and Standards (ABA, 2000) acknowledge the development of new forms of co-operation and conjoint arrangements between ABA, the National University of Ireland and its constituent colleges, the University of Dublin Trinity College, Dublin City University, University of Limerick, the National Council for Educational Awards (now HETAC) and constituent colleges and the Department of Education and Science. This signalled a new relationship of the partnership already established with the Higher Education Institution being the primary provider of education. The purpose of the Requirements and Standards (ABA 2000) was to provide guidance for the development of flexible, innovative, practice-orientated registration programmes to third level institutions and health care institutions involved in the education and training of nurses. The document in its statutory role further stated, “The policies and practices of the third level institutions and health care institutions shall meet the requirements specified in this document” (ABA 2000 p 5).

The Requirements and Standards document (ABA 2000) is divided into three sections. Section 1 provides extracts from the Nurses Rules, 1988 as amended by the Nurses Rules, 1988 (Amendment) Rules, 1991, 1994, 1998, and 1999. Section 2 outlines the requirements for nurse education programmes leading to registration including the learning outcomes of the programme, the Competencies for Entry to the Register, the requirements for registration programmes which includes the Syllabus/Indicative Content, Theoretical and Clinical instruction details incorporating the European Union requirements. The essential regulatory requirements of this

Standards document designed for the Registration Degree programme does not explicitly account for the rostered year placement. However, ABA issued circular AB/1/2002, addressed this aspect of the programme and provided guidance on the operationalisation of the academic and calendar years of the programme. These Requirements and Standards were used by ABA to validate Registration Degree curricula submitted by the partnerships. An Bord, as suggested by the National Implementation Committee which was set up following the publication of the Forum report to implement its findings under the Chairmanship of Ms Mary Rose Tobin, undertook to oversee the implementation of the recommendations of Forum and the National Implementation Committee, which reported to the Minister for Health and Children in 2002, in respect of the national requirements of the programme and ensuring that standards of education and training were achieved.

Section 3 of the Requirements and Standards (ABA 2000) outlines the Standards for the Approval of Third level Institutions, Health Care Institutions and Educational Programmes leading to Registration in respect to approval processes for (a) the third level institution and health care institution, and (b) approval of the programme. The third level and health care institution are required “to provide nurse education which demonstrate that the highest standards of professional education and training are in place” (ABA 2000, para 3.2.1). The twenty standards under this heading relate to meeting established national and EU standards, monitor changes in health care education and policy, keeping of records and attendance of students and that structural provision related to staff and procedures is made to effect standards of education and practice placements (see appendix A). Curriculum Design and Development are required to reflect researched educational theory and health care practice. The curriculum model to support this was also required to be “dynamic and flexible to allow for changes in nursing practice and health care delivery” (ABA 2000 para 3.2.2). The eleven standards under this heading reflect these principles in respect of partnership for curriculum development and monitoring for professional input that allows a variety of teaching strategies and breadth of experience for students in the EU while ensuring quality markers are observed. The Clinical Practice Experience standards, which number nine, require provision for “learning opportunities that enable the achievement of competence in nursing skills and stated learning outcomes” (ABA 2000 para 3.2.3). These standards state a support for the student to experience

quality-learning opportunities in a supported and facilitated manner that appreciates supernumerary status of the student and requires clinical placements to plan for the student experience. The Assessment Process is recognized through nine standards that reflect the need to demonstrate a balanced and integrated distribution throughout the educational programme” (ABA 2000 para 3.2.4). These standards acknowledge the integration and application of theory to patient care and the demonstration of competence (ABA 2000 para 3.2.4.3). The notion of a variety of assessment strategies and the absence of compensation between theory and practice components are made explicit as are the internal standards and processes to ensure the student is eligible to register with ABA. The final set of four standards refers to the external examiners. In this respect the Board acknowledge “external examiners have an important role in maintaining the standard of nursing programmes by providing an independent view about the content, structure, organisation and assessment of the educational programme” (ABA 2000 para 3.2.5). Whilst all the standards reflect statements of expectation and absence of indicators for achievement is a potential for confusion in practitioners applying them to their programmes.

Conclusion

Nurse educationalists are struggling with implementing a theory focus in the curriculum design that meets the needs of a practice profession. There is a struggle with the social structure and historic roots embedded in medicine and its empiric approach. The challenge for curricularists is the delivery of nursing care in practice. Safe and effective practice requires a sound underpinning of theoretical knowledge that informs practice and is in turn informed by that practice (ABA 2000, p 14). The aims of the programme to be realised, require innovative teaching methods and approaches and the assessors of nursing have to embrace a partnership approach with higher education institutions to achieve a unified, integrated seamless programme. The development of competence to practice and systems to assess the achievement of that competence as required by the regulatory body needs further explanation.

COMPETENCE

Introduction

The issue of competence in nursing is one that curricularists, educationalists, nurse managers and practitioners of nursing are being challenged to embrace in the new order of general nurse education. Utilizing a competence approach to the assessment of nursing practice is a major change to the structures, planning, delivery and measurement of outcomes from educational programmes of general nursing studies. This shift in emphasis is an indication that the educators, managers and the practitioners in the health care services share authority for nurse education and practice. It is acknowledged that sharing this decision-making has implications for many not only in the education sector but also in the health services and having partnerships of nurse management, nursing practice and nurse education is a component of the programme that requires special consideration by the curriculum team. This notion of competence supports the contention of Boyatzis (1982) of competence encompassing knowledge, skills and behaviours being causally related to superior job performance.

Brezinka (1988 p 76) traces the origins of the word competence back to the Greek term *aretē* or that of *virtus* in ancient Rome. According to Brezinka (1988) these words describe a relatively permanent quality of personality, which is valued by the community in which it belongs. In this sense it is not simply a skill but a virtue, a general sense of excellence and goodness. It involves being up to those tasks life presents. In most current usage it is stripped down to the ability to undertake specific tasks, it has been largely removed from its social, moral and intellectual qualities.

The Pew Commission Taskforce on Health Care Workforce Regulation recommended the concept of competence for professional practice (American Nurses Association, 1998), where "regulated health care practitioners demonstrate their competence in the knowledge, judgement, technical skills, and interpersonal skills relevant to their jobs throughout their careers." The history of continued competence is attributed to the consumer movement that required mechanisms for assuring the public of continued competence of practitioners (NCBSN 1991). The relationship of competence assurance and protection of the public assumes a role for the regulator. This role can

be characterized as either measurement of competence from an empirical standpoint or from a standards setting perspective. The National Council (NCBSN 1991) suggest the empiric approach is the more rigorous of the two perspectives and the most appropriate for initial entry to nursing practice. It does however require the regulatory body to define competence, determine how to measure competence, and develop measurement tools that are valid, reliable, psychometrically sound, and therefore, legally defensible. They further suggest that the standard-setting perspective is potentially less rigorous as it involves specifying standards, establishing processes for documenting adherence to the standards, and establishment of mechanisms to allow for flexibility and ongoing evaluation of both the process and the standards (NCBSN 1991). It is worth noting the context of the perspectives and in this respect the emphasis of the regulator is on assessment of initial skills necessary to protect the public at the time of initial registration and is mandatory in nature whilst the professional perspective is voluntary in nature and it emphasises growth and achievement. This interpretation denotes an exclusivity notion of either standpoint and it is contested that this needs to be such as demonstrated by Kerr (1992) there is place for self-regulation in professional constructs. Indeed the notion of competence for professional nursing practice is not unique to the US but the UK have grappled with the implementation of the concept for a number of years in nursing through 'Fitness for Practice' (UKCC 1999), 'Standards for Higher Level of Practice' (UKCC 1999), 'Agenda for Change' (NHS Executive 1999), and 'Making a Difference' (DoH 1999) all promote the development of nursing competence and promote the implementation of a competency/outcomes based approach to nurse education and nursing practice. The International Council of Nurses (ICN) supported a study to establish international competencies for the generalist nurse and as such commissioned a study to clarify the role of the nurse and to guide future mutual recognition agreements and multi-country licensure programmes, for which there is a growing demand (ICN 2000). Despite this growing acceptance and awareness for competency-based assessment of programmes Redman, Lenburg and Hinton Walker (1999) warn that accountability though integral to policy for competency-based assessment operationally it is most challenging.

Definition of Competence

There is no universal common approach or definition of competence ABA (2000 p 14) suggests, “competence is a complex multidimensional phenomenon” The Board further defines competence as “the ability of the Registered Nurse to practice safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice” Competence as defined by the ICN (1997 p 44) is “A level of performance demonstrating the effective application of knowledge, skill and judgement” Further the National Council of State Boards of Nursing (US) defines it as “competence is a synthesis of skill, knowledge and performance The ability to transform learning into effective and appropriate action is evidence of such competence” (NCSBN 1985) The UKCC (1999 para 4 8) within the document ‘Fitness to Practise’ defined the term as describing “the skills and ability to practice safely and effectively without the need for direct supervision” These definitions and frameworks reflect the diversity and complexity of the concept but share a vision that a competent nurse not only knows what to do and how to do it, she/he also is able to organise her/his work to act on the knowledge and skill she/he possesses (Waddell 2001) This is further articulated by Epstein (2002), who suggests, professional competence is the habitual and judicious use of communication, knowledge, technical skills, evidence-based decision-making, emotions, values and reflection to improve the health of the individual patient and the community

Competence, therefore, is not only what one knows, but also the appropriate acquisition and use of knowledge in a specific context In simple terms, it is the ability, on a moment-to-moment basis, to recognize the limitations of one’s own knowledge and skills Epstein (2002) claims that four habits of mind are central to clinical learning and competence attentiveness, or the ability to observe oneself in action, critical curiosity, the ability to self-critique and remain engaged, informed flexibility, the ability to think “outside the box” and manage the unexpected, and presence Epsteins (2002) ideas seem to resonate with Jarvis’ (1983 p 43) suggestion that competence to practice is not a legitimate aim in professional education Rather producing in the learner the ability to recognise good practice and the determination to ensure that his/her own future practice will not fall below this standard is a major aim

While the language is confusing the political and educational differences, as has been demonstrated above, between competence and competency are profound Smith (2001) maintains that the best way to deal with the situation is to differentiate between the term competence (competences) and competency (competencies) Smith (2001) continues that competence refers to broad capacities, which are a close relation to the sort of virtues that concerned Brezinka In contrast competency is a narrower more atomised concept used to label particular skills and abilities In the first instance the term relates to capacity and involves evaluation of persons, in the second instance the concept is dispositional and refers to activities Smith (2001) is of the opinion that in today's world competence as a fully human attribute has been reduced to competencies In this there is also an orientation to possessing and owning attributes rather than a concern with being This is similar to Fromm's (1978) differentiation that having persons rely on what they have, the being persons rely on the fact that they are, that they are alive Girot (1993) in examining competence in nursing practice from a phenomenological perspective suggests two senses in which competence can be viewed competence equating with performance, referring descriptively to an activity, and competence as a quality or state of being of an individual Benner (1984) in her seminal work *From Novice to Expert* excellence and power in clinical nursing practice goes further to emphasise that competence in nursing refers to the real world of practice and that there are different levels from novice or beginner nurse to experts who have a deep understanding and an intuitive grasp of situations Smith (2001) concludes his discourse by suggesting that a process model of curriculum is required to underpin the development of competence In this sense the author views the curriculum as an interaction between teachers, students and knowledge and defines it, based on the work of Stenhouse (1974) as "a proposal for action which sets out essential principles and features of the educational encounter" (p 70)

Competence-based systems operate with two different emphases Fletcher (1995) considers that the UK system focuses on 'standards of occupational performance' whereas in the USA the emphasis is on 'competency development' Whether one system or a synthesis of both systems is used it depends on the focus of the competence-based standards Benner (1994 p 25-26) suggests that competence

develops when the nurse begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware The plan dictates

which attributes and aspects of the current and contemplated future situation are to be ignored. Hence, for the competent nurse, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem.

She further contends “the conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation” (1994 p. 27). In order for this concept to find a real meaning in the practice environment it must be remembered that “competence at registration changes over time as roles and functions develop in response to many drivers affecting the provision of health care. It is not the nature of professional work to define it by tasks and skills” (UKCC 1999 p. 44).

Probably the most widely held conception of the nature of the origins for implementing competence is task based or behaviourist (Curtain and Hayton 1995). In this conception competence is perceived in terms of the discrete behaviours associated with the completion of identified tasks (Fletcher 1995). Its aim is the transparent specification of competencies so that there can be no disagreement about what constitutes satisfactory performance. In effect the task becomes the competency. This approach is unconcerned with the connections between tasks and ignores the possibility that the coming together of tasks could lead to their transformation. It is probably a testament to the continuing power of functionalism and technical rationality in education that a narrow notion of competence has gained such ground. The benefits of competency based approaches stem first from their concern with practice directly rather than with practice as an application of knowledge and secondly with their use of practice situations to derive objectives for development (Boyatzis 1982).

Eraut (1998) comments that the discussions around competence have been less than valuable when the term has been used mainly for its rhetorical effect, without clarifying the policy objectives or the nature of the problem. Some proponents have presented the concept as a kind of antidote to theory, derived from a theoretical common sense apparently unaware of the number of theories in practice, which govern people’s everyday thoughts and actions. Eraut (1998) continues that some opponents of the term have attempted to rubbish it by branding it as essentially behaviourist, positivist and modernist.

Competence and Curriculum

Smith (2001) argues that a curriculum model which is based on process involves active participation through learning rather than a passive reception of teaching and as such fits better with the cycle described above. The focus is concentrated on the participants and their actions rather than upon pre-determined products.

This approach to competence is based on holism and an appreciation of the interconnectedness and value based divergent nature of professional knowledge rather than the reductionism of the technical rational model. It treats the construction of knowledge and the validity of knowledge as problematic and therefore real practical issues in each individual practice situation always become condensed. It views methods and outcomes as interdependent and interacting and knowledge building from action as existing in a relationship to with practice. The construction of knowledge becomes critical and depends on a world-view and it is the responsibility of the professional to make informed but ultimately value based judgments about the application of knowledge. Lester (1995) however sees two problems with this approach.

1. It moves the responsibility for defining acceptable professional behaviour and competence from the profession as a whole to the individual practitioner in negotiation with the practice situation
2. It questions current notions of professional boundaries.

In this respect Lester (1995) continues that the post industrial society will see the practitioner less as a member of a definable occupation than as a capable individual with an evolving portfolio of experience and ability. This understanding of competence operates at the level of values and perspectives as one component of practice. The practitioner has choices and decisions to make about outcomes as well as methods and about which knowledge and which logic to use as well as how to use it.

Developing Competent Practitioners

Nursing has been described as a 'practice-based discipline' and as such requires competency frameworks that are sensitive to the academic achievements/outcomes and the requirements of practice. Lester and Chapman (2000) suggest that much of higher education especially at undergraduate level is concerned with developing

conventional competence i.e. academic ability, discipline-based knowledge, and occupational and professional competence and skill. Developing competence to enable a safe, caring, decision-maker willing to accept personal and professional accountability for evidence-based practice and being able to promote and maintain health, as well as be able to give care during illness, rehabilitation and dying (Nursing Education Forum 2000) requires innovative delivery methods and a range of competency assessment tools/methods to achieve a competent nurse capable of practice expectations.

The focus of nursing is on providing holistic patient care. The nurse requires technical skills but also personal skills and qualities of patient care (Ashworth and Morrison 1996). The notion of competence as the assessment of distinct items of work performance should be avoided and instead rewards for specific skills, capabilities, applicable pieces of knowledge and understanding that the individual has attained becomes the issue for reward. The task of higher education institutions providing nursing education programmes is to provide courses that will enable the learner to achieve identified competencies although these cannot subsume the educational experience.

The educational philosopher John Dewey (1938) in discussing experience and education states “everything depends on the quality of the experience which is had (sic). The quality of any experience has two aspects. There is an immediate aspect of agreeableness or disagreeableness, and there is its influence upon late experience” (p.26). The support issues to provide experiences, both in the third level institutions and the health care institutions, that embrace the need for engagement with critical experiences to effect ‘turning points’ associated with growth of a more reflective practitioner and a learning approach to match education and experience is one which must not be underestimated for the practitioners and the recipients of nursing care.

The problems associated with measuring competence, like most assessments, have been articulated by Waltz, Strickland and Lentz (1991) as firstly conceptualising the construct to be measured; selecting a measurement paradigm; selecting measuring instruments; and finally interpreting the measured data. While these problems are acknowledged they are not insurmountable for curricularists. The familiarity of the

assessors with the process is one that poses challenges for the stakeholders of the education programme. It is suggested by Exstrom (2001 p 118) that from a State Board of Nursing perspective the five most obvious agencies with a vested interest in competency are

- 1 Individual nurse
- 2 Employers of nurses
- 3 Nursing educators
- 4 The nursing profession
- 5 Boards of nursing

Thus the requirement for a team and partnership approach to developing, assessing and determining the student nurses' competence

Competence is a critical core element within the scope of practice for registered nurses. The acceptance of national competencies will enable ABA to use them as a tool to encourage self-regulation within the profession, protect the public and produce registrant nurses who are capable on taking up their first employment post. The main challenge that faces the partnerships of the nurse education programmes is in describing the core nursing competencies in ways that embrace the questions of what nurses do, and what are issues of values, motives, approach and capabilities behind the nursing interventions and actions.

ABA as the regulatory body for nursing and midwifery in Ireland supports the standards and competencies for registration that can be validly and reliably assessed. The five Domains of Competence representing the level the student must achieve on completion of education programme for entry to the Register held by ABA are

- 1 Professional / ethical practice
- 2 Holistic approaches to care and the integration of knowledge
- 3 Interpersonal relationships
- 4 Organisation and management of care
- 5 Personal and professional development

(ABA 2000 p 14)

The aim of the nurse education programme is to ensure that students acquire the skills of critical analysis, problem-solving, decision-making, reflective skills and abilities essential to the art and science of nursing. ABA (2000 p 14) further states that safe

and effective practice requires a sound underpinning of theoretical knowledge that informs practice and is in turn informed by that practice. The “Domains of Competence” represent a broad enabling framework to facilitate the assessment of pre-registration student nurses’ clinical practice and use of theoretical knowledge (ABA 2000 p 14). Each of the five domains outlines performance indicators (N=20) and indicators (N=43). Indicators in each domain describe the evidence that is to be produced for assessing competency in that domain. These indicators may be subdivided into learning outcomes. The learning outcomes reflect a more specific level of competence (and evidence) required in relation to the level of educational programme and placement area. The learning outcomes and the form or type of evidence necessary to prove competence are decided at local level (ABA 2002). All five domains of competence represent the level the student must reach on completion of the educational programme. Each domain consists of performance criteria and their relevant indicators. The assessment of competency from year one to year four correlates to the theory of experiential learning (ABA 2002).

In conducting a review of the literature on clinical competence in nursing spanning 20 years of the 20th century and yielding 61 papers of varying methodological approaches, Watson et al (2002) conclude that there are very few papers which have sufficient rigor to address the measurement of clinical competence. The implication of this assessment is that adopting a haphazard approach to training constituted a threat to patient safety (Bradshaw 1999). Another worrying observation of UKCC Commission for Nursing and Midwifery Education (1999 para 4.21) is that assessment strategies are not effective in identifying poor performance in practice, learning outcomes are often stated in vague terms, assessment documents lack clarity and assessors are often ill-prepared for the task and lack appropriate feedback from their academic colleagues. Girot (2000) further comments on the incongruence of the processes of assessment of students related to the academic and the practice elements of the programme.

The idea of competence to perform a work role inevitably involves a form of discipline. Educational practices have increasingly become part of a disciplinary framework in modern social formations where practitioners are measured, defined and regulated. Usher et al (1997) suggest that people evaluate themselves according to the

criteria set by others and develop a belief that they are living authentically and autonomously. This provides the grounds for a greater sense of personal responsibility and the conditions for the recognition and development of personal capacities. Within this process knowledge and competence are gained by various means but they are always potentially transient and subject to modification and reconstruction according to changing circumstances and practice demands.

A specified point at which a professional body defines threshold competence divides the spectrum of professional expertise, ranging from novice to expert. The area prior to this point is concerned with developing and establishing a base level of competence sufficient for an individual to be recognised by peers as a member of the profession concerned.

Conclusion

It would appear that there is a significant difference between a competency based curriculum and a curriculum designed to develop competent practitioners in the original Greek or Roman term. It would also seem that the approach to competence being advocated for nursing, centres on the overall development of practitioners in the traditional sense of the word. One of the advantages of developing practitioners within the context of domains of competence is that these can ultimately support a system of self-regulation where accountability is understood. Current policy emphasises the need to look at developing nurse education programmes that students acquire the skills of competence to enable a safe, caring, decision-maker willing to accept personal and professional accountability for evidence-based practice and being able to promote and maintain health, as well as be able to give care during illness, rehabilitation and dying (Nursing Education Forum 2000). A programme of this nature requires innovative delivery methods and a range of tools/methods to achieve a competent nurse capable of meeting practice expectations.

The purpose of nursing and the knowledge base required to practice nursing are debates that continually feature in healthcare. This is in no small way due to the evolving nature of health and the constantly changing political and social climate. Hence no single theory of nursing can ultimately explain what it is that nurses do and what they need to know, rather nursing and its knowledge base require constant

development as nursing is examined in the light of external contextual changes and internal theoretical developments. This poses many challenges for curricularists, educationalists and practitioners of nursing in determining competence of the profession. Determining how these processes are working or not working therefore becomes the subject of further review through mechanisms such as evaluation. The next section of this review examines the process and systems of others and lessons learnt as a consequence of systematic review.

EVALUATION

Introduction

An examination of a phenomenon is futile unless there is a purpose to the examination (Dewey 1968) In this case the purpose of the examination emerged at a time of unprecedented change of nurse education in Ireland This study utilising an evaluation framework to research the phenomenon of the regulatory concerns associated with this development in general nurse education developed an understanding of the new national requirements and standards of general nurse education In undertaking a study of evaluation of general nurse education programmes in Ireland from the perspective of the regulator a number of issues became apparent in relation to the mission of nurse regulation

The purpose of regulation of the professions is the protection of the public (ABA 2003) One of the roles and functions of a regulatory body is to set and monitor standards of education and thus ensure the public interest of nurses and nursing (ICN 1996) As in all other aspects of regulation there is no one international accepted model for nurse regulation, so too, is the diversity of models of evaluation and no one universally accepted model

Models of evaluation research and the application of these models to studies undertaken both in Ireland, the U K and internationally are explored with a view to explicate the current contexts of evaluation research and extrapolate issues for regulators of nursing to consider In essence this review considers approaches toward evaluation that support regulatory requirements

“Accountability is the cornerstone of professional practice” (ABA 2000, p 31) All nurses and midwives are required to be accountable “to the patient/client, the public, their regulatory body, their employer and any relevant supervisory authority ” ABA as the regulator for nursing and midwifery are accountable to the Oireachtas through the Minister for Health and Children (Nurses Act 1985) In this respect as Alkin and Christie (2004, p 12) suggest, “the need and desire for accountability presents a need for evaluation ”

Evaluation Research

This section examines the concept of evaluation research and reviews a number of common models and approaches to evaluation research that has influenced nursing in particular

The focus of this section of the review 'evaluation' was to illuminate the approaches undertaken within the study and the status, needs, and future directions of nursing education programmes, as well as the processes by which knowledge for nursing practice can be generated and supported. This information is vital for understanding long-range planning and ensuring appropriate regulatory governance

Definitions of Evaluation

The Concise Oxford dictionary (1984) defines "to evaluate" as "to ascertain amount of, find numerical expressions for, appraise, assess". This definition is one of a wide range, as a pure definition is elusive, as demonstrated by the numerous perspectives that are brought to the process and philosophies underpinning its purpose. Evaluation research according to Clarke (1999) does not have a unique methodology of its own but rather is used by many disciplines. Formal evaluation is defined as a form of 'disciplined inquiry' (Lincoln and Guba 1986 p 550) that "applies scientific procedures to the collection and analysis of information about the content, structure and outcomes of programmes, projects and planned interventions" (Clarke 1999 p 1). Rossi and Freeman (1993 p 5) suggests, "evaluation research is the systematic application of social research procedures for assessing the conceptualisation, design, implementation and utility of social intervention programmes". The approach involves the application of social methods of research that it is action oriented. This complements the assertion of Clarke (1999 p 3) that in many incidents it is viewed as a type of policy research based on the outcomes of its approaches

Quinn Patton (1997 p 192-194) describes an outline defining question or approach for 56 foci or types of evaluation ranging from 'accreditation focus' through to 'utilization-focused evaluation'. He identifies eighteen terms which incorporate the word 'evaluation' ranging from 'cluster evaluation' to 'utilization-focused evaluation' which illustrate the different types of evaluation and for which he acknowledges his identification is not exhaustive (Quinn Patton 1997 p 192-194). The common

understandings of the terms ‘curriculum evaluation’ or ‘programme evaluation’ ‘project evaluation’ and ‘materials evaluation’ (Joint Committee 1994 p 204-209) reflect the major concerns of the term. Additionally the U S Evaluation Research Society (1980) standards refer to “evaluability assessments, process evaluations, impact evaluations, monitoring evaluations” (Rutman 1984 p 225). Stufflebeam (2001 p 8) more recently attempted to sort twenty-two evaluation approaches through an assessment of the strengths and weaknesses of each approach. It therefore may be concluded that as Scriven (1991) identified a need for an “Evaluation Thesaurus” which he published following consultations and deliberations with the evaluation community, the topic has developed into an area of study in its own right but it is struggling with identity issues that could be said are associated with scientific advancement and operation of evaluation approaches (Stufflebeam 2001).

Rutman contends that “evaluation research” and “programme evaluation” is the same thing (1984 p 10) but that confusion has arisen around the topic in the purpose of the evaluation. He further contends that the idea of doing evaluation research to advance knowledge is far less compelling a reason for undertaking a study than programme evaluation to meet the information needs of decision makers” (1984 p 10). This argument is advanced by Quinn Patton (1997 p 24), who supports the contention of Cronbach and Suppes (1982) that the difference between research and evaluation is between conclusion-oriented and decision-oriented inquiry. This argument however is more fundamentally placed in the arguments associated with the perspectives of social inquiry and scientific inquiry.

The evaluation purpose debate is linked to the outcome of the evaluation and the purpose it is intended to achieve. Evaluation from some schools of thought usually involves critically assessing against defined standards (Tyler 1949). These standards in themselves lead to a debate as to whether the purpose is orientated for improvement in a process or to whether the purpose is for a summative judgement. The implication of evaluation as a means for decision-making and judgement, whether from either approach, is dependent on the approach and the methodologies of the study. According to Rossi et al (1999 p 32) “evaluation practitioners are drawn from a wide range of academic disciplines and professions with different orientations and methods, and this significantly contributes to the multiplicity of perspectives.” The common

feature is that most evaluations are rooted in social science research techniques (Rossi et al 1999, p 33) Rogers (2001 p 205) contends, “no evaluation of one human being by another can be objective. The opinions, bias, assumptions and knowledge of the observer inevitably get in the way.” Therefore a number of methodological issues associated with the conduct of a study of evaluation are explored

Alkin (2004, p 14) suggests, “evaluation simply provides the information for ‘being answerable’.” He further develops an argument he proposed in 1972 for three dimensions to accountability: goal accountability, process accountability and outcomes accountability

Goal accountability examines whether reasonable and appropriate goals have been established; process accountability reflects whether reasonable and appropriate procedures for accomplishing those goals have been established and implemented; and outcome accountability refers to the extent to which established goals have been achieved

(Alkin 2004, p 14)

If we accept Alkin’s definition of evaluation as having an interconnectedness of accountability and social inquiry this illuminates the notion of ‘explaining a situation’. Depending on the process embarked on to obtain the data e.g. psychology, anthropology or ethnography, the method determines the product. As a consequence a multitude of evaluation models have been developed by educational researchers based on an underpinning philosophy about the body of knowledge and methodology, the values and purposes of the evaluation and the evaluator

Origins of Evaluation Research

Current writers in contemporary educational evaluation (Alkin 2004, Singh 2004, Stufflebeam 2001, Whiteley 1992, Sanders et al 1994) consider Ralph Tyler (1942) as one of the primary theorists of modern educational evaluation. Tyler defines evaluation as “the process of determining to what extent educational objectives are actually being realised” (Tyler 1949 cited in Whiteley 1992, p 216). Tyler (1942) contended, “the purpose of evaluation is to validate the programme’s hypotheses.” The approach he proposed came to be known as ‘objectives-oriented’ had the following elements

- formulating a statement of educational objectives

- classifying these objectives into major types
- defining and refining each of these types of objectives in terms of behaviour
- identifying situations in which students can be expected to display these types of behaviour
- selecting and trying promised methods for obtaining evidence regarding each type of objective
- selecting on the basis of preliminary trials the more promising appraisal methods for further development and improvement, and
- devising means for interpreting and using results

(Tyler 1942, p 498-500)

This type of approach to evaluation is associated with the inputs outputs school of cost-benefit analysis and later the management by objectives school that was required of federal programme providers in the United States in the 1960's and 1970 where allocation of funding had to be justified according to results achieved (Whiteley 1992, Madaus 2004) Parlett and Hamilton (1972 p 13) describe this as the "agricultural-botany paradigm" Madaus (2004) in discussing Tyler's contribution to programme evaluation refutes the notion that Tyler was completely objectives bound He posits the political, cultural and educational ethos of the time coloured and impeded the more holistic approach that Tyler advocated particularly for assessment and the cyclical process of evaluation context of evaluation (Madaus 2004)

This accepted contemporary understanding of the origins of research in evaluation is argued as behaviourist in approach but according to Quinn Patton (1997 p 10) education has been a target for evaluation since 1897 when Joseph Roe conducted a comparative study of spelling programmes associated with achievement testing Quinn Patton (1997 p 12) further contends "early visions for evaluation focused on evaluation's expected role in guiding funding decisions and differentiating the wheat from the chaff in federal programmes "

Whiteley (1992) contends that the discipline of evaluation has developed from a strong behaviourist code of practice where measurement dominated methods used to collect analyse and report data to a more investigative and less prescriptive approach Some evaluation theorists advocate for a utilitarian approach to evaluation (Quinn Patton 1997) and criticise the poor methodological quality of evaluation studies (Rossi 1999) In this respect the Joint Committee on Standards for Educational Evaluation,

which represented the concerns of 12 organizations of professional evaluators developed thirty standards that all evaluators and clients of evaluation should attest. They identified four main conditions for evaluation; an evaluation should be useful; it should be feasible; it should be ethical; and it should be accurate (Sanders et al 1999 p.5). The definition that reflects this constituency states “evaluation is the systematic investigation of the worth or merit of an object” (Joint Commission on Standards for Educational Evaluation 1999 p.3). According to this definition if a study does not report on the value i.e. how good or bad something is then it is not evaluation. An argument against this position is rooted in the values orientation implicit in the power that becomes laden in the evaluator (Rossi 1999). The evaluation should therefore ascertain the value perspectives of the clients of the evaluation in order to determine what information to collect and what standards to invoke on determining the worth or merit of a service (Stufflebeam and Shinkfield 1985).

Skillbeck (1984 p.1) views evaluation at a number of levels. He suggests a view as: “...referring to those explicit, planned, designed and organised reviews and assessments by which we systematically appraise the curriculum, applying procedures and methods in a deliberate fashion.”

This definition considers evaluations as applying empirical systematic techniques to collect and analyse data and thus make a judgement. Stufflebeam (1971) contributes to this school of thought and develops the construct to include decision-making regarding the continuation or refocusing of a programme. However Quinn Patton (1997 p.8) contends from a review of a number of U.S. reports, “the findings of evaluation studies are largely unused for decision-making” and further he calls for the evaluations to be useful. In this he developed the “utilization-focused evaluation model and checklist (Quinn Patton 2002). On the theme of useful Alkin and Coyle (1988) suggest user-oriented evaluation has long emphasised that evaluation must attend to appropriate use not just the amount of use.

Curriculum evaluation, however, can be characterised in a variety of ways depending on the purpose of the evaluation and who is making the evaluation (Greaves, 1984, p.44). Many definitions emerge from the literature depending on the context and as such Harrison (1988 p.127) suggests, “evaluation looks at the total value of the learning event, not just whether and how it has achieved its learning objectives. It

therefore puts the event in its wider context and provides information essential to future planning ”

Evaluation according to the nurse educationist Burnard (1991 p 124), can cover the “effectiveness of teaching, whether or not students valued the teaching, whether or not learning took place, and the effectiveness of a course ” Whiteley (1992, p 315) in examining evaluation in nursing, supports this view, and called for “an improvement of evaluation methods in order that useful information can be gained to inform decision-making ” According to Stufflebeam and Shinkfield (1985 p 1) “the most important evaluations of professional services are those conducted (or commissioned) by the professionals themselves ”

Evaluation therefore, at its utility level, should assist decision-making and indicate the future direction of a course from possible options The fundamental purpose of this study of evaluation is to support, inform and influence future choices and actions for the accountability and social inquiry of the regulator Evaluation therefore requires that the regulator undertake an accurate description of the characteristics of the national programmes and assessment of them against relevant standards or criteria This examination, a study of evaluation, is required to inform decision-making (Whiteley 1992) in respect of the national framework of general nurse education programmes for the regulator of nursing in Ireland, ABA

Evaluation and Audit

Evaluation as a research methodology is reported to provide information that contributes to better-informed decision-making (Clarke 1996) Evaluation research within health care is argued to be at the heart of evidence-based practice In measuring the effectiveness of particular interventions by focussing on health outcomes nursing research has mainly concerned itself with illuminating the processes associated with nursing care It is argued that outcomes are often best measured using quantitative indicators, the process issues being more amenable to qualitative analysis In this respect Balogh (1996) argues that the policy trend for audit within the United Kingdom NHS review required that the relationship between audit and research were examined She concluded that the difference between audit and research was in the purpose for which they were conducted She argued that research “seeks to establish

and extend knowledge about effective practice, that is, 'the right things to do', audit concerns itself with ensuring that 'the right things are in fact done'" (Balogh 1996 p 8) Fundamentally this distils into the generalisability of research findings with the local significance of audit-based projects

In conducting an independent audit of the Nursing and Midwifery Council's (UK) Quality Assurance Model Watson et al (2003) sought to provide the NMC with independent evidence of how the statutory obligation for ensuring standards of educational programmes leading to registrable and recordable qualifications were met in the UK. The project, underpinned by a structure, process outcomes model for quality assurance, collected qualitative and quantitative data to provide insights into the operation of the process while also making a comparative analysis of the costs and benefits of the model in the four counties of the UK. The findings of the audit reassure the NMC that the quality assurance model is working but caution was expressed in regard to judging whether the procedures actually fulfil the statutory responsibility of education and training (Watson et al 2003). This study highlights the caution expressed by Balogh (1996 p 10) concerning audit, where she suggests "audits can not only highlight areas where research is lacking but also raise new questions for research". In this respect audit has its own research agenda that seeks to identify new strategies for promoting changes in practice. The relationship of audit as a component of action research is also argued by Waterman (1995). It is contended (Harvey 1996, Balogh 1996, Waterman 1995) that audit requires active participation of practitioners in an organisation context that is conducive to change. The advantage, therefore, of evaluation approaches is in providing generalisable findings and the basis for judgement (Byng, Norman and Redfern 2005).

Theoretical Underpinnings of Evaluation

There are multiple acceptable ways to pursue evaluation. According to Alkin (2004 p ix) "all evaluation has its roots in social science research methodology and accountability". While within nursing and education fields it could be argued that many evaluations have been conducted and theories have been used it is not the exclusive domain of either of these disciplines. Evaluation as a social construct is shared by many disciplines such as economics, political science, statistics, psychology, sociology, public administration, public health and education (Rossi

2004) This interest of course, is not exhaustive, as evaluation inquiry is also shared with product evaluation, personnel evaluation, bio-medical experiments and public accounting (Chen 2004)

A number of literature reviews from the nursing and education literature have contemplated the evaluation theorists underpinning philosophies and have posited 'classification' systems or 'types' to the orientation of particular writers (Whiteley 1992, Chavasse 1994, Melrose 1996, Quinn Patton 1997, Stufflebeam 2001, Alkin 2004)

In accepting Ralph Tyler (1942) as one of the primary theorists of modern educational evaluation and his definition of evaluation as "the process of determining to what extent educational objectives are actually being realised" (Tyler 1949 cited in Whiteley 1992, p 216) he contended, "the purpose of evaluation is to validate the programme's hypotheses" According to Rossi et al (1999 p 32) there is a growing interest amongst theorists towards "identifying congruent elements among different perspectives to advance what is referred to as 'evaluation theory' They quote from Shadish, Cook and Leviton (1991 p 30-31) a definition of the ideal evaluation theory

"the ideal (never achievable) evaluation theory would describe and justify why certain evaluation practices lead to particular kinds of results across situations that evaluators confront It would (a) clarify the activities, processes and goals of evaluation, (b) explicate relationships among evaluative activities and the processes and goals they facilitate, and (c) empirically test propositions to identify and address those that conflict with research or other critically appraised knowledge about evaluation"

(Rossi et al 1999 p 33)

While this concept of a theory to guide a study presents a logical framework to sort relationships and connections resources, political considerations and narrow disciplinary training are constraining factors associate with its effective implementation (Quinn Patton 1987) Stufflebeam (2001 p 9) on the other hand cautions against the term evaluation model, as it "is too demanding to cover published ideas about how to conduct programme evaluation" He prefers the term "evaluation approaches" as it is "broad enough to cover illicit as well as laudable practices" (Stufflebeam 2001 p 9) Quinn Patton (1987) argues that evaluators have a large selection of research methods and techniques available to use on a variety of problems and as such the skilled evaluator "works to design a study that includes any and all

data that will help shed light on the evaluation questions being investigated” thus the methodological flexibility required to conduct a study has led to the plethora of approaches now available

Alkin (2004, p 14) suggests, “evaluation simply provides the information for ‘being answerable’ ” Further he describes social inquiry in its broadest sense as a “the systematic study of the behaviour of groups of individuals in various kinds of social settings by a variety of methods” (Alkin 2004 p 15) This is based on “recognition that there is a unique social dimension to human action as opposed to merely a natural and psychological dimension ” The implication of this is that a professional group such as general nurses are a social group Developing descriptions and theories systematically gives rise to a need to develop a meaning of quality nurse education programmes as opposed to placing an overriding need of the regulator to control education programmes through predictive processes such as purely the stated curriculum In accepting Alkin’s definition of evaluation as having an interconnectedness of accountability and social inquiry this illuminates the notion of ‘explaining a situation ’

The theoretical approach to evaluation has generated debate and exercised the theorists to understand the philosophical underpinnings of this area of study in order to professionalise programme evaluation (Stufflebeam 2001) Prior to conducting a study the researchers justify the methods and approaches utilised In examining the writings of a few authors in the area Whiteley (1992) while conducting an evaluation of continuing education programmes in Scotland, traced the behaviourist approach of Tyler (1942) through to the work of Scriven (1967), who introduced the concepts of “formative” and “summative” evaluation as goal-oriented evaluation Formative evaluation is that which is conducted during the lifetime of a programme with the intention of improvement in the life cycle of the programme whereas summative evaluation reports on the completed cycle of a programme The difference as seen by Whitley for her study in the approaches available to her was that the evaluator does not interfere or change the programme during the evaluation process Whiteley (1992 p 320) further describes four “new-wave” models she considered namely Stake’s ‘Countenance Model’ (1967), Stufflebeam’s ‘CIPP Model – Context-Input-Process-Product’ (1971), Scriven’s ‘Goal-Free Evaluation Model (1972) and Parlett and

Hamilton's 'Illuminative Evaluation Model' (1972) Illuminative evaluation as described by Parlett and Hamilton is the "intense study of the programme as a whole its rationale and evolution, its operations, achievements and difficulties" The programme is not examined in isolation, but in the practice context or 'learning milieu' "observation, interviews with participants, questionnaires, and analysis of documents and background information are all combined to help 'illuminate' problems, issues, and significant programme features" (Parlett & Hamilton, 1972 p 10) In describing each of these models she utilized the Parlett and Hamilton model for the study she conducted and in order to make it more workable she incorporated the quality assurance framework of Donabedian (1966) to describe the provision of care, i.e. "the structures to provide and support the course, the processes by which the course is delivered, and received and the overall impact of the course in question" (Whiteley 1992 p 320) and in this way manipulated current theories and approaches to the advantage of her study

Chavasse (1994) on the other hand conducted a review of the literature in respect of curriculum evaluation in nursing She concluded that there was an absence of studies exploring relevance to "health care need, nurses' accountability to their clients and outcomes of curricula" as specified by the World Health Organisation (WHO) in a monograph from 1977 In this regard the call from Parse (1982) cited by Chavasse (1994 p 1025) "that the evaluation plan should be congruent with the conceptual framework of a given programme" warrants exploration from the perspective of the providers and the regulators of programmes Chavasse (1994) contends "professional validating bodies are likely to seek outcome measures as evidence of nursing competence" (p 1025) This statement is supported by the review undertaken but also by the classification she attributes to the curriculum type and the evaluation strategy or paradigm The objectives type is associated with classical and quantitative methods, the process type with illuminative and qualitative methods and the combined model is associated with comprehensive, holistic quantitative and qualitative methods The researcher's understandings and familiarity with approaches to conduct a study therefore are determinates for theory implementation and manipulation

Melrose (1996 p 3) suggests "three paradigms or world views about evaluation, functional, transactional, critical" She contends that models from the functional

paradigm have an emphasis on psychological testing and make assumptions “that there is a concrete truth to uncover about the worth of the curriculum and that evaluation will provide either a correct answer to a curriculum problem or a revelation as to whether or not a programme should continue in its present form” The main problem with this approach is the absence of a sense of context or process The transactional approach or naturalistic paradigm is based in liberal humanist and subjectivist ethics approaches This ‘illuminative approach’ involves many stakeholders including students to examine the unique context of their programme These models according to Melrose (1996 p 4) “acknowledge pluralistic values, shades of truth depending on the observer and the interpreter, and the subjectivity of any judgements” The critical, or emancipatory, paradigm of evaluation on the other hand is based on ideas about “learning communities as self-evaluating and critically reflecting entities which are empowered to set their own standards” (Melrose 1996 p 4) The uniqueness of this approach lies in the evaluation requiring “dialogue, collaboration and praxis” Critical evaluators are likely to consider the “organisational and societal context of their practice, the historical, political, and social context in order to work towards changing the context and monitoring the results of their attempts to change” (Melrose 1996 p 4) This develops a process orientation towards improvement from critically evaluating the organisational systems within which the curriculum occurs The implication of considering this wide sweep approach based purely on philosophical underpinnings negates the need to look for or follow a predetermined prescriptive theory to conduct an evaluation study

Quinn Patton (1997) also identified three approaches to programmes development for evaluation as the deductive approach, the inductive approach and the user-focused approach In examining the theorists assumptions associated with the approaches he warned that the temptation of the deductive approach is to make the study more research than evaluation i e theory testing takes over the evaluation In the inductive approach he warned that the “product of the inductive approach, and therefore a major product of the evaluation, would be an empirically derived theoretical model of the relationship between programme activities and outcomes framed in terms of important contextual factors” (Quinn Patton 1997 p 221) The user-focused approach requires the evaluator to facilitate the curriculum team to articulate espoused theories and then make a judgement in relation to theories-in-use as articulated by Argyris and Schon

(1978) Quinn Patton suggests that this theory of action approach is grounded in practice and attempts to put theoretical constructs on the programme after its inception and implementation. The importance of this approach is in the understanding the programmes theory of action as perceived by key stakeholders. Quinn Patton (1997 p 222) explains this as it “challenges decision makers, programme staff, funders, and other users to engage in reality testing, that is, to test whether what they believe to be true (their espoused theory of action) is what actually occurs (theory-in-use)” In essence utilisation-focused evaluation refers to a process where “the evaluator works with the primary intended users to identify the critical validity assumptions where reduction of uncertainty about causal linkages could make the most difference” (Quinn Patton 1997 p 225)

Stufflebeam (2001) in a monograph that critically examined and appraised twenty-two approaches to evaluation often employed in studies with the aim of deciding on the worthiness of their continued application for the new millennium. Of the twenty that he decided had continued merit he divided into questions/methods-oriented approaches, improvement /accountability approaches, and social agenda/advocacy approaches. He rejected two approaches, as pseudo evaluations as they were politically controlled and public relations based along with those that are associated with payment by results. All theories according to Stufflebeam (2001 p 91) have inherent strengths and weaknesses. The questions/methods-oriented studies such as case study methods of Simmons (1998) are vulnerable in that they often address questions that are too narrow to warrant a full study that leads to a judgement regarding merit and worth. The strength of these types of studies though is in the efficiency of the methodology employed to conduct the study, a weakness of both the improvement/accountability and the social agenda/advocacy approaches. The strength of the improvement/accountability approach such as decision/accountability of Stufflebeam is in the concentration toward merit and worth although he acknowledges the difficulty associated with the breadth of this task (Stufflebeam 2001). The social agenda/advocacy approach such as the utilisation-focused approach of Quinn Patton (1987) is strongest in its ability to include the stakeholders as participants of the study thus involving, informing and empowering stakeholders.

In examining the underpinnings of other current theorists, Alkin and Christie (2004, p 13 & 389) propose a classification system depicted in the symbolism of a tree to indicate the particular evaluation influences of the theorist. The symbolism of a tree they suggest was chosen as a common root of all the theorists was in social inquiry with social accountability and fiscal control (Alkin 2004 p 288). The tree has three even sized branches depicting “use”, “methods”, and “valuing”. Alkin in this composite book which “examines and compares current evaluation theoretical stances” (Alkin 2004 p ix) the editor posits and argument for an evaluation theory tree (Alkin and Christie 2004 p 12-65) and then revisits the theory tree after inviting comment on the proposed tree symbolism from the theorists or proponents of the theories reviewed (Alkin and Christie 2004 p 381-392). The rationale for the symbolism defended by Alkin (2004 p 381-382) is that it is “a category system with a distinct characteristic”. They acknowledge the difficulty this presented for a number of contributors as each had a notion of their own work and some had posited their own classification and category systems that were in conflict with that proposed by Alkin and Christie. Indeed Guba and Lincoln conceptualised the exercise as “a fragile, unstable, and highly-laden enterprise in and of itself” (2004 p 382). In defending the notion of the theorist classification where there is so much diversity, the common belief, comes down to an “epistemological/ideological” one that involves “a view of ‘truth’ and knowledge’ and science but also in social/political values” (Alkin and Christie 2004 p 383). The reason classification systems are important are because they cause thought and develop understandings of evaluation. The most significant thought though that developed from the critique was the journey that the theorists collectively brought to the debate in that they believed they had developed in their thinking associated with evaluation from the studies they had engaged in (Alkin, Christie 2004).

The first main change associated with evaluation was in the use of qualitative research methodologies and the inclusion of interpretive areas within the field of study examined. The establishment of a philosophical foundation to characterize the work and thinking of many qualitative researchers in education is espoused by Lincoln and Guba (1989) who argue that qualitative research assumes a different ontological position than traditional quantitative research. In short, they claim that quantitative research espouses the idea that reality is outside the control of the researcher and that

consequently inquiry is essentially a spectator activity. Qualitative research, on the other hand, is characterized by the fact that the researcher constructs the reality that he or she sees. Along with this idea is the notion that each person involved in the inquiry, as either participant or subject, constructs his or her reality as well (Lincoln and Guba 1989 p 70-91)

Guba and Lincoln (1989) argue that evaluation that encompasses a truly democratic process of consumer collaboration challenges some of the taken-for-granted assumptions of the traditional role of the evaluator. They argue that in Fourth Generation Evaluation the evaluator must take on four new roles. These are

The evaluator must move from the role of controller to that of collaborator,
The evaluator must assume the role of learner and teacher rather than that of investigator,
The new role of the evaluator is that of reality shaper rather than mere discoverer, and
The evaluator gets rid of the role of passive observer and recognises and embraces the role of change agent

(Guba and Lincoln, 1989 p 260 -262)

In summary the study of evaluation is in a period of constant development associated with current worldviews and value orientations. A number of thinkers in the field of evaluation express classification systems in an effort to categorise the intent and purpose of the varying developing approaches (Alkin 2004, Stufflebeam 2001). The evaluator in essence has to choose a model and approach according to his/her own value system, which can be made explicit but needs to be explored within the philosophical level of the research method.

Models for Evaluations

A theory is primarily an attempted solution to a puzzle or problem. Theories are proposals that give a reasonable explanation to an event and are ideas about how or why something happens (Pearson and Vaughan 1990). Using theories to underpin research and the research process has two purposes. Theories can be inducted or generated from the data leading to predictions about a phenomenon or they can be tested by the research process and deductively used to evaluate and modify a current theory. Theories are "linked to the real world through definitions that specify how concepts will be observed and measured" (LoBiondo-Wood and Haber 1998, p 140). A theoretical framework therefore offers a systematic, logical, precisely defined basis

for examining an issue, guiding the design of the study methodology and assisting in interpreting the findings

As discussed earlier a theory of evaluation is elusive. Evaluation theorists, of which there are many, undertake evaluative research as an approach and use models they have generated to guide their work and study. One of the main debates that have emerged is reflective of the research debate as regards positivistic assumptions (Rossi 1985, Tyler, Cronbach 1982) and naturalistic, qualitative based evaluations (Quinn 2002, 1997, 1987, 1978, Guba and Lincoln 1983, 1981, Stake 1973, Parlett and Hamilton 1972). Of significance, however, is the move of some of the theorists to embrace more qualitative and socially constructed methods of research toward evaluation in the 1980's (Rossi and Freeman 1985). In order to understand the phenomena of evaluation models or approaches as explanations to the concept of evaluation are described in an attempt to justify the methodology chosen to underpin this study.

The CIPP Evaluation Model is a framework for guiding evaluations of programmes, projects, personnel, products, institutions, and systems (Stufflebeam 1985). Corresponding to the letters in the acronym CIPP, this model's core parts are context, input, process, and product evaluation. Stufflebeam (1985 p 151) contends that evaluations should foster improvements, provide accountability of records and promote increased understanding of the phenomenon under review. The emphasis should be to improve rather than prove or disprove a theory or concept. He also prophesies that evaluators should subject their work to evaluation and he labelled this process 'meta-evaluation' (Stufflebeam 1985 p 183). Stufflebeam (2002) developed a checklist, patterned after the CIPP Model, which is focused on programme evaluations, particularly those aimed at effecting long-term, sustainable improvements.

Stufflebeam (2002) suggests the checklist especially reflects the eight-year evaluation (1994-2002) study, conducted by the Western Michigan University Evaluation Centre. The concept of evaluation underlying the CIPP Model and this checklist is that evaluations should assess and report on an entity's merit, worth, and significance and also present a review of lessons learned. Moreover, CIPP evaluations and applications

of this checklist should meet the Joint Standards Committee (Saunders 1994) of utility, feasibility, propriety, and accuracy. The model's main theme is that evaluation's most important purpose is not to prove, but to improve. The checklist is divided into sub-parts of impact to assess if the right beneficiaries were reached, effectiveness to assess were needs met, sustainability to assess if the gains for the beneficiaries could be sustained, and transportability referred to the processes being adaptable for effective use in other settings evaluations (Stufflebeam 2002).

According to Stufflebeam (2002) the checklist is designed to help evaluators evaluate programmes with relatively long-term goals. The checklist's first main function is to provide timely evaluation reports that assist groups to plan, carry out, interpret, and/or disseminate effective services to targeted beneficiaries. The checklist's other main function is to assist a review and assess a programme's history and to issue a summative evaluation report on its merit, worth, and significance and the lessons learned (Stufflebeam 2002).

The latest version of the checklist has 10 components (Stufflebeam 2002). The first component refers to the contractual agreements suggested to guide an evaluation, which is followed by the components of context, input, process, impact, effectiveness, sustainability, and transportability evaluation. The last two components are meta-evaluation and the final synthesis report. A number of authors suggest that contracting for the evaluation is an area that most contractors have difficulty (Stufflebeam 1997, 2002, Quinn Patton 1987). Stufflebeam further contends that a contract should be made explicit at the evaluation's outset, and then updated as needed. The implementation of the seven operational evaluation CIPP components may be employed selectively and in different sequences and often simultaneously depending on the needs of particular evaluations. Stufflebeam (1997, 2002) further contends that evaluators have the freedom to utilise any sound evaluation information the clients/stakeholders already have or can obtain from other sources. The implication of this is that CIPP evaluations have the capacity to complement other structures and processes already in place in an institution. Meta-evaluation, Stufflebeam (1997, 2002) suggests, is the component of reflexivity where the evaluation is evaluated independently to ensure credibility of the work. Adherence to such components gives

confirmation of the extent to which applicable professional standards sought of evaluation were met

The CIPP approach is oriented towards the needs of those planning and conducting a project and whether the assessed needs have been met (Stufflebeam 1985 p 162) Limited use of the model has been reported for evaluation of nursing programmes An example of the application of this model in nursing was the York-Seneca-Georgian-Durham collaborative BScN programme in Ontario conducted by Singh (2004) This study was conducted to address the accountability requirements and information for planning and guiding the delivery of the programmes utilised a triangulation of multiple methods of data collection In organising the study Singh (2004) developed an evaluation matrix based on the CIPP model that incorporated the programme evaluation standards determined by the Joint Standards Committee (Sanders 1994) Of note is that the focus of the study was to conduct it in such a way that the results obtained would remain unchanged if the same or another group of evaluators replicated the study This study developed a framework for programme evaluation

Evaluation Standards

In an attempt to provide “legitimacy” to the conduct of evaluations and the ethical issues that can arise as a consequence of conducting an evaluation two sets of standards have emerged to guide evaluators in their work The Joint Committee on Standards for Educational Evaluation published ‘The Program Evaluation Standards’ (1994), detailed wide-ranging specific standards for all programme issues and the American Evaluation Association published ‘Guiding Principles for Evaluators’ (1995 p 19-26) The five guiding principles identified by the AEA are “systematic inquiry, competence, integrity/honesty, respect for people, and responsibilities for general and public welfare ” These two different approaches i e practice standards as opposed to values based ethical principles outline the debate between a behaviourist and a more eclectic approach that is at the root of regulation and self-regulation dilemma

According to the Joint Committee on Standards for Educational Evaluation (1994 p 1) “education and training programmes are evaluated in order to determine their quality and gain direction for improving them ” The published 30 Standards “provide a guide for evaluating educational and training programmes, projects, and materials in a

variety of settings” (Joint Committee 1994 p 1) In preparing the Standards the Joint Committee intended they lead to useful, feasible, ethical and sound programme evaluations in diverse settings for those commissioning, conducting and or interested in the results of the evaluation Even though the intention of the Standards was for wide applicability the Joint Committee warns, “professional judgement must be used to identify those that are most applicable in each situation (1994 p 2) The Standards are organised around four important attributes or domains which include “utility, feasibility, propriety and accuracy” of an evaluation (Joint Committee 1994 p 5) Alkin (2004 p 44) suggests that Stufflebeam connects his evaluations to the four domains of evaluation that were described by the Joint Committee for Educational Evaluation (1994) The utility standards describe whether an evaluation serves the practical information needs of those interested in the evaluation The feasibility standards acknowledge the setting and methods used to conduct the evaluation as well as the structural supports to conduct the evaluation The propriety standards reflect the ethical conduct of the evaluation ensuring that as in any systematic enquiry ethical principles are observed and respected The accuracy standards, which number 12, respect both research approaches and assure the reliability, validity, truth value, applicability, consistency and neutrality of the conduct of the evaluation and the final report The Standards are not presented as rules for evaluation but as guiding principles to be followed when conducting or reviewing an evaluation process The essence of using the Standards is to make a judgement and the judgement is based on how the evaluators used the standard and the supporting evidence to substantiate the judgement

As in all qualitative based research, the research is best served if conducted according to a process or at least on principles that guide the process The American Evaluation Association following consultation with all its members described the “Guiding Principles for Evaluators as

- Systematic Inquiry Evaluators conduct systematic, databased inquiries about whatever is being evaluated
- Competence Evaluators provide competent performance to stakeholders
- Integrity/Honesty Evaluators ensure the honesty and integrity of the entire evaluation process
- Respect for People Evaluators respect the security, dignity and self-worth of the respondents, program participants, clients, and other stakeholders with whom they interact

- Responsibilities for General and Public Welfare Evaluators articulate and take into account the diversity of interests and values that may be related to the general and public welfare

(Shadish et al 1995, p 20)

These principles should guide the process chosen regardless of method or theory or approach of evaluation (Quinn Patton 1997)

In producing a monograph for the World Health Organisation (WHO) Allen (1977) articulated a “design for the evaluation of training programmes in nursing” which had the objectives of ‘enabling each individual school to develop an ongoing evaluation project for study, assessment and development, incorporating a system of evaluation within new demonstration-type nursing programmes, promoting the study of comparative education in nursing’ (p 18) Unfortunately as Chavasse observed in 1994 there has been a lack of studies exploring the WHO curriculum aims of “relevance to national health care needs and nurses’ accountability to their clients” (p 1030)

According to Allen (1977 p 9)

a nursing programme is regarded as consisting of a number of parts – curriculum, teaching of nursing, practice of nursing and research, and administration – functioning together to achieve common goals or purposes. The values that reflect the development of a programme are thought to be the relevance of the goals, activities, and outcomes of the programme to the particular community or country, the relatedness of the different parts of the programme in seeking common goals and in discovering the means to achieve them, and the accountability of the programme in assuming responsibility for its goals, methods, and outcomes. Thus relevance, relatedness, and accountability are viewed as the critical attributes or criteria of programme development

(Allen, 1977 p 9)

Allen (1977 p 10) further defines ‘relevance’ as “the extent to which the goals, activities, and outcomes of the nursing education programme are a response to the needs of a particular community” She argues the health situation and need for nursing services should be a response to attitudes of the community towards health goals that the graduates will perform in response to service demand. She warns that relevance is low when “the goals and purposes of the programme are not influenced by the changing needs for nursing and for health services” The ‘relatedness’ of a programme

is the “extent to which the parts of the nursing programme, i.e., curriculum, teaching of nursing, practice of nursing and research, and administration, influence each other in developing programme goals and in shaping their achievement” (Allen 1977 p 11) In essence it is argued that the way nursing staff practise nursing influences the way they teach nursing. A high degree of relatedness is achieved when teachers, clinicians, students and administrators work towards common goals. There is an understanding of the interdependence of practice and teaching in this environment. ‘Accountability’ is described as “the extent to which the programme teaches the student nurse that the primary responsibility in nursing is to the patient” (Allen 1977 p 11). This can be a consideration in assessing the development of a programme i.e. how “the student learns to develop nursing action as a response to the particular patient” (Allen 1977 p 12). The process how evaluation should be implemented is represented. The evaluator “observes, measures and describes the programme goals and actions and in general collects information to provide a data base for analysis” (Allen 1977 p 13). The evaluation is directed toward gathering information on the various parts of a system so that one may have greater understanding of its dynamics (Allen 1977 p 14). The criteria of relevance, relatedness and accountability provide the “structure for the analysis and the results, conclusions, or inferences indicate the development of the programme. The state of development provides the information base for monitoring the programme so that the direction of goals and activities may be changed, and the accumulated information provides a ‘feed forward’ into the programme plans” (Allen 1977 p 13). One of the aspirations stated by Allen (1977 p 19) was that “the opportunity of comparative study at an international level in different cultures provides one avenue of endeavour” and equally “comparative study of similar types of programmes within one country”. Studying nursing education comparatively illuminates development issues as demonstrated by the finding of Cowman (1994) who in a comparative study of learning through nursing education programmes for the Republic of Ireland and Northern Ireland found that “learning was context dependent” (p 220). In this respect utilising some of the principles of Allen warrants further consideration for this study.

This study will endeavour to expose such an aspiration and illuminate the operational and behaviour indices associated with relevance, relatedness and accountability in an attempt to meet the requirement of social inquiry and accountability for the regulator.

Evaluation in Nursing

Evaluation of nursing programmes as a subject matter in its own right is a relatively new phenomenon (Whiteley 1992). A number of nurse education programmes have been evaluated in their totality and for specific aspects of the educational experience and outcomes. However, these studies in the main are limited in that they are mainly locally based with the exception of commissioned studies by Departments of Health (Heath 2002, Simons et al 1998, Luker et al 1996) and the regulatory bodies (Bartlett et al 1998, Crotty and Bignell 1998, Phillips et al 1996, While et al 1995).

Most curriculum evaluations of nursing programmes have been reported by nurse educationalists. There is considerable variation in the depth and the scope of the reports that ensued and the methodologies employed range from the quantitative to the qualitative with some adopting a mixed methodology. The literature demonstrates an interest of evaluators in innovative programmes, the student experience and specific aspects of a course where policy decision-making is an issue. In these contexts the reports of these evaluations are not always shared with the academic community and publication within journals as they are for commissioned purposes. The English and Scottish National Boards of Nursing commissioned a number of significant studies during the 1990's and the published reports are reviewed for methodological and outcome purposes.

One of the difficulties of evaluation in nursing is reported in Burnard's study of experiential learning in nursing which identified through feedback, reports from students and the ward and observation that "evaluation of experiential learning is very difficult" (Burnard 1991 p 63 & 128).

Evaluation of Nursing Programmes

Bartlett et al (1998) undertook an evaluation of pre-registration nursing education through a literature review and a comparative study of three aspects of graduate and diplomat outcomes which was commissioned by the English National Board of nursing (ENB). This study was undertaken against a background of questions related to the outcomes of degree and diploma programmes in order to assess whether newly qualified nurses were adequately prepared to undertake the roles expected of them within the National Health Service (NHS). It was acknowledged by the authors that

research of this nature in the U K was “limited and of local nature” as opposed to the extensive US experience (Bartlett et al 1998, p 5) The primary purpose of the report as articulated by the authors was to “help inform nurse education policy and evaluation in the UK as important questions concerning the future of its educational provision are debated” (Bartlett et al 1998, p 6)

Bartlett et al’s (1998) study aimed to compare the outcomes of two different pre-registration nurse education programmes by examining the career aspirations, competencies and role orientation of degree nursing graduates and Project 2000 diplomats Through a longitudinal (one year) descriptive study of 52 graduates (four-year programme) of one university and 28 diplomats (three-year programme) of another university and their mentors, data was collected at three points The data collection instruments were a self-administered four item rating scale of 78 competencies questionnaire, and a career aspirations questionnaire This broad based study made eighteen summary points based on the findings of the analysis of the questionnaires Some significant issues for the curriculum in respect of leadership and management in the final year of the degree curriculum if qualifying graduates are to feel competent were made Additionally, more attention to social awareness and participation was identified for both programmes with a solution posited through increasing the liberal studies component in the curriculum” (Bartlett 1998, p 93) Differences were identified between the responses of the two groups with the most significant differences related to career progression and willingness to participate in continuing education The graduates preferred a wide range of courses to the diploma preference for a part-time locally available course, although all would study nursing The graduates displayed a higher professional orientation and lower bureaucratic orientation to their diplomat colleagues with consequent higher levels of role conflict Overall they concluded that there was little conclusive evidence to support a preference of one level of pre-registration nurse education programme over another, or an optimum length of nursing course in the UK

This study was preceded by another commissioned piece for the ENB that was conducted by Phillips et al (1996) to evaluate the pre-registration degrees in nursing and midwifery This report focuses on identifying the principles, which might inform the establishment of key criteria for formative evaluation of the quality of a degree

The evaluation was commissioned “for a period of three years with the purpose of comparing the effectiveness of three and four year undergraduate programmes in nursing and midwifery, looking in particular at the pressures made by undergraduate programmes on staff, students and standards” (Phillips et al 1996, p 5)

The study evaluation focussed on the twenty six willing institutions of a possible thirty two offering either a three or four year degree in either general nursing or midwifery. Data was collected using interviews of lecturers, students, clinicians and graduates, document analysis and observation (phase one only) in a two-phase study. The theoretical approach to the evaluation is not made explicit in the report. The authors though contend that the report offers a comprehensive account of successes and problems in the development and delivery of undergraduate nursing and midwifery degrees. A most useful outcome of the study was the model of the learning environment that emerged from the data. The conclusion for professionalism that emerged suggests

Professional action finds its development, its quality, its strength in the learning environments that it generates in order to sustain critical reflection upon practice for the purposes of developing public knowledge bases through which judgement and action are informed

(Phillips 1996, p 193)

The overriding message that emerges from the interpretation of the data was the complexity of the nursing learning milieu. The connectedness of the higher education institution and the clinical learning environment was identified. The challenge for educationalists in higher education institutions was “how to design curricula which reinforce the cultural embedding of reflective discourses within the pragmatic realm of occupational culture and practice” (Phillips 1996, p 218). It was suggested in this context that a dialogue for mutual education was required. The report concludes with

(a) principles for considering proposed curricula for undergraduate nursing and midwifery education, and (b) an indication of some of the structures and frames which have been noted in the research as major factors contributing to the development of a curriculum for high quality, client-focussed nursing and midwifery practice

(Phillips 1996, p 219)

The criteria for a quality undergraduate degree that emerged from the report encapsulate the principles to be adhered to in determining a quality programme. The report suggests structuring educational processes. The structures include material structures e.g. timetables, rooms, clinical placements, information packages, non-

material structures e.g. 'mechanisms' for dialogue, decision-making and prioritisation, and 'organic' structures such as flexibility, adaptability, responsiveness to the unexpected and risk taking which contribute to shaping attitudes and institutional dispositions. It further refers to avoiding unacceptable compromise while outlining the quality mechanisms to be adopted for the range and relevance of learning experiences and the resources. The education dispositions towards coherence can be achieved both by structures and cultural frames that will orient intentions and motivate actions (Phillips 1996). The educational principles offered reflect a new method of thinking for professional nursing education and practice in a new order of educational provision.

The NEATE Report

In 1996 the Department of Health and Children in collaboration with ABA commissioned an independent external evaluation study of nurse education and training in Ireland. This resulted in the publication of the Nurse Education and Training Evaluation in Ireland (NEATE) report (Simons et al 1998). The overall aim of the study was to evaluate the effectiveness in practice of the first site to design and implement the pilot undergraduate Registration/Diploma programme for student nurses namely at the National University of Ireland Galway (NUIG). The "tender specification from the Department of Health required the evaluation to focus primarily on implementation of the 'new' programme in the Galway site to inform future policy-making and provide evidence of how nurses trained under the three-year full-time Registration/Diploma Programme were prepared for the workforce" (Simmons et al 1998, p 3). Although the initial intention of the evaluation was to inform future developments a number of other sites began the Registration/Diploma programme six months into the evaluation timeframe. The evaluation team took this into consideration and extended the sample to embrace eight sites in 1995/6 "to ascertain whether issues they had experienced were similar issues to those identified in the Galway site" (Simons et al 1998, p 3).

An in-depth case study approach was adopted consisting of many different components. Various data collection methods were utilised including focus group discussions, observation of classroom and clinical teaching, case profiles of individual

students and clinical placement co-ordinators, questionnaires and individual in-depth interviews group in-depth interviews The sample comprised students, clinical placement co-ordinators, lecturers, nurse tutors, nurse managers, ABA, Department of Health, further other School of Nursing staff for the general and psychiatric nurse education programmes The interview transcripts, field notes, and observations were examined for key analytical themes that were categorized and triangulated with other data to search for patterns in the themes and interpret evidence to illuminate the key questions and aims of the study

The findings of the evaluation illuminated themes in terms of partnership (national and local), curricular structures and processes, theoretical and clinical assessment, staff preparation and development and student learning experiences particularly clinical learning In respect of partnership the main findings related to a need for a clear national vision for the development of nurse education which included issues of managing the national implementation of the programme and adherence to a national model of education was perceived as counter-productive to the development of nurse education (Simons et al 1998, p 258) The curriculum issues ranged from curriculum delivery through pedagogy to implications for the curriculum These broad and wide-ranging recommendations suggested that the curriculum was not too dissimilar to the 1992 apprentice-style curriculum in relation to content The implementation of two awarding type structures, i.e. the university accreditation systems and the requirements of ABA, however, provided a dichotomy for the curriculum planners and adversely affected the methodology and approaches that could be adopted One of the main issues identified was the front-loading of the curriculum The burdensome requirement for the student to meet the assessment methodologies of two systems was a most significant finding for the students and the teachers of the programme as it impacted on the sequencing of the programme and created a scenario within the curriculum for two opposing philosophies to be highlighted In respect of assessment the perception that theory and its application to practice were not linked arose from the front-loading of the biological and social sciences ABA were particularly identified for criticism in the report in respect of the

Disjunction and administrative anomalies in managing two non-aligned examination systems had negative repercussions upon students, teachers, nursing staff and managers and on the design and delivery of the curriculum

(Simons et al 1998, p 268)

And further

ABA Rules and practices governing the management of practice-based assessments required for registration purposes were considered inappropriate for Registration/Diploma students in relation to professional practice. Many course objectives and desired competencies of the students were not amenable to assessment through the Proficiency Assessment Form (PAF)

(Simons et al 1998, p 268)

One of the worrying aspects of this anomaly was the “different interpretations to regulations and uncertain responsibilities” (Simons et al 1998, p 269) that ensued for the student. In this respect recommendations to ABA were to review the PAF as a methodology for assessment of clinical skills and consider the appropriateness of national standards or competencies for registration purposes. The need to support staff in the clinical and teaching arena to assess students was also identified.

In respect of the student experience the students were mainly supernumerary to the workforce except for 14 weeks rostered (paid employment) placement in the third year of the programme. All students received a non-means tested grant. Students identified that the practice environment was the “main catalyst for their learning” and that “rostered service was a positive learning experience for students, but one period (including one night-duty span) was not considered sufficient” (Simons et al 1998, p 273). Community experience was greatly valued. The rostered service was seen to have a number of positive effects in that it

“clarified the responsibilities that the senior students would incur on qualification, it allowed students to integrate more into the multi-disciplinary team, it brought the students more into the nursing team and allowed more continuity of care to patients, it enabled them to experience the culture and reality of nursing more directly, which facilitated their transition from student to registered nurse and gave them a sense of success which increased their confidence, it provided opportunities for the students to appreciate different approaches to nursing gained through community experience and allowed them to reappraise institutionalised care”

(Simons et al 1998, p 274)

Supernumerary learning was a major change in nurse education and this brought with it had its positive and negative aspects for the students. The students and supervisors were unclear sometimes as to the role the student could perform in particular clinical areas i.e. were they only observing or could they participate in the team activities. This led to students’ reporting they “had no sense of belonging either to the hospital or to the University” (Simons et al 1998, p 275). Clinical Placement Co-ordinators

were perceived as making an enormous contribution to clinical learning. At a national level however it was identified that trained nursing staff were the most appropriate people to provide clinical teaching provided they were given educational support to conduct the teaching and assessment process. Students also reported financial hardship particularly associated with the periods of clinical placement, as they were unable to supplement their income during these periods with casual work.

The evaluation report in summary identified the shortcomings of the programme i.e.

“the absence of change in regulations, clear ownership of the whole programme, front loading and theoretical overloading of content, lack of partnership at several levels to develop the programme, lack of appropriate infra-structure to support the programme, insufficient mechanisms for effective strategic planning, inadequate attention to staff development at all levels, late scheduling of clinical practice, lack of clarity of supernumerary status, the future uncertain role of nurse tutors and clinical placement co-ordinators”

(Simons et al 1998, p 284)

In summarising issues for future planning Simons et al (1998, p 287) identify the driver for graduate preparation of nurses which supports the transition from apprenticeship modes of education and training towards those associated with third-level education as the World Health Organisation (WHO) in 1998 but she clarified that this needs to occur in the debate associated with a framework of professional education.

The findings of this evaluation research particularly related to curriculum issues contributed to the development of the published Requirements and Standards for Nurse and Midwifery Education (ABA 2000, 1999).

Summary

The elements of evaluation research that usually are conducted as continual processes of evaluating a programme, or programmes are described as both formative evaluation (ongoing) and summative evaluation (outcome) are explored (Shadish, Cook and Leviton 1991). A number of studies are explored that used evaluative research methods and these are critiqued with a view to informing a theoretical and methodological approach for this study as well as the findings to compare and contrast this study with reported other studies internationally.

Conclusion

The literature review has examined the concepts of regulation, learning to nurse and evaluation. The studies and literature critiqued has suggested methodologies and approaches that can be considered for the operationalisation of this study. Only one national study of nurse education has been conducted in Ireland (NEATE 1998) that evaluated the three-year registration/diploma programme. Reviewing the implementation of the four-year registration/degree programme from the perspective of the regulator and current regulatory processes will illuminate issues for development and knowledge generation.

CHAPTER FOUR - METHODOLOGICAL APPROACH

INTRODUCTION

This chapter presents the methodology for the study that was undertaken to inform the regulatory body (ABA) of a mechanism of accountable regulation utilising social inquiry methodologies. The methodology was chosen to illustrate the effectiveness of the “Requirements and Standards for Nurse Registration Education Programmes” (ABA 2000) as a mechanism to fulfil its obligation to “prescribe the manner and the conditions under which training shall be provided for general nurse education” (Nurses Act 1985 31)

This study

- examined the provision for courses of training and examination to be taken by candidates for registration” (Nurses Act 1985, 31) currently operating
- explored how the “Requirements and Standards” (ABA 2000) meet the obligation to “specify conditions of suitability for hospitals and institutions” (34 (2), 36 (1, a)), “the standards of theoretical and practical knowledge required for examinations,” and “the clinical training and experience provided in any training programme organised by a hospital or institution approved of by the Board” (36 (b), (c)) and
- proposed a framework of accountable nurse regulation to promote high standards of professional education and training” fulfilling the functions of ABA assigned to it by the Nurses Act (1985)

This study aims to develop a culturally relevant regulatory framework for programme approval, which meets statutory responsibility for “prescribing the manner in which and the conditions under which training shall be provided” (Nurses Act, 1985, 31)

ABA as the regulator of nurses and nursing exercise their powers by determining rules (ABA, 1988, 2004) which identify the mechanism of regulating nurse education programmes as ‘Requirements and Standards for Nurse Education Programmes’ (1999, 2000)

As indicated the stimulus for this study came from both a need to examine and learn about the regulatory responsibility for ensuring standards of education and training of general nurses in Ireland and from a need to determine if there are issues to be improved upon reflecting the national regulatory agenda of necessity, effectiveness, proportionality, transparency, accountability, and consistency (Department of the Taoiseach 2004) The methodology aimed to examine current systems and formulate a systematic, structured regulatory evaluation approach for general nursing programmes capable of supporting the development of professional nurse regulation

This chapter presents and explores the methodological debate and defends the adopted approach in detail and describes the creative process used to develop the evaluative framework for conducting this study It outlines the two-phase approach to the development of the proposed regulatory framework for the regulation of general nursing programmes The methodology used in phase one of the study was designed to capture how existing programmes meet regulatory requirements A tool was developed to systematically collect information about the operations and outcomes of general nurse education programmes, to make judgements about the requirements and standards (ABA 2000), improve their effectiveness and inform decisions about their future was guided by Stakes' (1985) five stages to generate data in evaluation

This first phase of the research reflects "descriptive evaluation" as described by Quinn Patton (1987) which utilised a large quantity of documentary evidence supporting the thirteen general nurse registration/degree programmes between 2001 and 2004 utilising a grounded theory approach to analysing data The purpose of the qualitative research methodology, rooted in grounded theory, as used in this study, was to acquire insights not by establishing causality, but through developing an understanding of how current systems of general nurse education are operating and meeting regulatory expectations The methodology utilised in the second phase of data generation was underpinned by the principles of concept development described by Schwartz-Barcott and Kim (2000) and data to suggest a process for regulatory governance was obtained using key stakeholder focus group discussion The analytical method is described in detail, as are the ethical considerations of conducting a national evaluation study of the general nurse registration/degree programme 2001-2004 from a regulatory perspective

DESIRED OUTCOME OF THE STUDY

The desired outcome of the study is to develop a culturally relevant regulatory framework for programme approval, which meets statutory responsibility for “prescribing the manner in which and the conditions under which training shall be provided” (Nurses’ Act, 1985 31)

In essence this study is designed to meet the three general perspectives of evaluation identified by Chelimsky and Shadish (1997 p 10) i e

- Evaluation for accountability (e g the measurement of results or efficiency)
- Evaluation for development (e g the provision of evaluative help to strengthen institutions)
- Evaluation for knowledge (e g the acquisition of a more profound understanding in some specific area or field)

More succinctly it can be interpreted according to Quinn Patton (1997 p 65) who determined a menu for using findings of evaluation research as “making overall judgements, facilitating improvements and generating knowledge” Fitzpatrick et al (2004) identify that standards, as a quality tool, can signal areas that may have been overlooked in the focus of an existing programme In this respect the focus of data collection for this study was immersed in the Requirements and Standards for Nurse Registration programmes (ABA 2000)

DEFINITION OF TERMS

The key terms are defined in an attempt to reduce ambiguity within the study For this study the following terms are defined as follows

An Bord Altranais (ABA)

The definition that best describes ABA is the one taken directly from the Nurses’ Act 1985 from which ABA derives its powers and functions, “The Nursing Board, the general concern of which shall be to promote high standards of professional education and training and professional conduct among nurses” (Nurses Act 1985 6 (1))

Evaluation

This definition is one that takes cognisance of the definition of the Joint Committee on Standards for Educational Evaluation (1994 p 3) “the systematic investigation of the worth or merit of an object” and is adapted for the operational purposes of this study to mean “the systematic collection of information about the operations and outcomes of general nurse education programmes to make judgements about current requirements and standards, improve their effectiveness and inform decisions about their future” (adapted from Quinn Patton 1997)

Regulation

This definition embraces “prescribed rule authoritative direction” (Concise Oxford Dictionary, 1998) or regulated by law In the context of this study it is used to mean the power conferred to ABA through the Nurses Act 1985

Statutory Regulation

The definition that closely resembles an international aspect of regulation is one posited by ICN (1997 p 46) “statutory regulation is regulation that is mandated by law, act decree or statute” The central purpose of statutory regulation of nursing should be to protect the public by ensuring competent, accessible nursing care (adapted from ICN 1997 and Pyne, 1998)

Professional Regulation

The definition of professional regulation as it applies to nursing consists “the forms and processes whereby order, consistency and control are brought to the profession” (ICN 1997 p 2)

Regulatory Principles

A number of agencies have identified regulatory principles e g ICN, but in this study a more specific culturally relevant definition is proposed The principles associated with regulation are ones that reflect cultural governance and embraces six principles identified with regulating better “necessity, effectiveness, proportionality, transparency, accountability, consistency” (Department of the Taoiseach 2004) and within nursing accreditation accountability, relatedness, relevance and uniqueness (CAUSN 1995 p 2)

Requirements and Standards

This definition reflects the utility of requirements and standards as the sets of principles or expectations of materials or practices of nurse education programmes designed to secure uniformity and protect the public interest as determined by ABA in the preparation of nurses

RESEARCH METHODS

In embarking on a study of evaluation of education in a regulatory context cognisance is given to the sentiments of Bush who suggests “theory in education management tends to be normative, selective and often based on observation in educational settings 1986, p 17) The intrinsic worth of research in this context reflects the selection of approach articulated as “Inevitably () research involves selection, selection is determined by, and determines perspective, perspective limits vision, vision generates questions, and questions in turn, help to shape and influence the answers” (Theodossin 1983, p 89 cited in Bush, 1886 p 17) Miles and Huberman (2004 p 30) further this argument through examples where “many permutations are possible but a selection process is invariably at work choices are determined by the questions being asked and the perspective ” As an investigation of this nature has not previously been undertaken in Ireland it is necessary to consider methodology and select an approach most suitable to the current investigation The discussion will commence by reviewing the research approaches and especially those of the post-modern era This approach offers a perspective for examining and thinking deeply about inquiry in a practice-based profession such as nursing (Hoshmand and Polkinghorne 1992)

Today’s world, according to Spitzer (1998), is developing from being technology driven to one where information will be the dominant currency The transformation in society’s values puts into question basic rules of how we understand and know and the mismatch of existing paradigms in various systems (Spitzer 1998 p 786) Developing this debate in healthcare is reflected in the simultaneous requirement for a reduction in health care costs and an improvement in quality of care Hoshmand and Polkinghorne (1992 p 55) identified in psychology a need to reconcile the “different interests of academically oriented researchers and service-oriented practitioners” and

offer suggestions for research on the epistemological processes of professional inquiry and practice Bensimon et al (2004 p 104) further berates what she terms “the disconnect that has occurred between higher education research and policymaker and practitioners” In positing a solution to this problem the answer she suggests is in studying problems of relevance to policymakers and practitioners and broaden the way research findings are disseminated Polkinghorne (1988) admits to struggling with the research-practice division and posits that practitioners are better commonsense epistemologists than academics This oversimplified comment doesn’t expose the real picture offered which is one of confluence Qualitative and quantitative methods should not be mutually exclusive or hierarchical in the knowledge development stakes Dey (2005 p 28) argues, “it is more useful to define qualitative data in ways which encourage partnership number depends on meaning, but in a sense meaning also depends on number” The methodologies debate, as both the quantitative and the qualitative traditions, need to be considered as each approaches the production of knowledge differently

Quantitative / Qualitative Debate

Both quantitative and qualitative traditions are rooted in values that purport in their own way the support a model of knowledge development Hoshmand and Polkinghorne (1992 p 56) contend that the “essential position of positivism is that humans can, with the help of tools of science, gain true knowledge of a reality that exists outside of human thought” Within the professions the positivist model associates with scientific investigation Empirical inquiry is associated with knowledge development that encouraged a one-way relationship between research-tested theory and practice (Polit and Hungler 2001) Accordingly

Only knowledge statements justified by positivistic methods of research are admissible as the knowledge base of a discipline Practitioners are assigned a secondary role as appliers’ rather than contributors of knowledge

(Hoshmand and Polkinghorne 1992 p 56)

Theory and research within this positivist paradigm are seen as the principle ways of producing knowledge that is sometimes translated for use by practitioners Dey (2005 p 5) warns against any form of “methodological imperialism” Parse (2001 p 1) furthers this view in suggesting “all inquiry into human phenomenon is conducted to

gain an understanding of something in a systematic way, but the goals of various approaches and methodologies are different ”

In debating this in clinical psychology Hoshmand and Polkinghorne (1992) contend practitioners derive their knowledge from practice and experience with clients that are not usually accepted by the scientific community The re-emergence of qualitative methods according to Polkinghorne (2005 p 137) has had “a significant impact in the disciplines of sociology, education and nursing ” The essential differences between the quantitative and qualitative approaches as suggested by Cormack (1991) and Polit and Hungler (1987, 2001) is that quantitative methods rely heavily on acquiring data that is numerical and can be statistically interpreted whereas qualitative methods are concerned with the study of understanding why, what, and how people interact Cohen, Manion and Morrison (2004) explain the difficulty that positivism finds itself in is that it regards human behaviour as passive, thereby ignoring intention, individualism and freedom

Crossan (2003) contends that the ongoing ‘quantitative/qualitative’ debate is fogged by a lack of coherent definitions and by a focus on methods rather than an exploration of underlying philosophy In this respect he calls on a triangulation approach where a multiplicity of methods can be used to illuminate a situation and deliver a contextual description of the issues under study Furthering this debate Proctor (1998) contends the consistency between the aim of a research study, the research questions, the chosen methods, and the personal philosophy of the researcher is the essential underpinning and rationale for any research project In supporting this contention this researcher takes issue with Webb (1989) who criticises quantitative nursing research for authoritarianism, paternalism and control, which she claims, are unwelcome concepts in understanding human experiences that occur in nursing In education Cohen, Manion and Morrison (2004 p 21) suggest, “classroom life can only be understood by knowledge of the specific organisational background and context in which it is embedded ” Quinn Patton (1987 p 167) furthers the debate in evaluation by claiming that truth seeking should be replaced by a search for useful and balanced information and replaces “the mandate of objectivity with a mandate to be fair and conscientious in taking account of multiple perspectives, multiple interests and multiple possibilities ” All research seeks to answer questions and while traditional

perspectives confer a uniformity of understanding as to how knowledge is constructed it is incumbent on researchers to explore all possibilities to gain a best match approach to generating that knowledge

Qualitative research is also criticised by some (Hart and Bond 1995, Clarke 1992) for being unscientific and producing different conclusions when a subjective element is present. Appleton (1995) suggests that if qualitative research is to stand up to the constant barrages of positivist thinkers' qualitative researchers must be clear about how they address issues of reliability and validity in their research studies. Qualitative research is usually conducted in real-life settings where the researcher can participate in the activities being studied (Taylor 1993). The argument for qualitative research is that it is doubtful whether a scientific approach can be used when dealing with 'human beings' (Bell 1992). One approach of recent interest in nursing is action research which according to Hart (1996 p 455) following a review of the literature, is

Part of a wider groundswell of criticism of positivism on a number of grounds, including the failure of positivism to take account of the social context in which actors construct meaning, the treatment of human beings as passive subjects, and its unsuitability for organisational problem-solving

One of the major obstacles to conducting nursing and educational research studies using the scientific paradigm is the complexity of human beings as the central topic of investigation. The inability of the scientific approach to meaningfully capture the human experience has led educationalists and nurses to explore alternative methods of generating and interpreting data. According to Whittemore (2005 p 58) qualitative research is "contextual and complex". The possibility therefore to combine the evidence from multiple sources has the potential to broaden the generalisability and clinical applicability of small sample research using primarily qualitative designs. Quinn Patton (1987 p 21) resolves this argument in suggesting from a practical standpoint "using qualitative methods is simply an interest in observing and asking questions in real-world situations". He further contends that in evaluation a challenge is to match research methods to the nuances of the evaluation questions and the particular stakeholders.

The Post-modern Perspectives

The Post-modern approach offers ways of thinking about the world in which nurses' (Cheek 2000) and educationalists (Constas 1998) work. Analysing what nurses do has been the subject of much nursing research and debate at both methodological and theoretical levels (Taylor 1992, Benner 1984, Carper 1978)

Current researchers still debate the qualitative and quantitative paradigm approaches. Post-modern approaches although usually located within the qualitative paradigm are described by Mohr (1999 p 1053) as "a recent trend in conceptual thought and study in the arena of arts and science". Cheek (2000) associates post-modernism with the writings of the French philosophers Foucault, Lyotard, Baudrillard and Derrida however she further contends a belief that the philosophers themselves would reject this categorisation of their thoughts. More succinctly post-modern thought is associated with non-linear methods of thinking that mainly involve deeper analysis and critical ways of thought and being. Cheek in building on the work of Best and Kellner suggests "post-modern thought discards the organic notion of all parts of society working together in an orderly way, and in so doing it rejects modern assumptions of social coherence and notions of causality in favour of multiplicity, plurality, fragmentation and indeterminacy" (Cheek 200 p 18). Mohr (1999) suggests post-modernism is associated with discourse and the extensive use of language. In her study of the charts of 26 patients from a sample of 600 patients who received hospitalised psychiatric care between the years 1985-1991 utilising the analytic method of Miles and Huberman (1994), she contends that "knowledge is framed and formulated from within certain patterns of discourse" (p 1054). She further posited, "it is a system of representation that has developed in order to circulate a coherent set of meanings pertinent to important topic areas. These meanings serve the interest of the section of society within which discourses originate" (Mohr 1999 p 1054). The discourse of how general nurse education regulation is actually being operationalised within programmes of study therefore will add a new dimension to the meaning of standards as the sets of principles or expectations of materials or practices of nurse education programmes.

Post-modern research approaches emphasise the plural nature of reality, the multiple positions from which it is possible to view any aspect of reality including health care,

and the partial nature of any representation of reality that arises from any form of writing and or speaking that attempts to explore, describe or explain that reality (Cheek 2000, p 5) It challenges that it is possible to represent reality, speak for others and attain universal essential understandings (Cheek 2000, p 5) Cohen, Mannion and Morrison (2004) suggest “it imposes on researchers an involvement with their subjects and a rejection of the ways of the natural scientist” The post-modern lens Cheek suggests becomes an instrument of analysis rather than rigid sets of rules (2000 p 2) but further she argues it is not a free for all “Any representation of reality which takes the form of empirical materials and data collected in a research undertaking will only ever represent partial aspects of the reality being studied” (Cheek 2000 p 125) Polkinghorne (2005 p 138) furthers this thought by contending, “experience has a vertical depth, and methods of data gathering, such as short-answer questionnaires with Likert scales that only gather surface information, are inadequate to capture the richness and fullness of an experience ”

Research in health care and practitioners of science-based programmes are usually seen as technical problem solvers (Saylor, 1990) but to contribute to improvement in health care practice this model of technical rationality suggests that basic and applied research dictate all procedures In respecting the opinion of Horsfall (1995 p 2) that “the research method should be consistent with the nature of the questions under investigation and the information gathered should be vigorously analysed” (Cheek 2000, p 1), this approach offers a perspective for viewing the diverse situations in which nursing occurs Cheek (2000, p 34) suggests, “post-modern research approaches give the opportunity to ask such questions as why such organisational strategies exist, why they are maintained, and how they affect understandings of health and health care ” She further contends that the post-modern perspective allows for the analysis of why health care practices have been shaped in the way they are, and why certain players and practices have been relegated to the margins, often designated as “other” rather than “another” (p 35) This trend towards negative labelling and associations is sympathetic towards a humanist perspective of those being cared for or the subject of health care This researcher is cognisant of the values that pervade the objective reality and positivist paradigm in which healthcare operates She is also aware of the warning from Mitchell (1994 p 226) that “current research in nursing is restrictively bound by an unacknowledged, medically

dominated, multidisciplinary framework and a generic mode of inquiry that does not advance nursing science” and therefore was open to exploring alternate methodologies

According to Cohen, Manion and Morrison (2004) three schools namely phenomenology, ethno-methodology and symbolic interactionism represent the anti-positivism movement in sociology. The common thread that links all three schools is a concern for phenomena of everyday life that don't always lend themselves to quantitative measurement. While as educationalists they report three schools the roots of the interpretative tradition appear to be associated with perspective whether sociological or philosophical. Although each school or approach has developed a label to confer a tradition or stance none of the approaches is homogenous, rather the commonality is a concern with people's interpretation of social reality. These three perspectives in the form of phenomenology, ethnographic/case study and grounded theory are further explored.

Perspectives of Post-modernism

One of the qualitative traditions, phenomenology, offers an alternative to the scientific method as it rests on different assumptions about the nature of humans from positivism and how that nature is to be understood. Phenomenology is a valuable philosophical mode of inquiry for discovering meaning and describing experience (Appleton 1995). It is described as a philosophy, a perspective and a method (Munhall 1988). While there are many phenomenological philosophers Walters (1995) refutes the notion of one superior approach for nursing research. Walters (1995) examines the approaches of Heidegger and Husserl and suggests that nurses require an understanding of the roots of each approach in order to conduct meaningful research with the approach. The Heideggerian approach as a method of generating and interpreting data is fundamentally concerned with ontological issues of understanding the fundamental dimensions of 'being-in-the-world' (Walters 1995). Heideggerian phenomenology is interested in the origin of knowledge embedded in everyday activities. The activity of engagement allows the researcher a primary source of understanding a situation of study. Bergum (in Morse 1991, p 55) also describes phenomenology as an "action-sensitive-understanding" method, which "finds its

beginning and end in the practical acting of everyday life and leads to a practical knowledge of thoughtful action ”

Phenomenology searches for meaning by describing experience and interpreting experience through hermeneutics. The problem associated with this method as suggested by Munhall (1988) and Morse (1994) is the inevitability of subjectivity in any exploration or description of reality. This subjectivity though can be seen as expanding and enriching the authenticity of perceptions and understandings of phenomena of interest (Munhall 1988). It may therefore be suggested that when one is describing lived experience one is describing a particular perspective of a lived experience. This, according to Bergum (1991), acknowledges lived experience as the ‘original’ way in which we perceive things. As living persons we have an awareness of things and ourselves that is immediate, direct, and non-abstractive. Bergum considers that “to understand lived through experience is to go beyond the taken-for-granted aspects of life” (1991, p 56). This according to Miles and Huberman (1994) explains the reluctance of subscribers to this tradition to utilise codes in a detached form but rather to reach a “practical understanding of meanings and action” (p 8). Ihde (1995, p 5) develops this and acknowledges that phenomenology is “realist” in aim. He states that although its “referentiality was never causal, or linear, or direct as it was in the simpler analytic theories of reference, its aim was to describe the structural relativities between the knower and the world” (Ihde 1995, p 5). He follows this with an undifferentiated support for the scientific for which he extols a sense of wonder and awe as he claims “our scientifically constituted world is in many ways richer than its pre-scientific predecessors” (Ihde 1995, p 5). In this study elements of phenomenology in relation to the description of the programmes as they are presented in documentation is required to answer the research question.

Social anthropologists according to Miles and Huberman (1994 p 8) rather are interested in the “behavioural regularities in everyday situations language use, artefacts, rituals, relationships” and these “regularities are expressed as ‘patterns’ or ‘language’ or ‘rules,’ and they are meant to provide the inferential keys to the culture or society under study ” The use of case study approach as avidly used in this tradition tends toward description by condensing large amounts of data towards the genesis or refinement of theory. Accordingly “the focus of a case study is on the case itself”

(Fitzpatrick et al 2004) In advocating for case study designs Guba and Lincoln (1985) argue that the goal is to develop a complete understanding using thick descriptions of the case being examined They further extol the method as “holistic and lifelike It presents a picture credible to the participants in a setting” (Guba and Lincoln 1981 p 376) While the inevitability of subjectivity resounds there is a commitment to capturing and respecting multiple perspectives and toward the integrity of uniqueness of a case (Quinn Patton 2002 p 102) Case study design is utilised in a number of nurse education evaluation studies (Simmons et al 1998, Owens et al 1998) Case study as a research approach is defined by Stake (1995 p xi) as “a study of the particularity and complexity of a single case, coming to understand its activity within important circumstances ” This in-depth approach identifies the salient features of a programme and illuminates the particulars of how a particular case operates in context In relation to this study an element of case study design in examining how each programme meets the requirements and standards of ABA is operationalised but as the research purpose is to examine how the programmes meet national requirements and standards it is not reported as individual cases of colleges but rather as a national implementation of the programmes

Grounded theory as a research approach, rooted in symbolic interactionism and pragmatism, is attributed to the works of Glaser and Strauss in 1967 (Parse 2001) Glaser and Strauss (1967 p 1) contend it is a “general method of comparative analysis ” Strauss (1987 p 5) later suggested it is a “style of doing qualitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines such as the making of constant comparisons the use of a coding paradigm” through a process of gathering and analysis-synthesis of data (Parse 2001) The purpose of the method is according to Parse (2001), through social theory methods to systematically collect and analyse data and develop verifiable hypothesis about relationships between concepts, and interpret, predict, and explain multiple perspectives of subjects or phenomena by illustrating “patterns of action and interaction between and among various types of social units” (Strauss and Corbin, 1994 p 278) As a method grounded theory is “tailored to study a diverse array of phenomena by systematically gathering and analysing multiple kinds of data from the field of study” (Parse 2001 p 37) Parse (2001 p 35) further contends, “multiple disciplines may use grounded theory as a theoretical perspective to guide research ” It

therefore like phenomenology is a method for collecting, managing and analysing data within the qualitative domain of research. The research debate, as discussed earlier, doesn't have to be confined to preordained boxed structures but should be available to the researcher to manipulate to the research task and question under study. Justifying a methodological choice should be about the pragmatic process required to achieve the task in hand. In this case the notion of intuiting, analysing and describing attributed to phenomenology (Spiegelberg 1976 in Parse, 2001 p 77) and making constant comparisons as described in grounded theory where there was a look for "similarities, differences, and degrees of consistency" (Strauss 1987 p 25) became the methodological basis of trying to develop a framework for conducting an examination about the operations and outcomes of general nurse education programmes to make judgements about the requirements and standards, improve their effectiveness and inform decisions about their future.

Discussing the methodological perspective of generating, gathering and analysing data led the researcher to explore methods of addressing the research issue. In exploring evaluation research as an approach, the writings of Alexander (1990) were explored where she compared the two dominant paradigms: the hypothetico-deductive, natural science paradigm and the holistic-inductive, anthropological paradigm. She contends the former aims at prediction of social phenomena and the latter at understanding social phenomena. She further illustrates a methodology for a convergence model where a bridge is offered to the evaluator of adult education to conduct programme evaluations grounded in a reality, which more closely resembles the needs of those requiring the evaluation. In entering the paradigm debate she calls for an approach that obtains an in-depth view as well as an in-breadth view to enable the evaluator to have the most complete picture available before making judgements about the programme being evaluated (Alexander 1990 p 17). Quinn Patton (1997 p 297) further argues for a paradigm of choices and suggests it is found in the utilisation-focused evaluation theory. This model he contends assists evaluators to use any and all data as deemed appropriate by the research team. Stufflebeam (1985 p 118) in a call for "improvement rather than to prove" recognises the importance of systematic inquiry to achieve the goals of research. A caution in researching for evaluative purposes is that "experimental design creates technical and administrative problems so severe as to make the evaluation of questionable value" (Weiss and Rein

in Stufflebeam, 1985 p 144) The use of systematic methods, using both paradigms where appropriate, is dependent on the evidence available. The audit ability of purpose and action where all decisions can be traced and understood within the emergent picture of the research findings leaves one with an ethically conducted study whereby truth can be believed in a context.

Conducting a study, therefore, with the purpose of evaluating a phenomenon poses methodological challenges. In examining the issues contained in general nurse education programmes it is necessary to respect the type of data on offer and then work out what can be done with it to ensure the principles of systematic inquiry are respected at all times. Finding an appropriate label or paradigm within which to locate the research approach becomes a challenge of best fit or in this case a study that respects both traditions, utilises systematic methods for collecting and analysing data and letting the emergent grounded approach to data dictate the path of inquiry.

Evaluation as a Research Methodology

According to Rossi et al (1999 p 11) "evaluation research emerged as a distinct specialty field in the social sciences" in the 1970's. He deduces this from the emergence of eleven cited journals on the topic and eight web-based professional organisations for programme and policy evaluators (p 12). Evaluation design can be structured around "three issues: a) the questions the evaluation is to answer, b) the methods and procedures to be used to answer those questions, and c) the nature of the evaluator-stakeholder interactions during the course of the evaluation" (Rossi et al, 1999 p 76). Evaluation according to Quinn Patton (1997) is a form of inquiry whose focus is on some programme, process, organization or even person, which results in "merit" and/or "worth" constructions (judgments) being made about it. Merit constructions converge on the inherent quality of a programme, irrespective of the setting in which it may find applications. Worth constructions converge on the essential usefulness or applicability of a programme to meet local need (Quinn Patton 1997). This definition reflects the essential core of the definition posited and universally used by the Joint Committee on Standard for Educational Evaluation (1994 p 3) "the systematic investigation of the worth or merit of an object."

An independent evaluation, in which the evaluator takes primary responsibility for designing and conducting the evaluation, is often expected (Watson 2003) In some circumstances, a more participatory or collaborative interaction with stakeholders may be desirable, with the evaluation conducted as a team project (Simons 1998) In the latter case, the evaluation may be designed to “help develop the capabilities of the participating stakeholders in ways that enhance their skills or political influence” (Rossi et al p 76) Successful evaluations it is argued include “the evaluation questions that are identified during planning and the methods for answering them, generally fall into one or more recognisable categories having to do with a) the need for services, b) programme conceptualisations and design, c) programme implementation, and d) programme outcomes or e) programme efficiency” (Rossi et al, 1999 p 77) Fitzpatrick et al (2004 p 11), however, identifies four purposes for evaluation “assessment of merit and worth, oversight and compliance, programme and organisation improvement, and knowledge development” Researchers using evaluative methods have developed relatively distinct conceptual and methodological approaches for each of these different categories of issues that include needs assessment, process evaluation, and impact assessment In practice, much of evaluation planning consists of identifying the evaluation approach corresponding to the type of questions to be answered in an evaluation, then tailoring the specifics to the programme situation This theme is further articulated as

Qualitative evaluators tend to be oriented toward formative evaluation that is, making a programme work better by feeding information on the programme to its managers In contrast quantitatively oriented evaluators often view the field as one primarily concerned with summative evaluation and focus on developing measures of programme characteristics, processes, and impact that allow programme effectiveness to be assessed with relatively high credibility

(Rossi et al 1999 p 423)

While the research approaches are debated inflexibility can occur based on a paradigmatic viewpoint that muddles the methods of collecting and analysing data

Stufflebeam (1997) argues for a pragmatic approach to collecting data that is supportive of the feasibility standards espoused by the Joint Committee for Educational Standards (1994) Singh (2004 p 3) in her study utilised multiple data sources and modes of collection to fully capture the complexity of a university nursing programme In looking at trends, however, Rossi et al further contend,

“Postmodernists tend to favour qualitative research methods that produce rich ‘naturalistic’ data and evaluation perspectives favouring those of the programme personnel and target populations” (1990 p 422) This contention does not fully support the notion that post-modernism is based on discourse of whatever type is available. Discourse usually is descriptive in nature but not always. Qualitative evaluations use qualitative and naturalistic methods, sometimes alone, but often in combination with quantitative data (Quinn Patton 1987). Qualitative studies reviewed mainly include three kinds of data collection methods: in-depth, open-ended interviews, direct observation, and written documents (Singh, 2004, Sumsion and Goodfellow 2002, Simmons 1998, Owen et al 1998). The debate about relevant approaches resounds about capturing the complex factors important particularly in innovative or new programmes (Owen et al 1998).

The data for qualitative evaluation typically comes from fieldwork. In many evaluation studies the evaluator spent time in the setting under study examining the programme in action, where efforts can be observed, people interviewed, and documents analysed (Simmons et al 1998, Owens et al 1998, Gerrish et al 1997, Phillips et al 1996, While et al 1995). These qualitative studies included the evaluation team talking with people about their experiences and perceptions. More formal individual or group interviews were also conducted. Relevant records and documents were examined. Extensive field notes were collected through these observations, interviews, and document reviews. The voluminous raw data reported that emerged in these field notes were organized into readable narrative descriptions with major themes, categories, and illustrative case examples extracted through content analysis (Simmons et al 1998, Owens et al, 1998, Gerrish et al 1997, Phillips et al 1996, While et al 1995). The themes, patterns, understandings, and insights that emerge from evaluation fieldwork and subsequent analysis are the fruit of qualitative inquiry with quantitative data used where found and requested through survey (Owens et al 1998).

The quality of qualitative data according to Quinn Patton (1997) depends to a great extent on the methodological skill, sensitivity, and integrity of the evaluator. He further warns that systematic and rigorous data collection, interpretation of data and presentation of the findings requires discipline, knowledge, training, practice,

creativity, and hard work. The methodological implication of this criterion is that the intended users must value the findings and find them credible. Qualitative findings in evaluation illuminate the operation of a programme and make meaning of the statistics to develop a deeper understanding of the issues of concern.

Evaluation of a proposed, or developing programme, is associated with the work of Scriven who coined the term “formative evaluation”, while evaluation of some developed programme is termed “summative evaluation” (Scriven 1981). Evaluation research, as it relates to programme evaluation in adult education has, at its core, a range of theories (Alexander 1990). Programme evaluation is usually conducted as a continual process of evaluation, both formative (ongoing) and summative (outcome) (Stufflebeam 1985). The formative evaluation provides feedback on the structure and processes of setting the agenda and its implementation. The summative evaluation analyses the extent to which objectives are being met. Programme approval on the other hand “is the process whereby regulating bodies review programmes to ensure consumer safety” (Huttlmger and Biorci in Keating 2005 p 258).

Rationale for Selection of Evaluation Research

Systemic programme evaluations are grounded in models or approaches that by their nature reflect the research question under consideration. Every research study requires a strategy or method to guide its conduct. Applying a theory-driven approach to evaluating the implementation of the new regulations and programmes for general nurse education has implications for research. In general the application of this approach requires a shift in the way evaluative studies are designed and conducted to reflect the needs of the regulator. According to Sidani, Drew and Mitchell (2004, p 61) “The theory-driven approach to evaluation is a strategy for conducting studies aimed at determining the effectiveness of interventions provided to individuals, groups or communities”. The implication of this is that the application of the theory-driven approach consists of developing a framework that shows relationships among factors affecting the outcomes, measuring these factors and testing the proposed relationships empirically. The factors to be included in a particular evaluative study need to be identified from theoretical or conceptual models (Stufflebeam 2001) and previous relevant research (Allen 1977, CAUSN 1995, Singh 2004). This leads to the study being guided by relevant factors and interrelationships that explain a

phenomenon. The identified factors and relationships, therefore, become part of a framework to guide data collection and analysis (Šidani, Doran, Mitchell 2004). In this evaluation study the design takes into account these factors, rather than controlling for their effects either by design or statistics. The implication for this study was the researcher was challenged to explore a number of theory-driven approaches to systematic evaluation of the general nursing programmes as the programmes of general nurse education were underpinned by requirements and standards (ABA 2000) identified by the regulator.

This evaluation study incorporates the sentiments of Rossi et al who suggest, “Programme monitoring is a form of evaluation designed to describe how a programme is operating and assess how well it performs its intended functions. It builds on programme theory, which identifies the critical components, functions, and relationships assumed necessary for the programme to be effective” (1999 p 231). Therefore for the regulator of nursing

The results of programme monitoring allow performance to be assessed against the stipulations of programme theory, administrative standards, applicable legal, ethical, or professional standards, and after-the-fact judgement calls

(Rossi et al 1999 p 231)

The final report includes an assessment of whether the programme is delivered as intended to the targeted recipients and determines what services the programme provides to complement findings about what impact those services have (Rossi et al 1999).

In choosing a conceptual framework to underpin the systematic evaluative approach it was necessary to match the study objectives with the values associated with the role of the regulator in protection of the public. The public protection role has an interpretation associated with maintaining high standards of initial preparation of education programmes and the role of codes of conduct to achieve minimum expected standards of education and training (ICN 1991). Following review by the researcher of a number of evaluation approaches and models doubt emerged as to whether a single framework would address the full range of methods needed for the regulator. The concern was tempering the scope of the evaluation and avoiding the minutia of

the programme and the issues best addressed at a local level through internal evaluation structures. This evaluation study had a different function in that it needed to capture the bigger picture associated with health need (Allen 1977) and meeting outcome standards that ensure the public interest is protected with safe competent practitioners. Stufflebeam (1985 p 54) warns that the advantage of policy studies, which incorporates governmental and professional bodies, is that they are essential in guiding institutions and society but also they face the problem of being corrupted by the potential environment in which they must be conducted and reported. In a follow up piece Stufflebeam (1997 p 10) further contends “the root term in evaluation is value. Evaluation involves assessing services against a set of community, professional and or organisational values.” He further posits, “an organisations’ values provide the basis for deriving its evaluation criteria. The chosen criteria along with the questions of stakeholders dictate information needs.”

The literature review in respect of regulation in particular highlighted that an evaluative structure specific to nursing concerns, as proposed by Allen (1977) and supported by the WHO, was notably not reported in the literature (Chavasse 1994). Subsequently the literature illuminated that the Canadian Association of University Schools of Nursing adopted a voluntary accreditation system based on Allen’s (1977) work and further developed it in 1995 to embrace an “outcome-focussed” approach to meeting standards (Earle et al 1995 p 14). The CAUSN (1995) model has four criteria

- Accountability i.e. the extent to which the programme teaches the student that the primary responsibility in nursing is to the client, community, family or individual,
- Relatedness i.e. the extent to which the components of a programme support and build on other parts, thereby promoting or negating the achievement of goals. The components are curriculum, the teaching of nursing, research, clinical practice and professional activities and administration. This quality is a measure of internal consistency
- Relevance i.e. the extent to which the mission and goals of a programme reflect a response to the major trends in society that impact on the health needs, present and future of the larger community,
- Uniqueness i.e. the extent to which a programme capitalises on the unique characteristics of its resources (faculty, community values, financial support within its particular setting (p 2)

(Cited in Earle 1995 p 16)

In adopting a framework of this nature regulation moves beyond minimal standards as benchmarks to adopting a stance that supports quality improvement to achieve excellence (Crawford 2004)

Although the initial framework was commissioned by WHO, to support the development and outcomes of nurse education programmes that they had supported over the years, there is a paucity of published research by regulators in respect of the processes they employ in quality assuring education (Watson 2004) While audit and description of current systems in place was operated (Norman et al 2004) and particular components of programmes were examined through the years (Neary, 2000, ENB, 1998, Garrish et al 1997, Eraut et al 1995) and voluntary accreditation (AACN 2002) processes were developed and utilised developing a framework that supports statutory based regulation by the regulator of general nursing programmes in Ireland is required to effect regulatory governance issues

Support for the idea of a culturally relevant framework was gleaned by the researcher from the literature associated with Irish policy (Department of An Taoiseach 2001) and international developments (NLN 2004) and European initiatives (Lisbon Agreement 2000) to develop transparent accountable systems and practices of operation In this endeavour cognisance was taken that guidelines and frameworks should not be rigidly procedural or prescriptive but allow scope for judgement, discretion and context specific assessments (Quinn Patton 1987) While accountability is one feature of evaluation roots the other dimension is social inquiry (Alkin and Christie 2004) and a third is professional / organisational development (CAUSN 1995) In this respect a concern had emerged from the literature for the systematic conduct of evaluation studies (Rossi 1999) Social inquiry that employs systematic and justifiable methodologies for determining accountability gives credence for the outcomes and emergent findings (Alkin & Christie 2004)

The idea then is to achieve the aim of this study, which is to develop a culturally relevant regulatory framework for programme approval that embraces the concerns and mission of ABA

RESEARCH DESIGN

Research with the purpose of evaluation is the utilisation of pragmatic methods and procedures to evaluate a programme. It uses systematic methodologies as means to document and judge the worth and merit of a programme (Stufflebeam 2001). Evaluation approaches to research have at their disposal a number of systematic methods of inquiry i.e. experimental, quasi-experimental and non-experimental for determining the effect or outcomes of a programme (Lo-Biondo Wood and Haber 1998). In nursing experimental and quasi-experimental designs are used when the researcher tests cause and effect relationships. Freeth et al (2002) in a critical review examination of evaluations of inter-professional education corroborated a finding from the literature that most evaluation studies in health care are associated with post-registration courses with only 30% interested in pre-registration and of these there was a noticeable paucity of studies conducted using qualitative methodologies. The majority of studies from a methodological perspective were pre-test post-test, although not many addressed the issue of cause and effect. Longitudinal type studies were also poorly represented in the literature.

Experimentation in evaluation approaches associated with educational programmes is reflected in studies by Clinton et al (2004), Drennan (1999), Fulbrook et al (2000), Lofmark et al (1999), Martin et al (2003), Norman et al (2002), Swindells and Willmott (2003). In nurse education this is usually associated with the pre-test post-test phenomenon of introducing an educational programme, technique or practice (Mattila et al 2005, Major 2005). Quasi-experimental designs differ from experimental designs in practical issues associated with randomisation or comparison group characteristics particularly in situations where the ethics of conducting an experiment are questioned (Lo-Biondo Wood and Haber 1998).

In choosing theorists to guide, focus and frame the evaluation the study focus was considered. The aim of this method where comparative analysis was a component was to establish a national picture and general nurse education programmes and determine the effectiveness of current structures to support an answerable regulatory framework. In essence the study about “appreciating context” (Alkin 2004, Stufflebeam 2000), “interpreting intended practices, institutional procedures, reactions and management

problems” (Kirkpatrick 1998), “assessing the implementation of plans to help staff carry out activities” (Stufflebeam 2004). In discussing the findings it wishes to judge these against the values of “transparency, consistency, accountability, effectiveness, proportionality and necessity” (Department of the Taoiseach 2004) in ways that are recognisable and useful to the regulator which can direct future evaluation approaches that reflect the regulatory concerns of ABA. In essence this study has a functional orientation to stimulate, strengthen and improve the regulatory activity of programme approval systems. This element of the study reflects the formative aspect of programme evaluation that is undertaken by the regulator to support and assist the HEI’s in implementing a new programme within a new setting. The summative aspects of programme evaluation address regulatory concerns of whether the programme meets ABA Requirements and Standards (2000) and thereby the European Union Directives (77/453/EEC) otherwise referred to as the goals of the programme and whether the programme met its objectives (Stufflebeam 2003).

The evaluation process is conducted to achieve the programme evaluation standards of utility, feasibility, propriety and accuracy (Shadish et al 1994). The ‘utility’ standards address the information needs of the regulator i.e. ABA. The ‘feasibility’ standards keep the evaluation manageable from a data management perspective to ensure enough data is collected and analysed to effect meaningful interpretation of issues. The ‘propriety’ standards honour the ethical and legal concerns and rights of the participants in this case this is the individual HEI and ABA. The context, inputs, and process of the programmes of the thirteen HEI’s offering the pre-registration programme between 2000 and 2004 were examined for patterns and comparisons in an anonymous and confidential manner in order to develop an insight and understanding of the current programmes and the evaluation needs of the regulator for future developments. The ‘accuracy’ standards refer to the conduct of the study adhering to the research concerns with validity, reliability and sound reporting (Shadish et al 1994).

A review of a number of evaluation models was undertaken and the definition of a model as a guide rather than as a prescription is again invoked. The models reviewed spanned early models (Tyler 1949) based on a pure objectives approach through to more constructivist approaches (Guba and Lincoln 1988). The utility and social

mission to be served by the study as described by Stufflebeam (2001) must override decisions related to choice of either qualitative or quantitative research approaches and respond instead to the evaluation questions that need to be addressed. Kinn and Curzio (2005) undertook a literature review to identify the amount of published work integrating qualitative and quantitative research and to assess the quality of the outcomes of studies purporting to use both methods. They concluded that further work is required to refine and develop ways to mix methods but consider their original contention for flexibility to include a variety of different research methods. In a quest to answer all questions relevant to evaluation and assessment of complex healthcare (Kinn and Curzio 2005), Quinn Patton (1990) supports this contention when he asserted that the choice between qualitative, naturalistic inquiry and the experimental approach is closely related to the relative importance of causal questions in the evaluation. Further he contends that if the main function of evaluation is to measure cause and effect relationships experimental methods are then preferred. In contrast, however, if the purpose is to capture the process of a programme and explore important individual differences in experiences, document variation and outcomes is the objective a more naturalistic inquiry is required (Boyle 1993).

Therefore, the focus of "Improvement/Accountability-Oriented evaluation approaches" as grouped by Stufflebeam (2001 p 42) were mainly considered and compared and contrasted to meet this need. Undertaking evaluation-focussed research into regulation in nursing is a new phenomenon in Ireland. As suggested by Pestieau (2003) "policy-makers seldom signal a need for research findings in advance and it is too late to start research when the issue is on the table" (p 3). This study is examining a current system and as such the principles of accepting stated wisdom and mechanisms of working. Relevant research results therefore have the capacity to inform future actions and practices.

In this respect analysing the structure of the curriculum provides information to help evaluate the effectiveness of the programme and judge its worth (Keating 2005). Keating (2005) further contends with the current emphasis on outcomes evaluation processes are charged with measuring success, establishing benchmarks and continually improving the quality of a programme. A master plan of evaluation is required if programmes and institutions are to meet accreditation standards,

professional discipline expectations and consumer demands. Having a master plan provides a mechanism for continually monitoring a programme so that adjustments can be made as the programme is implemented. Equally looking for measures of outcomes in terms of the programme intentions, goals, objectives and particular benchmarks indicate the quality factors associated with a programme. Keating (2005) warns of the major task of evaluators to integrate programme approval standards into the evaluation plan. The standards then become baseline criteria and requirements of the profession to ensure that programmes are of sufficient quality to meet the expectations of the discipline. The concern associated with using established standards is articulated by Dey (2005 p 104) and Fitzpatrick et al (2004 p 161) that cognisance must be made of the fact that standards are usually consensus derived. In forming this consensus trade-offs are inevitable and the emergent standards though adhering to a common sense set of categories can be explored over time for continued purpose (Dey 2005).

Another dilemma for the researcher was whether the evaluation was taking a formative or summative role (Scriven 1981). In resolving this dilemma the researcher acknowledged a need to embrace set standards and requirements but also acknowledge the process nature of assisting the HEI's implement a new programme of nurse education and as such elements of the formative and summative role were embraced. The formative role gives information designed to assist decision-making and quality assurance while as a regulator the role of summing up a programme's merit, worth, probity and significance cannot be underestimated or underplayed (Stufflebeam, 2004). In this respect related to 'context' a comparison of goals and priorities to assessed needs, problems, assets and opportunities of the programmes. In relation to 'input' a programme is compared for strategy, design and implementation rather than budget to other programmes being offered in the country. The 'process' elements i.e. the operational plan and implementation of a programme (based on site visits) is judged and compared to other programmes on offer. Finally the 'product' element of the evaluation model based on that of Stufflebeam (2000, 2004) assesses and interprets the results of the programme against assessed context, inputs and processes.

The results of this type of evaluation defines the status, needs, and future directions of nurse education programmes, as well as the processes by which knowledge for nursing practice can be generated and supported. This information is vital for long-range planning and ensuring regulatory governance. The study will therefore explore these identified formative and summative techniques within the evaluation research approach.

This study will inform the regulatory body of a process of ensuring safe standards of preparation of general nurses. My definition of evaluation that emerged as a result of reviewing the literature and taking an elemental approach in the context of this study was one of **the systematic collection of information about the operations and outcomes of general nurse education programmes to make judgements about the requirements and standards, improve their effectiveness and inform decisions about their future**.

Identifying the Stages of Research

The review of existing frameworks highlighted the different purposes adopted or attributed to the various available frameworks. The stages of the research design to which they apply reflect the researchers' struggle with intent, method, purpose and accountability for regulation of nursing. The struggle for regulators at a philosophical level is whether inputs and processes of education should be measured or whether it should be outputs and competencies achieved. In struggling with these competing philosophies the researcher acknowledged her own bias towards evolving education systems and processes and as primarily an educator wished to support innovative teaching and delivery models while respecting that a minimum standard of attainment must be achieved of the programme and the individuals completing the programme. In a world where outcomes are achieving political and international favour as measures of achievement (Lisbon Agreement 2000, Ingersoll and Souter 1998, Pew Commission 1997) the emphasis of this evaluation is in explaining the methods that general nursing programmes are utilising to achieve the outcomes stated and the regulatory requirements. This supports the contention of Alkin (1991) where he makes four assumptions about evaluation.

- 1 Evaluation is a process of gathering information
- 2 The information collected in an evaluation will be used mainly to make decisions about alternative courses of action
- 3 Evaluation information should be presented to the decision maker in a form that he can use effectively and that is designed to help rather than confuse or mislead him
- 4 Different kinds of decisions require different kinds of evaluation procedures (p 94)

In making the decision as to how to approach this evaluation study many frameworks were reviewed and advices sought in respect of how regulators have undertaken evaluation. Only a few nursing regulatory specific frameworks for evaluation of approval mechanisms are reported (Allen 1977, CAUSN 1995)

With these pointers in mind the researcher modified this approach in developing a question set from pre-established policy set standards of ABA namely the Requirement and Standards (ABA 2000). The challenge associated with this approach as articulated by Dey (2005 p 104) is in acknowledging the original categories of data identified by the Board as a policy for programme approval and re-conceptualising them (Dey, 2005 p 129). Miles and Huberman (1994 p 83) articulate a process for the “pre-structured case”. Elements of this approach were engaged by the researcher to determine the programme and illuminate a possible framework for future evaluation exercises for the regulator.

DATA GATHERING

Several methods of data collection are available to the evaluation researcher. Data gathering in grounded theory methods (Corbin and Strauss 1990) and phenomenology (Koch 1996) involves interviews and observations as well as such other sources as documents or any other source that informs the questions under study. In this study data gathering comprised the rich documentary sources as the research population was all the official data available to the regulatory body in relation to a programme and its approval and a key stakeholder focus group interview. In this case the regulatory body set out Requirements and Standard for Nurses Registration Education Programmes

(2000) for the registration/degree programme in anticipation of the implementation of the Registration/Degree programme in 2002. The official documentary evidence of the Board namely the Requirements and Standard for Nurses Registration Education Programmes (ABA 2000), submitted curricula and the processes of the regulatory body including existing on-site visit documentation were examined with college self-audit reports, annual reports and correspondence. The purpose of collecting data was not to evaluate the teaching of nursing but to describe the programmes of general nurse education as fully as possible in terms of the required standards to achieve registration as a nurse in Ireland. In other words, data collection is directed towards how the HEI's organise and implement general nurse education programmes and not from the negative point of view identified by Allen (1977) i.e. how they are not teaching nursing; or towards how are the students learning and what are they learning, not how and what are they not learning.

Data collection from non-human sources is discussed by Lincoln and Guba (1985), as being attractive in their availability. They also warn that they may be unrepresentative or selective. Historical research by its nature deals with existing documentation (Cohen, Manion and Morrison 2000). The identifying feature though in addressing issues of reliability and validity of documentary evidence for historical research utilising documents lies in whether the researcher uses primary or secondary sources. Historical research in education draws mainly on primary sources such as manuscripts, laws, charters, official minutes or records, files, log books, letters, official publications and transcriptions among a few and items that have "a direct physical relationship with the events" including "written and oral testimony" provided "by participants or witnesses" (Cohen, Manion, and Morrison 2000 p.161). Parker (1992 p.122) suggests research into discourse "should be led by the issues and problems that are to be addressed". Cheek (2000) working in the framework of critical analyses of print based magazine articles pertaining to Toxic Shock Syndrome contends, "discourse analysis applies to texts." Owen et al (1998) in a study to evaluate the implementation of the framework for continuing professional education and the higher award in the UK utilised validation documents including curricular, prospectuses, student handbooks and other documentation including module/programme review documents to appreciate both the intention and the evolution of the framework in six sites. It is acknowledged as warned by Cohen, Manion and Morison

(2004 p 163) that documentary evidence of this nature “tends to be neutral in character, though it is possible that some may be in error because of observer characteristics” Polkmghorne (2005 p 144) regrets that “documents are an underused source of data for counselling psychology” In this study documentary evidence was the primary data collection method along with a focus group interviews as the purpose of the study was to evaluate the current system utilising real documents that reflect the current scenario of programme approval This study was about examining these issues and looking at the underpinning values that were emerging and identifying a culturally relevant framework Gaining an insight into the current systems against the theoretical literature corroborates with Stakes stages (1985 p 233) in order that the evaluator judges the programme and identifies which standards to heed

Phase one of the study utilised documentary evidence of the registration degree programme as its population The purposive sample was the curricula for the 13 HEI’s offering the general nurse programme, the site visit reports of ABA that were compiled following a site visit to the educational and health care institutions between 2002 and 2004, self-audit report of the HEI’s if available, annual reports, student handbook if available, correspondence of the education and training committee in respect of the programme approval process In appreciating the issue of authenticity of the documentation direct access to the original documents was afforded to the researcher While it is appreciated that there are limitations to this type of approach in respect to intentions and implementation issues (Owens et al 1998 p 52) the documentation had a connectedness between the intentions and what was observed from the site visits The accuracy and worth of the data was official and had been approved as accurate by the HEI’s concerned through asking for accuracy comments following the site visits

Phase two of the study comprised a key stakeholder focus group discussion to explore what processes the regulator needs to develop in order to fulfil its regulatory obligation An independent note taker minuted the focus group discussion The minutes were circulated to the key stakeholders two days following the group interview and were validated for accuracy with the participants

The Sample

The large volume of documents considered as evidence to answer the question under study appeared as curricula of the thirteen programmes and ranged in size from 69 pages to 365 pages and in total constituted 2548 pages of text and graphs. The site visit reports ranged from 35 to 85 pages and comprised 648 pages. The self-audit reports spanned 48 pages and comprised 96 pages. In addition programme documents were considered as available. In total a great deal of reading was required to appreciate the general registration/degree programmes offered by thirteen HEI's in action offered in partnership with 21 identified healthcare agencies (ABA Nursing Careers Centre 2004). The purpose of this study was not to judge the individual worth or merit of each of the programmes rather it was to examine the programme against the Requirements and Standards for Nurse Registration Education programmes (ABA 2000) and explore regulatory accountability concerns. As such the detailed analysis of the documents sought to illuminate issues for regulatory concern on a national basis and the detail of the methods employed demonstrates the audit trail and the research trail that aimed to be precise, concise and manageable. Cheek (2000 p 86) refers to "a somewhat deceptive simplicity in good research design". In this defence it is worth noting the sentiments of Stake (1995 p 68) who contends "gathering of data by studying documents follows the same line of thinking as observing or interviewing".

Ethical Concerns

It is appreciated that this study is an evaluative design and as such is of a non-invasive nature in relation to subjects. The essence of the ethical concerns for the study of informed consent, right to privacy and protection from harm, are issues understood and respected by the researcher (Beauchamp and Childress 1994). The ethical considerations for any researcher involved in a study are articulated by the ICN for participants' as the right not to be harmed, the right of full disclosure, the right of self-determination and the right of privacy, anonymity and confidentiality (1996). House (1995 p 29) warns against ethical compromise in evaluation research as problems with clientism (the client's interest is paramount), contractualism (the initial contract focuses the study), managerialism (the managers' interest is paramount), methodologicalism (the use of a robust methodology abates ethical problems), pluralism/elitism (powerful stakeholders' interests are paramount), and relativism (all viewpoints have equal status in the report). Fitzpatrick et al (2004 p 511) warns

“attention to ethical issues will increase as evaluators become more involved in political issues ”

The Joint Committee on Standards for Educational Evaluation (1994) stipulate programme evaluation standards of utility, feasibility, propriety and accuracy Standards in respect of “Utility” address the information needs of the intended users of the evaluation, in this case the regulator of nursing Standards in respect of “Feasibility” address the information management issues of keeping the evaluation realistic, prudent and cost-effective Standards in respect of “Accuracy” ensure the results obtained and reported respect the social inquiry values of validity, reliability and sound reporting of results (Sanders 1994 p 5-6) The “Propriety” standards are particularly set to ensure that all activities are conducted within ethical and legal parameters and “with due regard for the welfare” of participants and those affected by the results of the evaluation (Sanders 1994 p 81) The eight standards of propriety embrace service orientation where the evaluation should effectively serve needs of the targeted population, formal agreements so that the parties to the evaluation adhere to all conditions of the agreement for evaluation, rights of human subjects should be protected and respected, human interactions reflect the need to respect human dignity and worth where they are not threatened or harmed, complete and fair assessment and recording of strengths and weaknesses of the programme being evaluated so that the strengths can be built on and problems be addressed, disclosure of findings should be full and unadulterated along with limitations of the evaluation, conflict of interest should be dealt with openly and honestly so that the processes and results aren’t compromised and fiscal responsibility should be adhered to in relation to accountability of finances (Sanders 1994 p 81-82) The Joint Standards became the quality markers employed by this researcher to guide the development of the approach for this study and the approach and emerging design externally as a process

In respect of these standards the researcher identifies that the client in this study was herself This study was not commissioned but was supported by a small research grant obtained through open competition prior to the researcher being employed by ABA The contract for conducting the study is only underpinned by academic requirements of the institution to which the study will be submitted The researcher as manager of the study process was granted access to documentation to support the study process

by the Chief Executive of the Board (Appendix K) and the Ethics Committee of the Board (Appendix L) The study approach is underpinned by a methodology that lends itself to conduct the study in a systematic robust fashion The notion of powerful stakeholders' interests in evaluation research is one that Quinn Patton (1997) and Alkin (2004) refer In this incidence the regulatory responsibility is to the public and this is acknowledged The other stakeholders to an evaluation of nursing programme are the students of the programme, the clinical practitioners, the health service providers, the lecturers, and the higher education institutions The researcher is conducting this study to improve the effectiveness and efficiency of the current system of programme approval to meet regulatory responsibility Cohen et al (2000) highlight the researchers' dilemma of, on the one hand striking a balance between the demands of pursuing the truth and the potential risk of the participants' rights and values The participant in this case is ABA where there is an examination and review of systems and documentation The systematic pursuit of truth in respect of the illuminations within the documentation was pursued in an attempt to provide the regulator i.e the Board, with an in-depth understanding of its role in regulating pre-registration education on a national basis Informed consent includes a detailed explanation of the study and the right to refuse to reveal information is respected by the researcher and was stipulated to the Chief Executive Officer of ABA Permission to access the data was sought and granted from the Chief Executive Officer A copy of the letters requesting both ethical approval and access to the documentation provided by the researcher are presented in Appendix L and K respectively

Ethical Issues for Focus Group Interviews

Ethical considerations for focus groups are the same as for most other methods of social research (Homan, 1991) In selecting and involving participants, researchers must ensure that full information about the purpose and uses of participants' contributions is outlined The principle of informed consent applies in keeping participants informed about the expectations of the group and topic, and not pressurising participants to speak (Parahoo, 1997 p 79) A particular ethical issue to consider in the case of focus groups is the handling of sensitive material and confidentiality given that there will always be more than one participant in the group Participants need to be encouraged to keep confidential what they hear during the meeting and researchers have the responsibility to make anonymous

data obtained from the group. The researcher respected this and no identifiers are included in the subsequent reporting of the findings.

Access

Access to research populations is usually predicated on having ethical approval granted. In this incident this was the case. The Ethics Committee of ABA considered the research proposal (appendix L) and granted approval to conduct the study. The letter of approval was copied to the Chief Executive Officer and permission sought to access documentation (appendix K). Permission was granted with the proviso of confidentiality, anonymity and that the system was being examined in a collective fashion (appendix K).

Data Collection

The literature review, context chapter and previous section have described the resources upon which the framework for this study is based. This section describes the creative process used to develop the evaluative framework for conducting this study and outlines a two-phase approach to the development of the proposed regulatory framework for the regulation of general nursing programmes. The methodology used to develop the instrument for phase one was derived from Stakes' (1985) five stages to generate data collection in evaluation and the second phase data generation was concept development described by Schwartz-Barcott and Kim (2000).

In scoping the methods for data collection and analysis the difficulty for the researcher was her relationship of being immersed in a process and reflecting on it in using a systematic evaluative approach of the documentation supplied to the regulatory body and generated by it in respect of programmes. The data to conduct the study comprised a documentary analysis approach to curricula and reports, which mainly lead to a qualitative technical design described by Quinn Patton (1987) as descriptive evaluation. In this approach there is an interest in descriptive data with a focus on interactions and processes exploring the nature of a problem or individualised experiences and outcomes, especially where there is "uncertainty about what interactions and variables may be most important" (Quinn Patton 1987 p 47). Guba (1978) however, warns about the problem of convergence or figuring out what things fit together and in this Stake's (1985) explanation of a descriptive matrix where

congruence analysis and contingency analysis form the basis of analysis. The “congruence analysis asks whether what was intended occurred” and he argued “contingency analysis” searches for “relationships that permit improvement of education” (p 220). The important issues that emerge are associated with correlations between actual stipulated self-reported plans and circumstances and observed activities.

The notion of causal relationships cannot be ignored and Stake (1985) suggests identifying standards and formulating judgements about the merit of a programme and standards then become explicit criteria for “assessing the excellence of an educational offering” (p 222). This equates with what King et al (1987) call a programme characteristics list, as it becomes the template from which to judge or make the initial evaluation. Stufflebeam (2001) advocates the use of checklists for the purpose of helping evaluators and their clients consider an appropriate range of generic values and criteria for underpinning evaluations. Dey (2005) on the other hand warns that checklists can also inhibit. He contends that the richness of qualitative data provides a “lubricant” (p 90) for analysis that in its absence shifts the focus “between different levels within the data” (p 88). The levels emerge as “a telescope considering the universe as a whole or as a microscope fixed on a particular detail” (Dey 2005 p 88). Scriven (1983) claimed, “checklists can function in different ways” from a “quick check on each of the checkpoints” through to a more “iterative nature” (p 258). It could therefore be contended that checklists have the potential toward superficiality. Many current advocates of checklists including Scriven (www.wmich.edu/evalctr/checklists) contend they support a consumer-oriented evaluation system associated with standards. Standards in themselves pose challenges for the researcher. Fitzpatrick et al (2004) refer to absolute and relative standards where absolute standards are a specification of policy with an understanding of achieving them. They also warn “in some cases, state standards have been established primarily for political purposes and do not reflect feasible or genuine outcomes” (p 252). Standards need to be specific for each criterion. In contrast relative standards compare programmes with available alternatives (Fitzpatrick 2004). In a situation where comparison is made “effect size can be used to specify standards. The effect size essentially conveys the degree to which differences between the two groups differ beyond and in comparison to the ordinary variability among individuals” (Fitzpatrick

2004 p 253) Pestieau (2003 p 10) supports the note of Quinn Patton that the desired outcomes, in our case standards, need careful consideration of developing indicators to avoid a weak relationship with the objectives of the study

The difference that emerges from examining the merit and worth of a programme are led by the methods employed to analyse the data generated. The process suggested by Stake (1985 p 223) of applying the following standards in stages 1 – 5, was used as a guide to generate the data collection in evaluation to obtain understandings of the general nurse education programmes and the first phase of this research. Stake (1985 p 223) advises

- The evaluator collects and analyses the descriptive information (and describes the program's rationale)
- The evaluator identifies the absolute standards (those formal and informal convictions held by relevant reference groups of what standards of excellence should obtain)
- The evaluator gathers descriptive data from other programmes and derives relative standards against which to compare the program of interest
- The evaluator assesses the extent that the programme of interest meets the absolute and relative standards
- Singly or in collaboration with others, the evaluator judges the programme, that is, decided which standards to heed. More specifically, he assigns a weight, an importance, to each set of standards

Within this structure what is ascribed to the notion “critical competitors” described by Scriven (1967) emerges. This value is incongruent with regulation whose purpose is to ensure minimum standards are met and those standards exceeding this and achieving excellence being acknowledged (Ryan 1997) unfortunately does not feature in current legislation provision. Spencer et al (2003), in a review of 298 Government Evaluative Studies that used qualitative methodologies, confirmed that the “field of qualitative Government evaluative research is dominated by four main methods – in-depth interviews, focus groups, documentary analysis and observation” (p 54-55). This study utilised analysis of curricula, programme plans, self-audit reports, site visit reports, including recommendations of the Education and Training Committee, and annual reports. The methodology for the second stage of this study where framework development was the aim is congruent with the processes associated with the Hybrid Model of Concept Development, which is oriented to developing concepts through an approach that integrates theoretical and empirical investigation (Schwartz-Barcott and

Kim 2000) The processes of this model consist of three phases theory, fieldwork and final analytical This model has been used by a number of nurse led studies (Lee et al 2004, Lerdal 2002, Chang, 2001, Majjala et al, 2000) Erdley (2005) used the model for concept development of nursing information Erdley's (2005) study applied the initial theoretical phase by formulating a working definition and identifying an existing knowledge base about the concept of nursing information in hospital settings The fieldwork phase involved qualitative data collection by participant observation and interviews, and the final analytical phase was operationalised by interfacing the initial theoretical analysis with insights gained from the empirical fieldwork phase Through clarification and refinement of both inductive and deductive analytical methods the modification of the concept occurred (Erdley 2005) This study utilised the core findings of phase one of the study and the literature to provide a theory base for fieldwork which was operationalised using a key stakeholder focus group discussion, the data from which was used in the final analytic phase to complete the study and propose a framework for regulatory approval of general nurse education programmes

INSTRUMENT DEVELOPMENT AND ANALYSIS

The development of the framework began with the initial literature review where there was an analysis of existing mechanisms used by regulators and evaluators of education programmes, taking note of nursing and health care concerns at national and European level and existing reported studies

The data available to the researcher for this study i.e. the curricula and the site visit reports and other documentation which included self-audit reports, programme plans, including annual reports and student handbooks became the sources of data and as such documentary analysis comprised phase one for this study

The approach to developing the data collection instruments and consequently analysing the data to develop the instrument for use are outlined Steps 1-6 inclusive below represent the staged 1-5 approach recommended by Stake (1985 p 223) are

outlined Steps 7 and 8 represent stage two of this study and the methods of data collection for concept development. The stage two is dependent and utilises the core findings of stage one.

- 1 The researcher in trying to understand how the programmes are meeting the Requirements and Standards (2000) took the template of the standards (n=53) and following consideration of the standard statements converted the individual standard statements into questions (see appendix A)
- 2 The existing standards (ABA 2000) were read and re-read for intentionality and the researcher examined the entire document (ABA 2000) and identified indicators of the sub-questions to the standards as recommended by Stufflebeam (2000) and Singh (2004). The researcher examined the questions for their capacity to capture the issues identified in the Requirements and Standards (ABA 2000) utilising this entire document related to outcomes of the programme, competencies to be achieved and indicative content. The recommendations of the Nurse Education Forum were considered and these were incorporated in the development of the indicators of achievement of the standard question (appendix B)
- 3 A matrix to assist the decision trail and support systematic inquiry was developed based on the standard and individual standard statements with a best-fit match against the standard question and indicators of achieving the standard. Documents available to the Board in respect of each individual programme were examined individually through documentary analysis and extracts from the documents or other evidence was collated to generate descriptions of achievement or not as the evidence supported. The researcher immersed herself with each programme individually and read and re-read the all available documentation in respect of each programme and made memos of evidence associated with the indicator of each question as recommended by Miles and Huberman (2004) and Tuckett (2005). The memo which in some cases became a description to tie together different pieces of data into a recognisable cluster (Miles and Huberman 2004 p 72) was examined to support a judgement in respect of full compliance, partial compliance, non-

compliance or unknown with the standard in the individual cell in the opinion of the researcher. The researcher made a judgement at this stage in respect of whether the programme was in full or partial compliance with the standards or if non-compliance was identified and could be substantiated in some instances the researcher had to admit to not knowing as the evidence couldn't be gleaned from the documentation available for each individual programme (appendix M). The following appendix (C) represents the filled in matrix for the thirteen programmes. Where quantitative evidence was available tables and charts were compiled and the mean and range and standard deviation identified. The matrix captured the qualitative evidence that was collected related to individual general nurse education programmes Higher Education Institutions and their respective health care facilities or each individual institution.

- 4 The accumulated evidence from the 13 HEI's was compiled into one large composite data set against the established individual standards and devised questions of ABA (ABA 2000) (appendix D). This generated a text for analysis using a form of discourse analysis informed primarily by the writings of Miles and Huberman (2004). Text generation is initially in the form of findings, which are a collection of the interpreted evidence generated by the researcher from the evidence associated with a programme if available for each individual cell. As suggested by Cheek (2000 p 128) generating the findings "is a form of reflexive interaction with the texts in order to give attention to the socio-political forces within which it is positioned." The text produced by transcript amalgamation from the memos and transcript abstraction provided the databits for data analysis. Data organisation by this method is integral to the process of data analysis (Dey 2005). Organising data logically was the foundation of analysis understood as coding (Miles and Huberman 2004). As in pre-structured case type research detailed data displays with narrative were constructed in the original standards in identifiable cells. Miles and Huberman (2004 p 85) further advise field notes should lead to coding which leads to a display of the data from which conclusions can be drawn to inform a report. The methods of data collection

and analysis therefore were documentary analysis using both qualitative and quantitative methodologies dependent on the type of evidence available

The researcher in examining the individual cells identified the broad categories. The analysis tactic was one suggested by Miles and Huberman (2004 p 106) as “noting patterns or themes”. In essence the process went from “data reduction” through “data display” which is “part of analysis” before embarking on the “third stream of analysis activity” where there was “noting regularities, patterns, explanations, possible configurations, causal flows and propositions” (Miles and Huberman 2004 p 11). The researcher was aware of the warning of Miles and Huberman (2004 p 11) to maintain “openness and scepticism” with these conclusions. The insights emerge as the process is engaged with and it becomes iterative in nature.

Verification of the analytical conclusions “may be thorough and elaborate, with lengthy argumentation and review among colleagues to develop inter-subjective consensus or with extensive efforts to replicate a finding in another data set”

(Miles and Huberman 2004 p 11)

In this instance the meanings emerging from the data were tested for plausibility and sturdiness as described by Miles and Huberman (2004). In this instance this was achieved by testing for validity with an expert group. Data organisation and decision-making associated with analytic preparation were considered. One method considered was in the mode of a hard copy file within word document of Microsoft Office software as recommended by Sullivan et al (2003) when they examined the perceptions of rural women and the management of chronic illness. Through identified individual files to represent the information related to specific words, a numerical construction occurred based on frequency of word generation with the aim of reducing the codes into broad categories or in the case of Sullivan et al (2003) they examined the major theme of illness and the emergence of subcategories. This mechanism was not utilised by the group who chose to inductively examine the data and verify the processes and the findings of the researcher.

- 5 The researcher utilised the skills and experience of an expert sub-group as suggested by evaluation theorists (Stufflebeam 1997, Quinn Patton 1997) and

researchers (Miles and Huberman 1994) In policy studies such as this Stufflebeam and Shinkfield (1985) warn against the political environment in which they can be conducted and as such the expert sub-group was made up of Board members and non-board members both involved with education and not involved with Irish pre-registration education but all with a grounding in qualitative research methods (n=6) The membership of the group represented theoretical sampling as described by Glaser and Strauss (1967 cited in Miles and Huberman 2004 p 29) where the choice of informants was driven by the question being considered and not from seeking to achieve “representativeness” This membership was designed to balance the special interests that can occur by virtue of involvement and experience The expert group examined the composite document for the data that were produced to them as codes (appendix D) The researcher asked the expert group to read and re-read the composite databits with a view to identifying broad categories and matches these judgements to verify the judgements according to the evidence supplied to them or the lack of evidence available in some cases Each member of the expert group did this exercise independently and then the group came together to provide a consensus of the broad categories The consensus broad categories identified by the expert group were compiled onto a master sheet that became the data source for the researcher

The expert group identified broad categories from the data The methodology they used was based on the research and education skills the expert group brought to the process The researcher had contemplated the positivist notion of frequency earlier in the analysis debate (appendix D(B)) but this was incongruous with the notion of Lincoln and Guba (1985) and as such the expert group considered “content, construct and concurrent validity” (Cohen, Manion and Morrison 2004 p 107) of the data presented to them (appendix D) Dey (2005 p 220) warns that this method is fraught if the reason is to bring a “neutral and objective” observer status to the process Rather he suggests the value of colleagues to the process is that they can “inspect the procedures through which evidence has been produced” and “check whether using similar procedures they achieve similar results with the data” (Dey 2005 p 221)

6 Following this process of data collection, as suggested by Stake (1985 p 223), the broad categories were cumulated outside their initial cells and examined by the researcher, which led to the reduction of the data and identification of higher order categories (appendix E) This was done “to relate or bridge already existing elements” and “reinforce main trends” away from the initial value set constructions (group of standards) and thereby “account for other information already in hand” and “provide more evidence for an important theme” and “qualify or refute existing information” (Miles and Huberman 2004 p 31) The higher order categories and the core categories that were identified by the researcher from her engagement with the data, the literature review and the theoretical perspectives and constructions Miles and Huberman (2004 p 85) further contend that wide data sampling of informants and settings should substantiate the field notes In this case this was achieved with an expert group Higher order categories became the theorised construction of the issues in the text (Miles and Huberman 2004) by the researcher Higher order categories through reading and theorising by the researcher where there was “creative interplay among the process of data collection, literature review and researcher introspection” (Quinn Patton 1990 p 163) emerged as three core categories

This notion of “data reduction” and “conclusion drawing” and “verification” followed the steps outlined by Miles and Huberman 2004 p 10-11) Consequently the researcher moved from a process of description to abstraction of current contexts and was challenged therefore to develop the findings of this abstraction into the story of general nurse registration programmes on a national level based on the three core categories that emerged as a consequence of data analysis, engagement with the process, and the theoretical literature This resultant narrative was manually organised to follow the suggestion of Dey (2005 p 180) who advises “identifying connections between categories” and making “hyperlinks between different bits of data” and in this case it was done on the basis of an “explanatory link” which identified three core categories (appendix F) The next issue to be addressed for the researcher was the issue of developing a theoretical framework for regulatory approval of general nurse education programmes

- 7 Phase two data collection was achieved through a key stakeholder focus group discussion. The principles utilised by the researcher in data generation of phase two of the research process was concept development described by Schwartz-Barcott and Kim (2000). The key stakeholder focus group in preparation for this task were presented with a background presentation related to principles associated with governance that were developed by the researcher from her engagement with the research processes, the literature review and the theorising described above as a research process utilised by Tuckett (2005), Erdley (2005) and Cheek (2000) where there was a reconceptualising the taken-for-granted understandings of regulatory approval. The principles as adapted for this research process (CAUSN 1995, Department of the Taoiseach, 2004) which formed the basis of “focusing and bounding decisions” (Miles and Huberman 2004 p 31) as presented are outlined in appendix H. The key stakeholder focus group was convened with an open question to guide the discussion to reflect on the core categories of the findings and discuss in open format the processes the regulator needs to develop in order to fulfil its regulatory function in relation to the core themes (appendix G).
- 8 The key stakeholder focus group had two tasks: one to explore the open questions (appendix G), and two to develop the principles for construction of a framework of regulatory approval. The open discursive format of the focus group led to the generation of debate on the process of nurse regulation as the core categories/findings of stage one. The notes generated from the group are included in appendix J. Analysis of this documentation “through reduction by selection, through summary” (Miles and Huberman 2004 p 11) allowed the group provide data to develop the final principles to inform the theoretical framework for programme approval (appendix M).

Key Stakeholder Focus Group

It is suggested by Morgan that focus groups are under-used in social research, although they have a long history in market research (1997) and Webb (2002) and

more recently Jacoby et al utilised them as a form of data gathering in nursing research (2005) Powell and Single define a focus group as

a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research (1996 p 499)

Although a form of group interviewing focus groups are distinguishable in being “an interaction within the group based on topics that are supplied by the researcher” (Morgan, 1997 p 12) whereas group interviewing involves interviewing a number of people at the same time, the emphasis being on questions and responses between the researcher and participants (Parahoo 1997 p 298) Hence the key characteristic, which distinguishes focus groups, is the insight and data produced by the interaction between participants based on the purposive sampling, which leads to development or engagement with the topic Webb (2002) contended from her study that the method had the ability to bridge the gap of understanding on a topic

In policy research expert focus groups are widely used as a conduit for “behaviour change in tandem with problem definition” (Pestieau 2003 p 12) In these circumstances participants have specific experience of or opinion about the topic under investigation Couchman and Dawson (1996) contend that an explicit interview guide should be used and that the subjective experiences of participants are explored in relation to predetermined research questions Sampling for focus groups is usually related to purpose (Jacoby et al 2005) and in this study it was purposive to reflect the key stakeholders in general nurse education

The attitudes, feelings and beliefs of the participants may be partially independent of a group or its social setting, but individuals enter the social gathering and the interaction of the organised event guides a focus group (Parahoo 1997) An individual interview on the other hand aims to obtain individual attitudes, beliefs and feelings, focus groups elicit a multiplicity of views and emotional processes within a group context as seen by Jacoby et al (2005) when retrospectively they investigated donor and non-donor family members’ perceived social support needs while facing the death of a loved one

Focus groups can be used at the preliminary or exploratory stages of a study (Kreuger 1988), during a study, or to evaluate or develop a particular programme of activities (Race et al 1994), or after a programme has been completed, to assess its impact or to generate further avenues of research. They can be used either as a method in their own right or as a complement to other methods, especially for triangulation (Morgan 1997) and validity checking. They are however limited in terms of their ability to generalise findings to a whole population, mainly because of the small numbers of people participating and the likelihood that the participants will not be a representative sample. Examples of research in which focus groups have been employed include understanding how media messages are processed (Kitzinger 1994 & 1995), an education study of school districts (Stufflebeam 1997), to explore from an Enrolled Nurse perspective what it was that prevented them coming forward for conversion to the First Level of the UKCC Nursing Register (Webb 2002) and an examination of the needs of families faced with the option of organ donation (Jacoby et al, 2005).

Although there are advantages to using focus groups in research as with all research methods there are limitations. According to Gibbs (1997), some limitations can be overcome by careful planning and moderating, but others are unavoidable and peculiar to this approach. The researcher, or moderator, for example, has less control over the data produced (Morgan 1997) than in either quantitative studies or one-to-one interviewing.

The Organisation of the Focus Group

Gibbs (1997) contends that one of the challenges in organising a focus group interview is getting people to group gatherings and setting up appropriate venues with adequate facilities to capture the interactions. The literature shows different recommendations in respect of the ideal number of people per group. According to Cohen Manion and Morrison (1994) the ideal is usually six to seven although MacIntosh (1993), suggests up to ten but some researchers have used up to fifteen people (Goss & Leinbach 1996) or as few as four (Kitzinger 1995). Numbers of groups vary, some studies using only one meeting with each of several focus groups (Burgess 1996), others meeting the same group several times. Focus group sessions usually last from one to two hours. Neutral locations can be helpful for

avoiding either negative or positive associations with a particular site or building (Powell & Single 1996) Gibbs (1997) contends the focus group meetings can be held in a variety of places, for example, people's homes, in rented facilities, or where the participants hold their regular meetings if they are a pre-existing group

The Sample

The purposive sampling frame was chosen according to the criteria identified by Exstron (2001) who consider the five most obvious agencies with a vested interest in competency from a State Board of Nursing perspective were

- 1 Individual nurse
- 2 Employers of nurses
- 3 Nursing educators
- 4 The nursing profession
- 5 Boards of nursing

In this study the group was seven members reflective of the nurse management, nurse education two sectors, the nursing board, clinical practice, health board management and nurse practice development. The chosen sample was selected from databases representing the five groups above on a random basis. The meeting lasted three and a half hours. Notes were taken throughout by a neutral note taker/typist, as it is difficult to tape record a group meeting when a number of people are talking together. The notes of the meeting are presented in appendix J. The venue was neutral and refreshments were supplied to ensure the group relaxed and participated as recommended by Gibbs (1997).

The Role of Moderator

As recommended by Gibbs (1997) the role of moderator or group facilitator was in providing clear explanations of the purpose of the group by outlining the principles of governance from the perspective of nurse regulation (CAUSN 1995) and the culturally relevant form (Department of the Taoiseach 2004), helping people to feel at ease by providing lunch, and facilitating interaction between group members by giving the group an individual open question guide related to the core categories identified from the data. The role of the moderator turned out to be one of promoting debate and assisting the group to tease out a diverse range of meanings on the topic under discussion without getting involved or participating in the outcomes. A secretary, independent to the process, kept notes of the interaction.

in the discussion, thus alleviating the moderator and the group members from diverting their attention

Data Analysis

The evaluation design for this study was based on the comprehensive theory-driven evaluation approach suggested by Stufflebeam (2000), Stake (1985), Quinn Patton (1997) and Alkin (2004) to effect accountability through social inquiry for the regulator of nursing in Ireland. The mixed methods for gathering data in respect of each programme were distilled using a matrix design of elements from the above theorists to gather an overall national picture of the implementation of the requirements and standards of the nursing board and make recommendations for programme improvement on a national level by developing the story of general nursing in Ireland through utilising narrative descriptions. The data being analysed is mainly of a narrative form (written documentation, reports) and also includes descriptive data that can be quantified as frequency, range and mean deviation.

Generating a category set reflects the type of data being analysed and also the aims, inclinations, knowledge and theoretical sophistication of the researcher (Dey 2005 p 97) "Generating categories can occur from the data itself." In this method similar data or related data is grouped together. The items then can be brought together looking for "interesting similarities or differences within the data" (Dey 2005 p 95). Distinguishing the related pieces of data therefore becomes the challenge. Criteria for identifying data are required for decanting the useful from the not so useful and making a distinction between the conceptual and the empirical as well as the emergent. Developing categories from the data itself or the ground (Corbin and Strauss 1987) requires a line-by-line approach to generating categories. Each line is examined as "a 'bit' of data and is considered against other 'bits' of data" (Dey 2005 p 103). The aim is to generate theory that is fully grounded in the data.

Once categories have been developed in this detailed way the researcher can identify the most relevant categories for further elaboration and thus proceed to a more integrated analysis around the core categories, which emerge from the process. In situations of policy research in particular where a set of categories exists, the analysis can move through sub-categorisation toward an integrated approach associated with

the 'middle-order categories' described by Dey (2005 p 104) Dey (2005) describes the middle order approach as one that is particularly suitable to qualitative data that is bound in a structure "Policy issues and programme conditions in evaluation research can provide a framework for generating a middle-order category set which can already be anticipated in the identification of 'key issues' used in collecting data" (Dey 2005 p 104) He further contends that this analysis in this mode lends itself to a number of approaches and especially a bit-by-bit approach applied to part of the data is most useful in generating categories for the analysis "The main purpose of a middle-order category set is to make possible a more detailed inspection of the data by extracting and ordering observations through some broad preliminary distinctions" (Dey, 2005 p 106) In adopting too narrow an approach to analysis i.e. identifying individual 'bits of data' the essences of the interaction can be lost (Dey 2005 p 117) In managing the data to 'meaning units', as opposed to 'bits', there is a respect for the integrity of the data where the sense of the overall meaning of the data is preserved Ordering the 'bits' into 'units of meaning' in assigning categories involves going through the data case by case in a systematic way and deciding whether and how bits of data should be categorised This step needs concentration to ensure all the data is considered and attributed to the appropriate category Categorising the data is not a mechanical exercise but it requires continual judgement both in assigning the categories and also on whether to modify the decisions already made

To be analysed the data must be interpreted Dey (1993) suggests, "analysis can go beyond interpretation" (p 94) Conceptual tools are required to classify and compare the issues under study This requires a process of abstracting from large amounts of data to find the salient issues being studied Dey (1993 p 94) "warns that abstractions are powerful means of making comparisons" and although they lend to greater clarity and precision their origins and context must be remembered Dunne (1997 p 141) suggests "interpretation is always the articulation in language of what we have understood" He further contends that "to interpret a text is to make it speak and to do this one must be able to make it available in the language of the situation into which it is to speak Interpretation is then a process of assimilation through which what is to be understood is drawn into the living discourse of the interpreter" (Dunne 1997 p 142) In summary the categories emerging from this exercise highlight areas whereby the

structures and processes of the whole programme for general students nurses are reported for the regulator through the existing standards

PROCESSING OF THE DATA

The data collection process yielded rich amounts of material that need to be systematically analysed in a logical fashion and follow an audit trail to outline the decision-making associated with processing the data. In this study an individual case synopsis (Miles and Huberman 1994 p 88) was made for each of the 13 programmes from the available official documentation held by ABA in respect of the programme. The entire documentation available related to an individual programme was read, re-read and re-read until the researcher felt familiar enough with the texts to provide answers to the questions forming the social units derived for the study (appendix C) and designed to reflect the Requirements and Standards of ABA (2000) and the recommendations of the Nurse Education Forum related to evaluation. The resulting document emerged as an individual case synopsis of the programme, which reduced the original documents and provided insights into how the programme was achieving or not achieving or trying to achieve compliance with the identified indicators for meeting the requirements and standards of the programme (ABA 2000). The answers to the individual questions, which formed the social units of data from each of the 13 colleges, were combined together into composite social units (Miles and Huberman, 1994) containing databits (Dey 2005) from each of the individual social units (n=619) (appendix D). In total 3846 databits were made from the raw data of curricula, site visit reports, annual reports of 13 general nurse education programmes and the self audit report of some programmes [c2, c3]. These produced databits gave rise to foundation patterns or codes, which as described by Miles and Huberman (2004 p 56) are "labels for assigning units of meaning to the inferential information compiled during the study". The analytic process was applied to the databits that were reduced to the 157 broad categories, which emerged and were related to the evidence within the retrieved data for the individual programmes against the individual standards of ABA (2000). The expert group, as discussed, verified and identified the broad categories previously discussed. The broad categories were examined which led to further distillation of the data to theoretical units that emerged as 13 higher order categories and further engagement with the literature and theoretical concepts and

examination of the higher order categories led to the final three core categories of governance, quality in education, and knowledge for practice

The second stage of systematic inquiry in relation to the data was to engage a key stakeholder focus group comprising representation from ABA, nurse education university sector, nurse education institute of technology sector, nurse management of a health care institution, nurse in clinical practice, health board management and nurse practice development examined the core categories extracted in respect of phase one of the research process. In a second phase of data collection the key stakeholder focus group were given a presentation by the researcher related to theoretical underpinnings of regulation (appendix H) as advised by Schwartz-Barcott and Kim (1993). Following from this presentation the group were asked to examine the open questions (appendix G) derived from the core categories in the knowledge of regulatory principles (appendix H based on CAUSN 1995, Department of the Taoiseach 2004) presented to them by the researcher. The emergent notes from the key stakeholder focus group (appendix J) were considered for analysis using the grounded theory stance of Lincoln and Guba (1989) who argue that the epistemological foundations of qualitative research are based on values and value judgments, not facts. In a common view held in the field, they claim that the researcher's values guide and shape the research conclusions because the researcher is busy constructing the reality of the inquiry. At the same time, the researcher had to be sensitive to the realities created by others involved, and the consequent changes and differences in values. All findings in a qualitative study, and, therefore, all "truth" claims, are socially constructed and negotiated (Lincoln and Guba 1989 p 160).

Lincoln and Guba (1989) using grounded theory principles within the qualitative research paradigm strive for the research process to conform to the rigours of "empirical" and "scientific" quantitative research, even though the philosophical foundations of qualitative research, from their perspective, is ontologically relativistic and epistemologically guided by subjective value judgements. Lincoln and Guba (1989) solve the "empirical problem" by utilising the "Grounded Theory" approach to develop comparators for the established research values such as reliability and validity measures. They validate the researcher as the primary "research instrument" of the research endeavour, and charge the researcher with the task of going through

the data with the intent of identifying "themes" that "emerge" from this data. In this case it is the core categories that emerged from the first stage of the research process. The process of fieldwork was the data generated from the key stakeholder focus group interview, which was considered with the theoretical literature of regulation and specifically culturally relevant frameworks.

The final analytical phase to develop the framework that emerged reflects the process attributed to Lofland (1974 p 102) who in a typology to evaluate ethnographic writing in terms of its overall structure described the eventful frame where "the framework was eventful in the sense of abundantly documented with qualitative data" (cited in Hammersley and Atkinson 1993 p 214). Schwartz-Barcott and Kim (1993) outline the three stage approach associated with the hybrid model of concept development as an interactive process of fluidity between the theoretical phase, the fieldwork phase and the final analytical phase where "the investigator steps back from the intensity and details of the fieldwork and re-examines the findings in light of the initial focus of interest" (p 123). They further advise that if the initial concept was supported the researcher should "begin by going back to the initial, tentative definitions and listings of key elements in, and analysis of, these definitions" (Schwartz-Barcott and Kim 1993 p 124). The writing up of such findings is further advised by Schwartz-Barcott and Kim (1993 p 127) as most reflective of "grounded theory approaches". In this incidence "the focus is on categorising key concepts and explicating theoretical relationships, rather than on defining and measuring these concepts" (Schwartz-Barcott and Kim 1993 p 127). They further encourage humanistic and reflexive styles of writing up the report. The audit outline of processing the data for this study is outlined in appendices H, G and J.

The "final analytic phase" as described by Schwartz-Barcott and Kim (1993) was conducted by the researcher where she linked the discussion findings of the key stakeholder focus group to the original theoretical outline provided to the group and in devising a new structure sought validation of the findings of the emergent framework from the members of the group. The emergent framework for overall regulatory approval was supported by the key stakeholder focus group.

RIGOUR OF THE STUDY

In a qualitative study, such as this, the issues surrounding objectivity and subjectivity, reliability and validity need to be explored as suggested by Field and Morse (1994) to acknowledge the process of research. Qualitative researchers according to Sandelowski (1986) need to explain if the form of inquiry is a form of scientific enquiry demanding a clear explanation of method or a form of artistic inquiry demanding faithfulness to the unique visions of those involved in the research process. Polkinghorne (1988 p 175) refers to “validity, significance and reliability” in respect of narrative research. He contends that “valid” refers to “grounded and supportable” and in respect of theory “validity” refers to the “relationship between the measuring instrument and the concept it is attempting to measure” (Polkinghorne 1988 p 175). Further in this debate is the contention that narrative research “does not produce certainty, it produces likelihood – an argument is valid when it is strong and has the capacity to resist challenge or attack” (Polkinghorne 1988 p 175). The issue of significance is addressed if the finding is important and reliability refers to “dependability of the data” (Polkinghorne 1988 p 176). While this perspective reflects the underpinning philosophy of the research method in narrative research other theorists suggest alternative wordings associated with the concepts traditionally referred to as reliability and validity in quantitative research (Polit and Hungler 1996). Lincoln and Guba (1985) suggest that dependability and confirm ability is achieved through close adherence to an audit trail. This audit trail allows for a clear description of the processes of collecting and analysing the data. Stringer (1999) contends it provides a means of demonstrating the raw data to the reader. In order to ensure confirm ability several procedures were employed during this study. Lincoln and Guba (1985) urge the researcher to maintain a residue of notes stemming from the enquiry.

By following this structured audit trail the researcher aims to demonstrate the steps taken to address issues of dependability and confirm ability. In addition ethical considerations were observed and a non-judgemental interest was conveyed during the study. The researcher enhances credibility by including rich descriptions of the study’s themes in the data presented in the study (Sandelowski 1986).

This study examined the standards normally applied in making quality judgments of evaluations, for example, the Joint Committee on Standards for Educational Programmes (Sanders 1994). The approach according to Stufflebeam (1997) is useful during the evaluation process as procedural checklists and afterward in assessing the completed evaluation report for determining the quality of the processes to achieve the product.

These evolved from an effort to produce criteria more or less parallel to those conventionally used, i.e., internal and external validity, reliability, and objectivity. They are probably most useful, first, in guiding methodological decisions during the evaluation and later in auditing the overall evaluation process. However, their very "parallelism" to positivist tenets, renders them less than fully adequate for determining the quality of a mixed approach that emerges as a narrative (Polkinghorne 1988).

In this study the utility standards (Sanders 1994 p 23) are intended to ensure the information needs of intended users are met. In this instance the researcher was the intended user. The "evaluator credibility" standard requires the evaluator to be trustworthy and competent so that the "findings achieve maximum credibility and acceptance" (Sanders 1994 p 23). In this instance the evaluator is employed as the accountable executive member of the Board in respect of programme approval mechanisms. The standard of "information scope and selection" of the report, roughly parallel to internal validity, was established by prolonged engagement with the curriculum, self-audit reports, on-site visit reports and continuous testing of standards as compliance data, preliminary categories, and confirmation of interpretations with existing report data by the HEI concerned. "Values identification" is carefully outlined in the audit process engaged in by the evaluator. The standard of "report clarity" was specifically designed in the narrative to explicate the story of general nurse registration programmes supported by evidence but engaging enough to illuminate issues for further exploration at a notional level. In relation to "report timeliness and dissemination" and "evaluation impact" the support of the Board is acknowledged in the provision of time to conduct the study and the availability of documentation (Sanders 1994 p 24). It is anticipated that this will be utilised in reviewing current systems.

The “practical procedures” refers to the “process of collecting and using information to judge the worth and merit of a programme” (Sanders 1994 p 65) In this incidence the study was being conducted for personal study purposes and therefore was curtailed at a methodological level from being a national consultation or perceived as a change of policy in that the profession were struggling with a great deal of concurrent change at the time of examining the processes. The methodology chosen did not require buy in from a large number of people or institutions and it was thus feasible to conduct the study using the methodology chosen. The “propriety” standards have been discussed as part of the ethical issues of this study. The section of standards related to “accuracy” are “intended to ensure that the evaluation will reveal and convey technically adequate information about the features that determine the merit or worth of the programme” (Sanders 1994 p 125) The data collection section of this report outlines a clear audit trail of “programme documentation”. The defined “purpose and procedures” of the evaluation were in respect of regulatory approval and as such were “identified”. The sources of information were described in detail to assess and make comparisons of the data. In this incidence the accuracy of the documentation in the curriculum was verified to some extent through the site visit report but the most important aspect of the evaluation was in the standards and requirements of the Board itself and the structures to effect regulatory approval. The general “context” of nurse education and regulation were presented from a review of the literature. The remainder of the accuracy standards are outlined as issues of data analysis in relation to “valid information,” “reliable information,” “systematic information,” “analysis of quantitative information,” “analysis of qualitative information”. The standard of “justified conclusions” was addressed by the verification of the broad categories by the expert group.

Dependability, roughly parallel to reliability, was established for this study through the use of the dependability audit trail established by the researcher and included in the appendices of this report. The researcher was dependent on the availability of documentation to support her study. The generation of the reports used was from a number of people from the HEI sector and the education and training committee of ABA. In all circumstances however the dependability of the documents used was assured through the confirmation process afforded to each institution in respect of

their individual programme at the time following the site visit. Every effort is made by the researcher to distance herself from the findings and final report to ensure “impartial reporting” (Sanders 1994 p 145-184)

Summary

The narrative nature of this study, which relied on documentary evidence and analysis, raised issues about representation. It required analysis of the sensitive and politically difficult issues of regulatory approval approaches and processes. It reveals the struggle of coming to terms with systematic inquiry in evaluation research where the purpose influenced the approaches that in turn influenced the methodology to substantiate the robustness of the research study.

Conclusion

This chapter has attempted to present the rationales for the methodologies considered and chosen to conduct an evaluation study of the regulatory approach to general nurse education. The step-by-step descriptions of the methods to collect and analyse data and develop a theoretical frame to underpin the study are presented in an attempt to address the issues of trustworthiness in a qualitative study such as this. The findings correlating to the objectives of the study are presented in the next chapter.

CHAPTER FIVE - FINDINGS AND DISCUSSION – PHASE ONE

INTRODUCTION

This study was undertaken to inform the regulatory body of a mechanism of accountable regulation that utilises social inquiry methodologies to evaluate the effectiveness of the “Requirements and Standards for Nurse Registration Education Programmes” (ABA 2000) of the Board. It was also designed as a mechanism to fulfil the Board’s obligation to “prescribe the manner and the conditions under which training shall be provided for general nurse education” (Nurses Act 1985 31)

This study

- examined the “provision for courses of training and examination to be taken by candidates for registration” (Nurses’ Act 1985, 31) currently operating and
- explored how the “Requirements and Standards” (ABA 2000) met the obligation to “specify conditions of suitability for hospitals and institutions” (Nurses’ Act 34 (2), 36 (1, a)), “the standards of theoretical and practical knowledge required for examinations,” and “the clinical training and experience provided in any training programme organised by a hospital or institution approved of by the Board” (Nurses’ Act 36 (b), (c))
- And proposes a framework of accountable nurse regulation to promote high standards of professional education and training” fulfilling the functions of ABA assigned to it by the Nurses’ Act (1985)

The main purpose of the study was to formulate a systematic, structured regulatory evaluation approach for general nursing programmes capable of supporting the development of meaningful professional nurse regulation. This chapter presents the findings and discussion of the study that was designed to meet the three general perspectives of evaluation identified by Chelimsky and Shadish (1997, p 10) i.e.

- Evaluation for accountability (e.g. the measurement of results or efficiency)
- Evaluation for development (e.g. the provision of evaluative help to strengthen institutions)
- Evaluation for knowledge (e.g. the acquisition of a more profound understanding in some specific area, or field)

More succinctly it can be interpreted according to Patton (1997 p 65) who determined a menu for using findings of evaluation research as “making overall judgements, facilitating improvements and generating knowledge” Fitzpatrick et al (2004) identify that standards, as a quality tool, can signal areas that may have been overlooked in the focus of an existing programme In this respect the focus of data collection for this study was informed by the Requirements and Standards for Nurse Registration Programmes (ABA 2000)

The initial research question asked was Are the general nursing programmes meeting ABA Requirements and Standards (ABA 2000)?

In addressing this question a mixed methodology was utilised in which the thirteen programmes offering the Degree/Registration programme were individually examined utilising a wealth of documentation available to ABA from 2001 to 2004 The Registration/Degree programmes in General nursing were examined against existing ABA Requirements and Standards for Nurse Registration Education Programmes (ABA 2000) The second phase of data collection was a key stakeholder focus group interview that provided guidance on the way forward in respect of the framework

The challenge of presenting these findings lies in making sense of a very large amount of data that was accumulated through curriculum review, site visit reports, self-audit reports, annual reports and some correspondence Every effort has been made to reflect the data according to the quality and ethical principles espoused by the Joint Committee on Standards for Educational Evaluation (Saunders 1994)

FINDINGS - PHASE ONE

Good data analysis requires efficient management of the data (Dey 2005 p 7) The findings for this study are narrated as “a storied account of an experience constructed from written reports and interview” (Hoshmand 2005 p 181) Decisions related to how the data was managed, to enable a focus on “meaning making” with the aim of

“illuminating meaning” (Hoshmand 2005 p 184) was established through generating displays (appendices A-FB) of the decision-making processes. The broad categories identified by the expert group were clustered by the researcher to form common themes associated with linkages and were split into these themes. The researcher developed a grid of broad categories and from examining connections with the literature formed higher order categories by asking the questions for “splicing data” advocated by Dey (2005 p 151) i.e.

- How central are the categories analytically?
- How are they distinguished conceptually?
- How do they interrelate?
- Are they inclusive or exclusive?
- Are they of the same status or super/subordinate?
- What steps in analysis led to their emergence?
- How have category definitions evolved?
- Does evidence of retrievals support these definitions?
- How much data do the categories encompass?
- How well do they discriminate among databits?
- How much overlap is there between categories?
- How do categories contribute analytically?

Categorising data, according to Dey (2005), is a powerful tool for organising an analysis that allows an exploration of the data in terms of the research. This requires abstraction of the data from its context. This was achieved for this study by forming the tables of themes. The interpretation of the theme leads to a reconceptualisation (Dey 2005) or a chain of evidence (Miles and Huberman 1994). The linkages (Miles and Huberman 1994 p 42) that emerged were formed from “noting patterns” and “building a logical chain of evidence” (Miles and Huberman 1994 p 100) and relocating the core categories with the literature. The responses associated with the individual detailed reports of each institution, from the analysis and verification of the findings of the documentation in the form of the curricula presented to the education and training committee, the on-site visit documentation and the annual reports received from colleges and the recommendations made by the Education and Training Committee and in some cases the self-audit report submitted by a college (see appendix C). An expert group was convened to identify the broad categories from this initial data (see appendix D). A narrative report based on the broad categories is presented along with the process used to focus the analysis and re-conceptualise (Dey

1993 p 127) it within higher order categories that led to the three core categories presented (see appendix F B) in conjunction with the literature. In presenting these findings cognisance is taken of the warning from Patton (2002 p 433) “there are no formulae for determining significance, there are no absolute rules except to do your very best with your full intellect to fairly represent the data ”

As described by Dey (2005 p 139) “conceptual relevance was established in terms of the main interests and objectives” and further he posits for the researcher “the data provides an anvil upon which we can shape and sharpen our ideas ” In transposing the data by this method of analysis consideration needs to be made of the relevance and boundaries of the categories themselves. Dey (2005 p 150) further contends that “we must first identify clearly the separate strands if we hope to weave them together” and in this study an examination of the data generated from the documentary analysis and an expert sub-group led to the three core categories of **governance, quality in education, and knowledge for practice**. The story of general nurse education programmes as gleaned from the evidence from each of the colleges is thus presented within the three core categories.

GOVERNANCE

The linkages associated with the emergence of governance as a core category are allied with the terms of the broad categories of partnership, systems/processes and support structures. The linkages led to governance which is associated with the definition of the European Commission the “rules, processes and behaviour that effect the way in which powers are exercised particularly as regards openness, participation, accountability, effectiveness and coherence” (European Commission, European Governance - A White Paper, 2001). These linkages are presented as they reflect the processes to support the structures required as evidence of achievement of the eligibility for registration. The “patterns, explanations, possible configurations, and causal flows” led to the “proposition” of Governance as a core category (Miles and Huberman 1003 p 11) based on the engagement of the researcher with the theoretical literature of governance which particularly reflected the necessity for “an

efficient and well-founded regulatory system and gives strength and certainty to society and the economy” (Department of the Taoiseach 2004 p 20) of the programmes Accordingly the table of themes is presented to illustrate how the interpretations for the higher order categories emerged as partnership, systems/processes and support structures

CORE CATEGORIES GOVERNANCE			
Higher Order Categories Making Up Governance			
B R O A D C A T E G O R I E S	<i>Partnership</i>	<i>Support structures</i>	<i>Systems/Processes</i>
	Committee	Course document	Entry criteria
	Group	Course handbook	Exit criteria
	Management	Marks and standards	Attrition rates
	Co-ordinates	No compensation	Interruption policy
	Administrative staff		Record of theoretical and clinical assessment
			Eligibility for registration

Table 5 1 *Higher Order Categories in Governance with the associated broad categories*

PARTNERSHIP

The higher order category partnership was spliced from the broad categories that were identified by the expert group from the databits and reflected in terms such as “committee,” “group,” “management,” “co-ordinates,” and “administrative staff” These terms according to the expert group reflect governance terms associated with how the programme partnership structures and processes support implementation, feedback and changing the programme

Committee / Group

All colleges had a partnership structure of some kind with a number of committees and groups evidenced in colleges The evidence that supports the emerged broad

categories of “Committee” and “Group” were from such databits as “course committee” which was found in six colleges [c2, c3, c4, c9, c11, c13] while another college reported that it had “a strategic group for the management of all registration programmes” [c7]. Despite the variety of terminologies used for partnership processes it is interesting to note the variety of committees identified from the documentation. These committees included joint academic working groups (JAWS) in one college [c9], with programme boards in four others [c2, c3, c5, c7], boards of studies in another [c6], steering committee in another [c12], a nurse education committee in another [c8], a course committee in six colleges [c2, c3, c4, c9, c11, c13], a local joint working group in two [c7, c13], a course board in two others [c9, c10], a professional advisory group in another [c5], a strategic group in another [c7], and a curriculum development group in another [c1], a staff and student consultative committee in another [c12] while another had a programme development group [c7]. Two colleges had two committees [c2, c3] one college had three [c5] one college had four [c7]. The observation that some colleges only required one committee is noteworthy when other colleges required four. However, this can be explained by a databit from one college who suggest, “Board of studies oversees the whole programme a range of committees function to co-ordinate the theoretical and clinical dimensions of the programme and facilitate effective liaison between the hospital and the university” [c6]. The main issue that emerges for the regulator in respect of committees is that the Board should ensure a committee is identified to monitor the programme and effect change as required. The committee must represent the partnership relationship of the programme to effect change and provide feedback to the programme. The board should monitor the activities of the committees to oversee the requirements of professional preparation.

Management / Coordinates

The purpose of these committees and groups was gleaned from the broad categories “management” and “coordinates” which was articulated by seven colleges which are reflected in the databit “meets to coordinate and manage the programme” [c2, c3, c4, c5, 8, c9, c12]. The notion of multiple committees to manage a multiplicity of functions associated with the programme implementation was evidenced in one

college by “the use of a flow chart detailing the committees and structures that manage the programme. A comprehensive detailed breakdown of the role and function of the key stakeholders within the management of the programme was provided” [c6] and in another college “site visit team was provided with a detailed breakdown of the local, regional and national committee structures in place” [c11] although what these structures were, is not outlined. While these broad categories emerged from the data it can be gleaned that a variety and range of programme management structures existed within the partnerships. The autonomy of these partnership structures must be compared between colleges where it appears there is a mixture of approaches evidenced by “agreement to major amendments will be obtained from (accrediting body) in a number of colleges [c4, c8, c9, c10, c11, c13] to “terms of reference of programme board includes “consider and recommend to Faculties new programmes following recommendation as appropriate from Course Committee” [c3]. The independent nature of the partnership committees within the university sector as opposed to the institutes of technology can be deduced. The programme board had in one college “the overall remit of programme development and monitoring quality” [c2]. This begs the question of the amount of meaningful partnership that can pervade to institute change, particularly where the health services have an issue related to the programme structure. This tension was reported in one college with “site visit report states challenges existed in relation to change and the differing perspectives within the partnerships” [c12].

In determining partnership the data were examined to look for clues of who was involved in the various committees. It can be gleaned that students were members of committees in two programmes [c5, c12], but this was not the norm throughout all programmes. Five other colleges’ committees, had “representation from college, nurse education, nurse management and clinical staff” [c4, c8, c9, c11, c13]. In one situation the “Professional Advisory Group exists to work in partnership with and provide advice of all relevant professional nursing and health service issues to the Head of the School” [c5]. In another it was seen that “membership emphasises partnership between the key stakeholders in the college and the health care institution” [c3]. While it can be deduced that partnerships exist the regularity of the

meetings, the agenda followed and the minutes were not reported as having been seen by the site visit reports and thus the capacity for instituting review and change or addressing problems encountered cannot be determined

Another membership issue associated with management of the programme was evidenced in one college where a databit suggests “nurses are central to the course board, academic council and the exams board” [c10] although no other evidence was found to support this contention and it was not universally evidenced that the partnership participated in exam boards or academic council. The membership issues, function and terms of reference for each committee group it is deduced was not collected. This it is suggested is an area particular to the achievement of meaningful partnership for programmes and as such should be countenanced as evidence worth collecting for the regulator of general nursing

Administrative Staff

A further broad category of relevance to managing the partnership of the programme was the provision of “administrative staff” as identified by the expert group. This broad category was derived from the databit in one college who aspired to the notion with “the teaching staff will be supported in their work by administrative staff employed within the school,” [c7] and in another college evidence was determined by “there was satisfaction expressed in relation to the administrative support provided this had been a concern” [c13]. In all other colleges no evidence had been collected or reported and as such the administrative links and processes to affect partnership workings have a potential for exposure. The reason why no evidence was collected should be noted and explored as to whether this was because there was no evidence or whether it was an issue that was deemed not relevant to the regulation of the programme in a college structure by both the reviewers and the college authorities. The necessity of keeping this standard needs exploration by the board

Summary

In summarising the higher order category ‘partnership’ a sense that does emerge is that committee/groups structures are present in a number of guises that vary from

college to college and that there was “evidence of partnership structure between college and health care institutions” [c10] Within one partnership communication was problematic, considerably limiting the operation of the committee structures as evidenced by “challenges existed in relation to change and the differing perspectives within the partnership” [c12] It should be noted however that a number of programmes collaborated in respect of curriculum development and “a national approach to curriculum development was adopted in the development of the curriculum” [c4, c8, c9, c10, c11, 13] The potential of this collaboration to effect change must be considered in the context of local modification to the programme as should the meaningfulness of the partnership to participate fully in all aspects of the programme structure including exam boards The appropriateness of the regulator requiring data on administrative staff is worth exploring The effectiveness of meaningful partnership as still an issue still remains unchanged since the publication of the NEATE report (1998) is one that warrants further exploration as to the perceived reasons between the stakeholders and the leadership requirements to effect them

SUPPORT STRUCTURES

The higher order category support structures reflect the “rules” (Department of the Taoiseach 2004 p 4) dimension of the core category governance The broad categories identified by the expert group were the “course document,” “course handbook” and “marks and standards” as mechanisms for prescribing and identifying the policies associated with the programmes, the mechanisms and requirements of the institution and guides to students for adhering and meeting these requirements These tools in the main provide a template to outline expectations to support the academic structure of the programme All the colleges refer that the curriculum outlines the proposed plan of the programme

Course Document

All colleges had evidence of a course document that was presented mainly in the form of a curriculum and this was presented to the regulator for approval prior to commencement of the programme However, it must be noted that six colleges had

taken a “national approach to curriculum development” [c4, c8, c9, c10, c11, c13] and two others shared a main document but they also included specific information related to the individual college, partnership, local philosophy and facilities to support a programme [c2, c3] The implication of the national approach adopted by the six colleges where no college or site specific information was included was that the document while embracing the tenets of the requirements for a general nurse registration programme as outlined by the regulator did not include local health profiles or philosophies associated with the local health care institutions where over half the programme is experienced by the students The connectedness of the course document to partnership expectations cannot be deduced from the evidence examined and especially the level of responsiveness to local health needs it is suggested warrants further examination

The size and breadth of the documents presented for approval to the regulator was noteworthy as a multiplicity of approaches were taken to presenting the documents The smallest document received was 86 pages [c1] long with the largest being 396 pages [c5] The type of information contained in the course document also varied with some colleges giving extensive detail in respect of philosophies, facilities, staffing, course plan, methodologies of teaching, assessment methodologies and plan, course outcomes and module descriptors with others gave only outline information of the module descriptors It could be deduced that the regulator should outline its expectations in the type of information required in a curriculum for submission

Marks and Standards / Course Handbook

It was not identified in the evidence reviewed, however, if the curriculum was provided to students on commencing the programme What was gleaned from the databits was that the structure to inform the student of exam regulations was provided in three colleges being in a “course handbook” [c1, c3, c5,] with the most common method of informing students of rules and regulations being seen as “copy of marks and standards in programme document” and this most popular method of ensuring knowledge of expectations with the schedule of examinations [c2-13] The marks and standards provided a kernel for these rules as evidenced in the databits “copy of

marks and standards in curriculum and also seen by the site visit team” [c1, c2, c3, c5, c6, c7] It was also reported that “students were given a copy in the course handbook” where it contained “details of the criteria for compensation, continuation and supplemental examinations” [c3, c5] Also attributed to the handbook was “the procedures for discussion, checking and appeal of examination results are explicit” [c2, c3, c5] The marks and standards and the course handbook were both utilised as mechanisms for communicating expectations of the programme to students Little evidence was collected in respect of the course handbook (three colleges) and this should be examined by the regulator as to whether the data was collected or deemed an issue as a mechanism for identifying requirements by the students of the programme It does appear that some mechanism exists and it would be useful to ascertain student perception as to the utility and effectiveness of each method with a view to establishing best practice of communicating expectations with students

No Compensation

The broad category “no compensation” as identified by the expert group was associated with a databit “no compensation reported” This theme has universal application to all programmes who all articulated in some manner that the theoretical and clinical components of the programme were not transferable in relation to compensation The marks and standards were also associated with detailing the following databit “no compensation reported and reference is made in the marks and standards” [c1], which is followed by a few other colleges suggesting “no compensation may be exercised from, or to, taught clinical placement” [c8, c9, c10, c11, c12] The notion that informing the students of the academic concept of requirements for achievement of the programme was evidenced in six colleges with “the curriculum states successful progression requires the student to be deemed clinically competent at each stage of the programme” [c4, c8, c9, c10, c11, c13] and “curriculum states students will be assessed on whether competence has been achieved within clinical practice and are deemed to be either competent or not competent and will be graded on a pass/fail basis” [c12]

Summary

In summary all the colleges had academic support structures of written curricula and marks and standards, with course handbooks being utilised in a small number of colleges. The awareness of the students of their existence was not collected. The objective of academic structures should be to support and inform students of the expectations of the programme to proceed and be successful. Having open systems that inform both the student and the public of the expectations of a programme supports “openness, participation, accountability, effectiveness and coherence” advocated by the European Commission (cited in Department of the Taoiseach 2004 p 4)

SYSTEMS / PROCESSES

The higher order category of systems/process is reflective of the “processes and behaviour that affect the way in which powers are exercised” (Department of the Taoiseach, 2004 p 4). The broad categories identified by the expert group reflect transparent systems and processes to promote consistency of approach with a student population of the general nurse registration programme. The broad categories associated with “entry criteria,” “exit criteria,” “attrition rates,” “interruption policy,” “record of theoretical and clinical assessment,” “eligibility for registration” were identified by the expert group.

Entry Criteria

The documentary structures associated with entry to the programmes were evidenced in most of the colleges. All colleges had policies associated with the broad category “entry criteria” to the programme, which is supported by databits such as “entry criteria explicit students comply with entry requirements of ABA and CAO” [c1-13]. The mechanism of this, however, is not reported or any reference to mature candidate entry procedures, numbers entering the programme and how they are complying with CAO policies. What was also not clear from the evidence was how procedures were operationalised and this is perhaps an area that could be examined by the regulator particularly in respect of overfilling or under filling the allocation of places and how this relates to workforce planning for the Department of Health and

Children, the funder of the programme The regulator currently maintains a candidate register of students who complete a form one month from commencing the programme There is no obligation of the student on the current programme to complete the form but it was traditionally a mechanism utilised to support the examination system that was maintained by the Board

Exit Criteria

A policy related to exiting the programme was found in a small number of colleges In examining evidence associated with the broad category “exit criteria” a databit from two colleges note “exit interview and form filling outlined in curriculum” [c2, c3] Another college reported, “exit criteria for students not achieving in the programme was identified in the Marks and Standards” [c6] However another college databits suggest, “exit criteria not reported” [c5] The variation of approach between the colleges is noted and the implication of not having an exit policy needs further exploration with colleges in light of the experience of running programmes One college however had a policy whereby “a mechanism exists to identify potential problems before they arise” [c8] and exploring the efficacy of this in relation to supporting student retention in the programme is an area that could be explored

Attrition Rates

In recognition of the popularity of general nursing as a career with applications exceeding places by a ratio of 5:1 (ABA 2005) it is useful to examine the attrition data of the programmes The broad category “attrition rates” identified by the expert group is useful to examine in relation to the exit criteria In examining attrition data in the absence of exit policies it must be questioned how the student informs the college of their intention to leave or indeed the criteria for progression The numbers of students exiting the programme, as reported in the annual reports submitted to the regulator, were noted and it is unclear as to the meaning of attrition whether the numbers reported refer to withdrawals and or deferrals The attrition rates noted on the annual reports and verified on the candidate register of ABA are outlined in figure 5.1

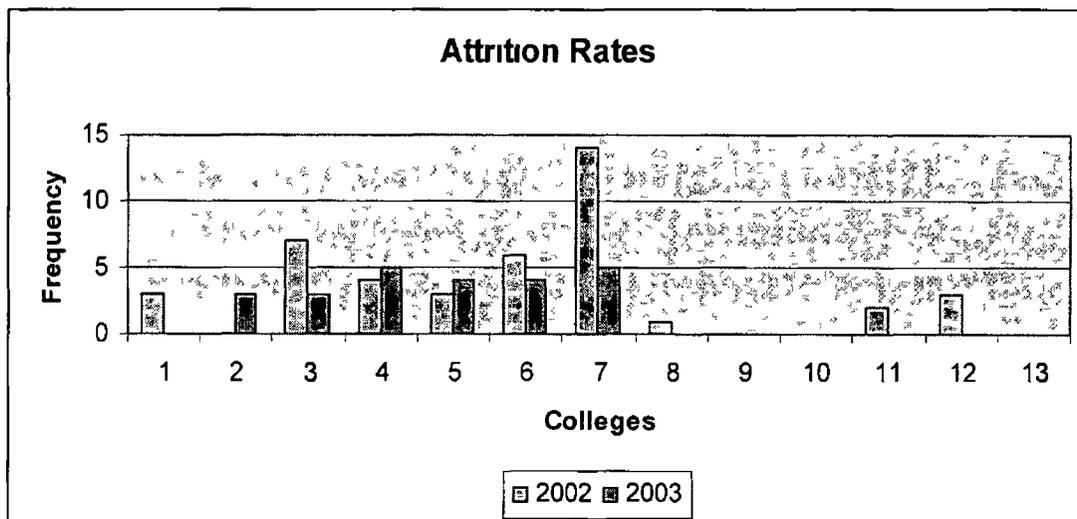


Figure 5.1 Attrition Numbers from the Colleges

Attrition from general nursing according to the data submitted to the regulator is not a large phenomenon accounting for 8.6% of entrants in 2002 and 3.5% between first and second years in 2003 as identified in the annual reports and candidate register of ABA. The accuracy of these numbers however is questionable in light of attrition data generally from education programmes in the HEI system and the fact that so few colleges submitted data in the form of annual reports. It is unclear if the numbers offered to the Board were of the students who self-selected to leave or who didn't achieve the progression requirements. Of note are "exit interview and form filling outlined in curriculum" [c2, c3] and "exit criteria for students not achieving in the programme identified in the Marks and Standards" [c6]. The information is incomplete as it was not submitted or collected in three colleges therefore complete data cannot be reported. The mechanism therefore operated by the regulator in respect of collecting data in the form of the annual report needs further exploration by the regulator. Another issue that warrants consideration is the efficacy of maintaining a candidate register that is not reflective of current attrition rates.

Interruption Policy

ABA has always made reference (ABA 2000 p 22) and provision for a student should they need, to interrupt their training programme for specified periods. In respect of students, the broad category "interruption policy" was identified as a component of

students meeting the requirements element to the programme. A databit of one college states “the issue of progression, EU requirements made explicit and no students referred to this matter” [c8]. Therefore it can be assumed that students have an accepting of the requirements of a professional programme as set out by the college. In view of this issue the presence of an interruption policy was evidenced in only three colleges [c2, c3, c6]. An example in one college, where the policy was explicit, is seen with the databit “all passed modules carry an exemption which is limited to a period of 5 years from the date the student originally achieved the exemption. Students who fail to complete required hours, and /or a pass judgement may repeat” [c6]. Associated with another college the databit read “the students reported they were unsure of the criteria if students missed time on placement due to illness or unforeseen circumstances” [c4]. Mechanisms to achieve the outstanding components of the programme are an issue as there was a diversity of approaches in the colleges. In examining the data it can be deduced that some colleges are more advanced in developing transparent systems and processes for governing the professional requirements of the programme. The benefits of having overt systems and processes in respect of determining eligibility for registration should be reinforced by the approval mechanisms of ABA.

Record of Theoretical and Clinical Assessment / Eligibility for Registration

The mechanism to collect the data to support eligibility for registration criteria was identified by the broad category “record of theoretical and clinical assessment”. Processes to support this system of identifying students had met professional general nurse registration requirements were evidenced from the databits in one college who acknowledged that “assessment records are kept in the examinations office” [c2]. Another two college’s databits suggest, “examinations office keeps records of theoretical and practice assessments” [c3, c5].

The student attendance issue is linked to the understanding the student has of meeting with EU requirements and therefore the programme requirements to achieve eligibility for registration. The broad category identified by the expert group of

“eligibility for registration” emerged as all programmes within the curriculum document outlined systems and processes to effect the rules associated with the regulator of nursing and understanding that the programmes were required to prepare a student for registration purposes. The databits that reflect this interpretation include “eligibility for registration is confirmed within the curriculum” [c1-8, 10-13] and “criteria for registration evident” [c9]. In identifying the professional expectations of nursing programmes, some colleges based the programme overtly on ABA requirements as seen by “curriculum based on ABA requirements” [c3, c5, c6, c7] and others on the EU requirements by “ensure minimum EU requirements are met” [c10] and others while being non-specific in making an overall statement of programme intent rather suggest “students must meet all requirements of the programme” [c7, c12]. It can therefore be assumed that the colleges interpret their programmes meet professional general nurse registration requirements. The notion of systems to support the identification of students who are eligible for registration is supported by the databits in a few colleges albeit in a variety of approaches whether underpinned by ABA or EU requirements. While it can be contended that colleges identify systems, examining the processes to gather data suggests otherwise.

Summary

In summary, the higher order category of systems/process is reflective of the “processes and behaviour that affect the way in which powers are exercised” (Department of the Taoiseach 2004 p 4). The broad categories identified by the expert group of “entry criteria,” “exit criteria,” “attrition rates,” “interruption policy,” “record of theoretical and clinical assessment,” “eligibility for registration” reflect systems and processes to promote “behaviour that affect the way in which powers are exercised” (European Commission, European Governance - A White Paper, 2001 cited in Department of the Taoiseach 2004 p 4) and consistency of approach with a student population of the general nurse registration programme. The colleges appear to have systems that ensure the requirements of the regulator related to rules and processes for identifying readiness for registration as a general nurse exist.

Conclusion

The core category “Governance” outlined issues of ‘partnership,’ ‘support structures’ and ‘systems/processes’ which feature as higher order categories reflective of the need of “rules, processes and behaviour that effect the way in which powers are exercised” (European Commission, European Governance - A White Paper, 2001 cited in Department of the Taoiseach 2004 p 4) The broad categories reflect issues warranting consideration by the regulator where colleges have adopted a diversity and variety of approaches, individually or collectively, in respect of one curriculum for six colleges Following up on this data the absence of systems and processes to effectively capture ways in which the regulator requires programmes to be governed or how the colleges themselves have developed systems and processes to effectively follow the governance agenda “particularly as regards openness, participation, accountability, effectiveness and coherence” (European Commission, European Governance - A White Paper 2001 cited in Department of the Taoiseach, 2004 p 4) highlights the need of the regulator to develop a regulatory framework that identifies “rules, processes and behaviour that effect the way in which powers are exercised” (European Commission, European Governance - A White Paper, 2001 cited in Department of the Taoiseach, 2004 p 4) if the regulator is to meet its mission of “protecting the public” (ABA 2004) with accountable systems In general it can be argued that governance systems are in place in the colleges The absence of indicators utilised by the regulator to compare and contrast data associated with the requirements and standards leaves a judgement of effectiveness untenable This challenges the current regulatory contribution to governance of the programmes The absence of clear indicators for programme developers also leads to confusion with understanding how to meet specific standards

QUALITY IN EDUCATION

The linkages associated with the emergence of ‘quality in education’ as a core category are associated with the terms of the broad categories of monitoring, resources and audit. These linkages which led to ‘quality in education’ being identified are associated with the broad categories identified by the expert group emerged from the databits that refer to basic principles associated with quality assurance and “demonstrating that quality” as advocated by the European Association for Quality Assurance in Higher Education (ENQA 2005 p 9). The European standards and guidelines for internal quality assurance within higher education institutions which comprise one part of the European standards for quality assurance (ENQA 2005 p 6) identify seven standards namely “policy and procedures for quality assurance, approval, monitoring and periodic review of programmes and awards, assessment of students, quality assurance of teaching staff, learning resources and student support, information systems, and public information.” In this respect the higher order categories ‘monitoring,’ ‘resources,’ ‘audit’ and ‘assessment’ were linked with the core category “Quality in Education.”

MONITORING

The higher order category of monitoring is reflective of a component of the “quality assurance of programmes” where there is “monitoring of the progress and achievements of students” (ENQA 2005 p 16). The broad categories identified by the expert group reflect formal mechanisms to promote consistency to monitoring the necessary regulations associated with the professional award of registration as a general nurse.

The broad categories to support this linkage appear as “individual student record,” “database,” “well monitored,” “monitoring in clinical placements,” “monitoring in college,” “difficulty in monitoring,” “transfer policy,” “ECTS,” “transfers,” “progression explicit,” and “annual report” were all associated with the notion of a mechanism to promote consistency to “monitoring” in one way or another.

CORE CATEGORY QUALITY IN EDUCATION					
Higher Order Categories					
	Monitoring	Resources	Student Support	Audit	Assessment
B R O A D C A T E G O R Y	Individual student record	Physical resources	Student services	Internal quality assurance	Assessment plan
	Database	Environmental resources	Student academic guidance	Quality and audit officer	Theory assessment
	Well monitored	Staffing issues	Health services	Clinical learning audit group	Clinical assessment
	Monitoring in clinical placements	Ratio	Counselling	Clinical audit	Progression
	Monitoring in college	Qualifications	Student clinical support		Assignment
	Difficulty in monitoring	Experience			Continuous assessment
	Transfer policy	CV's requested			Examination
	ECTS	CV's forwarded			Weightings outlined
	Transfers	Site report evidence			Competence
	Annual report	Prioritise the learning needs			Grading criteria
					Inter-rater reliability
					Early feedback
					External support
				External examiner system	

Table 5.2 Higher Order Categories in Quality in Education with Broad Categories

Individual Student Record

It appears all programmes did have a mechanism for monitoring the students' achievement of regulatory requirements. All colleges, as identified by the expert group in the broad category "individual student record" [c1-13] which emerged from the databit "individual student record maintained," suggests each college captured the attendance requirements of the students on the programme. The student record was identified in most of the colleges from the statement "student record is maintained by Allocations officer in the HEI with input from the health care institution" [c1-11, c13]. This suggests that there is integration in maintaining the student record between the college and the health service provider to indicate a central record of attendance in the college. The location of the central record of attendance however can be in the

School of Nursing and the exams office This contention is supported by the databit “data is centralised in the School of Nursing” [c12] and by another indicative databit “the Allocations Liaison Officer collates the clinical attendance information is amalgamated into one central record of attendance” [c13] and in another “all documentation from attendance at lectures and clinical placements are collated by the institute” [c8]

Database

The methodology of capturing the attendance achievements was identified by the expert group broad category as mainly through a “database,” as evidenced by “Database kept by the institute of individual student record” [c3, c4, c5, c7, c8, c9, c10, c11, 13] The utility of the “computerised record” [c3, c5, c8] was demonstrated in the databit “admissions and exam office maintain computerised record of student registration and exam results” [c3, c5] It can therefore be established that a mechanism for capturing regulatory requirements of individual student achievements exists in all colleges This mechanism embraces both the college and health care institution elements of the programme associated with an individual student It can however be inferred that elaborate mechanisms for monitoring the students are required to capture various elements of the record to ensure its completeness The college captures attendance of theory and collates this with the attendance in the clinical placements and another record is kept in respect of normal college issues of registration in the college and exam performance Typically therefore there are three elements to the student record to ensure the monitoring of achievement for professional nurse regulation purposes The burden this imposes on the management of the programme can be inferred from the individual broad categories associated with monitoring

Monitoring in Clinical Placements

Differences occurred with the monitoring system as the broad categories reveal codes of “well monitored,” “difficulty in monitoring,” “monitoring in clinical placements,” “monitoring in college ” The databits revealed a variety of success in some elements of monitoring student attendance in the programme Attendance monitoring

databases as discussed are maintained by the partnerships and the expectations of the students are illustrated to them by the databit “regulations regarding student attendance are clearly spelled out in the course and student handbook” [c9] and “mechanism for recording student attendance was explicit in the handbook” [c8] The variety of experiences associated with attendance monitoring had one common denominator in that monitoring attendance in the clinical component of the programme presented little difficulty for any of the programmes and this assertion is corroborated by the databit “Clinical placements well monitored” [c1-13] The clinical placement coordinator’s (CPC) and allocation staff were perceived as central to this process as demonstrated by this databit “CPC’s monitor placement attendance daily” [c8] The health services were very supportive of this element of monitoring as can be evidenced by one databit “clinical placements are well monitored and practice hours are measured to ensure each student has completed sufficient hours so that they may apply for registration on completion of the programme” [c5] It can thus be inferred that an accurate monitoring of requirements in terms of the clinical dimension of the programme is operationalised

Monitoring in College

The broad category identified by the expert group of “monitoring in college” however was the element that showed the most variety In a minority of colleges’ attendance was monitored daily as evidenced by “daily record of theoretical attendance” [c13] and twice daily in two colleges with “college record attendance twice daily” [c4, c10] and in three instances “attendance is recorded for every class” [c8, c9, c11] The commitment of these six colleges can be supported by an indicative databit of one college “policies, procedures and disciplinary approaches are used in a partnership approach to ensure minimum EU requirements are met” [c10] While the efforts of the six colleges to ensure EU and ABA requirements of registration were complied with the burden of this mechanism could be further explored

Difficulty in Monitoring

There is further evidence that this standard created challenges for some of the colleges by the databit “difficulties associated with recording attendance were

articulated” [c7] And this was further supported by another databit from three colleges “evidence reported less than 60% attendance in some lectures” [c1, c2, c3] In two colleges the databits suggest that “difficulty in monitoring lecture attendance but spot checks undertaken” [c1, c2] The difficulty was seen by individual lecturers in the databit “college lecturers within biological and social sciences have complained regarding poor attendance” [c6] In order to address this issue in other colleges there was evidence that the issue of recording attendance was refined, experimented with and changed over time by the databit “tutorial attendance in social science is afforded marks” [c6] and “attendance maintained during tutorials and laboratory sessions only” [c5] Some colleges however were trying to address the issues and committed themselves to devising a strategy for monitoring attendance as evidenced by the databit “spot checks are undertaken” [c6] and in another case there was “random checking of large groups” [c7] One other college monitored attendance in ways that were informal and unstructured as evidenced by the databit “recording student attendance occurs informally within the college” [c12] Significantly poor student attendance was addressed in a structured manner within one college “students with attendance problems are raised at programme board” [c7] In some programmes there was evidence that problems are addressed early with students in that the “secretary in the school keeps updated records of absences” [c9] This college further suggested that attendance and performance data is correlated with the databit “student attendance is discussed in combination with performance and actions agreed and implemented” [c9] Implementing a proactive policy such as described could be further explored as a methodology to share with other colleges

Attendance policies were explicit within all the colleges however without accurate monitoring in a number of colleges it is difficult to visualise the effectiveness of these policies The variety of approaches utilized by the colleges from recording attendance at each lecture [c8, c9, c11] to informal mechanisms [c12] and in some instances where there was less than 60% attendance [c1, c2, c3] is noteworthy It is suggested this requires further examination by the regulator to ascertain if the programme should be inputs or outputs driven and whether there can be a balance between the burden of monitoring and meeting requirements as experienced by all the parties to

the mechanism

Transfer Policy / ECTS / Transfers

The evidence in respect of the broad categories “transfer policy,” “ECTS,” “transfers,” refer to issues associated with students moving from one college and essentially one programme to another. The databits related to these broad categories was expressed as “transfer policy based on ECTS system and allows for inter-institutional transfer for students within Ireland and abroad” [c5]. The notion of supporting a quality based approach to transfer is indicated in the statement “students who have undertaken relevant studies may be exempt from particular modules, this will be at the discretion of the Board of Studies at the University” [c6]. The databits reveal that four colleges have a policy in operation [c2, c3, c5, c6] and a further three colleges report transferring students but the policy is not reported [c4, c7, c11]. The notion that “each application looked at on an individual basis” [c3], as found in the databit of one college, indicates the requirements of each individual is considered for registration purposes. The number of transfers both to and from Irish programmes in Ireland in 2002 and 2003 is relatively small and may be seen in Figure 5.2. This data was collated from the annual reports submitted to the regulator. It must also be inferred that the information supplied to ABA in this incidence is incomplete as three students transferred out and only two appear to be accepted.

TRANSFERS	
College 4	1 student transferred out in 2002
College 7	2 students transferred out in 2003
College 11	Accepted 2 in 2004

Figure 5.2 Transfer Numbers

Annual Report

The broad category of “annual report” as a measure of monitoring the changes and developments of the programme between site visits was received from twelve of the

thirteen programmes. It should be noted however that the approach to completing the annual report was inconsistent between the colleges. The report was received in respect of 2003 in eleven programmes [c1-10, c12] and 2002-2004 in one programme [c 10] with one received only in 2004 [c13] and the remainder received for the years 2002 and 2003 [c12]. The content of the annual report mainly referred to attrition, deferral and transfers both in and out of the programme [c1-10, c12, c13] but not consistently for each year. The paucity of information contained and the vagaries associated with its submission is an issue that the regulator needs to examine with the colleges in respect of the quality function it was designed to perform in monitoring the programme implementation. The regulator should further explore the variant compliance of the colleges to forward the annual report.

Summary

The higher order category of monitoring was reflective of the processes associated with quality in education. The mechanisms to capture the methodologies associated with ensuring the student achieved the requirements of a general nurse registration programme as determined by the regulator of nursing and the EU through the directive were outlined and range from very strict mechanisms to essentially no overt mechanism. The mobility of students to transfer between colleges in the country is one issue that is not always supported by an overt policy within the colleges. The variety of approaches adopted by the colleges to a number of monitoring issues is noteworthy and begs the question of whether the programmes should be inputs or outputs driven within the culture of the higher education system in a time when educational policy is directed towards measuring competencies and outcomes from education programmes.

RESOURCES

The higher order category “resources” emerged in the core category ‘Quality in Education’ through the linkages associated with the guidelines from ENQA (2005) “Learning resources and student support” comprise a standard that suggests, “Institutions should ensure that the resources available for the support of student learning are adequate and appropriate for each programme offered (ENQA 2005, p 18)” The broad categories identified by the expert group supporting this higher

order category were “physical resources,” “environmental resources,” “staffing issues,” “ratio,” “qualifications,” “experience,” “CV’s requested,” “CV’s forwarded,” “site report evidence,” “clinical assessment,” “prioritise the learning needs” and are further explained

Physical Resources / Environmental Resources

The broad categories as identified by the expert group of “physical resources,” and “environmental resources,” were another area where the databits identify a disparity between programmes. The broad categories were interdependent as demonstrated in the databits where the availability of environmental resources was dependent on the physical resources being available or not available as the individual college databits demonstrate. The range of evidence as seen in the databits spanned “excellent IT facilities were identified, ratio nearly 1:3 computer to student” [c8] in one college and “from anywhere the student has access to IT” [c10] in another to “a major investment in the nursing component of the library is required as a matter of urgency if the pre-registration students are to acquire the appropriate skills to enable them deliver evidenced based care to patients/clients” [c4]. The range of responses as identified in the databits could be explained as natural in a new programme that is settling into a new environment but for students on the programme the disparity of resources available to them to support their learning is a worrying issue when each college was provided with the capital funding to support the development of a programme in the college.

New facilities have materialised in some colleges as evidenced by one databit “there is a large modern library with an extensive nursing section” [c12]. The range of library and IT facilities varied considerable from college to college. A number of colleges had good IT facilities with a number of computer laboratories that the students could avail of and were linked to the clinical placement as evidenced by “good IT links between HEI and the main hospital sites” [c1, c2, c3, c6]. This integration however was not universal and is an area that the colleges could look at exploring in order to support a harmony between theory and practice. The databits to support the observation that the range of facilities was stark can be expressed in “one

of the most significant deficits in the library is the inadequate number of reading stations which was based on projected enrolments conducted in 1991” [c4] in one college to “College has excellent IT facilities and photocopying students have access to Ethernet, which has multiple applications of information technology, including CD-ROM and on-line databases, the internet and e-mail as well as word processing and other data processing software” [c7] in another Eleven colleges [c1-3, c5-12] an example of which is reported from the databits had “comprehensive range of audio-visual support resources” [c11] with another college “video conferencing facilities, laptops & LCD screen, OHP’s, TV and video in each classroom” [c8] were commented Teaching resources therefore it can be assumed are available to most programmes although they are not outlined in detail to make true comparisons The fact that some programmes are located in large long established colleges could be construed to confer an advantage of the facilities available to the students

Other evidence from the databits suggests that three colleges had very small libraries with limited IT and hardcopy resources “library under pressure to provide additional space” [c4, c9, c13] In one college there were particular difficulties with access to the library as demonstrated in the databit “students report being unhappy with access to college libraries due to geographical difficulties” [c1] however facilities were available in the main hospital sites The commitment to development, in relation to three schools and libraries, was evidenced by the databits “new building for nursing being constructed” [c4] to “there are advance plans regarding a new school” [c7] and “evidence of adequate facilities and plans for future developments demonstrated” [c9] The fact that development was planned for these three colleges begs the question as to the readiness of the colleges to take the students in the first role out of the programme and whether this affected the expectations of students or their ability to enjoy and learn on the programme

Some evidence from the databits associated with the broad category physical resources suggests colleges had librarians dedicated to nursing students with “fulltime librarian manages the services” [c6, c10] and “a librarian is assigned to address nursing” [c11] In another college it is reported, “there are three librarians” [c10] but

whether that is for the whole student population, or for nursing specifically, it cannot be assumed. The paucity of databits related to librarians to support the nursing programme begs the question should the regulator look for this data in a more coordinated way. The range of library resources was also evident by the databit “over 5000 nursing texts in library” [c2, 3] and “full extensive list of nursing journals and databases in library” [c2, 3, 6] and “library has a very large nursing section” [c7] while some libraries had only a small journal budget “a budget of 7040 euro per annum is dedicated to nursing journals” [c9]. The recent strides of a college are acknowledged by the databit “recently received 34,000 euro worth of books for the nursing programme” [c13]. The developmental nature of the library resource is noteworthy, especially if new programmes are being considered. Clear statements as to how the college support the achievement of evidence-based practice should be ascertained from the programme teams.

Other evidence of the physical/environmental resources broad category are associated with the simulated clinical areas, practice suites and skills/clinical rooms. These were evidenced at differing levels throughout the programmes by “well supplied practice suite and adequate teaching, meeting and office space” [c11] reported for one college to “development of the existing site for the construction of a new department awaited” [c13]. Standards at this structural level present a variety of compliance achievement as seen by the databit “new clinical skills facility represents a tremendous, if, belated step forward” [c13]. Again structural funding was made available for the programme to the colleges and by their nature construction takes time. The process as found in the databits relates to the developmental character of the programmes and it is speculated that a study in two years time would report this broad category quite differently. However colleges should assume responsibility for provision of a practice base course and as such state how they provide the necessary resources to achieve the learning required in the programme. The regulator on the other hand also needs to clearly identify the indicators required to achieve compliance with the standards.

Staffing Issues / Ratio / Qualifications and Experience

The higher order category of resources to deliver the programme in respect of the quality assurance of teaching personnel led to the identification of broad categories by the expert group of “staffing issues,” where “ratio,” of teacher to student became an issue in some colleges and in particular the “qualifications,” and “experience,” required to coordinate the programme and teach the course as gleaned from the databits. Linking these broad categories is the notion of the teaching resource. ENQA (2005 p 17) contend, “teachers are the single most important learning resource available to most students. It is important that those who teach have a full knowledge and understanding of the subject they are teaching, have the necessary skills and experience to transmit their knowledge and understanding effectively to students in a range of teaching contexts.”

The databits suggest the majority of programmes had a difficulty with this requirement of ABA. There were problems in relation to achieving the required ratio of staff to student but it was acknowledged by one college “recruitment was ongoing” [c13] and this college had 2 RNT’s and didn’t express the ratio. Ratios were not reported in some instances [c3, c4, c6, c7, c9, 12, 13] with only three colleges achieving the stipulated 1:15 ratio (ABA 2000 3.2.1.8) [c1, c2, c5], 2 colleges achieved a ratio of 1:16 [c8, 10] and one a ratio of 1:18 [c11]. With other colleges not reporting ratios it cannot be presumed that they met requirements. An interesting observation from the databits was that one college operated a ratio of 1 tutor to 12 students [c1], which was better than the 1:15 requirement of ABA. In a college where ratios were not explicit there were only 1.5 Registered Nurse Tutors (RNT’s) and 4 lecturing staff the databit suggests, “college lecturers in physical and social sciences provide a significant input into the programme. A variety of clinical nurses including nurse specialists, nursing practice development staff, nurse managers and medical staff also contribute to the programme” [c8]. The diversity of experience while laudable, the poor nurse teaching resource is noteworthy. The number of RNT’s employed to support the programme during the four years would require increasing with the increased number of students enrolling to achieve the ratios. It was also noted by another databit “specialist teachers, multidisciplinary health care

professionals provide input to the programme as identified at site visit” [c9] and in another “clinical nurse and nurse specialists and other members of the multidisciplinary team provide input into the programme” [c6] With the diversity of approaches to providing teaching input to the programme it would be interesting to study the effect of approaches

The evidence from the broad category “experience” could be linked to databits which suggested that the roles of tutors included committee membership with the health care and higher education institutions was a common responsibility for nurse teachers “experienced tutors are course coordinators” [c1, c2, c5] This led to another related broad category of “qualification” where nurse tutors were central to the nurse registration education programmes was evident throughout “all modules addressing nursing theory/practice content will be led and taught by appropriately qualified registered nurses/midwives” [c3, c6] The responsibility for ensuring professional preparation was identified as “degree coordinated and managed by college lecturers appointed as course leaders by the Head of School” [c7, 13] Further “the leaders are responsible for the day-to-day management of the programme” [c7] and “Module leader is responsible for ensuring the module is delivered as planned” [c6, c7] While module leaders are responsible for the programme implementation it is unclear if these personnel are Registered Nurses or Registered Nurse Tutors in Ireland The data to support the evidence of registration was not found The idea that professionals leading professional programmes of preparation for professional practice not being themselves accountable to the professional body is an issue that needs further exploration by the regulator

CV's Requested / CV's Forwarded

The broad category related to CV's, as identified by the expert group, is significant The databits suggest some colleges utilised a variety of other teachers on the programme as evidenced by the “ratio” broad category The databits suggest members of the clinical interdisciplinary team, lecturers from biological and social sciences and nurse experts and specialists “clinical nurses and nurse specialists and other members of the multi-disciplinary team provide input into the programme” [c1, 6, 7, 8, 10, 11,

13] There was evidence from the databits that many sites endeavoured to expose students to a wide style of experiences in terms of the backgrounds of people providing input to the programme with “interdepartmental lecturers from the department of life sciences, science, maths, government and society, psychology and philosophy” [c12] provide teaching It should be noted that CV’s were requested by ABA of the staff in twelve colleges [c1-9, c11-13] by the databit “CV’s of staff requested by ABA” The broad category “CV’s forwarded” applied to two colleges is evidenced by “ABA requested CV’s to be forwarded to them” [c2, c9] As most colleges were required by ABA to forward the CV’s of lecturers and nurse teachers, on the programme to them, the regulator needs to explore this issue with the colleges and the Board as to the criteria of other professionals being involved in professional programmes of education and if they meet the ENQA (2005) specification of quality learning resource

Site Report Evidence

The broad category “site report evidence” emerged associated with the databit “site visit reports evidence was supplied to the team” [c1-13] and in some circumstances “CV’s of extern identified at site visit” [c11, c12] Another databit gave insight into the extern relationship with “criteria in curriculum ” The role of the extern emerged with “external examination will examine and moderate assessment instruments and grades and will be guided by the HEI rules” [c12] The effectiveness of the extern is evidenced by “site visit team had full access to external examiners report, a composite of same per subject/cohort will be forwarded as part of an annual report to ABA” [c8] The site visit was therefore an instrument to collect data that is normally seen as sensitive in a college The effectiveness and utility of the site visit as a mechanism to collect data relevant to the evaluation of quality in education of the programme is acknowledged and in particular to the personnel issues associated with the programme

Prioritise the Learning Needs

The broad category “prioritise the learning needs,” as identified by the expert group emerged from the databits was linked to the higher order category of resources from

the association of words in one databit “there is a sense of the desire of clinical staff wanting to contribute to shared learning” [c12] In supporting the clinical learning needs of students it was also remarked “the emphasis is on learning through doing” [c11] It was commented in one college that “students feel that the clinical staff prioritise the learning needs of student nurses during placements” however “took time to adjust initially” [c1] The notion of “taking time” to adjust to supernumerary students was articulated in a number of colleges [c 1, c3, c5, c8] In taking time to adjust it must be stated that the databits of most of the colleges are reflected in the following comment “clinical staff are delighted to have students” [c9] Staffs were supported to undertake the role of mentor to students and the utility of this was evidenced in the databit from another college “staff articulated the focus on learning central to the concept, clinical staff highly supportive, very positive in relation to the contribution of the teaching and assessing programme to the support of students” [c7] It was also noted from another databit that “efforts to facilitate an awareness of the concept had taken place, however the site visit team were told of a difficulty in some areas of the hospital” [c3] The main difficulty associated with supporting the clinical learning of students was associated with another databit “difficulties expressed by students when overseas were on orientation assessments” [c5] The notion of the clinical staff resource being willing to meet student needs is acknowledged from the databits reviewed, however, when competing interests such as overseas nurses are being facilitated the staff resource to facilitate teaching can be stretched It can also be acknowledged that a resource implication of supporting students in the clinical environment was the provision of a teaching and assessing course to clinical staff

Summary

Resources to support the programme in the form of physical and environmental supports were in a number of cases in the process of being developed The fact that the infrastructure to support the programmes was so developmental is reflective of the speedy nature of the assimilation of the programmes into a college structure This is an issue that requires further monitoring to ensure the quality of resource provision to support the programme is actualised within a realistic timeframe The attitude of

students of the programme would be interesting to ascertain in this respect Likewise the diversity of approaches to supporting the teaching staff infrastructure is noteworthy The fact that the regulator is awaiting the CV's and PIN numbers of the teachers to the programme is one the regulator should re-examine in light of teaching students to undertake a professional practice role Colleges should capitalise on the enthusiasm of clinical staff to support teaching of students

STUDENT SUPPORT

There is evidence that students had full access to the broad categories of “student services,” “student academic guidance,” “health services,” “counselling,” “student clinical support ” The databits suggest that all colleges were committed to supporting students and had the following supports as seen by the databit of one college “college counselling services, student health services, chaplains and campus sport facilities” [c4] which is an example of other college responses

Student Services

The provision of “student services” was interpreted as facilities that supported students and these were quite diverse in interpretation through personal support with the databits such as “child care facilities” [c2] reported in one college and academic support such as “staff-student forum” [c5] in another Personal supports also included “chaplains” in most colleges [c1, c2, c3, c4, c6, c9, c10, c12] and sports and recreational facilities in a number of others [c3, c4, c6, c7, c8, 9, 10, 11, 12] The involvement of student nurses in these activities could not be gleaned from the databits

Student Academic Guidance

Academic support was achieved through “student academic guidance” in all colleges that was provided from “studies advisors” [c4, c8, c10, c11, 13] in five college and “personal tutors” [c1, c2, c3, c5, c6, c9, c12] in another seven with the remainder college [c7] not suggesting who was involved The purpose of these was outlined in the databits “studies advisors provided with both an academic and pastoral responsibility” [c4, c8, c10, c11] and “identified link tutor and CPC will support the learning process and be available to facilitate students to maximise available learning

opportunities” [c9] The databit “student booklet outlines all services” [c7] indicates where students became aware of the provision of these services through the “student handbook” [c3, c5, c6, c7] Where availability of student supports was established in all colleges no evidence was collected regarding uptake in practice or the student satisfaction with the personal and academic support structures This is an area that the regulator should revisit within the site visit structure in respect of providing a wide educational experience for students

Counselling

College counselling services were identified as broad category from the databits associated with ten colleges [c1-7, c9, c10, c11, c12] The nature of the counselling services, although acknowledged as being there, were not available in the databits to confer deductions related to use or utility by the students Counselling by its nature is a private event and it will never be possible to ascertain the use or efficacy of providing a confidential self-referring service

Student Clinical Support

The evidence for this broad category that student clinical support was available in programmes was gleaned from the databits “students are allocated to Registered nurses and are supported by CPC’s” [c12] and “CPC will support the learning process” [c9] The support given was seen in the databits “CNM’s and CPC’s considered invaluable” [c8] How this support was organised is gleaned from a databit of another college who state “CNE provides a four day teaching and assessing programme to prepare staff to support students in the clinical area” [c4] The only contrast to this was seen in one college where the databit suggests “students expressed concern regarding their placements within the large geographic area of the region” [c12] How this concern affected the support of clinical learning is not outlined

Summary

Student supports do appear to be available in the new education system The effectiveness of the support structures in facilitating learning and preventing attrition is one that should be further explored The views of students in this regard would be

useful to ascertain for the regulator in order to support a student's progress and achievement in the programme and thus the quality mechanisms in ensuring educational support. The regulator should ensure that information is collected within the site visit process.

AUDIT

The higher order category 'audit' linked the core category quality in education from the broad categories identified by the expert group. The broad categories include "internal quality assurance," "quality and audit officer," and "clinical learning audit group."

Internal Quality Assurance

The broad category "internal quality assurance," emerged from the databits associated with all colleges and is reflected in the comment of one college "internal quality assurance is in place through evaluation, course management team and curriculum development team" [c1]. The mechanism of quality assurance however although locally related through committee structures was also related to another databit "evidence of quality indicators across most dimensions of the programme" [c11]. The specificity or effectiveness of the quality indicators however was not outlined. Despite the acknowledgment that systems were in place another databit associated with a college was "a condition of approval was an outline of the quality indicators employed within the health care institution to be submitted to ABA" [c9]. Although the databits refer to systems, the details of the systems and how these are processed are not outlined. Other influences supporting quality awareness were evidenced by "a QAQI self-assessment has been set up in college" [c7] by one college and also the same health care institution was referred to as being "involved in accreditation" [c7]. The notion of having structures for quality was further expressed in one college as "student structures, evaluation process and the course management team meetings act as quality safeguards" [c12]. However, the process of how these safeguards act could not be gleaned from the databits. The rhetoric of quality assurance mechanisms appears confined to committees but the databits fail to identify the effectiveness of the systems as advocated by ENQA (2005 p 15). It can therefore be assumed the

regulator has not embraced a robust system to capture information of the current systems and understand its role as a “constituent part” (Kells 2002 p 35) being an agent in the regulatory system. This is an area the regulator needs to determine in appreciating its distinctive role in a collaborative system.

Quality and Audit Officer / Clinical Learning Audit Group

This connection of quality and audit is further evidenced by the databit of another college “internal quality assurance is in place through a quality and audit officer” [c5]. The development of “clinical audit,” or a “clinical learning audit group,” emerged from the databit “QA approach to the clinical area and to learning within the clinical area” [c7]. The focus of clinical audit as a separate identity of programme audit was further elaborated as a mechanism utilised by “clinical audit tool every two years” [c10]. The purpose of commissioning the audit could be gleaned by the databits “clinical audit tool requires each clinical area to identify learning opportunities for the student and provide a range of learning tools to assist the student achieve their potential in a supported manner” [c1] and “a most comprehensive audit tool has been devised and utilised to operationalise the site for use to identify and meet the educational requirements” [c9]. In another college it appears that the “educational audit tool utilised within all clinical placements” [c11]. Within the clinical environment there appears a great deal of activity surrounding audit with the databit “a clinical learning audit group has been formed” [c5] in one programme. This is further substantiated by another college who report “an active committee is in existence that is well supported by Practice Development and Nursing management” [c9]. Despite this level of activity around audit it appears only one college had forwarded this to the regulator by the databit “clinical audit tool was forwarded to ABA” [c9]. Another eight colleges were requested to provide the evidence by the databit “clinical audit tool to be forwarded to ABA” [c2, c3, c4, c6, c7, c8, c12, c13]. This issue of audit while being developed in a number of sites and attracting interest from staff is an issue that requires further exploration by the regulator to comment further on the quality assurance processes utilised.

Summary

Audit as a mechanism to identify and verify suitable quality placements for the undergraduate programme was utilised in all programmes. The regulator, however, requested the tools used. The concept of quality clinical learning permeated the programmes and mechanisms are in place to identify learning opportunities to support the programme. The details of the quality assurance mechanisms utilised in the colleges is in development and this area is one where the regulator could assist programme development teams. Providing evidence of quality in education structures for programmes is an area requiring development. It is proposed that the principles as suggested by ENQA (2005 p 15) as “the relationship between teaching and research in the institution, the institution’s strategy for quality and standards, the organisation of the quality assurance system, the responsibilities of departments, schools, faculties and other organisational units and individuals for the assurance of quality, the involvement of students in quality assurance, and the ways in which policy is implemented, monitored and revised” be considered as a pillar of the regulatory framework. It is further contended that the regulator needs to determine its role and responsibilities as an agent of quality within current existing systems.

ASSESSMENT

The higher order category ‘assessment’ emerged as a link from the broad categories “assessment plan,” “theory assessment,” “clinical assessment,” “progression,” “continuous assessment,” “assignment,” “examination,” “weightings outlined,” “competence,” “inter-rater reliability,” “grading criteria,” “early feedback,” “external support,” and “external examiner system.” Assessment of students is a component of the ENQA (2005 p 16) guidelines that recommend, “students should be assessed using published criteria, regulations and procedures which are applied consistently.” As well as providing “valuable information for institutions about the effectiveness of teaching and learners’ support” assessment, the “outcomes of assessment have a profound effect on students’ future careers” (ENQA 2005 p 16, 17). The recommendation is students should be clearly informed about the assessment strategy, the methods of assessment and examination they are required to complete, and the criteria that apply to the assessment performance (ENQA 2005).

Assessment Plan

The broad category “assessment plan” was evidenced as a databit in all programmes [c1-13] with an indicative comment being “assessment plan given to each student at beginning of the programme” [c2-4] The visibility of the plan was clear in that the majority of programmes gave it to the students at the commencement of the programme [c 2-5, c8-11, c13] In the other colleges the plans were available with the databits “assessment plan explicit in the programme” [c12] and “assessments strategy given to each student in the Book of Modules” [c6] It can therefore be deduced that an assessment plan is maintained in the colleges and this is shared with the students early in programme outlining the expectations of the assessment process for the students The details of the assessment plan however as received by the students are not explicit within the databits and therefore it is recommended that the regulator look for this evidence in the site visit process

Theory Assessment / Clinical Assessment

There was also evidence that “various strategies” were utilised in the assessment processes for each programme from the example databit “each theoretical unit is assessed using various strategies” [c1] The variety and number of assessments for each year of the programme varied and these were counted and compared and the comparative graph can be seen on Figure 5 3 over

As can be seen the number and range of theoretical assessments demonstrates diversity worth noting It can be noted that all programmes include a clinical assessment strategy The number of points of clinical assessment ranges between four in ten programmes [c1-4, c7-11, and c13], six in one [c6], seven in another [12] and eight in another programme [c5] The methodology associated with clinical competence is mainly through “workbook” [c1-4, c7-11, c13] with some programmes utilising a variety of assessment methodologies including clinical competencies, workbook assessment and written case study Theory assessment and clinical assessment it appears were accountable to the college examination systems although

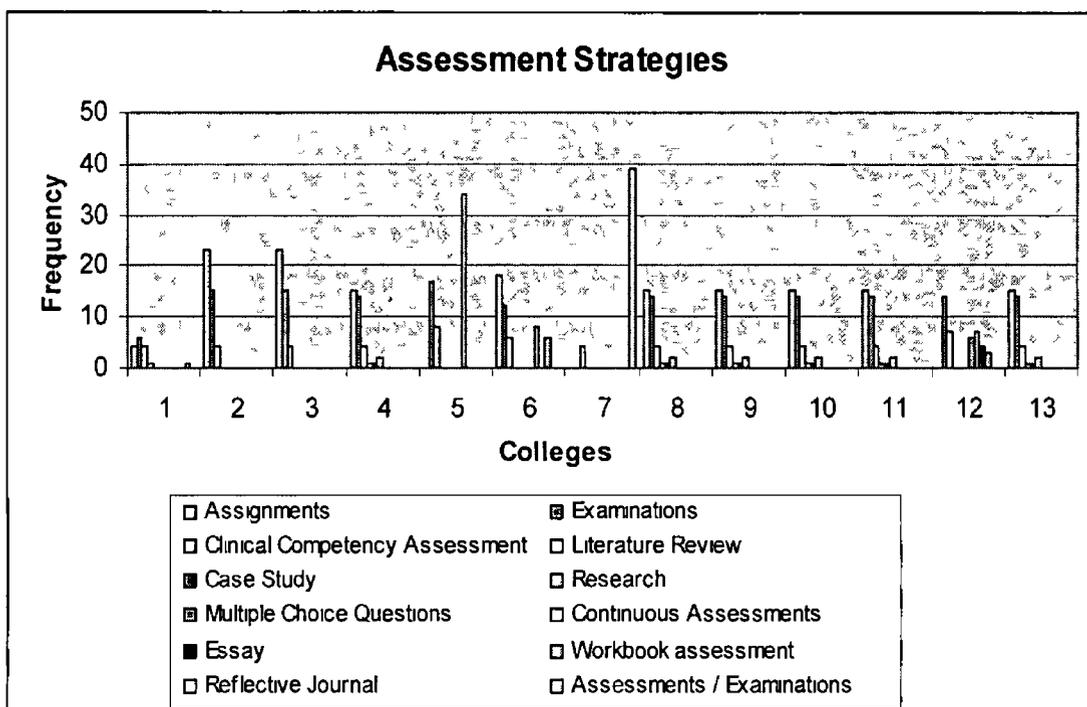


Figure 5.3 Overview of Assessment Strategies Utilised

clinical staff in the health service environment completes the clinical competence assessment component. The accountability issues of clinical staff in the academic environment of exam boards is one worth exploring in relation to judging suitability for practice in a programme that is based in the clinical environment for 50% of the time.

Assignment

One programme utilises a large number of unspecified course work assessments (n=34) [c5] while another utilises four assignments [c1], six colleges require fifteen assignments [c4, c8-11, c13], another eighteen assignments [c6] and two more twenty three assignments [c2, c3]. The range of examinations is also quite stark with one college using six examinations for the entire 4-year programme [c1] and another utilises seventeen examinations in the same period [c5]. The table below outlines the range and diversity in detail see Table 5.4 over.

Of note, however, is that in examining the documentation in detail, the specificity of the assessment strategies varies depending on the college. Some colleges forwarded very detailed plans while one utilised more generic details with “the programme

outlines assessment points of examination and assignment at the end of each semester and the four principles in the curriculum” [c7] but in the following direct quote numerical values of assignments are only possible to outline with “12 assessments in 1st year & clinical, 14 in 2nd year & clinical, 3 in 3rd year & clinical, 10 in 4th year & clinical” [c7] no other detail is available Assignments were the predominant

ASSESSMENT STRATEGIES													
College	1	2	3	4	5	6	7	8	9	10	11	12	13
Assignments	4	23	23	15	0	18	0	15	15	15	15	0	15
Examinations	6	15	15	14	17	12	0	14	14	14	14	14	14
Clinical Competency Assessment	4	4	4	4	8	6	4	4	4	4	4	7	4
Literature Review	1			1				1	1	1	1		1
Case Study				1				1	1	1	1		1
Research				2				2	2	2	2	4	2
Multiple Choice Questions												6	
Continuous Assessments					34	8						7	
Essay												4	
Workbook Assessment						6						3	
Reflective Journal	1											1	
Assessments / Examinations							39						
TOTALS	16	42	42	37	59	50	43	37	37	37	37	46	37

Table 5 4 Overall Assessment Strategies

methodology of assessment in all colleges bar one [c1] and as such it is worth further exploring the type, range and frequency of assignment as a teaching learning support Three other colleges did not utilise the terminology assignment in the databits [c5, c7, c12] and as such each college needs to be examined individually to understand the nuances of each programmes assessment strategy It is suggested the regulator capture this type of data while on site visit to identify the relationship of the teaching/assessment strategy to supporting the achievement of the course overall outcomes

Continuous Assessment / Examination

The college with the least number of assessments appears from the table to contain six examinations and four assignments, one literature review including critical analysis of practice issues supported by reflective journal and four points of clinical competencies assessment [c1] This can be compared to another college who require the students to complete thirty four unspecified continuous assessments by examination or assignment that include a clinical practice assignment, eight clinical competence assessments and seventeen examinations [c5] A number of colleges outline written case study [c4, c8-11, c13], research critique [c4, c8-13], literature review [c1, c4-11, c13], and research proposal [c4, c8-11, c13] as assessment methodologies with two colleges assessing the reflective journal [c1, c12] One college is quite specific in the methods used including four assessments surrounding the issue of research including a 10,000-word project, six MCQ's, seven continuous assessments and four essays in addition to the above [c12] It can therefore be deduced that the philosophy of assessment differed between colleges It would be useful to examine these philosophies related to depth and breadth of assessment and the overall outcomes of a programmes in respect of problem solving, analytical thought, critical thinking, reflective practice and the art and science of nursing as required by the regulator (ABA 2000) in respect of these philosophies and how each college provides evidence of achieving these programme outcomes In totalling all assessment points for each college the mean number of assessments are 42.8 with the range of 43 assessments

Competence

The broad category competence, as identified by the expert group refers to databits “clinical competencies assessment” [c1] ABA (2000 p 14) suggests, “competence is a complex multi-dimensional phenomenon” They further define it as “the ability of the Registered Nurse to practise safely and effectively fulfilling his/her professional responsibility within his/her scope of practice” In examining the broad category competence in relation to assessment it is worth noting the expectation of the regulator (ABA 2000 p 14) “Safe and effective practice requires a sound underpinning of the theoretical knowledge that informs practice and is in turn

informed by that practice. Within the complex and changing healthcare environment it is essential that the best available evidence informs practice.” In examining the databits it appears that details of how the competence assessment is conducted or the tools utilised to process the assessment are not outlined in five of the colleges [c1, c2, c3, c5, 6]. Six other colleges utilise a workbook to determine clinical competence achievement [c4, c8-11, c13]. The five domains of competence reflect the level a student must reach on completion of the educational programme for entry to the Register held by ABA. The requirement of ABA to achieve the identified five domains of competence for the nurse to be eligible for registration (ABA 2000) warrants further exploration by the regulator to seek evidence of how the colleges interpret that the competencies are achieved and at what point in the programme is the student deemed to have achieved them.

Early Feedback / Structured pro-forma

The broad categories “early feedback” and “structured pro-forma” refer to databits of “early provisional feedback reported using a structured pro-forma” [c1-5, c8, c10-12, c13] while other data bits confer that most colleges have some sort of system for feedback “a structured feedback sheet based on an educational taxonomy” [c7], “student policies support mechanisms and feedback on assignments” [c8]. Particular processes in some colleges could be gleaned from the databits “a separate marking grid for papers and assignments are used and returned for feedback to students” [c6] and “each student receives an evaluation/feedback sheet concerning their work” [12]. The contribution of feedback to students on their work as an established mechanism to support quality systems can be inferred from the databit “student feedback evident supported by favourable comments from external examiner” [8]. The timing of the feedback and effectiveness of it from the perspective of the student though is not ascertained.

Grading Criteria / Weightings Outlined

The broad category “grading criteria” was evident for all colleges [c2-13] except no databit was found for one college in this regard [c1]. It was associated with the databit “grading criteria included in curriculum and provided to students in

handbook” [c2-5, c9-13] and further “grading criteria for honours outlined” [c6] and “marks and standards outline the honours standard” [c7] Pass marks were identified in databits of some colleges with “pass mark practical 40% and project 60%” [c4, c8-11, c13] and “assignment marking criteria identify 40% as pass mark” [c8, c9] and “pass mark theoretical 40%” [c10, c11, c13] The issue of significance related to grading criteria was the expectation of performance for students in some programmes where the broad category “weightings outlined” referred to the significance of performance between examination and assignment with “the weightings are outlined between course work and examination” for five colleges [c3, c5, c6, c7, c12] In others “the weighting of which and the details of which have to be confirmed” [c1, c2] are not outlined [c4] Each college approached the weighting issue differently and in one college the databit suggests, “the weightings are outlined between coursework and examination and each is attributed credit values” [c6], and unusually in another college it suggests, “clinical skills is typically associated with another assessment strategy and attributes 10% of the weighting of the module” [c12] Detailing the particulars of the grading criteria and the weightings needs to be considered as useful information to the regulator in reflecting the philosophy of learning of the programmes and the outcomes required thus assisting in determining the quality of the programmes

Progression

The progression issue was addressed in another broad category reflective of the databit “students normally required to have completed the theoretical and clinical assessments in each stage of the course prior to progressing to the next stage” [c1] and “student must pass both written and practice assessments requirements to progress” [c2-6, c8-11, 13] Progression was linked with the databit “in order to progress there is no compensation between theory and practice” [c1-13] and “examinations office keeps records of theoretical and practice assessments achievement” [c2, c3, c5] The databit “compensation procedures” also emerged as “details of the criteria for compensation, continuation procedures for discussion, checking and appeal of examination results are explicit” [c2, c3, c5] and in another college “compensation between subjects shall not be permitted” [c7] The above

confirms that all programmes are in compliance with the requirement that there is no compensation between theory and practice in relation to progression or successful completion of the programme in that both elements of the programme must be passed independently of each other

Inter-rater Reliability

The issue of “inter-rater reliability” as a broad category was confirmed by the databit “external examiner commends the college for the reliability of its marking and its use of inter-rater reliability marking” [c3] This concept is further supported by the databit of another college “inter-rater reliability marking is utilised by the internal markers” [c7] The notion of a system to support the reliability of marking was also observed in the databit of another college “internal moderation employed, prior to external examination” [c11] No further databits were observed to suggest other systems of internal reliability marking but one databit suggests the regulator observed a process with “site visit team supports the assessment strategy” [c12] Reliability of marking as a quality indicator was therefore observed explicitly in four colleges and evidence of this nature is valuable to support the contention of ENQA (2005 p 17) who suggest, “where possible do not rely on the judgements of single examiners ”

Extern Examiner System / External Support

The broad category identified by the expert group of “external examiner system” emerged as a component of internal quality assurance where a number of programmes identified that the process of “student structures, evaluation process, external examiner process and the course management team meetings act as quality safeguards” [c2, c5, c9, c12] An extern examiner system was evident in all colleges [c1-13] The purpose of the external examiner and the role of the extern examiner was explicit in all colleges [c1-13] and is reflected in the indicative databit of one college “external examiners play an important role in monitoring the appropriateness of the programme and assessment and the standards achieved in both course work and examination” [c8] The broad category “external support” emerged associated with codes “extern supports the assessment strategy” in all colleges [c1-7, c10, c13] A strategy emerged associated with the extern as evidenced by one databit “internal moderation employed, prior to external examination Scripts and assignment also sent

to extern for approval” [c12] The reliability and validity of the assessment process is thus maintained however one databit suggests they need to be evaluated as evidenced by “validity and reliability of the assessment tools will be evaluated as the programme progresses” [c2] The European standards and guidelines for internal quality assurance within higher education institutions (2005 p 15) contend that “institutions should develop and implement a strategy for the continuous enhancement of quality” and in the colleges reviewed it appears that systems exist but whether “formal policies and procedures” are utilised is not captured by the regulator

Summary

Assessment of students is a component of the ENQA (2005 p 16) guidelines that recommend, “students should be assessed using published criteria, regulations and procedures which are applied consistently” It is acknowledged the assessment strategies are supported by a system with external review Quality processes of internal review of assessment structures and processes exist for all programmes and therefore provide “valuable information for institutions about the effectiveness of teaching and learners’ support” (ENQA, 2005 p 17) The interconnectedness, however, of how the assessment strategies relate to the overall outcomes of the programme was not gleaned from current regulatory processes The varying approaches taken by colleges to inform the regulator of the strategies used are noteworthy The diversity of approaches and number of points of assessment is also worth comment between the programmes and the effects this has on student performance and “public confidence in institutional autonomy” (ENQA 2005 p 15) It is unclear if students receive enough detail on commencement of the programme to meet the recommendation of ENQA (2005) that students should be clearly informed about the assessment strategy, the methods of assessment and examination they are required to complete, and the criteria that apply to the assessment performance

Conclusion

The higher order categories of ‘monitoring,’ ‘resources,’ ‘student support’ ‘audit,’ and ‘assessment’ emerged when the researcher reflected on the narrative presented with the theoretical literature to obtain the core category ‘Quality in Education’ Quality assurance in higher education as a two stage interdependent process

comprises external systems that consider the effectiveness of internal quality assurance processes. The regulator in this instance has some information but not complete information to support a judgement of internal quality review processes exercised by colleges to enable it to be an effective agent of external quality assurance. The regulator therefore needs to develop processes that capture a truly regulatory role as an external reviewer of programmes that confer approval to programmes that prepare general nurses for safe and effective practice as Registered General Nurses.

KNOWLEDGE FOR PRACTICE

The broad categories identified by the expert group are associated with the emergent databits and are presented here as a table to compare the broad categories within and between categories and to “clarify boundaries and relationships between concepts” (Dey 2005 p 150). In this respect the context of the data is most appreciated in order to “build a logical chain of evidence” (Miles and Huberman 2004 p 100) in order to generate meaning. The results of the examination as detailed here reflect the unique conceptualisations of the nursing programme and do as recommended by Miles and Huberman “subsume particulars into the general” (2004 p 255). The broad categories include some quantitative data that is presented in charts and figures as appropriate in order to “see what we have in a large batch of data, to verify a hunch or hypothesis” and keep analytical honesty “protecting against bias” (Miles and Huberman 2004 p 252). In these circumstances where quantitative data was available a content analysis of the data was undertaken, a total reached and subsequent figures and tables are presented for consideration. In achieving integration between variables of the broad categories they were “unbundled” from their origins and “differentiated” into the matrix below where “linkages” allowed the “integration” of the components into “clusters” otherwise known as “higher order categories” (Miles and Huberman 2004 p 254). In examining these higher order categories a “pattern code” as expressed within the core category of ‘knowledge for practice’ emerged. In achieving the “pattern codes” or “core category” the initial databits are “scanned” to “check out

rival explanations, rule out spurious relations and using extreme cases” (Miles and Huberman 2004 p 258) In deciding which variables went together a logical chain of evidence was utilised to “progressively focus” the data and utilise “constant comparisons” and “structural corroborations” where there was “an eliminative inductive method” (Miles and Huberman 2004 p 260) of working with the databits, broad categories, higher order categories and finally the core category In summary this process reflects the steps identified by Miles and Huberman (2004 p 262), “establish the discrete findings, relate the findings to each other, name the pattern and, identify a corresponding construct ” The table 5 3 outlines the broad categories, the higher order categories of the core category ‘knowledge for practice ’ The higher order categories were identified as course structure, curriculum, continuing education and values

CORE CATEGORY KNOWLEDGE FOR PRACTICE					
HIGHER ORDER CATEGORIES					
B R O A D C A T E G O R I E S	Course Structure	Curriculum	Curriculum	Continuing Education	Values
	ABA and EU requirements	Curriculum model	Reflective practice	Nurse practitioners	Centrality of practice
	Hours	Curriculum philosophy	Reflection	Shift by shift	Nursing concepts
	Elective module	Nurse education forum	Clinical placements	Two students to one RGN	Aim of nursing care
	Nursing in developing worlds	Indicative content	Range of placements	Clinical support	Holistic approach
	Student centred	Teaching learning strategies	Clinical placement map	Learning oriented to clinical practice	Ethical dimension of nursing care
		Teaching beliefs	Semester 1 /semester 2	CPC's	Integration of theory and practice
		Philosophy of nursing	Specialist placement	Workload	
		Models of nursing	Research	Liaison role	
		Learning outcomes	Problem solving	Clinical links	
		Evaluation		Professional development and personal growth	

Table 5 3 Core Category Knowledge for Practice with Broad Categories

COURSE STRUCTURE

The higher order category of ‘course structure’ was associated with the broad categories “ABA and EU requirements,” “hours,” “elective module,” “nursing in developing worlds,” and “student centred” These structures within the academic environment determine the processes of delivering a programme or are the prerequisites of understanding the unique issues that need to be considered within a general nursing programme as determined by policy The broad categories again emerged from the expert group who examined the databits

ABA and EU Requirements / Hours

The broad categories that emerged from the databits according to the expert group reflect issues associated with the capacity of the programmes to ensure graduating students meet the eligibility criteria of ABA in order to enter a name on the Register of Nurses The databits indicate that all colleges are in compliance with programme requirements of ABA with “Programme meets ABA and EU input requirements” [c1-13] although how this occurred is more clearly indicated in the reference to “hours” that was possible to chart from an analysis of the course documents as displayed in Figure 5 4

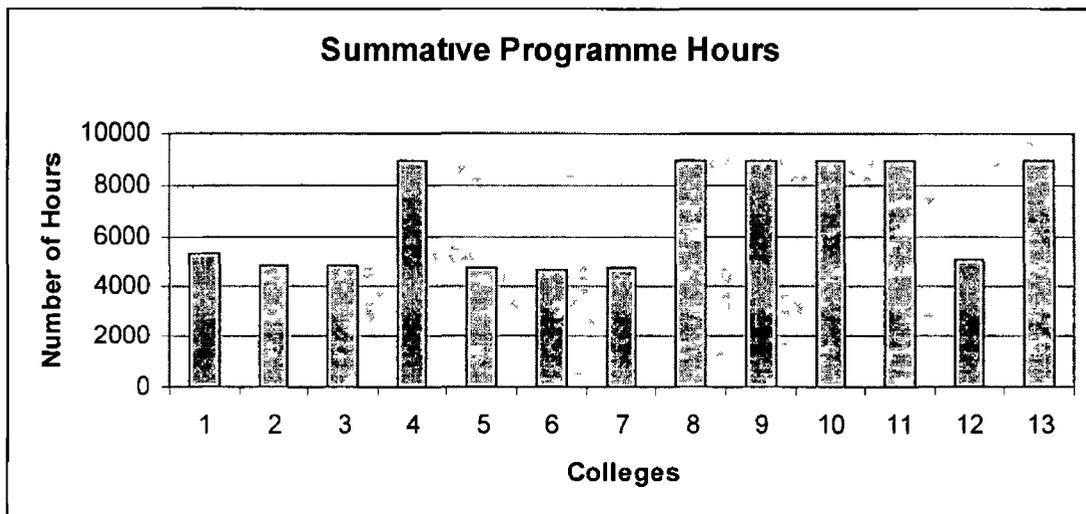


Figure 5 4 *Summative Comparisons of Programme Hours*

The variety of approaches to achieve the EU and ABA requirements in respect of hours of theoretical instruction is noteworthy The Nurses’ Act 1985 requires that

ABA ensure European directives are met and in this incidence it is worth mentioning that ABA requirements exceed EU requirements by 177 hours. The range of hours found among the thirteen colleges is 4308, which reflects the span of 8958 hours in six programmes [c4, 8, 9, 10, 11, 13] as the highest and 4650 hours [c6] as the lowest attributable to the programme in one college. Six of the programmes exceed the EU requirements of 4,600 hours by 4,358 hours and ABA requirements of 4,776 hours by 4182 hours. Significantly the ABA requirement of 4,776 hours is not achieved by three colleges [c5, 6, 7] although all achieve the EU minimum of 4,600 hours albeit with only 50 hours over the minimum in one instance [c5].

The total hours for the general nurse education programmes vary in the manner of achieving requirements as outlined in Figure 5.5. The Council Directive 77/453/EEC requires that theoretical instruction comprise no less than one-third of 4,600 hours i.e. 1,533 hours and clinical instruction comprise no less than one-half of 4,600 hours i.e. 2,300 hours. If contact teaching hours and effort hours are combined all programmes bar one [c6] meet this stipulation and all programmes meet in excess the clinical practice requirements. The one programme that doesn't meet this requirement when contact teaching and effort hours are combined totals 1500 hours theory [c6].

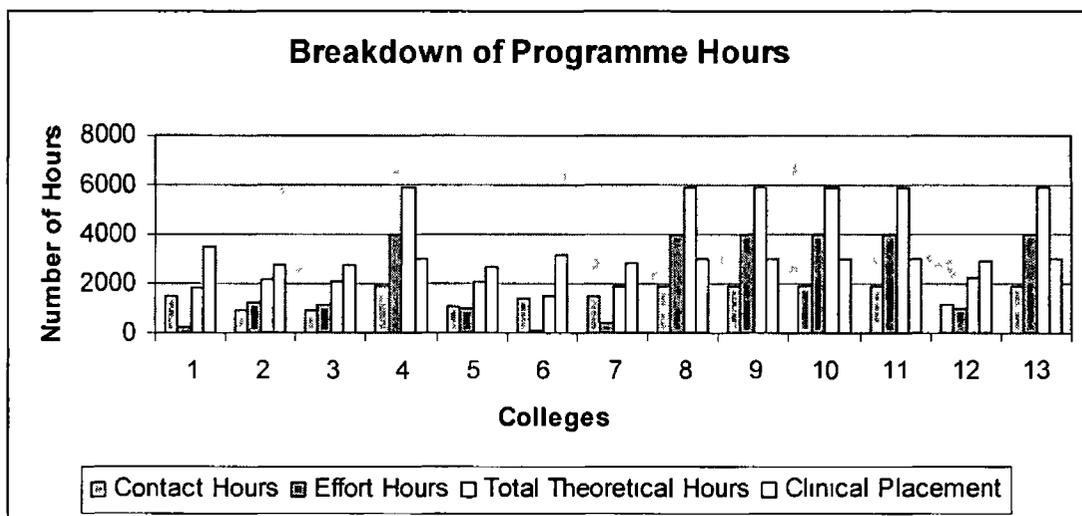


Figure 5.5 Breakdown of Total Hours for General Nurse Education Programmes

Another observation in respect of hours is the manner that each of the colleges used to achieve the theoretical hours requirements of the programme and the focus of these contact theoretical inputs. A breakdown of the theoretical hours was difficult to

achieve as a number of colleges were semesterised while others used threads or themes in the four years of the programme. The researcher in examining the content used the predominant headings of the thirteen programmes where there was similarity and only came into difficulty with three programmes [c1, 3 and 7] and as such in deference to them did not make judgment calls on their behalf to attribute hours to areas but observed where similar type content was seen. The breakdown of the theoretical hours of the programme is contained in figure 5.6

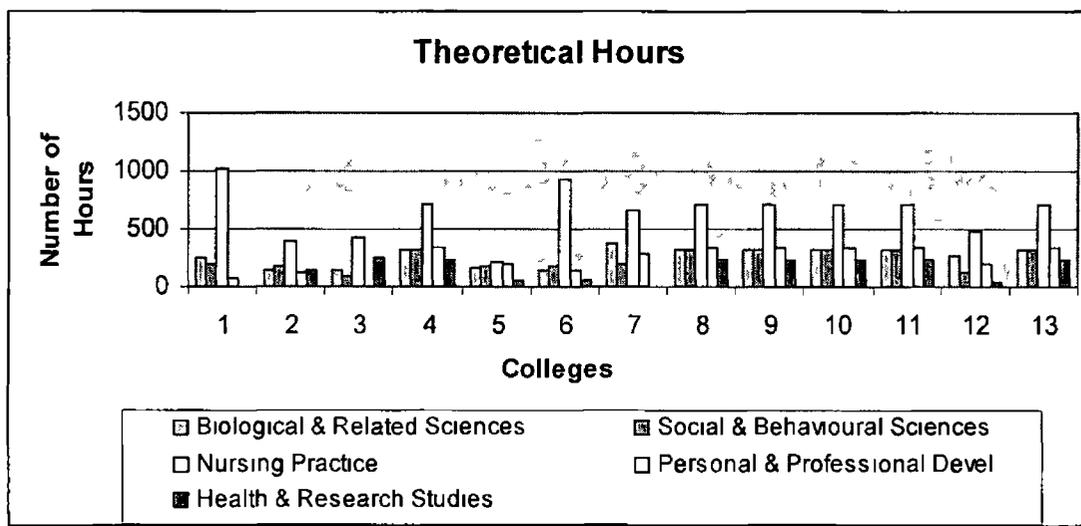


Figure 5.6 Breakdown of the Theoretical Hours of the General Nurse Programmes

Nursing practice studies was as the most prominent subject area and ranged 635 hours being calculated from 206 hours [c5] to 1020 hours [c1] with a mean calculation of 648 hours. Biological studies was the second most popular area of study input with a mean of 264 hours and a range of 190 hours made from a calculation of the lowest input 135 hours in two colleges [c2, 3] to the highest with 325 hours in six colleges [c4, 8, 9, 10, 11, 13]. Social and Behavioural Studies and Personal and Professional Development were closely aligned as the third most popular input areas to the programme with the mean for social and behavioural studies reading as 237 hours and the mean for personal and professional studies as 236 hours with ranges of 235 hours and 269 hours respectively. It must be noted however that with one college [c3] it was not possible to decipher a split between the hours for personal and professional studies and the health and research studies. The total breakdown of hours associated with Health and Research Studies was difficult to decipher in two programmes, as

these hours were included in the hours associated with personal and professional development [c1, c7] The mean hours for health and research studies was 153 hours but the range was 42 hours [c12] to 240 hours [c4, 8, 9, 10, 11, 13] with no data for two programmes as suggested [c1, c7]

The range of contact teaching hours as described in detail above in respect of the programmes is noteworthy The range of contact teaching hours is 1050 hours spanning 900 to 1950 hours with the mean being 1622 hours as can be seen in figure 5 7 This steep range of contact teaching hours needs to be explained in the context of course delivery and whether these impacts on the knowledge acquired and required for practice The practical implication of contact teaching of some colleges is also worth exploring related to resources both personnel and environmental facilities

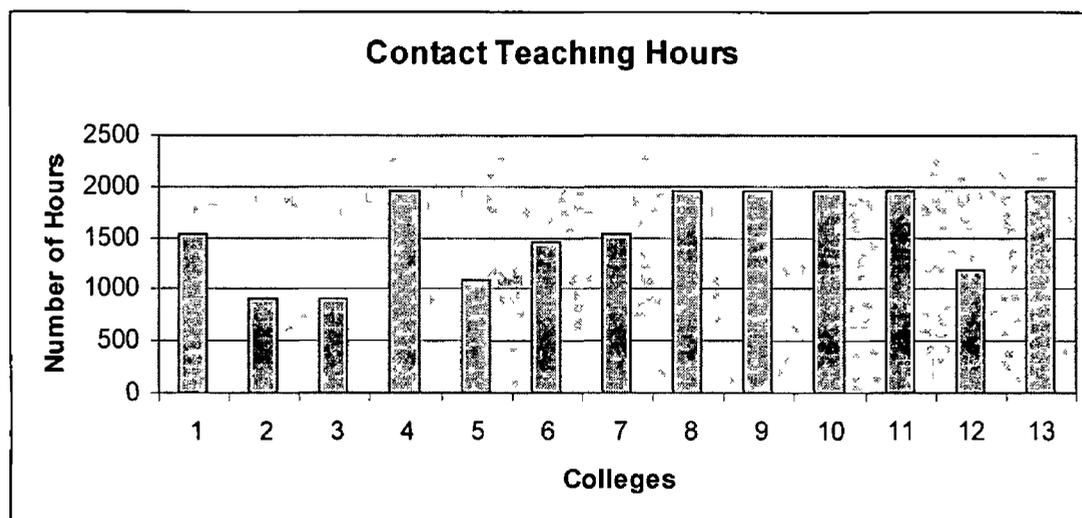


Figure 5 7 The Contact teaching Hours of the General Nurse Programme

While the majority of colleges met the EU theoretical requirement through contact teaching five colleges relied on student effort hours or identified independent learning time by the colleges to achieve the EU theoretical requirements [c2, c3, c5, c6, c12] The effort hours attributed to programmes as found in curriculum documents are presented in figure 5 8 over

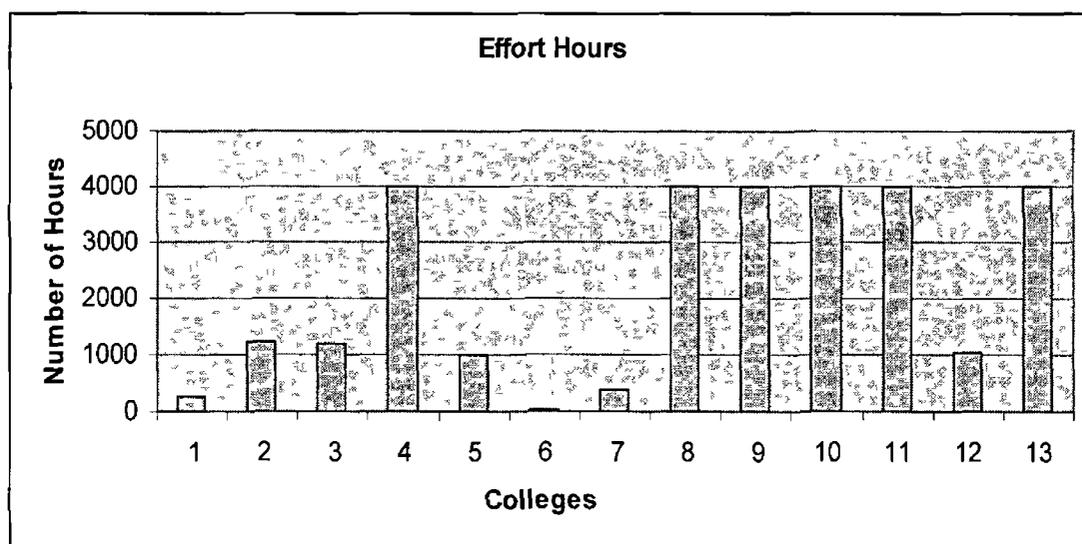


Figure 5 8 *The Effort Hours of the General Nurse Programme*

This was an area where a wide range was seen between colleges. Attributed effort hours were as low as 50 hours in one programme [c6] and as much as 4000 hours in six colleges [c4, 8, 9, 10, 11, 13]. The hours that each student in these six colleges as presented requires the student in the 148 weeks of the programme to devote to the programme is 60.5 hours a week, calculated between contact and effort hours. The college with the programme that outlined 4650 hours [c6] over a 148-week programme based on the same calculation expected the student to engage with the programme 31.4 hours in a week. A rationale for this range is difficult to ascertain from the data other than to observe that in six institutions academic structures are similar [c4, c8, c9, c10, c11, c13]. The notion of effort hours is attributed to modularisation processes and in this incidence it is not possible from the databits to ascertain why the large discrepancy occurs between programmes and colleges.

It can be summarised that all programmes meet EU input requirements as stated in curricular documents. A variety of approaches is however taken to implementing the EU requirements of 4,600 hours. Three programmes do not meet the ABA requirement of 4776 hours. The multiplicity of approaches to achieving the hours through contact teaching hours, effort hours and the breakdown of subject areas is quite stark. In reviewing the above data it is suggested by the researcher that the regulator should examine if the current requirements and standards (ABA 2000) as actualised in the programmes reviewed meet the intended provision of courses in

respect of its responsibility to ensure EU requirements are met and whether input measurements yield the data for approval needed in a competence based programme. This again begs the question as to whether an inputs model of regulation is congruent with current systems of quality and accreditation or whether the system should appreciate an orientation to competencies and outcome measurement.

Elective Module / Nursing in Developing Worlds

While the contact teaching hours and effort hours merit note, the choice for students related to educational experiences was evidenced with the broad category “elective module” which was supported by the databit “students complete one elective module in year 3 semester 1 which may provide opportunity for travel” [c2]. The elective was seen in one college as an opportunity for “nursing in developing worlds” [c2]. Not all colleges provided for elective modules or for students to travel but the databits suggest four colleges were actively involved in arranging and supporting elective placements and student choice [c2, c3, c5, c12]. The range of electives was seen in one college as “electives are literature, or community based” [c2]. The elective placement was seen as a useful opportunity in another college whose databit suggests “college utilises the ‘Leonardo’ programme and this has been successful with exchanges in place” [c12]. The support for organising students was gleaned from the databit “the International affairs coordinator in college liaises with the programme” [c12]. ABA currently supports students studying for 12 weeks within the EU (ABA 2000 3 2 2 11). In an era of mobility within nursing this warrants further exploration as to the uptake of providing an opportunity for students to experience other European Union health care systems and structures to support nursing in other cultures and jurisdictions.

Student Centred

The broad category ‘student centred’ was evidenced in a few colleges [c2, 3, 5] associated with a philosophy that purported to develop “student centred” approaches to learning that included computer assisted learning [c5]. The notion of negotiated learning is supported by the databit of one college “selected as appropriate to the subject, the student and teacher and the context in which the learning is taking place” [c9]. It was also noted that teaching “strategies were identified on a continuum from

student-centred to teacher-centred” [c8] The purpose of adopting a student centred approach to curriculum is evidence in a databit of one college, which reads, “students will be expected to reflect upon their own practice and the theoretical issues relevant to it” [c11] This is further supported by the databit “the focus is on the development of self-directed and autonomous learners” [c7] Whether this explains the philosophy of effort hours is unknown but it can be posited as a possibility

Summary

The higher order category ‘course structure’ refers to aspects of course unique determinants In this case this was determined the ABA and EU requirements in respect of course structure to meet expectations of course input or duration expressed as hours The notion that the course allowed for flexibility in structure to ensure a student centred approach that included choice expressed as elective module is indicative of a flexible structure The main manifestation of this flexibility is however in the diverse approaches taken by colleges to achieve the stated requirements of ABA and the EU to achieve the course input requirements This poses the question for the regulator as to its approach in relation to determining inputs rather than respecting outcomes of educational processes

CURRICULUM

In examining the higher order category ‘curriculum’ the broad categories identified by the expert group from the databits were “triangulated” and “weighted against the evidence” (Miles and Huberman 2004 p 263) Curriculum, as in research, depending on perspective, reflects the predominant paradigm of those engaged with it As warned by Cohen, Manion and Morrison (2004 p 33) “not all knowledge can be included in the curriculum, the curriculum is a selection of what is deemed to be worthwhile knowledge” It is acknowledged that curricula are value-based Understanding the predominant values therefore of the general nursing programmes as evidenced from the observations gained through documentation and site visits is worth exploring to ascertain what and whose knowledge is important and how the curricula and pedagogy meet the regulatory interest (Cohen, Manion, and Morrison 2004) The broad categories that were identified by the expert group include

“curriculum philosophy,” “curriculum model,” “nurse education forum,” “indicative content,” “teaching beliefs,” “teaching learning strategies,” “reflective practice,” “reflection,” “philosophy of nursing,” “models of nursing,” “learning outcomes,” “evaluation,” “clinical placements,” “clinical placement map,” “range of placements,” “specialist placements,” “semester 1,” “semester 2,” “research,” and “problem solving”

Curriculum Philosophy / Curriculum Model

The broad categories ‘curriculum philosophy’ and ‘curriculum model’ as identified by the expert group are evidenced by the databit of one college “an eclectic approach to curriculum development has been adopted informed by the post-technocratic model of French and Cross” [c3] There was explicit evidence that thought had occurred about the philosophy of education and the educational theories, curriculum models and interaction with nursing theories/models within the curricula in five colleges [c1, 2, 3, 6, 12]

The educational philosophy underpinning the curriculum was articulated as “Skillbeck’s Situational model and Lawton’s model of cultural analysis of nursing practice for health” in college one, Beattie’s fourfold model of curriculum design with Roach’s 5C’s of caring” in college two, “Post-technocratic model of French and Cross” in college 3, and “an eclectic approach based on Wiles and Bondi, Nurse Education Forum and Beattie” in college twelve In another college the databits state “the curriculum framework is conceptualised along two curricular strands – vertical and horizontal The vertical is based on becoming a professional nurse in five role dimensions and the horizontal relate to beliefs and values about nursing, knowledge in nursing and the nature of learning” [c6]

The evidence suggests the curriculum was developed in most cases through a consultative/partnership approach between the clinical and educational stakeholders [c1-13] by the indicative databit “curriculum development team comprises clinical, management and education expertise” [c2-11, c13] The data in conflict is seen in the databit of one college “curriculum development team comprises all key stakeholders according to site visit team but evidence from the curriculum suggests it comprises

only teaching staff” [c1] Another college suggests “philosophy developed through consultation” [c9] There was some endeavour to ensure that the nursing and educational philosophies within the curricula shared congruent beliefs, values and underpinning concepts as evidenced in one programme by “programme involves a strong emphasis on the practice on nursing and on an integrated curriculum design” [c5] Work by theorists such as “Beattie’s fourfold model of curriculum design” with “Roach’s ‘5C’s’ of caring identified as core skills which facilitate the delivery of systematic individualised nursing care” [c3] are indicative of this integration In some instances however no distinctive model was found by “an integrated curriculum design is attributed to the programme with no specific theorist identified” [c4, 8, 9, 10, 11, 13] However, some other theorists were evident with “French and Cross” were attributed in one college [c3] and “Beattie and Wiles and Bondi” in another [c12] The nursing philosophy within the curriculum included a “holistic approach” to care in three colleges [c4, c9, and c12] with other references to a caring approach evidenced by “the role of the nurse and the principles of caring for the client, in the specialist nursing client group settings” in another college [c1] An interesting databit from another six colleges suggests, “the diverse nature of nursing disciplines involved militated against adopting an explicit curriculum model” [c4, 8, 9, 10, 11, 13] In summary the philosophy as articulated and attributed in some of the colleges is not explicitly identified in others The impact of articulating or not articulating a curriculum philosophy is also worth exploring related to curricular decisions The evidence to support the direction of the philosophy and how it materialises in teaching and learning strategies or assessment strategies is interesting to observe from the databits

Nurse Education Forum

The broad category ‘nurse education forum’ emerged from the databits to the expert group associated with underpinning the curriculum document In most colleges the recommendations of the “nurse education forum” informed the deliberations of the planning team of the programme with the databit “the self-audit identifies that the programme has been shaped by the recommendations of the Nursing Education Forum (2000)” [c2, 3] In all other colleges it was suggested by another databit “the curriculum identifies that the programme has been shaped by the recommendations of

the Nurse Education Forum (2000) [c4, 5, 6, 7, 8, 9, 10, 11, 12, and 13] The principles, which were identified by nurse education forum (2000) were reported in the following databit as “flexibility, eclecticism, transferability and progression, evidence based practice and shared learning are outlined” in a number of programmes [c4, 8, 9, 10, 11, 12 and c13] while others attribute “dynamic and flexible” principles identified by the Nurse Education Forum to “Skillbeck’s Situational Model” [c1] The concept of “flexible” programmes was identified by ABA in 1999 in the Requirements and Standards for Nurse Registration Education Programmes (p 5) which suggested the document “provides guidance for the development of flexible, innovative, practice-oriented registration programmes to third level institutions and health care institutions involved in the education and training of nurses ” The Nurse Education Forum (2000 p 59) from consultation and discussion further developed this theme and identified the core principles to guide curriculum design as “flexibility, eclecticism, transferability and progression, utility, evidence-base and shared learning ” The principle of flexibility was identified by the Forum as “the need for autonomy to design curricula in a manner that is responsive to local need” (Nurse Education Forum 2000 p 59) The fact that six colleges jointly submitted a common curriculum does not support the achievement of this principle The principle of eclecticism refers to a recommendation “that the curriculum design be eclectic in so far as it draws on knowledge from diverse sources and uses a variety of teaching/learning strategies” (Nurse Education Forum 2000 p 59) which includes technology and particularly electronic methods of learning The principles of transferability and progression refer to “the notion of transfer between programmes” and “enhancing a range of clinical pathways” (Nurse Education Forum, 2000 p 59) The evidence to support these principles is in short supply to link decisions in relation to the curriculum to the educational experience The forum to support the curriculum having a theoretical basis identified the principle of evidence base As seen in the evidence reviewed most programmes state they utilised the principles of the Forum in curricular development but how this was supported by a theoretical base is yet to be determined The principle of interdisciplinary and shared learning with and from other healthcare professionals was recommended by the Forum (2000 p 61) and currently all programmes have evidence of a wide teaching resource to the

programme There is no evidence to support the notion that general student nurses share learning with disciplines external to nursing programmes How the principles were actualised, or what the colleges interpreted as evidence supporting the principles, is not so clear from the databits and warrants further exploration The relevance of the Forum's recommendations to the requirements of the regulator is one also worth exploring The status of independent requirements from those of the regulator is incongruent with good regulatory management

Indicative Content

The broad category "indicative content" as identified by the expert group is associated with the databit "indicative content requirements appear to be met" [c1] In another databit exemplary to all attributes a process to ensuring the indicative content requirements were met with "the planning team has ensured that the indicative content outlined by ABA (2000) has been addressed in the programme" [c2, 3, 4, 5, 7, 8, 9, 10, 11, 13] whereas other colleges suggest the curriculum specified it had met requirements [c6, 12] The details of how the indicative content was met are not specified ABA outline that the syllabus/indicative content is not exhaustive and rather it provides an indication of the content of the programme in terms of the range of topics and gives no indication of the weighting of each topic in the curriculum" (ABA 2000 p 18)

The broad category 'hours' rather outlines the emphasis in each of the programmes to the indicative content in figure 4.3 As seen in figure 4.3 nursing studies and the biological studies take the lion share of emphasis although the topic areas identified by the regulator include "nursing," "communication and interpersonal skills," "the individual in health and illness," "health promotion," "professional and personal development" and "health care systems" (ABA 2000 p 18-20) Each programme organised the themes or modules of teaching in various ways No college developed their programme related to the five domains of competence identified by ABA i.e. "professional/ethical practice, holistic approaches to care and the integration of knowledge, interpersonal relationships, organisation and management of care, and personal and professional development" (ABA 2000 p 14) The subject areas and

content in the curricula reviewed reflected more the curriculum structure identified in the Diploma/registration programme (NEATE 1998 p 64) rather than the new Requirements and Standards for Nurse Registration Programmes devised for the Degree/registration programmes by ABA (ABA 2000)

The uniqueness of each programme, with the exception of the colleges who collaborated to produce one curriculum [c4, c8-11, c13], is recognised as reflective of the principle of flexibility identified by the Nurse Education Forum (Government of Ireland 2000 p 59) It could therefore be argued that confusion has arisen around the plethora of reports and recommendations associated with the implementation of the degree/registration programme and as such has blurred the landscape for curriculum teams in understanding the regulatory function associated with indicative content issues The curriculum does therefore need to explain the connection of curriculum content decisions related to curriculum philosophy and curriculum model The indicative content of ABA needs to be examined in relation to relevance, necessity and relatedness to current health need as it is applied in all programmes

Teaching Beliefs

The broad category ‘teaching beliefs’ reflect ideologies or sets of beliefs related to what and whose knowledge, and what and whose interests such knowledge serves within what Cohen, Manion, Morrison (2004 p 33) describe the curriculum as “ideologically contestable terrain” The premise is that the existence of eclectic learning/educational theories and philosophies within the curriculum influenced the teaching strategies within programmes Across the programmes there were many and varied teaching strategies employed One college did not outline specific strategies for each module/unit but suggested a generic application of the strategies to all modules/units [c5] It was not possible to quantify the totality of the strategies used but it was possible to note the frequency of each strategy associated with each unit of study and the types of strategies for each unit of study There appeared to be a significantly greater emphasis upon a variety of teaching strategies within the nursing modules of the programmes when compared to the strategies identified in the module descriptors in the biological and social sciences There was a reported emphasis on the selection of strategies appropriate to the context, subject and the teacher and

student factors from the databit that can be associated with six colleges “congruent with the subject matter” [c2, 3, 9, 10, 11, 12] The databits further suggest a full range of strategies were employed in three colleges along a continuum with “strategies range from student centred to teacher centred The focus is on development of self-directed and autonomous learners” [c7, 8, 13] The teaching beliefs are therefore interesting to examine in respect of the teaching learning strategies employed in the colleges What was unfortunately not revealed was the relationship between the beliefs and the outcomes of the programme The relatedness of this should be captured by the regulator

Teaching Learning Strategies

The broad category ‘teaching learning strategies’ was supported by the databits of one college, which suggested that there was considerable endeavour from the colleges to utilise “a full and broad range of teaching methodologies is advocate in the programme” [c13] The commitment to teaching and learning was evidenced in one college who cited “college has Dean of teaching and learning” [c12] There was further evidence of the use of strategies such as role-play and critical incident analysis as innovative strategies Student effort and guided self-directed learning was prominent across programmes as evidenced by the emphasis associated with effort hours identified in most colleges (see figure 4 7) The centrality of the student clinical experience in facilitating learning was confirmed as a significant methodology by the hours attributed to clinical hours in the curriculum (see figure 4 10) However the databits of one college reported, “concerns regarding the length of the teaching day were raised by the students, these concerns are contrary to the philosophy of the programme” [c13] and another databit of one college suggests “students stated they spent many contact hours in the classroom and most of the theoretical component of the course was delivered by lectures” [c4] Another college from the databits is quite clear how the choices are determined with “strategies are determined within college based on subject matter and group/class size” [c12] Further this college suggested “lectures, tutorials, practical demonstrations and supervised practice are the dominant strategies within college” [c12]

The most popular cited strategies as determined from a summation of the strategies identified in the curricular document in order were

- Lectures
- Tutorials
- Interactive discussion
- Reflected Practice Exercises
- Group work
- Simulation
- Seminars
- Computer assisted learning
- Clinical Teaching

The breakdown of how these were achieved is represented per college as cited in the documentation and represented in Figures 5.9 and 5.10. The aim of the registration/degree programme is to ensure that students acquire the skills of “Critical analysis, Problem solving, Decision-making, Reflective skills, and Abilities essential to the art and science of nursing” (ABA 2000 p 14). The connection of these outcomes to the chosen teaching strategies is also an area worth pursuing with the course development teams to interpret their expectations of actual and intended outcomes in their programme. Of particular note is the emphasis of the college toward clinical teaching as a methodology as opposed to clinical learning where over half the time attributed to the programme is conducted. The involvement of the college teaching staff in the clinical learning environment is an issue warranting further exploration.

It cannot, however, be interpreted that the strategies identified over were used all the time in all the colleges but that the curricula identified the strategy associated with a unit of study or a module or as available in the curriculum. Of note is the summation of the main teaching strategies identified in the colleges.

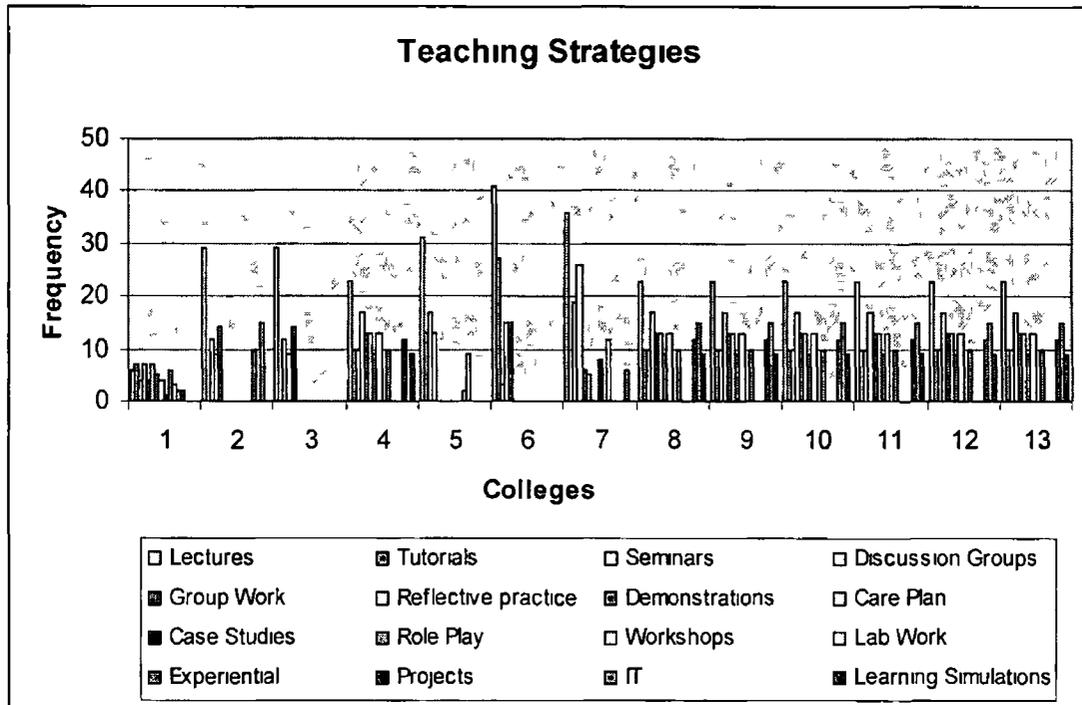


Figure 5 9 Teaching Strategies

This figure should be interpreted with caution as it reflects the intended, as opposed to the actual, identified teaching strategies. Of more importance is the perception of the students that lectures were the predominant teaching strategy.

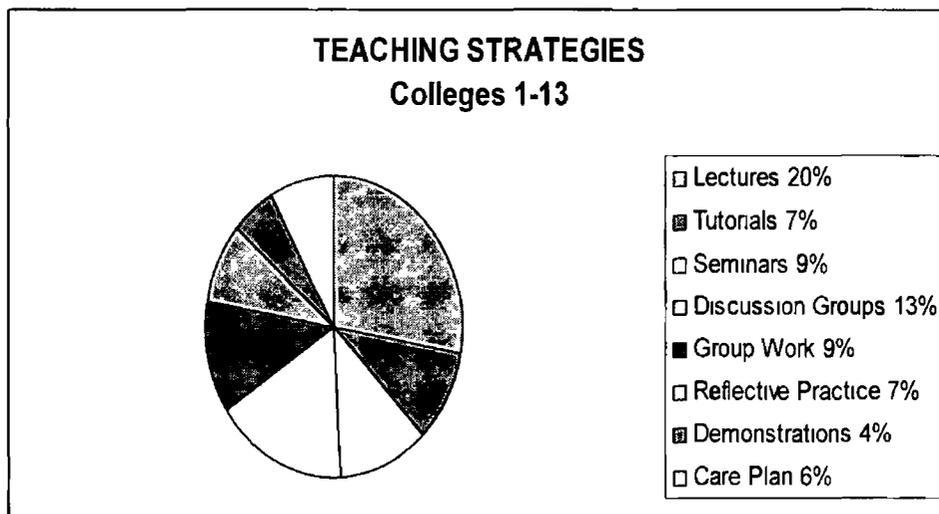


Figure 5 10 Summative Main Teaching Strategies

Reflective Practice / Reflection

The broad categories of ‘reflective practice’ and ‘reflection’ identified by the expert group are also outcomes of the registration education programme identified by the regulator (ABA 2000 p 13 & 14) and supported by the Nurse Education Forum (2000 p 71) Despite the evidence associated with teaching learning strategies the databits indicate “reflection is a key learning strategy employed in the programme” [c3] by one college and “students will be expected to reflect upon their own practice and the theoretical issues relevant to it” [c8, 9, 11] in another three Another college suggest the types of teaching learning strategies were “chosen to develop students’ deeper understanding rather than focusing on recall alone developing students’ problem solving and analytical skills” [c2] One college further explains the relationship of teaching learning strategies and reflective outcomes by suggesting the strategies include “reflective practice, negotiated learning contract, experiential learning includes role-play debating, student presentation, clinical laboratories and demonstrations” [c3]

Reflective practice was cited as a teaching and learning strategy in all the programmes and the centrality of it is demonstrated in the databit “reflection is a key learning strategy and each student is guaranteed 4 hours of reflective time per week in clinical practice” [c4, 13] In another college the databit suggests “reflection is identified throughout the programme as a teaching/learning strategy” [c1] The notion of reflection as a disparate strategy for practice alone was not supported by the following databit that states, “students will be expected to reflect upon their own practice and the theoretical issues relevant to it” [c8, c9, c11] The integration of teaching and learning methods in seen by the databit of one college that states, “reflection is incorporated into various units of the programme The CPC’s and the nurse tutors assist students reflect on their experiences during clinical placements A discreet section of the curriculum is devoted to reflective practice” [c3] In another college it is noteworthy that reflection was “only cited 5 times in all the unit descriptors” [c7] It must also be noted that another college states “students’ opportunity to reflect and engage in self-discovery is primarily confined to their time within clinical allocations” [c4] It should be noted that this particular college also

had databits that contradicted this stance with “in year 1 students are introduced to the concept of reflective practice in theory as a teaching strategy ‘group reflection’ and content as the nature of reflection, reflection and nursing, reflective journals and diaries” [c4]

The utility of reflection as a teaching strategy was gleaned from another college databit “adopt a reflective, problem-solving approach that ensures that the ethical dimension of nursing care is recognised and respected” [c5] The association of reflection with ethics was also seen in another college [c6] The one area where the actualisation of reflective practice was considered problematic was in the practice arena by the databit of one college “students are afforded the time for reflection however in many areas registered nurses find facilitating this difficult” [c13] In summary, the stated teaching learning strategies and the outcomes of the programme supported the broad category reflective practice A number of colleges however relegate it to the practice environment where 4 hours a week are allocated to reflective practice It cannot therefore be assumed that practitioners in the clinical area are prepared to facilitate this teaching and learning strategy The recommendation of the Nurse Education Forum (2000 p 71) “that specific periods of protected time be identified for reflection during supernumerary and rostered placement” appears to have been met It would be interesting to compare the effects of the different teaching learning approaches to reflection utilised in the various colleges and how these differences affect the programme outcomes

Problem Solving / Research

The broad categories ‘problem solving’ and ‘research’ as identified by the expert group relates to the databit which embraces two of the skills requirements of the programme identified by both the regulator (ABA 2000 p 13 & 14) The databit “content and assessment strategies will assist them to problem solve in a variety of contexts, select information appropriate to their practice and use pertinent research” [c2] conveys the integrated notion of teaching and learning strategies and the assessment processes The notion of teaching to cultivate a research culture was supported by the databit of one college who suggested, “research is taught in year 2

and year 4 and assessed accordingly” [c7] The overall learning outcome identified by ABA of “demonstrate development of skills of analysis, critical thinking, problem-solving and reflective practice” (ABA 2000 p 13) was supported by the databits of all colleges with “the concepts are part of the overall and individual unit learning outcomes and assessment strategies of the programme including formulation of formal essays, nursing care plans, critical incident analysis, research proposal and the submission of work demonstrating competence” [c11] The link of required learning outcomes to teaching and learning strategies in the curriculum is acknowledged. The challenge for an approval system is the explicit correlation of the concepts to curricular features in order to support the linkage of requirements to essential constructs inherent in knowledge for practice.

Philosophy of Nursing

The broad category ‘philosophy of nursing’ was associated mainly with the teaching teams’ beliefs of nursing. Within the programmes there was considerable evidence of the use of philosophies of nursing care as evidenced in one college by “philosophy of nursing addresses concepts of caring, dignity, health promotion, and the person as an individual” [c2]. Another databit suggests “the teaching team’s beliefs about nursing include facilitation, caring, accountability, teamwork and collaboration and knowledgeable and competent” [c3]. In some programmes there was a wide philosophy of nursing with databits that stated, “beliefs about nursing include interactive caring process, teamwork and most up-to-date knowledge and skills based on a model of nursing which reflects the holistic nature of patient care” [c5]. The aim of the course was also identified with the philosophy by the databit “the aim of the course is to prepare a competent, knowledgeable, accountable practitioner, who can provide holistic, systematic care for individuals and groups in a variety of settings within an increasingly culturally diverse health care system” [c4, 8, 9, 10, 11, 13]. These colleges refer that their programmes reflect “the learning outcomes of ABA 2000 p 13” [c4, 8-11, 13]. While the colleges advocated particular philosophies the evidence of one databit suggests the clinical practice environment also provided a perspective in “staff advocates a philosophy based on caring, competence, commitment and respect” [c10]. The integration of a nursing philosophy could only

be gleaned from the databits of one college by “the value of nursing as a contributory factor to healing, well-being and the centrality of the patient within the philosophy was realised in the individual units visited through the locally devised mission statements” [c12] The evidence therefore suggests that the centrality of nursing values permeates the programme The philosophies are articulated as value orientations

Models of Nursing

The broad category ‘models of nursing’ emerged from the databits to the expert group through association of the exemplar databit “the nursing process is utilised with the Roper, Logan and Tierney model of nursing care” [c4] While this congruence between the philosophy within the curriculum and clinical sites is espoused the evidence suggests the predominant model of nursing care in practice throughout Ireland is the “Roper, Logan Tierney model” utilised in the main health care institution of ten colleges [c1, 2, 4, 6, 8, 9, 10, 11, 12, 13] Limited evidence was found of additional models in other associated health care providers of colleges with the “Nottingham” [c1] model in one college, “Orem” [8, 9] is utilised in two others, although there is no evidence in the databits of the nursing model utilised in three colleges [c3, c5 and c7]

In one site where no overt model was identified it is suggested by the databit “beliefs about nursing include interactive caring process, teamwork and most-up-to date knowledge and skills based on a model of nursing which reflects the holistic nature of patient care” [c5] In many sites the philosophy of nursing was operationalised using the nursing process as reported by four colleges [c4, 9, 11, 12] The evidence supporting a systematic approach to providing nursing care was provided in the majority of programmes The critique however of the predominant model utilised suggests a systems approach to providing care, which it can be argued, is a model that supports a biophysical approach to understanding the needs of individuals One programme must have identified this dissonance as a databit suggests, “focussed care planning is employed to enhance the social and psychological dimensions of the programme” [c11]

Team nursing was identified from the databits as the methodology for organising nursing care in four colleges [c3, c4, c8, 10], and primary nursing in two others [c2, c8] was reported as the structure for organising nursing care. One college databit suggest “evidence of team nursing and the utilisation of a triage system are evident” [c4]. Concepts underpinning these philosophies were evidenced in “objectives available” in “each clinical area” [c1-13] where there was “evidence that clinicians and their experiences are central to change” [c8]. The evidence of one databit suggested the “aim of nursing care is to provide individualised holistic care to patients in a safe and friendly environment” [c2] and another “holistic approach to care espoused” [c6]. The notion of the centrality of the patient as a member of a family is also evidenced in the databit of one college with “provision of care also includes the family” [c2]. While a nursing model directs the understanding of an individual’s needs, the use of an individualised approach to providing care as in primary nursing or as a member of a team in team nursing, the predominant model i.e. Roper, Logan and Tierney (1990), suggests there is a dissonance between the taught philosophies and the practice environment. In this incidence demonstrated nursing care in the practice environment reflects an illness and disease orientation rather than reflecting the potential of nursing to promote a positive adaptation to the stimuli and stresses encountered by the client (Roy 1972).

Learning Outcomes / Evaluation

The expert group identified the broad categories ‘learning outcomes’ and ‘evaluation’ in response to databits that suggested “learning outcomes are available in each clinical area to promote and support student learning during placement” [c3]. Further evidence from most of colleges outlined, “learning outcomes were jointly identified by the nurse practitioners, clinical placement coordinators and nurse lecturers” [c2, c3, c4, c8, c9, c10, c11, 12, c13]. In nearly all incidents it can be asserted, as indicated in a databit of one college, that “evidence of clinical staff central to the development of clinical learning objectives/outcomes” [c10]. The joint identification of learning outcomes supports the provision of an integrated programme and was seen with the databit “groups develop policies that are pertinent to specific areas” [c9]. A focus on continuous review and evaluation of the objectives to support

learning outcomes was encountered in one programme with the databit “care planning documentation was reviewed in 1998 and is audited annually” [c10] This was also seen in another programme with the databit “there is a major emphasis within the hospital on auditing the nursing documentation and changes are then instigated following audit results” [c7] The link of evaluation and learning outcomes was also a component of the internal quality assurance that was reported in one college databit as, “formal evaluation exists” [c6] The notion of gathering data to inform the development of a course was gleaned from the databit of one college “feedback to course management from CNM’s and CPC’s considered invaluable” [c8] In many of these situations the objectives were viewed as a working document utilised to support and direct student learning through and for practice In a number of programmes there was evidence of local clinical staff being involved in the development of objectives tailored to the specific clinical context with the databit “the staff endeavours to provide evidence-based care while maintaining the patients’ privacy and dignity” [c2] This observation of integrated development of outcomes was in a databit that reflected the integrated philosophy of the curriculum and seen in “commended for the coordination and evidence-based approach to the development of policies, protocols and guidelines” [c7]

In respect of evaluation it was gleaned from the databits that colleges adopted different approaches to evaluation Students were reported as “having a role to play” in one college but were “not central to the process” [c4] In two others students were formally involved in evaluating the programme [c3, c5, c9] by “at the end of the year students will evaluate both theoretical and practical components” and in one college students were central to the evaluation process with the databit “students are central to evaluation and on the course management team” [c1] In another college the utility of evaluation was gleaned from the databit “evaluation tool included in the curriculum and is part of becoming a learning organisation Students staff and extern examiner evaluate programme” [c2] It was suggested by the databits of another college that harmonisation of the process would be appreciated by the databit “evaluation of modules and the programme occurs There is no formal evaluation of the clinical areas and this would be welcomed by the clinicians” [c13] In one other college the issue of evaluation was addressed in the databit “no formal mechanism

exists, evaluation is considered problematic” [c10] It can be summarised that learning outcomes are identified by a number of stakeholders to the programme and there is a mechanism to evaluate the relevance and utility of the outcomes in respect of the programme and the clinical environment Evaluation as a concept is varied throughout the programme structures and students are central to the process in only a few colleges despite this being a recommendation of the Nurse Education Forum (2000 p 62)

Clinical Placements

The broad category ‘clinical placements’ refer to issues with the clinical component of the programme Clinical practice, as seen in Figure 4 10, constitutes a significant component of the programme for the students The range of clinical learning hours is 829 reflecting spans of 2709 hours clinical practice in two colleges [c2, c3] as the lowest and 3468 hours [c1] as the highest with a mean reading of 2957 clinical practice hours The requirement of ABA in respect of clinical instruction was “2646 hours over 74 weeks” with the EU requirement specifying “no less than 2300 hours” (ABA 2000 p 22) All programmes meet both sets of requirements in respect of clinical instruction hours as seen in figure 5 11 over

The requirements of ABA further stipulated that the clinical instruction component “include 14 weeks at 39 hours per week” (ABA 2000 p 22) In reality all programmes supported the inclusion of 47 weeks clinical placement at 39 hours per week between year 3 and year 4 This element of the Requirements and Standards of ABA requires review to reflect the reality of the programme as outlined in the Report of the Commission on Nursing (1998), and the Nurse Education Forum (2000 p 78), to support a twelve-month rostered clinical placement

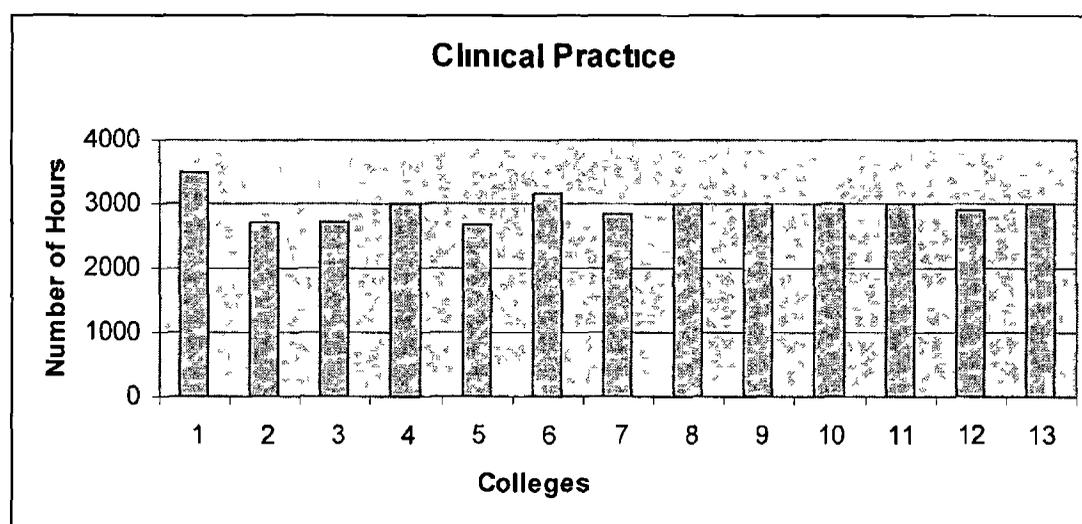


Figure 5 11 *Clinical Instruction Hours*

Range of Placements / Clinical Placement Map / Specialist Placement

The broad categories ‘range of placements,’ ‘clinical placement map,’ ‘specialist placement’ were identified by the expert group and are attributed to the core category of curriculum by the researcher as clinical learning comprises over half the learning of most of the programmes. The adequacy of the clinical experiences was in the main favourable with examples of databits such as “practice placements will provide the students with the required experience” [c2, 3] in two colleges and “the clinical placement map is designed to provide the students with sufficient exposure to the practice environment to meet the necessary elements of a pre-registration programme” [c5]. The significance of clinical instruction within the programme is demonstrated in the databit of one college “the clinical component of the programme is seen as most important in the learning experience” [c7]. The placement sites for obtaining the clinical practice experience varied depending on the availability of experiences. It was noted from the databits that there was “congruence between the curriculum and the clinical sites” [c7] and another databit developed this theme by suggesting “the proximity between classroom teaching and experiences in nursing practice, relating to particular issues will enhance the potential for integration between the two” [c5]. This was not universal however as evidenced by the databit of one college, which suggested “specialist placements can occur throughout the programme and do not appear to match theoretical input for all students” [c1].

The “range of placements” available to students was reflected in the main as a mechanism for academic achievement as evidenced by the data that “placement in the practice setting is considered central to students’ examination of the relevance and applicability of content explored in class to practice” [c2, 3, 4, 9, 10, 11, 12, 13] whereas one programme suggests “clinical placements are an opportunity to consolidate nursing theory and practice in preparation for her role as a registered practitioner. Placement in the practice setting is considered central to students’ examination when students are facilitated to reflect on their experiences” [8]. Some evidence was presented to support the notion that practice sites structured these objectives within taxonomies and linked them explicitly to the aims and objectives of the curriculum with the data that “there are core objectives for each year of the programme and specific objectives for specialist areas” [c6] and in another college “progressive development included in the expectations of each clinical placement opportunity” [c10].

The ability of the programmes to meet the specialist placement experiences as required by EU and ABA as “Medical Nursing –General/Specialist, Surgical Nursing –General/Specialist, Accident & Emergency – Outpatients, Child Care & Paediatrics, Mental Health & Psychiatry, Care of the Older Person, Home Nursing/Community, Operating Theatre, Maternity Care” (ABA, 2000 p 22) was identified with the data that “taught clinical placement is an integral part of the 4 year programme. Students will be exposed to a wide variety of clinical allocations which will prepare them to operate within an increasingly complex and demanding health care setting” [c8]. The specialist placement requirements posed a challenge in some of the programmes which necessitated “additional placements occur in sites that were visited by the ABA team to be approved” [c1, 2, 4, 5, 6, 7, 9, 10, 11, 12, 13] with remaining sites utilising sites previously approved. The identified types of sites where it was a challenge were midwifery, children’s nursing and psychiatric nursing. Three colleges had difficulty in obtaining psychiatric nursing experience alone [c2, 3, 4], two colleges had difficulty obtaining psychiatric and children’s nursing [c1, 7], with one college reporting a difficulty in obtaining psychiatric nursing and midwifery [c6] and five colleges suggesting difficulty in obtaining psychiatric nursing and care of the

elderly placements [c8, 9, 10, 11, 12] necessitating approval of new sites by ABA. It was noted that “objectives of placements reflective of ABA objectives” [c13] were noted in the databits where there was “one general hospital with 5 other sites used to achieve the experiences required” [c13].

The specialist placements it could be gleaned from the curriculum documents and the placement maps were experienced in year 2 and year 3 of the programme in some institutions [c2, 3, 4, 6, 8, 9, 10, 11, 13] where “theoretical preparation occurs in modules in these years” with the remaining four colleges utilizing the 4th year to achieve specialist placements. A number of programmes however identified problems with the specialist placements with examples of “procuring psychiatric placements for the general students was creating a difficulty” [c10] and “programme is dependant on a large number of external placements to achieve the required experiences of a registration programme” [c13]. The databits from one college indicate that in one programme it emerged “the content for each of the specialist areas for the 3 years is the same and the learning outcomes are the same ‘discuss the role of the nurse and the principles of caring for the client in the specialist nursing client group settings” [c1]. In another databit of another college the identifications of suitable placements was contested as it reported, “many clients are over 70 years and are dependent on total nursing care. Hospital management takes the view that this is an acute medical unit” [c13]. In summary the databit of college identifies the main issues associated with clinical learning were “students will be exposed to a wide variety of clinical allocations which will prepare them to operate within an increasingly demanding health care setting” [c8]. This aspiration is laudable in relation to current health policy.

The challenge of the programme in relation to clinical learning was the availability of suitable opportunities for learning, which was reflected in the databit of one college “programme is dependant on a large number of external placements to achieve the required experiences of a registration programme” [c13]. In total thirteen HEI’s are offering the registration/degree programme in general nurse training in association with 21 main approved teaching hospitals amounting to 1057 places. In practice a much larger number of sites are required to obtain the required learning opportunities.

The placement site for obtaining the clinical practice experience varied depending on the availability of experiences. The commitment of the colleges to seek and provide experiences is acknowledged and some colleges are not as challenged as others to provide the experience. The regulator needs to review the requirements in light of the rostered data and effectiveness and availability of sites to provide placements.

Semester 1 / Semester 2

The expert group identified the broad categories of ‘semester 1’ and ‘semester 2’. These databits refer to early exposure of the students to the clinical practice. The Nurse Education Forum (2000 p.61) recommended “clinical placements should be undertaken early in the programme.” There was evidence from an analysis of the placement plans that students were exposed to the clinical areas in a variety of timeframes with three programmes introducing students after the first three weeks of the programme in the guise of day visits in one college [c9] and four hours per week in the other two [c2, 3]. Three other programmes [c6, 11, 12] utilised a two-week placement prior to Christmas in the programme with the remainder of the colleges introducing the students to the clinical area in the second semester. Five colleges [c1, 4, 8, 10, 13] facilitated students in the clinical area in week 15; one college [c5] supported students in week 17; and one college [c7] just stipulates in the curriculum “semester 2 year 1.” In summary it is difficult to make a judgement as to whether the recommendation from the Forum was actualised in all the colleges by providing clinical exposure to students early in the programme. The regulator made no reference as to when the students should be introduced to clinical nursing and this is an issue that could be re-examined in light of current evidence and recommendations from the NEATE (1998) report.

Summary

The higher order category ‘curriculum’ in the core category ‘knowledge for practice’ outlines the essence of linking educational outcomes with processes to achieve requirements in a general nurse registration programme. The analysis of documentary evidence supported by the observations of an expert group suggests the core elements within the higher order category of curriculum was the identification of curricular

structures the content issues, the beliefs of nursing and the clinical practice issues required to support a practice based course. A diversity of approaches was observed to exist between programmes and colleges. The regulator needs to develop clear indicators of its expectations to programme planners to make judgements of whether compliance with standards is achieved.

CONTINUING EDUCATION

The higher order category ‘continuing education’ was associated with the core category ‘knowledge for practice’ from the broad categories identified by the expert group which supported the development of knowledge in students by practitioners and is evidenced in the databit. The broad categories include ‘nurse practitioners,’ ‘shift by shift,’ ‘2 students to 1 RGN,’ ‘clinical support,’ ‘learning oriented to clinical practice,’ ‘CPC’s,’ ‘clinical links,’ ‘liaison role,’ ‘workload,’ ‘staff development,’ ‘professional development and personal growth.’

Nurse Practitioners / Shift by Shift / 2 Students to 1 RGN

In support of the notion of the higher order category ‘continuing education’ the broad categories associated with professional developments and staff to support students was apparent. There was considerable evidence that advocated the centrality of ‘nurse practitioners’ or practicing nurses were the primary learning support for student nurses by the databit “learning outcomes were jointly identified by the nurse practitioners, clinical placement co-ordinators and nurse lecturers” in the majority of colleges [c2, 3, 4, 5, 8, 9, 11, 12, 13]. The role modelling of clinical nurses it was seen in the databit “the nurse practitioner seeks to provide services that meet the preventative, promotional, supportive, curative, rehabilitative and palliative health care needs of families, groups and communities” [c4]. There was consensus among the programmes that students were supervised at all times [c1-13]. The evidence supported student participation in patient care was under the supervision of a registered nurse “shift by shift” in eight programmes [c1, 3, 4, 5, 9, 10, 12, and 13]. This was not always corroborated by the student experience where a databit illuminates that in “A & E there was a problem with too many students being

allocated” [c11] although there appeared to be no problem with an ICU experience [c11]

Issues related to the shift patterns that student engaged in were gleaned from the databit “no evidence collected regarding the 24 hour shift” [c1, c2] A further problem was identified in the databit “problems are experienced particularly during the afternoon shift but largely the ratio is maintained” [c6] In the mam there was an endeavour to have a ratio of one registered nurse to each student [c4, 6, 7, 8, 9, 10, 12, 13] however problems were also encountered with the databit “ratio can be two students to one RGN when student cohorts overlap” [c1] and “problems are experienced with ratio can be six to seven students to four RGN’s when student cohorts overlap” [c2] In some clinical areas this standard is an item of the local clinical learning audit tool “the ratio is audited continuously on occasion the ratio can be 4 6 in general areas” [c7] with another databit “some wards are experiencing too many students per allocation” [c8] Generally the ratio of clinical support related to the number of registered nurses to students was maintained and ensures the clinical learning experiences of students

Clinical Support / Learning Oriented to Clinical Practice

The expert group identified the broad categories of ‘clinical support’ and ‘learning oriented to clinical practice’ The students in seven colleges perceived they received clinical support to achieve the learning outcomes of the programme by the databit “students report satisfaction with clinical support they receive” [c1, 2, 3, 4, 5, 12, 13] The key stakeholder involvement was also seen in the databit “evidence of clinical staff central to the development of clinical learning objectives/outcomes” [c10, 11] and with a further databit that identifies how the support was actualised in six colleges with “all nurses are offered various courses to prepare them for the role of preceptor” [c2, 3, 4, 5, 11, 13] It was reported that the primary function of the clinical placement was to facilitate student learning by the databit “taught clinical placement is an integral part of the four year programme” [c8] In identifying the centrality of clinical practice it was noted from one databit “nurse lecturers will liaise with students while on clinical placements” [c3] This was not universal however

where in one college there were attempts to achieve support with lecturing staff by “some flexibility has been introduced in relation to the specific lecturing hours of staff for improvement in the area of creating worthwhile links with the clinical area” [c13] Clinical nurses were enthusiastic in terms of providing support to students with all programmes It is acknowledged that clinical support from clinical staff is provided to assist students achieve the learning outcomes of the programme but only two colleges facilitate lecturing staff from the colleges to support clinical learning in the clinical environment

CPC's

The broad category ‘CPC’s’ was identified from the databits by the expert group Support from CPCs was universally identified as good by the databit “students identified CPC as good support” [c1-13] The number of CPC’s however was not identified in a number of sites [c1-6, 8, 10-13] with the databit “CPC’s have thirty students each and six areas approx ” [c7] as an indicator of the involvement of the CPC Apart from CPC’s it was noted that students received “considerable support from practitioners, nurse managers, the clinical development coordinator” [c9] although “each clinical placement setting has a named clinical placement coordinator” [c3] Sites accessed for student placement that did not have a history of pre-registration education received the students with considerable enthusiasm It was also identified from the databits that “each clinical placement setting has a named clinical placement coordinator” [c7] and that each area visited by the students had support in one way or another by another databit “named CPC link system in existence” [c8] and “a named CPC is linked to every internal and external placement” [10] It can be gleaned that the CPC is a good support and resource to the students in the clinical area This sentiment of support for the role was expressed by the Nurse Education Forum (2000 p 69) The number of CPC’s however is not identified and is an issue that should be monitored by the regulator to ensure the effectiveness and utility of the role as perceived by students is maintained

Clinical Links / Liaison Role / Workload

The broad categories ‘clinical links,’ ‘liaison role’ and ‘workload’ refers to the databit which states “nurse tutors acknowledged they could strengthen links with the clinical area but current time constraints and necessary prioritisation of workload limit this” [c3] The development of this “liaison role” was established from the databit which identified the role as “liaison/link tutor identified in all areas” [c9] but this was not universal as seen by the databit “nurse lecturers/tutors responsible for delivering the theoretical component of the programme do not have involvement in or contact with clinical areas” [c4] In contrast one programme stated “four lecturers maintain clinical contracts for 2-4 days per month” [c5] The difficulty in the same site of achieving the aspiration of links was evidenced by the databit which states “operate a link lecturer system reported as weak in some areas and non-existent in others” [c13] Another programme identified that “teaching staff are involved in the large number of committees central to the operationalisation of the programme and the hospital services” [c6] and this was seen to suffice as meeting the link criteria It should also be noted that in one college there was criticism of the current status of clinical links operated by lecturers with “students and staff were critical of the lack of nurse lecturer involvement in the clinical practice environment” [c4] This criticism was however not universal as a databit of another colleges states in relation to the liaison role and the link lecturer role contend “nurse lecturers will liaise with students while on clinical placements” [c3] The Nurse Education Forum (2000 p 70) recommended that the “development of joint appointments and other innovative strategies to enhance partnership between the third-level institutions and health service providers, the precise role and nature of which should be agreed within local partnerships” should be further explored and reviewed by those colleges who have not done so to date

Professional Development and Personal Growth

The broad category “staff development” reflected responses in relation to preparing clinical staff to undertake the supervision, support and assessment requirements of student nurses with the databit of one college “clinical staff reported a staff development department Professional development planning is in progress in the

hospital. It is well resourced and has increased staff morale” [c1]. The type of programmes offered could be gleaned from the databit: “currently teaching and assessing and degrees for nurses are offered - a regional programme exists” [c11]. The Nurse Education Forum (2000 p 68) recommended,

Health service providers, in partnership with the relevant third-level institution, should ensure that nurses who support students have attended a teaching and assessing course. It further recommends that within five years of the start of the degree programme all nurses who support students and who have not already completed such a course should have done so.

The databits of one college suggest support is given locally to staff to assist them in undertaking the mentoring role as opposed to devising specific courses away from the clinical environment: “ward based sessions are provided in relation to mentoring” [c8]. One college contends, “200 staff has undertaken the teaching and assessing course” [c9]. In-service education was evident in a number of colleges [c1, 7, 8, 10] and in others the “commitment to staff development acknowledged but mechanism not developed” [c2, 3] and in others this was associated with “research and publication” [c5]. The preparation of staff to support the student was evidenced by the databit, which suggests in three colleges “all nurses are offered teaching and assessing course” [c2, 3, 11] and with another college the databit contends, “60% of staff have completed ENB 998” [c8]. Further information as to the number of staff who completed courses specific to supporting students was not identified in the databits.

The notion of professional development and personal growth was associated with the databit of a college, which stated “a significant education and training culture in existence” [c7]. Another college attributed specific value to staff development in the databit: “clinical staff report a staff development planning is in progress in the hospital. It is well resourced and has increased staff morale” [c1]. The issues were also addressed in other databits as “lecturers engage in continuing and in-service education role involved in practice development” [c10]. The further issue of “research” emerged where it was identified in the databit of one college that “lecturers have a research remit” [c4] and in another “commitment to staff development acknowledged through research and publication” [c5]. The association

of research with development was acknowledged in one college with “a three week research appreciation is facilitated in the hospital” [c6] The health care institutions were further supported through the following databit that states, “a journal club exists to promote the appreciation of evidence-based practice at clinical level” [c6] One college identified that “one lecturer is completing a master’s degree to register as a nurse tutor” [c13] It was reported that the primary function of clinical placement was to facilitate student learning by “taught clinical placement is an integral part of the 4 year programme” [c8] It is suggested from the evidence that “a significant education and training culture is in existence - a large range of in-service programmes” [c7] and that there are staff involved in “available access and support for continuing professional development” [c12]

Summary

The higher order category ‘continuing education’ referred to the preparation of clinical staff to support registration/degree students in the clinical area both to supervise the student and to assess them in order that they fulfil the professional expectation in the core category ‘knowledge for practice’ The evidence gleaned from the databits in the guise of the higher order categories suggests that mechanisms are available in most programmes to support staff to undertake a mentoring role with students Staffs in the health care institutions are committed to the nursing programme and the CPC is viewed as a valuable resource by the students Students perceive that they received clinical support to achieve the learning outcomes of the programme

VALUES

The higher order category ‘values’ was strongly supported by the broad categories regarding beliefs supporting professional practice The broad categories identified by the expert group were ‘centrality of the patient,’ ‘nursing concepts,’ ‘holistic approach,’ ‘interpretation of theory and practice,’ ‘ethical dimensions of nursing care’ and ‘aim of nursing care’

Centrality of the Patient / Holistic Approach / Aim of Nursing Care

The value of nursing was encapsulated in the broad category ‘centrality of the patient’ in which the databit outlined the belief construct of nursing in one college as “the value of nursing as a contributory factor to healing, well-being and the centrality of the patient” [c7] This reflects a regulatory value of the centrality of the patient to the professional nursing role. The databit of one college suggest, “general nursing is conceptualised as a therapeutic caring process. It is concerned with meeting the deficits in the individual’s capacities for health maintenance and health restoration, with particular emphasis on the needs of adults experiencing altered health” [c7]. Understanding the core elements of the nursing contribution to the care environment was further elucidated in the databit from a number of colleges that stated “the aim of the course is prepare a competent knowledgeable and accountable practitioner who can provide holistic, systematic care for individuals and groups in a variety of settings within an increasingly culturally diverse health care system” [c4, 8, 9, 10, 11, 13]. This theme was also seen in another college whose databit suggest “the aim of the nursing care is to provide individualised holistic care to patients in a safe, friendly environment. The staff endeavours to provide evidence-based care while maintaining the patients’ privacy and dignity” [c2].

Learning in practice these values was viewed as a team effort involving the key stakeholders where institutions identified that “holistic care espoused” [c6]. This theme further elaborated on the learning philosophies that were evident within the clinical areas which stated the aim of nursing care was “to provide individualised holistic care to patients in a safe environment” [c3] and in some instances the student was facilitated to achieve and understand the permeating patient centred value by the comment “student orientation was provided” [c11]. The student was exposed to environments in one college where they could familiarise themselves by “experience a holistic approach to care for patients/clients experiencing a range of medical/surgical problems” [c9]. In respect of clinical learning it is noted that “practice placements were selected to ensure that programme learning outcomes are met” in seven colleges [c2, 3, 4, 9, 10, 11, 12]. The mechanism for identifying suitable learning placements was articulated in one college as “clinical audit tool

requires each clinical area to identify learning opportunities for the student and provide a range of learning tools to assist the student achieve their potential in a supported manner” [c1] The clinical audit tool was however requested by ABA in a number of programmes [c2, 3, 7, 8, 10, 12, 13] The audit tool was seen in some cases and “a most comprehensive audit tool has been devised and utilized to operationalise the site for use to identify and meet the educational requirements” [c9, 11] in two colleges In summary the imparting of values was seen as both an academic and practice based event Students were exposed to the notions of holistic care and the centrality of the patient to the care experience The fact that a number of colleges haven’t submitted self-audit evidence of how this is achieved in reality is an issue worth pursuing by the regulator

Integration of Theory and Practice

The broad category ‘integration of theory and practice’ reflects the underpinning value of a practice-based course for a practice-based profession The evidence to support the actualisation of this principle and requirements of ABA and the EU (ABA 2000) for no less than one-half the programme to be devoted to clinical practice ensures that the students achieve “transferable skills and their attributes of communication, group work, interpersonal, personal, organisational, problem solving, social and community awareness, resource management, information, clinical skills are identified” [c5] as stated by one college The reflection of integration was best seen in the databit of one college which states “programme involves a strong emphasis on the practice of nursing and on an integrated curriculum design In all programmes it was evident from the exemplar databit “the clinical component of the programme is seen as most important in the learning experience” [c7] The notion of students valuing the clinical component of the programme is seen in “placement in the practice setting is considered central to this examination of the relevance and applicability of content explored in class to practice” [c2, c3] The value of achieving the requirements was further articulated as “nursing students need exposure to practice through a range of placements in different setting in which care is delivered” [c5] There also was evidence within the structuring of assignments that attempts to capture the integration of theory and practice This is evidenced by the databit “taught clinical placement is assessed through a workbook and a project for

each of the four years” [c4, 8, 9, 10, 11, 13] A wide range of assessments appropriate to the nature of the module was evident within the module descriptors. Some programmes tried to achieve integration by the databit of one college, which stated “the proximity between classroom teaching and experiences in nursing practice, relating to particular issues, will enhance the potential for integration between the two” [c5]. There was evidence to support the integration further by the databit that stated the programme “ensured the acquisition of professional competencies at point of registration” [c12]. Overall, it can be surmised from the databit of one college, “structures and processes are needed to ensure the integration of theory and practice and effective collaboration between third-level nurse lecturers, students and clinical staff in practice setting” [c5]. The regulator needs to ensure that the value of the centrality of the patient and practice learning continue to be supported and enhanced if the programme is to continue to support a practice based professional.

Ethical Dimension of Nursing Care

The broad category ‘ethical dimension of nursing care’ is reflective of the inherent belief of professional practice being rooted in a code of ethical practice. The overt reference to the “Code of Professional Conduct” (ABA 1988), which is identified as an outcome competence of the programme (ABA 2000 p 15), was not gleaned from the databits reviewed. Rather the databits refer to the role of the nurse and the aim of the education programme with databits such as “emphasis is placed on the provision of the most appropriate care and in particular on primary health care” [c4] in one college and “caring identified as core skills which facilitate the delivery of systematic individualised nursing care” [c2] in another. The overall aim of the course is encapsulated in the databit of one college, which suggests the programme is “evidence based congruent philosophy centralised on caring” [c10]. Further another college databit states “concepts articulated include valuing the person, caring, rights of the individual, optimal health orientation, choice, knowledge and skill. There is recognition of frailty and illness as well as primary care” [c1]. The “philosophy related to beliefs and values on nursing, the person receiving nursing care, health and health care, the environment in which nursing is practised and learned, and education and learning are articulated” [c6] was expressed by another college. This college

further elaborated that the programme was designed “to enable students to develop critical thinking about moral perspectives and to deal effectively with ethical dilemmas encountered in practice” [c6] The explicit relationship of professional competencies required for registrants (ABA 2000) is not overt in the programmes This is an area the regulator needs to further explore

Summary

Values as a higher order category within the core category ‘knowledge for practice’ is identified with the centrality of the patient to the meaning of the education programme The regulator needs to gather further information related to the underpinning values of both these issues to affect a regulatory role that is concerned with protecting the patient/client

CONCLUSIONS PHASE ONE

Phase one data generation and analysis illuminated how the programmes are currently operating in the thirteen colleges offering the registration/degree programme in Ireland The findings and discussion relate to the methods employed to analyse the data generated and the process suggested by Stake (1985 p 223), in which Stake advises five stages but this discussion illuminated the first four stages of his approach

- The evaluator collects and analyses the descriptive information (and describes the programme’s rationale)
- The evaluator identifies the *absolute standards* (those formal and informal convictions held by relevant reference groups of what standards of excellence should obtain)
- The evaluator gathers descriptive data from other programmes and derives *relative standards* against which to compare the program of interest
- The evaluator assesses the extent that the programme of interest meets the absolute and relative standards

The overall main conclusion is that a variety of approaches have been adopted on a national basis to achieve the Requirements and Standards of the regulator (ABA 2000) Many of the colleges meet some of the requirements The core categories identified from the analysis of the data emerged as ‘Governance,’ ‘Quality in

Education,’ and ‘Knowledge for Practice ’ In examining these core categories in respect of developing a new framework the researcher determined it would be useful to understand which standards of the regulator posed a difficulty to adhere to and which standards were complied with as a component of the discussion to illuminate the next phase of the research process

Judging Compliance

In following Stake’s (1985 p 223) model for conducting an evaluation stage five suggests, “Singly or in collaboration with others, the evaluator judges the programme, that is, decided which standards to heed More specifically, he assigns a weight, an importance, to each set of standards ” In acknowledging this stage and addressing the question Is the programme being implemented as originally authorised and prescribed? A judgment was developed by the researcher to each set of standards Compliance was associated with making a judgement in respect of capturing how the

Requirements and Standards (ABA 2000) were being met on a national scale following the examination of the provision of courses currently operating In addressing this issue the original method of gathering data was re-examined and in respect of the identified indicators used to gather the data (appendix C) the researcher made a judgement as to the individual colleges compliance with the original standards of ABA being aware that the question, the indicator and the evidence to support a judgment were identified by herself

In trying to judge compliance the process notion of the implementation of the registration/degree programmes for general nursing was acknowledged by the researcher in determining whether compliance was achieved or not The compliance issue was looked at in three determinations i e full compliance, partial compliance, non-compliance and another determination of no evidence supplied In examining the fifty three standards of ABA that were grouped by the regulator into definitive areas of standards for the approval of the third level institution and health care institution, curriculum design and development, clinical practice experience, assessment and external examiners (ABA 2000 p 46-50) An overall picture of the compliance of the colleges to the individual standards is represented in figure 5.12 It was judged that

overall the programmes were mainly in full compliance with the indicators of the standards nationally. Of a possible compliance score (53 standards x 13 colleges = 689) full compliance represented 66% of the total items (454 items of compliance), with partial compliance representing 26% (178 items of partial compliance) of the total items of standards. Non-compliance was 1.5% (n=10) and unknown was 7% (n=47). The judgement of partial compliance was hard to establish and was attributed if any evidence no matter how small could be evidenced. The unknown group represented a judgement where no evidence was found by the researcher to enable a judgement. Of significance in this unknown group is the issue of data supplied and data gathered. This highlights the observation of the absence of indicators related to each standard to enable comparisons and judgements. Also highlighted is the inconsistent methodology of generating data and reports by the regulator.

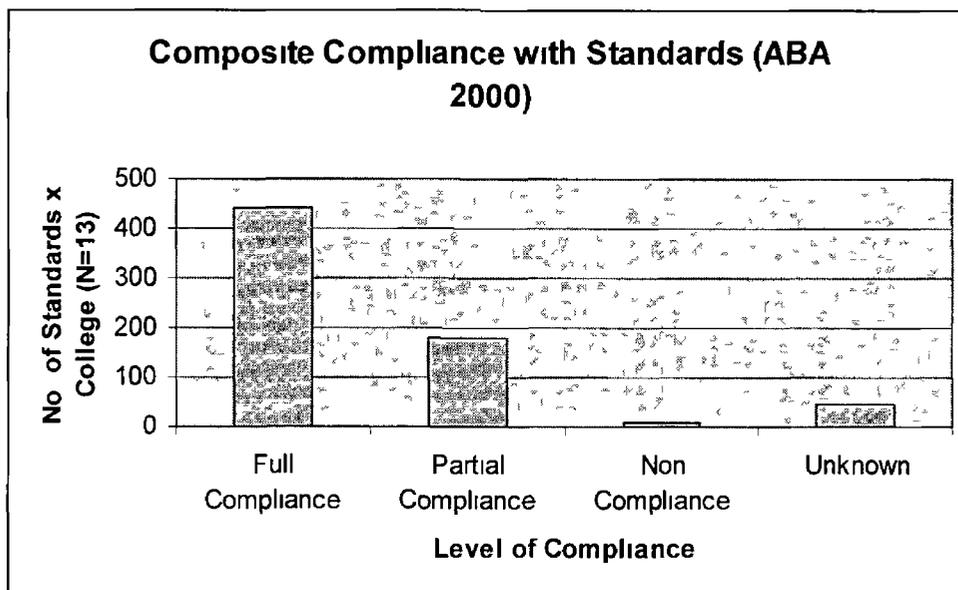


Figure 5.12 Composite Compliance with the Standards of An Bord Altranais (2000)

Of significance in looking at this representation is that a third of the programmes had a difficulty in achieving full compliance. No sanctions were imposed by the regulator in this respect and although there was evidence of conditions of approval to colleges and recommendations for approval to colleges, insight of such difficulty in achieving compliance of a new programme should be considered in relation to the international experience where the CCNE (2003) suggest that all new programmes receive initial approval for a five year period after which all standards should be met.

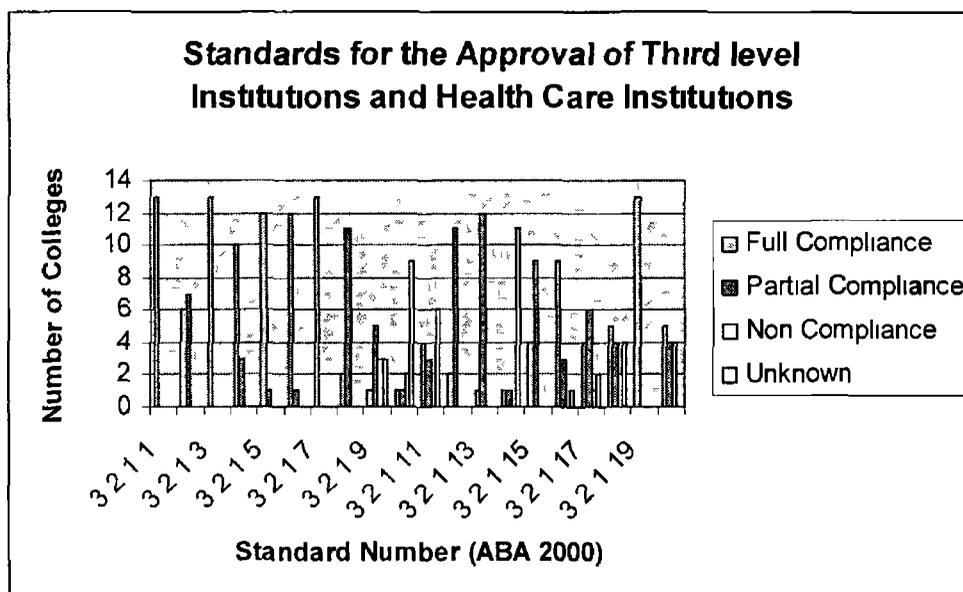


Figure 5 13 Standards for the Approval of Third level Institutions and Health Care Institutions

The standards related to curriculum design and development (n=11) identified issues of partial compliance related to adhering to the requirements of ABA and the EU in nearly half the programmes (ABA 2000 3 2 2 1) (see Figure 5 13) The development of the curriculum by registered nurse tutors “guided by professional nursing knowledge which is evidence/research based” (ABA 2000 3 2 2 3) and by a team that “comprises representative members of key stakeholders in nursing education and practice” (ABA 2000 3 2 2 4) is also a difficulty for about half of the programmes A lesser number of colleges had difficulty in providing a range of teaching learning strategies (ABA 2000 3 2 2 6, 3 2 2 7) though it posed a difficulty for some colleges as seen in Figure 5 14 The standards associated with quality assurance (ABA 2000 3 2 2 10) posed a difficulty of partial compliance for more than half the programmes This is quite a significant finding where the regulator is performing “guild regulatory activities” (Kells 1992 p 32) in the absence of clear institutional level and programme, discipline or departmental level and individual professional level activities This worrying finding is one worth further exploration with the higher education authorities and their relationship with the regulator as an agent of quality assurance No evidence was collected in relation to two-thirds of the programmes for “criteria and mechanisms for international exchange” (ABA 2000 3 2 2 11)

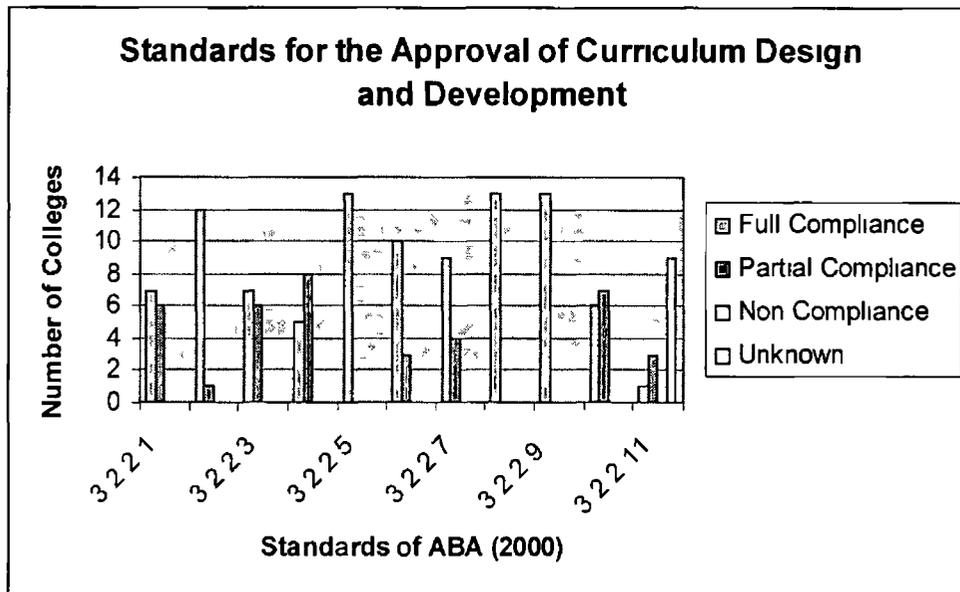


Figure 5 14 Standards for the Approval of Curriculum Design and Development

The standards for the approval of the clinical practice experience (n=9), as seen with figure 5 15, illuminate partial compliance in three of the standards. The support in the curriculum for identifying an integration of the theoretical and practice components of the programme was identified as partial compliance with “the selection of areas for clinical experience reflects the scope of the health care settings and supports the achievement of the learning outcomes of the educational programme” (ABA 2000, 3 2 3 2) Supporting the clinical experience of the students was seen as an area of partial compliance in a number of colleges with the standards “named registered nurse tutor on liaison with named clinical placements coordinators/preceptors and register nursing staff guide and support the students in ensuring that the clinical placement provides an optimal learning environment” and “clinical practice includes the 24 hour cycle of patient care. At all times there must be sufficient registered practitioners to facilitate the supervision of student nurses. It is recommended where possible this should be a ratio of one student to one registered practitioner” (ABA 2000, 3 2 3 7, 3 2 3 9) It can be assumed that the staff resource in the clinical area is an issue that the colleges need to be aware of to ensure clinical experience achieves the required outcomes of the programme.

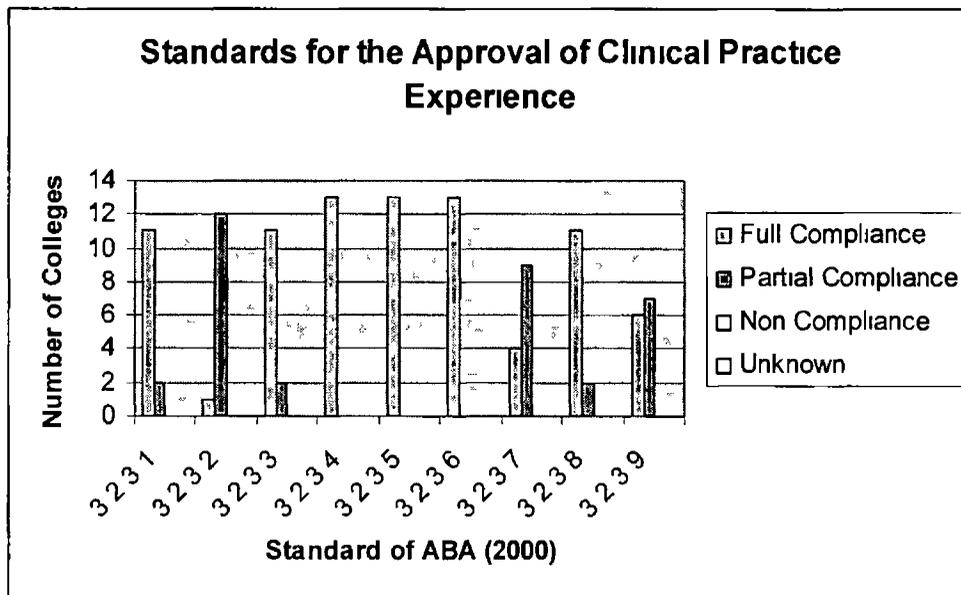


Figure 5 15 Standards for the Approval for Clinical Practice Experience

The standards for the assessment process (n=9) only identified one standard where partial compliance was an issue as seen in Figure 5 16 The standard “assessments, including final assessment, are based on a variety of strategies which are aligned with the subject area, practice setting, stage of the educational programme and expected learning outcomes” (ABA 2000, 3 2 4 2) is partially complied with This judgement is associated with the integration of the programme and the assessment outcomes

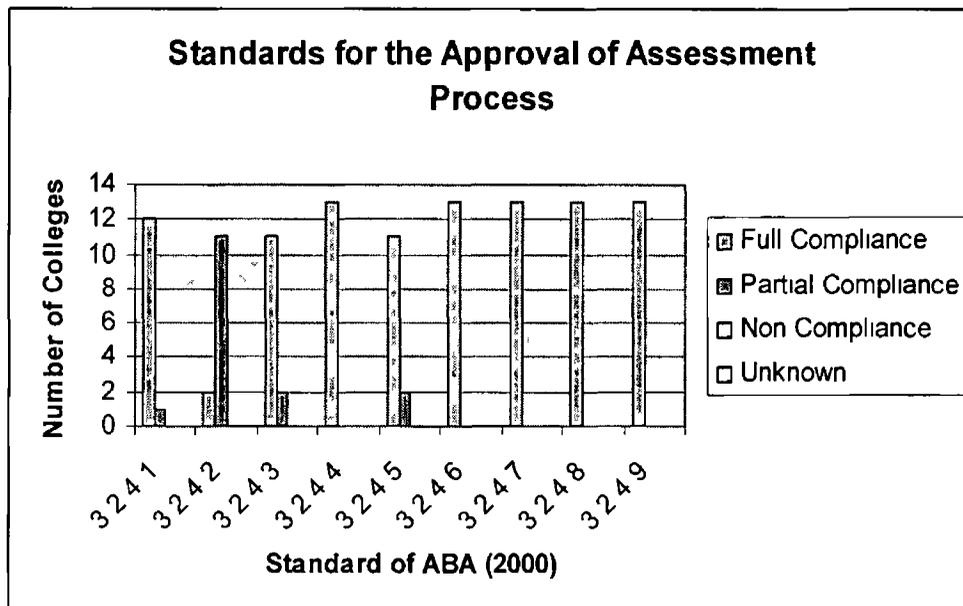


Figure 5 16 Standards for the Approval of Assessment Process

The standards in respect of the approval of the external examiners (n=4) showed the most compliance with only one standard revealing a difficulty for nearly half of the colleges in Figure 5 17 The partial compliance was associated with obtaining the CV's of the externs but more importantly it illuminated a difficulty associated with the two approval mechanisms i e the HEI established system and that of ABA The proportionality of approval systems i e the burden of one system as against another, was the subject of debate in the Dutch higher education system which examined internal and external quality control evaluation They recognised the tension between responsibilities of governing boards and higher education laws and found that responsibility for quality control rested with government but on an institution basis and not on a discipline basis (Maasen 1987)

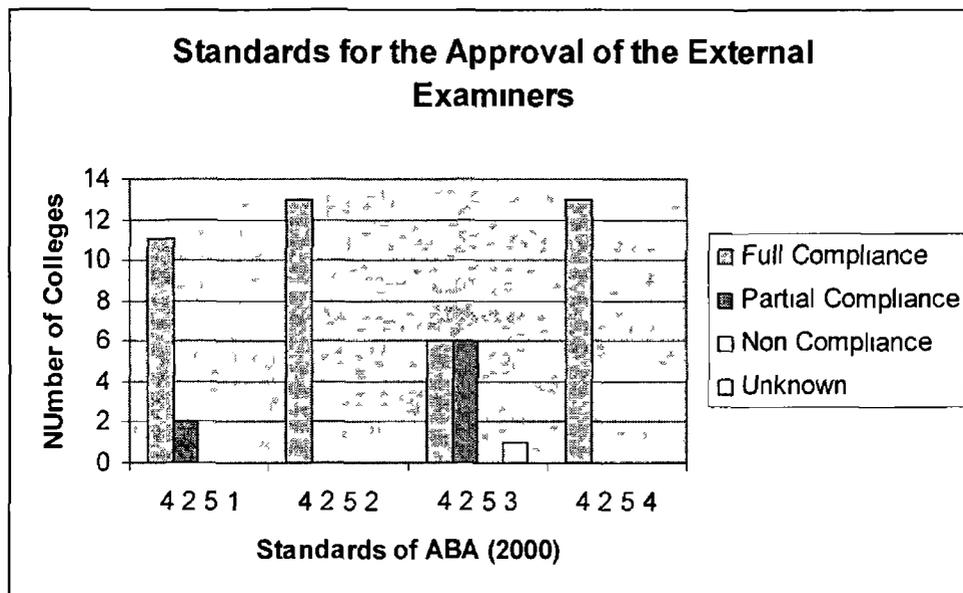


Figure 5 17 *Standards for the Approval of the External Examiner*

Summary

In summary judging compliance using subjective judgments of the researcher based on the evidence found in the documentary analysis (Appendix C), illuminated the issues of a programme in transition In essence the programmes were found to be 66% compliant with the standards of ABA (2000) The fact that there were issues associated with over a third of the programme was an interesting observation particularly related to the issues of difficulty The issues could be summarised as partnership to effect change, staffing issues both in college and in the health care

institution to support student learning, college facilities, integration of the theoretical and clinical learning experiences, integration of the assessment strategies to the overall learning outcomes of the programme, and the tension between the responsibilities of the regulator to look for standards in higher education system that is governed independently

Conclusion

Phase one and the judgement of compliance findings have illuminate theoretical issues in conducting an evaluative study The utility of the regulatory standards (ABA 2000) as the basis for data collection and generation in evaluation research is advocated by Stake (1985) Developing indicators (Stufflebeam 2001) to form the basis of data collection through documentary analysis utilising grounded theory approaches, the narrative story of general nurse regulation as it current operates was described The forming of judgments related to compliance with standards as a separate exercise with the data confirmed the issues of significance to current regulatory systems The operations of the regulator are questioned, as they do not lend themselves to universal understandings of indicators of standards The relatedness of the components of the education programme is also exposed by the descriptive findings of the study The site visit process requires review to ensure consistency of application of standards and report writing in order to establish relevant and transparent approaches The difficulties of the regulator of nursing exercising an approval process that is separate to the governance structures of the higher education system was demonstrated and in the interim of exercising a regulatory responsibility for approval of programmes, the core issues of governance, quality in education and knowledge for practice are issues requiring further debate and exploration with the other bodies responsible for quality control in the higher education sector

CHAPTER SIX - FINDINGS AND DISCUSSION - PHASE TWO

INTRODUCTION - DEVELOPING A FRAMEWORK

Phase two of this study was conducted to provide a framework of accountable regulation of general nurse education and inform the regulatory body of a mechanism to promote high standards of professional education and training assigned to ABA by the Nurses' Act (1985). The methodology for the second stage of this study, where framework development was the aim, is congruent with the processes associated with the Hybrid Model of Concept Development, which is oriented to developing concepts through an approach that integrates theoretical and empirical investigation (Schwartz-Barcott and Kim 2000). The processes of this model consist of three phases: theory, fieldwork and final analytical. This study utilised the core findings of phase one of the study and the literature to provide a theory base for fieldwork which was operationalised using a key stakeholder focus group discussion. The data generated by the discussion was used in the final analytic phase to complete the study and propose a framework for regulatory approval of general nurse education programmes.

A key stakeholder focus group was convened to provide direction on the way forward, validate the core findings and flesh out the framework contextually and culturally. The group was given a presentation and supplied with definitions of regulatory principles from a nursing perspective (CAUSN 1995) and the definitions of the principles of regulating better (Department of the Taoiseach 2004) which were prepared by the researcher as background information from the literature to ground the focus group discussion (see appendix H – Principles given to the Group). This methodology is reflective of the organisation of research using discourse analysis as described by Cheek (2000 p 53) where in a study to examine the nurse's role in medication management, a loose framework based on work by Parker (1992) was devised that began with "examining the literature" in order to link findings "about the dominant discursive frames" (Cheek 2000 p 54). In terms of this research this process was invoked against the examination of current regulation of general nurse education programmes. With the awareness of the definitions of regulation in an Irish context and the nursing regulation principles the group were invited in an open format to

discuss three questions supplied to them. The questions as supplied to the group (appendix G) read:

What processes does the regulator need to develop in order to fulfil its regulatory function in relation to:

- Governance
- Quality in Education
- Knowledge for Practice

An independent note taker took notes during the meeting and these are discussed as findings from the key stakeholder group discussion (Appendix J – Workshop Notes). The key stakeholder focus group (n=7) represented an informed multi-perspective approach to general nurse education with purposeful representation from teaching and leading nursing programmes in the university and institute of technology sector, a board member, a senior manager from a health service provider, a clinical placement co-ordinator, a representative of health board management and a representative of nurse practice development. The role of the researcher was that of poser of questions and observer to the discussion. The following presents the discussion of the findings from phase two data collection.

GOVERNANCE

In addressing the question of “what does the regulator need to develop in order to fulfil its regulatory function in respect of governance?” the group raised further questions to each other. The discussion commenced around “Management structures of programme” and these were questioned in respect of “What does it mean?” The meaning of governance in nurse regulation and the powers and mechanisms of influence were the focus of attention. This theme was further explored with the questioning “What constitutes governance?” in HEI based education systems that report into education based regulations. It became clear in the discussion that for ABA “Its remit needs to be clear and explicit” in relation to other legislation governing the same type of functions and precisely the role and responsibilities of the parties to the governance agenda of general nurse education. The group identified the competing interests in quality assuring programmes for accreditation purposes and

professional purposes that were not aligned

The discussion further outlined issues in respect of “organising the programme including resources” where it was suggested clarity is required to delineate the responsibility and accountability issues of the HEI’s and the professional requirements. The issue of ABA having no responsibility in respect of funding and not reporting on the “how finances appear to have been spent” brought into question the current effectiveness of the regulatory body in governing the programmes and whether the purely advisory role in respect of programmes in current site visits was an effective governing role when standards are stipulated. The advisory role was further questioned as to its appropriateness. It was discussed that programme providers should make explicit how decisions are made to utilise resources and make changes. The question “Do the board give a frame of reference for the committee?” or indeed can ABA “Produce terms of reference for the production of a self-audit”? capture that discussion. The issue of how the HEI’s manage the programmes, report on the programmes and account for the resources and finance associated with a programmes, summarise the points raised

The notion of linking current “judgement and accreditation” systems was explored and it was proposed that it should be possible to learn from the current approval systems used in the HEI and ABA. The note “ABA review of self-audits annually could show examples of best practice”, outlined the issues discussed of collective learning with new programme implementation. It was acknowledged that different issues were looked for by the approval systems and the added value of ABA was appreciated by some and argued by others. The first suggestion was to enforce a “compulsory self-audit” of all elements of the programme, the educational structures and the clinical components. However, another view expressed that in real terms ABA could only realistically “protect the clinical component and ring fence the governing of it” as the HEI’s current approval systems do not embrace professional recognition. Rather the discussion suggested ABA is respected currently but should financial pressure become a reality for the programmes the “uneasy alliance between ABA and the university” requirements would surface in favour of the HEI requirements. The negative consequence of endorsing a mechanism whereby ABA

stand back from the HEI systems and respect their independence and total control over the programme, was in supporting the current structure of “movement and accessibility to the theoretical element of programme” by students who are transferring to other colleges. Issues of preparation for professional practice are an identified issue but were mainly linked to the clinical component of the programme that indicates a misunderstanding of the integrated nature of a practice-based programme.

Members of the group elucidated the function of ABA as, “protecting the public” and this was further discussed with mechanisms proposed as to how it could be achieved. The discrepancy in relation to the assessment process utilised in the new system, as opposed to the old state exam, was reiterated. In challenging current systems it was suggested that ABA “introduce a state exam for levels of knowledge by means of a multiple choice type exam which incorporates an English competence test.” The notion of a “state exam to determine levels of knowledge” was universally discussed and following heated debate, which looked at the merits and disadvantages of introducing a national system. It was agreed an exam was as an impartial measure of the professional standard that was not subject to the vagaries of individual programmes, any untested teaching methodologies, or input related issues. Rather it was viewed as a method of objective, independent measurement that could be universally applied and is grounded in an outcomes culture as opposed to an inputs culture that currently prevails. The “cost of governance” as currently operated was discussed and it was proposed that it should be possible to explore the reallocation of “resources moved from visits to exams.”

It was noted that “clinical practice is an essential component” of the programme and again concern was raised about the “skill level governing clinical practice.” The concern related to “non-traditional areas are valuable” as learning opportunities “but there are problems with supervisors” and “in getting a named supervisor” in a number of sites particularly those not used to supporting student learning. The real problem, however, arose with the “competency assessment tool” which was observed to “give problems in assessing a student.” It was suggested that issues such as this could be addressed if “clinical practice were expanded and developed” particularly with

providing “support for professional development.”

It was noted that “clinical placements are tight and are a valuable but restricted commodity that needs to be protected” and ABA’s role in supporting the achievement of clinical outcomes should be maintained. It was suggested that it should be possible to “access practice in more innovative areas” where health care occurs and that HEI’s and curriculum development teams “should be looking at demographics and population health needs” of the area where the programmes are being offered, particularly to support the current primary health care strategy in the absence of a comprehensive “primary health network.”

The current general nurse education programmes were discussed and it was acknowledged that nurses are “currently being educating in a system that we hope will change” in how care is delivered. Current programmes, it was acknowledged, are “institution based” but it was argued whether this should be or whether programmes should be futures directed and reflect “knowledge for population based health care” and “population health need knowledge-based programme” as opposed to requiring inputs in a programme as deemed required in Europe in 1977.

The discussion suggested the real issues for ABA should be in deriving “policy initiatives of self-audit the why, what, when, etc. for the clinical component” of the programme and trust other mechanisms to govern the theoretical component. The fact that so few of the programmes had met the expectations of self-audit was discussed. This was seen as significant in a culture of quality if no measures or structures for accountability were present. However, in respect of a realistic governance role of protecting the public by ABA, it was discussed that ABA should adopt a policy of “name and shame to protect the public and publish the report” of site visits. This theme was further developed with a suggestion that the Board develop “league tables on the basis of results from the state exam, the number of registered staff and ratio of teachers, numbers of masters’ students and PhD’s” associated with a programme. Further it was suggested this should encompass the “clinical staff profile and support for students and their preparation.” It was suggested by one participant that there was a concern relating to the preparation of staff for supporting students by “slippage in

the student support structures, I mean the qualification of CPC's" would become visible if published reports were available. The notion of current staff in the HEI s was also raised in the discussion that suggested 'academic changes' will also occur with the current programmes and the prevailing nurse tutor requirement will not be a facet of HEI requirements, rather "research related activities will influence employment policies". In this respect that notion of requiring "ring fenced professional time" for all teachers to a nursing programme was discussed as a professional responsibility, although dissent was expressed by the HEI representatives who suggested that promotion in the HEI sector is not based on professional criteria.

There was discussion related to "public involvement" in the processes of "judgement and accreditation". This was expressed as a function of "write a report annually developed from the site visit reports" and includes the benefits of the accreditation system including the cost of regulation". It was suggested by the group that ABA consider "random visiting inspections and randomly selected inspections" based on the records of ABA and reports from schools, students and members of the public. The notion of ABA developmg "action plans and guidance on areas for improvement" that could be shared with all colleges was well discussed and supported by the group, as was the need to look seriously at the powers adopted by the board for programmes that in their opinion meet /don't meet requirements. This was expressed by comments such as "enforcement penalties need to address non-compliance" and if requirements are "compulsory they need sanctions for non-compliance". The mechanism for imposing the enforcement related governance issues was reflected in comments such as "there should be charges" for non-compliance and there "should be penalties, I mean withdrawal of approval" if programmes are not meeting the standards of professional requirements.

QUALITY IN EDUCATION

In answering the question “What processes does the regulator need to develop in order to fulfil its regulatory function in relation to Quality in Education?” the group considered that in developing a process it was important to know the structure of the programme and they debated whether the Board should be involved in the philosophical underpinnings of a programme. This is reflected in the comment “do you have an outcome based system or a modular one?” The discussion further agreed that the “components of the programme should be clear” to any reviewer and particularly to the students as the issue of transferability for the student must be remembered by the comment “are there special themes to allow for transferability of students and incremental learning?” The group considered it would be useful if the “curriculum could be written in a standardised format” for assisting the review process of the Board and it would give guidelines to assist curriculum development groups as to the information required by the Board.

This theme within quality in education for sharing examples of good practice was further elaborated on by the comment “ideas of best practice can be monitored and shared.” The processes for quality in education were further articulated as “institutions must complete self-audit in relation to academic and clinical practice quality.” The theme of self-regulation is supported but specific structures were seen as important to ensure regulatory function such as “resources such as the library for the School of Nursing should be submitted in the self-audit” and “There should be an inventory of the clinical skills resources with self-audit” that was to be “updated annually.” The other interesting issue of discussion was the notion that “students should evaluate” the programme and “this should be made available in a structured format to ABA.” It was acknowledged that quality systems were operational in some HEI’s and the benefit of such systems was seen through “QAQI outline these and the results are transparent and explicit.” A discussion ensued related to “how do HEI’s monitor scholarly activity and support it?” The group posed answers and suggestions in light of the topic being discussed with “board should develop frame of reference of quality in education that may replicate the HEI current structures and system.” The notion was further developed by the manager of the Health Board, who contended the

ABA system should 'link it to national hospital accreditation system ' Further the HEI personnel suggested that "clinical areas make a report on the QAQI for student learning in our institution" and in summary agreement it was contended that a "collaborative mode with other accreditation systems" should be established

The issue of monitoring was discussed at length with the problem of monitoring clinical attendance being an issue as exemplified with "monitor clinical placements but students still don't pass on attendance " This theme continued with an academic suggesting "I've changed my mind on this one I used to think they should not be monitored but I am tired of going into class with only half of them in there " Suggestions of how to resolve this issue were offered such as "monitor other mechanisms for example meeting personal tutor" and how the students were "engaging in scholarly activity like using the library and exam results" could be used as indicators of attendance and meeting programme requirements Of significance, however, was the sentiment that "making up time is the new debate" in the education institutions, both from an administrative and a student perspective, as the ABA requirements are taken very seriously by the programme personnel particularly in the clinical areas This was seen as the one constant of the programme and was seen as an advantage of the CPC in the clinical area

Among the other issues discussed were the various approaches to assessment and it was considered that there was "no national standard anymore" in relation to examinations as was previously with the ABA state exam The diversity of approaches to examination was also discussed and it was recommended that a "self-audit outline of the specifics of assessment, in the time taken to do it or the amount of words in the assignment" should be open and transparent for prospective students and current students and made available to ABA It was identified by the academics that some students "get too much free and don't value it" and as a consequence the commitment of the students to the programme was less than optimal in some cases It was suggested that students should return to a state exam and that they "Pay for the state exam " This would assist in the student understanding the real commitment to a professional role

On this theme the issue of structural philosophies of some colleges warranted that with “modularisation students will pay for failed modules ’ This was seen as a motivator to students who approach the programme with less than the commitment required. However, in respect of clinical education it was recommended that ABA increase their role in supporting students in the clinical learning environment as there is a “need for something on clinical education” and assessment to ensure a national standard. This was reiterated by the group who observed that as currently ABA have no requirements in the annual report to address clinical issues and consequently it was suggested that “annual report doesn’t talk about clinical area” and this should be included in any future process.

The discussion highlighted the under utilisation of the “nurse education centres collaborating about clinical learning” and suggested that this valuable resource in the health services be promoted by ABA to support the students learning experiences. This was further elucidated with “practice development should be utilised to develop clinical learning and assessment and be brought in to take responsibility for the clinical learning environment.” This was seen as a mechanism to bridge the current perceived schism that was occurring between the clinical and the theoretical elements of the programme as seen by “there are complications in merging two systems. I mean the theory and clinical and fitting in all the requirements.” Despite the obvious different agendas between the academic aspect and the health services requirement of the programme it was noted that “students should get proper academic holidays and status in college.” In concluding the discussion of the quality in education processes it was discussed that whatever system ABA proposed it should be flexible enough to allow for a “frame of reference for uniqueness of the individual programme and the key in the frame is the local needs to be adopted in the curriculum for each institution.” This leads to a conclusion that the current systems to ensure quality requires changing to meet the new context of education programme provision.

KNOWLEDGE FOR PRACTICE

In addressing the question of what processes does the regulator need to develop in order to fulfil its regulatory function in relation to Knowledge for Practice the discussion began with a strong call from both the health services and the academics that an outcomes approach to education should be debated. In particular it was discussed whether “the curriculum should specify outcomes as in how it supports a theoretical and practice competence based system and thereby integrate the parts.” Relating components of the programme would avoid confusion for the student but also allow flexibility for how the programme approached the achievement of competence. The discussion noted that the notion of competence was not seen as purely a practice responsibility but an academic one as well. This was further discussed as a suggestion to ABA “we need terms of reference for the curriculum” for an outcomes competence based approach. The group considered further direction from the board in relation to expectations of curricula within its requirements would be useful to them to provide the required information.

The group contended that there “should be interconnectivity between the knowledge for practice on the aims and objectives of the programme.” One of the academics suggested, “nursing theory doesn’t underpin the curriculum.” She further suggested it is interspersed in nursing theory teaching and doesn’t reflect what the health services do in practice. This disconnect emerged as the debate of needs based education versus a liberal education. The possibility was discussed of whether there was “scope for developing some sort of academic engagement in the clinical arena.” The discussion continued on the theme of looking to other professional groups and how they nurtured the professional aspects of education within the current drive for integrated education of the health care personnel with “collaborative modes of teaching with other health professionals should be developed. We need guidelines for this development and supervision in the clinical areas and guidelines for achieving this.” The purpose of the education experience was the underlying tension in the group.

The group suggested, current systems used by the HEI’s need to be understood by the regulatory body, with “need to seriously consider the path for modularisation” as

‘clinical practice doesn’t fit into modularisation’, and “some schools have semesterisation’ which impacts on how the colleges manage the programmes. In this vein it was acknowledged in the discussion that the “EU directive needs to be made explicit in relation to nursing” and if ABA has additional issues these should be made clear as to why they are in excess of the EU requirements. The group discussed that the programme certainly should be premised on “evidenced-based knowledge for practice to see trends in society and changes in population health needs”. Ideally programme development supports “involvement of the public in determining knowledge for practice, as one of the stakeholders locally in developing curriculum, and the structures they would like to see a regulator managing”. Supporting this initiative the “theoretical basis for nursing should be made explicit” where the “mission and local context were evident” and particularly where the “curriculum should reflect the uniqueness of local need”.

In discussing knowledge for practice and the end result of the programme it was suggested that ABA “don’t need to worry about stipulating the requirements in relation to assessment other than to get confirmation that it meets HEI systems” as there was a conflict of interest in this regard that should be overcome if there was a system such as “the state exam, and clinical competence assurance/bond, as the only mechanisms for entering a name on the live register”.

Summary

The above findings from the key stakeholder focus group, utilising a discourse analysis approach, suggests the current regulatory system requires review. The findings suggest a need for a system that reflects the governance, quality in education and the specific knowledge for practice agenda of general nursing. In undertaking a review cognisance of the other governing structures associated with education provision in the country is required to identify the unique contribution of professional regulation within a quality assurance system. New systems should reflect regulatory accountability.

The role of the regulator as an agent of a quality system requires clarification to

ascertain exactly what the regulator is accountable for in respect of general nurse education programmes. One finding suggests the regulator should be interested in clinical practice. Another finding suggests the profession is not ready yet to trust the new relationships for quality assuring programmes in the HEI, as there was a call for an independent “state exam”. In this respect it is suggested a clear structure to support the current Requirements and Standards for Nurse Registration Education Programmes (2000) is required. It is contended that confidence in the current new systems would be fostered if clearer regulatory expectations were outlined.

The principles and mechanisms of evaluating and reporting on education programmes by the regulator need to be outlined clearly for programme providers. This would include setting out the general principles underpinning the regulators practices associated with ensuring “Requirements and Standards for Nurse Registration Education Programmes” (ABA 2000) are met. In clearly outlining indicators of standards and audit the obligation to “specify conditions of suitability for hospitals and institutions” (Nurses’ Act 34 (2), 36 (1, a)) would be actualised. Outlining the expectations for presenting a curriculum for approval would again clarify “the standards of theoretical and practical knowledge required for examinations,” including “the clinical training and experience provided in any training programme organised by a hospital or institution approved of by the Board” as specified in the Nurses’ Act (1985, 36 (b), (c)).

The standards adopted by the regulator in conducting its affairs should be underpinned by an agreed set of principles. This incorporates the values inherent of nursing in a programme, the centrality of the patient, feedback mechanisms to ensure quality processes and how outcomes are achieved. A proposed framework of nurse regulation to promote high standards of professional education and training would underpin regulatory activities. The regulator in reporting on programmes should have open and transparent systems of generating data and compiling reports. The reports of the regulator should be consistent in approach and style of reporting.

The regulator should be cognisant of the compliance issues related to the

requirements and standards of the programme and determine methodologies for ensuring the regulatory responsibility of supporting issues of governance, quality in education and knowledge for practice are actualised

Conclusion

This and the preceding chapter have presented phase one and phase two data collection findings, which were generated using a grounded theory approach to the evaluation of the pre-registration general nursing programme from the perspective of regulatory obligation. Phase one data analysis illuminated how the programme is currently being implemented related to the Requirements and Standards for Nurse Registration Education Programmes (ABA 2000). The findings suggest that colleges to implement the requirements and standards adopt varied approaches, and a diversity of approaches is adopted across the country in delivering elements of the programme. Emerging from the data, assisted by the analysis of an expert group, were core issues or categories that identified the regulatory role as governance, quality in education and knowledge for practice. These core categories were supported by higher order categories, which in turn reflected broad categories from the numerous databits of evidence in the documentation generated from both the colleges and the regulatory body in respect of the thirteen general nurse programmes. In judging compliance with the standards of the regulator (ABA 2000) issues were identified, where partial achievement of compliance at a national level which require further support and interest from the stakeholders.

Phase two findings, the results of a key stakeholder focus group discussion, suggested processes the regulator needs to develop in order to fulfil its regulatory obligation in respect of the three core categories above. The findings suggest current systems need to refocus their efforts to ensure a process of regulatory management of its activities. The emergent framework of regulatory principles incorporates the issues of governance, quality in education and knowledge for practice.

The following chapter outlines the conclusions and implications of this study for effective regulatory management.

CHAPTER SEVEN - CONCLUSION

INTRODUCTION

This chapter concludes the discussion of the study and builds on the findings presented. The conclusion draws together the findings, generated through evaluation methodologies, of phase one and phase two data collection to propose a framework of accountable nurse regulation to promote high standards of professional education and training fulfilling the functions of ABA assigned to it by the Nurses' Act 1985.

The previous discussions interpreted, qualified and discussed the findings presented in relation to the evaluation of the requirements and standards (ABA 2000) and the formulation of an overarching mechanism of regulatory governance. This study has illuminated that current ABA approval mechanisms are focussed on programme structure and educational processes. Kusek, Rist and White (2005 p 12) contend "governments in developed countries for the past two decades have been working to improve the quality of public services and are changing the culture from one of focussing on input management to output and outcome management and demonstrate that expenditure is efficiently spent and effectively used." In the current context of a health service that is consumer focussed and outcome-oriented, the public will increasingly participate in professional regulatory processes. Although "prescribing and monitoring educational standards is one way the profession demonstrates accountability to the public" (Earle et al 1995 p 14) the Board of ABA need to re-examine the focus of its responsibilities and consider methods of working that embrace an outcomes orientation. The outcomes focussed model specifies criteria and indicators for the curriculum plan in terms of student achievement and the graduate outcomes of the programme.

This study was not designed to compare and contrast the Irish general nurse education system with international practices or policy recommendations but rather to give an overall picture of the implementation of the registration/degree programme and the regulatory issues associated with its implementation. Issues for the control of the

programme and the relationships to affect the integrated delivery of a modern programme are raised by some of the current structures outlined in the findings

The main issues related to these findings are the tensions associated with operating two approval type mechanisms in the education of nurses. The two systems are the existing HEI approval mechanisms and the approval mechanism of ABA. Both systems are underpinned by legislation albeit quality systems in the HEI and the protection of the public in providing the health services with safe competent nurses in ABA which in essence should be complementary of each other. The quality agendas used by the HEI and the regulator needs to respect each other's boundaries and the perspectives of the two approval systems. These systems should not be mutually exclusive but the value of each other's role and contribution to the quality agenda should be tangible. These systems also need to consider other parties as suggested by Kells (1992) to the quality agenda and the synchrony of the two systems within the wider quality agenda.

A further tension that emerges is one between the philosophy of modularisation and the large practice component of the programme where practice is viewed as developmental throughout the programme. The tension between the HEI system and the health care institutions is also manifest as the partnership relationships in the development of the programme, and the structures of examination, particularly in the clinical area, which consists 50% of the programme. This tension could be resolved with developing formal relationships between the teachers of the programme in the college and the clinical practice-learning environment and in reverse with practitioners contributing to course development and the exam boards of the college. The last challenge is that the programmes incorporate structures of supporting the preparation of nurses that are capable of working in intense, unstable but rewarding climates (WHO 1999). This can be achieved by incorporating knowledge for population health supporting primary health care.

Discourse with the Data

This study aimed, through evaluation research approaches, to examine the application of the current regulatory systems of general nurse education utilised in the registration/degree programmes. In examining the findings with the literature questions emerge for discussion from a regulatory and evaluation perspective. Cognisance is taken of the view of the OECD (2001 p 18) that “evaluation reports are just one component in decision-making”. The OECD (2001 p 60) further suggest the definition of evaluation feedback as

A dynamic process which involves the presentation and dissemination of evaluation information in order to ensure its application into new or existing development activities. Feedback as distinct from dissemination of evaluation findings is the process of ensuring that lessons learned are incorporated into new operations.

West and Scott (2000) in a call for the nursing profession to have an impact on policy acknowledge that the policy process is not linear or rational but is reliant on social relationships. They further contend that usually health care professionals are “included in policy-making networks because of their specialised knowledge and their ability to promote or thwart the aims and objectives of any policy on health care” (West and Scott 2000 p 819) but they are not always afforded “insider status” in the policy-making process. The relationship between policy and research, however, is not always clear.

Educational research and evaluation research in particular have embraced new approaches to understanding the phenomena and contexts of education (Parlett and Hamilton 1972). The implication of this change was identified by Bensimon et al (2004) who regard that there is a disconnect between the understandings of outcome associated with higher education research and policymakers and practitioners expectations. In pursuing this disconnect the politics of understanding how an evaluation will be used impacts on the approaches that can be undertaken to collect, analyse and interpret data (Riessman 1993, Patton 1997). Chen (2004) attributes the quagmire that has developed around the theoretical frameworks associated with evaluation research to the disconnect between evaluations based on positivistic

assumptions and the naturalistic qualitative tradition that currently is emerging Guba and Lincoln (2004) within this realm argue that naturalistic and rationalistic evaluations operate in different paradigms and methodologies. The choices therefore, taken by an evaluator in respect of design, influence the form of evaluations as well as the likelihood that the findings of the evaluation will be used (Patton 1997). In this respect this study aimed to look at policy and how it is implemented and what needs to be developed to revise or review that policy. In concluding the discussion of evaluation, cognisance is taken of the four assumptions about evaluation made by Alkin (1991 p 94) where he states

- 1 Evaluation is a process of gathering information
- 2 The information collected in an evaluation will be used mainly to make decisions about alternative courses of action
- 3 Evaluation information should be presented to the decision maker in a form that he can use effectively and that is designed to help rather than confuse or mislead him
- 4 Different kinds of decisions require different kinds of evaluation procedures

With this advise, the researcher in incorporating the Proposed Principles of General Nurse Regulation identified by the key stakeholder focus group re-examined the findings and discussion. The issues of difficulty in the implementation of the registration/degree programme could be summarised as

- Effective partnerships to effect change in the existing programmes
- Staffing issues both in college and in the health care institution to support student learning
- College facilities to teach and support evidence-based learning
- Integration and relatedness of the theoretical and clinical learning experiences within quality learning environments
- Relatedness of the assessment strategies to the overall learning outcomes of the programme, and
- The tension between the responsibilities of the regulator to look for standards in the higher education system that is governed independently

These issues could effectively be monitored through a clear system of regulatory governance associated with guidelines for submitting a curriculum to ABA basing it on the proposed principles of general nurse regulation. This guidance for submitting a

curriculum emerges from the core categories of the findings of phase one data collection and analysis and respect the contentions of Kells 1992 (p 32) in respect of guild involvement in external quality assurance mechanisms in higher education systems

Proposed Regulatory Framework

The findings related to the Principles of Regulation propose to operationalise an evaluation approach. As discussed it is based on documentary analysis of the existing programmes in action and the findings of this analysis. The literature was revisited and then examined through Stufflebeam's CIPP model (1997) as it applies to a nursing context (Allen 1977, Greaves 1984, Sconce and Howard 1994, CAUSN 1995, Johnson and Olesinski 1995, Singh 2004) of evaluation in order to illuminate a model for regulatory accountability and social inquiry of general nursing in Ireland. The criteria of "client needs, responsiveness and merit of plans to assessed needs, congruence between activities and plans, and range, quality, significance and cost-effectiveness of outcomes" (Stufflebeam 1997 p 27) is measured, observed and discussed. Schwartz-Barcott and Kim (1993) outline the three stage approach associated with the hybrid model of concept development as an interactive process of fluidity between the theoretical phase, the fieldwork phase and the final analytical phase where "the investigator steps back from the intensity and details of the fieldwork and re-examines the findings in light of the initial focus of interest" (p 123). They further advise that if the initial concept was supported the researcher should "begin by going back to the initial, tentative definitions and listings of key elements in, and analysis of, these definitions" (Schwartz-Barcott and Kim 1993 p 124). The writing up of such findings is further advised by Schwartz-Barcott and Kim (1993 p 127), as most reflective of "grounded theory approaches". In this instance "the focus is on categorising key concepts and explicating theoretical relationships, rather than on defining and measuring these concepts" (Schwartz-Barcott and Kim 1993 p 127). The principles of regulation identified for the regulation of general nursing draw on the existing regulatory literature (CAUSN 1995 and Department of the Taoiseach 2004).

The underpinning frameworks are reiterated as

PROPOSED PRINCIPLES OF GENERAL NURSE REGULATION

Consistency, Transparency and Accountability

- The standards of ABA support structural consistency, i.e. the same approach in relation to the requirements and production of reports apply to all parties. That all issues emerging from the regulation of programmes are addressed consistently by ABA to ensure greater confidence in the system, greater transparency in decision-making and promote greater efficiency between the function of ABA and the educational accreditation authorities.
- The standards of ABA support clarity and openness in the operation of an approval system that supports the safety of the public in relation to the graduates of the programme. The report documents of ABA related to programmes are written in a style that is unambiguous, provides clarity, simplicity and is available to the public.
- The standards of ABA support fair, open, efficient and effective appeals procedures.

Relatedness

- The standards of ABA direct that the components of a programme support and build on other parts, thereby promoting or negating the achievement of goals. The components are curriculum, the teaching of nursing, the achievement of programme outcomes, research, clinical practice and professional activities and administration. The quality of the programme is a measure of internal consistency of all components of the programme.

Uniqueness, Necessity and Relevance

- The standards of ABA direct that a programme identifies and capitalises on the unique characteristics of its resources (faculty, physical and environmental resources, community values, and financial support) within its particular setting.

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- The standards of ABA demonstrably benefit the public in assuring the quality of the education programme and therefore the quality of graduate nurses from the programme
 - The standards of ABA direct the programme teaches the student that the primary responsibility in nursing is to the patient/client, community, family and individual
 - The standards of ABA direct that the mission and goals of a programme reflect a response to the major trends in society that impact on the health needs, present and future, of the larger community

Proportionality

- The approval systems of ABA balance the advantages a professional approval system against the constraints it imposes. The approval system should synchronise with other approval systems operating in the higher education sector and health services where possible

Effectiveness

- The Requirements and Standards of ABA identify clear indicators for achievement that are clear and realistic and are complied with within reasonable time frames
- ABA considers the issue of compliance with the regulations and identifies criteria for success and communicating that success
- ABA considers methods of enforcement and how this will be applied

This framework if incorporated with the core category findings of this study as follows, has the capacity to inform the development of a Curriculum guideline for submission to ABA. The core categories with the unit broad categories are presented in table 7.1. It is necessary to visit the composite findings of stage one of the study to understand the issues the regulator identified in approving programmes. The three core findings with associated categories are presented as governance, quality in education and knowledge for practice. These findings inform the proposed curriculum guidelines.

In proposing as curriculum development structure that is reflective of ABA requirements cognisance is taken of Schwartz-Barcott and Kim (1993) who outline the three stage approach associated with the hybrid model of concept development as an interactive process of fluidity between the theoretical phase, the fieldwork phase and the final analytical phase where “the investigator steps back from the intensity and details of the fieldwork and re-examines the findings in light of the initial focus of interest” (p 123) They further advise that if the initial concept was supported the researcher should “begin by going back to the initial, tentative definitions and listings of key elements in, and analysis of, these definitions” (Schwartz-Barcott and Kim 1993 p 124) This step, utilised in phase two data collection, is again invoked, as a framework for developing the guidance related to educational providers for submitting a curriculum to ABA. It is, therefore, contended that a culturally relevant framework of regulation, as developed for policy (Department of the Taoiseach 2004), can be utilised for sectoral regulation such as the regulator of nursing

Outlining guidance for curriculum developers that incorporate the concerns of the regulator of general nurse education programmes develops the evidence-base for the regulator. This evidence emerged from phase one of the study (see Table 7.1) and utilising the principles of consistency, transparency, accountability, relatedness, uniqueness, necessity and relevance together with proportionality and effectiveness, as determined in phase two of the study, addresses one of the main recommendations of this study which was to give guidance to curriculum developers. The curriculum guidance is presented as a composite of the study methodologies of fieldwork, and an examination of the findings in light of the initial focus of interest (Schwartz-Barcott and Kim 1993 p 127)

CORE CATEGORY GOVERNANCE	
Partnership	Committee, Group, Management, Co-ordinates, Administrative staff
Support structures	Course document, Course handbook, Marks and standards, No compensation
Systems/Processes	Entry criteria, Exit criteria, Attrition rates, Interruption policy, Record of theoretical and clinical assessment, Eligibility for registration
CORE CATEGORY QUALITY IN EDUCATION	
Monitoring	Individual student record, Database, Well monitored, Monitoring in clinical placements, Monitoring in college, Difficulty in monitoring, Transfer policy, ECTS, Transfers, Annual report
Resources	Physical resources, Environmental resources, Staffing issues, Ratio, Qualifications, Experience, CV's requested, CV's forwarded, Site report evidence, Prioritise the learning needs
Student Support	Student services, Student academic guidance, Health services, Counselling, Student clinical support.
Audit	Internal quality assurance, Quality and audit officer Clinical learning audit group, Clinical audit
Assessment	Assessment plan, Theory assessment, Clinical assessment, Progression, Assignment, Continuous assessment, Examination, Weightings outlined, Competence, Grading criteria, Inter-rater reliability, Early feedback, External support, External examiner system
CORE CATEGORY KNOWLEDGE FOR PRACTICE	
Course Structure	ABA and EU requirements, Hours, Elective module, Nursing in developing worlds, Student centred
Curriculum	Curriculum model, Curriculum philosophy, Nurse education forum, Indicative content, Teaching learning strategies, Teaching beliefs, Philosophy of nursing, Models of nursing, Learning outcomes, Evaluation, Reflective practice, Reflection, Clinical placements, Range of placements, Clinical placement map, Semester 1 /semester 2, Specialist placement, Research, Problem solving
Continuing Education	Nurse practitioners, Shift by shift, Two students to one RGN, Clinical support, Learning oriented to clinical practice, CPC's, Workload, Liaison role, Clinical links, Professional development, and personal growth
Values	Centrality of practice, Aim of nursing care, Holistic approach, Ethical dimension of nursing care

Table 7 1 Core categories of General Nursing Programme with the associated higher order and broad categories

It is therefore suggested from phase one and two findings that curriculum submissions should contain

CURRICULUM GUIDELINES

Governance

- Committee structures and memberships for managing the programme are outlined
- Structures for regular monitoring and review of the programme are described
- Partnership structures and mechanisms to evaluate the effectiveness of the partnership relationship are outlined
- Student information sources are provided

Student Progression and Achievement

- Entry requirements are outlined
- Duration and modes of attendance – including monitoring policy are included
- A circuit of clinical placement(s) is described
- Awards and Relationship of the programme to the NQAI framework are shown
- Relationship of the programme to others in the college – transfer policy arrangements in college are described

Quality Management

- Audit of learning environment relevant to the programme aims and outcomes including clinical audit tool are provided
- Evaluation policy – internal and external are explained
- Extern examiners are identified with outline CVs
- HEI quality structure / process are explained

Learning Resources

- Teaching accommodation – outline of resources, including laboratories
- Human (academic and clinical) qualifications, CVs and PIN numbers are provided
- IT – resources available to each student are outlined

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- Library – holdings hardcopy, remote access is provided
 - Student support in practice and academic support is outlined

Teaching Learning and Assessment

- Methods of facilitating learning are outlined and relate to the learning outcomes
- Marks and standards for programme are included
- Assessment policy and procedures including grading criteria are explained
- Assessment plan included with theoretical and clinical assessments including weighting if appropriate
- Assessment strategies are related to the learning outcomes of the programme

Curriculum Design, Content and Organisation

- Background to the programme, evidence including service evidence at policy and local level to support or justify the local health care needs for the programme are described
- Programme design, balance of theory/academic and clinical/practical experience, coherence evidenced in the programme plan
- Philosophy of nursing outlined, philosophy should be congruent with identified health need and clinical practice experiences
- Philosophy of education, philosophy should be congruent with the teaching and assessment methodologies
- Nursing and educational theories underpinning programme are made explicit
- Aims of programme are outlined
- Learning outcomes of programme are outlined
- Full unit or module descriptors are provided

In defining evaluation for this study as “the systematic collection of information about the operations and outcomes of general nurse education programmes to make judgements about current requirements and standards, improve their effectiveness and inform decisions about their future” (adapted from Quinn Patton 1997) the researcher presents the recommendations that emerged from this study

RECOMMENDATIONS

Research

It is recommended that a national evaluation of the degree/registration programme be conducted on its completion in 2006 and one year later on the competencies and achievements of the programme in relation to the five domains of competence of the programme

It is recommended that evaluation initiatives be outcome focussed utilising criteria that highlight the need for programmes to be accountable for graduate outcomes that, in turn, emphasise ABA responsibility to ensure that the graduates are able to meet the standards and competencies for nursing practice as registered nurses

It is recommended that lessons learnt from the study become the focus of interest for research within the education department of ABA for the next period of five-year approvals

Education

It is recommended that unless there are grave reservations regarding a new school or new programme each new applicant programme be granted initial temporary approval for a five-year period with a view, through support of self-evaluation and consultation, to achieve full approval on completion of that five-year period

It is recommended that ABA undertake a review of the Requirements and Standards (ABA 2000) with key stakeholders in light of the findings of this study

It is recommended that ABA in reviewing the Requirements and Standards (ABA 2000) consider a combination of performance-based standards and design standards (Coglianese 2004) with associated clear indicators to determine accountability and social inquiry for the nursing regulator

Practice

It is recommended that ABA develop an electronic database of information related to the approval mechanisms of ABA that assist in identifying outstanding issues from approved programmes

It is recommended that the regulatory body for nursing in Ireland utilise information technology to develop an electronic form of self-evaluation for Higher Education Institutions and Health care services

It is recommended that consistent approaches be adopted in relation to conducting onsite visits and generating reports for programmes

It is recommended that the Education and Training Committee of ABA consider the Guidelines to educational providers submitting a curriculum to ABA for adoption. This template encompasses the main issues that need consideration in respect of the Requirements and Standards of ABA. The issues of governance, quality in education and knowledge for practice components of the programme in the educational experience can be extrapolated and utilised in a systematic method allowing for comparability of data and ultimately accountability by ABA of its authority for determining “the manner in which and conditions under which training shall be provided” (Nurses Act 1985, 31)

It is recommended that the education and training function of ABA re-examine its role in an external review partner within new European quality assurance and evaluation structures

Professional nurse education is a partnership between the Higher Education Institutions, the Health Care Institutions and An Bord Altranais. The enhancement of the quality of the learning experiences to develop competent, safe, effective, critical and reflective practitioners is the common agenda. In this respect ABA should adopt procedures that demonstrate accountability for how it operates its functions. It is recommended that ABA conform to the principles of better regulation

LIMITATIONS

The nature of this study, an examination of regulation processes by the regulator, is a first step by the Irish nursing regulatory body to examine its own processes and acknowledging the need to further underpin regulatory practice with an evidence base. The notion of insider research is appropriate in a number of research situations and in a range of cultural groupings (Hodkinson 2005). The relationship of the researcher to the issue under study is acknowledged. The sensitivity of the data that was reviewed for the purposes of this study required a high degree of ethical understanding of the issues. In the situation where this study was aiming to develop a framework of regulation based on current situations a template has emerged which respects the sensitivities of a challenged new relationship of nursing within the HEI structures. In this respect the academic context of the study, and how the project was managed, is worth consideration to the contribution of learning provided.

The implications of the outcomes of each programme, offered in thirteen higher education institutions with the partner health service provide, were explored using a conceptual framework drawn from an understanding of evaluation research in the post-modernist paradigm. Regulatory frameworks, particularly in the realm of self-regulation, utilise “expertise-oriented” evaluation approaches (Fitzpatrick 2004). It is acknowledged that this approach has lent itself to criticism associated with subjectivity of professional expertise. Developing a team of experts, who complement each other, to assist in data collection is more likely to produce a thorough study of evaluation (Patton 1997). The researcher acknowledges this context.

In evaluation research there were many models from which to choose. There is no one best way to conduct evaluation research and in determining a theoretical framework to underpin this study the work of a number of theorists were reviewed along with the studies that utilised their approaches. The final model, although a hybrid of models, fundamentally utilised a systematic approach as advocated by Stufflebeam (1997) and although a model was not rigidly adhered to the insights of systematic inquiry allowed the emergence of a culturally relevant model for consideration by the regulator.

Evaluation at its utility level should assist decision-making and indicate the future direction of a course from possible options. The main thrust of this study was to utilise existing data to illuminate processes. It therefore became an issue that methods were pre-determined and restricted by the permission granted, although the capacity for a framework of accountability and social inquiry emerged.

Conclusion

This evaluative study commenced during a period of unprecedented major reform of nurse education in the Republic of Ireland. During this time there was extensive examination of the regulatory structures and practices that heretofore supported professional nursing practice. The manner in which nursing programmes were delivered and accredited came under scrutiny within the overall context of a general review and reform of the health services, as evidenced in Government reports published by the Department of Health and Children (2001) and the Department of An Taoiseach (2001). Additionally the education sector seeing an opportunity to welcome undergraduate and post-graduate nursing education into the third level sector explored how professional education could be delivered within a culture of quality and accountability. The changes proposed as a result of the reports and documents posed challenges for the regulatory management of nursing programmes within ABA. An Bord Altranais, as the professional regulator of nursing, has set broad standards for all elements of the educational processes associated with nurse education. Developing an understanding of how these have been implemented and what mechanisms the Board needs to consider in order to exercise its role toward better regulation is proposed in the pillars of governance, quality in education and knowledge for practice. As a result ABA can quality assure their mechanisms to safely enter a name on the Register of Nurses as maintained by legislation under the Nurses Act (1985) by ABA fulfilling the mission 'to protect the public'.

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