Can Introducing a Set of Practice Review Documents Into Community Nursing Improve Practice?

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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 Education is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, 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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‘Little strokes fell great oaks’

Benjamin Franklin

‘

REFLECTION

'Scaffolding'

by Seamus Heaney

Masons, when they start upon a building,
Are careful to test out the scaffolding;
Make sure that planks won't slip at busy points,
Secure all ladders, tighten bolted joints.
And yet all this comes down when the job's done
Showing off walls of sure and solid stone.
So if, my dear, there sometimes seem to be
Old bridges breaking between you and me
Never fear. We may let the scaffolds fall,
Confident that we have built our wall.

'To those that matter – Thank you
Our wall, has been tested and found to be both as strong as ever and still standing'

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GLOSSARY

ADPHN: Assistant Director of Public Health Nursing

ANP Advanced Nurse Practitioner

ANCC: American Nurses Credentialing Center

AR: Action Research

CN: Community Nursing (Combination of PHNs and RGNs)

CNS Clinical Nurse Specialist

CHN: Community Healthcare Networks

CPD: Continuing Professional Development

DOHC: Department of Health and Children

DPHN: Director of Public Health Nursing

HCA: Health Care Assistant

HSE: Health Service Executive

KPI: Key Performance Indicator

MH: Magnet Hospital

NMBI: Nursing and Midwifery Board of Ireland

NMPDU: Nursing and Midwifery Planning Development Unit

NPM: New Public Management

OMNSD: Office of Nursing and Midwifery Services Director

PAR: Participatory Action Research

PCC: Patient-Centered Care

PDC: Practice Development Co-ordinators

PDP: Practice Development Plan

PEP: Pathway to Excellence Programme

PHN: Public Health Nurse

RGN: Registered General Nurse

SDL: Self-directed Learning

ABSTRACT

Sheila Geoghegan

'Can introducing a set of practice review documents into community nursing improve nursing practice?'

The desired outcome of this study was to develop and implement a set of practice review documents (the Tool)into community nursing with the intention of improving practice. The study explores the development of the documents in the Tool, their implementation and it then investigates if any changes occurred as a result of their implementation leading to an improvement in nursing practice.

The literature associated with the study involved an examination of the role of continuous professional development and career planning in maintaining best practice. In addition, the Magnet Hospitals and the Pathway to Excellence Programmes were examined and the role they play in producing gold standard practice and how they instil these values in staff. Key issues used to improve quality in nursing were also investigated; these included maintaining competence, best practice delivery, staff retention, succession planning and capacity building. Various management approaches used to improve the quality of nursing care delivery were also observed like effective leadership, empowerment of staff, reflective practice, mentorship, staff accountability and ongoing support. Finally, the literature focused on investigating the usefulness of potential key elements being introduced through the Tool in the research, in the hope of improving practice, like case review, early identification of clinical issues and speedy intervention all of which claim to assist with a quicker improvement and/or resolution of clinical issues, which enhance the prospects of better practice outcomes and assist staff feel supported.

An action research methodology was used in the research as it allowed for the development of knowledge together with the implementation of actions and it also supports the change process. Grahams et al (2006) model of action research was applied through four action research cycles: an exploratory phase; a consultation and development phase; a pilot phase and a re-development and roll-out phase. The research findings demonstrated that the documents were successful in improving practice and delivering safer healthcare while supporting staff. This in turn, leads to better staff retention and improved patient outcomes. Several recommendations were made, including the introduction of the documents for future practice.

Chapter 1

1.0 Introduction

This chapter outlines the context to the research and background of the study. It looks at the justification for the research and why it is important to nursing and in particular to Community Nursing (CN). It introduces the framework or set of documents called the 'Tool', developed by the author and co-participants, which this research will test and analyse for its ability to improve CN practice. Chapter two examines the literature pertinent to the topic and following this, chapter three introduces the approach used for the research project, including key issues like paradigm choice and the rationale for the author's choice of an interpretative approach using action research (AR) as the research mode.

Building on this foundation in chapter four the author and co-participants begin the AR process by scoping out the subject of practice issues from the nurses and the patients perspective. This information is then used to develop the Tool. In chapter five the Tool is launched through a pilot project and following this, final adjustments are made to the Tool and it is then launched in the research project. Data is collected and collated and the findings are also presented in chapter five. The final chapter chapter six, presents conclusions drawn and recommendations which will inform future practice. Also discussed here, are what this study adds to the existing body of knowledge and how it informs future research. Finally the rigour and the limitations of the study are addressed .

1.1 Context

The author works as a Director of Public Health Nursing (DPHN) within one of Irelands Community Healthcare Networks (CHN) in the Health Service Executive (HSE). There are nine CHNs in Ireland. Part of the role of a DPHN is to provide strategic and clinical leadership and direction for community health nursing, in a defined geographical area, with the intention of delivering an effective, efficient, patient focused, quality nursing service. Included in the remit, is ensuring that the team are adhering to all codes and guidelines relating to professional nursing practice and behaviour and that the team are complying with all statutory responsibilities as proposed by the rules of the Nursing and Midwifery Board of Ireland (NMBI).

In recent times, CN has undergone huge changes due to staff shortages and increasing case load size and complexity. Nurses are over worked and burn out is becoming an issue. There is a rise in missed care

(Phelan and Mc Carthy, 2016) and complaints from the public are rising (Health and Information Authority (HIQA), 2008). In an attempt to examine these issues and perhaps assist to remedy some of them, the author chose to develop a Tool and apply it in this research, to investigate if it could improve some of these conditions in CN and bring safer better health care to patients while supporting staff in the process.

CN like all other areas of nursing has suffered a severe depletion in staff numbers (Directors of Nursing Report, 2011; Phelan and Mc Carthy, 2016). Many existing staff are under pressure to cover their own caseloads, in addition to being asked to cross-covering colleague's caseloads when they are on leave or perhaps even left the service (Phelan and Mc Carthy, 2016). To add to these staffing issues, delivery of care in the community has also become increasingly challenging due to several facts. Firstly, a bed shortage in the acute hospitals has led to patients being discharged earlier. Also, as medicine advances, more complex cases are living longer and being discharged from hospitals and nursed in home environment (Child Protection and Welfare Policy 2016 ; Phelan and Mc Carthy, 2016; Coffey et al. 2017). In addition, our elderly population are living longer and this has brought an increase in the number of patients suffering from chronic health conditions, These have all added to the generic CN caseload volume and complexity. Also the updating of child protection policies by government has brought an additional dimension and further responsibilities to the Public Health Nurses(PHNs) workload also (Byrne et al., 2007; Phelan and Mc Carthy, 2016 ; Coffey et al. 2017).While all these issues impact on the nurse's caseload, the nurse for the main part, has continued in his/her generalist role, delivering care to all care groups in the community 'providing a cradle to the grave service'. While there seems to be an eternal increase in the workload of CN staff, there are less staff available to do this work (Coffey et al. 2017; Phelan and Mc Carthy, 2016). Caseload management in this environment is, therefore extremely challenging. In essence, the PHN role encompasses the role of the team leader, district nurse, school nurse and health visitor in the U.K. (Pye, 2020).

While there is an increase in the CN workload, there are, as stated above less staff available to complete this work. There are many reasons for this; one of the main reasons is the Governments attempts to control public spending by capping the headcount in Public Services (Department of Public Expenditure & Reform, 2018). When a nurse leaves, the post often remains unfilled for a long period of time or on occasion, if funds allow and staff are available, an agency Registered General Nurse (RGN) may be em-

ployed to fill the post though usually on a part time basis only (agency staff are not reflected in the headcount). The hiring of these 'temps' or 'hidden workforce' is becoming more prevalent in public services worldwide as governments 'tighten their belts' (Berman et al., 2015). While all welcome the use of agency staff for filling vacancies, care must be taken as to the potential loss of efficiency and effectiveness due to the change in skill mix in the workforce, and this is becoming an issue (Berman et al., 2015). For example, increased reliance on agency RGNs to replace Public Health Nurses (PHNs) is causing its own stresses. Both nurses have very different roles, the PHN is a Clinical Nurse Specialist (CNS) in community healthcare and s/he works in all areas of community healthcare delivery but particularly in assessment of child development in the under-fives and child protection. Theirs is a specialist role and no other nurse can carry out this role. PHNs also act as team leaders, review clients care and delegate work to RGNs and Health Care Assistants (HCAs). They manage the team, ensuring all clinical work is completed and clinical returns and the Key Performance Indicators (KPIs) are returned on behalf of the team and they retain overall responsibility for the care delivered by the team (Mc Donald, et al., 2015). However, some RGNs do take on a case holder positions and this role gives them responsible for their own caseloads and they are line managed by ADPHN as is the PHN. However, the majority of community RGN work under the guidance of the PHN. All community RGNs (case holder and non-case holder) work involves caring for the older person, and completing sick nursing for the team such as wound care, looking after the terminally ill and seeing all sick patients in need of nursing care. They do not complete any child development assessments nor are they involved in child protection- this is PHN work only. Even though the majority of RGNs are professionally accountable to the PHN, they still work as independent practitioners in their own right and have authority to admit and discharge patients to the caseload, but it is the PHN who holds ultimate responsibility for the overall management of the caseload except for the case holder RGN who manages her own caseload . So PHN and RGN roles are very different with the PHNs role usually being more extensive and wide ranging than the RGNs remit (Philibin et al., 2004). So the hiring of agency RGNs to replace PHNs is not a replacement of like with like and it leads to poor skill mix.

In addition to poor skill mix there has also been work overload as staff cross cover more than one area and caseloads numbers expand. This in turn has led to great difficulty in delivering care and providing a safe service for patients. Capturing this fact is not easy, in 2019, Pye presented a new way of recording Key Performance Indicators ((KPIs) in CN in Ireland. This new returns of KPIs demonstrated clinical activity in the home and clinic setting relating to referrals, discharges, direct and indirect activities.

However, Pye (2020), admits herself that further work is needed as these KPIs do not capture the existing patients within the caseload nor is their acuity or dependency levels measured. These KPI returns now form part of the National KPIs returns and while this move is welcomed as it increases the visibility and the profile of CN services and the data can be used to augment business cases for future service planning and resource allocation, but the author agrees with Pye (2020) there is still a need to demonstrate the true reflection of CN caseloads. These statistics are needed if we are to truly reflect the acuity and dependency levels of caseloads within the service and accurately map future workforce planning and effective caseload management. However in the meantime all that can be done is to support staff who are carrying excessive caseload's and are finding it difficult to maintain best practice.

Many studies have been done exploring the relationship between work overload and poor skill mix and how its effects the health and wellbeing of the nurse, the quality of the care being delivered and how it increases the risk of errors being made in care delivery, with missed care in particular escalating (Aiken et al., 2012; Phelan and Mc Carthy, 2016; Pennington and Driscoll, 2019). So sufficient staff and appropriate skill mix are both important factors in safe care delivery and they are getting more difficult to maintain in today's current working environment of CN.

Due to recognition of work overload, the nursing division of the DOH has recently prioritised a taskforce to examine workload measures in CN. The Health Service Capacity Review (Department of Health (DOH), 2018) was commissioned to complete this piece of work. This report has already recommended a fundamental health service reform with significant investment in both acute and primary care services. To keep pace with both population growth and healthcare needs, the review has forecasted that a rise of 46% in PHNs and 70% in home support services is required by 2031. Critically, this means an increase in PHN grade by 67%. In numerical values this means a rise from 1500 PHNs in post in 2016 to 2600 PHNs in post by 2031 (Pye, 2020). However until the report's findings are implemented the heightened risk remains in present practice.

While low staffing levels are an issue recruitment of new staff is also becoming an issue with extensive nursing shortages now abounding. However, it is probably easier to recruit RGNs and Health Care Assistant (HCAs) although numbers have reduced significantly; they are still available for recruitment from

nursing agencies. However, when it comes to recruiting a PHN, this is a much more complex situation. Recruiting a PHN is usually done through training a replacement student PHN to replace a staff member that has left the service. There are little to no PHNs available for work outside of this system, due to PHN shortages. So, when a vacant PHN post is filled it is usually filled by a novice PHN who has just completed his/her college course. (A novice nurse is a nurse less than 1 year qualified). The recruitment of a PHN can take up to two years or longer to fill the post and this has led to staff constantly cross covering two areas for extensive periods of time, which in turn raises the chances of work overload, burn out and staff leaving.

To complete the picture of staffing issues when the student PHN has completed his/ her training s/he is placed in his/her new position and there is no prescribed system for mentoring these novice nurses. For many novice staff this is a very vulnerable time for them, for despite having completed a Higher Diploma in Public Health Nursing, the novice often lacks CN experience and requires further mentoring into his/her new role (Meskell, 2009 & Holland, 2016). Chavasse (2001) called this the 'practice – theory gap'. Meskell (2009) also looked at a similar issue in the UK nursing system. Both authors suggested that this 'practice – theory gap' emanated from the lack of academic input with the student, while the student was in clinical placement. Mescall (2009) suggested that to assist the student assimilate their academic knowledge and apply it to their clinical setting, the role of 'link lecturer' should be introduced into clinical placement sites. A link lecturer is a college lecturer who spends time assisting student PHNs during clinical placement to apply academic learning to practice; this could ameliorate the issue (Mescall, 2009). However, in Ireland presently there are no link lecturers available due to time constraints on lecturers. This is a real deficit in the training system considering so much time is spent working alone in public health nursing and the expectation is that the student PHN arrives to work post qualification on day one as a competent practitioner (Holland, 2016). This style of introduction to CN for the novice nurse can be a very stressful and it raises the risk of losing the new staff member considerably. Mentoring is required to assist the staff member settle in and ensure safe practice delivery, but as yet there is no national programme for link lecturer from college or a national mentorship programme for new students PHN on first year of placement.

In today's world of CN with poor staffing levels, mentoring can be a challenge (Irish Nurses and Midwives Organisation, 2012, 2013). Nevertheless, utilising mentoring can enhance the novices' development, and assist them to adapt to new and different roles, this improves staff satisfaction, enhances effective nursing care, and promotes safe practice leading to quality health care outcomes (Bally, 2007).

MacLeod et al. (2008) looked at this issue in Canadian community nurses and they found that while mentorship was needed by all nurses it was essential for novice nurses. Armstrong and Laschingers (2006) also held this belief and they spoke of the important role that nursing management play in supporting and developing staff. Coventry et al (2015) added that managers who facilitate an empowered work environment, assist and guide novices to become established and competent team members and this then assists them to embed into an organisation and stay with it.

Begley (2005) noted that nowhere else in nursing do nurses spend as much time working alone and unsupervised as in CN. The author agrees with this and she believes this places nurses and the organisation in a vulnerable position. This means that if a nurse is struggling with practice issues it could take a longer period of time to identify this in CN in comparison to the hospital setting where nurses work in a team setting, with constant supervision. To overcome this, CN management often place new staff with experienced staff where possible to mentor and support them in their initial work placement (Phelan & Mc Carthy, 2016). However, in today's climate of staff shortages, it is becoming more difficult to find mentors for novice staff (Phelan & Mc Carthy, 2016). This is leading to some novice nurses being less closely monitored and spending large parts of their working day alone and unsupported. This increases clinical risk particularly for the novice nurse (Phelan & Mc Carthy, 2016 and Hanafin 2013). The author believes that there is a need to develop and introduce a standardised tool into CN to support the manager to conduct support visits and practice reviews with staff and in particular novice staff. It would bring a structured universal approach to this important function.

In addition to working alone, community nurses also have more decision-making autonomy than most other areas within nursing. (Zurmehly, 2007).Community nurses make decisions around client's welfare on an ongoing basis. These decisions are dependent on the nurse being an expert, and an experienced professional, that remains up to date on latest practice (Ball et al., 2014). Yet CNs have less access to education, or schools of nursing or to practice development, than any other area of nursing (Phelan and Mc Carthy, 2016). The author would support National Directors of Nursing and Shannon's (2013) view that a standardised system for early identification of clinical and performance issues needs to be established and she believes that the Tool may go some way towards introducing this into CN. The author will now introduce the Tool and its function.

1.2 The Tool

The Tool is made up of four documents

Document One was developed to assist staff to reflect on their practice and acknowledge their achievements and discuss any issues they may have or need support with. Also, it was developed to assist both nurses and nursing management look at nurses professional learning needs and help them to develop a learning plan and future career plan for nurses.

Document Two was developed to assist nursing staff to seek help/ advice when an issue arises in their practice. In addition, it encouraged staff to look for resolutions to their own issues before reporting them. Also, the issue is reported in writing to ADPHN a week before site visit and this gives ADPHN time to discuss issue with colleagues or DPHN prior to visit.

Document Three was developed to assist ADPHN to identify an issue that is interfering with practice delivery and it also gives them the tools to approach the issue in a professional manner and set up a plan for resolution of the issue. This form is completed by both the nurse and ADPHN after discussion and agreement to the specific steps to be taken.

Document Four is an audit of the nursing service which is completed by clients who are in receipt of the service. It looks at the service from the client's perspective. When completed the form is evaluated by ADPHN/ DPHN and if necessary changes are made to service delivery according to findings.

1.3 Rationale and Scope of the Research

Bearing all of the above points in mind and recognising that after much discussion with colleagues from different levels within the organisation, the author decided to develop a Tool for community health nursing. It is hoped the Tool will assist managers to help staff review their practice and support them if they are having practice issues. The Tool will also assist staff review their professional development plans so they can update their competencies and plan their future career development. If successful the Tool could assist in preventing situations developing where patient care is compromised or staff's wellbeing put at risk. It is also hoped that this piece of research will add to the current body of knowledge around CN work related issues and the need to support staff if best practice is to be maintained and staff retained. These are the main reasons the author chose to develop the Tool and to research this topic.

1.4 Justification of the Research

The author believes that some intervention is needed to assist staff who are struggling with staff shortages and escalating caseloads. Safe practice needs to be established which supports staff and helps them deal with practice issues in timely fashion. Also staff competence needs to be maintained with ongoing development of staff and plans made for staff career development to meet succession plans and future organisational needs. The purpose of this study is to establish if the Tool can do any or all of these things. The Tool focused on five areas that are within the remit of nurse managers and these are (a) Strong Leadership, (b) Regular Practice Review between nurse and manager, (c) Ongoing Support from managers, (d) CPD to maintain competence (e) Assisting staff to develop a career pathway for themselves.

None of these are new or ground-breaking discoveries but it is the combination that the author feels is needed if we are to stem the leak of nurses from the service. In present times of staff shortages, we seem to resent giving the necessary time to these practices and yet these are the very systems that will maintain staff and retain them and assist them to deliver best practice. The author suggests we are so busy running; we don't have time to examine what we could be doing better or see what we need to change. It is time to stop running and examine practice and examine what we could do better to improve practice and support staff.

1.5 Previous Research on this Topic

While a limited enquiry of this nature has been undertaken in Ireland before, the author has broadened the view to international research where there have been many different approaches to looking at this matter. However, no literature is as pertinent to the Irish situation as an Irish author's contributions, and although there is a paucity of Irish literature comparatively speaking to the international literature, both sets of literature are drawn on and used extensively throughout the research.

When CPD was examined, many different authors with many different views were identified; this led to CPD being examined through several different lenses. The three main lenses used to examine CPD were the need for CPD in nursing, the advantages of CPD to the nurse and organisation (Joyce and Cowman, 2007) and the role that CPD plays in maintaining competence in nurses (Casey et al., 2017; Coffey et al. 2017).

Another areas explored in previous research, included leadership in nursing. International literature was used mainly here and leadership and the work of three seminal authors on nursing leadership, Aiken, Spence Laschinger & Leiter were studied extensively throughout the study. These authors looked at authentic leadership, empowerment and burnout in nursing extensively in many of their papers. They are particularly interested in staff effectiveness and organisational performance and their writings reinforce the view that nurses need to be provided with access to information, support, and resources to optimise their practice and deliver best practice.

The subject examined was nurse shortages and staff retention and the far-reaching consequences of both, this was examined from an Irish CN perspective and an international perspective (Pennington & Driscoll, 2019). All of these issues the author hopes to address in the literature review which compromises the following chapter. It is hoped that this piece of research will add to CN literature but particularly to Irish CN literature and improve CN practice, enhance patient care and support staff as they struggle both with extensive and complex caseloads and staff shortages. This research will focus specifically on improving CN practice through CPD, career development, strong leadership and staff support.

1.6 Development of the Tool for the Research

The Tool used in the research was developed by the author after completing an international literature review on which elements are commonly found in institutes that deliver gold standards nursing care worldwide. The same themes constantly kept appearing in the literature and these were CPD, on-going practice review, staff support, strong leadership and career development. The author suggests that if CN practice is to deliver a high standard of patient care going forward, it needs to embed these structures into practice. This would ensure that care delivery remained constant and safe (Maxwell et al., 2011). It is hoped that the Tool will encompass these elements and assist to embed and maintain them in CN. This in turn would lead to best practice being delivered by a more flexible and skilled workforce. These are important factors considering the imminent changes that are about to occur, as Slainte Care brings a change in focus to care delivery with chronic disease management and older persons care moving away from the hospital setting to the community setting (Department of Health, 2017).

Having now recognised the required structures to assist staff to feel supported in their job and deliver best care the author set out to research these frameworks that purported delivering these standards. It was hoped to develop a Tool based on these frameworks that could improve Irish CN. One such framework, was Magnet Hospitals (MH) which emanated in the United States of America (USA)(Aiken et al., 2009). MH are considered the Gold Standard of health facilities (Aiken et al 2009). To achieve Magnet designation, hospitals must go through a rigorous and lengthy process. The organisation must meet stringent eligibility requirements and address standards within five major components that compromise of the Magnet Model. These are transformational leadership and structural empowerment, exemplary professional practice, new knowledge, innovations and improvements, and empirical outcomes. (American Nurses Credentialing Center (ANCC), 2014; Bates et al., 2020) (See Figure 1.0 on next page)

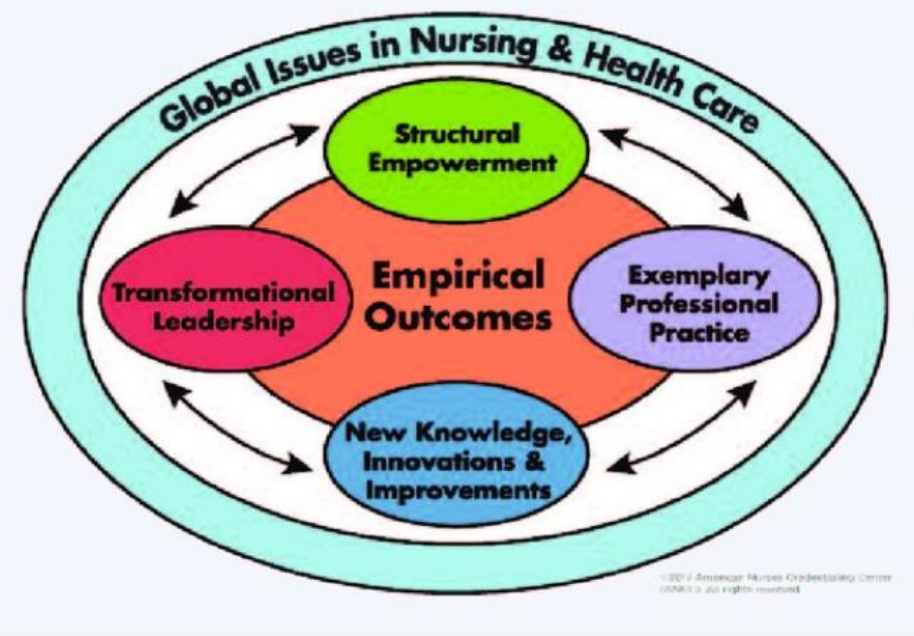


Figure 1.0 The Magnet Model (ANCC, 2014)

There are many advantages to being named a MH some of which are attracting & retaining top talent in all disciplines, including nurses, which leads to a better staffed organisations excellent patient care, more job satisfaction and less burnout (Aiken et al 2009; Bates et al., 2020). Teams in these environments take on a collaborative culture, leading to better team building, mentoring and staff engagement. (Aiken et al., 2009; Bates et al. 2020). These all lends themselves to job embeddedness with staff retention (Aiken et al 2009; Bates et al 2020).

While there are only 460 MHs in the USA which is roughly 7% of all their acute care facilities, (Kutney-lee, 2015), the Magnet Model has spread worldwide. Several countries have adapted the MH vision and standards, however, because of its extremely high standards there are only 600 Magnet recognised facilities worldwide to date. Healthcare organisations on this side of the Atlantic have been slower to embrace Magnet Recognition, but since 2015, and following a recommendation by The Lord Willis Report (Willis, 2015) several hospitals in the UK are now actively pursuing Magnet Recognition. While this work has also been extended to Europe, as of yet, no hospitals have adapted it yet here in Ireland.

While the MH is gold standard and a model to aspire to, the author suggests that it is not as appropriate for a community setting as it is for a hospital setting. For this reason the author sought a different model to base the Tool on. It is a model that was adapted from the MH model for CN in 2008 by Texas Community Nursing staff. It was termed the 'Pathway to Excellence Program™' (PEP): (Wilson et al 2015) and this model is a better fit for CN service here in Ireland. It was from this model that the author developed the Tool. The criteria required to meet these PEP organisation standards were developed in 2008 (Bushy, 2009) and are illustrated in Table 1.0 below.

Table 1.0 Pathway to Excellence Standards (ANCC, 2008:6).

1. Nurses control the practice of nursing
2. The work environment is safe and healthy
3. Systems are in place to address patient care and practice concerns
4. Orientation prepares nurses for the work environment
5. The Chief Nursing Officer (CNO) is qualified & participates in all levels of the organization
6. Professional development is provided and utilized
7. Equitable compensation is provided
8. Nurses are recognized for achievements
9. A balanced lifestyle is encouraged
10. Collaborative interdisciplinary relationships are valued and supported
11. Nurse managers are competent and accountable
12. A quality program and evidence-based practice are utilized

These standards were used in the development of the Tool for this research. The author believes that the ANCC framework offers many characteristics and traits required for CN today. These traits include a strong Director of Nursing and a focused senior nursing team, also staff having ready access to this team to discuss any practice issues they have, this allows staff to feel valued, supported and listened to. Also, included is access to good quality CPD, staff involvement in practice decisions and being updated regularly on the organisation's strategic plan so as they can map effectively their future career development. Furthermore, these standards are delivered in an environment which has family friendly working condi-

tions, with ongoing support from management and access to an Occupational Health department for staff well-being if needed. This framework fits well with Irish CN beliefs and it portrays standards that all CN areas could aspire to. TheANCC standards were subsequently updated in 2020 and while they remain similar a few of them were further expanded, the newer version of theANCC framework is demonstrated below in Table 1.1.

Table 1.1 Additional Standards added to ANCC Pathway to Excellence 2020(Bates et al., 2020 p8)

Pathway standard	New concepts
1. Shared decision-making	• Nurses involved in selection and implementation of new technology
2. Leadership	• Nurse manager role-specific orientation • Organizational strategies to maintain a positive practice environment during executive leadership change • Strategies to retain senior nursing leadership and nurse managers (adopted from Pathway to Excellence in Long-Term Care)
3. Safety	• Organization promotes a culture free of incivility, bullying, and violence among the healthcare team • Organization safeguards nurses from abuse by patients or families
4. Quality	• Organization promotes a culture of person- and family-centered care (adopted from Pathway to Excellence in Long-Term Care) • Organization provides opportunities for nurses to learn about EBP
5. Well-being	• Employee well-being and resilience are integrated into strategic planning • Nursing leadership supports a culture of recognition • Organization provides support to address the well-being of staff members who've experienced work-related adverse situations • Organization has strategies in place to address physical and compassion fatigue experienced by the healthcare team
6. Professional development	• No new concepts added

1.7 Using an Analytical Framework to review the Documents in the Tool

The Tool compromises of 4 documents and the author will now use an analytical framework to examine these documents and their pertinence to improving practice in CN. Cairney (2013:1) describe an analytical framework *'as* a means of helping make sense of the complexities, ambiguities and driving forces of multi-faceted phenomena'. Cairney described the use of frameworks in the social sciences and humanities in particular, as a method to seek to simplify reality and reveal the foundational structure upon which the phenomena under investigation rest.

1.7.1 Choice of Framework

Researchers have developed many different frameworks that are useful for understanding as well as developing policy document. Choice is dependent on the theoretical perspective of the researcher or analyst. Howlett et al (2016) and Sabatier and Weible (2007) believed that the choice of a framework bringing with it, the selection of theories and within these theories there are associated models and these models can be tailored to a particular problem. Miles and Huberman (1994: 60) agreed with this view and added that 'by making choices around framework selection, we are selecting the process which determines the questions we want asked, thus we develop the perspective taken.' So correct choice of framework is important and may be seen by many as critical to the situation as it shapes the outcome. So having given due consideration to the matter, the author choose to employ Stephen Balls Policy Cycle Framework (1992) to examine the documents.

1.7.2 Stephen Ball's Policy Cycle used to Assess Documents in the Tool

Balls policy cycle was developed by Ball and Gold (1992). It is a nonlinear, interactive cycle approach. There are three stages in the cycle, and they are:

1. Context of Influence (why the documents were developed)
2. Context of Production (origin of the documents and what influenced their development)
3. Context of Practice (when applied to practice how it was interpreted and applied) See Diagram 1.3 of Stephen Balls Policy cycle on next page.

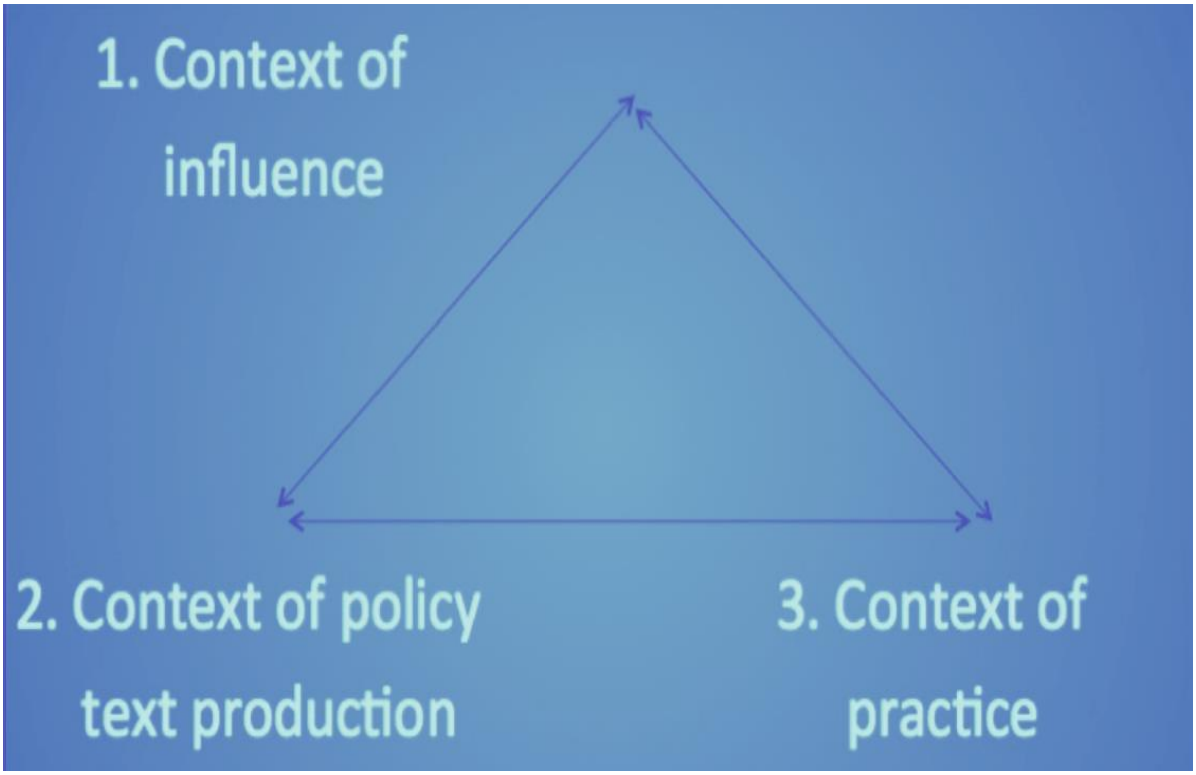


Figure 1.1 the Policy Cycle (Bowe, Ball and Gold, 1992: 2)

Ball's Policy Cycle attempts to examine processes from influence to text production to practice. It is about how and where policy is made and remade in the three different contexts. The context of influence is where interest groups struggle over the construction of policy discourses and where key policy concepts are established; the context of policy text production is where texts represent policies. Texts have to be read in relation to time and the site of production, and with other relevant texts. The context of practice is where policy is subject to interpretation and recreation.

1.7.3 Rationale for Choosing Balls Policy Cycle Framework to Analyse the Tool

The author chose Ball's Policy Framework as these documents are part of a cycle of production. They are made and remade continually as AR cycles evolve and then they begin again. The Tool production is a never-ending process; the production of the text itself is not one static moment, nor is it a linear process. Making and remaking and updating of the documents will always be present, so using Ball's Policy Cycle which too is based upon cycles of change makes it an appropriate framework to choose.

In Ball's Policy Cycle Framework each of the three contexts has a public and private arena of action. Each of these arenas involves input from and negotiation with staff while making the texts of the Tool Negotiation, compromise and power struggle with staff at all levels of the organisation will be part of each cycle. Bowe et al (2017) spoke of there being room for dialogue and discourse at all stages so as to explore and understand the histories and ideologies of the people who use these documents as much as the maker of the documents. This will give the document much more credence and bring buy in from staff that will invest in it, take ownership of it and adapt it for use in their practice. This will make it a much more valuable policy document for CN practice; it will make it a Tool that staff will want to adapt into their practice as they feel they developed it and they own it already.

1.7.4 Context of Influence (why the documents were developed)

In the context of the research, the author works as a DPHN and in today's world of CN there have been many changes, particularly in the last ten years with staff shortages, and caseload size increasing in both number and complexity (Hanafin, 2013 & Phelan, Mc Carthy et al., 2016).The launch of the Sláintecare Report (2017) is bringing a major impact for CN, with a new way of doing business which means embracing an integrated approach to healthcare delivery with a big emphasis on keeping patients at home for treatment and care delivery (Sláintecare Report, 2017).

Examining these issues, the author suggests that there is a need to look for a way in which we can assist staff through these changing times, particularly if best practice is to be sustained and staff retained. Time needs to be dedicated by nursing management to reviewing practice and supporting staff before they become overwhelmed with change in addition to their everyday caseload management. Nurses need to have the space and time given to them, to seek help and advice when they are experiencing issues, particularly novice nurses (Barton et al. 2005:41). While audit of caseload is important, support is essential at this time (Armstrong and Laschinger, 2006). Organisations that support nurses empowers them to practice their profession optimally, thus providing better and safer patient healthcare (Armstrong and Laschinger, 2006).

1.7.5 The development of the Documents and their Functions.

1.7.5.1 Development of Document One (Found in Appendix A)

Document One was sub-divided into three sections. The three sections looked at three different areas.

Section A of the form dealt with ***staff recognition***, ***staff wellbeing and i supporting staff when needed with clinical issues*** as advocated in the Pathway to Excellence Programme (PEP) Framework (ANCC, 2008:6 in Bushy 2012). This section of Document One,in the Tool asks staff 'what they have accomplished in the last year or since their last practice review'. The author found that staff found this a little "Americanised" at the beginning as they were not accustomed to considering their accomplishments, however with repeated use; the staff became more comfortable with the idea and completed it without prompt. Also asked in this Section A was if the nurse was experiencing any issues at work and if so would they would like to discuss this and seek support from the ADPHN.

Section B of the document was developed to give nurses the opportunity to reflect on their professional needs and it allows them the time and space to look at **building a future career development plan** for themselves This idea was in keeping with the standard of the 'provision and utilisation of professional development' as stated in the PEP Standards (Bates et. al, 2020). Section B of the form also includes **competence updates that are mandatory to practice, development of new competencies to meet new practice developments and also courses of study that the nurse would like to pursue and are appropriate to the organisation.** In addition, it gives the ADPHN an opportunity to update the nurse on any upcoming developments in the organisation and the nurse and ADPHN can then discuss these developments before they agree the nurse's development plan for the coming year. This 'shared decision making' ensures the 'nurses' involvement in future organisational developments' (Bates et. al, 2020). It is hoped this document will also give the management team an opportunity to complete '**succession planning'** through appropriate CPD planning (Bates et. al, 2020). The CPD plan is agreed and signed off by both nurse and ADPHN.

Section C completes the document and it includes **formulating the nurses CPD plan in writing** for the coming year or until the next review. This is agreed by ADPHN and nurse and applications are made for courses, and study leave and funding organised. Again, this evolved from the PEP standard that all staff are encouraged to 'access and use continuous professional development' (Bates et. al, 2020).

1.7.5.2 Function of Document One

It is hoped that use of Document One will allow staff to have protected time to sit and reflect on their practice. This will assist them improve future practice delivery (Howatson Jones 2019). The document will also give nursing staff the chance to discuss practice issues with the nurse manager and receive support and advice. It also allows the manager to acknowledge the nurse's accomplishments and thank him/her for a job well done. (Howatson Jones 2019). When staffs are supported by an effective manager in this way, they grow in assurance and competence and are more capable and confident of taking on new roles (Laschinger et al., 2009). This approach from management also assists nurses to feel supported and appreciated and assists to embed them into the organisation (Tan et. al. 2019 ; Tan et. al, 2019 b) and embedded staff stay with an organisation (Mitchell et al., 2001).

Another role that it is hoped that Document One will supply is to open discussions between the nurse and ADPHN regarding future practice needs of the organisation and from this, future training opportunities for staff. The nurse would also have an opportunity to discuss their present mandatory training needs, their future practice training needs and their future career development needs with the ADPHN. To maximize returns' from CPD, managers need to invest in appropriate CPD for the organisation (Joyce and Cowman, 2007). In addition to organisational needs, nurses also need to feel their CPD needs are being catered for, as this leads to the nurse feeling more valued and staying longer with an organisation and contributing additional years of expertise and experience to the job (Gibson, 1998 & Joyce and Cowman, 2007) Thus, good choices in CPD planning, with joined up thinking between management and staff, add investment to an organisation and its staff. It is important to align the needs of both and to get to this stage; organisations and staff need to plan their CPD requirements strategically. It is hoped Document One will assist with this function.

It is proposed that this document is used at all levels in the organisation between novice and ADPHN, nurse and ADPHN and also between DPHN and ADPHN. The one difference in this document's use between novice and experienced nurse is its frequency of usage. In the case of the novice it is hoped to use the document to review their performance and support them on a fortnightly basis initially and then extend this to longer periods between meetings as the nurse develops in confidence and competencies (Benner et al., 2009). It is hoped that the document will assist them with this transition from novice to experienced and competent nurse. For the more experienced nurse, the form can be used annually or

more frequently if needed. This is in keeping with The Ganey Report (2017) view, that through supporting staff, nurse managers exert substantial influence on the work environments, nursing performance, the safety and quality of healthcare delivery and the patients experience, as well as increasing staff job satisfaction and staff retention. This view is also upheld by the 'MH' and the 'PEP' frameworks who advise that managers play a leading role in influencing staff and producing positive practice environments. These in turn affect patient safety, job satisfaction, organisational commitment and patient outcomes (Aiken, 2008, 2012; Laschinger et al., 2003; Laschinger et al., 2009). These were the beliefs behind the development of Document One.

Attached to Document One are three attachments or indexes and these give the user a quick reference to documents needed to complete the nurses future development plan and review practice

I. The first document includes the HSE Annul Service Plan, the Local Community Healthcare Network Plan and the National and Local PHN plans. These are for review by ADPHN and nurse annually and training is aligned when the nurse's development plan is completed.
II. Also included is a copy of the Professional Development Cycle as developed and introduced in 2018 by Office of the Nursing and Midwifery Services Director (OMNSD) which may be of assistance in identifying training areas for maintenance of competencies for present and future practice and for future career planning for nursing staff.
III. The final document attached is the five domains of competence for nurses as advocated by NMBI. This document is included to assist staff assess the nurses competencies and it can assist to highlight if there is an need for an update and this can then be added to the nurses development plan for the coming year.

1.7.5.3 Development of Document Two (Appendix B)

This form was developed in the hope of assisting staff t**o deal with an issue in an early and timely fashion that is interfering with their practice delivery** and something which they have not been unable to resolve themselves. Document Two is completed by the nurse and forwarded to ADPHN 7-10 days before meeting. The ADPHN/DPHN meets the nurse and discusses the issue and the manger supports the staff member throughout the process. A plan is agreed by all after discussions have taken place. This plan is documented with review dates to review improvement or resolution of the issue. Several

meeting may need to take place if the issue is extensive. This document was developed in line with the PEP Standards (Bates et. al, 2020) on **supporting staff during an issue to maintain their wellbeing**.

1.7.5.4 The Role of Document Two

Document Two will deal with staff issues that are not resolved in Document One at the primary practice review meeting. Document Two may also be used without Document One if a clinical issue arises and the nurse needs advice, guidance and support from the ADPHN. The document begins by asking the staff member to write an account of the issue s/he wishes to discuss, and it also asks what has been tried prior to this, to resolve the issue and what worked or what did not work to date. It then asks for two suggested solutions to the issue from the nurse and this form is then submitted to ADPHN to review. The ADPHN may seek counsel or guidance from other ADPHNs or DPHN before making an appointment to visit the nurse. They then look at the issue together, discuss what options are available to them and then jointly agree and develop an action plan to resolve the issue.

Document Two takes this format on purpose, as it is important for community nurses to use reflection to assess their issues and to try to resolve them on their own as they spend much of their working day alone (Philibin et al., 2010; Coffey et al., 2017). However, it must be noted that despite empowering the nurse to problem solve, s/he is not abandoned, the line manager is always available by telephone to assist if needed. This style of management empowers the nurse to learn more from the event and become more confident and competent to able to manage the issue or similar issues alone in the future (Benner, 2013).

This document's main function will be to assist the nurse to self-manage as much as possible and to look at problem solving alone prior to looking for assistance. However, it will also help the nurse to realise that support or advice is readily available when needed, and while s/he may work alone a lot of the time, s/he is still part of a team and all teams support and mentor their staff when an issue arises that needs assistance from a line manager.

1.7.5.5 Development of Document Three (Appendix C)

Document Three was developed to assist and deal with issues that are interfering with work performance. From time to time staff develop issues – some are work related while others are related to private or family issues. Document Three assists in dealing with these issues when they interfere with work. This is following the PEP updated standards (2020), which discusses **systems being in place to address patient care concerns and the well-being of staff, with managers being accountable for practice delivery.**(Bates et al., 2020). This ensures best practice is being delivered by competent staff, happy in their job and that patient care is regularly reviewed by managers to maintain standards (Aiken, 2008, 2012; Laschinger et al., 2003; Laschinger et al., 2009).

However, it is hoped Document Three will be seen as useful and not as punitive by staff. Document Three **encourages ADPHNs to identify issues, seek the reason behind the issue and then work with the nurse to find a resolution.** The employees well-being and resilience is integrated into the plan (Bates et al., 2020) Also Document Three ensures that the organisation supports staff through crisis and it enables working arrangements that facilitate regaining and maintaining of competence in staff (Bates et al., 2020).

1.7.5.6 The Role of Document Three

From time to time staff develop issues, these issues may be small and staff overcome them alone but occasionally they need help and they need management to intervene, particularly if the issue is interfering with practice delivery. So it is important that a procedure or a policy be developed in the form of a document that can be implemented when this situation arises. This `was the hope in developing this Document tThree. It brings both a method to assess the issue and it supplies a plan of action to resolve the issue. This is the reason for development of Document Three for the research.

The commonest and least difficult issues that need addressing are staff competencies. These are relatively straight forward to discuss and most staff will welcome this discussion or sometimes they will approach the manager themselves, seeking the required updates for training themselves. Different types of updates or training are available and include skill practice sessions, skills demonstration sessions, skills

updates, complete training courses, coaching or mentoring. Whichever route is chosen, an Action Plan is made and objectives are set which are SMART– specific, measurable, agreed, realistic, time-bound and are recorded between nurse and manager.

Other things dealt with by Document Three could include things like issues of a more personal nature. Sometimes a nurse may experience an issue in his/her private life which is interfering with his/her work. While most staff and families resolve these matters privately, occasionally some staff may need assistance to do so. This is where having a manager with a good working relationships with staff is important as it makes it much easier for the nurse to seek help from the manager or for the manager to give assistance (Ehrhardt and Ragins, 2019). The manager discusses the issue with the staff member and together they draw up an individual action plan tailored to support the needs of the employee (Ehrhardt and Ragins, 2019). However, on a cautionary note, managers need to be mindful of staff's privacy (Ehrhardt and Ragins, 2019). While employees should be encouraged to communicate their needs, equally they should be encouraged to set their boundaries and managers need to take cognisance of this. They also need to be effective listeners at these times (Ehrhardt and Ragins, 2019). This involves more than good intentions; it requires strong communication skills, emotional intelligence, and the ability to understand nonverbal cues (Ehrhardt and Ragins, 2019).

During times of crisis, it is not unusual for staff to have difficulties balancing their work and personal lives (Ehrhardt and Ragins, 2019). Help is needed from management and it can come in several different forms and these includes referral to Occupational Health for assessment for physical and emotional wellbeing or referral to auxiliary support services like counselling or staff supports may also be useful at this time. A staff member and a manager may decide that reducing the working hours or introducing flexible working hours until the situation resolves or becomes more stable may be the best approach. These hours can be reduced for a stated period and then the staff member and manager meet to review the situation. However, on occasions and when a crisis is acute, none of these solutions may work and the manager and nurse may agree that a leave of absence would be the best approach. Again, a date to review the situation is set and the situation is managed through an Action Plan with SMART objectives.

It is hoped Document Three will supply the action plan for these situations and it can be used at all levels of the organisation. On most occasions it is the nurse that approaches her line manager to discuss an issue but on occasion it is the manager that notices the performance issue and may have to approach the nurse. The Appendix attached to Document Three assists the manager to identify what specifically the issue is that needs to be addressed and when it is identified then Document Three specifies what style plan is needed to address it.

It is hoped this will be another tool to add to the arsenal of Tools that assist in improving and maintaining good nursing practice while supporting and caring for staff that are experiencing an issue. Ideally in any issue, the relationship between staff is key and it is hoped that this document will help maintain and maybe even improve relationships between a nurse and her line manager as it clarifies in writing what is needed and how to accomplish it, in specific steps. The author suggests that if this document is applied correctly, that it will be an invaluable Tool to both the nurse and the manager. In the long term it is hoped this document will assist staff when they have issues to come forward and seek support, enhancing better relationships and improving practice.

1.7.5.7 The Development of Document Four (Appendix D)

Document Four was developed to complete the 360-degree evaluation of practice delivery. It is an evaluation of the service from a patient's point of view. In PEP Standards on quality (Bates 2020) it states that 'organisations should promote a culture of person and family centred care'. This means that the patient receives a quality service that is tailored to meet their needs or their family needs. This is the role of Document Four. It asks - are we delivering a service that is both a quality service and suitable to the patient's needs? As nurses, our work emanates from this very goal. We are service providers and patients are our clients. We strive to meet their needs, not what we think they need. If we are to do this successfully, **we need to hear the patient's opinion** on whether we are doing this or not.

1.7.5.8 The Role of Document Four

Document Four is a patient satisfaction survey. This document is offered to all patients when the nurse first meets them, or patients can access the form on the table in the waiting room in the primary care centres. When completed, the document can be returned to the nurse or patients may decide to maintain their anonymity and post the completed questionnaire into a sealed post box in the waiting area where it is later collected by ADPHN. The third method of submitting the questionnaire is through the post and the patient may post it back directly to the Director of Nursing (whose address is on the questionnaire) if they so desire to do.

Over the past 20 years, patient satisfaction surveys have gained increasing attention, they are now viewed as significant and essential data sources commonly used to develop quality improvement plans in healthcare organisations or they are used to identify practice concerns (Al-Abri and Al-Balushi, 2014). They assure us that healthcare delivery is being delivered according to the needs of the patients and it ensures that patient's views are represented in all healthcare planning (Whitehead, 2001). It completes the 360-degree feedback in the suite of documents (The Tool). It ensures we develop our service in such a way that it is user-friendly as this enhances greater patient satisfaction with more compliance by the service user.

In no other area of nursing is patient's self-management and compliance more important or such an integral part of their care, as it is in CN. This is because many patients' in the home setting suffer from long-term chronic illnesses and gaining their cooperation and compliance in self-management is essential (Glasgow et al., 2003). Document Four gives staff the opportunity to ask patient's for their opinion so as to shape how their healthcare is delivered. This is not alone desirable, but essential in CN (Clarke, 2004) as patients are the main providers of their own healthcare, nurses are only the facilitators. Taking cognisance of patient's opinions, leads to better compliance with better healthcare outcomes, it is imperative that we involve patient's opinions in all care delivery (Glasgow et al., 2003).

1.8 Research Question and Hypothesis

The desired outcome of the study is to examine, whether this suite of documents when introduced can improve nursing practice by early identification of work issues and /or assist with timely intervention to provide staff with support in situations where they are experiencing difficulty. The research questions for the overall research project are as follows:

Do these documents

1. ***Assist with early recognition of work issues and /or contribute to timely identification of work situations where staff are in need of support?***
2. ***Prevent escalation of issues and lead to better outcomes*** (like more prompt correction of issues leading to better client outcomes, increase in staff wellbeing, more job satisfaction, better staff retention and a reduction in the risk of litigation)?
3. ***Give nurses the time and space to plan for their CPD, their competency building and career development?***
4. ***Assist in improving practice?***

The author has developed the suite of documents 1-4 which will be trialled in CN and if found suitable then adapted into CN practice. This suite of documents will henceforth be referred to as **'*The Tool',*** (Appendix A-D).

In this research the author hopes to pilot the Tool through AR. After the first cycle of AR, it is planned to adjust the Tool according to feedback and then pilot the adjusted Tool a second time, again through another AR cycle. In phase three it is hoped to finalise the research and report the data and findings on its effectiveness as a Tool to improve practice in CN.

1.9 Limitations and Rigour of the Study

This is a national piece of research, but the numbers involved were small-scale as an AR approach was used in the research. However, it is hoped that it is a good representation of the general CN populations and that all views are represented fairly and without bias in the research. While every effort was taken to ensure validity, it has to be stated that this research is still an interpretation of

the findings and although it is a shared interpretation with all who participated in it, it is still an interpretation.

It must be stated that the author (in her role as a Director of Nursing) has detailed views on improving nursing practice and was cognisant of the risks posed by anticipatory bias even though the author chose to spend two years away in a different job while carrying out the research so as to minimise bias as much as possible by influencing staff. Also it must be stated that the author worked from an assumption that senior nursing managers had the knowledge and education to discuss and understand what is meant by the term practice improvement.

It may also be stated that this study examined the subjective experience of community team members. Their experience may be different to others and also there may be differences between reported experiences, espoused values and what transpired in practice, but in an effort to minimise bias all research obligations were completed even to the point of the author/researcher removing herself from the field of practice being studied.

1.10 Summary and Conclusion

This chapter has outlined the context to the research and background to the study. Today's world of CN is no different to the rest of the nursing world with its many practice issues. While there is much literature supporting staff and assisting them to deliver good practice, we do not usually see a constructive plan or tool formulated to help staff and management resolve practice issues. The author has worked on both sides of this divide, she has been employed as a lecturer with a college and has seen how new nurses in particular struggle with the need for mentorship and support to initiate and maintain good practice. As a Director of Nursing the author has seen mature, competent nurse's struggle with heavy caseloads and leave before anyone even noticed that were finding it difficult to cope. In an effort to move from acknowledgement of this issue, to searching for a tool that could be used to assist resolve the matter, the author has chosen to develop and implement a tool which it is hoped will support staff in their clinical practice, no matter what level in the organisation they are working at.

When the Tool is implemented it is hoped to review the evidence and decide if this Tool makes a difference to improving practice or supporting staff. The author wishes to know does the Tool encourage staff development and retention and finally and most importantly does it improve patient care delivery?

In the next chapter, the author will present the literature reviewed. The literature presented includes topics which repeatedly appeared when examining the best ways to improve nursing practice. These will now be presented and their relevance related to the Tool development.

CHAPTER TWO

Literature Review

2.0 Introduction to the Literature Review

A literature review takes the reader on the journey of demonstrating, what is previously known about this topic and what is worthy of further investigation and why. Webster and Watson (2002; 13) described this well in their definition stating that an effective literature review is one that 'creates a firm foundation for advancing knowledge. It facilitates theory development, closes areas where a plethora of research exists, and uncovers areas where research is needed'. Hart (1998: 1) agreed and spoke of the meaningful literature review adding 'something new' to the present knowledge on a subject and that it should include appropriate breadth and depth, rigor and consistency, clarity and brevity, and effective analysis and syntheses.

2.1 Purpose of the Literature Review

The literature review forms the basis of the research, it informs the author of previous knowledge and highlights areas where new research is needed, thus providing a solid theoretical foundation from which this study begins. The areas of literature chosen for review were areas that related directly to improving nursing practice, which is the aim of the Tool developed for this research.

In addition to shaping the research question, the author also hopes to use the literature review findings to inform how best to approach the methodological development and design of the research project. These ideas were guided by the work of Stevens, Schade, Chalk and Slevin (1993) and Holmes (1996).

2.2 Scope of the Literature Review

The types of literature, research studies and policy documents included in the study were, initially kept broad. The search began by systematically reviewing both published and unpublished scholarly literature including both data based and conceptual literature in print and non-print forms. The search included published journal articles, book chapters, reports, conference papers, legislation and theses. In addition, information was accessed from professional, educational, management, leadership and government internet sites. Exclusion criteria for the literature review included reports or studies at feasibility or pilot stage only, literature published in a language other than English, book reviews, discussion papers, opin-

ion pieces and literature published mainly before 2009, unless a significant and pertinent piece of work or seminal work related to the topic.

2.3 Search Strategy

An extensive search of databases was conducted which included, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Education Resource Information Centre (ERIC), Joumals@Ovid, International Nursing Index Nursing Research Abstracts, Nurse2Nurse, and the Registry of Nursing Research. The key words used in the search related to the purpose of the review and included leadership, empowerment, management support and mentorship, continuous professional development (CPD), continuous professional education, CPD and competency in nursing, CPD and maintaining well-trained staff for safer practice, personal development plans, and the role of career planning in personal and organisational development. All of these were then cross-referenced against safe nursing practice in the literature review. Combinations of key terms were used. All terms were used in the fields: title; abstract; keyword; subject headings; and outline headings. All abstracts resulting from the search of the databases were inspected to identify related content. The principles of relevance, significance, depth, breadth and authentic presentation, as described by Holmes (1996), guided the analysis. A wealth of literature was identified pertinent to the topic.

2.4 Study Selection and Review Process for Literature Review

Having identified the relevant literature, the author then chose to use a systematic literature review (SLR). The SLR method has been used for many decades and is synonymous with health care. It produces a systematic approach to the literature review that is transparent, reliable and is capable of producing valid results. Petticrew & Roberts (2006) saw SLR as a suitable method to make sense of large bodies of information while seeking to answer a question posed by a researcher. The outcome of the SLR is to provide a combination of results retrieved from multiple studies (regardless of theoretical or methodological characteristics) which all relate to an assessable topic. These results are then evaluated for purpose and strength and the results summarized for evidence for practice (Whittemore & Knafl, 2005). Bettany-Saltikov, (2012) also spoke of the SLR as being a suitable method to cope with overwhelming amounts of academic evidence and this was the case in this research also. In addition, the SLR system of researching the literature provides a transparent system as to how the research was carried out and by its

transparency it provides the researcher with the tools to repeat the literature review for his/her own research if s/he chooses to. Thus, SLR was the method of choice considering the research question generated such a large volume of literature and both quantitative and qualitative style studies, which were included in the review.

All records (n=2221) retrieved during the database search process were examined and duplicates were identified and removed both automatically and by hand. The total search output (n=1550) was reviewed and each record was individually screened by title (n=1550) and (n=1337) excluded and then the abstract was read (n=413) and (n=140) removed, according to the inclusion criteria and with consideration for which papers needed full text review and which did not. Carnwell and Daly (2001:59) suggest that dividing the literature into distinct themes and categories is a gainful approach; they also recommend maintaining inclusion and exclusion criteria. This method was used as there were six main themes overall. The potentially eligible full text papers (n=273) were then read independently and included in or excluded from the review according to the three themes developed. That left (n= 201) papers to be included in the literature review. They were then divided into 6 groups to cover the 6 themes and these were (n=69) Leadership (48) and Empowerment (21), (n=46) Continuous Professional Development, (n=26) Staff Retention, (N=6) Career Development, (n=5) Organisational and Career Planning, (n=49) Staff Support/ Mentorship.

These were saved to Zotero, a referencing online tool. A summary of the search outputs from the review process was added to each paper. 201 studies met the inclusion criteria. (See diagrammatical representation of the literature review in Fig 2.0 next page).

While the originl literature review process is explained in detail, the author would also like to mention that the literature review did not stop there. The review was an iterative process and literature was revisited as each research cycle was completed and its findings revealed new areas that required further reviews. So the search and selection processes listed here are from the main initial literature review but several less extensive literature reviews followed.

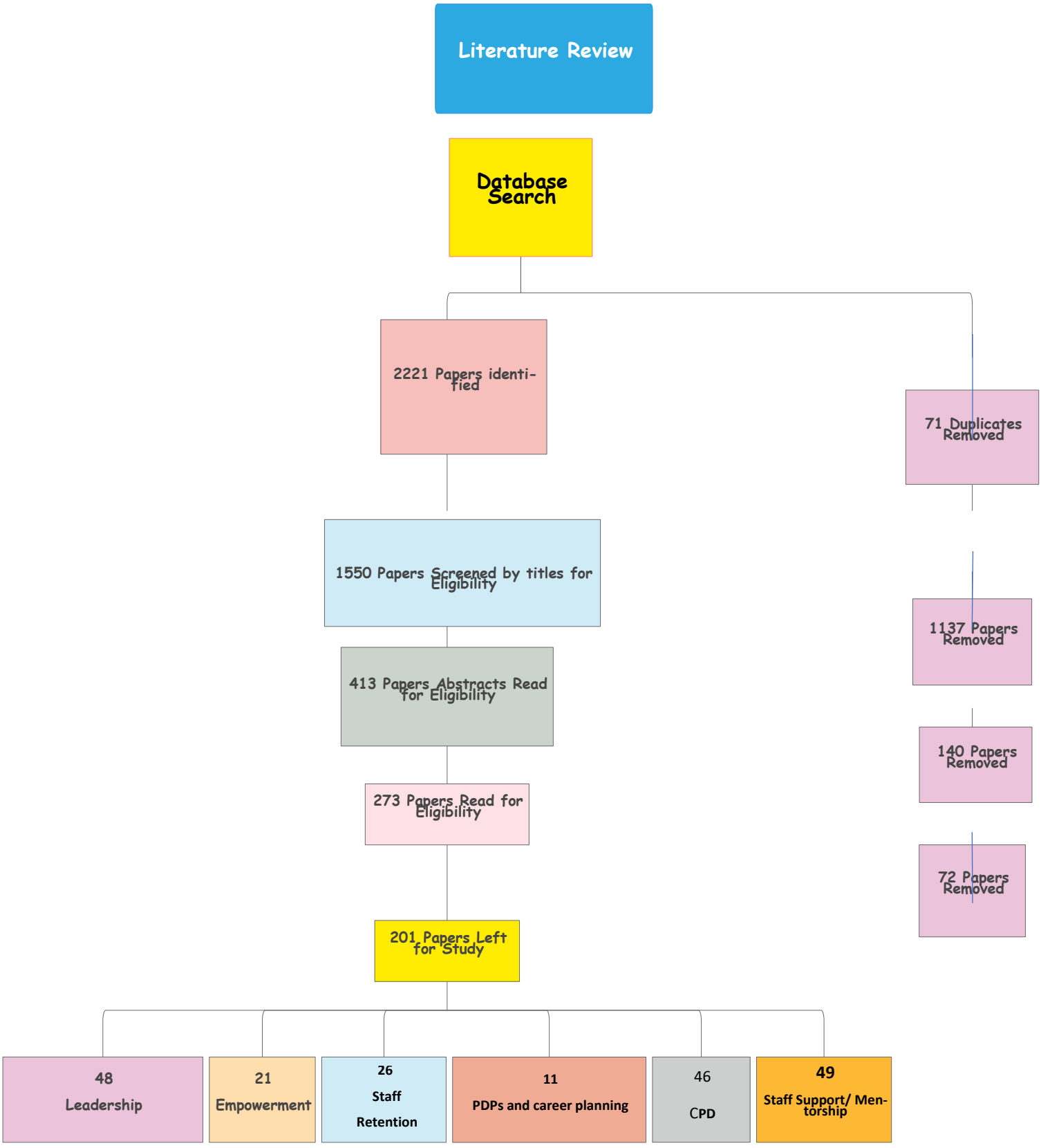


Figure 2.0 Diagramatical View of Database Search in the Literature Review

2.5 Approaches to the Readings

Given the interpretative stance of the thesis, a critical reading approach was adopted to the reading. Knott (2001) describes critical reading as an active intellectually engaging process in which the reader participates in an inner dialogue with the writer. It means being open to entering into the writer's world, seeking their point of view on a matter and then relating it to what you already know about the world. The process involves actively looking for assumptions, key concepts, reasons and justifications, supporting examples, parallel experiences and other structural features of the written text to interpret and assess it for accuracy and fairness. The author used this approach when reviewing the literature to seek greater understanding and to get as many points of view as possible on the chosen subject (Knott, 2001).

2.6 Developing the Themes in the Literature Review

As the author reviewed and critically appraised the literature, commonalities and themes were sought in the writings, particularly themes that were associated with improving nursing practice. As said earlier the author noted that Magnet Hospitals (MH) and the PEP Program (PEP) were recurrent subjects in the readings regarding best practice in nursing. Also appearing consistently were four other themes which were part of these programmes and these were

- The role of leadership and empowerment in improving and maintaining best nursing practice.
- The role of management in supporting and mentoring novice and experienced staff particularly when a clinical issue arises and how case review can lead to better practice. In addition, the role of management in improving practice and retaining staff is discussed.
- The role CPD plays in developing and sustaining nursing competencies and maintaining well-trained and up to date staff.
- The role of career planning in future nurse and organisational development and its role in succession planning.

The author felt these themes if adapted and implemented into community-nursing practice could improve practice and assist with job satisfaction and staff retention. These were the themes investigated and developed in the literature review.

2.7 Relating the Themes to the study

When discussing the four themes in the literature review the author examines them in relation to CN. While considering leadership, the author defines transformational leadership, empowerment, and looks at the role they plays in creating an engaged and satisfied workplace and asks do they promote job satisfaction in CN and do they motivate staff sufficiently to deliver high quality care to patients.

When discussing practice review the author asks if nurses are given time and opportunity to evaluate their own practice, do they identify clinical issues accurately and do they then seek support or advice on them. The theme also looks at the role played by nursing management in practice review. Do managers welcome practice review as a method to support staff, improve practice and does it lead to better staff retention or do they see it as a punitive implement.

The third theme discussed is CPD and the author asks does CPD plays a role in maintaining and improving nursing competencies and does it advance nursing careers or is it an instrument to be used by management to prepare staff for the organisation's future needs and succession planning.

The final theme discussed is career development and the author asks does it have the potential to lead to improved nursing practice, better succession planning and enhanced staff retention. See diagrammatical form of themes examined in Fig. 2.1 on next page.

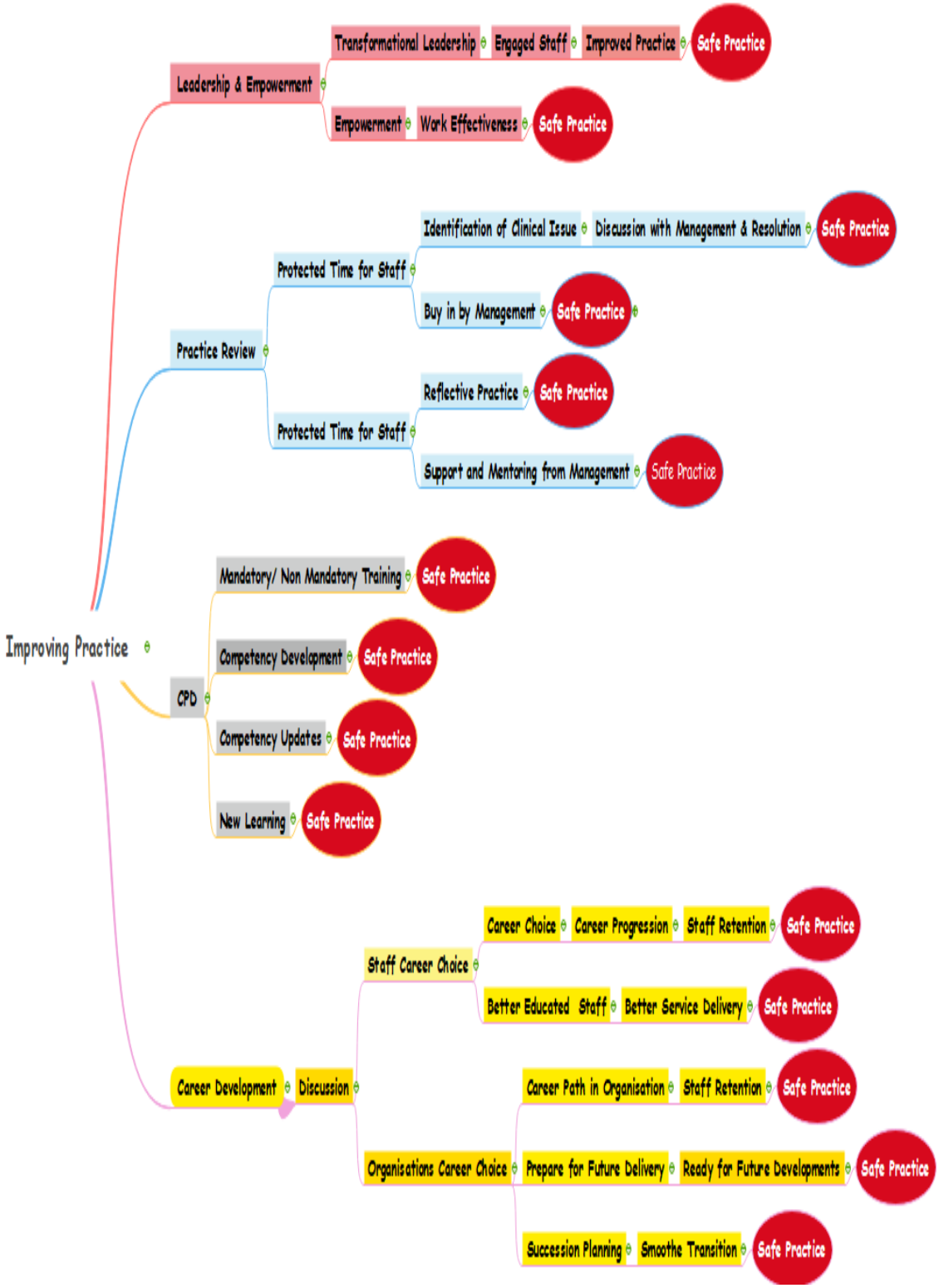


Figure 2.1 Diagrammatical Representations of All Themes Discussed in Literature Review

2.8 Discussing the Themes

2.8.1 Theme One – Leadership in Nursing

Leadership is one of the greatest skills any manager can possess. However when it comes to defining leadership, definitions abound. Various scholars have attempted to define leadership operationally and theoretically. Druker (1996: 41) one of leadership's founding fathers and a seminal author on leadership defined it as 'the ability to influence others, to lead individuals or a group to accomplish a task and to provide direction which others seek and accept.' Druker's definition includes the concept of leadership as a process, where there is agreement between leader and follower about their purpose, as well as the notion of individual and collective accomplishment. Both of these phenomena appear to be key in much of the literature on leadership (Day et al., 2014; Dinh et al., 2014). However, Winston and Patterson (2006:7) add a some more to the definition and they define a leader 'As one who selects, equips, trains, and influences follower(s) who has diverse gifts, abilities, and skills and focuses them on the organisation's mission and objectives causing the follower(s) to willingly and enthusiastically expend spiritual, emotional, and physical energy in a concerted coordinated effort to achieve the organisational mission and objectives.' This definition while extensive does resemble what the author believes good leadership should look like in nursing, it clearly establishes and validates that in leadership, the followers are happy to be led and that they play a key role in the fundamental success of an organisation.

2.8.2 Leadership versus Management

Before proceeding to examine leadership further, there is one distinction that needs to be made and that is discerning leadership from management. The two titles of leader and manager are often used interchangeably, yet the leader and the manger have very different roles. Bennis & Nanus (1985) sum up the differences quite well when they explain that managers are facilitators of team success by ensuring that staff have everything they need to be productive and successful at work. A manager's job is planning, organizing, budgeting, staffing, problem solving and other fundamental tasks necessary to run a business (Bennis & Nanus 1985). However, a leader's job is to provide the vision of where the organistionon is going and how it will get there – leaders drive the performance of the organisation to realising its goals (Druker 1996). Leaders provide the vision and the strategy and managers implement it. (House and Aditya 1997, Bass et al 2003, Bass and Riggio 2006). Bennis (2007) goes on to add the distinction that managers do the 'thing right' and their job pertains to implementation, but leadership is about doing the 'thing right' and their job is concerned with vision and direction. Hence, the common belief that a successful business

needs both a manager and a leader (Bennis & Nanus ,1985; Druker, 1996 and Benincasa 2012). Table 2.0 below provides a summary of the various views of several seminal authors on the differences between leadership and management.

Table 2.0 - Summary of Leadership versus Management

Category	Leadership	Management	Source
World view	Advocate change and new approaches	Advocate stability and status quo	Lunenberg (2011; Zalzenick, 1977)
In ambiguous contexts	Leaders do the right thing	Managers do things right	Bennis (2007)
Internal coping mechanisms	Cope with change	Cope with complexi-ty	Kotter (2008)
Key processes	Create and articulate vision and strategy	Plan and implement vision and strategy	House and Aditya (1997)
Relationship with others	Empower, influence and trust	Transact, control and use authority	Rost (1998); House and Aditya (1997); Kotter (2008);

2.8.3 The need for Leadership in Nursing

Today many community nurses are experiencing changes to their roles. Their jobs are being affected by alterations in organisational structures, demographics, increased complexity in caseloads, pressures from political, social and economic factors, and advancing technology. In addition, care is being given to a public who are better educated, and more litigation minded. Given this environment, it is becoming increasingly more difficult to maintain delivery of an effective and efficient nursing service and staff are finding it progressively more difficult to attain job satisfaction. This is one of the greatest causes of burn out and staff leaving a job (Aiken et al., 2014). There has to be job satisfaction for staff to stay. So to break this cycle of staff losses, we need to get to a position where ‘what we train we retain’. We need to stem our losses to get to a place where we have a sufficient number of staff to run an efficient and effective service. However this will not be easy. The World Health Organisation (WHO, 2016) warn that

nurse shortages is now a global concern, and Gizaw et al. (2017) s warn that worse is yet to come. Gizaw states that a large number of nurses worldwide are presently planning on leaving the nursing profession, so this raises further concerns over adequate staffing levels for future care delivery (Buchan and Aiken 2018). Thus, staff retention is an extremely important function going forward, for without staff we have no service (Sabanciogullari and Dogan 2015).

To move healthcare organization's successfully forward, both strategic and effective leadership is required (AbuAlRub and Nasrallah, 2017). A leadership style is needed that is capable of appealing to nurses, inspiring and supporting them, and being able to reward their commitment and their efforts, this would lead to minimal turnover intention (Dotse and Asumeng 2014). However, the question remains, which is the most suitable style of leadership given today's climate of ongoing change in nursing. Aiken (2016) and Williamson (2020) hail transformational style leadership as the new way of leading. They believe that transformational leaders are capable of changing an organisation's values, beliefs and behaviors according to organisational needs. They encourage staff to innovate and change according to work need. These are all much needed skills in today's world of ongoing flux and change in nursing (Aiken, 2016, and Williamson, 2020).

2.8.4 Transformational Leadership

The concept of transformational leadership was first introduced by leadership expert James V. Downton in the 1970s. Wolf, Boland and Aukerman (1994: 38) defined it as 'an interactive relationship, based on trust that positively impacts on both the leader and the follower. The purpose of the leader and follower become focused, creating unity, wholeness and collective purpose'. In 2000, Dunham-Taylor (2000 : 291) spoke of 'Transformational leaders being committed leaders who had vision, and who empowered others with that vision, assisting them to accomplished more with less'. Now more than ever, CN needs good leadership, because of the present demands associated with the introduction of a new CN healthcare model here in Ireland (DOH, 2017). A steady hand is needed in the helm that can provide support while realigning the organisation and its functions to the new vision and its associated future developments (Bass and Avolio, 1993). Williamson (2020) advises that instead of hampering leadership, chaotic workplaces are often environments that transformational leaders rise from.

Irish CN is presently entering a watershed, a time of instability and flux, a time of increasing demands and diminishing staff levels with big changes ahead as the Sláintecare Programme is introduced (Batista-Taran, 2013; Sláintecare Report 2017)).CN will need transformational styled leaders to step forward to drive healthcare delivery in a new direction (Bennis & Nanus (1985), Batista-Taran (2013); Derler et al., 2017 and Williamson (2020). Transformational leaders are strong leaders who relish a challenge and rise the stronger from it (Bennis and Thomas, 2002).They are leaders, who support employees, engage staff, improve job satisfaction and increase retention rates (Aiken et al., 2009; Batista-Taran et al., 2013, Prado et. al (2018). Transformational leaders are also noted for influencing things like culture, climate, competitive advantage and organisational learning (Sarros et al., 2008; Wang and Rode, 2010; García-Morales et al., 2012; Kamali, 2014; Ekuma, 2014). DPHN's will need to adapt this transformational style leadership, if they are to rise and meet the national corporate agenda and drive CN forward. They will need to be far-seeing and strategic and use their ability to influence others. Both power and political clout will be needed to maintain and improve patient care and nurses working conditions. DPHN's need to view the upcoming, imminent changes, not as a challenge, but as a golden opportunity, to reshape the service. If a transformative and innovative approach is taken by them, it will initiate and sustain influence in CN at all levels in the organisation –from the workplace, management and finance up to government level. DPHN's need to recognise they have this power and activate it, to mobilise and focus energy and resources in the organisation to shape a better future in CN for both the patient and the nurse.(Sullivan and Decker 1992).

However, one final word of caution regarding transformational leadership. While at present the transformational leader is hailed as the ideal leadership style and an elixir for all ailments, many management theorists warn that transformational leaders will not drive the day-to-day running of a business. (Bass, Avoliio & Goodheim, 1987; Dunham & Klafehn 1990; Lipley 2013). They say that while transformational leaders possesses many highly desirable qualities these qualities need to be mixed with other leadership styles to run any work environment in an efficient and effective way For example when an acute medical emergency arises, a manager needs to be directive and use a transactional approach (Thomas, 2016). Even a style such as authoritarianism could be called upon in a crisis like this (Bass, Avoliio & Goodheim, 1987; Dunham & Klafehn, 1990; Lipley, 2013). Therefore, it would be more accurate to say, that while we aspire to be transformational leaders for most of our working life in CN , other styles of leadership are also needed when the occasion calls for them (Lipley, 2013).

2.8.5 Empowerment and its Role in CN

As stated above transformational leaders empower staff but what is empowerment, and does it make a difference? Empowerment as we know it today, originated in the late 1970s in American psychology and it was adapted by nursing in the 1990s. Rodwell (1996) defined 'empowerment as a helping process; a partnership valuing of self and others, which involves mutual decision making'. 'Strader and Decker (1995, p 62) defined 'empowerment as the process by which a manager or leader shares power with others' It is a means of giving individuals freedom to make choices and to accept responsibility for their own ideas, decisions, and actions. So it taps into and uses hidden resources, which would otherwise remain inaccessible. On paper it seems exciting and idealistic but Cahill (1997) and Carney (1999) advises it is not a 'pill' or a quick remedy, it requires time and dedication both to introduce and to maintain it.

Empowerment in the workplace has been investigated by many theorists in an attempt to understand its influences on nursing outcomes (Aiken et al., 2011; Chang & Liu, 2008; Cho et al., 2015; Dahinten et al., 2014; Laschinger et al 2001; 2003; 2004; 2005; 2013; 2014 ; 2017; Olds et al., 2017; Purdy, et al., 2010; Tervo-Heikkinen, et al., 2008). Laschinger in particular has written prolifically on the relationship between staff performance and empowerment in nursing. Much of her work has built upon previous work completed by Roseabeth Kanter (1977; 1993) who believed that power was the ability to mobilise information, resources, and support to get things done in an organisation See Figure 2.2 on next page of Kanter's work. Laschinger et al (2001) built further on Kanter's work and went on to specifically design a Figure of the use of empowerment in nursing, see same in Figure 2.3 on page 41. Laschinger et al (2001) believed empowering a nurse changes their attitudes and behaviours and as a result, of this they tend to commit to the organisation and engage more readily in continuous learning and skill development making them more effective practitioners (Laschinger et al , 2001; Spence and Laschinger, 2012). So, effective leadership and empowerment appear to be essential ingredients if management is to engage nurses, promote job satisfaction, reduce burnout and retain staff.

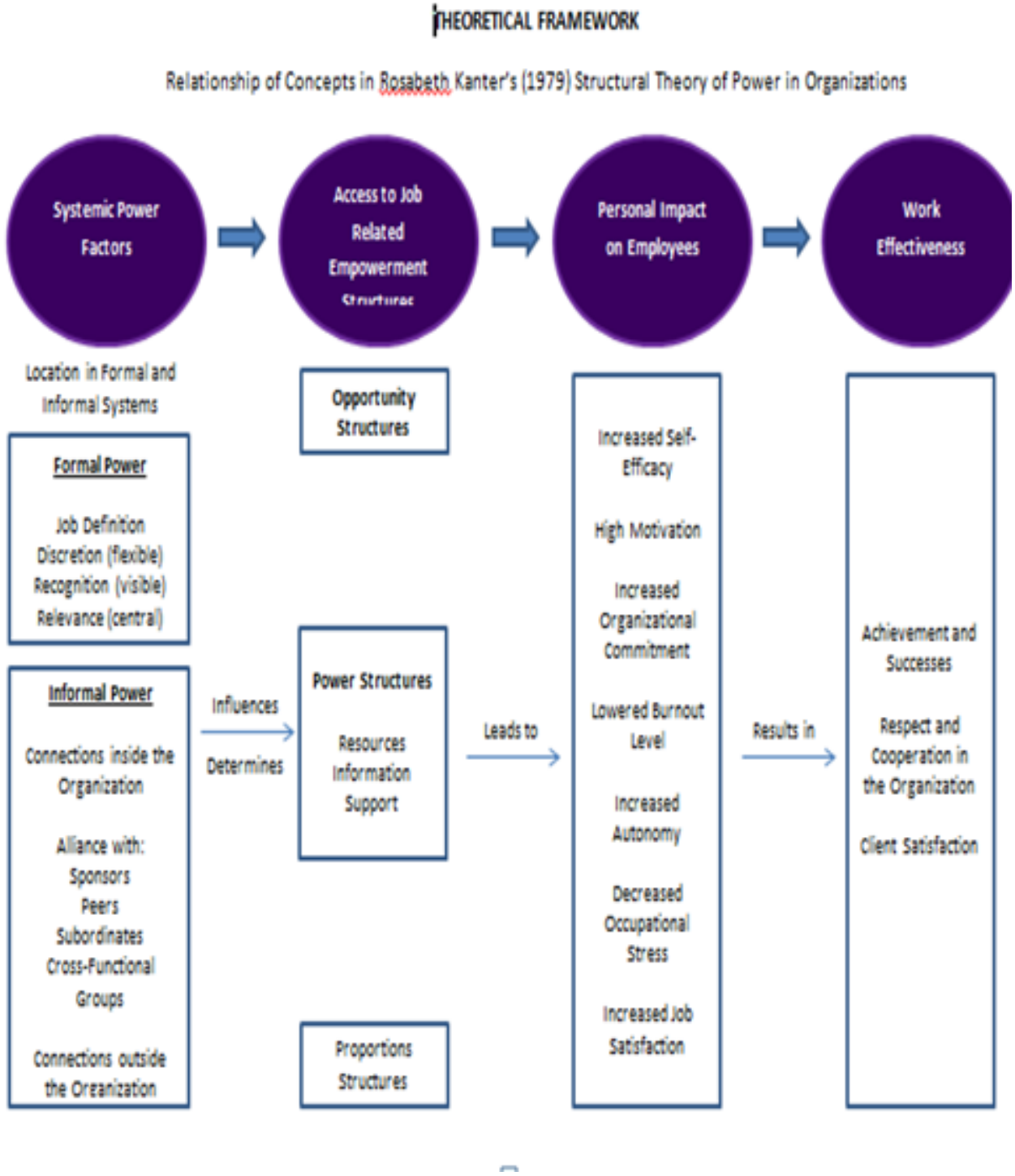


Figure 2.2 Roseabeth Kanter's (1979: 43) Empowerment Model - Sources of Power in Organisations and the Outcome of Possessing Power

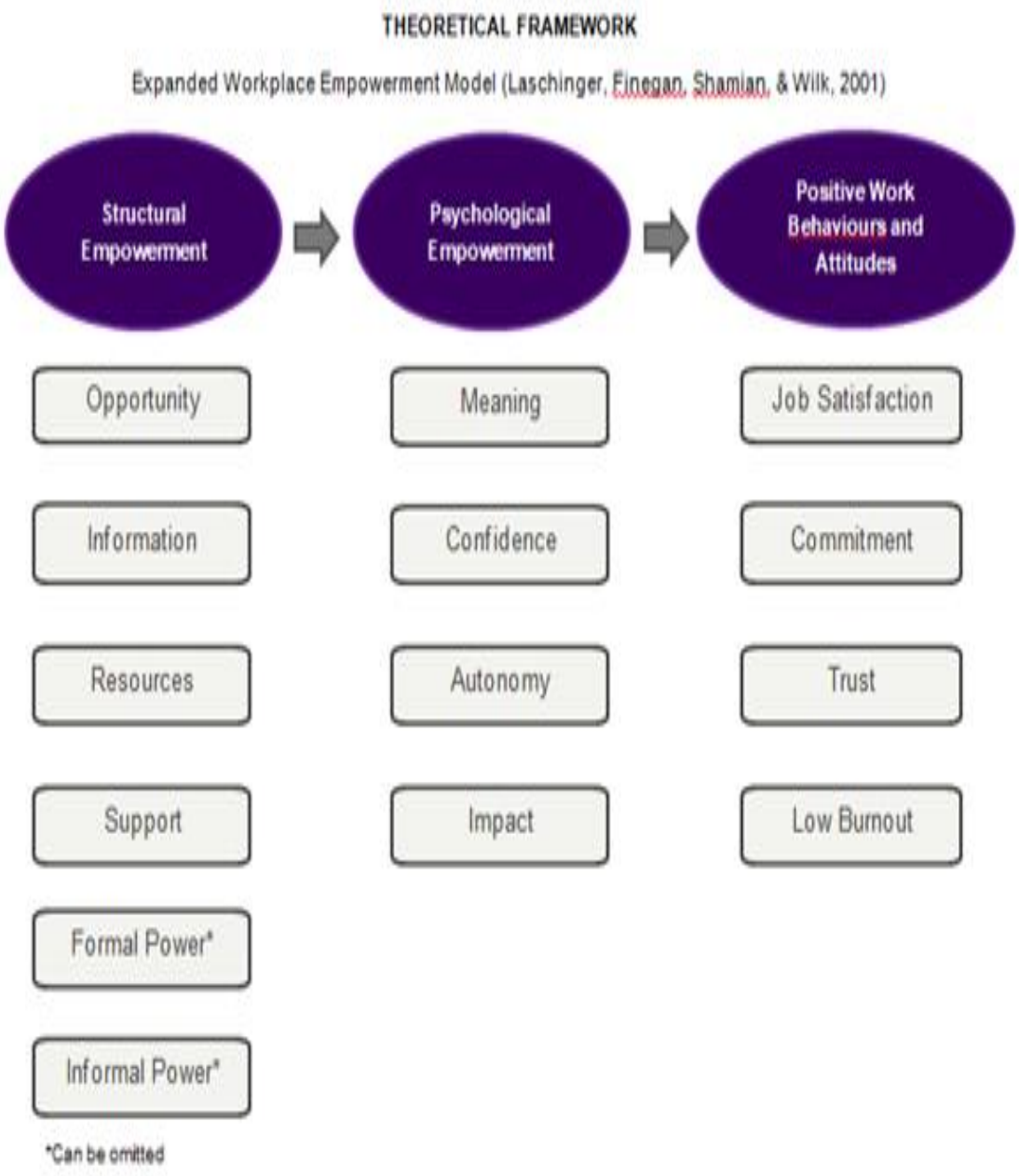


Figure 2.3 Laschinger et al (2001; 264) Empowerment Model (which is an expansion on Kanter's (1979)Work

2.9 Theme Two – Staff Support

2.9.1 Tools Used to Support staff

Nurse Managers play a crucial role in influencing workplace culture and creating a supportive environment. They are the human face of practice and they encourage good practice and learning experiences by monitoring nurses and providing feedback (Drach-Zahavy et al., 2014). They also provide job autonomy and social support to nurses (Bering's et al., 2010). Managers have dual roles, being both directive and supportive of staff (Bering's et al., 2010).

Nurses in their everyday practice face unique and complex situations; this can pose difficulties for them. However with time and experience they learn and adapt to these situations. To get to this level of competence, novice staff need assistance and guidance to grow from novice to expert status (Benner, 2009). They need assistance and supportive relationships, each of which are key to establishing supportive work settings, places where people want to come to work and want to stay (Mills et al., 2005). There are three types of support commonly used in nursing and these are preceptorship, mentorship and reflective practice. While similar, they are different and offer different functions to nurses.

Preceptorship is a term used generally for an arrangement when a competent nurse takes on the clinical teaching of a student nurse. A preceptor is defined as 'an experienced practitioner who teaches, instructs, supervises and serves as a role model for a student or graduate nurse for a period of time in a formalised programme' (Usher et al. 1999, p 507). A preceptor is involved with the student to enhance her /his learning until they qualify as a nurse. It is a relationship that lasts for a given period of time until the nurse has completed his/her studies.

Mentorship on the other hand is a different relationship. Mentorship is 'a long-term relationship between two people one of whom is much more experienced than the other…resulting in the advancement and progress of the less experienced nurse' (Welsh National Board for Nursing, 1992 : 13). As the name suggests it is a support system, it is long term and its objective is to develop a nurse from novice to expert (Benner et. al, 2009). It is commonly used in CN as one of its main support systems for staff. It is used in particular for newly qualified nurses or other staff who need support with clinical issues.

The final support system used in CN is Reflective Practice. Johns and Freshwater (2009: 3) defined it as 'a process of accessing previous experience which helps to develop tacit and intuitive knowledge.' Ghaye & Lillyman (2000) saw it as a transformative process that changes individuals and their actions and Howatson and Jones (2010) described it as an examination of nursing experiences in order to look for the possibility of other explanations or alternative and more suitable approaches to practice. Presently, reflective practice is being developed in CN but not all areas have access to it yet. It is an action-orientated support system, that aims to develop practical wisdom (Howatson and Jones, 2010; Johns and Freaswater, 2009).

Thus, when it comes to supporting nurses, nursing managers have three very effective tools at their disposal. Preceptorship is used with all student nurses and is a strong supportive tool, mentorship is an equally strong tool, but it is a longer-term relationship and has the ability to increase retention as well as support staff. Reflective practice, when available, is an ongoing life-long tool, that supports nurses at all levels and enhances the prospects of them delivering, better, safer patient care. It is from this arsenal of tools, that the manager chooses which tool is most appropriate for the support required.

West, Bailey and Williams (2020) looked at staff support from different view. They saw it as bigger than work related issues and viewed it from the role it plays in supporting and maintaining staff well-being. If you have staff well-being, then you have the potential to deliver safe practice. In a study carried out in the UK during the Covid 19 pandemic and released in Sep 2020, they found that the pandemic worsened nurses working conditions considerably. They found it exacerbated longstanding problems like poor working conditions, chronic work overload and lack of support (West, Bailey and Williams, 2020). The research highlighted how the pandemic had affected the health and wellbeing of nurses to such an extent that they felt "burned out" with 25 % reporting that they wanted to leave the service (and this is a service which is already suffering from a shortage of 40,000 nurses). The West, Bailey& Williams (2020) report sets out eight key recommendations for mangers to apply in practice in an attempt to assist and support staff. These recommendations were condensed down under the three headings of Autonomy, Belonging and Contribution, and called the ABC Framework (See same in Figure 5.10 on next page).

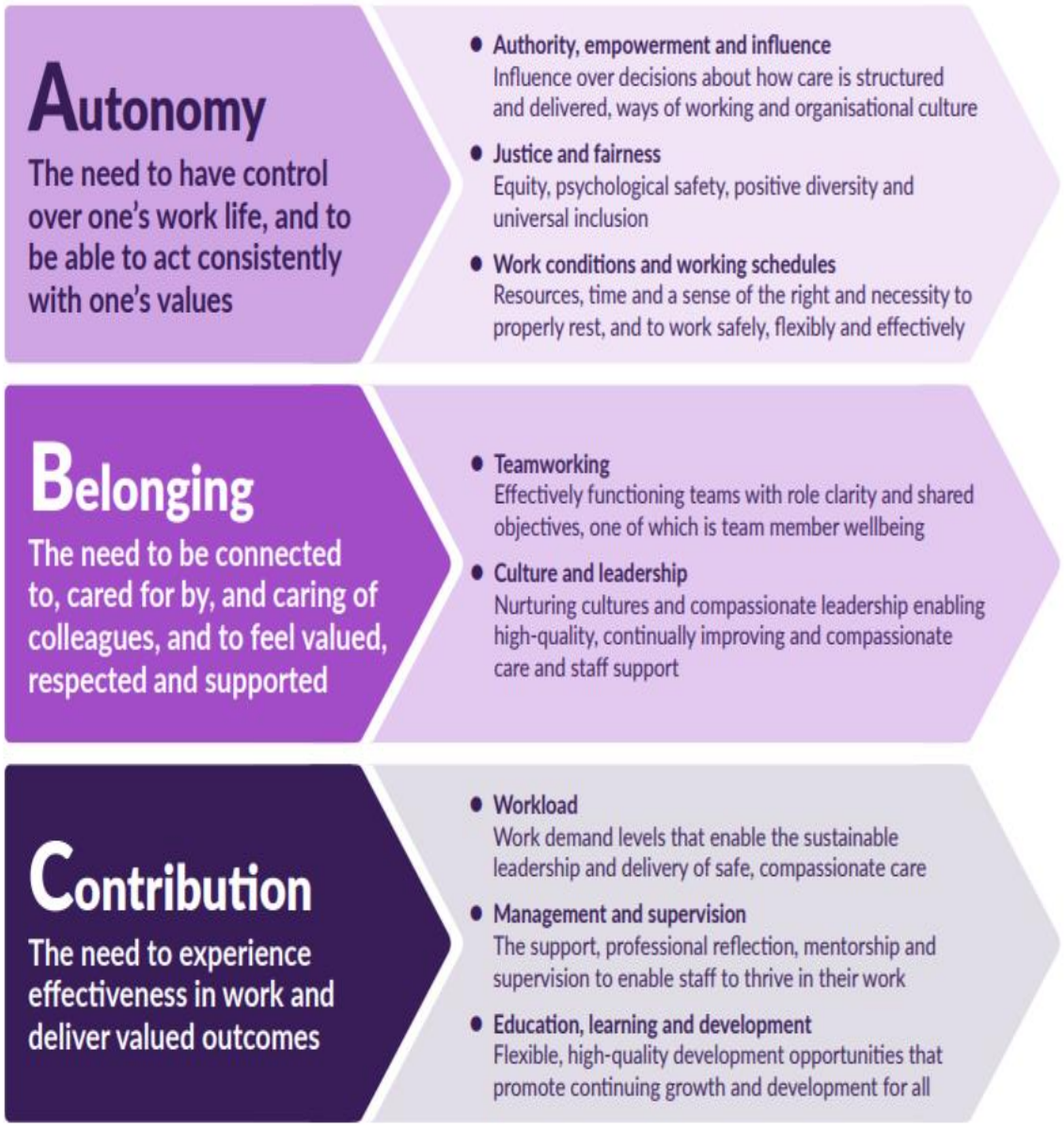


Figure 2.4 The ABC Framework of Nurses and Midwives Core Work Needs

(West, Bailey& Williams 2020)

In the framework, A is for autonomy, staff need to have control over their work environment and feel they are treated in a supportive and equitable manner and given a manageable workload. B is for a sense of Belonging. A compassionate and nurturing leader gives staff a feeling of being valued, respected and belonging. This improves teamwork and supports the individual, embedding them into the organisation. C is for Contribution, nurses need to feel they are contributing, making a difference and that they are

supported, mentored and supervised while doing so. In addition, contribution gives them the opportunity to develop further through education. This framework belongs to what West, Bailey& Williams (2020) term 'The Courage of Compassion' approach to managing staff. This approach supports values and respects staff for themselves as much as for the work they do. The 'Courage of Compassion' culture promotes fairness, fosters individual, team and organisational wellbeing and this in turn leads to deliver improved, quality healthcare. These are values the author hopes to emulate in the Tool.

2.9.2 Supporting Novice Staff

While nursing managers support all staff, novice staff in particular, requires extra, ongoing support. An effective manager supplies this support while observing how a novice is managing (Benner et al., 2009). While the Nursing Education Forum (2000), state that all students are educated to a level of competence and this is true, the author would agree with Winter et, al. (2007) who states that not all students can cope with the complexity of the caseload they are presented with, on entry into CN. Several authors discussed how many novice nurses felt inadequately prepared for entering the work force and meeting the demands of today's CN environment (Goode & Williams, 2004; Beyea, et, al. 2007; Burns & Poster, 2008; Marchburn et al.2009; Phelan and Mc Carthy, 2016). When it comes to assisting new graduate to enter the work force as competent novice practitioners Mescall (2009) put forward the argument in the United Kingdom (UK), which Holland (2016) has also advocated for here in Ireland, that there is a need for development of a 'link lecturer' post to be onsite with students during their clinical placements. This link lecturer would assist student nurses apply their academic learning to practice during their training, while out of college on clinical placement. However, despite best efforts, this post still has not emerged in Public Health Nursing in Ireland. This is a real deficit in the training system, particularly as so much time is spent working alone in Public Health Nursing and the expectation is that the new nurse arrives to work, post qualification on day one, as a competent practitioner.

Another deficit is the lack of an organised mentoring system in place for novice nurses (Holland, 2016). Missen et al (2016) spoke of how as little as just over thirty-three percent of newly qualified nurses are prepared for entry into practice. Yet as newly qualified practitioners, we expect them to carry a caseload and work alone for much of their working day. This can lead to feelings of isolation, loneliness and stress, and many often require help to sustain them in their new role (Phelan and Mc Carthy, 2016). Zhang et al (2017) spoke of the first year being the most stressful in nursing practise as nurses try to es-

tablish their professional identity. They spoke of the need for mentorship particularly in the first year (Zhang et al., 2017). They believed a manager's support is critical at this time, and that it greatly influences a novice's decision whether to stay or go (Zhang et. al, 2017). Managers need to assist nurses with issues, to support staff and help them build both their competence and confidence levels (Benner et al., 2009). Figure 2.5 below adapted from Manzi et al (2017) work where mentorship (and coaching) was used to support staff. They found it supported all staff from novice to expert and assisted them to resolve their issues and deliver safer better healthcare. The felt it also assisted novice staff, in particular as it bridged the gap between education and its application to practice. See figure 2.5 below, as staff progress from the stage of novice to competent practitioner, meeting desired practice and organisational goals.

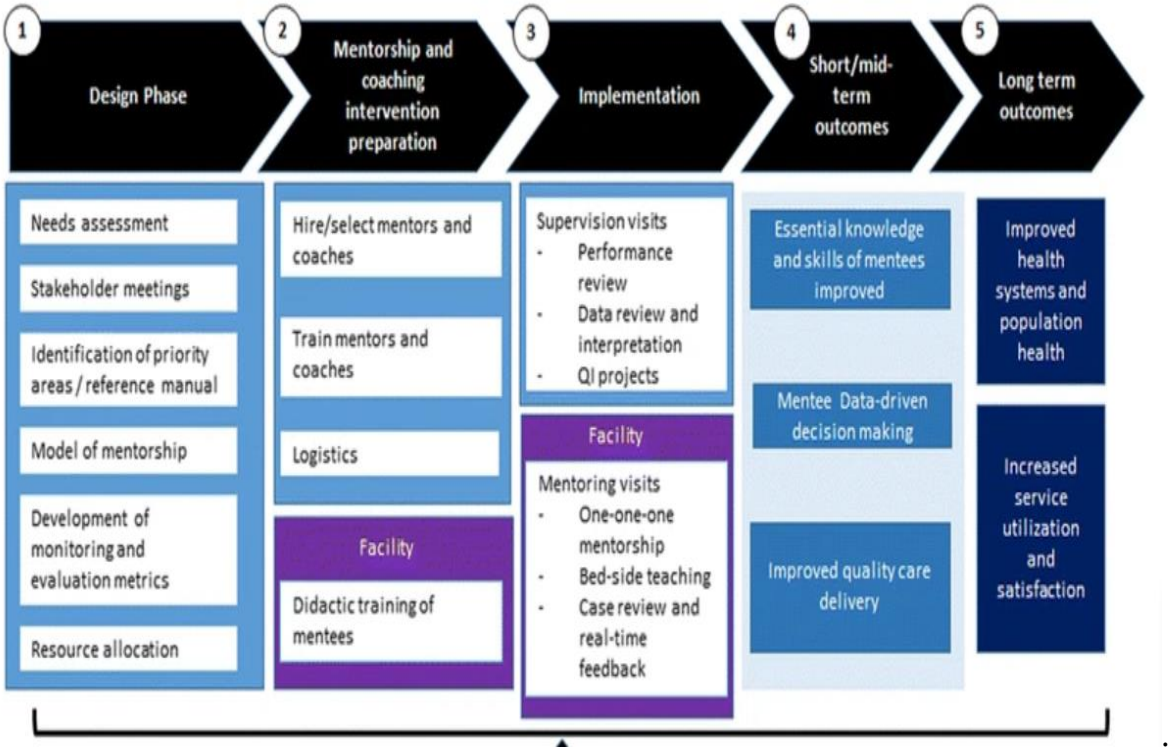


Figure 2.5 The Value of Mentoring Adapted from Mazi et al. (2017: 6)

Benner (1984) was one of the founder authors in nursing to support the idea of mentoring staff. She seen it as both a powerful support and a learning tool for nurses and she advocated for its implementation to advance and develop nurses from novice to expert (Benner, 1984). She spoke of the there being five stages in a nurses development and these are (1) Novice (2) Advanced Beginner (3) Competent (4) Proficient and (5) Expert (Benner, 1984). See Figure 2.6 of Benner's Novice to Expert Model explains all five stages of the competency ladder and what each level represents.

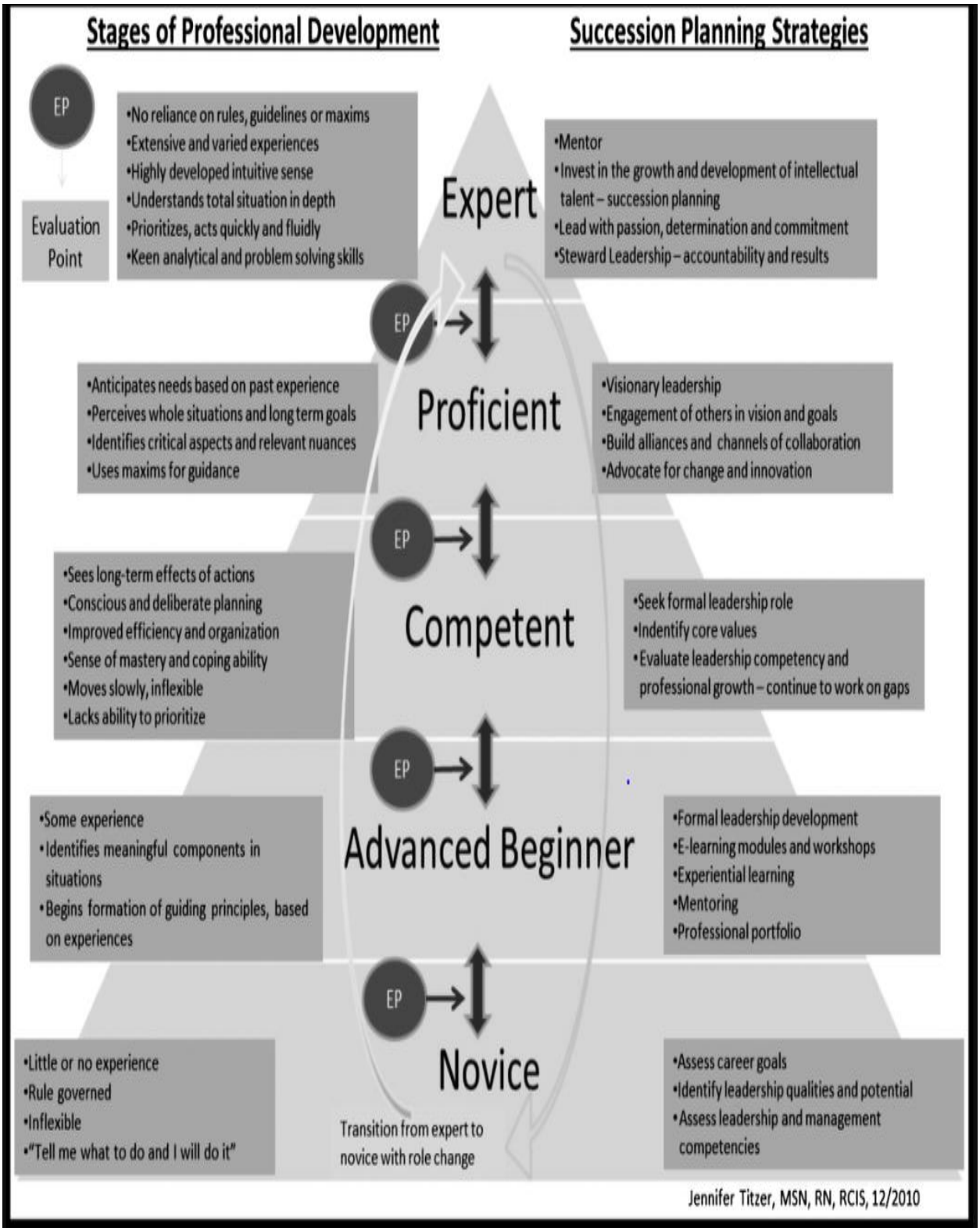


Figure 2.6 Benner Novice to Expert Model Adaptation by Titzer (2010:38)

2.10 Theme Three - Maintaining Best Practice

2.10.1 Maintaining Best Practice in CN

As can be seen from the discussions above, both mentoring and reflective practice sessions can improve practice. Their introduction gives staff the space and time to discuss any concerns they have in their practice and receive feedback on it. It brings a growth in confidence and competence to staff, something novices often lack, as they take on their new role and adjust appropriately. A supportive network like this would assist staff to become competent practitioners, leading to safer practice delivery, better patient outcomes with less risk of litigation (Ekmekci, 2013; Heath & Utiera, 2014a; Kruijver et al., 2000; Wenghofer et al., 2015).

In CN in Ireland, many nurses continue to work in their generalist role, despite increasingly bigger caseloads. The idea of dividing PHN roles into two roles of child health specialist and clinical nursing has been adapted in some areas, but most PHNs remain in their generalist roles still, combining both roles. While the generalist role gives the nurse great scope, it also brings with it, the need for the nurse to be an up to date competent practitioner at all times and in all things (Brady et al., 2004; Coffey et al. 2017). Day on day the generalist role is being added to and expanded further, and more skills and competencies are required as hospitals discharge new and more complex cases home earlier and the number of people with chronic illness and frailty is rising also (Brady et al., 2004; Leng, 2014; Phelan and Mc Carthy, 2016; Coffey et al. 2017;). While specialist roles are starting to appear in CN, their development is still only in its infancy. A response is needed to assist with the dilemma of the ever expanding competencies required in CN, the author suggests that nurses be supported in the form of mentorship, reflective practice, and case review on a regular ongoing basis. This would assist them cope with their new and an ever-changing healthcare environment and its associated clinical issues.

In the past CN was less complex than today and there was more time available both for supporting nurses and for practice discussion. Today, as we advance, we are losing many of the opportunities for reflection on practice. Things like the traditional ‘annual count’ are disappearing. This was completed annually between the nurse and her line manager, they sat and counted and assessed all cases on the nurse’s caseload, This could take as long as a whole day or as short as two hours. The nurse received great support and advice as they discussed cases that were difficult or cases they needed guidance on. Today this

practice is being replaced by a Key Performance Indicator (KPI) style system which can be done online. The nurse records the numbers of patients and the number of care episodes completed online and while the line manager visits, it is a much quicker process than previously. Less time is spent going through the case load and discussing the cases and supporting the nurse in her decision making or examining her practice issues. While KPI recording has many advantages, like increasing the visibility and the profile of CN services on the national health care stage and bringing validity to business cases for CN funding, its online approach discourages the time spent supporting and mentoring staff and it reduces their opportunity to discuss cases and practice issues. The physical sitting and counting of cases was more than a count, it was an annual event when the nurse took stock of his/her caseload and how he/she approached it. It was a time for mentoring and practice review with a manager and this is something that staff need today more than ever before. Today, many areas are so short staffed, that nurses often end up prioritising care delivery (Irish Nurses and Midwifery Organisation, 2013; National Directors of Public Health Nursing Sub-group, 2011). Community nurses no longer have enough time to continue doing surveillance visits on older patients, now these ptients are only seen if they present with an issue. Also many vulnerable clients in receipt of a home care packages do not have regular care plan reviews due to time constraints and it is getting more difficult to reach all child welfare developmental requirements also. Missed care is starting to appear in all areas of CN work (Phelan et. al, 2016). Practice review if introduced, could assist staff to examine their workload, decide what work to prioritise and assist them deal with clinical issues in an early and timely fashion. Other advantages of clinical review include assisting staff to feel listened to, reassured and valued, bring learning to practice and reduce staff stress levels (Pennington and Driscoll, 2019). This all leads to reduced burnout, less staff loss (Aiken et al 2012) and more job satisfaction (Mitchell et al., 2001 & Tan et al., 2019). Other advantages of practice review include improved staff competency levels in staff with better practice delivery for patients (Aiken et al 2012). These are all desired outcomes, particularly given the current climate of staff shortages, poor skill mix and escalating complexity in caseloads.

2.10.2 The Role of the Manager in Improving Nursing Practice

A manager's influence is important to nurses at all levels of experience. The Ganey Report (2017) spoke of important role that managers play in exerting substantial influence on the work environments and influencing performance, safety, quality and patient experience, as well as other things like job satisfaction and retention. The MH and PEP literature also spoke of the managers leading role in producing positive

practice environments and how they influence patient safety, job satisfaction, organisational commitment and patient outcomes. They believe that best care starts with effective leaders and managers who disseminate good practice down to all staff at all levels in the organisation (Aiken, 2008, 2012; Bauman et al., 2001; Laschinger et al., 2003; Laschinger et al., 2009.

When reviewing practice there are several instruments available to a manager to assist with the review such as patient surveys, Key Performance Indicators (KPIs), incident reviews all of which are good indicators of how well care is being delivered. However, none are as informative as staff feedback. Completing a practice review with staff both informs the manager of staff performance, their competencies, and of any areas where staff are experiencing clinical issues. The practice review also gives the manger the opportunity to support staff and it gives staff the opportunity to identify and deal with clinical issues early and in a timely manner with minimal repercussions for service. When combined with the other instruments, clinical review assists the manager and staff to examine practice closely and decide what is going well and what needs changing. Priorities are discussed and agreed and areas are chosen that show clear potential for improvement (The Health Foundation, 2012).This approach of developing and agreeing priorities enhances the prospect of them being adapted and implemented by staff. It must be remembered though, that if plans are not agreed or are too ambitious, they may fail, so it is important to be realistic and choose approaches that are likely to succeed. Managers play a large part in service improvement (Aiken et al., 2009).Also it is important for staff morale to work in an organisation that delivers a quality service as this improves staff retention (Aiken et al., 2009).

2.11 Theme Four- Staff Retention

2.11.1 Retaining Staff in the Service

All areas of nursing today are experiencing staff shortages. It is a worldwide phenomenon. CN is no different. Many factors are contributing to this condition such as increasing and more complex healthcare demands from a shrinking workforce. This has led to staff stress and burnout with many nurses leaving the profession and others retiring early (Both-Nwabuwe, 2018). This loss of staff needs to be stemmed, if adequate staffing levels are to be maintained to deliver safe, quality assured patient care (Vardaman et al. 2020).

Staff retention means retaining more experienced staff that have attained job mastery and can deliver better care with fewer errors (Waldman, 2006). It also increases productivity, as experienced staff perform quicker, more efficiently and efficiently (Waldman, 2006). Staff retention benefits the patient also, as it brings continuity of care; with care being delivered by more experienced staff, leading to better care delivery. Regarding the organisation, staff retention means fewer disturbances to team work and team dynamics (Mitchell et. al, 2001). In addition, it means more staff being available to deliver the service (Vardaman et al., 2020). If an organisation has poor staff retention, it can increase financial costs significantly, for example the cost of replacing a staff member sometimes exceeding 100% of the salary. Also, when a staff member leaves, others staff may follow, leading to serious implication for the organisation in today's world of staff shortages (Mitchell et. al, 2001; Vardaman et al., 2020). Therefore, staff retention is an important organisational goal.

Reynolds (2019) investigated this phenomenon of staff retention in nursing and he believed that nurses look at much more than pay when reviewing their present job or when searching for a new one. He believed that nurses looks for things that make them happy or things that will help advance their career, he believed that these are the things that increase staff embeddedness in an organisation (Reynolds, 2019). Hiring the proper employees and tactically embedding them into the organisational minimizes employee turnover (Dawson, Abbott, & Shoemaker, 2011). Mitchell et al. (2001) developed the job embeddedness theory and defined 'job embeddedness as the fit, links, and sacrifices that influence employees to stay or leave an organisation' (Mitchell et al. 2001: 1102). Links are ties to the organisation, fit is a person's belief that they belong to the organisation and sacrifice is the cost of leaving the organisation (Mitchell et al. 2001:1102). Employees who have job embeddedness have higher job satisfaction levels and are committed to the organisation (Mitchell et al., 2001; Tan et al., 2019). Job embeddedness theory can be a very valuable tool if utilised appropriately and it can enhance staff retention greatly (Ghosh and Gurunathan, 2015). Thus, it is in the interest of managers to encourage job embeddedness in the organisation (Borah & Malakar, 2015; Holtom & Inderrieden, 2006).

However despite best efforts every organisation has some staff loss, how much depends on management, the job and work conditions. Every attempt should be made to examine why staff leave if it is not for retirement reasons. In recent years many organisation have begun using the exit interview to gather as much information from the employee as possible. This can be particularly accurate information as the employee having terminated their contract, is free to give accurate information without fear of repercus-

sions (Spain and Groysberg, 2016). It can be a very useful tool to demonstrate what does or doesn't work inside the organisation; it can highlight hidden challenges and generate essential intelligence (Spain and Groysberg, 2016). This information can then be applied to improve working conditions for those that stay. Focus needs to be placed on examining and facilitating the needs of nurses who stay, improving their working conditions and identifying what's working well and continue to replicate this (Pace and Kisamore , 2017). Use of both sets of information can assist in improving staff retention by focusing on processes to improve work situations, and lead to new innovative ideas that give the organisation a competitive edge when it comes to recruitment and retention of staff (Pace and Kisamore , 2017).

2.11.2 The Role of the Nurse Manager in Staff Retention

Managers play a pivotal role in increasing job satisfaction (Duffield et al. 2009). Managers are highly influential in establishing and maintaining positive working relationships, they ensure that nurses have appropriate workloads, with sufficient support from management and other team members (Duffield et al. 2009). An effective manager puts in place a good orientation programme for new staff, encourage competency building and maintenance among staff, and ensures that there is ongoing financial support available for CPD at all levels (Duffield et al. 2009). Rafferty et al (2001) found that in well-managed areas where support was available from management, it led to positive work environments with less burnout. All of these things harmonise, to ensure staff feel respected and stay with an organisation (Bartram et al. 2004: Duffield et al. 2009). In addition, nurses who feel supported by management, have lower levels of absenteeism (Kalisch & Begeny, 2005). It is important that management develop a supportive atmosphere, as it filters down and is adapted by all, with staff then becoming supportive of each other (Kalisch & Begeny, 2005). This supportive environment provides better working conditions and Ishihara et, al, (2014) wrote about how this kind of atmosphere can enhance staff retention and lead to approximately a thirty percent reduction in staff leaving. Therefore, management support of staff plays a very pivotal role in staff retention (Duffield et al., 2009).

Kanter (1977, 1983) and Greco et al. (2007) concurred with the belief that managers play a vital role in staff retention. They encouraged nursing managers to take steps to ensure that work environments are of sufficient quality that staff feel supported and empowered to do their work in optimal ways that engage them and foster job satisfaction (Kanter 1977, 1983; & Greco et al. 2007). Armstrong et al. (2009)

agreed with this and went on to say that if nurse managers are to empower and engage staff, they need to maintain a constant visibility and be there to support staff, listen to them and examine their concerns or issues and assist them with solutions. There needs to be a consistency in management support (Armstrong et al. 2009). This is the main reason the author has chosen to develop and test the Tool in this research project. Today, due to changes in practice and time constraints, in addition to staff shortages we have less opportunities and methods to support staff and their practice like we did in the past. We now need to replace these older methods with a tool that gives managers and staff back the opportunity to sit and examine practice together in a place where they are safe to seek support and assistance to improve the quality of their work life and their patient care - both of which enhance staff retention.

2.12.0 Theme Five - Professional Development

2.12.1 Continuous Professional Development (CPD)

Chipchase et al. (2012: 89) define continuing professional development as the 'maintenance, enhancement and extension of knowledge, expertise and competence of health professionals following graduation from entry level training'. The Nursing & Midwifery Board of Ireland (NMBI) (2015:19) defines CPD as 'something that encompasses experiences, activities and processes that contribute towards the development of a nurse or midwife, as a health care professional'. So, CPD is normally recognised as involving formal, non-formal, and informal educational elements (Colardyn & Bjornavold, 2004; Collin et al., 2012; Kyndt et al., 2016). Formal education involves learning which occurs within an organised and structured context, including university accredited courses and mandatory competency attainment (Chenoweth et al. 2010; Chipchase et al., 2012; Kyndt et al., 2016). Non-formal learning takes place outside formal learning environments but within some kind of organisational framework. It arises from the learner's conscious decision to master a particular activity, skill or area of knowledge and is thus the result of intentional effort (Kyndt et al., 2016). Informal learning takes place outside schools and often at the bedside, it is sometimes called experiential learning and it is very much part of nursing CPD. Informal or experiential learning is in keeping with Kolb's Experiential Learning Cycle (1984). In this cycle Kolb describes how experiential learning involves a four-step process that includes concrete experience, reflective observation, abstract conceptualization and active experimentation. Kolb suggests that for the complete learning experience, students must go through all four stages of the learning cycle as shown in Fig. 2.7 (next page). Benner et al. (2009) also took this stand regarding CPD in nursing and wrote many papers on the importance of bedside learning.

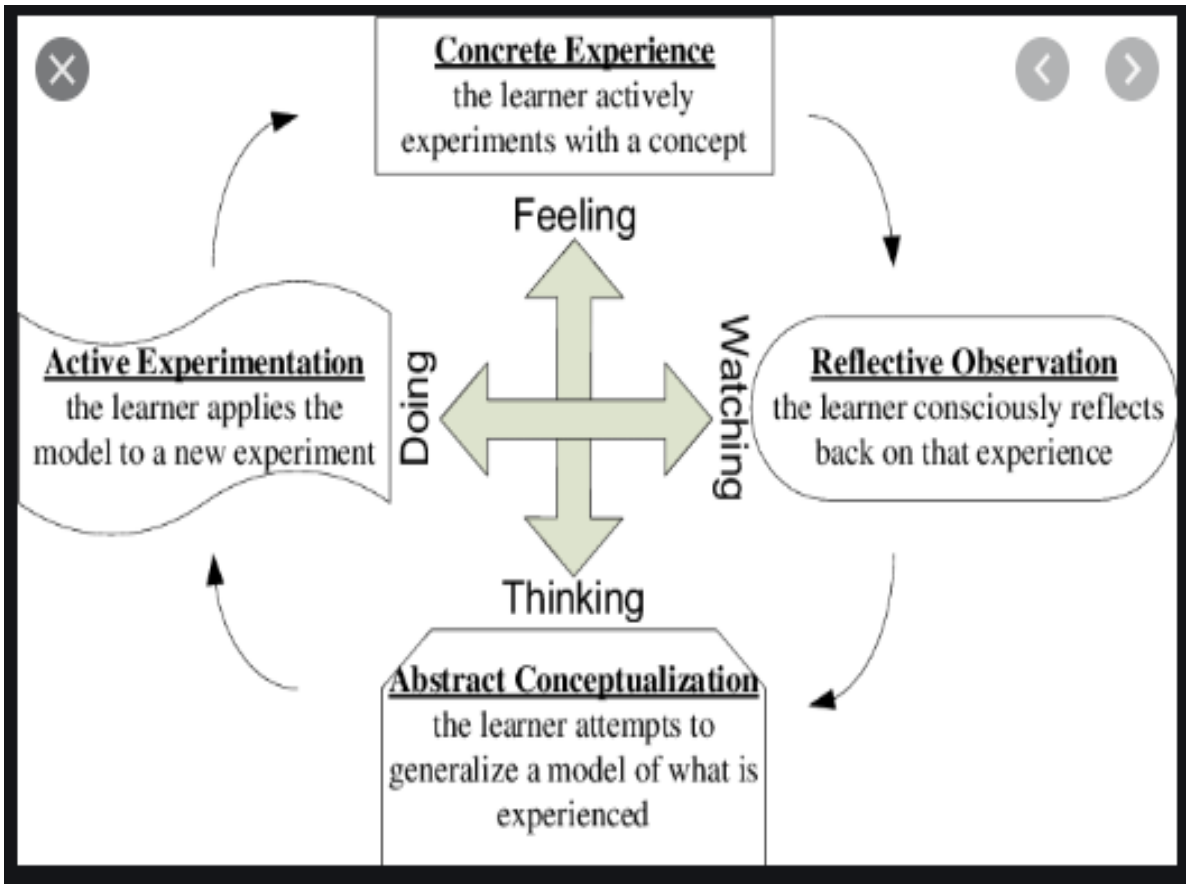


Fig.2.7 Kolbs Experiental Learning Cycle (1984) from Kolb (1984:21)

2.12.2 The Significance of CPD in CN

Nurses will play a vital role in contributing to the goal of achieving 'health for all by 2030' (World Health Organisation, 2020). However, one big obstacle to this will be the shortage of nurses, the WHO, state that based on current estimations; there will be a global shortage of 9 million nurses by 2030. (World Health Organisation, 2020). This puts high demands on organisations to retain their present staff and to maintain them at an educational level where they are professionally competent and able to take on multifaceted assignments (Lachmann and Nilsson, 2020). New and ongoing learning will be needed to keep abreast of constant changes,(Numminen, et al., 2013; Pijl-Zieber et al., 2014; Burrow et al., 2016; Tranquillo and Stecker, 2016). Funding of on-going education and training will be key to future healthcare delivery (O'Connell et al 2014; Ross et al., 2013). Thus, going forward CPD will become a large part of CN going forward.

2.12.3 Motives for continuing professional development

CPD could be described as having three interested parties. The first is the Nursing and Midwifery Body of Ireland (NMBI) which is the National Regulatory Body for nurses, the second is the employer and the third the nurse (Kruijver et al., 2000; Ekmekci, 2013; Heath & Utiera, 2014a; Wenghofer et al., 2015). The regulatory body deals with registering nurses as they complete their academic studies. They also ensure that all practicing nurses remain updated and competent to meet professional standards (NMBI, 2020). If they fail to meet these professional standards, NMBI has the power to remove them from the live register (NMBI. 2020). Regarding the employers interest in CPD, they view CPD as a method of producing competent nurses who deliver safer and more effective healthcare (Friedman and Philips, 2010). In addition, CPD also gives the employer the added opportunity to recruit and up-skill staff for future developments in the organisation and for organisational restructuring and succession planning. Thus, many employers investment in CPD is not benevolent and could be described as self-serving (Ekmekci, 2013; Heath & Utiera, 2014a; Kruijver et al., 2000; Redman, 2006; Wenghofer et al., 2015). The third interested party is nurses They use CPD, as a way of expanding their professional knowledge, improving clinical skills, improving their academic qualifications, advancing their career or for other personal reasons. (Lai, 2006; Levett-Jones et al , 2010; Chong et al., 2011; Chunping et al 2014 and Pool et al., 2016).

So, as can be seen there are many motives for nurses engaging in CPD and the motive varies according to who is viewing it (Griscti and Jacono, 2006; Nolan et al., 2000). In the work place this can result in a mismatch between statutory requirement, the nurses' personal motives for completing CPD and the employer's reasons (Munro, 2008). However, the best outcomes for CPD appears to occur when there is a match between all (Munro, 2008). This is one of the reasons that the author developed the suite of documents. The documents give staff and management the opportunity to sit and discuss the planning of CPD and develop a plan that suits all.

2.12.4 Planning and Evaluating CPD in Nursing

As stated above to be successful, CPD needs to be strategically planned so as it meets the needs of both the individual and the organisation (Cossham & Fields, 2007:573). However, it is up to both parties to align these needs, which ensures best outcomes for all involved (Gibson, 1997 and Joyce and Cowman,

2007). This may not be that simple, for when nurses identify their learning needs they examine present and prospective practice needs, and also look towards own their future career plans. Organisational learning needs, on the other hand, are generalised to the overall workforce and are identified by the CPD planners who evaluate overall legislation, mandatory training requirements, current workforce practice behaviours against best practice standards, in addition to future practice demands (Todd, 2020) and they plan accordingly (Shannon, 2003). The author believes that if a manager and nurse are in regular contact reviewing clinical practice, then CPD planning would be a simpler and an ongoing process. Both would be aware of previous learning, present and prospective clinical needs and future organisational development plans and succession plans would be discussed regularly. This evidence would then be used to build the nurses future CPD plans in line with organisational needs.

This style of CPD planning is what the author hopes to produce in the research. Document One in the Tool for the research is a portfolio type document and serves this purpose. It is proposed that this document will lead to investing in CPD in order to bring a real-world validity and direct relevance to day-to-day CN practice (Days et al., 2002). The author believes that Document One is congruent with these aspirations. The document being introduced asks the nurse and manager to examine the practice and identify issues and learning needs these can then be used to develop an appropriate and relevant learning plan. This will bring closer integration of theory and practice and deliver the best and latest health care relevant to current and prospective practice through updated competent practitioners.

In 2018, OMNSD introduced a Practice Development Plan (PDP) document for nurses here in Ireland. This is a great advancement for nursing practice, as it offers ongoing CPD development and career planning. However the Tool in this research extends this further and in addition to CPD development and career planning the Tool offers nurses the opportunity to review their practice and seek support with practice issues. The author believes that these extras are essential ingredients and that regular practice review with ongoing mentorship are necessary elements to development of effective PDPs. Regular meetings between nurses and managers bring the opportunity to discuss and examine nurse's practice and their competencies and future learning needs on an ongoing basis and then plan future CPD needs based on these discussions and observations. In return, staffs have access to the manager's professional knowledge for support with clinical issues as well as access to knowledge on future organisation development's and succession planning, and they can base their CPD plans on this knowledge. A joint plan is

then developed and agreed between both parties and it is this joined up thinking that gives the Tool its greatest chance of success. However it must be remembered that while agreement may not always be reached, these open discussions bring clarity to both parties re the others CPD needs and this raises the prospects of both parties agreeing a CPD plan that will meet both party's needs in the future. (Griscti and Jacono, 2006; Lawton and Wimpenny, 2003; Nolan et al., 2000; Poell and Van der Krogt, 2014a). This raises the prospects considerably of career advancement for nurses and staff retention for the organisation and overall, this improves practice by producing more competent staff delivering safer healthcare (Friedman and Philips, 2010). This style of CPD planning is another target the author is aiming for with the introduction of the Tool.

2.12.5 Outcomes of Appropriate CPD planning

When CPD delivery is completed, there is a need to evaluate the outcome, to ensure that the CPD has been effective (Clarke et al., 2007). Todd (2020) believed CPD could only be termed successful if two things happen and these are (1) learning has occurred (2) practice standards have improved. However, Eraut (1985) and Goodall et al. (2005) both believed that evaluation is not straightforward. Draper and Clark (2006) and Draper et al., (2007) agreed with this view, stating that to be successful all stakeholders requirements need to be met and they named many stakeholder groups including the nurse, manager, nurse educators, the organisation and the profession nursing board. Each of these stakeholders all have a different understanding of what successful CPD looks like. So completing a review is a complex and multi-dimensional event, if account is to be taken of all potential stakeholder perspectives (Draper and Clark, 2006; Draper et al., 2007).

To complicate assessment further, Draper et al. (2016) and Pijl-Zieber et al. (2014) added that the measuring of outcomes is not straightforward either. For example attempting to measure the so-called transfer of learning to the workplace and link it to behaviour changes, can be problematic, as assessment of success depends on the assessor. Assessors include practice assessors, peer and co-workers assessment and service users, also clinical observations, group practice feedback and case reviews. However key challenges in these assessments are ensuring that there is objectivity, replication, reliability and scalability (Brightwell and Grant, 2013). Because such complexity exists in assessment, knowledge testing is often the only level of assessment carried out post CPD activity, yet passing a knowledge test is a long way from proving professional competence (Bolderston, 2007; Cowin, Hengstberger-Sims, et al., 2008; Gar-

side & Nhemachena, 2013; Nilsson et al., 2014). So while knowledge testing is welcomed the author would suggest distribution of survey six months post CPD to staff and managers when staff have had the opportunity to apply the CPD and can the assess its benefits. The author believes that the Tool being trialled in this research could help resolve this issue or at least improve things. If the Tool was used six monthly (or annually) as proposed, to review CPD, it would give all staff the opportunity to review how effective the CPD was, did it improve practice, was it relevant, should it be repeated and if so should there be any changes or additions made to the CPD?

2.13.0 Theme Six- Career Development

2.13.1 Career Planning Using a Professional Development Plan (PDP)

Many international nursing boards have introduced PDP's with some countries like UK, Canada, Australia and New Zealand making them mandatory (Casey et al , 2016). In these countries, a PDP or 'Competence Programmes' is a necessity for annual renewal of membership. This is not the case here in Ireland, the PDP which was introduced by OMNSD in 2018, was developed to ensure ongoing CPD was taking place with staff updating their competencies. However as the document is not mandatory, very few staff are using it.

While developing the Tool the author had considered the advantages of getting staff to use a PDP. Some of these advantages include motivating the nurse sufficiently that s/he completes her own CPD assessment and identifies a need or a want in her/his own practice that needs updating or developing or perhaps identifying their own personal future career plan. However as the uptake of the OMNSD PDP document was low, the author felt there needed to be additional advantages in the document to increase its uptake and use, for this reason the author developed additional functions of practice discussion and review as part of this PDP conversation. In addition to completing a PDP, the Tool also gives the nurse and the manager an opportunity to sit and discuss the nurse's practice. The manager has an opportunity to get to know the nurses and their practice and they become aware of skills, talents, and abilities and if there are any difficulties with practice. This assists both parties to make specific CPD recommendations and plan accordingly. In addition, nurses get to know their manager and they have the opportunity to express an interest in future organisational plans that interest them and do some career planning. This information sharing is very valuable as it offers staff the opportunity to effectively plan their CPD and use it for future career prospects. It

also offers managers a great opportunity to meet future organisational needs and succession planning in a smoother and more organised way (Soonhee, 2003). It enhances the prospects of having the right person in the right job, at the right time. This style approach keeps staff and organisations happy and this increases staff retention (Beheshtifar, 2011) Staff stay with an organisation that shows an interest in them and in their development and gives them the opportunity for career progression (Gould, 2007).

When using PDPs as a career planning tool, many nurses initially state that they have no ideas where they wish to progress to. However, repeating the PDP process triggers the nurse to focus on where s/he wants to go in their career (Gould, 2007 and Stewart, 2016). This does not have to be advancement in their career; it could be updating of skills in present practice or it could lead to advancing into a different area of nursing that they would want to specialise in. The PDP assists them to focus and as it is repeated the nurse becomes more focused and directed with each planning episode (Roberts, 2014). This funnelling of ideas concentrates the mind and enhances the nurse's chances of success with planning their career more effectively and advancing and the organisation retains staff in the process (Roberts, 2014).

In addition, nurses using a PDP realise that CPD is a lifelong and continuous process. They remain competent practitioners and the PDP brings a planned approach to setting developmental objectives for career and for life developments. This means the nurse is equipped and skilled to deal with existing or prospective job roles. A PDP has staff prepared educationally in advance of when a career opportunity presents itself thus, greatly increasing their prospects of success (Gould, 2007 and Roberts, 2014). The PDP is a method of planning this change and without a PDP, the chances of their success are significantly reduced (Roberts, 2014).

A final advantage to staff using PDPs is the fact that all staff are seen at least once to twice annually, by management. This meeting is bigger than PDP development, it assists staff to feel listened to and valued and it gives them space to discuss practice issues and seek resolutions if needed. From a manager's point of view it gives them the opportunity to discuss succession planning and upcoming development posts that may interest to staff. This presently is not a subject usually broached n practice and it is often a missed opportunity. PDPs like Document One in the Tool leads to more open discussions and the building of trusting relationships between management and nurses. In addition PDPs improve compe-

tence and lead to safer practice with less risk of litigation (Ekmekci, 2013; Heath & Utiera, 2014a; Kruijver et al., 2000; WeingWenghofer et al., 2015). This gives managers the opportunity to display the human face side of practice improvement; (Drach-Zahavy et al., 2014) and it allows them provide social support to nurses (Bering's et al., 2010). However, the biggest advantage of the PDP meetings is the job embeddedness and staff retention that they are capable of producing (Mitchell, et al.; 2001)

Document one, contained in the Tool is to be tested to see if it focuses staff on maintaining their CPD needs and/or planning their future career. However, whether successful or not the authors main hope, is that this document will assist staff to feel more empowered and valued by an organisation that has a vested interest in them and their needs and that these elements of the PDP, will support them and improve practice and staff retention.

2.14 Overall Conclusions to the Literature Review

This review has explored several key groupings of literature using a clearly delineated and reproducible process. As set out in the introduction to the literature review, the desired outcome of the study is to develop and trial a Tool or framework which could be used to improve CN practice. Relevant aspects of the historical context and evolution of ways to improve nursing practice, while supporting staff with clinical issues have been examined. Key policy documents produced by seminal authors and more recent writings in these areas have been discussed and their influence explored. The roles played by nursing managers and leaders in empowering, supporting, and mentoring staff while encouraging CPD and career development in relation to improving nursing practice and retaining nursing staff have all been presented. Critical analysis and debate have been provided for these bodies of literature, in particular, how they apply to CN.

The literature review illustrates the influence that a manager has in supporting staff and maintaining best practice while retaining staff. Having gained an improved understanding of the importance of the manager's influence in these areas, this has given the author a very valuable insight into methods and methodologies which could be applied to nursing practice to produce safer and higher quality patient care while supporting staff and engaging and retaining them. The author will use the findings from the literature review to apply to the Tool development and apply it to the research project with the aim of trying

to improve CN practice. The information gleamed from the literature review speaks directly to the development of the authors Tool. It influences how it was designed and best evidence was incorporated into the Tool in an attempt to replicate and use this learning to improve CN practice and support staff. It should be noted that the literature review was not completed in its entirety prior to engagement in the research project. When particular issues presented themselves during the early cycles of the research the author moved between the research and the literature resolving issues and exploring best practice in the literature and applying it to the research. This then informed the reshaping of the Tool to try and produce a better and most useful version to improve nursing practice.

As a pragmatist the author is convinced by the argument, that nursing can operate more efficiently and effectively and improve if it is well managed and supported to do so. However, the author suggests, given the current climate, nursing staff can be so busy with practice that they fail to see what is needed to change or improve things. If we continually use the same approach, we will continually get the same outcome. The author feels this research is a golden opportunity to complete the design of the Tool, then trial it and make adjustments to it, so as to present a Tool which can maximise staff opportunities for early resolution of practice issues, enhance career development and improve practice in CN. It is hoped overall that the Tool will contribute to the improvement of community nurses' working lives and their patients care. The methodology for this research project will now be examined more fully, demonstrating clear rationale and justifications for the selection of the particular methodology and methods used. These are both vital component to every research design. It is intended now to provide the evidence base for this selection in chapter three.

Chapter Three Methodology

3.1 Introduction

This chapter outlines in detail the methodological approach to the research project including the key issues in relation to paradigm choice. Building on this foundation the author describes Action Research (AR) as a methodology and outlines the rationale used in selecting such an approach and the implications this decision has for nursing practice. The author also discusses the reflective journey associated with AR; the insights, the frustrations and the structuring effects of reflexivity on nursing practice. Data collection techniques are discussed as well as data analysis. The research design is outlined in detail to assist the reader understand the methods employed to gather the data, and how they worked to facilitate the research move along the path to findings and conclusions drawn. The author has also includes the pilot study which informed the design. Finally, ethical issues and limitations of the research are evaluated. Therefore, it is intended in this chapter to provide a robust justification of the methodology and methods chosen for this research but also to demonstrate that sufficient attention has been paid to rigour and associated quality issues.

3.2 Logic of the Enquiry

The author has chosen to investigate if introducing a suite of documents (The Tool) into community nursing can assist with early recognition of issues, thus allowing for timely intervention to improve nursing practice. This research project asks:

Do these documents

- *Assist with early recognition of clinical issues so as there can be timely intervention to resolve the issue and support staff?*
- *Prevent escalation of issues early and lead to better outcomes (like assisting with correction of practice issues early thus leading to better client outcomes, increase in staff wellbeing, more job satisfaction, better staff retention and a reduction in the risk of litigation)?*
- *Do these documents assist in improving practice?*

3.3 Framework for the Research

Examining this piece of research, it is necessary to consider an approach that is suitable to the current investigation. An approach is needed that offers a perspective for examining and thinking deeply about inquiry in a practice-based profession like nursing (Hoshmand and Polkmghome 1992; McCormack, 2003). The author sought to frame this study in a way that nurses concerns around practice issues, featured as a major element in the research. She wanted their voices heard. In addition, there was a need to look at ways of improving or resolving these issues through robust scholarly research, thus maintaining a better quality, safe, effective and efficient patient care delivery system. However, this research needed to be shaped in a fashion that was acceptable to practitioners and their practice also; otherwise there would be little value in it, if it failed to change clinical practice and reflect this evidence (Kitson 2008; Benner et al., 2010). It was important to the author, to choose an approach that would be useful for practice improvement going forward. Equally it was important for the co-researchers or participants to feel that they were part of the research process, that the solutions sought were developed by them and for them and that their views and opinions were being valued and represented in the research. The aim of the research was to show how the development and use of an appropriate research approach could lead to staff becoming actively involved in research and apply their findings in a way that it was hoped would improve nursing practice and deliver better patient care. To begin the process a suitable paradigm would need to be selected.

3.4 Paradigm

Thomas Kuhn (1962) first used the word paradigm to mean a philosophical way of thinking. The word has its aetiology in Greek where it signifies pattern (Kankam, 2019). In research the term paradigm is used to define a researcher's 'worldview' (Mackenzie & Knipe, 2006). This worldview is the perception, or thinking, or school of thought, or set of shared beliefs, that informs the meaning or interpretation of research data (Kankam, 2019). Lather (1986) believed that a research paradigm reflects the researcher's beliefs about the world that s/he lives in and wants to live in. It represents the abstract beliefs and principles that form how a researcher sees the world and how s/he interprets and acts within that world (Kankam, 2019). It is the lens through which a researcher views the world. It is the conceptual lens through which the researcher examines the methodological aspects of their research project to determine the research methods that will be used and it determines how data will be analysed (Kankam, 2019).

Guba and Lincoln (1994) believed that a paradigm was a basic set of beliefs or a worldview that guides research action or an investigation. Similarly, Denzin and Lincoln (2006), saw paradigms as human constructions, which indicate what the researchers view is of the world, so as to construct meaning to data. Paradigms are thus important because they provide beliefs and dictate what should be studied, how it should be studied, and how the results of the study should be interpreted (Kankam, 2019).

Paradigms also have significant implications for the researcher on other decisions made in the research process, including the choice of methodology and methods used (Kankam, 2019). Therefore, there is a need in all research to clearly state the paradigm in which the research is located, because the understanding is, that your research will uphold and be guided by the assumptions, beliefs, norms and values of your chosen paradigm (Kankam, 2019). Creswell (2009: 16-17) stated that paradigms 'consist of a stance towards the nature of reality (ontology), how the researcher knows what they know (epistemology) and the methods used in the process (methodology)'. Research paradigms can therefore be termed as philosophical beliefs which are used to study and interpret knowledge in three perspectives: namely epistemology, ontology, and methodology (Mertens, 2005). Thus, it is worth noting a paradigm serves as a basic model which reflects in-depth knowledge of what a researchers observes together with the manner that they understand the model of a study (Babbie 2011, : 32).

The most common paradigms discussed in the literature include: positivist, post positivist, constructivist, interpretivist, transformative, emancipatory, critical, pragmatism and deconstructivist (Mackenzie and Knipe 2006). Kim (2003) outlined three primary research paradigms, positivism, interpretivism and critical science. Creswell (2009) a semantic scholar on research, spoke of four main types of research design and he named them as Post-Positivism, Constructivism, Advocacy/Participatory and Pragmatism. See Creswell's (2009:6) four paradigm World Views in Table 3.0 on next page).

Table 3.0: Creswell's Four World Views (Creswell 2009:6)

Post-positivism • Determination • Reductionism • Empirical observation & measurement • Theory verification	**Constructivism** • Understanding • Multiple participant meanings • Social and historical construction • Theory generation
Advocacy/ Participatory • Political • Empowerment • Collaborative • Change oriented	**Pragmatism** • Consequences of actions • Problem-centred • Pluralistic • Real-world practice oriented

While there are many paradigms and all warrant further explanation, for the purpose of this research the author has chosen to discuss three of the key and best known paradigms to discuss in further detail.

- Positivism
- Interpretivism
- Pragmatism

3.4.1 Positivism

Theories in the positivist paradigm assume that reality is objective and that 'reality is both a stable and unchanging reality and that it can be captured and understood' 'using the empirical methods of objective social science (Denzin and Lincoln, 2006: 8). In the positivist stance the belief is that objects have an independent existence and are not dependent for their existence on the knower (Cohen, et, al, 2013). 'This view assumes that there is a real world out there, independent of our experience of it, and that we can gain access to that world by thinking, observing and recording our experiences carefully' (Moses and Knutsen, 2007:8).

This view of the world was first articulated in the natural sciences (Cohen, et, al, 2013). Positivism uses scientific method to develop general abstract laws which describe and predict patterns in the physical world (Suppe & Jacox, 1985). Theory is established deductively through formal statistical testing of hypotheses (Lincoln & Guba 1985). Objective generalizable theory is sought via stringent control of contextual variables but as Clarke (2008) highlights a drawback in positivism, is its failure to acknowledge the inherent social nature of knowledge development and its inability to identify and record any underlying unobservable or unmeasurable factors. Cohen, et al. (2013) agreed that positivism fails to take account of the social context in which actors construct meaning, and that it treats humans as passive subjects.

In the past positivism has played its part in nursing and its influence can be seen in the conceptual models of Orem (Hartweg, 1991)and Roy (Roy,2011;Nagle & Mitchell 1991) and in such tools as nursing diagnoses and practice standards (Dzurec, 1989; Drew & Dahlberg 1995). However, in recent times, positivism has faced a number of significant challenges, and its use in nursing has weaned (Corry et al., 2019). These challenges have emanated at least partially from a four part typology of paradigms proposed by MacKenzie and Knipe (2006) interpretivist /constructivist; transformative; pragmatic; and post positivist. (Corry et al. 2019). Nursing is moving towards these new style paradigms, where researchers value the opinions of nurses and patients in its encounters with research. While qualitative data collection methods have value, they are not the only approach available to gather data in this field of research.

3.4.2 Interpretivism

In contrast, theories in the interpretive (or constructive) paradigm assume that reality is (at least partly) subjective and it focuses upon uncovering the meaning actors give to events. This style of approach is concerned with the lived experience of the participants. A crucial aspect of interpretivism is the belief that only those who have experienced a particular event, can go on to describe it to the outside world (Parahoo, 2014:42-43). This study is concerned with the lived experience of the participants and aims to evaluate the converse ways in which people comprehend their environment. Both of these elements are supported by an interpretivist stance (Burns and Grove, 2011:20-21). The interpretivist paradigm is rooted in the fact that approaches used to understanding knowledge related to human and social sciences differs from its usage in physical sciences because humans interpret their world and give it meaning and then act based on this meaning while the world does not (Hammersley, 2013 : 26). Consequently, interpretivists adapt a relativist ontology in which a single phenomenon may have multiple interpretations rather than a truth that can be determined by a process of measurement (Hammersley, 2013: 26).

In this research the author chose to use an interpretivist approach, as it offered the opportunity to gain a deeper knowledge of the phenomenon in all its complexity, in its unique setting, instead of trying to generalise the findings to understand the whole of the population (Creswell, 2009).This style approach tries to understand 'the diverse ways of seeing and experiencing the world through different contexts and cultures' while trying to avoid the bias of studying events and people with their own interpretations and views (Hammersley, 2013).

The qualities of interpretivism are manifold; it centres on the belief that human beings are perpetually trying to understand their social environment and accredit meaning to their various interactions (Milburn et al., 1995:349). Versatile and interactive methods of data collection are promoted in interpretivism; this suited this research, where narratives and conversations presented the information and were used to describe human reactions and events, and to understand these in a social context (Parahoo 2014:72). This approach suits studies where the researcher aims to explore different perceptions of the same phenomenon as was the case in this research.

3.4.3 Pragmatism

The third and final view of epistemology is pragmatism. Its ontology is based on relativism and this is a more recent philosophy of science. It partly reconciles both the post positivism stance with the interpretative stance and it uses mixed methods for data collection which is consistent with both quantitative and qualitative research methods (Curry & Nunez Smith, 2014). It is used quite frequently in research nowadays and it has helped break the divide between the positivist and interpretative views (Sovacol et. al, 2018). This proves the fact, that not all research needs to align closely and explicitly with one paradigm only (Sovacol et. al, 2018).

Pragmatic researchers are not committed to any one system of philosophy (Mackenzie and Knipe 2006). The pragmatic approach to research focuses on the research problem and uses whatever methods are necessary to understand and solve the problem (Patton 1990) including qualitative and quantitative approaches. Researchers focus more on the outcomes of the research such as the actions and consequences (Creswell, 2009) in an attempt to produce socially useful knowledge (Feilzer, 2010).

Morgan (2007) speaks of how the pragmatic approach has a connection between theory and data that allows for movement back and forth between induction and deduction and is more in keeping with how researchers naturally operate rather than the linear fashion that linear induction or deduction normally occurs. Morgan (2007) rejects this idea of artificial dichotomy between subjectivity and objectivity and he promotes intersubjectivity, where researchers move between various frames of reference in an attempt to improve communication and develop shared meaning with participants in a research project. Morgan (2007) also argues that knowledge is not always context-dependent or generalisable. Morgan (2007) believes that rather than choosing between these two extremes, research needs to be more distinctive, he believes that research cannot be applied to every context or to every situation. However, pragmatists argue this point and they prefer the view of transferability and therefore endorse the most appropriate application of research outcomes along the continuum of context specific and generalised use (Creswell, 2009).

3.4.4 Summary on Paradigm Choices in Nursing

Positivism has reigned in the social sciences for many years as the best and only paradigm to use in nursing research. Its previously hegemonic position has now gone. (Corry et al., 2019). Many social and healthcare researchers have abandoned it in favour of paradigms that they believe better incorporate the experiences, needs and aspirations of human subjects. 'However, while the interpretive, transformative and realist paradigms challenged the dominance of the positivist paradigm, they have not rendered it redundant' (Corry et al., 2019: 9). There are areas in nursing research where it is still sought, such as policy and regulation development which are considered 'hard science' areas.

While debate continues about where best to locate healthcare research, views differ with many softer approaches to research now contending for the position that positivism once held. It therefore now falls to the nurse researcher to investigate the most appropriate paradigm for the approach s/he wishes to take to his/her research. However, consideration must be given to discovering and using an approach that brings suitable theoretical underpinning with an appropriate framework and tools to complete the research in a suitable fashion and bring credence to the process (Whitehead, 2018). There is no one size fits all in nursing research.

3.5 Methodology

Methodology is the broad term used to refer to the research design, methods and approaches used in a research project (Keeves, 1997). For example, data gathering, participants, instruments used and data analysis are all parts of the broad field of methodology (Kivunja and Kivunja, 2017). There can be some confusion about the different meanings of a method and methodology, a method is a way of collecting data, or a technique of analysis. A methodology provides the rationale for how the research is carried out in generating theory (Whitehead, 2018). A methodology provides the theoretical analysis of the methods and principles associated with contribution to knowledge being made in the research. A methodology does not set out to provide solutions (Whitehead, 2018). A methodology offers the theoretical underpinning for understanding how the research will be carried out (Whitehead, 2018). Crotty (1998:3) defines 'Methodology as a strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcome'.

When it comes to methodology choice, Cohen et al. (2009) reminds us that now we must become tactical and make choices about our research design. They advocate that 'the general aim or purpose of the research must now become specific, using concrete questions which will give specific concrete answers' Cohen et al (2009:75). The methodology also examines what assumptions will be made and how limitations encountered will be mitigated or minimised (Kivunja and Kivunja, 2017). When deciding upon the methodology for your research proposal, decisions need to be made as to how the researcher will go about obtaining the desired data, and how they will use this knowledge to enable them to answer the research question, thus making a contribution to knowledge (Kivunja and Kivunja, 2017).

3.5.1 Research Methodology Adopted for this Research

As stated, methodology is where the research process moves from the general to the specific and from the abstract to the concrete (Cohen et al., 2009). The research question, the area of research, philosophy and context are the key drivers in methodological selection, as recommended by Nastasi et al. (2010:305-338). In this research the author has chosen to use an interpretative paradigm as it assumes that reality is (at least partly) subjective and it focuses upon uncovering the meaning actors give to events. This approach is concerned with the lived experience of the participants. The author feels this is crucial to this piece of research as she is trying to develop a Tool which could be successfully adopted into nursing and used by staff to improve practice and support staff and patients, therefore the opinions of the co-researchers is very significant to this research piece.

Regarding design, an AR design was utilised for research methodology as the author wanted to use a research method that had a problem-solving ability. Regarding the Conceptual Framework, for the research, the author has chosen to use Grahams et al (2006) conceptual framework and will expand on the reasons why in section 3.6. For data collection the author chose mainly qualitative styled tools which included focus groups, interviews and reflective diaries, however, questionnaires were also used. While the use of a questionnaire, is often associated with positivism, the author believed like Saunders et al. (2012:161-165) that surveys, when conducted quantitatively, can sit well within an interpretivist philosophy. Such data based on participants' feelings and opinions can be referred to as qualitative numbers' (Saunders et al. 2005). The author will now go on to discuss these methods in further detail.

3.5.2 Action Research (AR)

Kurt Lewin is generally considered the 'father' of AR. Lewin, a German social and experimental psychologist, was concerned with social problems and focused on participative group processes as a means of addressing conflict, crisis or change. This is the very strength of AR, while it is a research method; it also has a problem-solving ability. This ability is spoken about in many of the definitions that define it, for example Adler et, al (2005:91) define it as a 'Collaborative research, which is an approach developed to cope with complex and boundary-spanning problems...and which requires a close partnership between researchers and stakeholders'. The idea behind AR, is that by engaging the participants in the research process you co-create a partnership (Fitzgerald and Dopson, 2005). Mc Kernan (1988: 6) described AR as 'A form of self-reflective problem solving, which enables practitioners to better understand and solve pressing problems in social settings'. However, the author finds the Reason and Bradbury (2001:1) definition even more relevant to this research as they add an emphasis on collaboration and practice improvement. They spoke of AR being '…a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. This definition brings together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally to the flourishing of individual persons and their communities'. This definition addresses all the potential benefits of AR needed in this research.

At the core of this approach, is a participatory worldview that requests staff to be reflexive and then explicit on their perspective on practice, so as new knowledge can be created (Reason and Torbert, 2001:3). From this knowledge, the Tool will be created and perfected to enhance practice and support staff in their development. An advantage of using AR is that it helps to build communities of inquiry; it goes beyond description towards implementation, it brings together participation to find solutions to mutual concerns and to generate actionable knowledge (Coghlan & Casey, 2001). This AR approach also involves active participation by participants to take the learning processes beyond reflection and towards action, implementation and capacity-building. This enhances the knowledge and skills of community nurses and they act as agents for creating change for sustainable development (Tilbury, 2011). Accordingly, this project will provide community nurses with the facilitation, support and resources needed to develop and implement a method of improving CNs with an impact in the context of individual, patient and practice needs.

A core value of the participative nature of AR is that the co-researchers and co inquirers, co-design, co-implement and co-evaluate. This underpins professional development and community healthcare service enhancement. AR seeks to generate practical knowledge in the present tense through cycles of constructing, planning, taking action and evaluating action (Coghlan & Shani, 2017). Its focus is change and improving practice (Reason & Torbet, 2001). Heron and Reason (2006) argue that AR is a way of researching with others and democratically exploring how people might extend and deepen their understanding of their situation as well as concurrently learning to improve their actions. AR is a spiral of self-reflective cycles normally involving a series of four steps in each cycle. These are 'planning a change, acting and observing the consequences of the change, reflecting on these processes and consequences, and then re-planning acting and observing, reflecting, and repeat again until research is complete (Kemmis and McTaggart, 2000). See Figure 3.0 which demonstrates diagrammatical AR cycle.

Figure 3.0 Single Action Research Cycle Adapted from Susman, 1983

Figure 3.1 below demonstrates the cyclical nature of the AR process. Each cycle has the same four steps, with the cylindrical practice being continual until the process is completed (Susman, 1983).

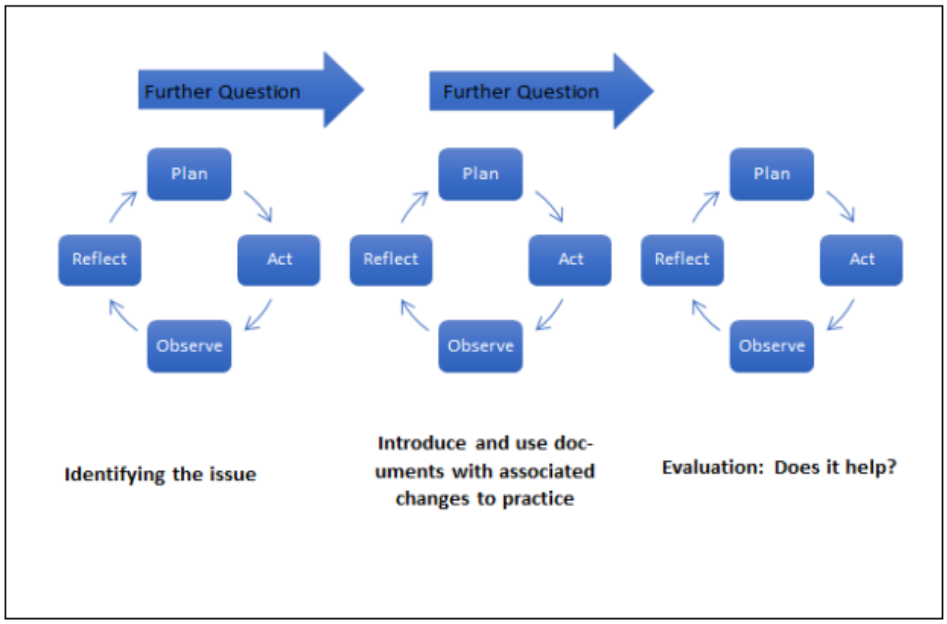


Figure 3.1 Simple AR Model Demonstrating Several Cycles in the Process

3.5.3 Why Choose AR

The author set out to investigate practice issues in the hope of making improvements to practice. All research aims to generate knowledge, however, 'the epistemological focus of AR is the production of knowledge that is of direct relevance to people and informs both their work and lives' (Koshy et al., 20:54). The author agrees with Heron and Reason (2006) and Herr and Anderson (2015) who suggest that traditional research approaches are inadequate to practice improvements as they produce abstract rather than practical thinking, they do not directly change anything and produce only academic papers. While a distinguishing feature of AR is that it is future orientated and produces change and solutions to practice issues. It attempts positive development as it generates this new knowledge (Chandler and Torbert, 2003; Herr and Anderson, 2014).The author felt this approach suited the research needs ,which were to improve nursing practice. AR engages people in a collaborative relationship, opening new forms of dialogue in which communication and development can flourish as it addresses issues of concern to individuals and organisations in their everyday lives (Kelly, 2005). So, AR is about nurturing relationships and engaging participants to assume responsibility in the research process. Also, when individuals have the opportunity to make changes that they identify as most appropriate to their practice, this greatly

enhances the chances of the adaptation of these changes into practice. This was the main reason the author chose AR. It was also hoped that the research methodology might confirm to practitioners that AR is a reliable form of research and that it is a tool capable of improving practice through an academic approach. Also, it was hoped that this approach might encourage future collaborations between the two worlds of practice and academia (Herr and Anderson, 2014; Mc Kay and Marshall, 2001).

3.5.4 Which model of AR

Within the tradition of AR, there are a number of approaches. This study will apply co-operative inquiry. Co-operative inquiry involves working with people on issues important to them and is grounded in creative action and practicality (Heron & Reason, 2001). Participants work together in a co-operative inquiry group as co-researchers. Heron and Reason (2008:366) define it as 'Where participants research a topic through their own experience, to understand their world, to make sense of their life and to develop new ways of looking at things and learn how to act to change things they want to change and find out how to do things better.' The focus of co-operative inquiry is to work with others who have similar interests to develop new and creative ways of looking at practices and identifying the best way to address improvements (Reason & Heron 1995). This is particularly suited to this project as community nurses, academics and collaborators work both within and between clinical practice and educational settings, responding to identified practice issues and decide how best to change them so as to enhance service delivery to patients.

As AR takes place in the real world, the context of the research and the inquiry are important considerations. AR adopts a systems approach, which acknowledges that changes in one aspect of the system can influence other parts of the system. To maximise the potential of the research, the author proposes to use this systems approach. This means involving various types of patients in addition to staff from different levels in the organisation in this co-operative inquiry. These co-operative inquiry groups will enable a systems wide view of care delivery thus allowing the author to gather maximum views on service delivery and its impact on patients care. The groups compromised of

1. ***Management Level:*** The formation of self- selected representative co-operative inquiry group of community nursing management with membership drawn from DPHN and ADPHN level.
2. ***Community nursing level****:* Self-selected groups from Practice Development Coordinators (PDCs), RGNs and PHNs focusing on topics identified in the document and identification of further domains of practice enhancement (based on emerging data from the co-operative inquiry groups and the findings as the cycles progress.
3. ***Patient's level****:* Self-selected group who volunteered to complete questionnaires and interviews on nursing practice and to explore mechanisms of practice improvement.

Meetings: Monthly for duration of project.

Self-selection and bias will be discussed in section 3.10.

3.6 Conceptual Framework Choice

The project adopted Graham et, al. (2006) Knowledge To Action (KTA) model (See Figure 3.2 of same on next page). It was originally developed for health care professionals as a method of introducing the latest research finding into practice. While Graham et al (2006) supported the view that there should be ongoing continuous professional development in healthcare staff they also realised that researchers and clinicians see themselves as separate groups with distinct cultures and perspectives on research and knowledge, with neither group fully appreciating the other's world. The author, having spent her working career working in both the academic and the practical fields would agree with Grahams et al (2006) view, that staff in both fields believes that the world of academia and practice lack cohesion and interconnectedness. This in turn results in the poor adaptation of research findings into practice. In an attempt to overcome this Graham et al (2006) developed the Knowledge To Action (KTA) model.

The author chose this model because she believes Graham et al (2006) model is capable of facilitating the application of academic findings and knowledge into practice. It allows for adaptation of academic knowledge and research findings to a format that is acceptable to practitioners. This model demonstrates the author's belief that it is possible for staff to introduce and complete an academic development within a practical setting with the assistance of an AR approach that interests them. The author also believes that this model ensures that knowledge generated is relevant and applicable to practice as well as useful

to researchers and that it focuses on a collaborative research approach between both the practitioner and the academic (Graham et, al .2006:13).

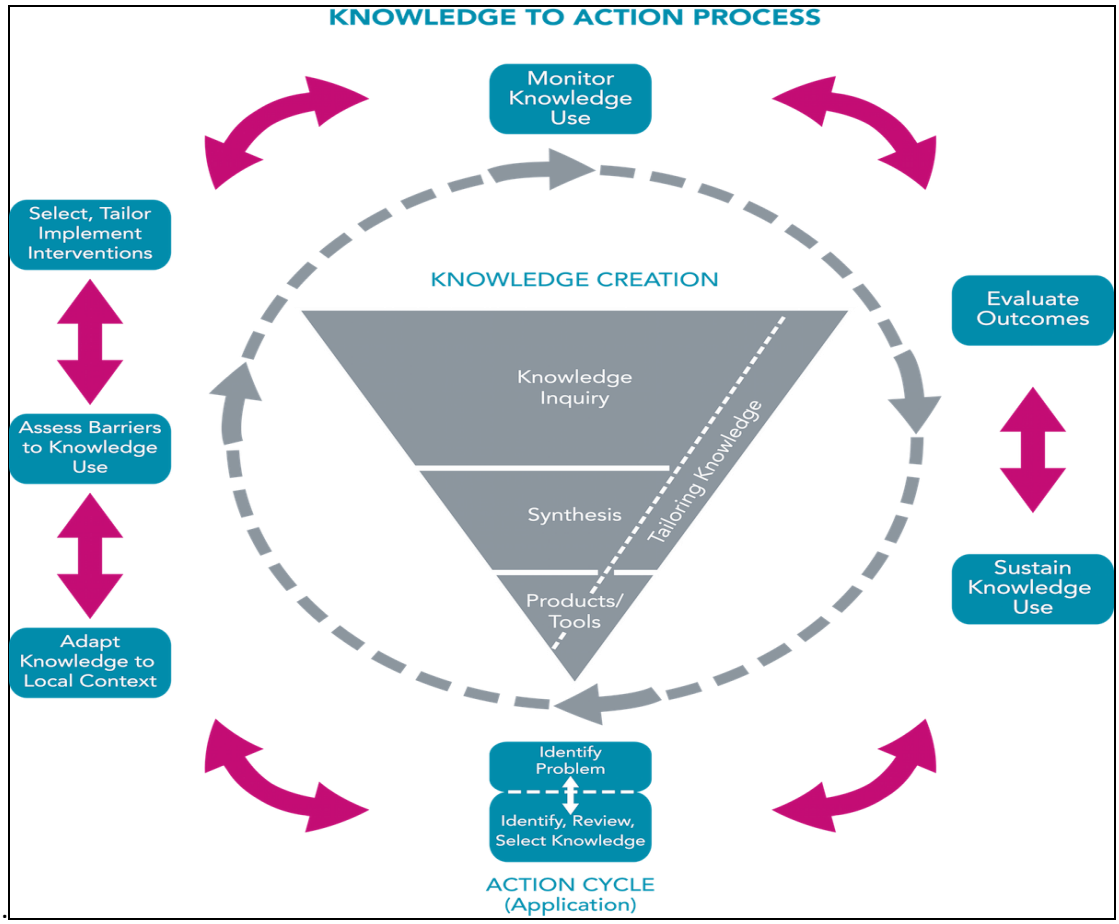


Figure 3.2 Knowledge to Action (KTA) Cycle / Process (Graham et al. (2006)

In Figure 3.2, for conceptual and illustrative purposes, the KTA process is divided into two concepts: The inner funnel in the diagram symbolises knowledge creation, and the surrounding cycle represents the activities and processes related to the use or the application of this knowledge into action. 'In the inner funnel, knowledge becomes more distilled, pertinent and useful to stakeholders as it moves down the funnel' (Graham et al., 2006:16). This knowledge is then applied to practice, followed by evaluation and the findings documented (outer cycle). This process continues until a solution is found or practice improves. While implementing Grahams KTA model, the different phases can be completed by different stakeholders working independently of each other if desired. However the technique most commonly used in applying this model is that knowledge producers, researchers and knowledge implementers work collaboratively throughout the process, this was the case in this research. Graham et al., (2006).

All phases in the model are dynamic, influence each other, and can be influenced by the knowledge creation phases' (Graham et al., 2006:18).

They are divided into the following phases:

• Identify a problem that needs addressing

• Identify, review, and select the knowledge or research relevant to the problem (e.g., practice guidelines or research findings)

• Adapt the identified knowledge or research to the local context

• Assess barriers to using the knowledge

• Select, tailor, and implement interventions to promote the use of knowledge (i.e. implement the change)

• Monitor knowledge use

• Evaluate the outcomes of using the knowledge

• Sustain ongoing knowledge use

These are the stages that the author hopes to use in the implementation stage of each AR cycle.

3.7 Research Activities Mapped Throughout the Project Period

3.7.1 Identifying the Stages of the Research

The model proposed by Graham et al. (2006) details individual cycles rather than stages in a research project. In this research the cycles (which ran sequentially) compromised of the following cycles. Cycle one, the author met with patients to examine their issues, in cycle two she met with staff to examine their issues. Shen then revisited the literature review and made a draft version of the Tool. In cycle three, the author introduced the Tool to a pilot group of staff to test it. Following review of the pilot cycle adjustments were made to the Tool and it was reintroduced in the fourth and final cycle of the research to a larger group of staff. After implementation, the Tool was evaluated and the findings recorded with recommendations made for future practice. Each cycles of AR uncover insights which led to learning and changes in the Tool for the next cycle. See table in Table 3.1 for overview of the research process,

Table 3.1 AR Cycles for the Development of the Quality Framework for the Tool

Date/ Timeframe	Cycle	Methods
November 2016- April 2017	Cycle 1 Exploratory Phase and scoping out of patients views	Questionnaires and Focus Group with Patients Literature review revisited Themes developed Tool Honed and Re-Developed Notes documented on Findings to date
May 2018 August 2018	Cycle 2 Consultation with nurses and Development Phase	Focus Groups / Interviews with Nurses and Nursing Management Literature review post new data collected Review data gathered with co-researchers and more themes developed Use of Socratic Wheel to confirm themes and rate importance of themes with focus groups Meetings with Co-Researchers to • Seek commonalities in themes in data collected from patients and nurses • Decide which of these themes we could influence with the Tool to improve practice Agreement reached and Themes finalised Tool re-developed for launch in pilot Notes documented on Findings to date
2018 Research Formally Initiated		
Oct2018- October – Dec 2018	Cycle 3 Pilot Phase Re-development of Tool and Rollout to pilot group	Purposive sampling for pilot Tool launched Observe/Questionnaires/Interviews/Focus groups Data collected, analysed Notes documented on Findings to date Tool re-developed
Oct 2019- March 2020	Cycle 4 Redevelopment of Tool and Rollout to study group,	Documents relaunched with suggested changes made Observe/ Focus Group/ Interview/ Questionnaires and reflect Data collected, and analysed Use of Socratic Wheel to confirm themes and rate importance of themes with focus groups Notes documented on Findings

3.8 Methods

Methods are the technique or procedures used to gather and analyze data related to the research question or hypothesis (Crotty 1998:3). In this research the methods consist of:

3.8.1 Data collection methods

- Questionnaire to Nurse/ Nurse Manager / Patient
- Interview Nurse/ Nurse Manager/ Patient
- Focus Groups Nurse/ Nurse Management/ Patient
- Data obtained through personnel records
- Journal Entry
- Researcher summary on findings at end of each AR Cycle
- Socratic Wheel

3.8.2 Modes

Modes refer to the way in which the data collection tools are administered. In this research,

- Three Questionnaires were developed (One for management and one for nursing staff and one for patients). Staff questionnaires were circulated via the post and email with an explanatory letter. (Appendix O). Patient questionnaires were given to clients on first visit or could be picked up in waiting rooms at nurse clinics (Appendix D).
- Focus groups were carried out by same researcher; groups were divided into patients, nursing management and nursing staff. Three different sets of questions were used as prompts and to keep the group focused, one was developed for patients and used in Cycle One (Appendix L) another sets of questions was developed for nursing (Appendix M)and a third for management (Appendix N). These same set of questions were used in interviews and focus groups for staff in cycles two. While questions were preset, they were used as guidance only and space was given for patients and staff to give their own opinions, which were insightful and led to much richer data collection.
- Interviews questions were developed for interviewing post introduction of the Tool in cycles three and four. (Appendix Q) The interviews were recorded then transcribed and the transcription verified for accuracy by the interviewee before being admitted to the data collection.

- Data obtained through personnel records, journal entries and researcher summaries were also recorded.

3.8 .3 Questionnaires

Questionnaires provide anonymity and can help the researcher 'learn about individual attitudes, opinions, beliefs and practices' (Creswell 2015:384). Patient questionnaires were completed first and this was offered to all new and existing patients over a 6 month period. A web based questionnaire was available but 99% of returns were hardcopy. 'Web-based questionnaires do allow effective and economical surveying and can reach a geographically dispersed population' (Creswell, 2015:384) but in this research many clients were seen face to face and in addition many patients elderly and web-based communication would not be their first choice. The nursing staff questionnaires in the pilot study which had 7 staff were handed out and circulated via email. In the larger research group the questionnaires were circulated via email to the targeted population of 51 nursing staff which included 2 DPHN's, 9 ADPHNs, 1 PDC, 33 PHNs and 6 RGNs. They were sent in hard copy also to avoid bias towards certain groups that tend not to use computers' (Creswell 2015: 384).Regarding questionnaire layout and following guidelines on good question format, questions which addressed sensitive issues were 'tactfully stated' to avoid running the risk of individuals over or under-representing their views, which could leads to bias (Creswell 2015: 386). Sensitive questions were placed late in the survey 'after the individual had 'warmed-up' by answering neutral' and closed-ended questions which had clear 'parameters of response options' (Creswell 2015;386). While the open-ended questions did not restrain individual responses, the categorisation of their responses into themes did prove to be time-consuming. Respondents had to answer all questions; as the survey questionnaire assesses information at different points in time as it was a longitudinal study (Creswell 2015: 405). The results of all questionnaires were used with triangulation of data to prevent bias of small return and to enhance findings (Creswell 2015: 390).

3.8.4 Interviewing

Interviews are a much-focused method for gathering data on a specific topic. They elicit large amounts of data over a short period of time (Dikko, 2016; Yin 2003). Interviews are useful for gaining insightful views of peoples lived experience (Dikko, 2016; Yin 2003). They openly demonstrate the relationship between an individual's capacities and the demands that exist within their role or within the context of the organisation or environment (Helsing and Howell, 2014). Hence, taken in the con-

text of this research, interviewing was the ideal research tool to provide a deeper understanding of patients and staffs experiences. It gave the researcher a chance to illicit the patients view on the quality of the nursing service being delivered and it also gave the researcher a chance to illicit the nurses issues with practice delivery and ways they felt might improve things.

Certain skills are needed if a researcher is to conduct interviews in a responsible, professional and ethical manner. Effective listening skills and emotional control are among the most critical skills to develop. Good social skills are required to initiate interviewee participation and get them to talk freely (Adams , 2010) as the interviewer attempts to 'get behind' the content to the hidden drivers or assumptions that people make about their experiences (Ellis & Berger, 2003; Kegan and Lahey, 1984; Spradley, 2016).

However, interviewing is not without its challenges, Yin (2003) spoke of bias occurring in interviewing due to poorly constructed questions or even response bias in the interviewee. In addition, Ellis & Berger (2003) and Spradley (2016)) spoke of poor preparation or poor social skills in the interviewer producing poor interview results. In this study, to overcome bias and demonstrate accuracy of findings the author used a list of recommendations from Seidman (2013) for successful interviewing. See Table 3.2 for same.

Interviews were done face to face, recorded and then transcribed. Ample time was set aside immediately after the interview to prepare the 'facsimile' and interpretive commentary. As advocated by Yin (2009), care was taken to listen intently to avoid misinterpretation and the typed-up interview was submitted to the respondent for accuracy and stylistic improvements. Changes were made according to respondent's views on same. Despite this, Yin (2003) warns of bias with interviews and suggests that interviews should be considered *verbal reports* only and are subject to the common problems of bias, poor recall, and poor or inaccurate articulation. However the author sought to keep the interviews as accurate as possible and the information obtained through interviews was triangulated with other data sources as recommended by Yin (2003). For this research, the desired quota of 25% management to 75 % nurse mix was met as was the mix of urban and rural setting taking part in the research These percentages are reflective of practice. Also the 103 patients who returned questionnaires were a good urban rural divide and involved all age groups with representation from each CN care group.

Table 3.2 (2013) Seidmans recommendations for Successful Interviewing

Seidmans recommendations for Successful Interviewing

- **Well prepared questions**
- **A pilot interview to test validity of the questions**
- **Interviewer well prepared and experienced enough in subject to interview his/her interviewee**
- **Rapport with interviewee**
- **Listen more than speak**
- **Explore avenues opened in the interview.**
- **Recording of interview and good field notes kept.**
- **Early transcribing of the interview for clearer more accurate data collection**
- **Confirmation of accuracy of transcript by interviewee**
- **Accurate/ordered data analysis system which demonstrates validity of data.**
- **Align themes as they emerge and use critical friend to review**
- **No prior agenda in researcher regarding findings**
- **Accurate report of findings with an evidence trail.**

3.8.5 Focus groups

Kitzinger (1994, 1995) argues that interaction is the critical element of focus groups because the interaction between participants highlights their view of the world, the language they use about an issue and their values and beliefs about a situation. Another advantage is that focus groups elicit information in a way that allows researchers to find out why an issue is salient, as well as what is salient about it (Robinson, 2020).

Although focus group research has many advantages, as with all research methods there are limitations. Some can be overcome by careful planning and moderating, but others are unavoidable and peculiar to this approach. The researcher, for example, has less control over the data produced (Robinson, 2020) than in other quantitative data sources such as one-to-one interviewing. The researcher has to allow par-

ticipants to talk to each other, ask questions and express doubts and opinions, while having very little control over the interaction other than generally keeping participants focused on the topic. By its nature focus group research is open ended and not entirely predetermined (Gibbs, 1997).

Another issue that may arise and is not always easy to identify is the issue of getting the most appropriate participants for a focus group: If a group is too heterogeneous, whether in terms of gender or class, or professional standing perspectives, the differences between participants can make a considerable impact on their contributions (Fern et al., 2001). Alternatively, if the group is homogenous with regard to specific characteristics, diverse opinions and experiences may not be revealed. It should not be assumed that the individuals in a focus group are expressing their own definitive individual view. They are speaking in a specific context, within a specific culture, and so sometimes it may be difficult for the researcher to clearly identify an individual message (Fern et al., 2001; Gibbs, 1997). In addition, participants need to feel comfortable with each other. Meeting with others whom they think of as possessing similar characteristics or levels of understanding about a given topic, is much more appealing than meeting with those who are perceived to be different (Robinson, 2020).

Given the above detail, this was one of the reasons the researcher divided the focus groups into different categories. There was a focus group for patients, one for the pilot group, three for the nurses in the research group (due to numbers) and 1 for management. This allowed everyone to speak more freely. All data collected was cross-referenced with the group using the Socratic Wheel exercise (Chevalier & Buckles 2013). This information was then triangulated with other research findings and then documented.

3.8.6 The Socratic Wheel exercise (Chevalier & Buckles 2013)

The Socratic Wheel was developed by Chevalier and Buckle (2013) as a tool for use in Participatory Action Research (PAT). It is a 'deceptively simple and powerfully visual tool' that allows for the establishment of baseline criteria which can be used to evaluate, assess and compare participant profiles or their beliefs or opinions throughout a project (Chevalier & Buckles, 2013:120).

The author used it as a tool to assist team members decide what themes were interfering with best practice and it also allowed them to rate the relative importance of the different themes. Participants used a five point Likert scale (1 = Less important, 2 = Somewhat important, 3 = Moderately important, 4 = Very important, 5 = Critically important) to rate each theme. The tool was used again later in the re-

search, to identify and to rate the importance of topics that should be included in the tool to assist staff deal with the causes of practice issues. As the research progressed, the Socratic Wheel was used, to rate the effectiveness of these topics in improving practice issues.

3.8.7 Documentary Data Sources

Some data was obtained through personnel records, but this was only with full consent from all involved (nurse, manager and organisation). No names or identifying data were included in the research, just the identification of the issue, the dates of meetings, action plan used, review dates, the role of those who attended the meetings and outcome of the plan implemented and the staff and managements view of the effectiveness of using this method in Document Three. As in all research, the records viewed were only ones directly relevant to the research. And the data utilized from these was used to develop emergent themes and assisted with triangulation of evidence and findings later. Four personnel files were used with permission in this research.

3.8.8 Journal Entries and Written Reports

During the course of the project, journal entries and written reports from the end of each AR cycle were also recorded. These analytic memos outlined the authors 'systematic thinking about the evidence' collected (Elliott, 1991:3; Coughlan, 2019). They included things like new ways of conceptualizing the situation under investigation; hypothesis which had emerged along the way, and which could be tested further; and comments in relation to emerging issues or problems. The analytic memos are referred to as journal entries in the findings and discussion section.

3.9 Sampling

Data gathering is a crucial element of research, as the data contributes to a better understanding of a theoretical framework. It then becomes imperious that selecting the manner of obtaining data and from whom the data will be acquired, be done with sound judgment, especially since no amount of analysis can make up for improperly collected data (Etikan et al., 2016). In this research a purposive sampling technique was used. In purposive sampling the sample is approached having a prior purpose in mind (the research) and the criteria to be included in the study is predefined (representatives were needed from Pa-

tients, RGNs, PHNs, PDC, ADPHNs and DPHNs groups). Representative sampling is valuable, as it allows generalisation to a population type as a whole (Burns and Grove, 2019). While the author would concede that the numbers used in this research are low, she would contend that this was a study which processed an in-depth investigation, representative of the groups involved in the study and this study adds value and allows generalisation to be applied to the CN population as a whole (Burns and Grove, 2019). This study has allowed the voices of CN staff to be heard, which gives greater authenticity to CN research than replication or duplication that some researchers seek. Table 3.3 on the next page elaborates on the steps taken in each cycle

Table 3.3 Redefining the Research Questions

Cycle	Nurses	Data Analysis	Need for next Cycle	Patient	Data Outcome	Needs for Next Cycle
1				Patient questionnaire circulated to all patients	Data collected and analysed Focus Group Held	Findings cross referenced with patients and findings documented Themes elicited and cross referenced against Literature review themes
2	Focus Groups with all nurses to establish what causes Practice Issues Repeat Focus Groups to introduce Socratic Wheel. This was used to confirm themes found and allow staff rate themes	When data analysis completed from patients and nurses research group met to discuss practice issue theme commonalities. When agreed, the commonalities were discussed further and a decision made as to which ones we could make an impact upon in practice	These practice issue themes, were examined against literature review for best practice and recommendations made were introduced into the Tool. So Tool was redeveloped and honed further for Pilot Study			Themes developed and cross referenced against lit review findings (DCA Analysis) Scoping out Research completed Pilot documents developed by group
3	Pilot study carried out in one Primary Care Centre (7 participants) over 8 weeks. Interviews / Focus Groups/questionnaires following use of Documents 1-2	Cross reference data collected with staff from pilot, analysed and documented,	Changes made to Tool and reintroduced to large research group 51 participants			
4	Tool introduced and used over 6 Months Interviews / Focus Groups/Questionnaires following use of Documents 1-3	Cross reference data collected with staff for accuracy. Then analysed.	Findings documented and Research completed			

Cycle 1 This involved asking the patients how they found nursing service delivery. The author had developed a patient's questionnaire to get their view on nursing service delivery. This was reviewed by co-participants and then distributed by staff to patients. 103 were returned in 6 months. 6 patients also volunteered to be interviewed and after this was completed all data was analysed for themes.

Cycle 2 This involved scoping out the subject of what causes practice issues in nursing, using focus groups to ask staff and management about their opinions regarding practice issues and what caused them. The discussions were recorded and on completion of the data collection, the author analysed it for themes. The themes were documented, and the author then revisited the group and cross-referenced the themes for accuracy with the staff. When this was complete the Socratic Wheel (Chevalier and Buckle, 2013) was introduced to rate the relative importance of the different causes of practice issues using a five point Likert scale (1 = Less important, 2 = Somewhat important, 3 = Moderately important, 4 = Very important, 5 = Critically important). The points agreed upon, remained as themes that needed to be resolved through the use of the Tool.

Socratic Wheel can be used as a cross reference for accuracy of themes developed in data processing. It was also used to confirm the rating or the importance a theme held for a participant in the research.

On completion of the scoping out cycles (1-2) data was discussed and these were cross referenced against the literature review themes, which cited improving nursing practice. The suggested changes for practice improvement were introduced into the Tool and the Tool launched in cycle 3.

Cycle 3 Documents was the pilot study involving 7 staff in one Primary Care Centre.

Questionnaires were completed by all on the documents they had used. Focus Groups and interviews also took place. One staff member was unable to complete the research leaving 6 who did complete it. Findings were documented and then discussed with AR group and appropriate changes made to documents for Cycle 4

Cycle 4 Re-introduction of the newly honed Tool to the large research group of 51 participants for testing for effectiveness.

When the research was completed all staff completed questionnaires related to the documents that they had used. This was followed by focus groups and interviews.

Table 3.4 on next page provides a view of the conceptual framework used throughout the research process. This shows how the research issues were compiled to provide a framework from which the research questions were focused. While Graham et al., (2006) model was used to complete the AR, the table in 3.4 kept the research clear, focused and concentrated on the specific questions the research was asking to get an effective working document that was of value to the CN service.

Table 3.4 Antecedent data and evolving research questions -CN practice

Document	Research issues (antecedent data)	Evolving research question
Document 1	A broad range of skills and competencies are required by CN staff to provide multi-faceted care within the community. Are there any areas where staff are experiencing difficulty with their caseload and require support or advice? Are staff competencies and CPD up to date and is more training required. Does the nurse have a career development plan? Are there any issues with clinical practice that need addressing	Does this document give staff the opportunity to look at and recognise their achievements during the past year also to look at where things have not gone so well? Does it provide them with the opportunity to ask for advice or support with practice issues? Does it allows time for ADPHN and staff member to look at updating competencies or planning new learning that is pertinent to both their present position and future career development?
Document 2	Clinical issues arising and/ or help, or support needed.	Does this document assist staff with early recognition of work issues and /or contribute to timely identification of work situations where they need to seek support or advice before it impacts on them or patient care? From managements perspective does this document give timely notice of work issues and / or Areas where support is needed thus aiding early resolution
Document 3	Need to identify specific issues arising that are affecting practice delivery	Does this form assist Nurse/ADPHN identify the specific work related issue(s) and develop a corrective plan of action to resolve it while supporting staff member. Is the document appropriate to this use
Document 4	Has the patient been given the opportunity to voice their opinion on service delivery and their satisfaction/ dissatisfaction with same? Have any issues arose.	Has cognizance been taken of patients view re satisfaction with service delivery? Have areas been noted where work issues have contributed to poor service delivery? If so, has the document assisted with early recognition of the issues and prompted formulation of a plan to correct these issues. Has this plan been implemented.
Overall Assessment	Has the use of the documents lead to better outcomes for staff, patients and the HSE	Has using the documents led to 1. Improved practice 2. Increased staff wellbeing, 3. Improved job satisfaction 4. Improved staff retention 5. Improved patient outcomes 6. Reduced risk of litigation

3.10 Adding Validity to the study and Trying to Eliminate Bias (on Insider Research)

Constant reference to the framework in Table 3.7 which was developed in the reconnaissance stage of the research, assisted in identifying the questions that needed asking, the data sources that needed to be used and the best data analysis strategies to use. Developing this framework at the early stages of the research reinforced the fact that there were no preconceived researcher's answers or hypothesis to begin with, only set questions. This framework adds validity and assists to authenticate the findings in the AR, by assuring the reader that this research and its findings could be replicated and applied to other studies elsewhere, thus contributing to both scientific and literature development.

The author also adhered as closely as possible to Herr and Anderson (2014) five validity criteria found in successful AR. These are:

1. Outcome validity, that is the extent to which actions resolve the problems;
2. Process validity which is ongoing reflection and learning throughout the AR project;
3. Democratic validity, the extent of collaboration with all involved;
4. Catalytic validity, the degree participants were reoriented and energised by the AR inquiry;
5. Dialogic validity, the extent the research was deemed good by peer review and plus/minus publication.

Overall, these criteria enhance the research validity and add credibility to it.

When assessing validity of this AR research, it also has to be acknowledged that the author and co-researchers were 'insiders' in the organisation (Moller 1998:73). In an effort to prevent bias, the author chose to step out of her job for 2 years, to work in the academic setting in an attempt to complete the research and reduce or prevent insider bias. However, she concedes that she may still have been recognizable to some staff as a DPHN and this could have influenced staff responses. While it is hoped not and the author made every effort to prevent this happening, it is still a possibility.

Another issue that needs to be mentioned is that staff who work inside an organisation and are involved in research, come with perspectives and these could lead to an agreed common perspective. Also there is role duality and organizational politics (Coughlan and Casey, 2001). These could influence the research and lead to a diminished pluralistic perspective being presented - as both the researcher and the participants come from similar backgrounds. However, the author accepts and realizes that 'our knowing is from a perspective, and that by being aware of this bias, helps to reduce the likelihood of its interfer-

ence in the research' (Moller, 1998:73). Despite these issues, every reasonable effort was made to ensure that biases were minimised and rigor was maintained. These efforts included the following

Rigor was maintained by adhering strictly to prescribed research methods for data generation and gathering. Also all findings were tested in more than one way to evaluate the findings and outcomes for accuracy (Greenwood, 1994 and Eden and Huxham, 1996). This reduced the risk of "insiders" involved in the research influencing the research outcomes or driving their own agenda.

Credibility of the research findings was maintained by demonstrating engagement in multiple and repetitious AR cycles where diagnosing, planning, taking action and evaluating was carried out. This was then manually reviewed several times in groups and then reviewed and recorded on Socratic Wheel with all staff involved to check credibility before findings were documented (Coughlan and Casey, 2001)

Challenge of Findings also took place - findings were challenged and tested throughout the project by means of management, nurse and patient input, so that any staff familiarity with and/or closeness to issues were exposed to critique from all including "outsiders" like patients (Coughlan and Casey, 2001). Also findings and interpretations were reviewed and compared to and challenged by the literature and academic colleagues or "critical friends" after each AR cycle (Bambino, 2002 ; Coughlan and Casey, 2001).

The author feels that the thesis produces evidence of rigor, credibility and it displays challenges to its findings in all cycles as is required of research that is without bias, can be replicated, adds to organisational learning and contributes to knowledge.

3.11 Data analysis

Yin (2003a:109) maintains that data analysis consists of 'examining, categorizing, tabulating, testing, or otherwise recombining both quantitative and qualitative evidence to address the initial propositions of a study'. In general, data analysis means a search for patterns in data' (Neuman, 2014:329). Neuman et al (1997:426) states that 'once a pattern is identified, it is interpreted in terms of a social theory or the setting in which it occurred, and that the qualitative researcher moves from the description of a historical event or social setting to a more general interpretation of its meaning'. In fact, 'the ultimate goal of the research is to uncover patterns, determine meanings, construct conclusions and build theory' (Patton & Appelbaum, 2003:67; Neuman 2014) Leech and Onwuegbuzie (2007) describe seven types of analyses namely constant comparison analysis, classical content analysis, keyword-in-context, word count, do-

main analysis, taxonomic analysis, and componential analysis; and choosing the appropriate analysis for your works can be a daunting task (Leech & Onwuegbuzie, 2008). However, after much research the author employed content analysis. O Leary (2004), recommended that when using content analysis that the data is logged at each stage of the research process. In this research

- The data was systematically organised. This involved grouping similar sources, developing preliminary codes and removing documentation that was irrelevant to the analysis.
- The data was screened for potential problems. This involved checking all documentation to see if it was legible and complete.
- Both the qualitative and quantitative data were entered into a computerised programme (Nvivo software package).

3.12 Content analysis

Hsieh and Shannon (2005) show that content analysis describes a 'family' of analytical approaches providing the qualitative researcher with flexible methods for analyzing text data. However, they suggest that the lack of a definitive definition or classification has limited its application. After analyzing the literature in this area Hsieh and Shannon (2005) defined content analysis, classified it into three types and provided analytic procedures for each approach. The three approaches were

1. Conventional content analysis,

2. Directed content analysis

3. Summative content analysis.

Directed content analysis was used in this research.

3.13 Analytical approach - Directed content analysis (DCA)

The goal of a directed approach to content analysis is to validate or extend conceptually a framework or theory. DCA starts with a theory or relevant research findings or results of a literature review as a guide to initial codes. Where an existing conceptual framework is in place, some notions about preliminary codes already exist (Hsieh and Shannon, 2005). However, the purpose of the research is not to limit the analysis of these 'preconceived codes' but rather to extend them by further description or to refute them

as meaningful in the particular context. As with Stake (1995), Yin (2003) and Simons (2009), Hsieh and Shannon (2005) point out that the pre-existing conceptual framework can provide predictions about the variables of interest and about the relationship between variables. This helps, Hsieh and Shannon suggest determining the initial coding scheme or relationships between codes. This process is described by Mayring (2000) as deductive category application. This was the method applied here after the literature review. The literature review provided the initial coding system; however, caution is important in protecting from an overemphasis on the conceptual framework to avoid blinding the researcher to contextual aspects of the phenomenon. In this case the pre-determined issues were mostly broad contextual issues rather than narrow or restricting, e.g. 'prevailing discourses' allows for various discourses to be extrapolated as opposed to analyzing for say practice issues only.

Research bias is another risk associated with directed content analysis, particularly if the development of the conceptual framework has been biased. Stake (2005), Hsieh and Shannon (2005) recommend that alternative accounts should be sought so that supporting and non-supporting evidence for a theory is properly examined. To follow this and assist with validity, the author ensured that the preliminary 'properties' were identified from the data, irrespective of the framework, and as stated earlier it is the quality of the evidence which impacts mostly on the assertions developed about the case.

3.14 Process of analysis

Data from each AR cycle was analysed, and findings were reported prior to engaging in the next AR cycle. All data was read and re-read to allow the researcher to become immersed in the data and in order to give an overall impression of the findings and to develop emergent insights. Main themes were identified in relation to patterns that recurred throughout the data. These themes were also checked against the conceptual framework which arose from the literature review. In order that the conceptual framework would not drive the analysis but rather guide it, preliminary 'properties' were identified from the data, irrespective of the framework, such as; practice issues, staff support, job satisfaction, staff retention and patient outcomes. Eventually this list aggregated into a 'master' list of properties. At this point the extent to which the conceptual framework had pre-determined the codes was becoming more evident as some issues reoccurred again and again. However other emergent properties such as job embeddedness and risk management had not been anticipated and were added and included in the literature review. Nevertheless, all properties were retained until a category was developed to incorporate them. (See Table 3.5 Braun & Clarke Theme Analysis and Figure 3.3 for Conventional Content Analysis theme development, both of which were used in process analysis)

Having developed the categories, these were then subsumed into two overarching themes. The first theme, named 'structural discourse' is inextricably linked to the conceptual framework comprising the research issues and was to a greater extent categorically pre-determined. It was a more deductive process. The second theme, named 'spontaneous discourse' arose out of a more interpretive approach to the research and it produced unanticipated themes for coding. This process was inductive.

Analysis of documentary data was performed in much the same way. The personnel records and field notes were examined for particular pre-determined questions such as issues arising; plans of action, staff involved, review dates and outcomes were all examined for emergent properties. Similar categorical development was undertaken ensuring that the data from the personnel records and other documents which were available for triangulation with the data from other sources.

Table 3.5 Thematic analysis process (Braun & Clarke, 2006)

Step	Activity
1. Familiarization with the data	The entire data set will be read through on numerous occasions to immerse the researcher in the data
2. Coding	Initial coding involves the production and collation of patterns related to experience of the intervention, process or service
3. Searching for the themes	Codes will be examined for potential themes and reviewed as representing the narrative of the participants
4. Reviewing themes	Initial themes will be reviewed and refined to ensure they meet the research questions objectives
5. Defining and naming themes	Themes will be built up using detailed analysis of each theme which enables a coherent description of the theme
6. Writing up	The final stage involved the interrogation of the data and the contextualising with the relevant literature

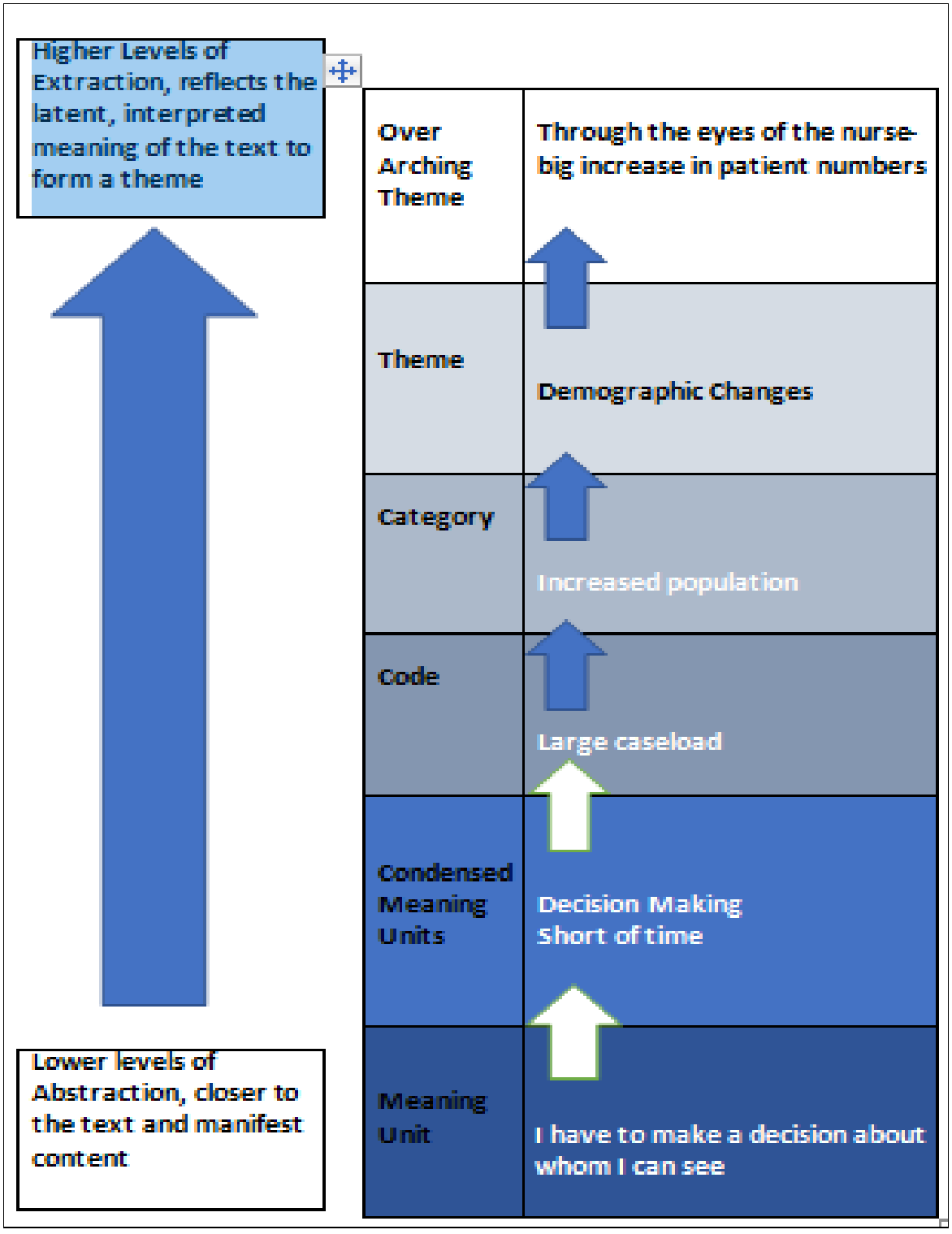


Figure 3.3 Developing a Theme from the Data Collected

Conventional Content Analysis

The specific strategies used to generate meaning were guided by Zucker's (2001) adaptation of Miles and Huberman's work (1994):

What Goes with What

- Noting patterns
- Clustering
- Seeing plausibility

What's There

- Making metaphors
- Counting

Sharpen our Understanding

- Making comparisons
- Partitioning variables

See Things and Their Relationships More Abstractly

- Subsuming particulars into the general
- Factoring
- Noting relations between variables

Assemble a Coherent Understanding of the Data

- Building a logical chain of evidence
- Making conceptual/theoretical coherence

A reduction of data began as similarities were drawn from the data. 'The reduction process includes questioning the data, identifying and noting common patterns in the data, creating codes that describe data patterns, and assigning these coded pieces of information to the categories of the conceptual framework.'(Bloomberg and Volpe 2008:10).

All data was imported into Nvivo software package. The first stage was open coding, where the author assigned units of meaning to codes idenitifed as relevant. As the data was entered into Nvivo, codes were set up for classification. Coding gives an identity to segments or units of data and it allows for cross referencing and tracking of findings back to the original raw data. These codes were then re-

grouped according to the themes they emerged from in the data and the literature. The NVivo 11 software was invaluable in keeping the data in order. As more data was collected, it was also transcribed and coded; it was then re ordered until consolidation of the codes was completed. Validation of the process was ongoing, and new and emerging ideas from the transcribed data were brought to the research group for verification. A sample from the code book illustrating the emergence of codes and subsequent assignment to the main themes is presented in Appendix X.

The second stage of analysis involved the reduction of data by placing the nodes with similar meanings into themes. These themes were arrived at from both an examination of the data and an awareness of the key themes arising from the literature. Each unit of data was then clustered under each theme through a process of cutting and pasting each line from the data base. This process facilitates triangulation of the data between sources. Some units of data were coded using more than one label. Clustering and reduction of data was used by the author until the all themes were identified.

3.15 Triangulation

Heale and Forbes (2013) highlight the need for effective triangulation; Brymman (2016:173) defines triangulation in research as 'the use of more than one approach to researching a question. The objective of triangulation is to increase confidence in the findings through the confirmation of a proposition using two or more independent measures'. Triangulation has been used to compare data from different sources in this study and to corroborate findings. For example, data source triangulation involved comparing and contrasting the meanings established from one data source with another. In this way confirmation of meanings or conflicting of meanings were examined, until an assertion or a number of assertions could be made about the case. In addition throughout each cycle the author has checked the data and findings with each stakeholder group. In terms of dependability, the study outlines in detail how data was collected, managed, coded and analyzed prior to triangulation. This has provided an 'audit trail' and the final step of triangulation is an added assurance to increase confidence in the findings. (Bloomberg and Volpe 2008 :78).

3.16 Research Sequence and Analysis

Completing AR over four cycles can be a complex matter, in an attempt to bring clarity to the sequence of the study and how each AR cycle was analysed the author completed Table 3.6 to explain same.

Table 3.6 Sequence of Data Collection and Methods of Analysis

Cycle	Mode of Data collection	Group Data Collected from	Method of Data Analysis
Cycle 1(A) Exploratory Phase and scoping out of patients views on service delivery/Practice Issues	Questionnaires	101 Patients	Data examined by hand and systematically organised before entering into Nvivo Codes and then themes identified. Using Directed Content Analysis (DCA) Themes reviewed against conceptual framework developed from literature r/v Findings noted and used to inform next AR cycle research
Cycle 1 (B) Further exploring and Consolidating of data on patients views on service delivery/Practice Issues	Focus Group	8 Patients	Data examined by hand and systematically organised before entering into Nvivo Codes and then themes identified. Triangulation of all data Using Directed Content Analysis (DCA) Themes reviewed against the conceptual framework developed from literature r/v Findings noted and used to inform next AR cycle research
Cycle 2 Scoping out causes of practice issues with co researchers(nursing staff/ nursing management)	Focus groups x 3 with Co-researchers	51 participants consisting of 2 DPHN's 9 ADPHNs, 1 PDC 33 PHNs 6 RGNs	Data examined by hand and systematically organised before entering into Nvivo Codes and themes identified. Triangulation of all data DCA used to review themes against existing conceptual framework, some new themes found, further literature reviewed and new themes added to conceptual framework Review of findings Socratic Wheel used to confirm themes and rate importance of these with staff in Focus Groups Focus Groups x 3 1. Socratic wheel used to get agreement from group on naming practice issues 2. Socratic wheel used to rate practice issues in importance of impact on practice 3. Decisions made regarding which practice issues we could influence through using the Tool Tool re-developed for launch in study (Decisions were based on using the Tool to influence issues to improve practice) Findings documented and used to inform next AR cycle research

Cycle	Mode of Data collection	Group Data Collected from	Method of Data Analysis
Cycle 3 Pilot study ran over 8 weeks looked at launching and reviewing the Tool for usability and hone it further for launch in study	Questionnaires Interviews Focus Groups using Socratic Wheel to review themes	Staff from 1 health centre- 7 participants consisting of 1 manager and 6 nursing	Data examined from questionnaires and interviews by hand and systematically organised into themes regarding value of the Tool to staff and to practice Triangulation of all data Using Directed Content Analysis (DCA) Themes reviewed against conceptual framework developed from literature r/v Socratic wheel used in focus group to review themes developed. Socratic wheel used and reach agreement on the uses and the value of Tool Socratic wheel used also to agree what needs to change in Tool to improve its functionality for staff and practice Agreed that an additional document be developed and added to Tool to support and assist novice nurses Changes made to Tool according to findings and Tool launched in study
Cycle 4 Introducing the redeveloped Tool and the additional Document One to a large research group of 51 nurses Study ran over 6 months	Questionnaire Interviews Focus Groups Using Socratic Wheel	Group made up of 51 nurses which consisted of 2 DPHN's 9 ADPHNs, 33 PHNs (including 5 novices PHNs), 6 RGNs and 1 Practice Development Co- coordinator	Data examined by hand from questionnaires and interviews and systematically organised before entering into Nvivo Codes and then themes identified. Focus groups held and Socratic wheel used to consolidate agreement on themes- These examined usefulness of the Tool to individual nurses practice and to improving practice Triangulation of all data gathered Using Directed Content Analysis (DCA) Themes reviewed against conceptual framework developed from literature r/v Findings documented and conclusions drawn Study completed and recommendations made

3.17 Maintaining a research data base and chain of evidence

Consistent with Yin's (2003) advice, the data base for this study contains four main types of data: documents tabulated materials, notes (written and spoken) and reports. These are organised and arranged according to the stage of research and all are preserved and available as part of the chain of evidence.

The chain of evidence is also further defined by the identification and the recording of the research processes used to access clients, also the methods used for data collection, data analysis and identification of findings. This evidence can be traced from the beginning of the study to its conclusions and it is supported throughout the study with relevant documentation.

3.18 Ethical Approval

Ethical approval was sought and got from both Dublin City University and the HSE ethics committee. See same in Appendix F and HSE letter of approval from one of the sites in Appendix G. Ethical issues can arise at any stages of a research process so focus should always be directed at protecting the rights of participants. Such issues should be considered at design stage (Berg, 2004). There was two key concerns in the research and that was confidentiality and consent. At all stages of the research, the author was aware of the need to maintain the anonymity of the participants involved in the research project. Where data is presented and discussed codes were used to protect identity. The author reassured participants that information given would be kept in strict confidence. However, in focus group meetings the author warned participants that she could not guarantee that information would be kept confidential by all participating in the focus group. In terms of consent, all participants gave consent and engaged voluntarily and knowingly in the process. (Plain language Statement and Consent form signed by participants in Appendix I and Appendix J.

The issue of power relationships between the researcher and those participating in the research was also a key concern throughout the research project. The researcher's role as Director of Public Health Nursing may have influenced the response given by participants at various stages of the process. For this reason, the researcher took two years out to complete her research and worked in a position as lecturer with a college at this time. She also chose to do half of the study in the south of the country where it was hoped most staff would not recognise or be influenced by her position as a DPHN. Nonetheless, some participants may have responded positively in order to avoid giving negative comments directly to the researcher who had a vested interest in the initiative. While the author was aware of this possibility, she

was also aware that she was not in a position of power 'over' the participants, in the sense that she was not in a position to influence their employment or the allocation of resources to them. However, steps were taken to encourage honest responses from participants and the author did her best to main high ethical standards in all situations within the research as prescribed by ethical committees and the 'usual' ethical approval mechanisms attached to all studies who seek their approval.

3.19 Gaining Access

Each of the requirements stipulated by the participating CHNs were met and the relevant forms completed. Access was granted to CHN areas for the duration of the project with the caveat that any issues arising or revision to schedules would be discussed and agreed with the departmental heads. See same in letter in Appendix G.

3.20 Limitations of the Research

This was a small piece of research, N=51 as an AR approach was used, but the population is represented fairly and without bias. The data was collected from four separate sources using questionnaires and semi structured in-depth interviews, focus groups and data collected from personnel files. The research methodology was designed to provide triangulation which would highlight consensus of opinions, beliefs and attitudes. While every effort was taken to ensure validity, this is still an interpretation of the findings and although it is a shared interpretation with all who participated, it is still an interpretation.

A limitation was the absence of literature on the subject from an Irish perspective. While there is a lot of international literature, very little is written on the subject from an Irish point of view. It would have been interesting to get a fuller understanding of the matter from an Irish point of view before beginning the research as this would have assisted in framework formation.

Finally, there may have been voices omitted from the research who could have added either greater depth or another dimension not covered in the current data. Unfortunately, I will never know, but can only say that the greatest effort was made to ensure inclusivity for all who might have had something to say within the limited boundaries of this research case.

3.21 Conclusion

An outline has been presented for the author's logic in conducting this enquiry. In addition, there has been an explanation provided for the chosen epistemological stance for the research and the philosophical underpinnings of the work. The study itself, which uses an AR approach explores the influence, if any, the introduction of the Tool has in improving CN practice. The prominent data collection methods used are questionnaires (utilising a Likert scale), semi-structured interviews and focus groups, journal entries and periodic reports as each AR cycle ends.

Cognisance has been taken of the principles of credibility, transferability, dependability, and confirmability of research as suggested by Lincoln and Guba (1985), Cutcliffe and McKenna (1999) and Cho and Trent (2006) throughout the study so as to ensure rigour and trustworthiness. In addition, data analysis has been enhanced by including thick description with multiple coding and respondent validations throughout the study (Meyrick 2006; Cho and Trent 2006). Also, elucidation of Burnard's et al (2008) data analysis framework was used in conjunction with NVivo software package for data analysis. Recognition has also been given to the strengths and limitations of this study and while not all voices were heard, great effort was made to ensure inclusivity for all within the limited boundaries of the research case. Finally, ethical practices have been considered in detail, with great care been given to maintaining the confidentiality of all parties associated with this research. All of the aforementioned elements of the research methodology become more obvious in their application, as we move to the data analysis chapter.

CHAPTER FOUR

4.0 Introduction

This chapter provides a sense of direction for the next phases of the research. The author first introduces the context of the issues being researched, and then examines how the participants were selected and the makeup of the participant groups. Grahams et, al. (2006) Knowledge to Action (KTA) framework is expanded on further, it is the framework through which the study will flow, particularly cycles three and four. Implicit and unique to this research process is the focus on a collaborative approach, which spans the entire research project (Graham et, al .2006).

In cycle one; we begin by assessing patient's perspective on how the nursing service is performing and if the patient has any issues with service delivery. 103 patients completed questionnaires and 8 patients took part in follow up focus group. This data was collated, cross referenced with the patient for accuracy and documented, concluding cycle one.

Cycle two involves another scoping exercise but this time with nursing staff. Focus groups were held with nursing staff and management and they are asked what causes practice issues. The data was collated and then the focus groups were repeated and the data was presented to each group Socratic Wheel used to get agreement from group on naming practice issues to rate the practice issues in importance of impact on their practice and the findings are then documented and used to inform next AR cycle

The two sets of findings from cycle one and two are discussed by the author with the research co-participants. Decisions are made as to which practice issues we are able to influence and improve through using the Tool in this research. The themes chosen are cross referenced against the literature review to ensure we are using best practice. This learning is then applied to 'the Tool' to improve it for application to nursing practice. The Tool is then ready to be used in the pilot study. Cycle three is the pilot study and cycle four is implementation of the Tool and these cycles are located in chapter five and will be discussed then.

4.1 Context

CN like all other areas of nursing has suffered a severe depletion in staff numbers (Directors of Nursing report, 2011; Phelan and Mc Carthy, 2018). In addition to staff shortages, work demands have intensified with an increase in population, earlier hospital discharges in addition to more complex cases being nursed at home (Coffey 2017; Nic Philibin et.al, 2010; Phelan and Mc Carthy, 2018). Due to a contracting economic system in Ireland there has been a rise in the population entitled to medical cards and community nursing services (National Directors of Public Health Nursing and Shannon, 2015). All of these have placed a significant burden on community nursing and it has led to a prioritisation system within community nursing services (National Directors of Public Health Nursing Subgroup, 2015). In addition there has been evidence in recent studies of missed care occurring and there has also been a rise in legal cases (Ball et. al, 2014; Scott, 2014; Ball et al., 2018). Several investigations and inquiries have been carried out to investigate what has led to these incident's (Government of Ireland, 1997, Department of Health and Children, 2006, Health Information and Quality Authority (HIQA), 2008) . While some of these may have been due to a more litigious minded public, it is reasonable to assume that many are undoubtedly due to practice issues caused by reduced staff levels and an increase in caseload size. Nurses are under severe pressure and stress levels are raised, they need support. All of these issues are leading to poor practice delivery with decreased job satisfaction and staff leaving the service.

Against this backdrop the author has developed a set of documents (the Tool), which it is hoped will improve practice, give access to continuous professional development (CPD) , support staff and lead to better patient care. However, these documents have only been developed by the author and they need to be introduced to staff to view them, refine them, pilot them and use them to determine whether they are effective or not. The author chose a Participative Action Research (PAR) Model as the approach to use to look at the causes of practice issues and examine if the Tool can bring changes to CN practice for the better. To begin with the author needs to recruit co-participants for the research.

4.2 Recruitment of Co-participants

It is essential to explore nurses' first-hand knowledge and experiences in order to create knowledge and social change for them (Hampshire 2005, Fine et al. 2001). A requirement therefore was to recruit a set

of co-researchers who could assist with this process. In research staff need to volunteer, so this prevented me from approaching staff directly. Emails and posters advertising the study were distributed and information packs were available in all primary care centres. Information packs contained an introduction to the research, a plain language statement about the purpose of the research and a consent form to sign if participating in the research (see Appendices 8-10). Also enclosed were my contact details so that staff could contact me directly if interested. A mix was required of RGNs, PHNs and nursing management so that the group was representative of the community nursing (CN) service. In addition, the author sought to have both mature career PHNs and novice career PHNs as she believed they differed in how much support they needed how they perceived practice issues. 51 staff took part voluntarily in the focus groups and it was carried out in 3 different CHNs with a mix of urban and rural staff. Overall the research group was representative of CNs in its skill mix and nurses work location. The participants were divided into four groups Table 4.0 below shows the makeup of these research groups.

Table 4.0 Make-ups of Focus Groups

Group 1 (Management) 11 Staff	**Group 2 (Nurses) 11 staff**
2 x DPHN's **9 x ADPHNs**	**8 x PHNs (6 expert PHNs over 6 years qualified /2 Experienced PHNs 3-6 years qualified)** **2 x PHNs (Less than 1 year qualified)** **1 x RGN**
Group 3 (Nurses) 18 Staff	**Group 4 (Nurses) 11 Staff**
10 x PHNs (6 expert PHNs over 6 years qualified **4 Experienced PHNs 3-6 years qualified)** **5 x PHNs (Less than 1 years qualified)** **3 x RGNs**	**1 x Practice Development coordinator(For Consultation)** **5 x PHNs (Over 3-6 years qualified)** **3 x PHNs (Less than 1 year qualified** **2 x RGNs**

The author decided to separate management from nursing staff when examining the topic of practice issues, as it is a subject that can vary greatly between both groups. Also it was felt that nursing staff may believe their issues emanated in management and vice versa. By dividing the groups, participants would

feel more comfortable expressing their views among their peers, whom they felt possessed similar beliefs or views as them (Robinson, 2020).

4.3 Grahams et, al. (2006) Framework Cycle

Grahams et, al. (2006) Knowledge to Action (KTA) framework, is the conceptual framework being used in the study and each cycle will follow this framework. This framework was chosen by the author having worked in both practice and academia, she has witnessed first-hand how researchers and practitioners see themselves as being very different to each other with distinct cultures and perspectives on research and knowledge, with neither group fully appreciating the other's job, this is referred to as the 'two-communities theory' Graham et al (2006).This has led to much research never getting implemented The author supports Graham et al (2006) view on this and she believes that if practitioners become involved with research, it has a much greater chance of being implemented . In an attempt to break this cycle of the 'two-communities theory', the author, using Graham et, al. (2006:14) Knowledge to Action (KTA) framework, set out to assist both communities to work collaboratively together to find new ways of improving CN practice. This framework operates by transferring knowledge from the academic setting to the practitioner, and from here, the practitioner implements it into practice. It bridges the theory practice gap and gets practitioners using theory to improve their practice. Graham et, al. (2006) framework is used in all cycles and it is made up of eight stages

1. Identify a problem that needs addressing
2. Identify, review, and select the knowledge or research relevant to the problem (e.g., practice guidelines or research findings)
3. Adapt the identified knowledge or research to the local context to formulate a plan to address the problem and outline the steps to be taken
4. Assess for barriers
5. Tailor, and implement the action plan
6. Monitor the implementation of the action plan
7. Evaluate the outcomes and discuss the findings
8. Make recommendations for next cycle

4.4 Cycle One

4.4.1 Identification of A Problem that needs Addressing

There is a growing consensus among community nurses that they are finding it more difficult to maintain and deliver a safe, effective and quality nursing practice. The rise in practice issues has led the author to develop a Tool in the hope of giving community nursing staff an opportunity to reflect on their practice and seek support, advice or guidance with clinical issues in a timely fashion. The Tool also provides a link to CPD for maintenance and updating of competencies for future service delivery and encourages staff to look at developing a career pathway for themselves It can also be used to develop a plan of action for implementation to resolve clinical issues. The Tool was developed to improve practice and lead to better outcomes for staff, patient and organisation and it is to be introduced through this research.

To do this the author chose an AR approach, as this is the only research method that actively involves staff in the research process, offering them the opportunity to change and improve their practice. While all research aims to generate knowledge, the focus of AR specifically, is the production of knowledge that is directly relevant to peoples work and their lives' (Waterman et al. 2001:54) and it sets out to problem solve, change and improve their work conditions. The research asks :

Does the Tool

1. *Assist with early recognition of work issues and /or contribute to timely identification of work situations where staff are in need of support.*
2. *Prevent escalation of issues and lead to better outcomes (like more prompt correction of issues leading to better client outcomes, increase in staff wellbeing, more job satisfaction, better staff retention and a reduction in the risk of litigation).*
3. *Give nurses the time and space to plan for their CPD, their competency building and career development.*
4. *Assist in improving practice?*

While the Tool may not be a panacea, it is hoped it will improve practice in CN.

4.4.2 Need for Patients input

(Nelson et. al, 1998: 881) believed as a professional carrying out research 'we don't have the personal experience of what it is like to be a recipient of our service, nor do we know what it is like being a patient trying to navigate our service as someone who is debilitated through disease or old age ' They spoke of healthcare professionals considering themselves' to be experts with expert power carrying out research, but having an inherent weakness in their research unless they involve the patient' they state 'Nothing about me without me' (Nelson et. al, 1998: 881). They promote the use of the PAR approach to research, as it involves the patient and their opinion. The author agrees with Nelson et al., (1998) approach to research and in cycle one she tries to emulate this approach by involving the patient and asking

'Are patients satisfied with current nursing service delivery and if not, in what areas do issues exist and what suggestions would patients make for improvements to the service. '

4.4.3 Recruitment of Patients

In the author's area, every patient who was seen by a nurse or a health care assistant was offered a questionnaire to complete. This survey ran for 6 months. The questionnaire used is Document Four (Appendix D). Patients could also access the questionnaire in waiting rooms in primary care centres. A locked box was provided to post the completed form into, and ADPHNs collected these and returned them to the author. Patients did not need to sign their name and could remain anonymous if they chose to, however they were asked which area they lived in so as any local issue could be identified. If patients preferred, they could also return the forms by post directly to the author and address was supplied. This also made it easy for the patient to have the contact details of the author (who was DPHN at this time) to discuss issues if they wanted to. In an attempt to access all age groups, forms were offered and distributed at wound care clinics, school screening clinics, child welfare clinics and breast-feeding support groups.

The author visited clinics during this time and 8 patients volunteered to attend a focus group at the clinic and discuss how they felt the nursing service was performing from a patient's point of view and also to explore if there were any issues that needed addressing.

4.4.4 Research Methods Used

Questionnaires were given to all patients that staff came into contact with over a six-month period and 103 were completed and returned. These came from various services within community nursing, such as primary care centres and wound clinics which have a predominately-older age group. Child health clinics and breast-feeding support groups were also involved, and these were mainly younger women who attended with their babies. The school's immunisation teams, audiology and vision services were also included in the questionnaire distribution and this service compromised of parents of school going children. The final group included were the young chronic sick and while their age group can be mixed, they were all aged under sixty-five years. Thus, mixes of all age groups were included in the study but the majority were parents of young children or older patients aged seventy years and over. This is in keeping with the age groups most commonly seen by CN, and the ratio of men to women involved in the study as 38% to 62% which is also in keeping with the profile of CN clients.

4.4.5 Observations Made During the Research

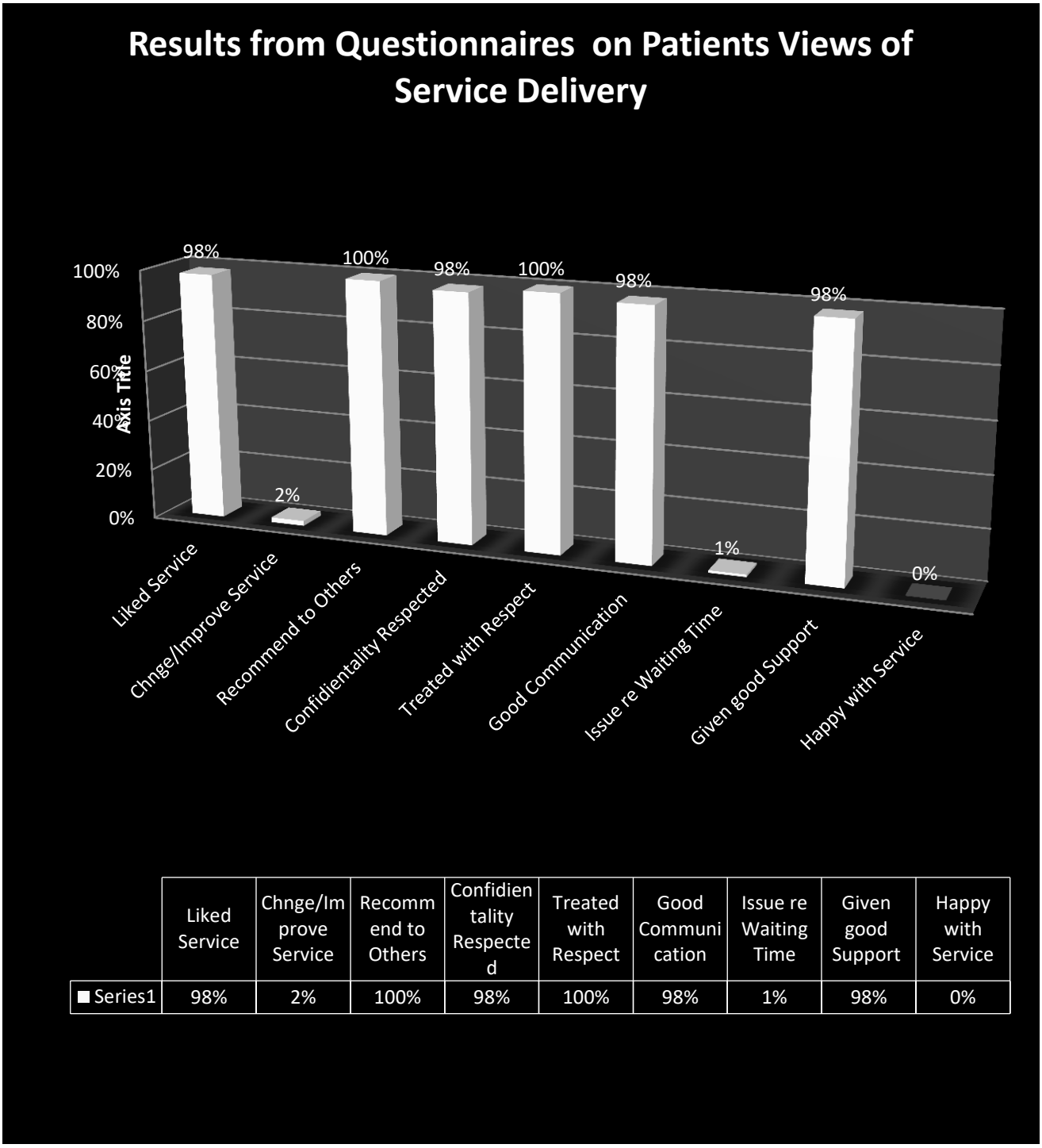
There were some interesting general points which the author observed while carrying out the research and going forward, these should be noted for future research in CN. These included older people are less vocal than younger people when it comes to expressing their views on paper or orally even, when they find short comings in a service. Ordun (2015) spoke of these generational differences when it came to complaining and he noted that older people are much less likely to complain when a service fails to reach their expectations. Also observed was that while all age groups wanted to see the same nurse on a regular basis, generally speaking older people were more prepared to wait longer to see that nurse, whereas younger people appear to have less tolerance for waiting and are happier to take the first available appointment. This is also in keeping with previous research by Sharp and Hamilton (2001) and Waller and Hodgkin, (2001) who spoke of highest levels of intolerance to delay at appointments being more prevalent in age groups 15- 39 years, and that this is due to the fact that they had busy lives and often have difficulty in getting time off work or re arranging childcare to attend appointments. These reasons also partly explain the peak age range of 20-30-year olds as our highest group of non-attenders at our clinics overall.

4.4.6 Findings from Patients Questionnaires

When the questionnaires were examined most clients spoke highly of the staff and the service, with very few making negative comments about staff. However quite a few made comments on the facilities and they made suggestions for improvements. For example, the survey was carried out over a summer period with very warm weather and many commented on the need for better ventilation in the centres and the need for water coolers in waiting areas. Other comments came from younger clients and their mums who spoke of not having a TV in the waiting areas which could amuse children when there was a delay. Overall, though, the author obtained a lot of evidence from the questionnaires that stated what was going right but not so much evidence on what we could improve. See Figure 4.0 on next page. For this reason, she decided to visit the clinics and asked for volunteers from patients to take part in a focus group about the nursing service to investigate further if there were any issues.

4.4.7 Focus Group for Patients

Eight patients agreed to take part in a focus group and this produced much richer evidence of how we were performing as a service. The author used a small prompt sheet to assist with discussing the issues and themes, which emanated from data collected in the questionnaires. The profiles of the clients involved in the focus group were four over 65 years (2 men and 2 women) and two mothers (of infants) who were both aged in their late 20's and two patients who suffered from a chronic illness (One man, one woman) one in her forties and the gentleman was in his fifties.



	Liked Service	Chnge/Improve Service	Recommend to Others	Confidientality Respected	Treated with Respect	Good Communication	Issue re Waiting Time	Given good Support	Happy with Service
Series1	98%	2%	100%	98%	100%	98%	1%	98%	0%

Figure 4.0 Results of Questionnaire on Document Four Patients View on Service Delivery

4.4.8 Findings from Focus Group

- When it came to service delivery two older clients spoke of the inconvenience of having to attend the clinic. In recent years and in an attempt to save time and get to see more patients, nurses have increased care delivery from the clinic and now it accounts as the site where one third of patients care is delivered (Pye, 2020).

  'We liked when the nurse called to the house, it saved all this inconvenience of calling to the clinics especially in poor weather'.

- While two of the four older clients liked the nurse calling to their homes they still mentioned that they liked visiting the clinics for the social aspect of the visit.

  'I catch up on all the news and now that I know all the regulars, myself and a neighbour walk up together and sometimes we even go and have a cuppa after the visit'.

  So, it appears that they have formed their own social network from clinic visiting and they spoke of enquiring about anyone who did not turn up to know if they were well.

- The younger mums on the other hand did like calling to the clinic as they found that this left their day free thento go out and not worry about missing the nurse. Also, they liked having a 'drop-in' baby clinic between 2 and 4 as they could fit this well into their schedule. However, one of the mothers felt

  'That the clinic is always on the same day each week and that this means taking the same day off work and this did not always suit - there needed to be more choice in days that the clinic was available'.

- Another interesting comment a chronic illness client made regarding home visiting being reduced was that they felt they could discuss things better in the home environment and that they were more restricted time wise and felt reluctant to discuss confidential matters at a clinic.

  'When the nurse calls to me at home, I can discuss problems that I'm having with her, here they are so busy, and you can't really say too much as there is only a curtain between you and the next patient and everyone would know your business'.

I did ask the lady would she seek advice or report an issue if she needed to because she was attending a clinic for treatment as opposed to home, but she said

'I would eventually seek it, but it is much more of an effort to ask the nurse could I speak to her in private'.

- When this comment was made, two other older patients also agreed that the clinic lacked privacy and the "personal touch" of seeing the nurse in your home. Also, it lacked time dedicated to listening as the nurse was too busy. . The younger patients did comment about this also saying

  'When visiting the clinic, I feel rushed and unable to discuss everything as other patients are waiting. Also, there is a lack of privacy'.

- When we discussed time and staffing the patients felt that the nurses did not have much time anymore for enquire about or discuss patient's wellbeing. Also the patient felt the nurse prevented issues escalating. When I asked why they felt this, one gentleman gave the example about his wife's case. He said

  'The nurse used to call to our house regularly, she sorted things for her before problems occurred but when my wife's needs grew, she was referred to home care packages for care…we miss our nurse, it's not the same, we don't see her much anymore. She looked out for us and advised us and she made life easier knowing where to go before things went wrong. Now you only see her when thing have gone wrong '.

Due to staff shortages a lot of care required in the community has been given to outside agencies. The other three older patients and one chronic sick patient agreed with this statement also, they felt that they did not see as much of the nurse now that the patient was being cared for by a home care package or the home help service. The strongest comment regarding this change in service came from the two older patients who said

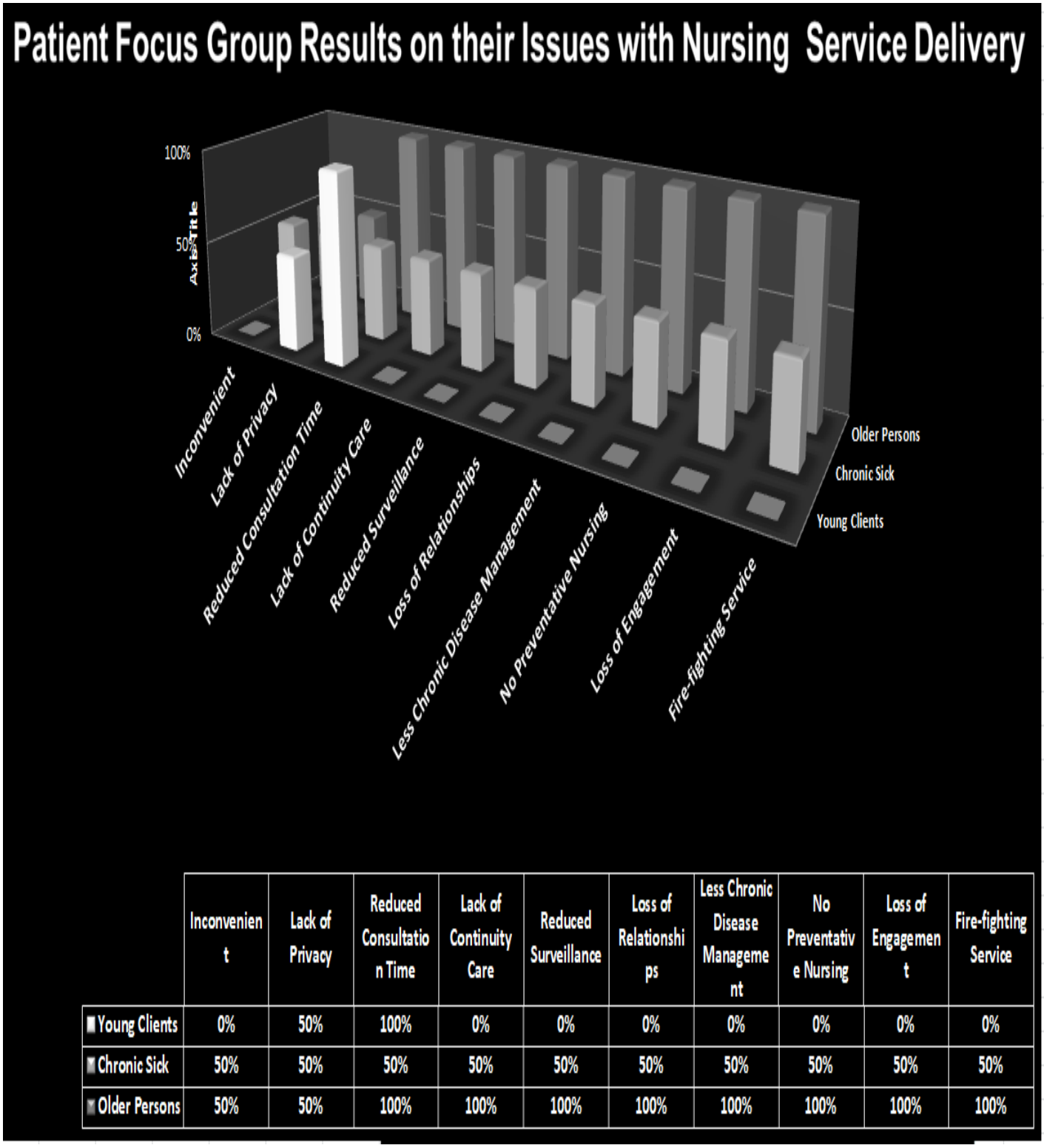
'the nurse used to call on a regular basis, this has all stopped now, she informed us she was not able to call unless there was something wrong or we needed something. She used to keep an eye on the ulcer or helped us with our medical referrals or applications or got us equipment when we needed it like the raised toilet seat. Nowadays it seems you need to be in hospital to get to see her. It used to be a great service, she was always there and we knew her well and she knew us'.

Health promotion, particularly surveillance of the elderly was a big part of CN in the past, however due to staff shortages and time constraints this has now stopped in most areas (Phelan and Mc Carthy, 2016).

Health promotion includes health risk assessments; implementation of risk reduction strategies for individuals and communities; health education and counselling for patients, families, and groups on chronic disease management; and assisting patients and families to interpret and assess health information and the use of technologies to improve their health' (Zenzano et al., 2011;263). Health promotion is a primary component of CN practice and it is one the most important tools in the CN tool bag. However, due to time constraints and staff shortages, this role has now been eroded, so disease management is reduced, acute episodes have risen and cost to the state and the individual has increased significantly (Zenzano et al., 2011). A major challenge facing CN today is how to bridge this gap. However the summary of this situation is best portrayed through the final comments of a client in the focus grou, speaking about the lack of health promotion and surveillance service presently in CN. She said

'At least we knew our nurse, many younger patients do not and I wonder who sorts their issues out for them when the need arises.'

All the older patients and one chronic illness patient agreed with this comment. The patient focus group findings are to be found in Figure 4.1 on next page



	Inconvenient	Lack of Privacy	Reduced Consultation Time	Lack of Continuity Care	Reduced Surveillance	Loss of Relationships	Less Chronic Disease Management	No Preventative Nursing	Loss of Engagement	Fire-fighting Service
Young Clients	0%	50%	100%	0%	0%	0%	0%	0%	0%	0%
Chronic Sick	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Older Persons	50%	50%	100%	100%	100%	100%	100%	100%	100%	100%

Figure 4.1 Patients Issues with Nursing Service Delivery

4.4.9 Tailor the action plan

When the author and the co-researchers examined the data, all patients noted the lack of time available for consultation in the clinic setting and the lack of privacy. However it was the older person who seemed to be impacted upon most, by the CN s new way of delivering care. They appear to feel that the reduction in time available to them due to poor staffing, has led to a loss of continuity in care, reduced surveillance visiting, damaged valued relationships and led to a lack of early interventions in chronic illness management (Zenzano et al., 2011). The author and co-researchers discussed this matter, it was agreed by all, that things were not satisfactory for patients and while we cannot produce more staff, we should look at the skill mix and how we deliver the service in the future. This was agreed by all and it was felt that the most appropriate approach to this issue would be to

A. Develop an appropriate skill mix to meet clients' needs
B. Attract and retain staff

A. Developing an Appropriate skill mix to meet Client Needs

There has been as much as 9.4% rise in population in the last 10 years nationally (CSO, 2016). This should have brought a similar and appropriate rise in staffing rates, but this has not been the case (NMBI, 2020). There are two main reasons for this, firstly cost containment in public services and secondly there are no extra staff available to fill these positions due to nurse shortages, however, looking to the future, the Government now plans a new way of delivering healthcare as advocated in the Sláintecare Report (2017). This will bring new CN roles to meet the need of older persons and chronic disease management at community level. The appointment of Consultant Doctors, Advanced Nurse Practitioners (ANP) and Clinical Nurse Specialists (CNS) to various areas of community nursing such as diabetes, cardiac and respiratory conditions and older persons. These specialist roles will work between the acute and the primary care setting in what is termed an 'integrated approach' to care delivery. This means these specialist nursing staff will spend up to 80 percent of their time in primary care with 20 percent spent in the hospital setting. This will link the two services closely together and allow for care delivery in the home with access to acute hospital consultant during an acute episode or exacerbation of the condition without admission to hospital (Sláintecare Report, 2017).

These new specialist posts of CNS and ANP will bring care back to the patient again in the primary care setting. Staff will be established local clinics to review client health and meet and work with local

groups of patients ensuring their health needs are being met locally. (Sláintecare Report, 2017).It will return the "personal service delivery" to the patient with close-by consultation available on request from experts in the area. In addition, investing in this new way of delivering healthcare will bring health promotion and preventative medicine back to CN, which in the long term, will improve healthcare delivery, reduce costs and improve outcomes due to earlier and more appropriate health interventions in disease management (Sláintecare Report, 2017).

B. Attract and retain staff

From the view of attracting and retaining staff, these new posts (CNS, ANP) offer staff a new career pathway, which has been lacking in CN for many years, particularly for RGNs. Better career pathways lead to more job satisfaction for staff and this leads to improved nurse retention rates and better patient care (Aiken et al., 2009 and Batista-Taran et al., 2018, Prado-Inzerillo et. al 2018 (2009).The group felt that this was a win-win situation for both the nursing staff and the patient ensuring better care delivery.

4.4.10 Making Recommendations for Future Cycles

Both developing new posts and ensuring an appropriate skill mix are two areas that attract and retain staff and both need to be incorporated into the Tool. In addition to encouraging staff to stay with an organisation, these new posts would also bring delivery of healthcare nearer to home for patients and return the continuity of service that patients seek. Also, these CNS and the ANP grades will give a lot more scope to extend career ladders to all grades within the CN team.

The second part of the scoping exercise now begins in cycle two. This examines what staff believe predisposes or causes practice issues for them and how could we assist staff to reduce or prevent these occurring.

4.5 Cycle Two

In cycle two, the author and the nursing staff met in focus groups to scope out practice issues and asks do they occur and if so, what predisposes or causes them? The data is collected from four focus groups, it is then examined, themes identified and these themes are then presented back to the focus groups to confirm accuracy of findings. The Socratic wheel is then employed to rate the causes of practice issues for staff (rated 1-5, with 1 being not relevant and 5 being the most applicable). When the theme identification and rating is concluded, the author presents the overall findings back to the groups. The findings are examined in tandem with the findings from the literature review, which looked at ways of preventing practice issues and improving practice. The group work collaboratively on both sets of data to select methods that could be introduced to reduce or stop issues occurring. These methods are then added to the Tool, in its final development stage before piloting it in cycle three.

4.5 .1 .Identify a problem that needs addressing

The author and co-participants continue the scoping out of the problem; to identify if practice issues exist in CN and if so, what is the causes of them.

4.5.2 Identify, review, and select the knowledge or research relevant to the problem

The author began the research by assembling focus groups to scope out the issue. When the focus groups began, the author allowed staff to speak freely but an effort was made to keep some control over the direction that the group took. The purpose of this was to obtain the data required for the research (Ward and Delamont, 2020). However, in an attempt to keep the groups somewhat focused, the author developed and used prompt sheets, one for nursing groups and one for management and these can be found in Appendices N**.** The author followed the guidance provided by Stewart et, al. (2007:13), who stated that the role of the facilitator is to encourage group discussion by participating with only 'occasionally clarifying or using directional questions' to keep the discussion moving ahead. In addition, to noting key words and phrases, an audio recording of the focus groups took place to help capture the main ideas.

4.5.3 Nurses views of what caused or predisposed them to practice issues

Initially the author asked had anyone witnessed practice issues. All staff (100%) identified that they had witnessed practice issues. When it came to considering what caused these issues there were several reasons.

4.5.3.1 Lack of time for support of self and others

Staff reported they had very little time to support each other or to support new staff adequately. This theme ran throughout every level of the organisation. This was very much in keeping with the literature review. Staff spoke of nurses in their everyday practice facing unique and complex situations, which posed difficulties for them, particularly novice staff. Therefore they needed assistance and guidance to lead them through these situations and to learn from them and then they could bring this new knowledge to their future practice (Benner, 2009). Due to time constraints nurses all reported a lack of giving or receiving support at all levels. They said

'We used to be able to discuss a case when we needed advice, now it's all rushed and we can hardly talk to each other. I really feel sorry for the new girls as they are really under pressure, they get thrown in at the deep end and they should have someone to help them'.

The author found in the literature review, that supportive relationships are the key to establishing supportive work settings, places where people want to stay (Mills et al., 2007). This is an essential ingredient in retaining staff, yet staff were reporting that there was no time at work to support staff. The novice nurses interviewed agreed with this and spoke of

'Feeling overwhelmed, and only when I ring another 'newbie' like me do I feel I'm not alone, we are all struggling here together to stay afloat. ... Some days I wonder will I stay, a lot of the time I'm so stressed and then when it's going well, I'm fine'.

We can see from these exerts from the transcripts that staff are very stressed by not having any definitive support structures in place, particularly the novice nurses. It was evident from the novices input in the focus group that they required more support but staff did not have the time to give it. Armstrong et al. (2009) advocated that nurse managers need to maintain constant visibility and be available to support them, listen to them and their concerns and assist them with solutions. There needs to be a consistency in this support and assistance for staff (Armstrong et al., 2009). This support and direction from managers is a necessity to delivering improved, safer healthcare as well as improving staff retention'.

In addition to novice support and colleague support, the team felt they were losing the 'feeling of team'.

'While we all get on great, there is less and less time for fun or craic or socialising at lunch. We are so busy we often work through lunch and grab a bite in the car somewhere. You need a bit of fun though to survive in this job and it's getting harder to find this.'

While nurses have steadily increased their workloads, it now appears that they have reached capacity, and are starting to burn out and need support. In recent research it has been found that employees who are supported in their work place, develop job embeddedness, have more job satisfaction and commit to the organisation and remain with it (Borah and Malakar, 2015). If we are to improve retention rates we need to utilise this information. We need to understand and replicate it, to give employees a sense of belonging and involvement and a feeling of being valued enough to want to stay (Borah & Malakar, 2015; Holtom & Inderrieden, 2006). The DPHN's and the ADPHNs also spoke of the need for support too. The ADPHNs felt they have a difficult job trying to support staff under pressure and they asked

'Who supports us? The DPHN is so busy, it is difficult to get to see her sometimes, I get most of my support from colleagues. You have to have a good relationship with colleagues as there are days when you really are in need of support yourself, when staff are under pressure and take their frustrations out on you'.

The DPHN's seemed the most isolated of all. They spoke of having no DPHN nearby to go to, they did telephone colleagues for support but a face to face meeting meant travelling considerable distances. They spoke of

'Having limited support from other heads of disciplines but they don't understand nursing like another DPHN does. It is difficult; DPHN's really need to be resilient. While DPHN meetings help to support us and we do email queries to each other in between meetings but nothing replaces face to face contact for support.'

Often in organisation's when we speak of burn out, we are speaking of front-line staff, but here we were hearing from nursing management, they too were suffering from burnout. Laschinger (2004) and Spence et, al. (2009) spoke of this. Laschinger (2004) found 58% of nurse managers have some degree of burn-out and need ongoing support. Here in CN in Ireland the author found very little written about burnout in Directors of Nursing (DON). Given the current climate in healthcare, there is a need to ensure that nursing staff at all levels, including DONs, work in environments that foster high quality supervisory and collegial working relationships. This ensures that these highly skilled nurses remain engaged in their work, stay with the organisation and that adequate resources are in place to support them in today's chaotic health care settings.

4.5.3.2 Lack of Time to Complete Duties Adequately

All staff spoke of the lack of time to complete their duties properly. Due to staff shortages, they often end up cross covering two areas. To use an example from the transcript for this theme one nurse summed it up well when she said

'I had been cross covering two areas, I felt unable to give an adequate service to either area. For example, I had a terminally ill patient and the family felt I could have called more. I met the family later and they said in the end, he deteriorated rapidly between my final visits, but I knew if I had been in a position to have called more often, I would have seen this sudden and rapid decline myself and increased my visiting '... ' I felt guilty and I left this area of nursing shortly afterwards, I did not want to deliver

this type of service anymore, letting patients down, particularly terminally ill patients that needed me, so I decided to work with the immunisation team'.

This was a very good example of how the increased workload in PHN s has led to missed care. Missed care is now appearing in many areas of CN due to the vast increase in workload and the scarcity of staff (Phelan et. al, 2016). Practice review assists staff and manager to examine practice together and to prioritise work, thus helping to reduce the risk. While it may not be possible to avoid all missed care, reducing the risk, does improves practice.

4.5.3.3 Lack of Time to Reflect on Practice

Other nurses spoke of nursing staff no longer having time to discuss or look at best practice or attend study days. This leads to staff not keeping up to date with best practice. This is becoming more difficult as caseload sizes increase and staff spoke of

'Being so busy doing I don't have time to stop and think I often feel I could be doing this better or differently, but I don't have time to check it out. I hardly go to study days anymore as it is too much of an issue trying to get away. Even coming here today has put serious stress on me but I wanted to say how difficult it is for us and I hope you will say it for us.'

While carrying increasingly larger caseloads gives the nurse great scope, it also brings with it the need to be an up to date competent practitioner at all times and in all things (Brady et al., 2004; Coffey et al. 2017). Day on day, this role is being added to and expanded further, and more skills and competencies are required. In addition, early hospital discharges of new and more complex cases have added to the workload as medicine advances. The author believes there is a need for case review through reflective practice on a regular basis to assist nurse's deal with clinical issues. ADPHNs and DPHN's agreed with this view and they also felt reflective practice should be introduced. They believed it was

'A good way of discussing case management and practice issues with staff. I think though that staff might find it difficult to make time for it at first, but if they tried it, I think they would see the benefits of it and see how useful it was to them to improve their practice. '

Reflective practice can be a transformative process that changes how individuals' practice for the better. It is an examination of nursing experiences in order to look for different or better alternative approaches to practice (Howatson and Jones; 2010). It opens the mind to viewing how we practice and what alternatives are out there which could improve practice (Johns and Freshwater, 2009).

4.5.3.4 Poor Skill Mix and

In the focus group's nurses spoke of poor skill mix. There were two aspects to poor skill mix

1. Staff not being replaced by similarly qualified staff

'When staff are replaced, by agency staff who are not the same grade eg PHN then they are limited in how they can help, and while all help is welcomed, they can only work in certain areas of nursing and cannot complete all clinical work like child welfare visits. This then has to be completed by staff cross covering an area. So on paper staff seem replaced, but in reality this is not the case'.

And

'You need to replace like with like, if you don't, the patient loses out as they don't get the service. So, no service or reduced service is getting more common place. '

2. Continuous turnover of staff with novice staff in Dublin area transferring out eighteen months post training when they had worked the obligatory post training term in the area that trained them. These were replaced by another newly trained novice and the process began again. Staff spoke of being tired of spending a lot of their time training new staff, only to lose them and as soon as they were trained and competent, they moved to a job nearer home outside Dublin. They said

'This constant training and loosing of staff has me burned out. This constant changing leads to staffing an area with inexperienced nurses on an ongoing basis and we as older staff are expected to do our own work, keep an eye on the younger nurses and train the novice. Maintaining good practice is very difficult in circumstances like these. Staff are just competent when they leave'

It does appear to be a real issue in the Dublin and some surrounding areas where there appears to be a constant stream of training staff leaving for other areas. This leads to poor skill mix with higher risk of poor practice. The DPHN's as a group used to control the transfers and the recruitment of staff for their areas, but this has now been taken over by HR and all staff spoke of this not being as successful now as when DPHN's controlled it, particularly the staff transfers. Dublin and some surrounding areas in particular appeared to be in constant flux due to staff shortages. Having adequate staff and good skill mix means retaining more experienced staff, who have attained job mastery and can deliver better care with fewer errors (Waldman, 2006). Staff experience also leads to increased productivity as they perform quicker and more efficiently and effectively (Waldman, 2006). Staff retention benefits the patient also, as there is more continuity in care; delivered by more experienced staff, leading to better care delivery (Waldman, 2006). This was not the case in these areas, where replacing staff was a like revolving door as soon as they entered other left and in addition they never appear to reach full staffing capacity.

4.5.3.5 Care Complexity

Nurses also spoke of complex cases being discharged home. One nurse spoke of having a complex child discharged home into her caseload and the child's parents needed a lot of support initially as the child was quite ill and had a home care package, but the hospital had informed them that

'The PHN will call daily and support you despite the fact I was covering my own area and cross-covering another area. These are complex cases and I feel we need more staff if we are to meet needs like these. Without adequate staffing, it increases the risk of poor practice'

The DPHN's and ADPHNs agreed that there is an escalated risk attached to complex case management and staff shortages and it predisposes to practice issues. Also, specialist posts are needed to look after these cases safely as they are quite complex and to date most areas do not have this post , nor funding for it. One ADPHN also spoke of hospitals being under pressure to empty beds.

'*When the hospitals contact me regarding a complex case for discharge home and I inform them that I cannot meet the need due to a staffing issue and I need time to get a package of care organised, the hospitals will not accept this and they resort to putting pressure on our managers or using political clout through politicians, to get the patients home, We are reaching a crisis point for all, with risk increasing all the time, particularly now as nursing agencies don't have nursing staff.'*

4.5.3.6 Rationing of care

Staff spoke of rationing of care in some areas. They felt they prioritised patients according to need. When I asked for an example, they stated that they used to visit all discharges but now

'I ring them and if I feel they are coping well and have good recovery and have adequate supports in place then I don't visit, however I do give them my contact details in case they need me. But I would still like to visit them like I used to do, that way I know they are alright.'

They also spoke of no longer visiting older vulnerable patients

'I don't have the time anymore to visit them, I really loved this part of the job and I miss it. This is poor practice at its best; we used to see those little changes in them and step in early before it became an issue.'

One DPHN also described how through rationing of care they have omitted health promotion and preventative medicine from their agendas as they hardly have enough staff to cope with the day to day essential calls. One DPHN described it as

'The loss of these services and the rationing of care has left us continually 'firefighting'. I feel we are downstream pulling people out of the river, when we really need to be upstream, stopping them jumping in. We are always in crisis. We don't see patients unless there is an active issue'.

4.5.3.7 Dependency growing on outside agencies

The ADPHNs spoke of when a nurse takes leave, they have to assist the remaining staff to look at the calls so as they can decide what calls to prioritise and whom to cancel. ADPHNs also spoke of how in recent years they have had to change service delivery**,** set up local clinics at primary care centres where patients can call in for their dressings and injections to minimise travel time. However, they stated

'Not all patients like this but by reducing time spent on travel we can use it for more face to face contact with the patient. You have to be ingenious in this job reinventing yourself and the service all the time if you are to meet the needs and minimise risk. However, it is getting more difficult to keep operating at a safe level. We do see errors appearing more often now and sometimes care does get missed. In recent years, I think we are becoming more dependent on outside services like home care packages to cover cases we can no longer cover, so nurses are seeing the patient less , can this be good for patient care?'

Other nurses agreed with this and spoke of worrying because they had no time to call to see these patients and review their home care package care for effectiveness and examine patient care delivery.

'I have introduced myself and I call as often as I can, but I am still hoping either the family or the agency will tell me if something is wrong. The maddening part of this is that HSE pay large amounts of money to these agencies and if they would only employ more nurses, we could deliver the service ourselves for less and see the patient regularly. It's worrying, you are afraid something may be wrong, and you won't know until it's too late or worse again a legal case'

4.5.3.8 Demographic Changes

The author had not expected this theme to arise as it had not arisen in the literature review. Demographic changes seem to have affected more urban rather than rural areas. There was a mixture of agreement from the urban centres, but the rural centres did not necessarily see it as an issue.

'There has been a shift in the demographics of the area where I work. Twenty years ago, when I started here, there were very few non-nationals in the area, now they make up thirty percent of my child welfare

caseload. On top of this, my caseload size has grown also, it's now one and a half times bigger than when I started out and still no more help despite me constantly asking'.

The nursing management also agreed with this view and spoke of their caseload numbers having increased dramatically during the last ten years in particular. They also spoke of no extra staff being supplied to meet this need, nor were there any additional resources given to areas of high density of non-nationals other than the usual services. They described it as

'Staff are expected to continue to meet an increasing need with fewer resources. We have wasted more paper making representations on behalf of staff, but it falls on deaf ears'.

4.5.3.9 Leadership

Leadership was an interesting theme as here again the novice nurses differed to the experienced nurses. All the novices needed leadership in their practice and it was supplied through their line manager or a senior colleague usually who supported or advised them or was available in a crisis or when an issue arose. One novice said

'I can ring her and she guides me, she is always there for me. I would be lost without her advice.'

The more experienced nurses saw leadership in a different light, with less than 40% seeing leadership as important to practice issues. The author felt these experienced nurses worked well on their own, they were not adverse to leadership, but they only sought it when they needed it. Due to their own experience, they were not as dependent as the novice. One nurse said

'I feel we deal with our own issues, I can seek their (management) support and help when I need it, but mainly I deal with issues myself.'

Both experienced and novice nurses identified leadership as meaning *'*managing*'* the author felt. When asked about strategic leadership in CN both sets said it was necessary for future strategic planning but neither set could give any examples of leadership. They felt they were so busy firefighting that they or their managers had little time for strategy or strategic thinking. Mangers agreed with this and said

'I feel we are so busy averting crisis, dealing with staff shortages, trying to keep areas covered and recruit staff we have very little time for leadership. Leadership, very difficult to find time for that! Our DPHN does that when she has time, we do try but there are not enough hours in the day.'

CN is presently entering a watershed, a time of instability and flux, a time of increasing demands and diminishing staff levels with big changes ahead as the Sláintecare Programme is introduced (Batista-Taran, 2013; Sláintecare Report 2017)). Now is the time when leadership is crucial to CN. A time for DPHN's to step forward to meet the national corporate agenda and drive healthcare delivery in a new direction (Bennis & Nanus (1985), Batista-Taran (2013); Derler et al., 2017 and Williamson (2020). DPHN's need to be adaptive and far-seeing and use the upcoming imminent changes as a golden opportunity, to reshape their service for a better future in CN for patients and staff.(Sullivan and Decker 1992).

4.5.4 Examining Data to Identify Themes that Caused Practice Issues

When the data from cycle two was examined and the themes that caused practice issues identified, these were presented back to the staff for accuracy. Further focus groups were held and the Socratic wheel approach was used again. Staff reviewed the themes on the Socratic wheel for accuracy and then rated the significance of the theme to their practice. See photographs of both Socratic Wheels in Appendix R for nursing staff and Appendix S for Management.

4.5.5 The Themes Identified by Nursing staff that Predisposed or Caused Practice Issues

- Rationing of Care
- Change in Demographics (Not all areas- More prevalent in urban areas)
- Lack of reflective practice
- Increased Complexity of care
- Poor skill mix with staff being replaced by different grades who are unable to perform at same level
- Stronger leadership needed in times of crisis to lead, support and advise
- Dependency levels growing on outside agencies to provide care for patients

As stated on completion of each Socratic wheel, it was photographed and then diagrammatical representations were developed from the photographs. Figures 4.1 on next page represent the novice nurse and Figure 4.2 represents the experienced nurse's views on the causes of practice issues. The causes of practice issues are presented on the outside of the Socratic Wheel and then along each spoke of the wheel are numbers ranging from 1-5, against which staff rated the significance of the issue to their practice. It is interesting to see the differences in how the themes were rated between the experienced and the novice staff. While the causes of practice issues are identical on both Socratic Wheels, it is the rating of these themes that makes them so different. In the novice nurse, any issue that arose was deemed a serious issue to his/her practice. However, this is not the case for the more experienced nurse, who rated the issue much lower than the novice did in 50% of practice issues. Experienced staff felt this was due to the fact they had met and dealt with this or similar incidents before and this experience had given them insight, knowledge and competence to deal with them again which is reflective of Benner's (2009) 'novice to expert' nurse theory.

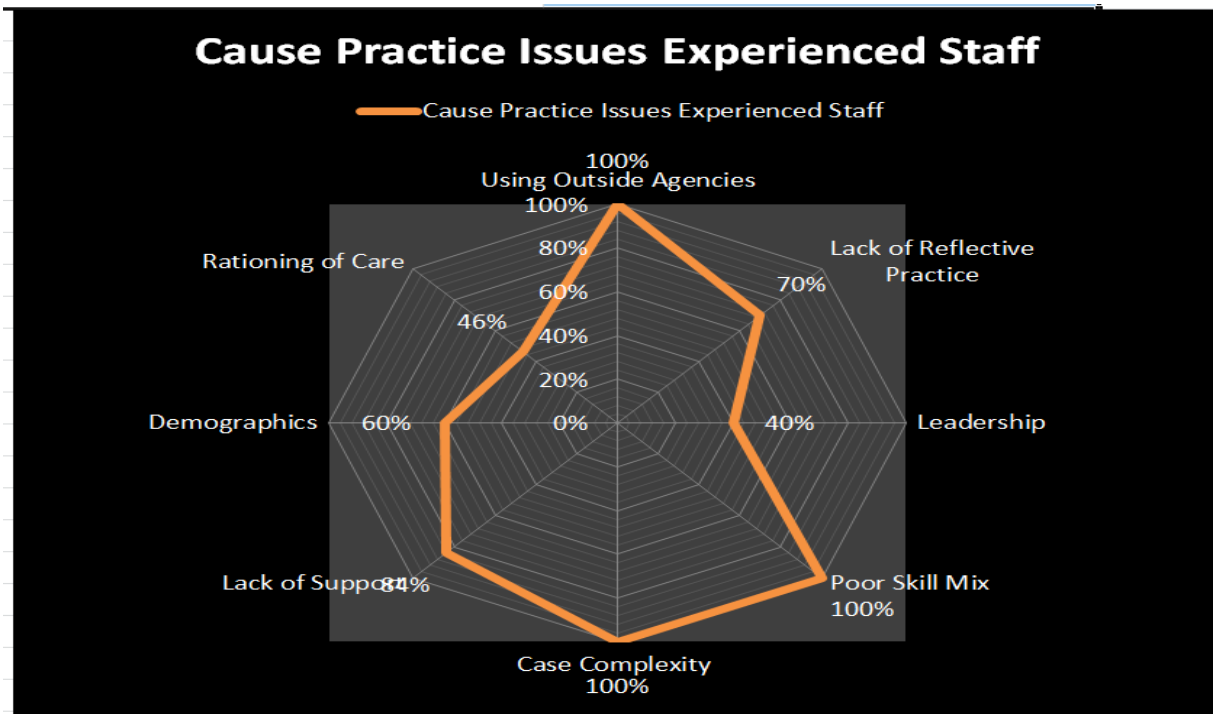


Figure 4.2 Socratic Wheel Illustrating Causes of Practice Issues in Experienced Nurses

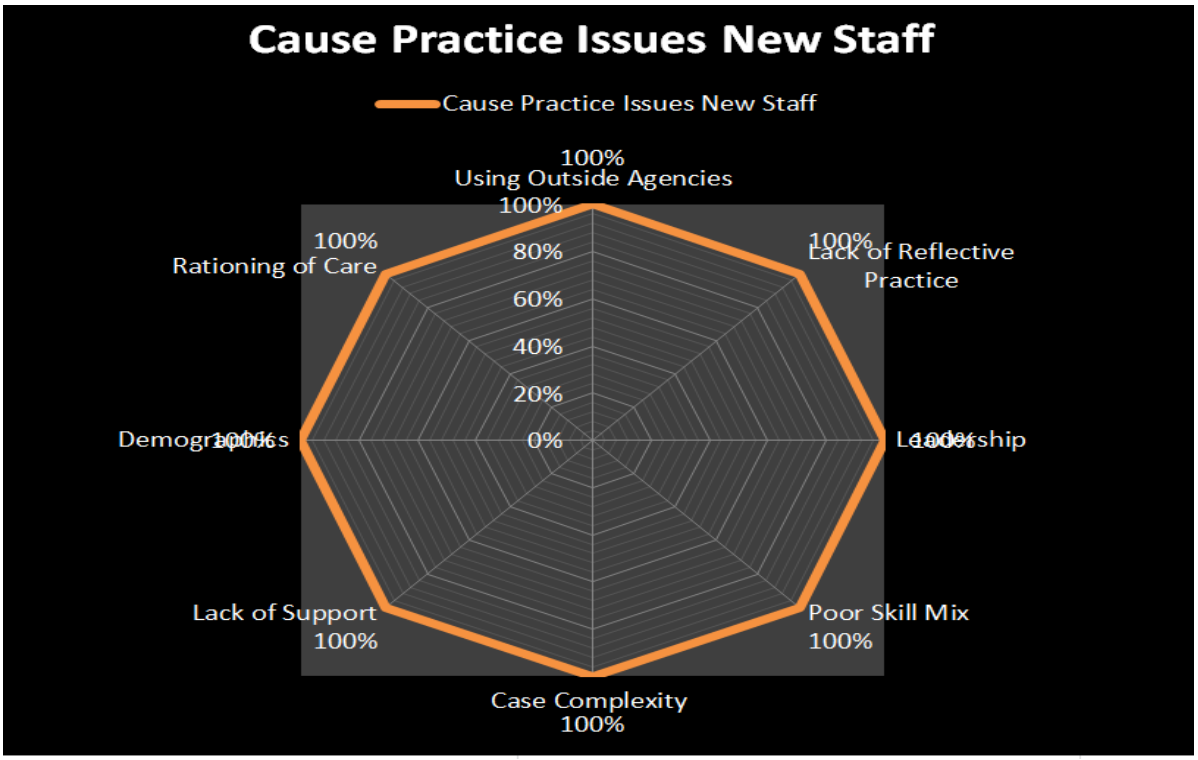
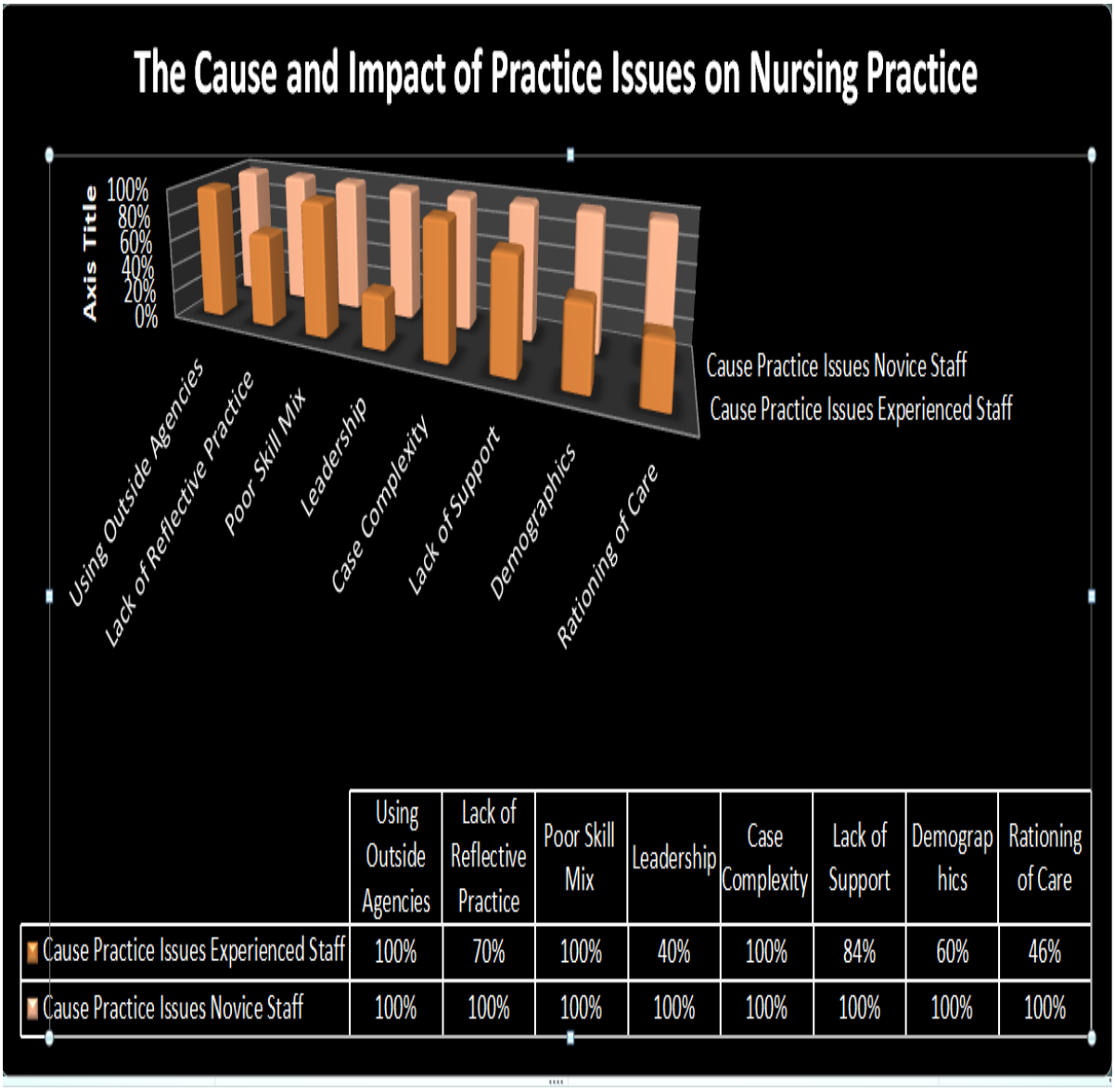


Figure 4.3 Socratic Wheel Illustrating Causes of Practice Issues in Novice Nurses

Diagram Fig 4.3 below is a diagram also developed from the same data in the Socratic wheels and it details the two sets of views- both novice and experienced nurses – as to what caused their practice issues and it gives a different (columnar style Figure) view, of the same themes and ratings found in the Socratic wheels in Figures 4.1 and 4.2



	Using Outside Agencies	Lack of Reflective Practice	Poor Skill Mix	Leadership	Case Complexity	Lack of Support	Demographics	Rationing of Care
Cause Practice Issues Experienced Staff	100%	70%	100%	40%	100%	84%	60%	46%
Cause Practice Issues Novice Staff	100%	100%	100%	100%	100%	100%	100%	100%

Figure 4.4 The Cause of Practice Issues in Nursing Practice

(Comparing Novice and Experienced Nurses)

4.5.6 Discussion around the Causes of Practice Issues in Nursing Management

The nursing management had separate focus groups to the nursing staff, thus allowing everyone speak freely and without fear of offending others. In the Management group there were 2 DPHN's and 9 ADPHN and they had similar views to the nurses, but the Managers had some additional themes not found in the nursing focus groups and these were.

4.5.6.1 Being a 'Catch All'

Management felt they took on cases that did not necessarily belong to CN as they were not clearly nursing cases. For example, these included clients in the disability service or young patients who sustained an injury leaving them with care issues. Also there are other vulnerable clients/ groups aged under 65 years like the homeless and vulnerable clients with mental health issues. Many of these clients are already attached to disability or mental health services, yet they are referred to CN for some care need and then left with the service due to their vulnerability, long after the care episode is completed. One ADPHN said

'I think we need to be clearer about what we do, everyone else is. Saying we provide a service from the cradle to the grave helps no one, we end taking on everything; we never say no, we are a 'catch all'. We need more guidelines to try and control caseloads.'

4.5.6.2 HR and the Recruitment Process

All of nursing management appeared to have great difficulty with HR. They found it less than effective in recruiting staff. They felt it took up much of their time when they could be using it much better elsewhere. One DPHN said

'I spend almost 30-40% of my time on HR business. It is a serious loss of time and resources to have a DPHN's spending this amount of time on HR business' not to mention a very ineffective use of our time.'

Others spoke of the present ineffective recruitment system for PHNs where a caseload can be left up to two years with no PHN -as it can take this long to recruit and train a PHN.

4.5.6.3 Need for Practice Development Co-ordinators

The management team spoke of the need for practice development co-ordinators (PDC) to support pre and post registration nurses in developing good nursing practice. One DPHN said

'There is a real need for a practice development coordinator to provide guidance and support to staff, in particular to new staff. They also develop and evaluate policies for best practice. I feel this is a necessity if practice is to improve. It is a post all areas should have. '

These were the themes identified and rated on the Socratic wheel by nursing management. Figure 4.4 is the diagrammatic Version of Socratic wheel for the ADPHNs and Figure 4.5 is the diagrammatic Version of Socratic wheel for DPHN's. These were both adapted from the photograph taken of the original Socratic wheel which can be found in Appendix S

As can be seen from Figures 4.4 and 4.5 the ADPHNs and the DPHN's agreed on all aspects of what caused their issues in practice. The only difference was in demographics and this was because management staff came from different areas and demographics varied between areas.

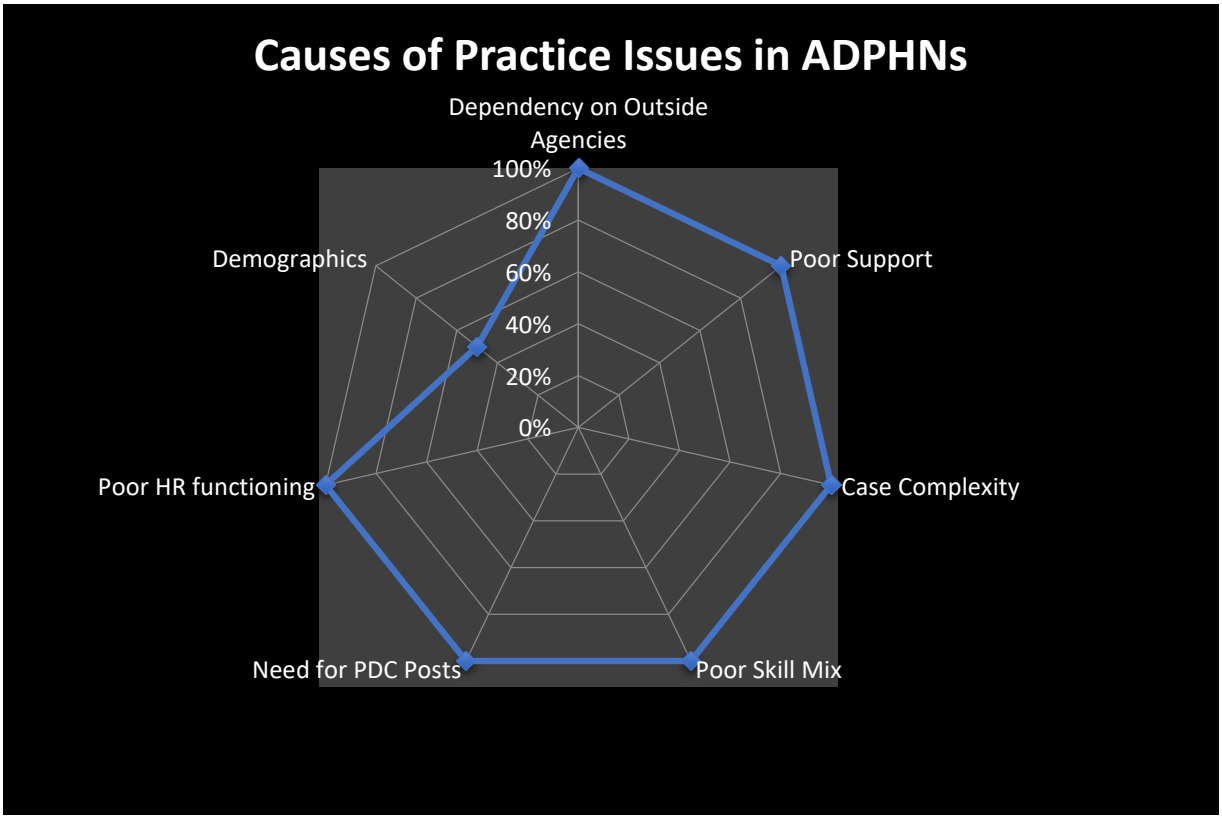


Figure 4.5 Socratic Wheel Illustrating Cause of Practice Issues in ADPHNs

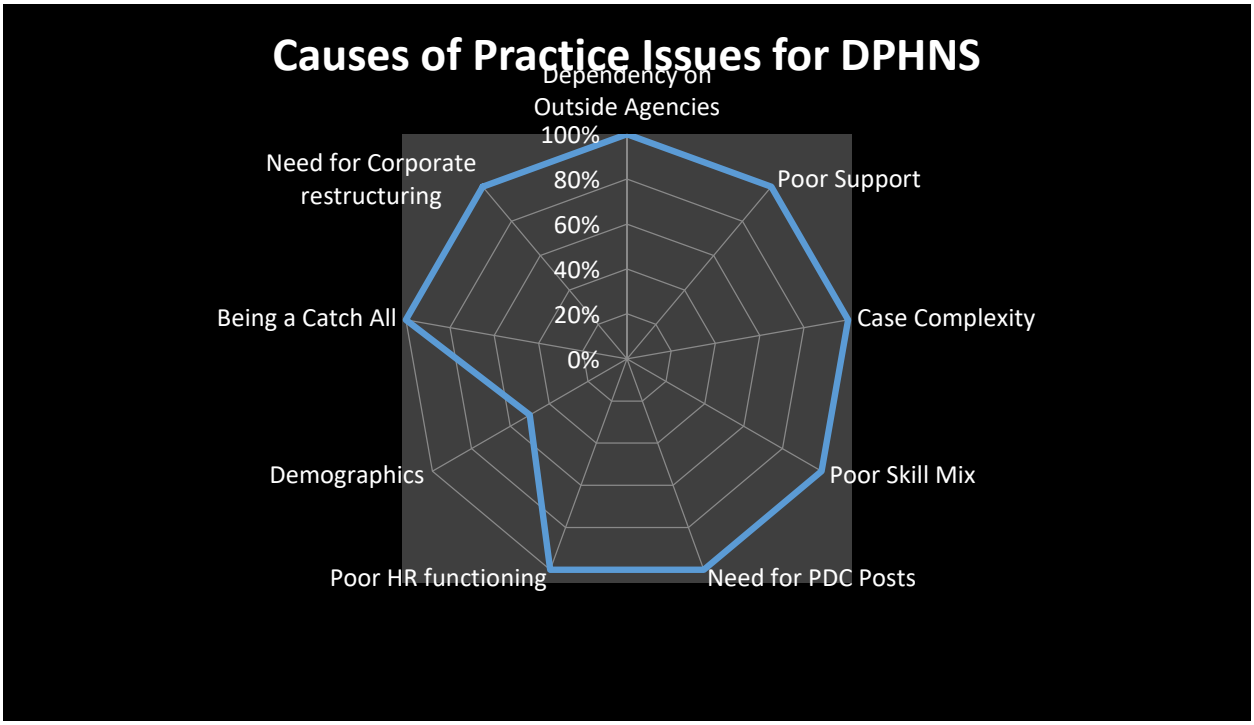
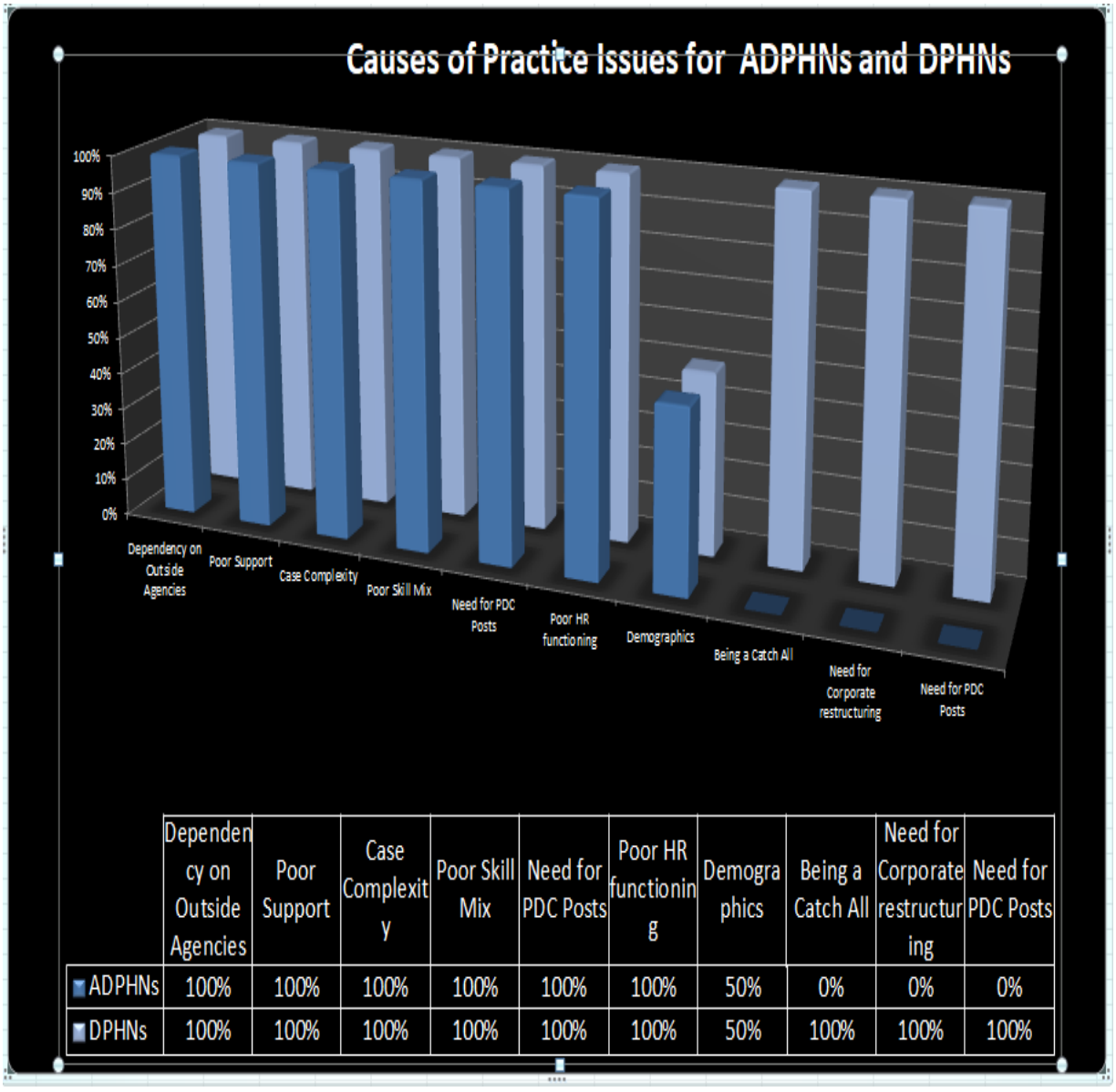


Figure 4.6 Socratic Wheel Illustrating Cause of Practice Issues in DPHN's

Diagram Fig 4.6 below is a diagram also developed from the data in the photograph of the Socratic wheel and it details the two sets of views in management - both DPHN and ADPHN as to what caused their practice issues and it gives a different (columnar style Figure) view, of the same themes and ratings found in the Socratic wheels in Figures 4.4 and 4.5.



	Dependency on Outside Agencies	Poor Support	Case Complexity	Poor Skill Mix	Need for PDC Posts	Poor HR functioning	Demographics	Being a Catch All	Need for Corporate restructuring	Need for PDC Posts
ADPHNs	100%	100%	100%	100%	100%	100%	50%	0%	0%	0%
DPHNs	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%

Figure 4.7 comparing the findings on the causes of Practice Issues between DPHN's and ADPHNs

4.5.7 Other Observations in the Data Collected in Nursing Management Focus Group

4.5.7.1 Lack of Support

When nursing managements and nursing staffs Socratic wheels are examined side by side, it is obvious from the management's Socratic wheel how much they lack support. When asked about this issue, it really became obvious how resilient nurse managers need to be. They spoke of visiting staff who are so stressed that they can 'let off steam' on them and this is often due to the staff shortage situation. They reported having to continually deal with issues, from prioritising of care to constantly supporting staff, especially novice staff. However, when the ADPHNs were questioned regarding their own support systems they said they had colleagues who supported them and they also mentioned the DPHN as a source of advice and support too but more supports were needed. However, when questioning the DPHN who had the same difficulties as the ADPHNs, they had no support systems in place. They said

'We attended the monthly or bi-monthly DPHN forum meetings with colleagues and this gives us some support, but there are no local systems in place for ongoing support. During Covid times the DPHN forum meetings have moved online, thus reducing our face to face support system further, in a time of crisis when everyone is expecting us to lead them through this crisis. '

One DPHN mentioned that

'While you try to cultivate some form of support locally, no one really understands nursing like a nurse does. If I was to seek support from another DPHN face to face, I would have to travel 32 km round trip, (the other DPHN 40 km), so face to face support is not usually done. Being a DPHN is a lonely place. '

It was obvious from speaking with them, that great resilience is needed in all nurse management teams but particularly in the DPHN.

4.5.7.2 Lack of Training for the Job

The other fact that emerged was the need to induct staff into management. Several ADPHNs agreed that

'ADPHNs need an induction course with mentoring and training during a prescribed induction period before taking on the role fully. '

4.5.7.3 Changes to Corporate DPHN office

The DPHN's spoke of a need for clarity in the National DPHN office.

'There needs to be a separation of structures in the office into three different areas, namely policy development, education and project management with representation from DPHN or clinical management group in each area. This would bring clarity and make it simpler to deal with for any queries we need to escalate up. Presently, policy development is in its infancy and while it is ongoing, it is disjointed and different in all areas. While a National lead works in this office, no real progress will be made until a practice development coordinator post is developed in each LHO areas throughout the country. This would bring uniformity to policy development, support and engage staff and enhance practice. '

The management team also had thoughts on education in CN,

'This is disjointed and while there is some uniformity in competency based education, the remainder remains dependent on local agendas, staffing levels and availability of resources. Some improvement took place with the addition of nursing tutors but these posts are no longer supported and are not being replaced after the two year contract expires. There is no uniformity and while the tutors brought improvements, there still needs to be a dedicated national educational lead to drive a national educational agenda. '

Regarding national project management, they spoke of the need for a DPHN or ADPHN suitably qualified in project management be recruited for this office also. They said that

'Input is sought from DPHN's on national projects and we are often too busy locally to fully undertake or give fair representation to these groups. This can lead to delays in projects or DPHN's appearing uncooperative due to being unable to cooperate as a result of excessive workload. A DPHN or senior community nurse manager experienced in project management would get trust and respect from DPHN colleagues and they would add practical experience to the national management team. This would bring buy-in and early adaptation of projects.

At present the expectation is that DPHN's will facilitate these three jobs locally themselves, however in this study they were now stating

'We are too busy to dedicate the time needed to adequately meet the needs of these jobs in addition to doing our own work. This is an ideal time for these changes to take place with the introduction of Sláintecare. These posts will interface well between practice and corporate level and build a strong working relationship between them, which in turn would boost uniformity of approach in practice and

education, enhance buy-in and give the assurance of cooperation and earlier adaptation to new ways of thinking and working in CN. '

4.5.7.4 Need for Strategic Leadership

Regarding leadership, all spoke of the need for strategic leadership in the service to drive focus, vision and performance forward. The ADPHN spoke of

'There is a need to develop ADPHN forum in each CHO area for support and strategic development nd there is a need for training and mentoring by senior staff before being expected to work as ADPHN. '

Also the DPHN's believed that the post of project manager mentioned above in addition to an outside management consultant could also be employed to work with the DPHN's forum to assist them develop an annual strategic plan based on latest developments, thus placing them in a position to work in tandem with other services and adapt best practices based on latest knowledge and developments. '

4.5.7.5 National DPHN Group Need Budget for Strategic Development & Ongoing Education

The DPHN's also spoke of the need to acquire an annual budget dedicated to DPHN's education support and development.

'If the national DPHN forum is to become more strategic as a group, we need funding to be able to make choices regarding our ongoing educational needs, instead of being beholden to NMPDU or National DPHN office for funding. For example we need to employ outside consultant to educate staff and assist us develop an annual strategic plan for the group, these could be funded from this fund. Following on from this developmental plan, we should have bi-monthly meetings dedicated to the implementation of this plan only; the alternative months could be used for day to day work and planning. We need to use our time together constructively, for us, not for the use of outside speakers who see our meeting' s as an opportunity for them to deliver a message for their benefit nationally. Many DPHN's had made onerous journeys to get to this meeting, as it serves as one of their few support structures we have, as well as being our strategic planning forum. We need to prioritise us and our needs more. '

4.5.7.6 National DPHN Group Need Budget for Development of Support System for DPHN's

'We also need to dedicate budget to developing a support system for ourselves, everyone else on the team have support from a line manager but not ourselves. We need to look after ourselves for a change.'

4.5.7.7 National DPHN Group Need Budget for Employing Administrative Support

Another requirement was for their forum to be seen as a professional organisation and given funding to employ a fulltime secretary to alleviate the work load placed on the lead DPHN/ chair person.

'Presently, it is difficult to get a DPHN's to step up and take on the leadership role of the DPHN forum. If there was a secretary it would take away a lot of the clerical work associated with the post and this would make it a more attractive position for a DPHN to take up the lead position and it would allow it to be run in a more professional manner like many other groups who have paid secretary's. '

4.5.7.8 Need to Develop Clear Guidelines for Referrals to Service

Management spoke of the need to develop clear guidelines around what cases could be referred to CN, however they too discussed dispensing with the "cradle to the grave" *logo for the service*

'This leads to a lack of clarity about the type of referral that is appropriate for the service. '

4.5.7.9 Reduced effectiveness of HR System

Management spoke at length about the ineffectiveness of HR recruitment in the HSE especially when it came to recruiting PHNs.

'There can be up to a two year vacancy in a position when it comes to recruiting PHNs. We spend between 30-40% of our time recruiting staff and this is both ineffective use of my time and poor use of resources. '

The rest of the reasons listed as causing issues in the nurse management's focus groups were similar to those found in the nurse's focus groups. The author has summarised these reasons from cycle two for both groups in Table 4.7 on next page As can be seen both management and nursing share many similarities in their views on the causes of practice issues. More Figures developed from the findings can be found in Appendix R for nurses and Appendix S for management

Table 4.1 Summaries of Causes of Practice Issues from Cycle Two

Causes of Issues which are Common to all Staff Grades are in Yellow

Cuases of Issues for Nurses	Causes of Issues for Nursing Management
Demographic Changes	Demographic Changes
Increased Complexity of Care	Increased Complexity of Care
Poor Skill Mix	Poor Skill Mix
Growing Dependency on Outside Agencies	Growing Dependency on Outside Agencies
Need better Leadership	Need better Leadership
Lack of Support	Lack of support
Lack of Reflective Practice	Lack of Reflective Practice (Not listed as theme but spoken about)
Rationing of Care	Rationing of Care (Not listed as theme but spoken about)
Not Reported by Nurses	Changes to Leadership and New posts need to be Developed in/ for National DPHN Office
Not Reported by Nurses	Need to Develop Clear Guidelines for Referrals to Service
Not Reported by Nurses	Clarity re Function of National DPHN Group & Need for Dedicated Budget & Secretary for this
Not Reported by Nurses	Reduced effectiveness of HR System

4.6 Adapting the Findings to Local Context

When the data from cycle two was analysed, the author and co-researchers used this knowledge to hone the Tool further. A decision was made that the best way to approach the matter was

- To seek commonalities between the nurses and management issues, that caused practice problems and work with these commonalities to get maximum effect.
- To eliminate issues that we have no control over, such as demographic changes, early discharges, complexity of cases etc.

We set up regular meetings to discuss and reduce the data collected regarding identifying practice issues that we would be able to work with and make changes to so as to improve practice. We would then embed these into the Tool, to improve practice and support staff.

Having eliminated demographics, early discharges and the complexity of cases being discharged home, the commonalities for all nursing staff were

- Need for support for Staff
- Regular practice Review +/- Reflective Practice
- Need for Better skill mix with effective job embeddedness and staff retention
- CPD to ensure competent , up to date staff
- CPD for Career Pathways eg CNS ANP to deliver care in right care in right place at right time
- Need for strong Leadership

Regarding patients' needs, we felt that their biggest concern was with the nurse failing to deliver the right care at the right time in the right place (Sláintecare Report, 2017). Much research was done on this by the AR group on how best to support patients in their desire to reclaim their home visiting again. We felt that by developing a specialist CN service, we could augment the present generic service delivery. We felt patients would benefit most from the development of specialist posts like CNS and ANP to manage chronic illnesses and older persons in the community setting. This would bring expertise to the community and reduce hospital visiting. In addition, it would lead to a defined career pathway for nursing staff, particularly RGNs who often lacked this in CN. The Venn diagram in Figure 4.8 on next page reflects the findings between all three groups. The yellow section is the area of commonality between all groups. These were the issues we decided to work with as a group, issues we could make most some impact upon to improve practice. It was hoped to improve these through the Tool.

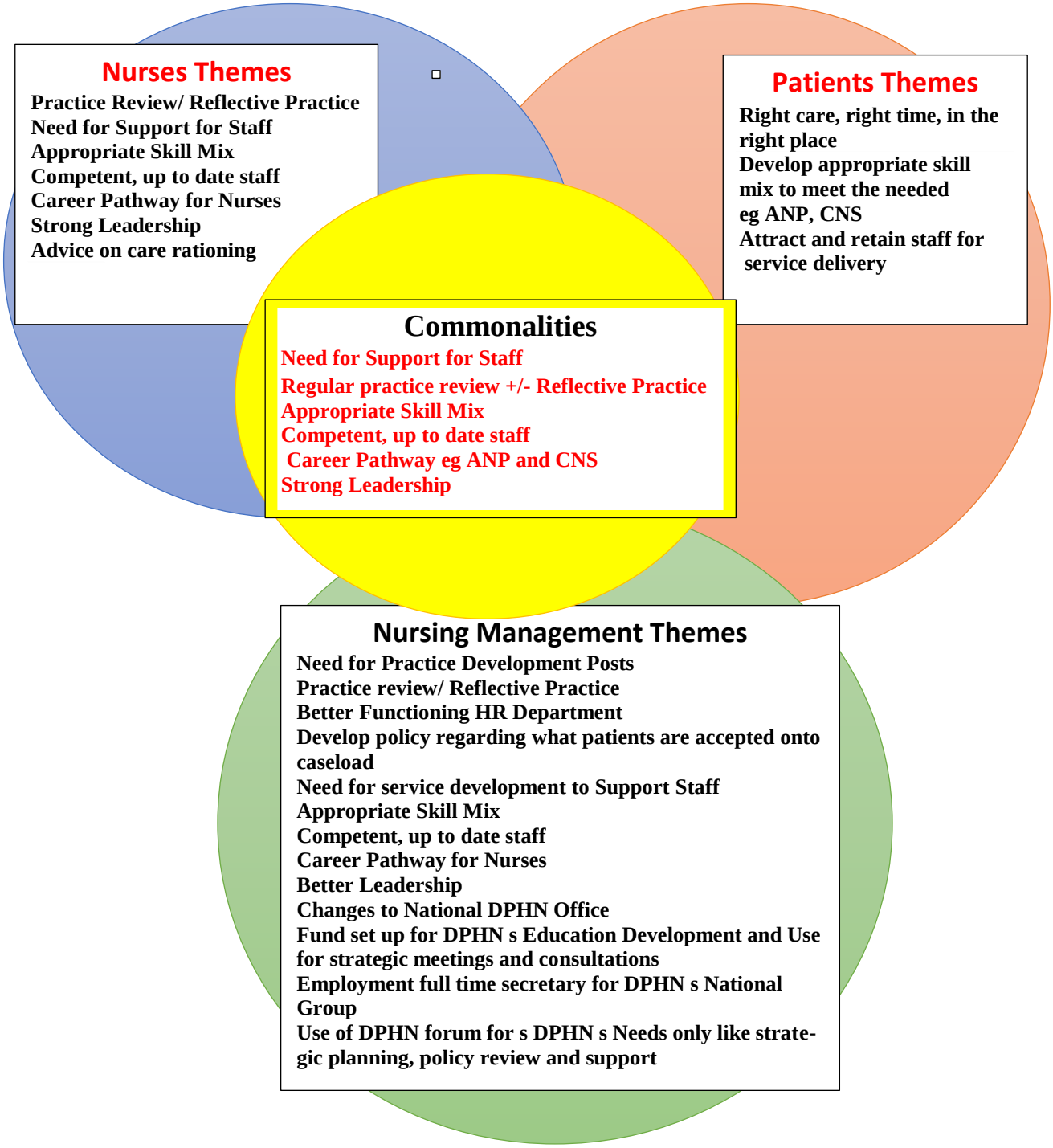


Figure 4.8 Venn diagram Demonstrating the Common Themes found on the Causes of Practice Issues. Commonalities in Middle will be developed further to Improve Practice (in Tool)

4.7 Developmental Plan for Next Stage of the Research

At this stage, having chosen the issues to work with from all three groups, the author reviewed and critically appraised the literature for commonalities and themes to adapt that could improve practice in the issues we chose to work with. The following themes matched most closely the common issues we chose for improvement. These were

I. Continuous professional development (CPD) for competent and updated practitioners
II. Nurses engaging with professional development planning
III. Ongoing Staff support and mentorship
IV. Regular Practice review with early resolution of issues +/- reflective practice
V. Leadership and staff empowerment,

These themes chosen by the group were then applied to the Tool.

4.8 Conclusion

In chapter four, cycle one and two of this AR project scoped out the reasons why practice issues occur in CN. The learning from this was then cross referenced against methods identified in the literature review that prevent these practice issues occurring. These methods were then embedded into the Tool to be used in this AR project to support staff and prevent practice issues reoccurring if possible and improve practice. Chapter five consists of cycle three and cycle four, it begins with cycle three which is the pilot study of the Tool in practice in a primary care centre. Following this, data is collected and the learning used to adjust the Tool again one final time before it implementation into practice, in cycle four. After cycle four the data is collected, collated and findings documented on the implementation of the Tool in CN practice and recommendations made.

CHAPTER FIVE

CYCLE THREE

5 .1 Introduction

This chapter takes the AR research from the scoping out phase of the study and the Tool development stage to the point of implementation. There are two cycles involved in this part of the research, cycle three deals with the pilot implementation of the Tool to CN staff at one Primary Care Centre followed by a review of the findings which leads to further honing and redevelopment of the Tool before its launch into practice. The launch itself involves 51 co- researchers using the Tool over six month period, after which data is collected, findings are documented and recommendations made.

5.1.0 Identify a problem that needs addressing

The author and the co-researchers have identified that there are concerns in CN practice which are predisposing or causing practice issues for nursing staff and /or leading to poor practice delivery. The reason behind developing the Tool and introducing it into practice is to help staff recognise these issues early and seek timely intervention, which leads to earlier resolution with better outcomes (improved client outcomes, increase in staff wellbeing, more job satisfaction, better staff retention and a reduction in the risk of litigation). It is also hoped the Tool will give nurses the time and space to plan for their CPD, their competency building and their career development. All or even some of these functions would lead to improved nursing practice.

5.1.1 Identifying Knowledge and the Research Approach Relevant to the Problem

The author is convinced by the arguments that nursing would operate more efficiently and effectively and improve if well managed and supported to do so. However, that is a very simplistic explanation of how we could improve practice, in reality we are often so busy ‘doing’ that we often fail to see what we needs to change to improve things. We continually use the same approach, so we continually get the same outcome. The author feels this study was a good opportunity to implement some changes that could be made quite simply and then re- examine practice to see if the changes introduced improved practice. The author developed ‘The Tool’ (set of documents) with this objective in mind.

The Tool was first introduced as a small pilot project to seven staff and then to the larger research team involved (which compromised of the author and fifty one staff/ co-researchers). As the research progressed the Tool was honed by the group to meet local need.

An AR approach was used throughout the research as it is the only research method capable of producing change and solutions to practice issues (Chandler and Torbert, 2003; Herr, 2015). Also, AR engages people in a collaborative relationship, and gives them the opportunity to make changes that are appropriate to their practice. This brings a better chance of these changes being adapted locally on a permanent basis.

However, there was also another reason the author chose AR. Throughout the authors working career she has worked in both the academic and the practice fields of nursing. She has frequently witnessed staff in both areas inform her that the two fields never meet. The author believes that this is not the case, and she welcomed the opportunity to assist staff to see that it is possible to achieve an academic development within a practical setting with the assistance of AR and interested practitioners. Also, it was hoped that this project might encourage future collaboration between both fields and AR is the only research Tool available that deals with improving the future of practice through academia. (Herr, 2015; Mc Kay and Marshall, 2001).

5.1.2 Assess for barriers

In the beginning, the biggest barrier the author had anticipated was getting staff interested in the research however, time constraints and nurse shortages proved to be bigger barriers to securing a research site. While these reasons were some of the main issues the author was trying to highlight in this research it was difficult to highlight it, if access to staff could not be gotten. This was a very frustrating situation at the beginning of the research. As a researcher, it was difficult. However I am thankful to have had supportive critical friends who advised me to document this as a finding in my diary and move-on and by doing so, I would engage in a potentially more fruitful inquiry eventually where staff had time to report their issues with practice. I reflected on their advice and did just that, and moved on. The author learned that hard as it was to accept, if AR is to be true to its core function it had to be voluntary with staff being

happy to participate. When I moved on, I gained admission to new sites and I knew I had made the right decision as the new sites had better staffing levels and they had more time to evaluate the documents and thankfully they seen a project they liked and felt could be of value to them. Also they were happy to participate and they were open to change (Herr and Anderson 2005, Reason 2006). If I chose the original sites, I might not have honoured all of the requirements needed for the AR process to be deemed as accurate and cooperative research. This was one of the main barriers to the research, but we eventually overcame this issue.

5.1.3 Tailor and implement the action plan

After this set back and when site access was gained the author introduced the documents with a PowerPoint session (Appendix H) followed by a question and answer session. The seven staff who took part were given a plain language statement (Appendix I) explaining the research to them and then they signed a consent form (Appendix J) to participate in the research. While six nurses volunteered only five took part with their ADPHN. The nurse that failed to complete the research did so for personal reasons.

5.1.4 Monitor the implementation of the Action Plan

When reviewing the findings in AR cycle two, it was obvious that different levels of support were needed by novice nurses compared to experienced nurses. For this reason, the author requested, if possible, that both a novice nurse and an experienced nurse be included in the pilot project. This request was honoured and the staff who volunteeed included three senior staff who were qualified over 5 years, two nurses who were 3 years qualified, a novice nurse less than 1 year qualified and their ADPHN. It was a senior nurse who dropped out later, leaving five nurses and their ADPHN to take part in the pilot study.

The documents were introduced by PowerPoint and an agenda was given to staff (Appendix H). A full explanation of the use and function of each document was given. The author took the contact emails of all staff in the study so that she could email them the questionnaires which evaluated the documents after 8 weeks of using them. The nurses were supplied with Document One and the ADPHN was supplied with Document Two and Document Three. The nurses were informed that they could get Document Two from the ADPHN if they wished to use it, but all must complete Document One before moving on to Document Two . Everyone seemed to understand the documents and their function, and the author

then supplied the participants with her name, telephone number, work address and email in case they had a query or wanted to get in contact and she said she would return in 8 weeks' time. On that day it was hoped to complete some interviews and a focus group for review of the documents. The novice nurse and a senior nurse volunteered for interview as did the ADPHN. The remaining staff agreed to complete the questionnaire and give feedback in a focus group for about 20 minutes on the day the author visited again. The author only received one email during the 8-week period and that was from the nurse who excused herself from the study. At the six-week period the author sent out questionnaires one and two to the nursing staff and questionnaires one to three (Appendix O) to the ADPHN.

The author attended at the arranged date, eight weeks later to collect the questionnaires and conduct a 60-minute focus group with three nurses and the ADPHN and a 20-minute interview with the novice and a senior nurse. All staff had completed Document One and only one RGN had completed Document Two. Document Three was not used but was reviewed for the author by the ADPHN and a colleague for its usefulness to the service. Both the focus group conversations and the interviews were recorded. When the author had transcribed these, she later checked the contents with staff for accuracy and made any changes suggested by staff to them to reflect their true meaning. The findings from this pilot project were used to modify the document for its launch.

5.1.5 Discussion on the Evaluation of the Outcome of AR Cycle 3

The novice nurse was interviewed first, and she found the documents extremely helpful. She felt that by meeting with her line manager (the ADPHN) she had established a relationship that she could now use. She said she now felt free to ring or email her with any issues she was experiencing. She found the document legible and easy to use but she had one suggestion and that was that in several places in Document One annual review was mentioned and she would like this changed. So instead of asking 'how has the last year been for you' we could ask 'how has your practice been since the last review'. She felt this document suited novices and she certainly liked using it. With the support she now received from her line manager she was settling in and her confidence was growing. When asked how often she would recommend using the document, she replied she would like to use it fortnightly for novices initially and then look at a monthly use and extend this out as the nurse grew more confident and secure in her work. So, for the novice the document was very successful.

The experienced nurse was next for interview. She liked the document too, but she felt it should be used twice yearly. When the author asked why she suggested this, she replied that when a nurse is using this document as an annual review document, she may be seen any time in the year and if wishing to make a college application, the closing date could be passed before her review date and she may well miss college entry for another year. A twice-yearly review would ameliorate this issue. Regarding using the form, she found it user-friendly and easy to understand. An interesting point she mentioned though about the form, was that it asked what she felt had gone well for her in her practice in the last year, she said Irish people are not used to being asked this, she found it easier answering what had not gone so well in the last year. She felt it was 'Americanised' approach and language and said Irish nurses do not think this way and she had to take time to think about her reply here before completing it. She felt others might feel the same way. For this reason we added the question 'what had not gone so well'.

When it came to the focus group feedback, everyone used Document One and one nurse used Document Two. Regarding the feedback on document one, two of the group said that they had a good ADPHN and that they were happy with the informal arrangement that presently existed where they could approach or ring the ADPHN to discuss any issues they had, they did not need Document One. Also, it irked one nurse in particular, that someone would need a form to ask for advice from an ADPHN. I explained it was more than this, but she still felt the Document was not relevant to her. The other nurse felt the form was encouraging her to do courses, she said she was happy as she was and that she did not need to be always doing courses. When it was explained that this was not the intention of the form she still was not convinced. She felt her study days were over except for mandatory training. However, she did say that she was the nurse that had used Document Two to bring an issue that was unresolved to the attention of the ADPHN. She said she found Document Two very good and had recommended it to others. The issue was not resolved but it had greatly improved and would hopefully resolve shortly. The ADPHN who was also in the group confirmed this and said she had found Document Two quite useful in assisting her work with the nurse on a clinical issue. She pointed out that the document gave nurses the opportunity to try and resolve the issue locally first before reverting to her with the issue. The document asked the nurse for two previous resolutions that had been tried, and this section needed to be completed before submitting the form. This ensured the nurse(s) had examined the issue and had tried to resolve it. In this case where Document Two was used, all nurses working at the Primary Care Centre had become involved in trying to resolve the issue and this had led to great improvements with the issue, even if a resolution had not been reached yet.

The final nurse to speak at the focus group was one of the nurses with three years' experience; she said she had only used Document One and that she found it helpful. She was not in a position to begin any career development at present due to family commitments, but she was now looking at options for her future career development. Document One had made her think about her career. She had not thought about it in recent years, but after using the document, she thought if I am going to be in nursing for the next 20 years why not move into an area I really like. I asked her had she made any decisions as to what this was and she said she had actually thought it through and was thinking about becoming a clinical nurse specialist for older persons with dementia, as she liked working in this area in particular.

The ADPHN also supported this evidence and she said that when she had completed Document One with staff, it surprised her how the staff had not thought about their career pathway before. She mentioned that not everyone was in a position to study at present but now they knew about career pathways they could use it. She also mentioned that she thought the document was particularly helpful for novice nurses and gave them support. She suggested that perhaps another version for novices could be developed that was different to the one in the Tool because it mentioned the annual review only. The author noted this and planned to add to the document before the next AR cycle began.

The author found it interesting that only the novice spoke of using the document to access support from their line manager; However when examined it transpired that the reason for this was because the ADPHN (Line manager) worked onsite with the staff in the Primary Care Centre, so Document A was not needed when they could seek advice by simply making an appointment and calling into her office any morning.

The final question, how useful the documents were and how often should they be used all drew different replies. The majority (4 out of 6) found the documents useful and they even said they now knew when their mandatory training needed updating. Regarding how often the documents should be used there were many answers from fortnightly for the novice, to twice yearly, to yearly, to not at all. So time frames varied. When the information was collated the author again used the Socratic Wheel to present the information and themes back to the group and to confirm they agreed with the themes and the findings and it also allowed the staff to grade their themes. This data is presented in figure 5.0—5.3 for Document 1 and 5.4 for Document Two. The themes in the questionnaires were similar to the themes already identified in the focus groups and the interviews.

5.2 Summary of findings

Document One was most successful with the nurse manager and the novice as can be seen in Diagrams in Figures 5.2 and 5.3. Both felt that it supported staff, helped them identify and resolve issues, assisted them with CPD but they felt career planning was not applicable to them right now as they tried to adapt the skills needed for their new job. Both novice and manager liked the document overall but they wanted a specific Document One document developed for novices, that could be used for regular reviews and the time frame would start at fortnightly and extend out as the novice gained in competence and confidence. Its role would be to support novices and identify courses, training updates or other needs they required. They both wanted to see this added to an induction pack developed specifically for novices.

However, not all staff were as enthusiastic about the merits of using Document One. Diagram 5.0 displays that 50% of expert nursing staff felt that it put pressure on them to do courses outside of mandatory training and 100% of them felt it was putting pressure on them to advance their career when they were quite happy where they were. The researchers discussed with the expert staff that this was not the case and that the role of Document Ones was to give staff a forum to plan and agree their CPD needs, professional development and mandatory training needs with their manager. However, the research suggests that staff were confused around the function of Document One and more clarity was needed in the next roll out of the research and perhaps more on-the-ground support to reinforce the correct role of the documents. Despite this confusion, the staff who were three years qualified did correctly identify the role of Document One and they welcomed it as a Tool which ignited their desire to return to CPD and plan their future career. The author felt it was interesting the difference in CPD and career development planning alone between the various nurse groups.

1. Novice nurses were so intent on getting to grips with the job they looked at immediate CPD needs with no future career planning mentioned.
2. The middle career nurse (3-4 years qualified) was beginning to look at taking on more education and career development (if it suited life style).
3. The expert, competent practitioner was stating that they were less interested in career development as they were now in a work position they liked and wanted to stay. They believed that outside of mandatory training, their educational needs now revolved around becoming more expert in the area they were now working in.

4. The ADPHN showed an interest in all areas of education. This is more common in nursing managers as these are professionals who are well educated and are more likely to see education as an ongoing process.

These findings were very interesting, and the author felt these findings warrant more research, especially as the HSE spends copious amounts of money on education and career development. In addition, the author believes that nurses are not unique and that these findings could be applicable to other work areas outside of nursing.

Another interesting observation by the author regarding using Document One was that, neither experienced staff nor expert staff used it for discussion or for support on practice issues. Yet, they informed the researcher that they used Document Two and found it excellent for discussing and improving/ resolving clinical issues (see figure 5.1 and 5.2). The author investigated this further as the need for introducing Document Two emanated from using Document One first to discuss the issue and if no resolution was found, the ADPHN offered Document Two. When investigated, it appeared that all nursing staff at the Primary Care Centre felt that they did not need to complete Document One to get their ADPHNs opinion on a practice issue, as they all worked in the same building. They simply made an appointment and discussed the matter with her. The author felt this was also a very relevant point for future research. It appeared that if a manager worked in the same site as her nursing staff they have access to regular face-to-face communication and support whereas working in different sites limited this, so there was more need for use of Document One (and Document Two) when staff and managers worked on separate sites.

Comparing the Effectiveness of Document One between Four Groups of Nurses

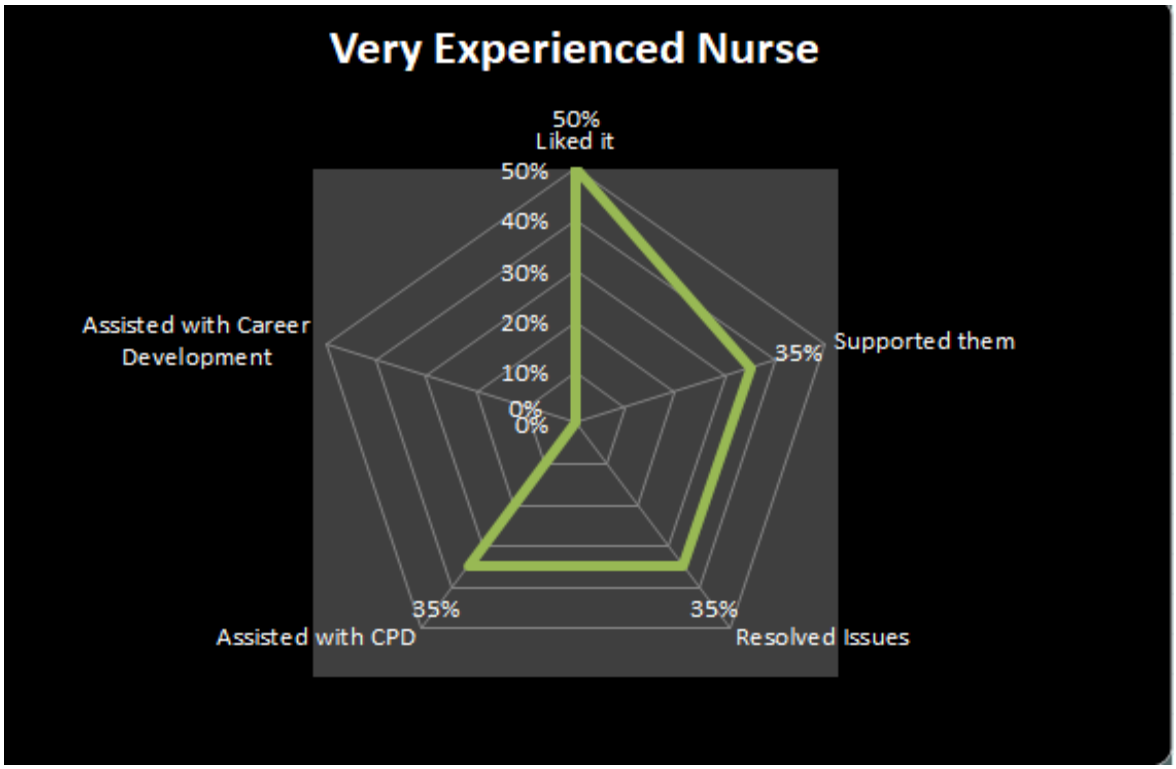


Figure 5.0 Very Experienced Nurses View on the Effectiveness of Document One

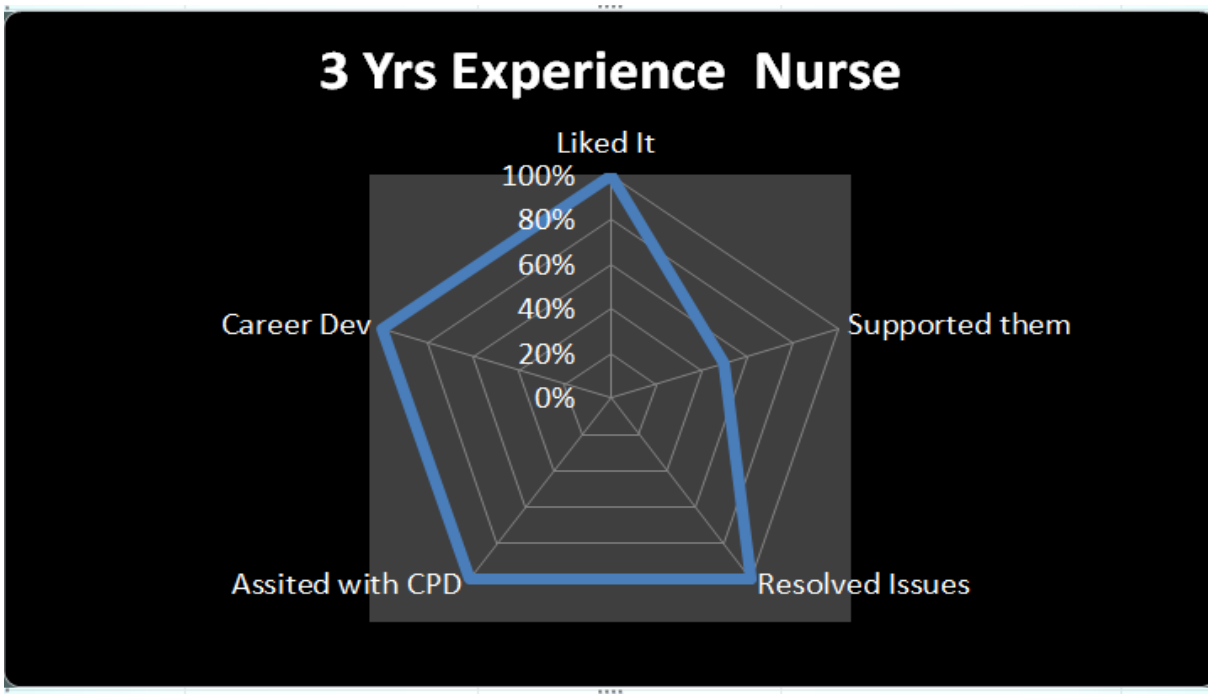


Figure 5.1 Experienced Nurses View on the Effectiveness of Document One

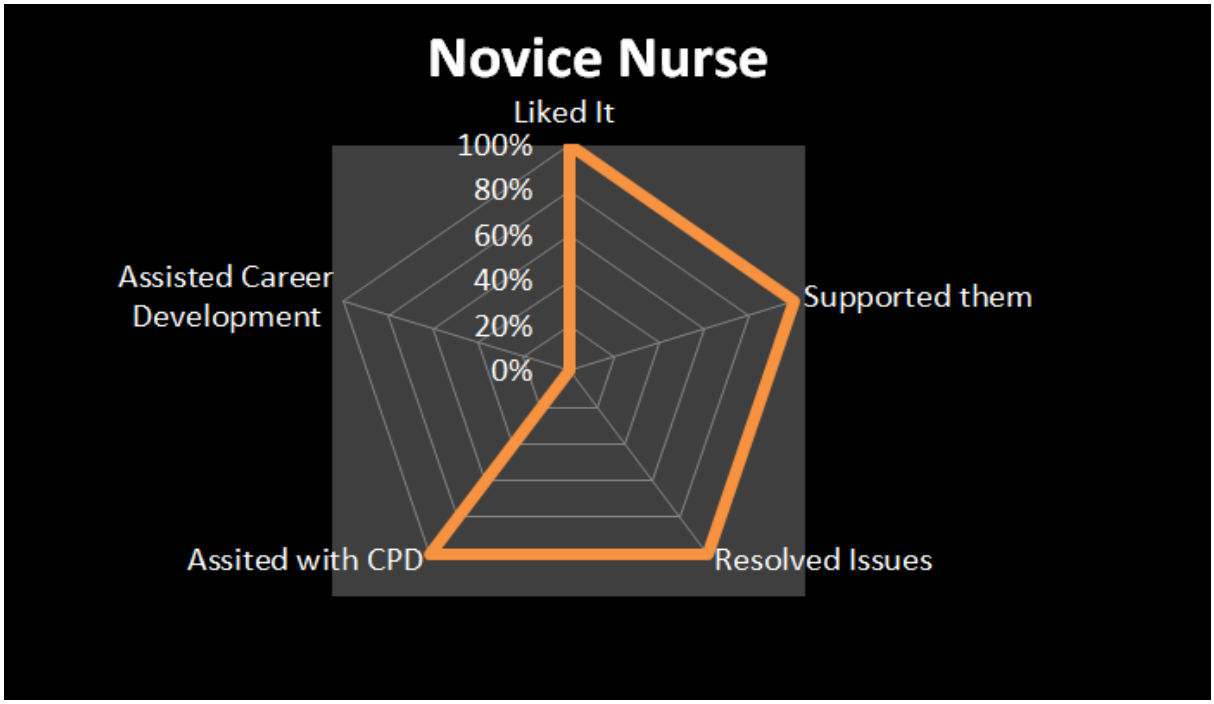


Figure 5.2 NOVICE Nurses View on the Effectiveness of Document One

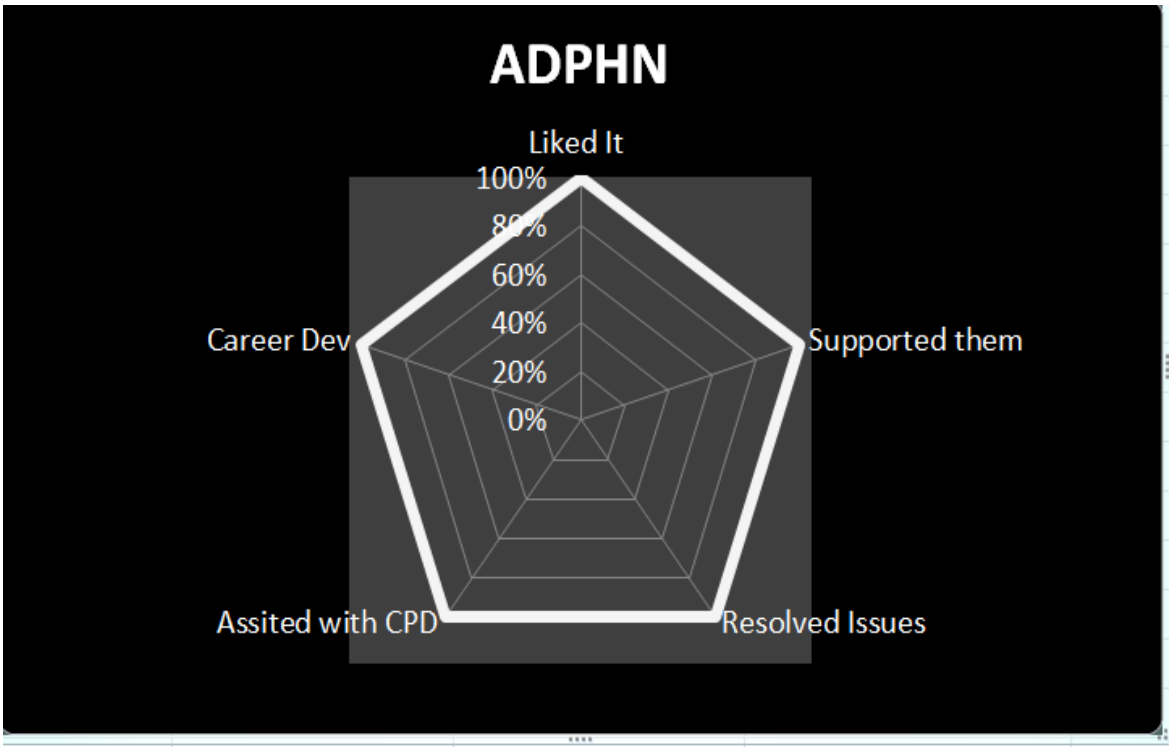
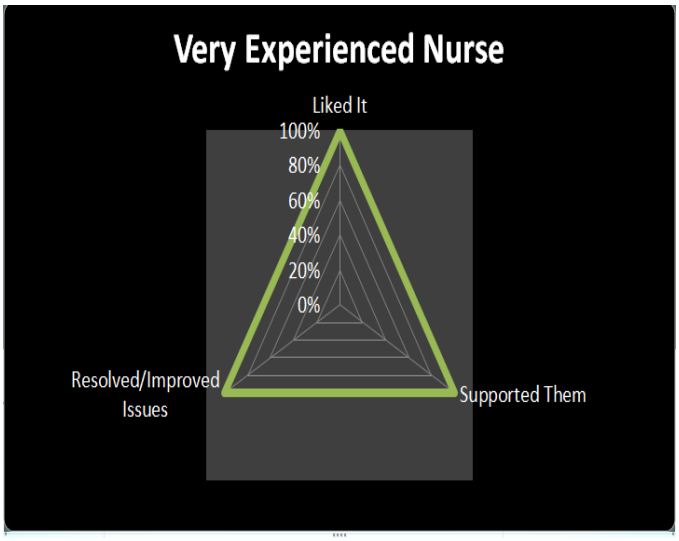
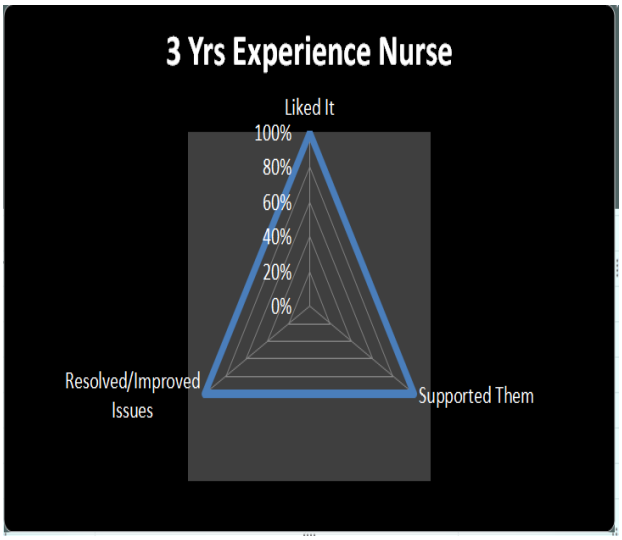


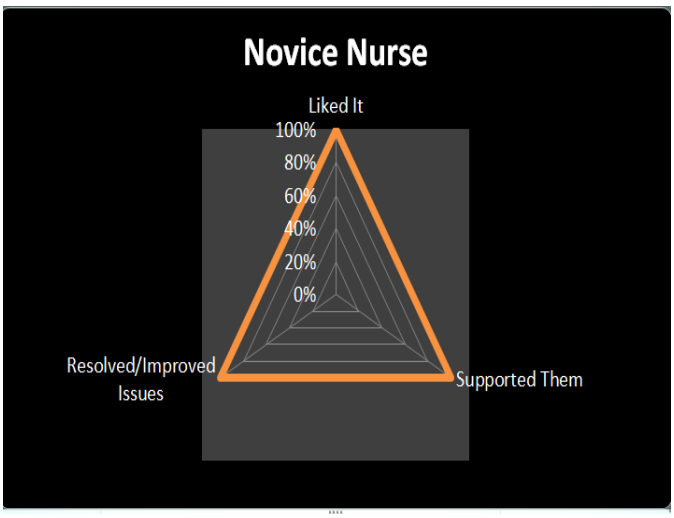
Figure 5.3 ADPHN View on the Effectiveness of Document One

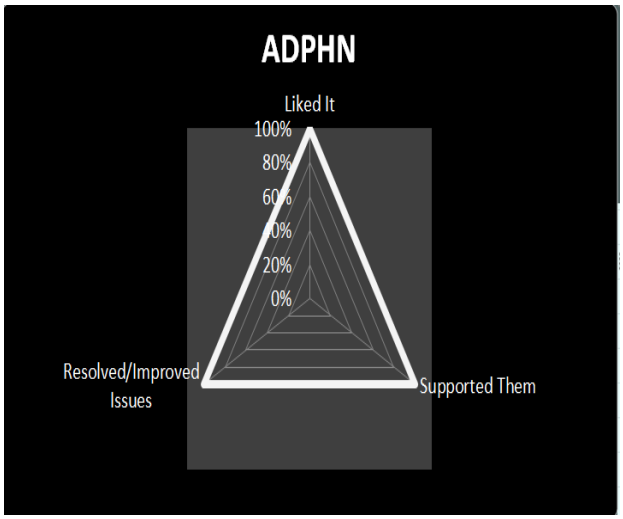
Regarding Document Two it was successfully used by all. Both nurses and managers felt it assisted them in resolving practice issues (See results in Figures of findings Figure 5.4). In addition, management liked Document Two in particular, because it had the ability to coach nurses to try to resolve their own issues before seeking help. Which truly is a skill needed in CN staff.





Very Experienced (Expert) and Experienced Nurses View on Document Two





Novice and Nursing Managers View on Document Two

Figure 5.4 Comparing the Effectiveness of Document Two between Four Groups of Nurses

(All results the same, all groups liked Document Two and found it Useful in resolving /improving clinical issues)

5.3 Discussion On Findings

The author and co-researchers felt the pilot study had gone well. It supplied quite a lot of learning which was used to hone and develop the Tool further. To give an example, a comment made by ADPHN in the pilot programme regarding Document Two assisting nursing staff to resolve their own issues was a very useful comment. In previous editions of Document Two (before the pilot study) Document Two was used by management to resolve practice issues for staff. This approach dimishes nurse's ability to resolve their own issues and this is not good for practice. Therefore, changing Document Two in the Pilot study encouraged staff to own and problem solve their own issues with some assistance from management. Problem solving is a necessary and pertinent skills required by CN staff and the newly developed Document Two was now assisting staff to cultivate and maintain this skill. This would lead to more competent practitioners capable of dealing with their own clinical issues in a timely fashion thus, improving practice.

It was also interesting to observe the differences in the prospective uptake in CPD between staff. Nurses who had three years' experience began showing evidence of looking at career planning for the future if family circumstances allowed. Senior nurses felt they had completed all the extensive studies they needed and most were now interested in maintaining the necessary competencies for their present and future work situation or else becoming more expert in an area they were working in. The final group was the novice nurse. She/he appeared least interested in education at present as she/he was trying to cope with the steep learning curve of become a competent practitioner in their new practice. For this reason the author decided to divide the nurses in Cycle Four into three categories to examine if the same differences in attitude to education could be replicated. The three groups were Novices (Nurse less than 1 year qualified in Benner's Model), Experienced Nurse (3 +years qualified seen as competent to proficient in Benner's Model) and Expert Nurse (Senior Nurse seen as team leader and expert in practice in Benner'Model)

The other stark difference in the findings was how much in need of support on an ongoing basis that novice nurses are. This led to the development of Another point that came to the fore in the data was the fact that an onsite manager plays an important part in suppling support to staff. This support role of Document One may not be required as much by staff if they have regular ongoing access to their line manager.

There was one other final noteworthy point in the pilot study and that was that no one used Document three, so its usefulness could not be determined. We await AR Cycle Four to review its usefulness. Further adjustments were made to the remaining documents post findings in the Pilot Study and a new Document One A (Appendix A) was developed for Novice Nurses. The remaining documents were updated according to recommendations and were ready to launch in Cycle Four.

5.4 Making recommendations for next cycle

- Need to involve novice nurses to use Document One A in the next cycle to see how useful it is for them.
- Need to identify a case in the next AR group if possible, that would activate the use of use Document Three to assess usefulness of the document.
- Need to decide how often to use Document One (Document 1A) in practice.
- Would like to get the involvement of a Practice Development Co-Ordinator (PDC) to trial all Documents in the Tool but Document 1A in particular as they play a large role in supporting and providing training to novice staff in their first year post training?
- Would like to examine if we could repeat the CPD / Career Development findings obtained in Cycle Three which associated CPD and career development with different life stages in a nurse working life
- Need to assess if Document One is successful in supporting experienced staff or do they feel they don't need a document to discuss an issue or seek support from their line manager
- Do staff find Document One useful to assist resolve clinical issues when they and their line manager work on a different work sites and lack ongoing daily access to each other for support and advice.
- Need to very clear in presentation which introduces the Tool to staff involved in the study regarding functions and use of all Documents in the Tool, particularly Document One, as there seemed to be some confusion in Pilot Study around functions and use of Document One

CYCLE FOUR

5.5 Cycle Four Introduction

Cycle Four involved introducing the Tool, with its redeveloped documents and the addition of Document One A for Novices, to a large research group compromising of 51 nurses. The group consisted of 2 DPHN's 9 ADPHNs, 33 PHNs (including 5 novices divided into 3 groups), 6 RGNs and 1 Practice Development Co- coordinator.

5.5.1 Identifying a problem that needs addressing

Having identified the existence of practice issues, the author and the co-researchers will now introduce the newly honed Tool to investigate if it enhances the prospects of early identification and resolution to practice issues, improves nursing practice and supports staff throughout the process.

5.5.2 Identify knowledge attained from Previous Cycles relevant to the problem

After the pilot project concluded, changes were made to the documents in the Tool for example Document Two changed to allow nurses attempt to solve their own clinical issues before seeking support, also Document One A was added for assist and support novices who need a higher level of guidance and support when they come to work in the community setting. A manager's support is critical at this time and their support influences whether a nurse stays or leaves during this time (Zhang et. al, 2017).

5.5.3 Adapting the knowledge gathered from previous Cycles to formulate a plan

While the researchers are trying to establish the effectiveness of the Tool to nursing practice, there are also some additional questions specific to cycle 4 also that need to be answered like

- Is the newly developed Document One A an effective Document for the novice nurse?
- How often should the novice nurse use it?
- Do experienced staff find Document One useful and do they need it seek support in resolving clinical issues.
- Is Document Three an effective document (not used yet)?
- What is the PDCs view on the documents particularly Document One A. Does s/he feel it supports novice nurses and meets their requirements?
- Will it be possible to replicate the findings re CPD and ongoing education found in pilot study.
- Does document two enhanced staffs problem solving skills

5.5.4 Assess for barriers to the research

Need to make clear presentation to introduce the Tool to staff regarding the functions and use of all Documents in the Tool, particularly Document One, as there seemed to be some confusion in Pilot Study around functions and use of Documents. Also, there is always the issue around time constraints, due to staff shortages. This has been a common theme throughout the research and while we cannot solve it, we encourage staff to attend as many data collection events as possible, given the circumstances

5.5 5 Tailor and implement the action plan

The same format was used again as done previously. The documents were introduced by PowerPoint and an agenda was given to staff (Appendix H). A full and extensive explanation of the use and function of each document was given to avoid any confusion with regard to the use and roles of the documents in the tool. The author took the contact emails of all staff in the study so as she could send them the questionnaires to evaluate the documents. The nurses were supplied with the documents. However, there were two differences this time, the first was regular ongoing support was being supplied to staff during this research on a monthly basis or more often if needed to assist staff to use the documents appropriately and prevented any misinterpretations. Secondly, the research period was being extended to a 6 month period so this also gave staff more time to use the document appropriately. The co-researchers also met on a monthly basis to discuss how research was going and in hind-sight this was a very good idea as it kept the motivation high.

5.5.6 Monitor the implementation of the action plan

As stated there was much more support for staff involved in the research on this occasion. Also when an issue occurred, the author tried to visit the site herself if possible, because her co- researchers were all employed in the area and from an ethical point of view, it was more appropriate for her to visit. Still, very few incidents arose throughout the 6 month period and none that infringed upon the research.

At the beginning, there was little outside interest in the research however, when seven of the researcher participants decided to move on to make applications for third level education, this enhanced interest in the project. Nurses sought to join the group who were at the initial information sessions but chose not to join at that time. Unfortunately, we were unable to take any late applicants into the project as the research was already underway. However, it gave the group great satisfaction to see the interest that was

being ignited by their research and the documents. We had no staff losses from the research group on this occasion.

Due to the authors specific interest in seeing how effective Document One A was, the author chose to follow two novices during the research to see first-hand how the new document was working for them. Other cases she visited included two cases that required the use of Document Three. These were great opportunities to assess the usefulness of Document Three. When it came to looking at the confidential notes in files on both cases, the author sought permission and only she gained access to the notes after permission was granted by management and the staff involved in the case. No other researcher accessed these notes and the notes kept by the author were anonymised to ensure confidentiality.

5.6 Evaluation of the outcomes

5.6.1 Evaluation of Document One

Data from questionnaires, interviews and focus groups were read and re-read to allow the researcher to become immersed in the data and in order to give an overall impression of the findings and to develop emergent insights. Main themes were identified in relation to patterns that recurred throughout the data preliminary 'properties' such as; ongoing CPD, plans for future career development, plans for future learning, good support with work issues, issue improved, issue resolved, better relationship with manager/nurse, improved patient care delivery, more updated and competent nurse. All of these themes emanated from Document One. All staff agreed that there was a change for the better to their practice. However, the biggest changes were with the novice staff using Document One A. One nurse said

'It was like a lifeline, I felt I was drowning until I got it, it really made a difference. '

Another had similar views saying

'*Now I know where to go when I have issues, I don't feel scared coming to work now'.*

It was obvious that for the novices, the Document One had brought great support, Figures 5.5 to 5.8 demonstrate findings from the data collected on Document One

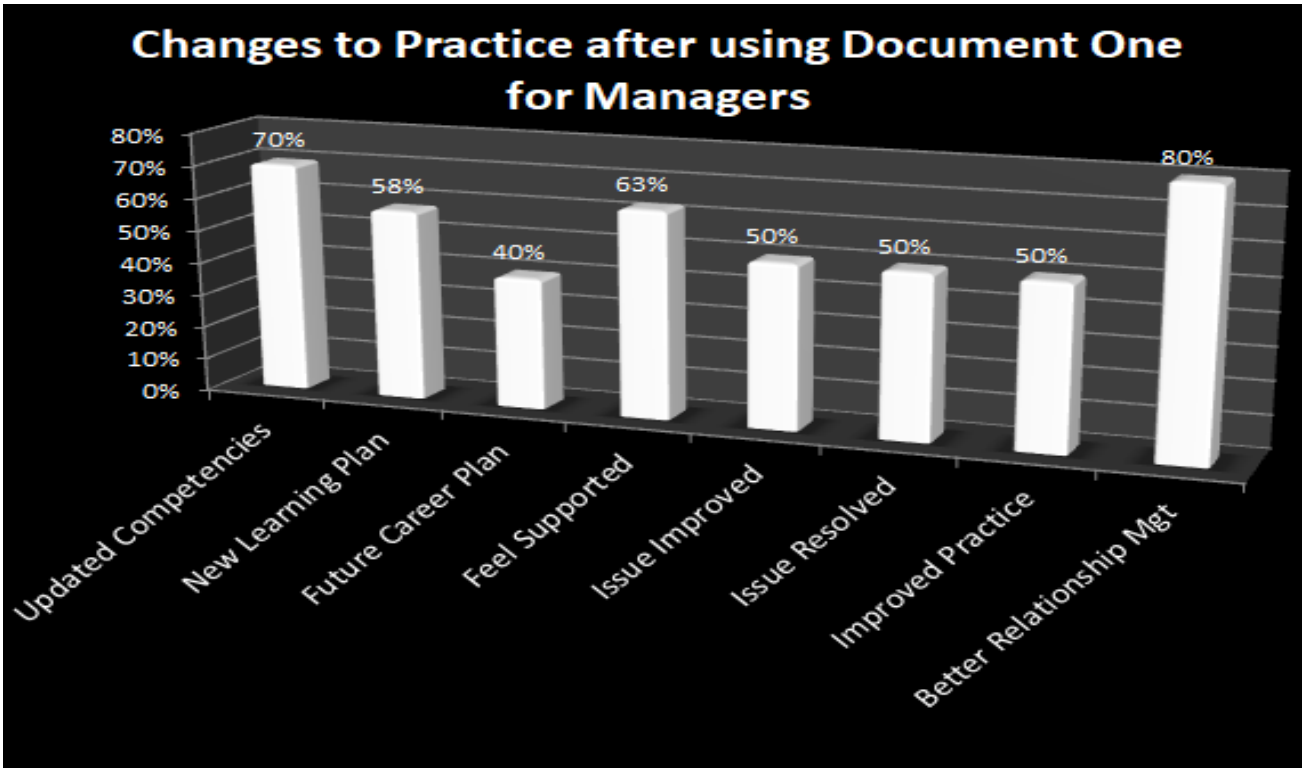


Figure 5.5 Changes to Practice after using Document One for Managers

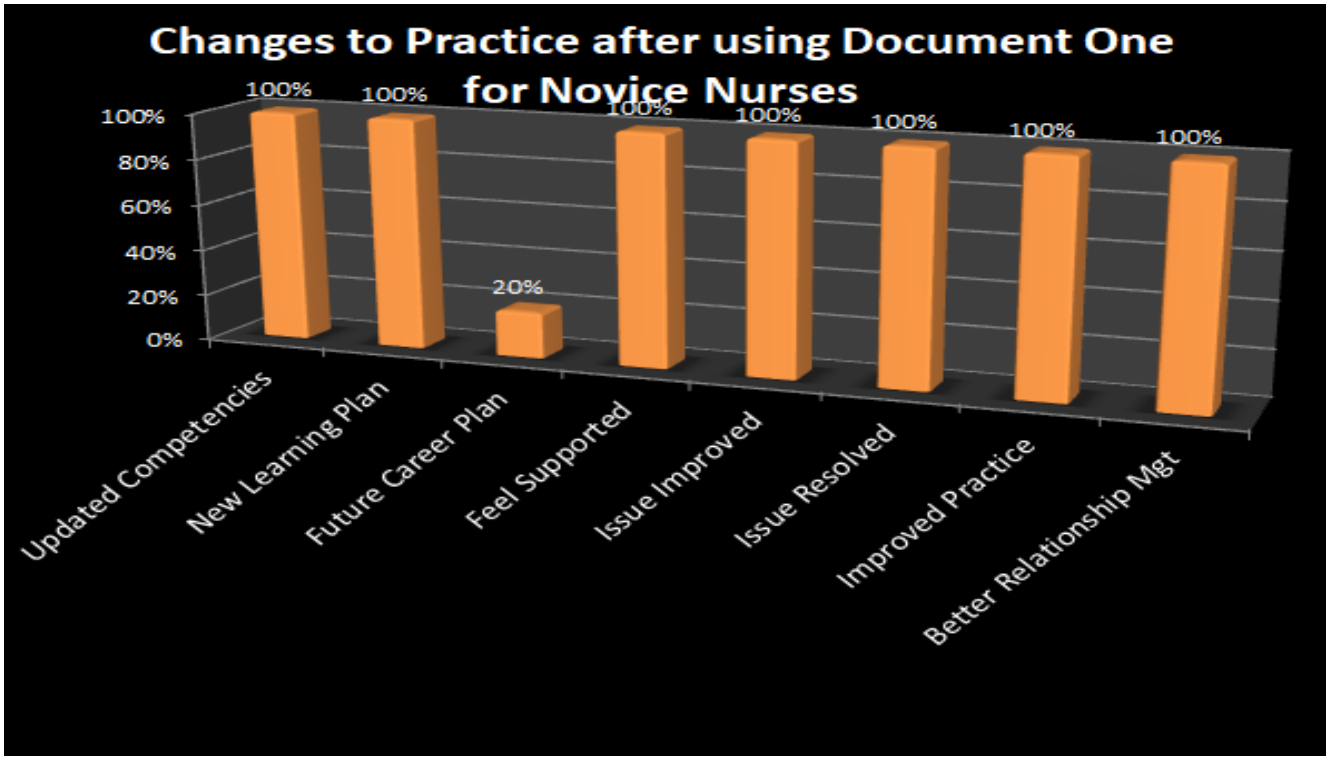


Figure 5.6 Changes to Practice after using Document One for Novice Nurses

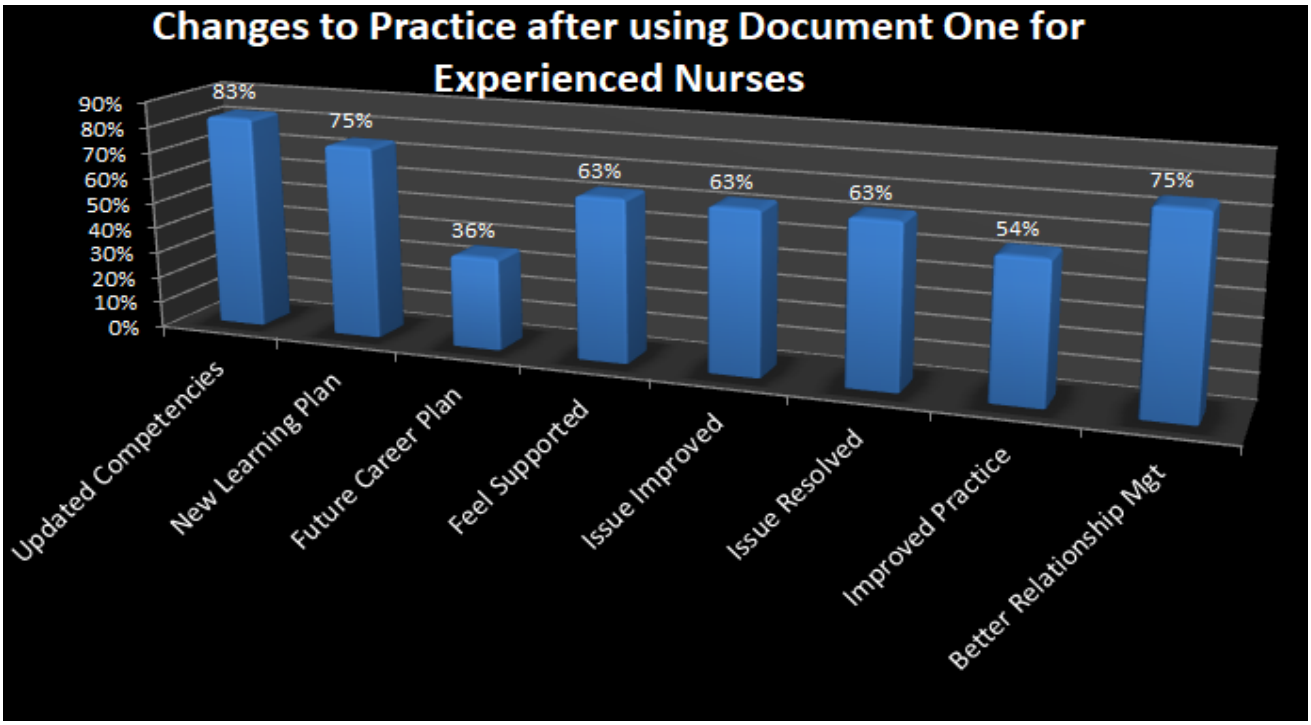


Figure 5.7 Changes to Practice after using Document One for Experienced Nurses

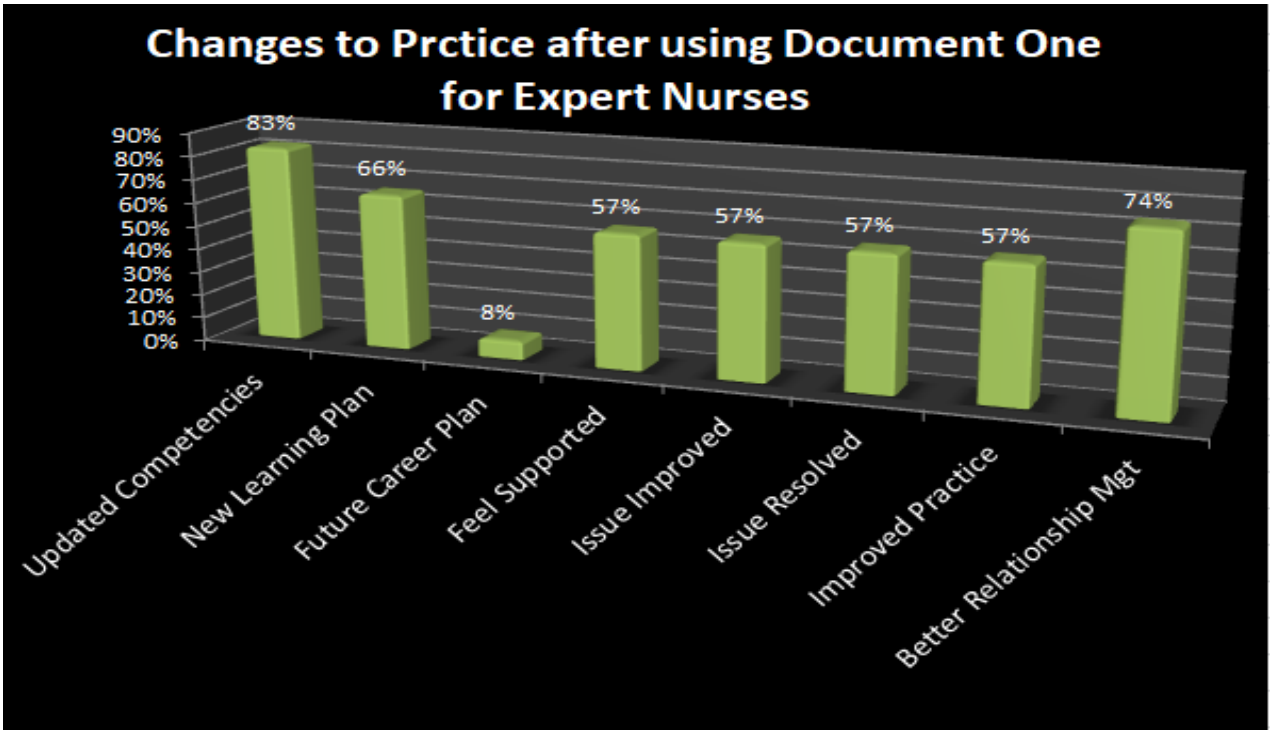


Figure 5.8 Changes to Practice after using Document One for Expert Nurses

5.6.2 Findings from Staff who used Document One

Document One appeared to be a good overall document that suited all grades. However there were some findings that stood out in the data. One of these was how the novice benefited most from Document One. All ten novices (100%) felt their competencies improved, they developed new learning, improved or resolved issues and improved patient care. Only 20% of novices sought new formal learning and this was associated with developing necessary competencies for their new role. The other 80% said they felt saturated with new learning, as they adjusted to their new job and they had no plans for further education or future careers plans at present. The vast improvement by novices in all other practice areas examined in the study was a real indicator of how much in need of practice review and support novices are. This was the most noticeable finding in the data. There were several other findings and these are grouped according to themes.

5.6.2.1 Support

Novices reported that Document One brought support to their practice. In the two novices that the author followed, they used the Document One A, fortnightly on two occasions, then reduced it to monthly. They felt as time evolved, they could reduce it even more, but for the moment they were happy at present with a monthly review. All of the novice staff (100%) felt that the document gave them an opportunity to get support from their line manager and they felt it had an impact on their practice for the better. They felt it made them more secure in their practice and now that they had support to assist them.

63% of nursing management felt they got a good opportunity for support with their practice issues through using Document One. However, when this figure was broken down into ADPHNs and DPHN's it was 70% of ADPHNs felt supported by DPHN and colleagues but no DPHN (0%) felt supported in their job. It was the lowest score in support of all groups involved and the author felt that having listened to the DPHN's they really lacked a support system. However for the duration of this study each DPHN availed of the other DPHN to support them with their issues and both reported finding it very beneficial and hoped to continue to use it after completion of the study. It was obvious that some form of support system needs to be developed for DPHN's to prevent burnout and DPHN's leaving the job. 57% of expert nurses and 63% of experienced nurses felt Document One helped them feel supported by management. While this was a great improvement on the Pilot study, and the expert nurses did welcome the opportunity the document offered, they did report that they had developed their own support networks so they were less dependent on this document to support them than the other nursing groups were. The ex-

perienced staff agreed with this statement also and reported that they too had cultivated their own support networks. Despite this, both groups welcomed Document One as a go to document when they had an issue that needed discussing and they had not resolved it themselves.

5.6.2.2 Better Relationships

All grades had said that using the document had greatly improved their relationships. Novices said they felt the document had improved their relationship 100% with their manager and they now felt able to approach and ask for help and advice when needed. Management felt their relationship with staff had improved by 80% and nurses reciprocated this by 74-75% reporting better relationships with management. This was a substantial overall rise and the author asked why. The staff reported that taking time initially seemed an onerous task as they felt they did not have the time to give. However as the study progressed and each nurse took time out to participate, it gave them the space they needed to group and reform. They felt speaking to their manager about other things was a welcome respite and break from the stress. They felt they had time to take stock and they were glad of the support they received. The line managers also reported it was a much more pleasant experience for them also. Both parties admitted afterwards that they felt initially it would be a loss of good practice time, but afterwards they said they enjoyed taking time out and they needed it and would continue to use it.

5.6.2.3 Improvement and Resolution of Issues

All staff felt that having the opportunity to examine practice, helped them identify and discuss practice issues early and this lead to improvement or resolution of issues in a timely fashion. Novices again scored highest here but all staff - both nursing and management welcomed the opportunity to seek advice on practice issues.

5.6.2.4 Future Career Planning

This was the only area where the novice nurse fell below 100%, they rated this area at 20%. This was because they said they could hardly keep up with new knowledge generated on a daily basis as they became accustomed to their new position. One of the two novices interviewed replied

‘ *I only put yes in my reply, in case my line manager needed me to get updates but I have no intention of any more studying until I get to grips with this new job’*

When it came to career development plans, managers scored highest with 40% planning future career. This is in keeping with Gould et al. (2001) view which highlighted the importance of CPD in nurse managers. Managers are more likely to continue with ongoing education and career development and are often more interested in further-development than frontline staff.

One significant fact regarding future career planning stated that 37% of experienced nurses were interested in career development. There was a significant difference again between the expert and the experienced nurse in this category, with only 8% of expert nurses looking to advance their career. This is a significant difference and one worthy of further investigation.

In a post study review of the 37% of staff who reported being interested in planning their future career, 7 staff (13.7%) of the whole group went on to pursue a college course and another 3 (5.8%) staff are presently preparing for entry next year. This was an increase of over 100% uptake in 3rd level education among nursing staff from the previous year in that CHN, and it is above the average of any other CHN. This brought great interest in the Document One and since completion of the study, other nursing staff have volunteered to use the document and continue to look for it from their line managers in that area.

While 37% of experienced staff showed an interest in career development the remainder of the experienced staff felt they were not in a position to take up third level education. When the author queried further would there be changes to their future plans one nurse said

‘I’m not ready yet as the children are still too small, But, I am looking into it for 2 years’ time when my youngest is in school’.

The author found that while staff were not actively progressing a career plan they had intentions of seeking one in the future particularly in the CHN where the biggest return to education had occurred. Experienced staff found that Document One helped them to refocus again and they began to make career plans. However, there was a consensus among many that rearing a family had put a hold on their careers. The

author researched this phenomenon, and there are several papers written on this subject in nursing. The author wondered if a different approach would bring more opportunities for education, career development and succession planning for nurse, especially female nurses. Many career promotions in nursing are full-time positions and this constitutes an automatic block to the careers of many women (Davies and Conn, 1993). So the author asks should we offer job-sharing in promotional positions. Could we deliver educational courses in a more flexible way and use more modular courses that nurses can do online and complete over a longer period? Covid has brought much learning to the delivery of inline education, and perhaps we should use this learning going forward to improve things, particularly for the female nurses who make up 92% of the nursing work force (NMBI, 020). Simple changes like these mentioned above could assist female nurses succeed and gain promotions and speed up career promotions to a level where they are equal to their male nursing colleagues who form 8% of the work force but make up almost 19% of management grades and higher pay grades in nursing (Pudney and Shields, 2000). Again, the author suggests this is an area worthy of further investigation.

5.6.2.5 Planned New Knowledge

This brought a much bigger response from nurses with 66% expert and 75% experienced to take courses. They reported that wanting

'Short courses are OK with children, but you could not be doing a Masters'

58% of the management team were also interested in short courses and 100% of the novices (this was in keeping with their profiles). The Novices again said they were not actively seeking anything. They replied positively in 20% of the replies, in case they were sent on courses to update their competencies.

Overall, the author felt these findings were in keeping with the interest in education for future career planning and some staff were using courses as a stepping to get ready for taking the bigger step into third level education when ready to do so. However again, online family friendly methods of educational delivery would enhance uptake and given the current climate, with the big upsurge in education being delivered online, the author feels this is could new approach should be encouraged to continue as it assist female nurses return to education with less risk of delaying career plans for them.

5.6.2.6 Updated Competencies

As expected, the novices scored 100% as they were updating competencies on a daily basis. In Figures 4.3, 4.5 and 4.6 it is also worth noting the differences between nurses and managers. Nurses scored higher than managers when it came to updating competencies and this is to be expected as the nurses are working frontline and need regular competency updates. Management scored 70% and nursing staff 83%. So using Document One had ensured that both nurses and managers had checked their competencies ensuring they were up to date and many booked updates. Document One was very successful in this area of education.

5.6.2.7 Improvement in Practice

This was what the author set out to examine if there was an improvement in patient care by using the Tool. Novices rated the document to have improved their patient care delivery by 100%, managers by 50% and nurses 54-57%. When the author asked what helped improve their practice, it appears that

'...by sitting and discussing issues with my line managers I reached better clinical decisions and mde better prioritisation decisions and this improved my patient care. '

One of the expert nurses said that

'I found the document helpful when it was not a nurse related issue, but a clinic or a team related issue that needed attention. I felt the document did a good job in getting us together to discuss the issue and solve it locally. '

This surprised the author as she felt that the expert nurse would have operated at this level but she said

'As an expert nurse you look after your own caseload and you help others but there are local issues like trying to coordinate leave, caseloads being covered, prioritisation of care, lack of clerical help, clinic supply ordering, and other Primary Care Centre issues that need to be discussed and Document One did make this easier. 'It puts an agenda on the table and meetings got called and resolutions found'.

5.6.3 Evaluation of Document Two

This was used in six cases where staff asked the ADPHN to visit to discuss matters that they could not resolve themselves. The document resolved three of the six issues and three improved, so staff felt that

this was a good outcome despite only resolving 50%. In a case that had improved one nurse reported

'Teose issues are chronic, and I can't get them fixed but the advice has certainly helped. I feel even by discussing them it helps, at least I feel someone else knows about it and I'm less worried.'

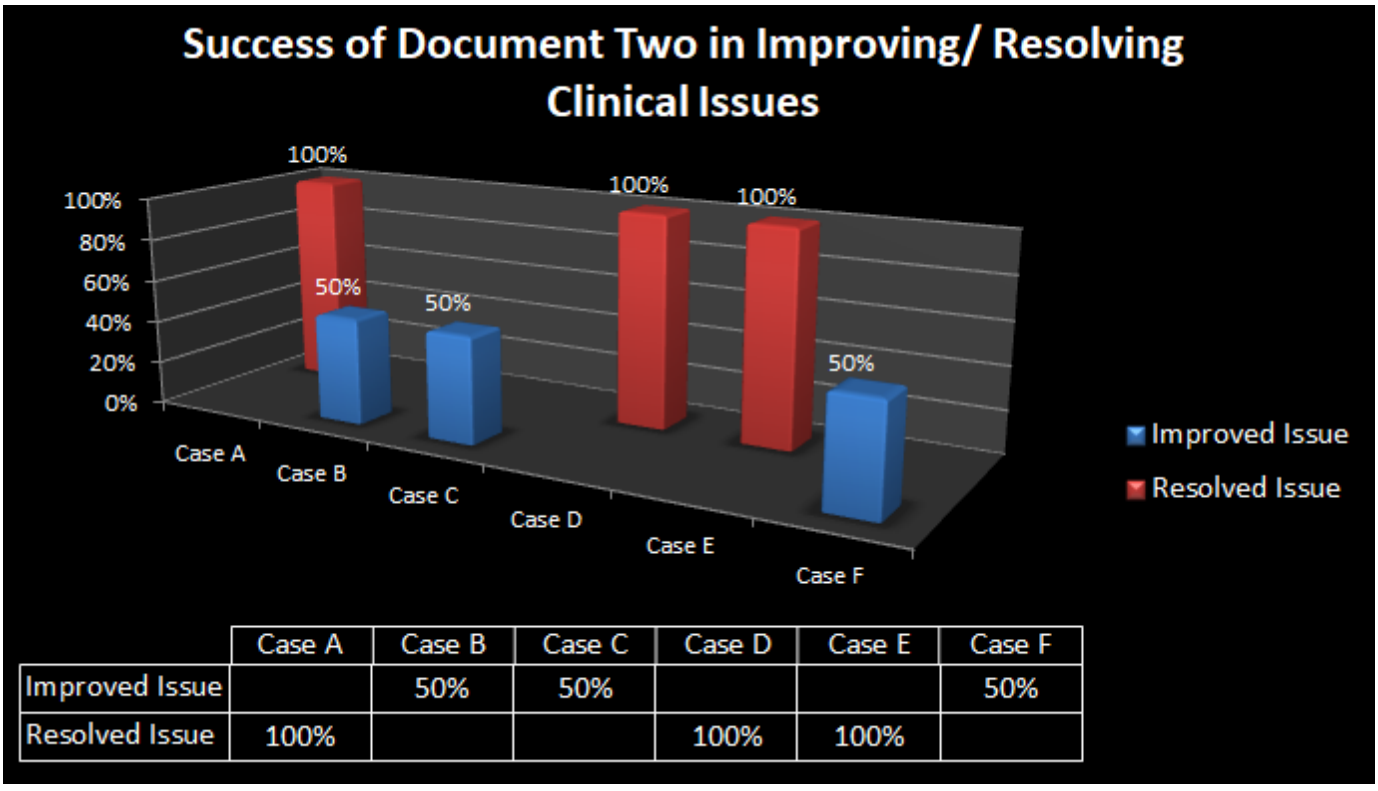
So the author was happy some success was felt if resolution not found, but as one other researcher said

'We *are dealing with patients here not problems; we don't always get solutions'*

In hind sight, the author believes this statement is accurate. Making improvements is as important as getting resolution and accepting this is equally as important. We cannot solve all issues. The nurses felt too, that being given space to discuss their issues helped them cope with the chronic issues. One said

'*…even if I didn't resolve it, now that others have given opinions I know I'm doing the best I can with this case. Talking about it has helped…I'm reassured I'm doing the right thing'*

Figure 5.9 below demonstrates graphically the success of Document Two in improving or resolving clinical issues. It scored a 50% for improvement and a 50% for resolution.



	Case A	Case B	Case C	Case D	Case E	Case F
Improved Issue		50%	50%			50%
Resolved Issue	100%			100%	100%	

Figure 5.9 Success of Document Two in Improving or Resolving Clinical Issues

The overall score of 50% resolution 50% improvement for issues dealt with in Document Two was similar to the pilot study. It was enlightening to hear that the outcome that resonated most with staff as successful was not the resolution of the issue but the release from stress by unloading and discussing the problem. So to staff the release of stress by discussion of the case was as important, if not more important than reaching a resolution- the author felt this was also a key finding.

Regarding managements view of the Document Two they liked it as they felt it assisted and encouraged staff to examine their own issues and try to resolve them before they presented the issue for assistance with its resolution to management. Also these tried resolutions were presented pre visit by line manager so there was no time-wasting on similar suggestions. Also the fact that Document Two had to be submitted 7 days prior to ADPHN site the ADPHNs and DPHN's liked it as it gave them time to discuss the issue and examine resolutions. Management found this beneficial to practice.

In one of the areas in the study, reflective practice was introduced as a structured method to reflect on practice. All managers and some senior staff were trained in reflective practice and it was hoped to introduce this practice to all staff in the area, however due to the Covid crisis it was only used locally on the management team and not rolled out to frontline staff. However to date the response to its very limited use has been rated highly. While no formal study has been completed due to Covid, it does appear to be another successful method of allowing staff review their practice and it gives them the space in which to make appropriate decisions re future care delivery. The author feels it could supplement the use of the Tool.

5.6.4 Evaluation of Document Three

This document was used by management when an issue develops that was interfering with practice. This document gave management a tool that could clearly identify what the issue was and then the opportunity to discuss it and look at different ways of resolving it. It assisted identify what the issue was and what needed to be done to correct the matter. Where used staff reported that it led to a more open discussion and the building of trusting relationships, safer practice and reduced risk of litigation.

Document Three was used in two cases. The author was able to access the clinical notes from these cases after permission was granted by all concerned including the staff involved. When asked about the usefulness of the document, management found it a very valuable and functional document. The all rated it highly and said it was easy to use. They felt it simplified dealing with the complex matter of practice issues and they have gone on to adapt it locally.

The author interviewed the management staff that used Document Three and they felt it led them through the procedure of dealing with the practice issue in a very professional manner. First it identified the issue staff said

'Naming an issue can sometimes be the hardest part of the dealing with the issue, the index attached to Document Three assisted me identify and name the issue.'

When the issue is named, the document then presents options to choose from to improve practice and support staff. The choice is discussed, the action plan is formulated and agreed upon and review dates set. Both management and staff liked the document and while no one wanted to be in a situation where they needed to use it, they found it a very usable document and they felt it brought clarity and direction to all involved.

When I examined the notes from the two cases I could see where the entries were made about practice issues and then I could clearly see how the plan was made and used to improve the practice issue. I also spoke to the two nursing staff involved in using Document Three. Both staff were clear about what the issue was, and they knew what was expected of them to improve this issue and what date this was expected by. Both reported

'It brought clarity to my situation; I knew what has to be done, by whom and when it was to be done'.

Managers who used Document Three felt that while it was

'A clear, concise document and brought clarity to practice issues, its strength was it removed the personal element, made it more business-like'

One ADPHN added

'*It simplified matters and removed the personalities from the procedure. '*

The two ADPHNs and DPHN's that used this document have recommended it to other areas and it is now being used in a few different sites since the research completed. It has also been adapted by 2 other discipline working in the HSE also.

5.7 Make recommendations for next cycle

The author was happy with the success of the Tool particularly Document One A for Novices and Document Three for correction of Practice Issues. The Tool has been adapted in its totality in two areas and Document One A and Document 3 has been adapted by several areas. The newer version of Document One A is presented in the Appendix A which is the last version of the document and is currently being used in some areas. However if there was to be recommendations going forward the author would suggest that

- Document One A (latest version) be adapted for use with novice nurses
- Document One be completed by all staff twice annually to get college applications in on time as suggested. It would also give staff the opportunity to plan their career and keeps them updated in their competencies and it does appear to improve nursing practice. However, Document One should be voluntary and not mandatory, 74% of staff said they liked it and would use it again.
- Document Two continues to be used as needed. It is there for referral when needed.
- Document Three has been very successful and has already been adapted by several areas.
- The final thing that emanated from the document was the need for reflective practice in nursing. When staff were given the space and time to discuss their practice it did improve practice.

5.8 Discussion on the findings

Chapter five has presented AR cycles three and four. In cycle three the 'Tool 'was launched through a pilot study. This was a small study which involved six staff from one Primary Care Centre. Following the pilot study, the Tool was adjusted according to findings and then re launched in cycle four. Cycle four was a more extensive study and it involved 51 participants' who assessed the Tool for usefulness for practice. It ran over a six month period, after which data was collected and analysed and the findings were then documented and presented. The findings showed the Tool was successful in that it brought

many improvements to the staffs working lives and it assisted in improving practice. We will now examine the improvements and changes it made in greater detail.

Regarding education this was a very successful outcome in that the numbers entering education elevated way above the average elsewhere. There was a 100% increase on previous year for third level education in one area and a 40% increase in the other area for entry into third level education. Regarding ongoing courses there was a 45% increase on previous year in one area and a 35% in the other. While these figures are good, the element that interests the author most is where this education will lead. Will the nurse who completed this study and entered education use it to improve practice, improves competencies and will it open career doors for the staff member? The author feels this is another area that warrants future studies at a later date. However having used the document with staff it is felt that even if it is not successful first time, the repeating of the exercise six monthly as suggested, hones the procedure and brings more focus with each attempt. This then enhances its effectiveness and raise the prospects of staff successfully planning their career pathway (Roberts, 2014) or else being appropriately prepared for when the career opportunity presents itself (Gould Williams, 2007 and Roberts, 2014). However, from an organisational point of view, giving staff an opportunity to advance their career and / or engage in educational courses that interest them, greatly enhances the prospects of retaining staff. They are more likely to stay with an organisation that demonstrates an interest in its staff, needs and their career progression (Aiken et al., 2009).

On the topic of better relationships and support the research found that 74.5% of nurses and 100% of novices felt the documents assisted them to receive support from their managers and they felt this led to better relationships. Managers agreed with these findings. These results reflect the manager's ability to build trust and relationships, as well as expressing caring for staff (Turke, 2014). It cannot be emphasised enough how nurse managers exert substantial influence on the work environments and influence performance, safety, quality and patient experience, as well as other things like job satisfaction and retention (Aiken et al., 2009; Spence and Laschinger, 2012; Yang et al., 2013). This is true of nurses at all levels of experience but particularly pertinent to new nurses (The Ganey Report, 2017). The author feels the research demonstrated the real need for this support in the novice nurse. This is a serious short coming and it existed in both areas that took part in the research; our community nursing system needs to change to correct this serious deficit (Holland, 2016). Missen et. al., (2016) spoke of how just over thir-

ty-three percent of newly qualified nurses are prepared for entry to practice. Yet as newly qualified practitioners, we expect them to work alone so much of their time. When the author was compiling this data she contacted three novices PHNs and asked them could she interview them regarding this finding and it was found that the findings were correct. They found that the regular reviews supplied through Document One A, assisted them lower their stress levels and feel less isolated and lonely. These views were backed up by a PDC who spoke of how much better support for novices was in areas a PDC existed to mentor and support novices (Holland, 2010). Given this detail it would seem appropriate that all areas in CN should have a PDC and it would be a recommendation from this research. In the meantime while we await this development, the author recommends using Document One A for regular practice review with the novice. It is hoped this will assist in retaining staff and give them the chance to develop into competent and confident practitioners.

Finally the Tool examined the area of correcting poor practice. This can be an area that managers fear tackling. However the simplicity of Document Three appears to have worked well for the managers in the study. It must be remembered that tackling poor practice plays a large part in a managers work and in service improvement (Aiken et al , 2009) Also it is important for staff morale for managers to work to deliver best practice and organization's that delivers a quality service have better staff retention (Aiken et al , 2009). An interesting point the author noticed when completing the analysis of the data was, that neither of the issues that required the use of Document Three were picked up on the patient survey. However, when I investigated both cases, one was not a patient related issue and in the other case, the patient did not return a patient questionnaire. This is possibly due to the patient choosing not to complete the questionnaire. The author was not in position to enquire but it does highlight the fact that managers need to be alert to pick up on all indicators of practice issues in an area. It can present as rapid staff turnover in an area, low productivity, excessive sick leave, staff disengagement or other indicators (Branham, 2012). Perhaps coaching is needed or building social connectedness within the team or even creating the vision (Branham, 2012). While exit interviews are good at identifying issues, they are too late by their very nature, in that a staff member is already lost (Branham, 2012). Perhaps, we need to form some sort of system that promotes employee voice and builds it into a feedback system. It could include remaining anonymous. Such a system could reflect more learning for managers especially in incident's that are ongoing and other staff are reluctant to raise the issue and often remain silent (Branham, 2012).

5.9 Conclusion

While the author is happy that this Tool has been a success and its adaptation and use in CN is testament to this. However, the author's biggest wish is not that it be adapted by others, but that it will prepare staff for where we are going as we enter a world of rapid change, new roles and new ways of doing business. The author believes that the Tool could assist managers to drive organisational performance forward (Derler et al., 2017). It has the ability to support staff while meeting their personal and their work needs and to develop and engage them, leading to better career pathways, more job satisfaction and improve nurse retention rates and ultimately, better patient care (Aiken et al., 2009 and Batista-Taran et al., 2018, Prado-Inzerillo et. al 2018). The introduction of this Tool happened in the midst of a pandemic with rapidly changing clinical environment, staff shortages and considerable external and budgetary challenges, yet it succeeded. Given the background to its launch, the author believes that it processes many of the necessary hallmarks and the essential ingredients needed to drive improved nursing performance in a world of flux and change. She feels the testing of the Tool in such an environment, only adds to its credibility.

The final chapter –chapter 6, will now take a final view of the context of the study, followed by the methodological issues revisited, a summary of the key findings, and the overall outcomes from the research. Also addressed is the contribution that the study makes to present practice and future recommendations are made. Finally the limitations of the study are discussed.

CHAPTER SIX THE FINDINGS

6.0 Introduction

The desired outcome of this study was to develop and implement a set of practice review documents (the Tool) into community nursing with the intention of supporting staff, improving practice, maintaining safe patient care and preparing staff for future service delivery. The study explored the development of the Tool, its implementation and it then investigated if any changes occurred as a result of its implementation leading to an improvement in nursing practice.

This and the preceding chapter present data collections which were generated when evaluating the introduction of Tool into CN. This data was generated using an AR approach and it is presented from the perspective of nurses and nurse managers who used the Tool. In the final chapter the author will take one final look at the context of the study and why she chose this topic for investigation. Also the methodological approach taken for the study will be revisited and there will be presentation of the overall key findings from the research. Then the contribution that this study makes to community nursing will be discussed and conclusions drawn and finally recommendations for future practice will be made.

6.1 Context of the Study and Reason for Project Selection

In today's climate, staff shortages and escalating workloads have left nurses working in the community under severe pressure. If managers do not take a strategic direction and become responsive to both staffing and patient needs, then service delivery will no longer be adequate or fit for purpose (Phelan and Mc Carthy, 2018). Recent years has brought a major change in demographics, with early discharges, increased complexity in caseloads, pressures from political, social and economic factors bringing an increase in the number of medical card issued, leading to increased eligibility to community nursing services. In addition, there has also been a rise in population with no corresponding rise in staffing levels. and care is being given to a public who are better educated, and more litigation minded. Given this environment, it is becoming increasingly difficult to maintain and deliver of an effective, efficient and safe nursing service.

In addition, to all of the above the launch of Ireland's new Sláintecare Programme (2020), which recommends a relocation of many hospital services to the community setting is about to be launched (DOH, Sláintecare Programme , 2019: 41). However, to date there have been very limited discussions with community nursing management around these new proposed developments (Phelan and Mc Carthy, 2018). Community based staff are already feeling over whelmed and the author believes that nurse managers have now three parts to play. Firstly they need to support staff in these difficult times of increasing workloads and staff shortages so as to maintain and retain them. Secondly they need to maintain safe practice and prepare staff for future service delivery changes and thirdly they need to lead the CN service forward into their upcoming, imminent changes, and to recognise these changes not as a challenge, but as a golden opportunity, to reshape the service. It is an opportunity to activate, mobilise and focus energy and more resources in the organisation so as to shape a new and better future for both the patient and the nurse in CN (Sláintecare Programme, 2020). Now is the time for a visionary and proactive style of leadership in CN (Phelan, 2018).

The author based this research study upon these points, which is being a leader who is visible, leads from the front in turbulent times and introduces a Tool capable of 'maintaining safe practice while supporting staff in community nursing ' during these times of flux. It has focused on improving practice and in particular on the phenomenon of delivering better patient care while supporting staff. While completing this study, the author has reviewed existing literature in order to ascertain the validity of popular claims of high and rising practice issues among nurses, nationally and internationally, to explore the possible explanations for this phenomenon and to examine how practice could be improved. It has drawn upon international writings and the author has adapted these to the Irish context, focusing on CPD, leadership, practice review, staff mentoring, staff support and methods to enhance staff retention. This part of the study concluded that in order to understand the processes behind practice issues, we need to understand the struggles of nurses and the experience of patients to identify what is going on in practice on the ground. Therefore, this research took on an investigative side, which involved, scoping out exactly what is going on in Irish CN practice from the patients and the nurses perspectives, then a developmental side where using this evidence, the author developed a Tool in the form of a suite of documents, to apply to improve practice and support staff. In the implementation part of the study, the Tool is tested in practice and then suitably adjusted according to feedback and then implemented fully into practice. The study concludes that the Tool was successful in maintaining practice standards, supporting staff, improving patient care delivery and encouraging staff to engage in CPD both to remain competent, updated practitioners and to enhance their future career prospects.

Going forward, the author also sees the Tool as being an effective way to assist staff to be educationally prepared for their new roles and new career pathways which are about to emerge with the roll-out of the Sláintecare programme (2019). Chronic disease management is soon to be to be managed by GPs and community nurses in primary care, with hospital admissions, being reserved for an acute exacerbation of the conditions only (DOH, Sláintecare Programme, 2019). This will mean an expansion of the CNS and ANP roles in chronic diseases management in community. Staff need to be prepared and at the cutting edge of these developments and positioned appropriately and educationally to take on these new roles, enabling this shift to enhanced community-based healthcare, to happen seamlessly. The author sees the Tool, as a vehicle to maintain practice standards, support staff in turbulent times, improve patient care and most importantly to prepare staff for future developments. While change is never easy, it is a necessary process.

For this project the author chose an AR approach (AR), as this is the only research method that offers the opportunity to change and improve practice. While all research aims to generate knowledge, the focus of AR specifically, is the production of knowledge that is directly relevant to peoples work and their lives' (Waterman et al. 2001:54).

6.2 Methodological Issues Revisited

The use of an AR approach permitted the process and experience of partnership to be explored from various perspectives, timeframes and contexts. The study contributes to a better comprehension of AR and confirms previous claims that the AR methodologies provides a good method to simultaneously study and manage change initiatives in an organisational setting. However, a limitation of AR is that it is regarded by some as not being scientific enough to be called research and this is compounded by the fact that it deals with specific problems thereby lacking the breath necessary to ensure generalisability (Mc Caugherty 1991; Wilson-Bamett and MacLeod Clark, 1993). Conversely, the author found that the flexibility of the AR approach allowed greater freedom to explore the causes and the possible solutions to practice issues in CN; other research approaches could not have as easily accommodated this. This dynamic partnership moved with ease through the different cycles of the research and was capable of accommodating the need for various types of knowledge to be discovered in relation to different participants like patients, nurses and managers and their range of perspectives and views on nursing practice and nursing practice issues. The AR approach was capable of being adaptable enough to adjust to differ-

ent situations while maintaining the integrity of the research approach from a paradigmatic viewpoint and acknowledging that each cycle of the research contributes to the whole story of a single AR project. However, it is the subjective nature which generated the reality based data; high in context and description which was most suited to the purpose of this study. In addition to and because of this, appropriate steps were taken to promote the quality and rigor of each cycle of the research. Hence issues in relation to the validity and reliability of the themes elicited from the data were checked with the participants in terms of the validity and reliability of interpretation in the pre documentation phase after each cycle. Also some cross-referencing between author and co-participants of their experience of our partnership was also secured, as was triangulation of all data gathered. These systems afford the required, additional support to the validity, reliability, credibility and trustworthiness of the outcomes.

AR is also a collaborative process and the collaborative participation of the participants and the researcher added to the quality of the study in terms of presenting a pluralistic view which is reality based, as it is grounded in the experience of the participants, both patients and nurses. The study therefore produced knowledge which is representational, relational and reflective and which has already been tested practically in terms of value to bring about change. In addition, the literature review provided general agreement and support to the outcomes of this study. Thus, the chosen AR design facilitated informative outcomes and enabled translation of learning into the development of a useful Tool for supporting CN staff and improving their practice. The research has shown that this Tool has enhanced the prospects of early identification of practice issues, lead to timely resolution or improvement of the issue with better outcomes for patients and staff and less risk of litigation to the organisation. In addition the Tool has increased the uptake of CPD and competency training and career planning among the staff that used it. These all lead to better care delivery and improved practice. Also this piece of research will add to the Irish literature written on CN and managing work related issues and the need to support staff with these issues if best practice is to be maintained and staff retained. The author will now move on to discuss the findings in each AR cycle

6.3 Summary of the Key Findings

The evidence shows that the documents were successful, with findings revealing that they enhanced practice and staff spoke of feeling better supported (particularly novices). Document One findings revealed that staff were happy to discuss practice issues and get support and advice on them. Document One also enhanced CPD uptake and career planning improved. Regarding Document Two, staff felt that fifty percent of their issues were resolved and fifty percent improved. They welcomed it as a tool to use to highlight and deal with their clinical issues going forward. Document Three was also found to be a very valuable Tool and the attached index, was very useful in identifying the actual practice issue for nursing management (naming an issue can sometimes be a problem in itself) and when identified it supplied a clear and concise plan to aid resolution of the issue. The nurses who used it, spoke of being clear about what the issue was and what the plan and timeframe for resolution of it was. In addition, both parties felt it was easier to deal with the problem using Document Three. Document Four also functioned well, bringing the patient's point of view to the fore. It emphasised their views and it was a good indicator of what we were doing well and what we needed to change. When we service plan, cognisance must be taken of patient's views if we are to shape service delivery appropriately. The patient input was invaluable in the research, it produced rich data and their views also confirmed other findings. Patients liked the document, particularly the older clients who were less likely to voice their complaints verbally than their younger counterparts.

Overall, all staff who used the documents reported feeling better supported, they felt the Tool improved practice and delivered safer healthcare for patients, while supporting staff. These are all important elements for staff retention and improving patient outcomes. Staff felt it was beneficial both to their practice and their well-being and recommended its introduction into practice, with use every six months. Novice staff found their adapted version of Document One an invaluable resource and of all staff they benefitted most from its introduction to support them and assist them adjust to their new role. The advocated for use of their support document fortnightly extending to monthly then three monthly for their first year of practice. They also required a regular mentor to apply the tool, such as ADPHN , PDC or a senior expert colleague. While this group got most benefit from the Tool, all staff felt it was needed; particularly now as the annual case review is aimed at key performance indicators and staff well-being is not raised or discussed as much. The Tool is already in use in some areas in nursing and its use has extended outside of nursing to other healthcare professions in one area. It is the intention of the author to introduce the set of document (The Tool) nationally to all CN areas. While completing this research,

other important findings emanated in the data also and the author will now discuss these and recommendations will be made.

6.4 Other Findings

In addition to the research producing a Tool capable of assisting staff improve practice, seek support when clinical issues arise and engage in future development, the research also produced evidence of four very pertinent findings. Firstly, missed care has become more prevalent in CN with one hundred percent of staff in the study reporting having experienced or witnessed it. Also in an attempt to prevent missed care many staff appear to now be rationing care and seeing only the most urgent and needy of cases. This new way of working appears to be due to the second key finding which is poor skill mix, associated with and in addition to, staff shortages. However, in the present climate, with the introduction of Slainte Care, CN is now being offered a golden opportunity to improve staffing levels and develop career pathways leading to better staff retention. This new way of working will mean DPHN's assessing the healthcare needs in a Network and allocating an appropriate number of staff with a suitable skill mix to meet the need in the network. This is the vision but this will depend on the availability of staff to fill these new positions. The third finding is the need for DPHN's to work more strategically. DPHN's cannot sustain the pressure they are under, to continue to practice in a demanding job, leading large teams through turbulent times in addition to being strategic planner in all things pertaining to future developments and practice in CN. The demand is too much, they need support. Two DPHN's (with practical DPHN experience) need to be assigned to the corporate office of the lead DPHN, one post for a National Lead in Education the other for a National Strategic Planner /Project Manager who would engage with groups dealing with ongoing and projects, external consultants, examine new service developments and produce an annual strategically plan for CN. This would give direction and allow DPHN's to set priorities and plan effectively for the upcoming year leading to more effective service delivery. The final and fourth finding is the great need that exists at all levels in CN for staff support. While some professional reflection has been introduced, and this needs to be developed further, there is a large lack of a personal support system for CN staff. Nurses lead stressful lives and without a built in support system they risk burnout and often end up leaving the service prematurely. All nursing staff, except DPHN's, seem to have a very limited support service in place with support from their line managers but DPHN's have appear to have no support system at all in place. Some formal support system needs to be established for all CN staff.

6.5 Future Recommendations

6.5.1 Staff shortages

The first significant finding was that practice issues had been witnessed by 100% of staff. This is a very pertinent statistic and it is evidence of how much practice is being impinged upon by staff shortages and excessive caseload in addition to poor skill mix in today's world of CN (Pennington and Driscoll, 2019). There have been many studies completed referencing excessive workload and how its effects the health of the nurse, the quality of the care being delivered and how it increases the risk of errors made in care delivery, with missed care in particular escalating (Aiken et al., 2012; Pennington and Driscoll, 2019). In cases like this, the nurse suffers stress and mental exhaustion, with burnout and even poor physical health (Aiken et al., 2012; Pennington and Driscoll, 2019).There is increased risk of mortality and morbidity for patients and their safety is not guaranteed(Aiken et al 2018). In addition to the risks for patient and nurse, there are also economic implications for the system, with escalating costs for the organisation which are as a direct result of poor care delivery (Aiken et al 2018).

So what needs to be done? Things will escalate further as nurse shortages escalate. It is now a worldwide problem and will worsen over the upcoming years (WHO, 2016). In CN, PHN staff are be more difficult to recruit and there is a need to increase the number of college places to meet this need. Presently only three colleges deliver this course, there is a need to extend this course to other colleges thus increasing the number of places available to train PHNs. In addition PHN recruitment should be done at CHN level, not nationally. This would increase chances of recruitment of staff living in the area and reduce the risk of transfers out post qualification. Regarding RGN recruitment, this requirement can no longer be met in Ireland by the graduate supply. Rolling local national and international campaigns need to be put in place with interviews held every second month (Behan et al., 2009).

Effective staff recruitment is also a big issue for CN; it can take up to 2 years to replace a PHN. In the meantime s/he is being replaced by an agency RGN (if staff and funding are available) who is costing similar money but is not able to perform the extensive range of duties they perform. There is a need for both prompt and appropriate grade replacement so as to maintain safe and effective service delivery. Human Resource's (HR) who complete the recruitment process in HSE are presently not working at a level that is either effective or efficient in recruiting nursing staff and in particular PHN staff and a review of this system is required. In addition to this issue, in recent years PHNs transfers has been re-

moved from the DPHN's remit and given to an administrative office. Presently many staff report this is not working in tandem with the recruitment process, where all transfers should take place in a given period before staff recruitment begins so exact vacancies can be identified when recruitment begins. Neither PHN nor DPHN are satisfied with present structure. The author suggests that staff transfers between areas in the HSE should be returned to DPHN's remit, where it was a much simpler and more effective operation.

6.5.2 Reshaping the Service while Launching Slainte Care

Debates need to take place and decisions need to be made, regarding what patients gets treated, in what setting and what services are going to continue to be delivered. Community care is more complex than hospital setting when decisions like this need to be made. In a hospital setting when staff are unavailable they close wards; unfortunately in the community setting this cannot be done. So decisions concerning CN and our service delivery need to be 'made for us, by us' and not the service being informed by others of what is expected of it.

While Slaintecare will bring new ways of doing business, it will be dependent on delivering it through the already established nursing services. We are the experts in this area and we need to use this expertise in tandem with Sláintecare to reshape and build a new service around the needs of patients and staff. We need to make Sláintecare a positive development as we move on to a new way of providing healthcare. Furthermore, the expansion of new roles in CN, with the addition of ANP and CNS roles will give patients back a service that is delivered as near home as is possible and it will also open up opportunities for staff to develop a career pathway, particularly community RGNs, making it a much more attractive job and helping to attract staff to the service and assist in retaining them.

6.5.3 Skill Mix

A review of caseload by DPHN's for appropriate skill mix needs to be completed at least annually, followed by application for and approval of the necessary posts. When an organisation has the correct skill mix in place, it retains experienced staff, who have attained job mastery and can deliver better care with fewer errors (Waldman, 2006). Also, job embeddedness and staff retention techniques (mentioned be-

low) play large roles in retaining appropriate staffing levels and suitable skill mix (Waldman, 2006). However, looking towards the future and the predicted staff shortages, preparation must begin if we are to make best use of staff skill mix. This is an opportune time to recruit and train care assistants and other non-nursing staff to assist nursing staff, so as to maximise the effective utilisation of nursing skill mix in the future (World Health Organisation, 2020).

6.5.4 Need to Develop a Link Lecturer between College and Practice

There is a need for a "link lecturer" post to be developed for Student PHNs on clinical placement (Holland, 2016). Novice nurses felt this post would enhance the learning experience of the student and support them during practice placements. The support of the link lecturer would assist students and their preceptors to discuss and resolve practice issues early. Also having a link lecturer would support the application of academic learning to practice and assist novices become more competent practitioners on qualification, making it an easier to transition to practice and take on a caseload as an independent practitioner. Also the role would unite the two fields of practice and academia.

6.5.5 Need for Support of Novice Nurse Post Training

One of the most notable finding in this study was the need for staff support. This was universal from the novice to the DPHN. In the data gathering process the novice in particular was most in need of ongoing regular support. The Nursing Education Forum (2000), state that all students are educated to a level of competence, and while this is true, the author would agree with Winter et, al. (2007) view that , not all students can cope with the complexity of the caseload they are presented with, on entry into CN. There is a need for mentorship and support in the first year post qualification for PHNs. The author believes that this is part of the functions of a PDC, among their other duties. However, if there is no PDC in place, then a student needs to be assigned a mentor for the first year post qualification to support, them maintain best practice and embed into the organisation. There is also a need to develop a national document to be used throughout the mentorship programme in the first year post qualification for ongoing support and practice planning to enhance novice nurses learning. Document 1A and its accompanying indexes (from the Tool) in Appendix A (after Document 1) was developed with these functions in mind. It gives ongoing support which minimises the feelings of isolation that novices have post qualification,

and increases the chances of embedding and retaining them, both important factors in the current climate of reduced staffing levels (Mitchell et al., 2001; Chen et al., 2019).

6.5.6 Reduce Stress and Enhance Job Embeddedness through Social Supports

When the issue of support was examined, it was obvious that staff welcomed the support offered by the Tool. It brought the opportunity to discuss issues and form better work relationships. Good relationships and friendships in the workplace provide a social support system and this reduces stress and heightens nurses coping ability (Buunk & Hoorens, 1992). It leads to the generation of positive emotions through social exchanges with others (Cropanzano & Mitchell, 2005 Lawler, 2001). This is sometimes referred to as Social Exchange Theory (SET). In today's climate there is a great need of such a structure in nursing to reduce stress which in turn, improves staff retention (Buunk & Hoorens, 1992). Managers play a large role in SET, they are the human face of practice and they are in a very strong position to facilitate SET into practice. They lead by example and they demonstrate how staff should behave towards each other and while managers should be directive they also need to be supportive (Bering's et al., 2008).

In today's world of ongoing staff shortages, nurses have almost forgotten how to generate positive team spirit. Chronic stress is almost an expectation in staff. However to help alleviate this there is a need to introduce some pleasure to the workplace with small regular social events being introduced and encouraged. These events don't need to be big changes, just small events that add the human touch of kindness to the workplace and break the cycle of stress. Small events like remembering and marking staff birthdays or special events, weekly staff bake mornings, lunchtime walking clubs, yoga, weekly lunch meet ups or any social event that is suitable and interests the staff could be introduced. Small budgets are also available to managers for setting up events through staff wellbeing, line managers should be encouraged to make use of these funds to enhance staff wellbeing and bring some fun to the workplace , thus reducing stress levels and improving staff retention and job embeddedness.

6.5.7 Support for Nursing Management

Management also need support, and it was suggested by ADPHNs that they set up a local Forum in each CHN area. This would bring a larger group together to support each other and it too would lend itself to standardising practice and policy. However, there was one other key finding the author felt stood out, and that was the lack of support for the DPHN. The author felt this was an issue that needed addressing in a formalised way. The DPHN is the line manager to the largest team in any network with many DPHN's having teams of over one hundred staff, yet they had no support in place for themselves. There is an obvious need for the setting up of some formalised method of support for DPHN's. Again a local CHN meeting of the three to four DPHN's could be arranged on a monthly basis where they could meet, undisturbed to discuss their issues and support each other. The author would suggest that other forms of formalised support also be introduced for management. The lack of any present support is a serious short coming in the service and one that needs to be corrected to enhance DPHN's well-being and prevents burnout.

DPHN's/ADPHNs also need to introduce a social element to their work and the DPHN/ ADPHNs forum meetings would be an opportune time. Some type of social event could be introduced at these meetings perhaps a few times per year. It could be an hour dedicated to an event of their own choosing; anything that assist them to feel supported, increase self-care, learn to relax and allow themselves the time to examine their issues and manage their stress. While the author advocates for the use of 'The Courage of Compassion Programme' (West, Bailey & Williams, 2020) for all nursing staff, it is vital it be introduced for management also. Compassion begins at the top of any organisation, and DPHN's and ADPHNs need to look after themselves before they can look after anyone else.

6.5.8 Introduction of Reflective Practice

Because the evidence in this research showed how successful providing support can be to improving practice, the author also believes that reflective practice should be incorporated into the support system of CN in all areas from management to nursing staff, in addition to the introduction of the Tool. During this study, reflective practice was introduced into one of the areas and while its introduction and use has been limited due to Covid, staff have reported that they found it very helpful and found that it enhanced the functions of the Tool which was already in use. So while reflective practice was not included in this study, the author would like to mention that its use has been shown to support staff and enhance practice

and if added to the support given by the Tool, the expectation is that it would further enhance the support service for staff if introduced.

6.5.9 Changes at Corporate Level to National DPHN Office

Also in discussion, DPHN's and ADPHNs felt that the corporate office of the lead DPHN/ADPHN needs to work in a different way. They felt it needed to be divided into three divisions Educational, Policy Development and Programme Management. These three areas then need to develop an annual corporate plan with input from an elected group of DPHN's. This would bring a more professional appearance with a more corporate approach to business and it would lend itself to the development of strategic plans for the coming year, giving more direction to the National DPHN group. Overall this new division into three departments would add clarity to structures and their functions and give a more proactive style of management and a professional image of the group. It would also simplify structures for outside agencies looking to work with the group.

It was also suggested that the national DPHN's group need to take on a more strategic role. They need to develop an annual strategic plan for service developments and delivery and to do so effectively they needed to engage an external consultant to facilitate this meeting and produce an annual service plan. This would give direction and allow them to set priorities and plan effectively for the upcoming year. In addition, DPHN's need to have a dedicated fund for their own educational needs and use. This money could be used to fund planning forums with expert advisors, pay consultant fees to assist with strategic planning, fund invited guest speakers of their choice and pay for other educational events they wish to engage with. This would allow them the freedom to make their own choices around their educational and development needs as a group. In addition funding is required for a part-time secretary for the DPHN's national group. This post would reduce the workload placed on the lead DPHN and make it a more attractive job. Presently the lead DPHN position is a difficult position to fill.

6.5.9.1 Development of PDC Posts

Regarding the practice development coordination, DPHN's felt that although this post is presently filled in the corporate PHN office, it is of very limited use, without having a local PDC in place to feed the

policies down to for implementation. The role of the PDC is to develop and implement national policies at local level and educate staff in them. The PDC also uploads and maintains the local policy repository on the local server for staff use, while keeping all policies updated and reviewed. The author suggests that each local healthcare office needs a PDC for the national policy development post to be a success. In addition the PDC also has a large remit in the mentoring and supporting of new and novice staff. PDCs are an invaluable service, which is required for all areas to enhance better practice while supporting staff at all levels.

6.4.9.2 Development of National Educational Lead

A recommendation also was for the standardisation of educational delivery, particularly PHN training and postgraduate education for CN staff. This is an area where a national educational lead needs to be appointed to work with DPHN's and third level colleges to standardise the programme delivered in the Higher Diploma in PHN and also to bring uniformity to all education being delivered post-graduation nationally. In addition there is need for the development of a career pathway for RGNs working in community. Also an educational needs analysis needs to be completed annually to meet present service demands and future practice developments. This style of planning would lead to delivery of an effective well-planned national curriculum for staff working in CN. In recent years, there has been some advancement in this area, with the welcome introduction of education specialists to CN; however, there is still a great lack of national direction. There needs to be an appointment of a lead to bring national direction, solidarity and cohesion to future educational delivery. This approach would also facilitate a more corporate approach to business with the development of a well thought out strategic five to ten year educational plan for CN going forward.

6.5.9.3 National Strategic Projects Manager

DPHN's final recommendation was that a DPHN/ADPHN be appointed to the post of national project manager at corporate level. They said many organisations seek input from DPHN group regularly on national projects or prospective developments which would involve CN and they don't have the time to give fair representation on their own behalf. This often leads to delays in projects or DPHN's appearing uncooperative or argumentative and sometimes some organisations are slow to seek their advice or input due to this. They felt a DPHN representative from the field was needed who would bring practical

experience to the national project management team. Here they could work strategically planning future developments and direction as well as representing CN in discussions on future proposals and developments. This role would enhance buy-in and early adaptation of projects and avoid delays and it would feed into DPHN's annual strategic plan.

So overall, DPHN's suggestions were for two more representatives from practice to enter the National DPHN office, to work in education and project management. They also advocated for PDC posts to be developed for all areas to work with National lead PDC and bring uniformity and best practice to all.

6.5.10 Need for Continuous CPD and Career Planning

The need for CPD and career planning also emanated also from the Tool. The data showed how well staff used the opportunity to update their competencies and take on new educational challenges. The author was surprised by this fact given the staff shortages encountered, nonetheless, it was quite exciting to see how the nurses took up the opportunity to advance their careers and, as said earlier, this was one of the biggest selling points of the Tool. Many staff are now seeking to use Tool for this benefit alone. While the author had expected to see some uptake, the doubling of entry to third level education was quite remarkable in one area. In this area, staff had been mentored very well and supported initially and they repeatedly returned to managers to discuss educational prospects before decisions were reached that suited staff and organisation for future needs and development. The author felt this would be worthy of further research alone to examine if there was a gain for the organisation and/ or the nurse from this engagement in CPD. This proactive style of engaging staff in CPD was shown to be very successful and cognisance must be taken of this, if we are to prepare an appropriate talent pool, for future developments and to cultivate potential future nurse leaders to lead the CN service into the future and embrace the Sláintecare programme (Ekmekci, 2013; Heath, 2018; Kruijver et al., 2000; Wenghofer et al., 2015). This display of interest in staff and their education also enhanced staff embeddedness and retention (Banning and Stafford, 2008).

6.5.11 Telehealth- A new Way of Working

One final recommendation, pertinent to the future of all areas in nursing is the use of Telehealth. While this was not a subject the researcher set out to examine, nonetheless its use became very significant during the period in which the research was conducted. This was due to the fact that during the Covid 19

pandemic, nurses and other professional groups have had to find innovative approaches to delivering care services in fast-changing conditions. One consequence of this has been the increasing role that technology has played in the delivery of healthcare (Barrett, 2020). This approach offered a range of benefits: it empowered patients to play a more proactive role in their own care, and enabled the delivery of health care across geographical distance and barriers. Previously, telehealth's growth was hampered by issues such as technophobia, cost, reliability and availability of technology, and the impact of remote care on the practitioner-patient relationship (Barrett, 2020). However this seems to have been resolved or improved greatly during the pandemic with even the elderly embracing technology during the lock-down; this has now enhanced its use in health care delivery.

Another use of IT that came to the fore during the last year was the delivery of nurse education online. This style of education delivery is family friendly and many nurses reported they would engage much quicker with this style of learning. The author believes that this style of delivery would enhance educational uptake, particularly in female nursing staff and this would assist keep staff competent and up to date in their practice as well as assist them develop their career pathway. OMNSD is also encouraging the sustained use of technological solutions in healthcare for nurses post Covid and shortly are rolling out the National Nursing and Midwifery Digital Health Capability Framework (2020) adapted from Australia for a new and innovative way to deliver safer healthcare here in Ireland (OMNSD, 2021).

So looking to the future of healthcare delivery and nurse education in CN, a new and very different horizon is emerging. E-Health solutions used in response to COVID-19 have left behind an appetite to maintain and build on. In addition to a new approach Slainte Care is also applying a new way of delivering healthcare in the future. This study has shown that present day service delivery structures and modes are not meeting the needs neither the client nor the staff, then surely it is time to redesign. The author has placed the key findings and the future recommendations in a Table form in Table 6.0. She has ordered them in a colour coded chart according to importance with red for immediate intervention, amber for prioritisation of implementation and green for planned approach to implementation).

Table 6.0 Key Findings in Research

Time Frame	Issue	Resolution	Comment
Immediate Intervention	Missed care and /or rationing of Care by 100% staff	Research shows that regular support visits and practice review using Document One improves practice Introduce and use Doc 1 every 6 months Introduce Reflective Practice Document 2 & 3 used when issues need addressing	Corporate level andNational DPHN group need to become proactive, and make decisions concerning the future of service delivery
Immediate Intervention	Need for Support of Novice	Link Lecturer Mentorship of novice x 1 year plus use of Document 1A nationally for Practice Review/support Need for PDC Post in all areas	DPHN post developed to bring uniformity to all educational needs & educational delivery in CN including student PHN support during and for first year post training
Immediate Intervention	Poor staffing levels Need for staff retention Need for recruitment	Change to present HR recruitment system Discontinue PHN national recruitment and begin regional recruitment to reduce transfers Introduce Staff retention policies Need to return PHN transfers to DPHNs Ongoing International and National recruitment Decisions re ongoing service delivery priorities	Needs to recruit appropriate skill mix Need to developed strategies to retain staff Changes needed to how staff are recruited to prevent time lag between loss of staff and new staff being recruited to fill the position
Immediate Intervention	Standardise Care Support Novice	PDC Posts developed Nationally in each CHN Use Doc 1A to support Novice	PDC posts need to be developed nationally
Immediate Interventio	DPHN Support System Needed	Need Support System to be introduced for all	DPHN needs to develop Support System Corporate need to be involved with funding
Priority	Support Management	Monthly meetings with colleagues at Network level for support Ongoing Practice Review & support 6/12 or as needed Funding part-time secretary for DPHN forum ADPHNs need to develop CHN Forums for support National forum DPHN fund for use for ed. And to pay guest speakers and put in place support projects Develop national DPHN education and project leads	Survey staff for ideas for social events that interest them and build SET into work environment Develop these Social events at work Lead out on SET(top down approach) Avail of funding from health and well being Need to introduce the Courage of Compassion for all
Priority	Support Nurses	Ongoing Practice Review (form 1) Introduce Reflective Practice Introduce Courage of Compassion Introduce Social events at work for all grades PDC posts in all areas	Often the importance of social events is not recognised. They are needed now more the ever to retain and embed staff
Priority	Poor Skill Mix	HR System needs addressing Address Skill mix Rationing Care needs to be addressed corporately Corporate decision re safe service delivery	HR Need full review group to look at recruitment process as presently not effective
Priority	Reduced Job Satisfaction	Review and support staff to retain them Introduce social events all levels(embed staff)	Regular support to maintain morale and assist in decisions re rationing of care.
Planned Intervention	CPD/ Career Pathway /Planning	Review 6/12 Use Form 1 for all staff Need for DPHN Forum to develop strategic plan to give CN direction and drive it forward	Recognise three levels of CPD in nursing CPD /Career Planning often related to life stage more research needed re use of family friendly education delivery.
Planned Intervention	Standardise Education/planning	Introduce National Lead education in CN Need to develop career pathway for RGNs Need strategic planner at Corporate level	Need to introduce post at National level
Planned Intervention	New approach	Discussions and Site Preparation for Slaintecare introduction Need strategic planner at Corporate level	Develop strategic plan for service Development new way of working

6.6 Contributions of the Study

It is felt that this research is original, important and will make a contribution to knowledge in the field of community health / quality health care delivery here in Ireland. This research concurs with previous research in Ireland which speaks about missed care in CN (Phelan and Mc Carthy, 2016, Phelan et al., 2018).However, this research has gone a step further though by adding a Tool to assist in initiating some small changes to CN practice to help resolve issues and improve practice.

The Tool brings regular reviews to practice to support staff and assist them seek help early and in a timely fashion when a practice issue occurred. By so doing, the Tool assists staff to maintain practice standards, receive support and improves care delivery. In addition, the Tool encourages the uptake of CPD to maintain present competency and develop new ones. It also gives staff an opportunity to discuss and develop career plans for themselves. The author believes this research is especially important given the recent surge in various tools introduced to assist staff continue their CPD and plan for career development and also the frameworks developed to improve practice both nationally and internationally. The author believes this Tool amalgamates both of these functions together. It contributes to improving practice (particularly in times of staff shortages and work overload) through supporting staff with practice issues it assists staff keep their competencies up to date and it helps keeps ongoing education in line with new developments while encouraging staff to look at their career pathways for their future development. The author feels it adds to improving practice and supporting community nursing here in Ireland.

6.7 Future Recommendations for the Tool

The next steps in this process involves engagement with the management, at executive and policy level, and the dissemination of the messages of the research throughout the profession through the means of publications, seminars, workshops and conferences.

The adoption of this Tool will require further detailed negotiation and development. An important dimension of strategic planning is that of timing. It is important to have a clear time frame for any implementation as this will provide a sense of purpose and will define the urgency with which tasks need to be tackled. With this in mind, the strategy for the introduction of the Tool should be implemented over a 1-

1.5 years' period with 3 month review points throughout that period. The detailed indicators for each 3 months need to be negotiated with the individual stakeholders. At the end of year one, the implementation plan should be revised and an updated version developed to complete the process. This would provide the opportunity for a rolling dynamic adaptation and implementation process for the Tool. Details of the timing of specific elements of the implementation will be the subject of the negotiation and development within the organisation.

This research does not pretend to be complete; by its very nature it needs to be constantly refreshed and updated according to service and staff need. It is, however, an important step along the way to building a more quality assured and safer health care delivery system for the patient while supporting staff within a changing health service where staff shortages and large caseloads are now a worldwide scenario. While this Tool may be viewed as a tool that brings support, stability and respite to staff and assists in improving the quality of patient care, it does not address or cannot address the escalating worldwide problem of nurse shortages and its associated risks to both patients and staff. Decisions need to be made on a much bigger stage, as to what nursing services continue to be delivered, by whom and in what setting. However, we must work on what we can change in our own practice, right now, to assist staff and improve practice. The introduction of this Tool is one of them and while it is not a panacea it has been shown to assist staff and improve practice so it should be introduced. However, a word of warning, it must not be cast eternally in its present form; it should evolve and develop, adapt and change and grow with service needs. No tool is eternally useful if it fails to change and redevelop and evolve as the situation it was invented for continues to do so.

6.8 Limitations of the Study

A limitation of the study relates to the group size. There were 103 patients involved in the scoping out exercise. After the Tool was developed its first implementation was to a pilot group of 6 staff and after review of the pilot group outcomes, the Tool was adjusted and implemented again with 51 nurses/ managers involved in the study. Despite the small number in the research, all patient profiles and age groups were represented in the study and the 51 nursing staff were a representative group of CN staff by both experience, grade and location. Therefore, while the numbers involved were relatively small. the different sources and different perspectives used were representative of the experience of all groups in the patient and nursing context in CN here in Ireland.

Another limitation of the study relates to the impact of staff shortages on the research. The difficulty in accessing sites and staff were directly related to this issue and where access was gained, some of the transcript manifested staffs views and attitudes in relation to trying to give time to research and development, when they were under huge stress as they worked in turbulent environments, covering large caseloads and were already prioritising care according to need. While the author needed these nurses input, as this was at the very heart of the subject she was researching, she wishes to acknowledge how difficult this was for these staff and she is eternally grateful to them for partaking in this study under such stress. Their input has been invaluable and it has impacted greatly on the development of this Tool. But for the sites she could not access due to staff shortages, the author hopes she has represented them appropriately through the voice of others in similar situations who have taken part in the research.

The process of participatory AR could be viewed by some as a limitation, and for this reason the author will list it; however the author would debate this view. The author believes that participatory methods of research are creative tools, which when used ethically and correctly they facilitate participants in producing rich, multi-layered data that can bring participants and researcher closer to critical engagement on the participants lived experiences. The author believes she used the tools appropriately to bring together the lived experience of nurses in the pursuit of practical solutions to issues of pressing concern to them and their practice. The author felt the reciprocal relationship which developed, was used appropriately throughout this research.

The issue of power relationships between the researcher and those participating in the research was also a key concern throughout the research project. The researcher's role as Director of Public Health Nursing may have influenced the response given by participants at various stages of the process. For this reason, the researcher took two years out to complete her research and worked in a position as lecturer with a college during this time. She also chose to do half of the study in the south of the country where staff were not known to her or her to them, in the hope they would not be influenced by her position as a DPHN. Nonetheless, some participants may have responded positively in order to avoid giving negative comments directly to the researcher who had a vested interest in the initiative. While the author was aware of this possibility, she was also aware that she was not in a position of power 'over' the participants, in the sense that she was not in a position to influence their employment or the allocation of re-

sources to them. However, steps were taken to encourage honest responses from participants and the author did her best to maintain high ethical standards in all situations within the research as prescribed by ethical committees and the 'usual' ethical approval mechanisms.

6.9 Conclusion

In summary, this study was about developing and testing the effectiveness of a Tool to assist in maintaining practice standards, support staff and improving care delivery in CN in addition to encouraging staff to engage in CPD and career planning. It has also shown how ongoing development of staff leads to competent staff, better career planning for both individuals and organisation and improved staff retention. The Tool has performed well in the study and has been successful and it has been adapted by several sites already. It has also moved outside of nursing and has been adapted by other disciplines too in healthcare delivery. It has improved practice while supporting staff and it has also been successful as a CPD and career development tool.

However, success can only be achieved fully through the disseminated of this evidence to others. The implication of this now rests with the author, who has to meet this stipulation. The Documents in the Tool will take on new titles and these are

Document 1 will be known as **Practice Review with CPD and Career Development Planning**
Document 1 A will be known as **Document to Support and Mentor Novice Nurse**
Document 2 will be called **Reviewing clinical issue(s) and Seeking Support & Advice from Management**.
Document 3 will be called **Plan for Up Skilling / Supporting of Staff**
Document 4 will be referred to as **Clients Feedback Form on Nursing Service**

Meetings need to be arranged to discuss and distribute these findings with other DPHN's and the lead team in NMPDU. When the findings are examined an agenda needs to be set for introducing the Tool and other relevant findings into practice nationwide. This will then fulfil the initial reason the author set out to investigate this topic in the first place, which was to contribute to practice improvement, deliver better and safer healthcare and improve support for staff in CN going forward.

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Appendix A

Document 1 from the Tool

Practice Review and CPD and Career Development Plan

Document 1

Nursing Staff Bi Annual Practice Review with CPD and Career Development Planning

To be completed by employee annually. **It gives the staff member an opportunity to look at and recognise their achievements during the past year. It also gives the staff member time to reflect on their own professional needs and allows time to look at building a future development plan for themselves.**

Section A - Your Present Practice
Has the past year at work been good/bad/satisfactory or otherwise for you? Why?
What do you consider to be your most important achievements at work for you in the past year?
What elements of your job interest you the most?
What elements of your job interest you least?
Are you experiencing any difficulties in your job now? Yes / No
If yes what are these issues?
If not, competency-based issue, have you sought help and advice re this difficulty from your ADPHN? Yes / No
Have you agreed and set solutions with ADPHN? Yes / No

Have you agreed and set solutions with ADPHN?	Yes / No
Have you tried these solutions?	Yes / No
What worked well?	
What did not Work?	
If issue remains unresolved or further support is needed, please complete ***Form Two*** and submit to ADPHN	

Section B of this form lists courses to be completed by you in the coming year, please review Section B and complete same

Section B Courses to be completed in coming year

Courses to be completed in the coming year that are mandatory to your present jobie. Manual Handling Course, CPR Training, Online Training National Healthy Childhood Programme

Number	Course
1	
2	
3	
4	

Do you need to develop competencies or update existing competencies in your present work situation? Yes/ No

If yes, please list relevant courses below

Number	Course
1	
2	
3	
4	

Are there some courses to be done in the coming year that are necessary for new practice developments in your present work situation? Yes/ No

If yes, please list relevant courses below

Number	Course
1	
2	
3	
4	

Where do you hope to be in 3-5 years' time? Are there courses you would like to complete for your own personal development Yes/ No
If yes, what courses are needed for you to develop this knowledge, skills or experience?

Please discuss same with your ADPHN (& DPHN) and if agreed list relevant courses below.

Number	Course
1	
2	
3	
4	

Please submit this form to ADPHN at least ***3 days in advance*** of her visit to YOU where together you both will complete Professional Development Plan for your education and development for the coming year

ADPHN Reviews Part A and B of form with the nurse and an annual practice review discussion takes place between her and the nurse

Section C is then completed by ADPHN in unison with Nurse and the professional development plan is completed and arrangements made for application for courses.

Professional Development Plan

Name	
Job Title	
Employee HSE Staff No.	
NMBI Registration PIN Number	
Work Location	
Length of time in current position	
Line Managers Name	
Line Mangers Email	
Line Managers Telephone Number	
Director of Public Health Nursing (DPHN) Name	
DPHN Email Address	
DPHN Telephone Number	

Section C

Professional Development Plan

No.	Agreed Goals/ Courses	Training/ Course Action	Person Responsible for Training Action	Proposed Date of Completion
1				
2				
3				
4				
5				

Have you discussed and agreed Professional Development Plan with Nurse? Yes/ No

Is there is a need to make application for approval to DPHN? Yes/ No

If yes, have you advised re procedure for same? Yes/ No

Is there is a need to make application for Course? Yes/ No

If yes have you advised re procedure for same? Yes/ No

Is there is a need to make application for Study Leave? Yes/ No

If yes have you advised re procedure and leave allowances for same? Yes/ No

Is there is a need to make application for funding? Yes/ No

If yes have you advised re procedure for same? Yes/ No

If yes to above, then complete professional plan and make appropriate applications

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Nurse - Any other comments you would like to make that were not covered in form Yes/No

If so, please make comments below

ADPHN - Any Issue that need to be discuss after review of completed form Yes/ No

If so, please state issue(s) below to be discussed

1._____

2._____

3._____

4._____

Signed Nurse_____

Signed ADPHN_____

DATE_____

Checklist for Planning My PDP

Where do I want to be in 5 years' time	How will I get there	What needs to Happen next and in what order	How can I improve my chances of getting my gaols accomplished	What re my obstacles to achieving this	Where can I get support to achieve this	Threats to Plan
Working as ANP in diabetes	Discuss prospect with family Discuss prospect with work colleagues(who may assist cross cover your area when you are in college Seek meeting with line manager /DPHN See does my plan fit with organisational developmental plan Research suitable University that completes M Sc (Diabetes) plus additional 3 modules to for ANP post M. Sc.	Work on plan to present to line manager and DPHN Make appointment with line manager/ DPHN to discuss plan and seek advice and approval If approved given complete Make application to university Make application to DPHN and NMPDU for funding approval	Planning my PDP provides Focus on where I want to go Makes me strategize Helps me map out a path towards my version of success Gives me a plan to support my decisions, so it increases my success rate	No Plan No wish to progress	Family Colleagues Line Manager DPHN University	Not being motivated enough to achieve it Not making appropriate plan Failing to follow plan Miss application dates or not successful in application Need to plan family needs round my plan Need to plan work needs around my plan

Example of Checklist for planning PDP

Checklist for Planning My PDP

Where do I want to be in 5 years' time	How will I get there	What needs to Happen next and in what order	How can I improve my chances of getting my gaols accomplished	What re my obstacles to achieving this	Where can I get support to achieve this	Threats to Plan

Blank Assistance sheet Plan for Staff Plan

Appendix A Attached to Form 1

Example of Training Plans that can be used to assist ADPHN and Nurse identify the nurse's specific training needs and prepare PDP for coming year

- Sample National Plan for HSE setting out
- Sample CHN Plan
- Sample DPHN Plan Training Plan
- Sample Primary Care Centre Training Plan for local patients healthcare delivery needs
- Sample Personal plan specific to this nurse which maintains and updates her mandatory competencies, meets her patient healthcare requirements, gives her a personal training plan to develop her training wishes in line with organisational needs and one that enhances and develops her future career prospects.

National Service Plan Annual Priorities

A. Education sessions and updates on Implementation of Sláintecare and its priorities

B. While birth rates are decreasing, the child population (aged 0 to 17 years) represents 25% of our total population, approximately 7% more than the EU average.

- Children First - Implement the Children First Act 2015, conferring new statutory obligations on HSE employees, funded services and contracted services to report child abuse / neglect. Primary Care Services 30 National Service Plan 2018 Corporate Plan
- Immunisations uptake
- Implement Nurture Training
- Policies for safe implementation of paediatric home care packages.
- Provide additional packages of care for children discharged from hospital with complex medical conditions to funded levels. -
- School Audiology and vision testing referrals dealt with appropriately

C. The population is also ageing. The number of people aged 65 years and over has increased from 11% in 2011 to 13% in 2016. Each year, the population aged 65 years and over increases by almost 20,000 people, and by over 2,500 for those aged 85 years and over. Approximately 65% of people aged 65 years and over currently have two or more chronic medical conditions and the prevalence of age related disease continues to show signs of increase.

- Implement the Integrated Care Programme for the Prevention and Management of Chronic Disease. Training and appointment of ANP & CNS for Chronic Disease management
- Palliative care service access improvement
- Expand CIT and outpatient parenteral antimicrobial therapy coverage and services and refocus CITs to facilitate a high volume of complex hospital avoidance and early discharge cases and strengthen the governance and quality of services provided. Promote health and wellbeing particularly falls prevention and flu vaccination uptake

- Provide additional packages of care for older persons discharged from hospital with complex medical conditions to funded levels.
- Provide fair, equitable and timely access to quality, safe health services that people need e.g. Therapy services, Day centres, Social Clubs, Respite Care.

D. Roll out primary care IT Service and use of eHealth systems to support safe and effective provision of services.

- Training of staff in IT use in healthcare delivery and ongoing education delivery

E. Develop a primary care patient management system to support safe and efficient delivery of services.

F. Quality - Promote quality and safety of services in line with the Framework for Improving Quality in our Health Service. - Promote safe services in line with the Integrated Risk Management and Incident Management Frameworks

- Training of staff in Integrated Risk Management and Incident Reporting Frameworks

CHN Community Nursing Service Plan Annual Priorities

Updates on and Implementation of local Sláintecare Priorities

Child Care

- Implement the Children First Act 2015
- Raise Immunisations uptake
- Implement Nurture Training
- Provide additional packages of care for children discharged from hospital with complex medical conditions.
- School Audiology and vision testing referrals dealt with appropriately

Older Persons

- Chronic Disease management
- Palliative care service access improvement
- Expand CIT.
- Promote health and wellbeing particularly falls prevention and flu vaccination
- Provide additional packages of care for older persons discharged from hospital with complex medical conditions.
- Expand Nursing, Therapy services, Day centres, Social Clubs, Respite Care for elderly

Sick Nursing

- Promote Pressure Area management
- Promote wound care management,

Policy and Procedures

Develop and update Policies and Procedures for all healthcare procedures

Health and safety

Ensure Integrated Risk Management and Incident Management Frameworks in use

Staff health and safety policies implemented

Others as Set by CHN area

Development Primary Care centres

IT roll out

Value for money and stay within budget

Expansion of GP services and Introduction of patient diagnostics to local level

Extension of Primary Care services

DPHN Service Plan Annual Priorities

Informing staff and Implementation of Sláintecare

Child Care

- Appoint ADPHN to Children First - Implement the Children First Act 2015 who will be responsible for training and also available for case evaluation
- Immunisations uptake liaise with ADPHN on this and feedback on progress at monthly management meeting
- Implement Nurture Training and Appoint ADPH to this area
- Policies for safe implementation of paediatric home care packages.
- Provide additional packages of care for children discharged from hospital with complex medical conditions to funded levels. Each ADPHN looking after own area and accessing training needed for her staff
- School Audiology and vision testing referrals dealt with appropriately Review with school nurse and ADPHN and feedback on progress at monthly management meeting

Older Persons

- Training and appointment of ANP & CNS for Chronic Disease management
- Staff training in Chronic Disease Management Appoint ADPHN to this area.
- Palliative care service access improvement
- Expand CIT.
- Promote health and wellbeing particularly falls prevention and flu vaccination uptake Advise staff at team meetings re same, also train interested staff in this area if available and set up course delivery eg. Daycentres.
- Appoint ADPHN to meet with HCP team to advance additional packages of care for older persons and feedback on progress at monthly management meeting
- DPHN meet with manager Older Persons regularly to review any missing services needed to provide fair, equitable and timely access to therapy services, Day centres, Social Clubs, Respite Care for elderly and feedback on progress at monthly management meeting
-

Sick Nursing

- Appoint ADPHN for Pressure Area reporting and training, who will give monthly update at management meeting
- Appoint ADPHN for wound care training, who will give monthly update at management meeting

Policy and Procedures

ADPHN or PDC to develop and update Policies and Procedures and circulate to all and feed-back on progress at monthly management meeting

Health and safety

Integrated Risk Management and Incident Management Frameworks in use

Staff health and safety issues examined regularly, and policies implemented if risks identified

Nursing Staff Training Service Plan Priorities

Statutory Community Nursing National Training Priorities (Must be completed in all CHNs)

Child Care

- Children First training for implement the Children First Act 2015
- Immunisations training and associated anaphylaxis training for immunisation team
- Nurture Training and Appoint ADPH to this area
- School Audiology and vision training for school nurse staff and relief

Local Community Nursing Training Priorities (As prioritised in National Plan)

Child Care

- Staff training in breast feeding
- Staff training in sleep issues in babies and toddlers
- Staff training in obesity and exercise and any other relevant health promotion talks for school going children
- Staff training in relevant health promotion talks for mothers and babies

Older Persons

- Staff training in Chronic Disease Management
- Staff training in Palliative care service
- Staff training in skill expansion eg IV antibiotic administration for expansion of CIT if approiate
- Staff training in falls prevention and health promotion talks for older persons

Sick Nursing

- Staff training in latest Pressure Area treatment
- Staff training in latest wound care techniques

Policy and Procedures

Training in Policies and Procedures use

Health and safety

Training in Integrated Risk Management and Incident Management Frameworks use

Training in Staff health and safety issues

Others as Set by CHN area

Patient Record keeping

Local Primary Care Centre Training Priorities

- Neurogenic Bowl Care
- Training for specific patient needs

Personal Training Priorities

- Training/ updates associated with National Training Priorities(Statutory)
- Training/ updates associated with Local Training Priorities
- Training associated with personal development plan
- Training/ updates in Specific patient needs in nurse's work area
- Training/ updates for Specific case load needs in nurse's area e.g., Student PHN Preceptor training
- Training/ Updates for the individual nurse as deemed necessary by nursing management

Appendix B Attached to Form 1

Professional Development Plan (PDP)

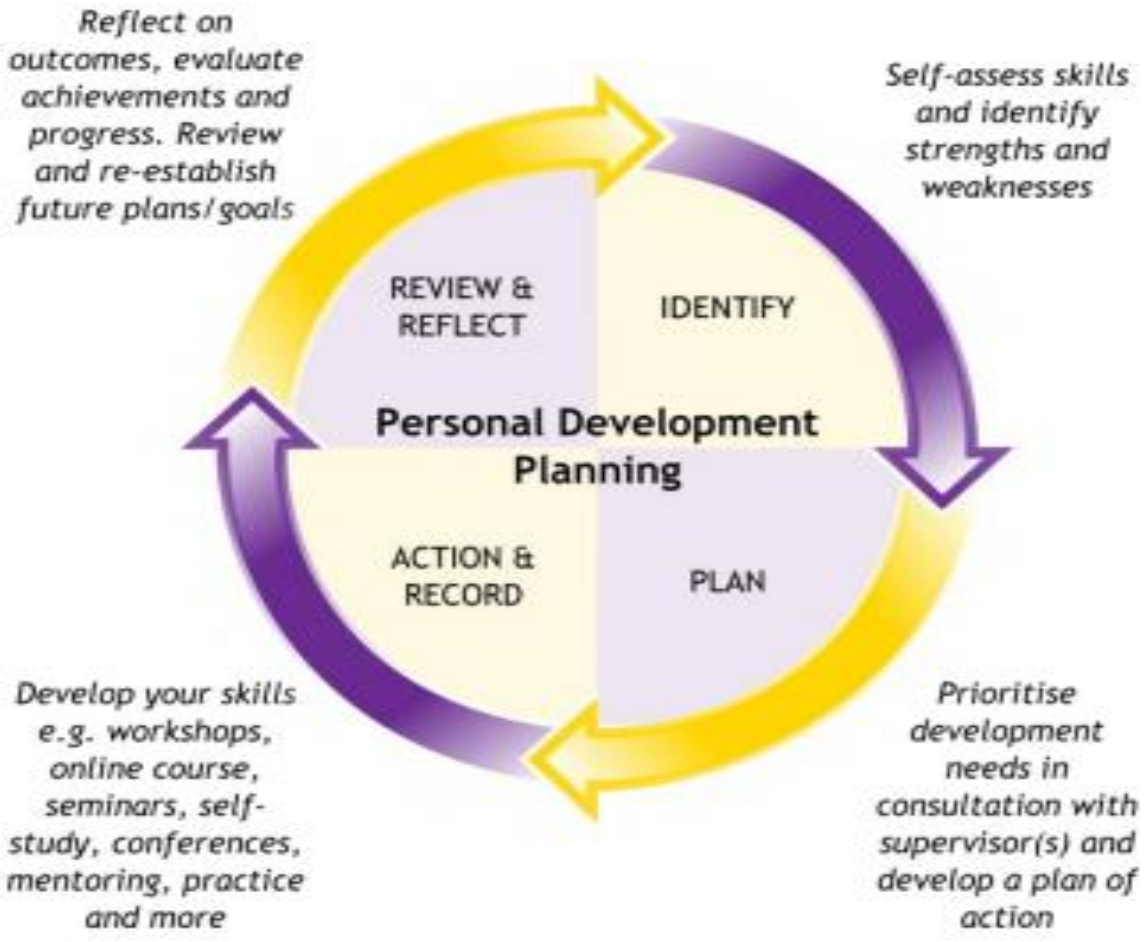
Developed by National Council for the Professional Development of Nursing & Midwifery

May be used to aid nurse and ADPHN plan PDP

Aim of a Professional Developmental Plan (PDP)

- To promote lifelong learning for staff and encourage them to identify their own personal and professional development needs.

- **PDP Cycle**



Appendix C Attached to Form 1

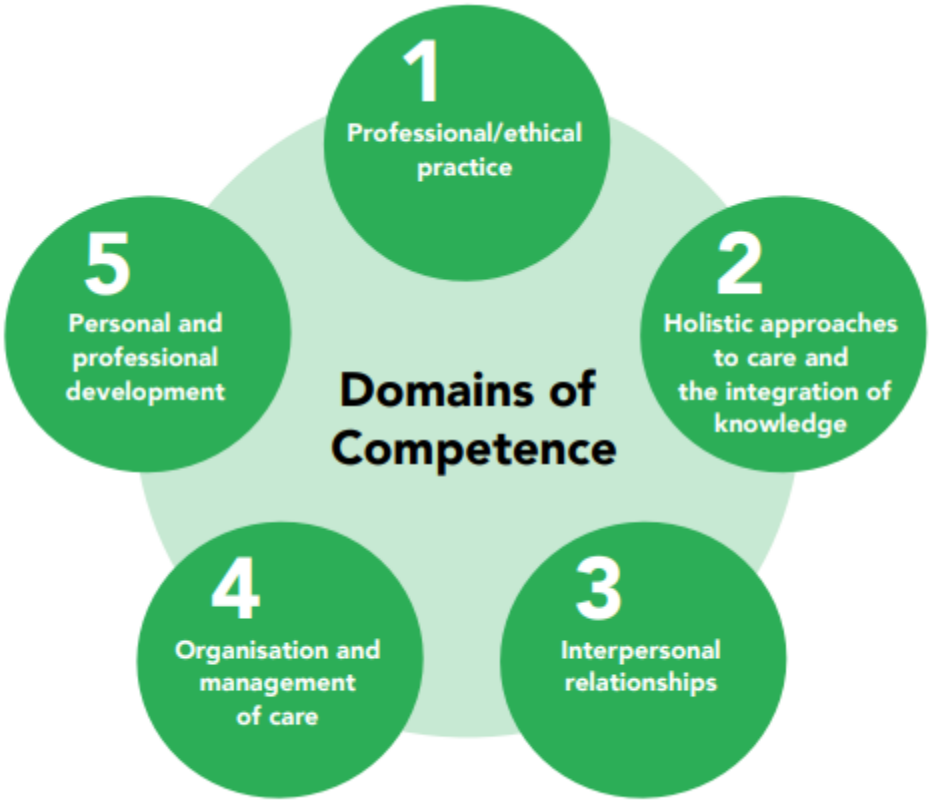
Professional Development Plan (PDP)

Developed by National Council for the Professional Development of Nursing & Midwifery

May be used to aid nurse and ADPHN plan PDP

Aim of a Professional Developmental Plan (PDP)

- **To promote lifelong learning for staff and encourage them to identify their own personal and professional development needs.**
- **To comply with HIQA standards.**



Domain 1. Professional / Ethical Practice

Practices in accordance with legislation affecting nursing practice.

Integrates accurate and comprehensive knowledge of ethical principles, the Code of Professional Conduct and within the scope of professional nursing practice, in the delivery of nursing practice. Utilises and critically evaluates the knowledge of:

1. Ethical principles and their implications for nursing practice,
2. Code of professional conduct
3. Scope of practice.

Fulfils the duty of care in the course of nursing practice.

Applies and evaluates principles of the above to nursing practice.

Practices in accordance with legislation affecting nursing practice.

Implements the philosophies, policies, protocols, clinical guidelines of the health care institution.

- Utilises and critically evaluates a knowledge of service philosophies including mission statement, policies and procedure and standards.
- Integrates the above into nursing practice.

Responds appropriately to instances of unsafe or unprofessional practice.

- Demonstrates knowledge and adapts a proactive approach in the identification and prevention of instances of unsafe or unprofessional practice.

Integrates knowledge of the rights of clients and groups in the health care setting.

- Demonstrates in practice knowledge of:
  - Client/Patient rights
  - Freedom of Information Act
  - Legal Rights
- Disseminates knowledge of the above to individuals/groups/ communities and colleagues

Practices in accordance with legislation affecting nursing practice.

Serves as an advocate for the rights of clients or groups

- Acts as an advocate for the rights of individuals / groups / communities

Ensures confidentiality in respect to records and interactions.

- Demonstrates confidentiality in nursing practice.
- Maintains patient confidentiality

Practices in a way that acknowledges the differences in beliefs and cultural practices of individuals/ groups/ communities.

- Demonstrates confidentiality in nursing practice.
- Shows respect for the differences in beliefs and cultural practices of individuals / groups / communities.
- Respects the impact of gender, ethnicity, aging and the family on health and illness.
- Disseminates knowledge of the above to individuals/ groups/ communities and colleagues.

Practices within the limits of own competence and takes measures to develop own competence.

Determines own scope of practice utilising the principles for determining scope of practice in the Scope of Nursing and Midwifery Practice Framework document.

- Identifies own abilities and learning required with reflective logs in nursing practice.
- Demonstrates dissemination of knowledge and development of skills, attitudes and behaviour to fulfil nurse's role.

Recognises own abilities and level of professional competence.

- Develops and demonstrates practical clinical nursing skills based on observation, participation and integration of knowledge.
- Critically evaluates own ability and level of professional competence within Code of Conduct and Scope of Practice.

Accepts responsibility and accountability for consequences of own actions or omissions.

Consults with supervisors if allocated nursing assignments are beyond competence

Clarifies unclear inappropriate instructions.

Practices within the limits of own competence and takes measures to develop own competence.

Formulates decisions about care within the scope of professional nursing practice utilising the Decision-Making Framework in the Scope of Nursing and Midwifery Practice Framework document.

Domain 2. Holistic Approaches to Care and the Integration of Knowledge

Conducts a systematic holistic assessment of client needs based on nursing theory and evidence-based practice.

Uses an appropriate assessment framework safely and accurately.

- Implements and utilises an appropriate assessment framework safely and accurately.
- Integrates relevant research findings to underpin nursing assessment.

Analyses data accurately and comprehensively leading to appropriate identification of findings.

- Identifies client needs and gives rationale for findings.

Incorporates relevant research findings into nursing practice.

- Critically evaluates research findings that underpin nursing practice.

Promotes research designed to improve nursing practice.

- Disseminates findings to colleagues

Plans care in consultation with the client taking into consideration the therapeutic regimes of all members of the health care team.

Establishes priorities for resolution of identified health needs.

- Supports and defends priorities in resolution of identified health needs in consultation with the individual/ group/ community and other members of the health care team.

Identifies expected outcomes including a time frame for achievement.

Identifies criteria for the evaluation of the expected outcomes.

Plans for discharge & follow up care.

- Develops a discharge plan and follow- up care in consultation with the individual/group/community and other members of the health care team.

Implements planned nursing care/interventions to achieve the identified outcomes.

Implements planned nursing care/interventions to achieve the identified outcomes.

Delivers nursing care in accordance with the plan that is accurate, safe, comprehensive and effective.

- Delivers accurate, safe, comprehensive and effective nursing in accordance with the plan.

Creates and maintains a physical, psychosocial, and spiritual environment that promotes safety, security and optimal health.

- Identifies, creates and maintains a physical, psychosocial and spiritual environment for the individual/ group/ community to ensure safety, security and optimal health.

Provides for the comfort needs of individuals

Acts to enhance the dignity and integrity of individuals/clients/ groups/communities.

- Identifies and maintains sensitivity to the dignity and integrity of individuals/ clients/ groups/ communities.

Evaluates client progress toward expected outcomes and reviews plans in accordance with evaluation data and consultation with the client.

Assesses the effectiveness of nursing care in achieving the planned outcomes.

- Critically evaluates the effectiveness of nursing care in achieving the planned outcomes in consultation with the individual/ group/community and other members of the health care team.

Determines further outcomes and nursing interventions in accordance with evaluation data and consultation with the client.

- Determines further outcomes and nursing interventions in accordance with evaluation data in consultation with the individual/ group/community and other members of the health care team.

Domain 3. Interpersonal Relationships

Establishes and maintains caring therapeutic interpersonal relationships with individuals/ clients/ groups/ communities.

Reflects on the usefulness of personal communication techniques

- Critically evaluates the usefulness of personal communication techniques.

Conducts nursing care ensuring clients receive and understand relevant and current information concerning health care.

- Demonstration of the provision of nursing care that ensures clients: - Receive relevant and current information concerning health care. - Understand relevant and current information concerning health care.

Assists client/groups/communities to communicate needs and to make informed decisions.

- Identify strategies that enable clients/groups/communities to communicate needs and to make informed decisions.
- Implement strategies that enable clients/groups/communities to communicate needs and to make informed decisions.
- Critically evaluates strategies that enable clients/groups/ communities to communicate needs and to make informed decisions

Collaborates with all members of the health care team and documents relevant information.

Participates with all health care personnel in a collaborative effort directed toward decision making concerning clients.

- Demonstrates the ability to contribute as part of the health care team in a collaborative effort directed toward decision-making concerning clients.

Domain 4. Organisation and Management of Care

Effectively manages the nursing care of clients/ groups/ communities.

Contributes to the overall goal/ mission of the health care institution.

- Applies and contributes to the overall goal/mission of the health care institution.

Demonstrates the ability to work as a team member.

Determines priorities for care based on need, acuity and optimal time for intervention.

Selects and utilises resources effectively and efficiently.

Utilises methods to demonstrate quality assurance and quality management.

Delegates to other nurses' activities commensurate with their competence and within their scope of professional practice.

When delegating a particular role/ function account is taken of the principles outlined in the Scope of Nursing and Midwifery Practice Framework

Facilitates the coordination of care.

Works with all team members to ensure that client care is appropriate, effective and consistent.

- Demonstrates the ability to co- ordinate care and work with all team members to ensure that the client care is appropriate, effective and consistent.

Domain 5. Personal and Professional Development

Acts to enhance the personal and professional development of self and others

Contributes to the learning experiences of colleagues through support, supervision and teaching.

- Participates in the support, supervision and teaching of colleagues to enhance their personal and professional development.

Educates clients/ groups/ communities to maintain and promote health.

- Participates in the education of clients/groups/communities.

Document 1A

Developed to Support the Novice Nurse

Document 1 A

Novice Nurse Document

To Support Novice and Mentor Novice Nurse through Reflection on Practice

(and Identify and Plan Future Developmental and Training Needs)

To be completed by novice nurse as needed. **It gives the nurse an opportunity to look at and recognise their achievements. It also gives the him/her time to reflect on their own professional needs and seek ongoing support and it allows time to look at any further development or training needed for the job.**

Section A - Your Present Practice
How has practice been since your last review good/bad/satisfactory or otherwise? Why?
What do you consider your most important achievements at work for you since then? Do you meet the PDC / Mentor regularly? Yes / No
Do you feel that you are receiving adequate support? Yes/ No
Are you having any clinical issues in your job now? Yes / No
If yes, list the issue(s)
Is this a competency based issue Yes/ No
Is training needed in these areas? Yes/ No

If not a competency –based issue, have you sought help from your Mentor/ PDC/ADPHN	Yes/ No
Have you agreed and set Solutions?	Yes/ No
Have you tried these solution(s)?	Yes/ No
What worked?	
What did not?	
If issue remains a problem or further support is needed, please contact Mentor/PDC/ADPHN Name ---XXXXXXXXX------- Tel No XXXXXXXXXXXXXXXXXXX Email Address XXXXXXXXXXXXXXXXX	
Section B of this form is your development plan and it is completed when you need to I • **Complete further courses/ training or develop/ update competencies** • **You need to meet other service providers whom you will work with on the team or refer patients to** • **You need an introduction to outside agencies which you will refer to through work and you need to meet the relevant personnel and be updated on their role as advised by Mentor/ PDC/ADPHN**	

Section B Courses to be completed by Nurse in coming year

Training /Courses to be completed that are mandatory to your present job ie. Manual Handling Course, CPR Training, Online Training National Healthy Childhood Programme

Number	
1	
2	
3	
4	

Are there competencies you need to develop in your present work situation?

Yes/ No

If yes, discuss with Mentor/ PDC and when agreed list relevant courses below

Number	Course
1	
2	
3	
4	

Are there some skills you need to develop for your present work situation or for upcoming new practice developments?

Yes/ No

If yes, discuss with Mentor/ PDC and when agreed list relevant skill training below. Wound care clinic, child protection case conference, family support workshops, ect..

Number	Course
1	
2	
3	
4	

Are there people on the multi-disciplinary team you need to meet **Yes/ No**

if yes, please list name below and this can then be arranged

Example. PDC , Family Support worker, MSW, OT, Physio, Dietician, Speech and Language Therapist, G.P. DPHN ,ADPHN, CNS for wound care, CNS Diabetes/respiratory conditions, Older Persons Safeguarding team, Hospital Liaison Nurse, Equipment ordering staff, Clerical staff both locally and at HQ.

Number	Organisation
1	
2	
3	
4	

Are there people from outside agencies you need to meet **Yes/ No**

Example. TUSLA, Local Family Support services, Local sponsored Childcare, Social Inclusion Officer, Hopelessness Shelter, Local women's shelter/ refuge, asylum seekers housing, local drugs and alcohol support groups etc..

Number	Organisation
1	
2	
3	
4	

The Mentor / PDC Reviews Part A and B of form with the nurse as part of the practice review and discussion takes place between both and then Section C is completed by Mentor / PDC and agreed with ADPHN in unison with Nurse and the professional development plan is completed and arrangements made for application for training, competency updates or introductions.

Development Plan

For Nurse_____

Mentor/PDC_____

Name	
Job Title	
Employee HSE Staff No.	
NMBI Registration PIN Number	
Work Location	
Length of time in current position	
Line Managers Name Mentor/ PDC Name	
Line Mangers Email Mentor/ PDC Email	
Line Managers Telephone Number Mentor/ PDC Telephone Number	
Director of Public Health Nursing (DPHN) Name	
DPHN Email Address	
DPHN Telephone Number	

SECTION C

Professional Development Plan

NO.	Agreed Goals/ Courses	Training / Course/ In-troductions	Person Re-sponsible for organising this	Proposed Date of Completion
1				
2				
3				
4				
5				

Have you discussed and agreed Professional Development Plan with Nurse? Yes/ No

Is there is a need to make application for approval to DPHN? Yes/ No

If yes, have you advised re procedure for same? Yes/ No

Is there is a need to make application for Course? Yes/ No

If yes have you advised re procedure for same? Yes/ No

Is there is a need to make application for Study Leave? Yes/ No

If yes have you advised re procedure and leave allowances for same? Yes/ No

Is there is a need to make application for funding? Yes/ No

If yes have you advised re procedure for same? Yes/ No

If yes to above, then complete professional plan and make appropriate applications

Re there any other comments you would like to make that were not covered in the review form? Yes / No

If yes , please make comments below.

ADPHN- Any issues that need to be discussed after review of form

Please make comments below

Signed

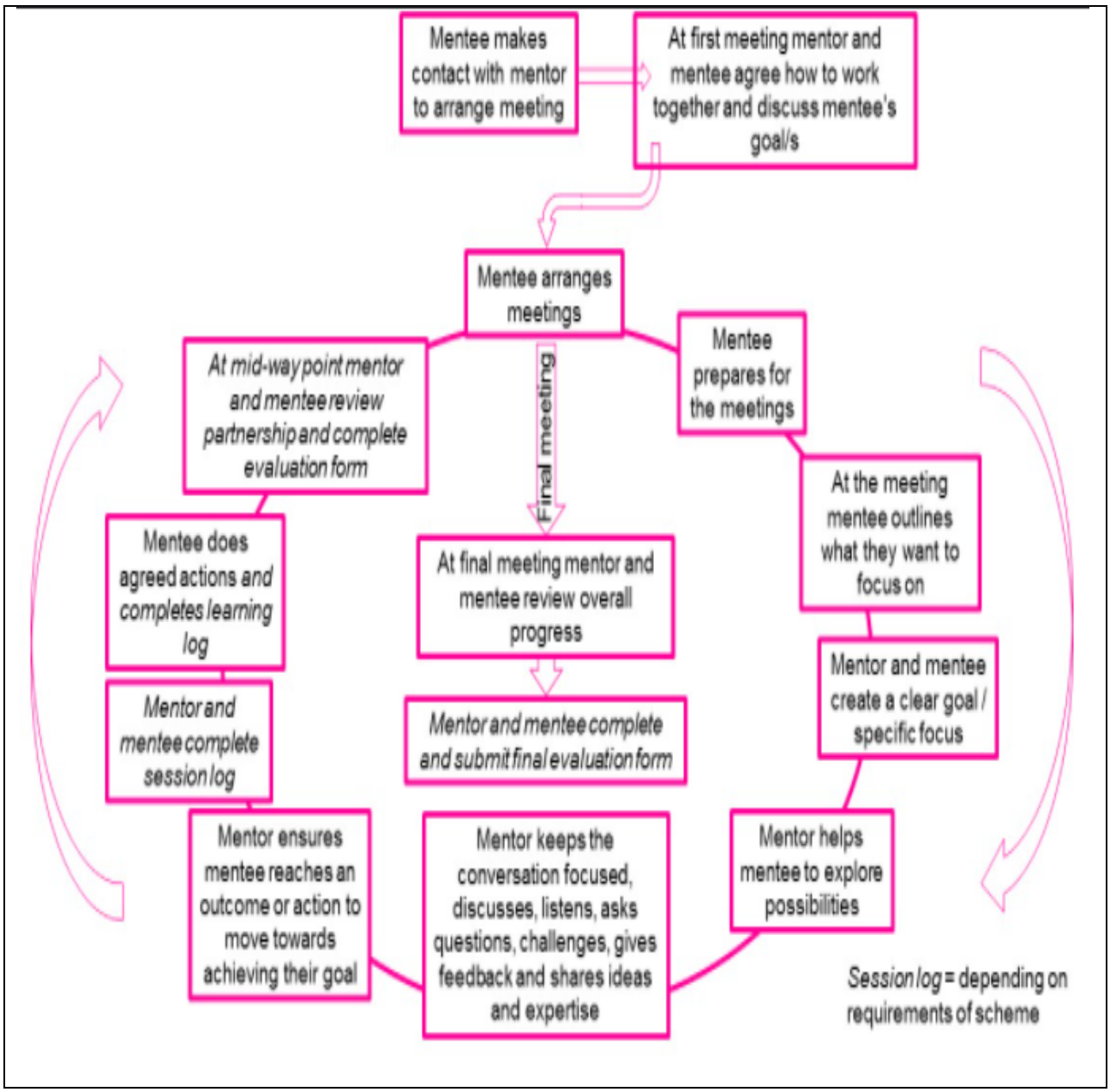
Nurse_____

Mentor/ PDC_____

ADPHN_____

Date_____

Mentor / Mentee Cycle



For use during Mentoring period

(ScreenSkills , 2021)

Mentoring Action Plan (MAP)

Use the following worksheet to write down your goals and develop an action plan for achieving them. The number of goals that you set is up to you.

Career Goals: Goal for MAP Program:

1. _____
2. _____
3. _____
4. _____
5. _____

Verify that your goal is SMART.

Specific: What exactly will I accomplish?

Measurable: How will I know when I have reached this goal?

Achievable: Is achieving this goal realistic with effort and commitment?

Do I have the resources to achieve this goal? If not, how will I get them?

Relevant: Why is the goal significant to my life?

Timely: When will I achieve this goal?

Mentoring Goal 1:_____

Action Steps	Resources	Beginning Date	Ending Date	Indicator of success

Mentoring Goal 2:_____

Action Steps	Resources	Beginning Date	Ending Date	Indicator of success

Mentoring Goal 3:_____

Action Steps	Resources	Beginning Date	Ending Date	Indicator of success

Mentoring Goal 4:_____

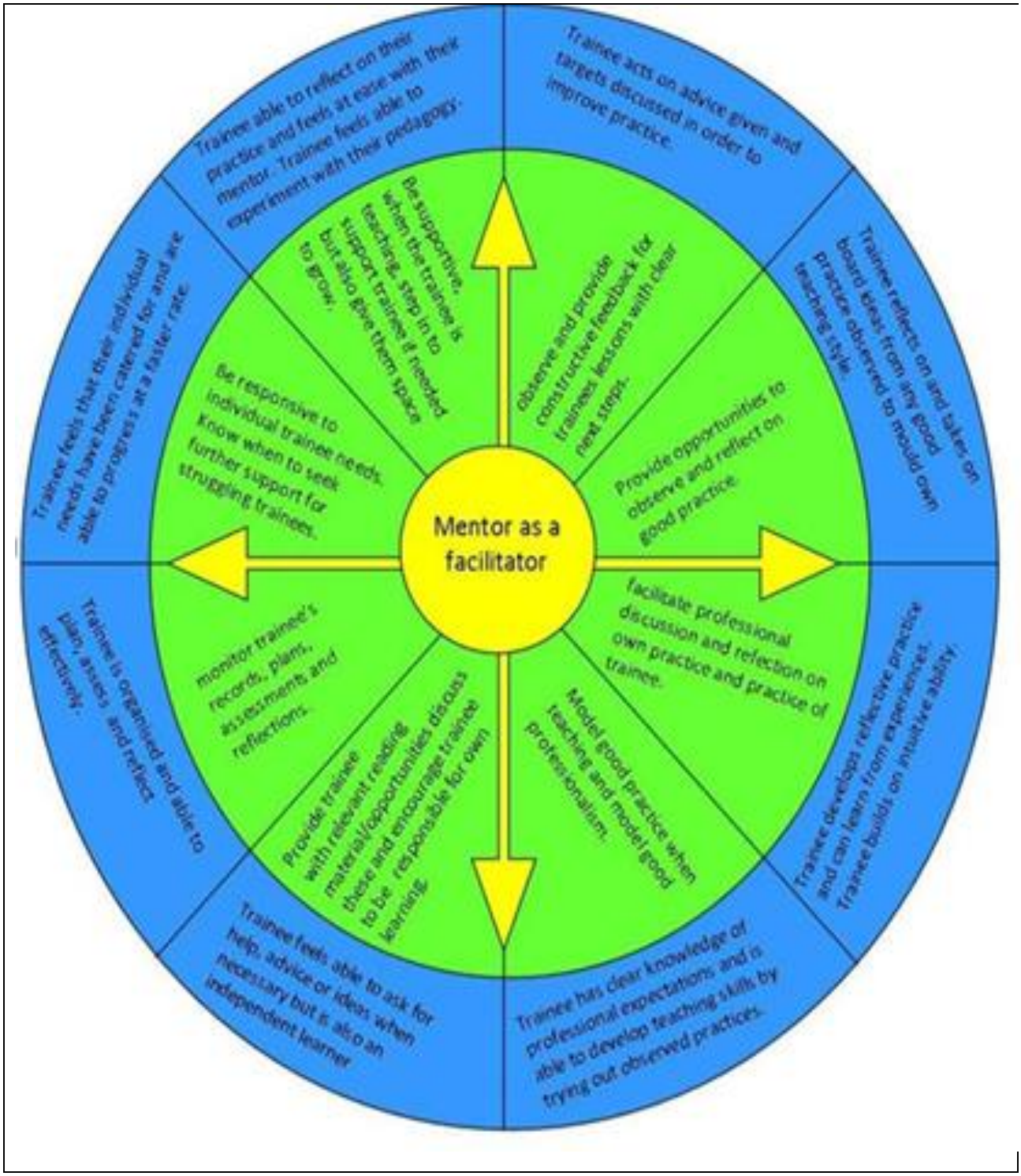
Action Steps	Resources	Beginning Date	Ending Date	Indicator of success

Mentoring Goal 5:_____

Action Steps	Resources	Beginning Date	Ending Date	Indicator of success

Program Accomplishments:

Graph Demonstrating the Roles of Mentor and Mentee

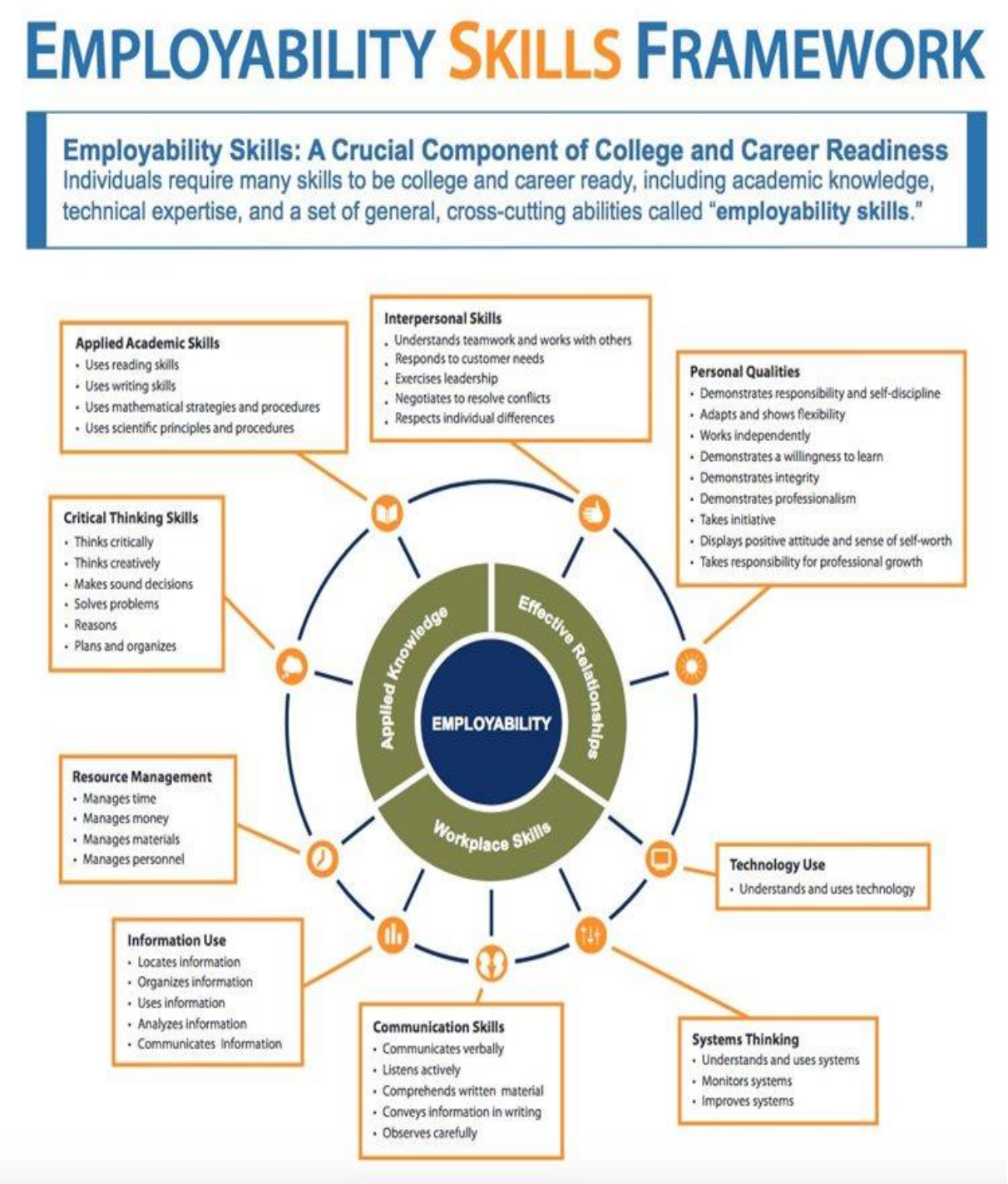


Good Practice in Mentoring

How to be a Good Mentor(@Teacher Toolkit, 2021)

Employability Skills Framework

Infographic framework offers suggestions for valuable topics to discuss with your mentor



Employability Skills Framework Adapted from U.S. Department of Education Office of Career, Technical, and Adult Education Division of Academic and Technical Education (2021: 2)

Appendix B

Document 2 from the Tool

For use when issue arises and advice Required

Document 2

Reviewing Clinical Issue(s) and Seeking Advice and Support from Management

To be completed by Employee who are reporting issue(s) in their Clinical Working Area and with which they need advice, guidance and support from ADPHN

Clinical Area Assessment Form

The individual should complete Page 1 & 2 and send form to manager one week *in advance* of the meeting. The Manager will complete page 3 during the meeting, having discussed it with the individual during the meeting.

What do you want to achieve from a visit from DPHN?	
What is the present issues(s)	
Has anything changed lately that has caused this issue?	**Yes/ No**
What has changed?	
Have you discussed this with your line manager?	**Yes/ No**
Were solutions advised?	**Yes /No**
What solutions were tried	**Yes /No**
What worked well?	

What did not work?
List any other issue/ challenge that may be adding to the issue
(1)
(2)
(3)
List two suggested solutions to issue
1st Suggested Solution
2nd Suggested Solution
Any other Information pertinent to the issues not mentioned above

Plan of Action

(To be agreed and form completed on day of visit)

Action	Person Responsible for the action
1.	
2.	
3.	
4.	

Any other information pertinent to resolution_____

_____

_____

_____

_____

_____

_____

_____

–

Signed and Agreed

Employee_____

ADPHN/DPHN_____

Review Date _____

Appendix C

Document Three Of

Tool

Completed when Issue Emerges that is Interfering with Practice Delivery.

Document 3

Plan for Up Skilling / Supporting Staff

This form is completed when an issue is identified that is interfering with practice delivery. This form is completed by both the nurse and ADPHN after discussion and agreement to the specific steps to be taken to resolve the issue or assist the staff member to be supported in current role.

When an issue is identified by either Nurse or ADPHN that is interfering with practice delivery, both the nurse and ADPHN meet to discuss same and both agree the specific steps to be taken that will resolve the issue or assist the staff member to be supported in current role. This process is called an Action Plan

An Action plan involves

1. Naming the specific issue
2. Clarify what needs to change. Name any issues that have arisen. Be specific about the issue and cite examples. Set a plan for resolution of each issue identified with a time frame.
3. Clarify goals and actions required
4. If there are skills, knowledge or attributes are needed to be developed specify same in plan with targeted dates
5. If support services are required by the staff member specify which support resources will be provided to assist the employee. (mentoring, coaching, referral to occupational health, counselling or other support services etc.).
6. Set the learning/ development or support plan if required with targeted dates.
7. Identify employees and employer's responsibilities in the plan.
8. Identify the method and the measure that will be used to evaluate progress and the time frame involved
9. Agree a time plan to meet to assess progress and provide feedback to the employee.
10. Record these dates and the timescales in the Action Plan.
11. A copy of the completed plan should be held by both manager and the individual with on-going monitoring of the situation being recorded in both plans.

An Action Plan must adhere to the SMARTER rules when setting objectives – specific, measurable, agreed, realistic, time-bound, ethical, recorded.

After the practice issue have been identified and the method to be used is identified then a summary of plan is completed and signed by staff employee, ADPHN and DPHN.

Action Plan

Identifies the method to be used to correct issue / support nurse. It also determines the measure to be used to evaluate progress and the time frame involved (where possible

Name Issue:

_____

Method to be used to correct / manage issue:

Agreed By Nurse_____

Agreed by ADPHN/DPHN_____

Method of measuring correction of practice issue

Time-frame for reviews

1st Review Date_____

2nd Review Date_____

3rd Review Date_____

4th Review Date_____

5th Review Date_____

Date	Progress Notes on Issue	Signature

ADDITIONAL SUGGESTIONS FOR ACTION PLAN

PLEASE COMPLETE AS NECESSARY

ACTION PLAN FOR _____

	Name Specific Plan	**DELIVERY DATE**
• **Further training or courses**		
• **UPDATING OF PRESENT SKILLS**		
• **SKILL DEMONSTRATION BY OTHERS**		
• **SKILLS PRACTICE UNDER SUPERVISION**		
• **Mentoring**		
• **Coaching**		
• **Referral to Occupational Health**		
• **Referral to Auxiliary Support Services**		
• **Reduce Working Day / Week** (***FOR A GIVEN PERIOD***)	**From** **TO**	
• **Introduce Flexible Working Arrangements** (***FOR A GIVEN PERIOD***)	**From** **TO**	
• **OTHER**		

OTHER AREAS OF DISCUSSION

This section should record any other points raised at the meeting.

_____

Signed by Employee

_____

Signed by A/Director of Public Health Nursing

_____

Signed by Director of Public Health Nursing

Date_____

Appendix Attached to Form 3

ADPHN Document to Aid **Identification of work Issue and / or Areas where support is needed, or competency training required**

Identification of Area of work Issue / or Need for Support in Staff

(A) Work Ethic

1. Work requires little supervision

2. Complaints re work are low

3. High levels of work productivity

4. Good work performance

5. Takes pride in work and strives to improve work performance
e

B) Dependability of attendance

1. Good timekeeping

2. Good attendance record

3. Never misses work without prior approval and appropriate notification

4. No unscheduled absences, except for documented emergencies

5. Can be counted on to change schedule or cross cover to facilitate others if needed

6. Arranged leave agreeably with colleagues

C) Cooperativeness – working with people

1. Good attitude to clients

2. Good attitude to other Staff members

3. Cooperative with others

4. Always cordial and willing to help co-workers, students, and clients

5. Enthusiastic, energetic and displays positive behaviour

6.Good team player

(D) Adaptability – adjusting to change

1. Adjusts well to changes in the work place

2. Maintains good customer service relations, even under stress

3. Looks for ways to streamline procedures and improve efficiency

4. Sets priorities and adjusts them as needed when unexpected situations arise

5. Adapted to new systems and processes well and seeks out training to enhance knowledge, skills and abilities

6. Always seems to know when to ask questions and when to seek guidance

(E) Communication skills – giving and receiving information

1. Demonstrates excellent oral and written communication skills

2. Takes messages, deals with customers and co-workers in a timely manner with sufficient attention to detail

3. All monthly returns, KPIs, reports, referrals and other forms and correspondence are completed on time and accurately

4. Students and co-workers feel comfortable coming to him/ her with questions and comments

5. Comes to ADPHN with any queries that she does not know off-hand

(F) Daily decision making/ problem solving - thinking on the job

1. Uses good judgment in solving problems and working with others

2. Displays strong analytical skills

3. Always offers ideas to solve problems based on good information and sound judgment

4. Displays initiative and enthusiasm during everyday work

5. Keeps practice evidence based

6. Adheres to all policies, procedures and guidelines

(G) Service to clients/public

1. Maintains a competent and professional demeanour in dealing with clients and the public

2. Courteous and knowledgeable

3. Helpful

4. Answers all questions promptly and accurately

5. Forwards any complaints or problems to supervisor immediately

6. Follows through and finds the answers to any questions and reports back to the customer promptly

H) Use of equipment and material

1. Inspects regularly and takes good care of equipment

2. Turns off and secures all equipment at the end of the shift

3. Reports problems immediately to the appropriate personnel

4. Uses supplies efficiently with rotation of stock and does not over order or overstock

I) Planning and implementation

1. Plans and prepares work diary well in advance with sufficient detail. Ensures work is distributed fairly

2. Uses inter disciplinary working and develops the concept of care planning in collaboration with other health care professionals

3. Plans and evaluates own work and delegated work for best practice and standard of care

4. Provide strategic and clinical leadership to nursing team resulting in delivery of effective, efficient, quality assured, and patient centred care

5. Develops or is part of a shared sense of commitment and participation among staff in the management of team working and sharing of care

6. Prioritizes in times of scarce staff resources

7. Anticipates problems before they occur

(J) Work group management

1. Draws on the knowledge and skills of others

2. Available when needed by subordinates

3. Resolves disputes and grievances fairly

4. Very supportive of co-workers and team works well

5. Ability to explain and teach

6. Inspires others to do better

7 Is capable of working alone and unsupervised
d

(K) Personal appearance, behaviour and general demeanour

1. Presents clean, well-groomed and dressed appropriately on duty with ID badge on display and adhering to HSE Dress code

2. Portrays professional image of the organization while on duty

3. Behaves appropriately and in professional manner while on duty

4. Appears well adjusted and happy while on duty

5. Coping well with workload

6. Seeks support and assistance from colleagues and/ or/ line manager when necessary

7. Does not allow private life to interfere with work life
e

8. Has good work / life balance

9. Interested in work colleagues and has good working relationship with them
m

10. Appears to have a good support network and uses same appropriately

11.Interested in her own work and interested in her client's
s

12. Appears able to cope with work

13.All aspects of Health appears good

14. Deals with stressors appropriately like challenging people, deadlines or difficult assignments ect..

15. Completes tasks in appropriate time frame and work up to date

Appendix D

Patients Feedback Form on Service Delivery

Document 4

Clients Feedback Form for Nursing Service

To be completed by Clients who are in receipt of Nursing Service

Seirbhíse Sláinte
Health Service Executive

Kildare / West Wicklow HSE Primary Care Nursing Feedback Form

How was your experience of the primary care nursing service?

We value your opinion about your experience of the Primary Care Nursing Service. Feedback you provide will help us to review and improve our service.

Completing this survey is voluntary and will not affect the service you receive. All responses are confidential and will only be used for quality improvement purposes. If you wish your responses to remain anonymous, please do not put your name on the survey.

(1) How would you rate your satisfaction with the Nursing service?

Very Satisfied	Satisfied	Average	Poor	Very Poor

(2) How would you rate the level of support you received?

Very Good	Good	Average	Poor	Very Poor

(3) How would you rate the waiting time from when you made initial contact until you engaged with a Nurse?

Very Good	Good	Average	Poor	Very Poor

(4) How would you rate the communication between you and your Nurse?

Very Good	Good	Average	Poor	Very Poor

(5) How would you rate the respect for your privacy and confidentiality during your involvement with the Nursing service?

Very Good	Good	Average	Poor	Very Poor

(6)Would you recommend this service to others? **Yes / No**

If Yes why? /If not, why not?

---

(7) I Liked

---

(8)I would Change or improve_____

Please feel free to write any other comments below or on an additional page:_____

_____**Do you consent to any comments you have made been used anonymously in improving the Primary Care Nursing Service? Yes ☐ No ☐**

Area you Live:

Gender: Female ___ Male ___

(You may wish to remain anonymous – if you do not supply your name and address, your comments will still be included anonymously)

Name/Address (Optional): _____

Contact Telephone Number (Optional): _____

thank You.

This form can be posted in the box for Feedback Forms in the waiting area or if receiving care at home your form can be returned via your Nurse or if you wish to remain anonymous you can post the form to,

Sheila Geoghegan

Director of Public Health Nursing,

HSE Offices Address, XXXXXXXXXXXX

XXXXXXXXXXXX

XXXXXXXXXXXX

Appendix E

Pathway To Excellence Self-Assessment Tool

Completed by Author

Pathway to Excellence

The first step in pursuing recognition as a Pathway to Excellence healthcare organisation is an Organisational Self-Assessment. This assessment must be deliberate and honest if it is to serve as an organisational measure of whether or not to pursue the Pathway to Excellence designation. Specific guidance on the following Self-assessment checklist can be found in the Pathway to Excellence Manual (ANCC, 2008; 2009).

1. Are all members of the nursing staff actively engaged in and aware of the Pathway to Excellence application? Aware Yes Engaged No
2. Are staff nurses involved in decision-making and all phases of projects that affect nursing, including quality processes? Yes
3. Is there evidence that a delineated nursing shared governance model is in place and integrated throughout the organisation? Yes
4. Is the development of policy/procedures evidence–based and are at least two of these being implemented? Yes
5. Is there nurse input on staffing plans and do they serve on nursing and hospital committees? Limited
6. Are protective security measures in place for patients and staff? Yes
7. Are prevention measures in place to decrease injury, illness, stress and accidents? Yes
8. Do nurses actively participate on safety committees and in product evaluation? Yes
9. Are employee support structures in place for reporting and addressing work environment events or concerns? Yes
10. Are supportive processes in the work environment perceived as restorative and/or holistic? Yes
11. Are non-adversarial, non-retaliatory, and alternative dispute resolution mechanisms in place to address concerns about the professional practice of healthcare professionals? Yes
12. Are there systems to assess quality of patient care Yes these may vary in style and use from manager to manager and from area to area.
13. Are there systems to assess the rights and culturally sensitive needs of patients? Yes
14. Are error prevention and management procedures disseminated to all staff on an ongoing basis? Yes
15. Do orientation activities incorporate general and specific mandatory training requirements? Yes
16. Does nursing orientation involve a personalised plan with close supervision of the orientee /new nurse by peers and supervisors providing timely feedback. Yes but may vary from manager to manager and also according to nurses previous experience
17. Do staffing patterns accommodate the orientation activities of new nurses? Not always it depends on staffing levels but every effort is made to accommodate orientation activities
18. Is a cross orientation program in place if assigned to multiple staffing areas? Yes but may vary with its application according to staffing levels and availability of staff to orientate.
19. Are nurses provided education/training to serve as a preceptor and receive feedback? Yes
20. Does the Director of Nursing (DON) hold a B.Sc.Nursing? Yes
21. Has the DON one of the following:

    Master's prepared in nursing, business or a health related field Yes

    Certified in management or administration

Or Actively progressing under a written plan towards achievement of additional education/course work to meet above criteria?

22. Is the DON accessible and an advocate to patients? Yes usually by appointment but can be contacted straight away in an emergency
23. Is the DON accessible and an advocate to nursing staff? Yes usually by appointment but can be contacted straight away in an emergency
24. Is continuing education supported and geared toward the nurse's roles and responsibilities? Yes
25. Are there examples of development opportunities through mentoring of staff in both the clinical and administrative arenas? Yes
26. Is there a process for nurses (i.e., nursing clinical ladder) that facilitates the development of competence, recognition and/or advancement. Yes
27. Can we demonstrate that nurses' wages and salaries are competitive, market adjusted and commensurate with education, expertise, experience and longevity? There are scales of pay for nursing and we do not have ability to change these , however they are competitive, market adjusted and commensurate with longevity but not with education, expertise, or experience unless a nurse changes her career pathway to reflect new education, expertise or experience gained
28. Is incentive pay based on performance and goal achievement? Not available
29. Are opportunities and rewards or incentives offered to nurses who serve as outstanding role models for exceptional service? Opportunities to progress through mentoring and education exist, there are no monetary rewards available in salary or payments but sponsorship of educational courses is possible
30. Do external entities, such as community and nursing organisations, recognize the nurses employed at the healthcare organisation for the accomplishments and contribution to the community and/or profession? Yes there are awards for nurses from the Nursing and Midwifery board, the Institute of Community Health and also HSE awards for innovative work or research
31. Are flexible staffing options provided? Yes but limited due to numbers of staff available to cross cover
32. In addition to Employee Assistance Programs, are other health and wellness support services in place? Yes
33. Are nurses involved in developing their work schedule to meet organisational and personal needs? Yes
34. Are mechanisms in place that foster and support collaborative interdisciplinary initiatives? Yes
35. Are established procedures utilized to constructively manage interdisciplinary conflict? Yes
36. Does the nurse manager participate in self-evaluation, development, and achievement of predetermined goals? Looking at commencing of self-evaluation but not in place yet. Do have reflective practice sessions and through these they are encouraged to develop and achieve pre-determined goals
37. Is the nurse manager able to describe examples in which s/he has advocated for patients and nurses? Yes
38. Do both staff and manager's peers have input to manager's/supervisor's evaluation? No
39. Is the nurse manager's performance evaluated on outcome measures? No
40. Are incentives awards provided for nurse managers to achieve outcomes beneficial to the patient and/or organisation? Limited in incentive giving. No personal monetary gain available but normally recognition for a job well done is given. Can offer funding for appropriate future development or mentoring in areas of staff choice. Can also encourage developing for specific post that uses their skill set and is appropriate for nurse and organisation. If outcome is significant can write formally to thank him/her on their accom-

plishment and also bring their accomplishment to attention of senior management team so as they can formally thank him/her also. May also nominate for bursary or award if significant piece of work.

41. Is there a current, written nursing quality plan? There are policies and procedures developed and stored online for ease of access for staff. These are used to set the standards for quality and safe care delivery. In addition to these policies, each patient has a written care plan and it is updated according to patient's needs.
42. Do nurses actively participate in outcome based quality initiatives? Yes but they may be asked to do so, most feel too short of time to initiate it themselves
43. Are evidence-based practices utilized by nurses? Yes

Appendix F

Ethics Approval from DCU

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

Ms Sheila Geoghegan

School of Policy and Practice

6th September 2018

REC Reference: DCUREC/2018/130

Proposal Title Improving Practice in Public Health Nursing

Applicant(s): Ms Sheila Geoghegan, Professor Gerard McNamara

Dear Sheila,

Further to expedited review, the DCU Research Ethics Committee approves this research proposal.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

Donal O'Gorman

Dr Dónal O'Gorman
Chairperson
DCU Research Ethics Committee

DCU
Research & Innovation

Taighde & Nuálaíocht Tacaíocht
Ollscoil Chathair Bhaile Átha Cliath,
Baile Átha Cliath, Éire

Research & Innovation Support
Dublin City University,
Dublin 9, Ireland

T +353 1 700 8000
F +353 1 700 8002
E research@dcu.ie
www.dcu.ie

Appendix G

Examples of One Letter Granting Permission to Carry Out Research

Access was granted to different CHN areas for the duration of the project with the caveat that any issues arising or revision to schedules would be discussed and agreed with the departmental heads. Sample of one such letter given to gain access to the study site and participants as provided in Appendix G

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

LHO Manager
David Walsh
Manager of LHO 7
Oak House
Millennium Park
Naas
Co Kildare

Re Ethical Approval for Sheila Geoghegan, to carry out research in CHO 7

To whom it Concerns,

This is to confirm that approval has been granted to Sheila Geoghegan DPHN to carry out research In CHO 7 Area. The research involves the introduction of a set of documents developed by her to examine if they assist with early identification of work issue in nurses and /or assist with timely intervention to provide staff with support in situations where they are experiencing difficulty.

The research will involve mainly interviews and some surveys of staff after they have used the set of documents. The data will be used solely for the purpose of her doctoral study and course tutors and examiners will have access to it. All materials will be checked for accuracy and anonymity will be used where required.

Yours Sincerely

David Walsh

David Walsh

Appendix H

Recruitment Advertisement

Recruitment Advertisement

Director of Public Health Nursing Office

Kildare West Wicklow

Beech House

Naas

Co. Kildare

Date

Dear Nurse

You may not know me, but I am the Director of Public Health Nurse in Kildare West Wicklow Area and presently I also a Doctoral student in DCU and I am seeking your help on a research project that I am conducting in LHO 7. I am investigating if the introduction of a suite of documents (same attached) can *Improve Practice in Public Health Nursing Health Nursing by providing Public Health Nursing staff with a tool which gives you the opportunity to*

1. Review your service delivery from the client's point of view
2. Review annually your achievements and allow time to reflect on your own and the organisations future professional development needs and allow time to look at building a future development plan for yourself.
3. Review any issue(s) in your Clinical Working Area and seek advice, guidance and support from ADPHN if necessary.
4. Jointly agree a plan to resolve the identified issue(s) with management team.

If you are interested in taking part and using the documents I have created an anonymous questionnaire which you can complete to give your opinion on the effectiveness and usefulness of documents to your practice and it also allows you to make suggestions for future changes to the documents to improve them. I will also carry out interviews and focus groups if you are interested in taking part. I am happy to

answer any questions you may have and you can reach me at the mobile no and / or email address below.

If you volunteer to be part of this research study, your legal and ethical rights will be honoured and you can withdraw at any time, without giving reason, and that decision affecting any future treatment or medical care. I will also supply an Information Sheet and you will be asked to sign a consent form and will be supplied with a copy of same.

Sheila Geoghegan

Director of Public Health Nursing Kildare West Wicklow

Tel 087 9188151

Email sheila.geoghegan@hse.ie

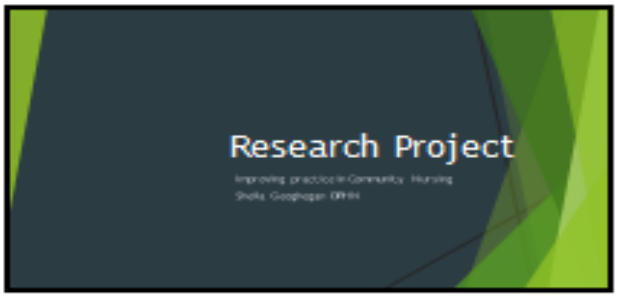
Appendix I

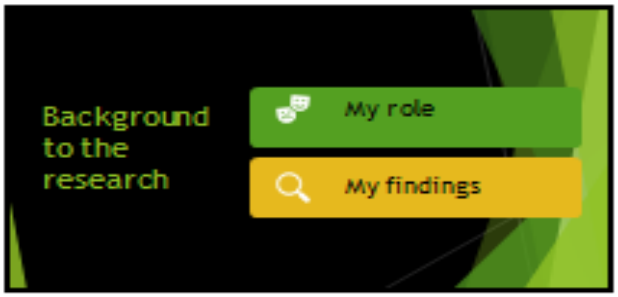
Example of Presentation Made and Timetable used from one of the Research Sites

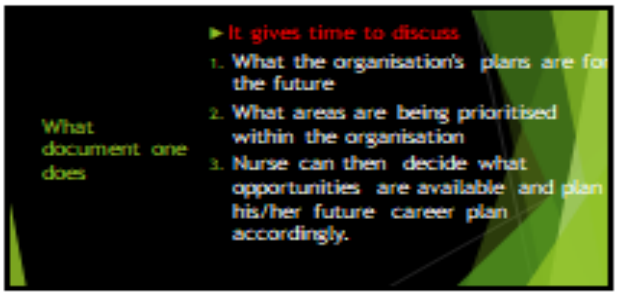
AGENDA FOR THE RESEARCH IN XXX

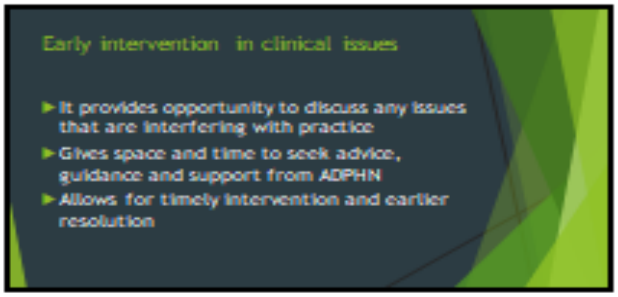
DATE	SESSION TIMES	ATTENDEES	Plan for day
1st Oct	11am-12pm 12pm-1pm 2pm-3pm 3pm-4pm	Everyone (RGN, PHN, ADPH, DPHN) to attend one of the four sessions	1. PowerPoint Introduction of the research introducing form 1 and form 2 2. All staff given 'Plain Language Statement' 3. All staff sign Consent Form 4. Form 1 distributed to all (TO BE COMPLETED IN NEXT 15 WEEKS) 5. Form 2 and Form 3 given to ADPHN
1ST Oct -15th Jn (15 weeks) Form 1 completed by all nursing staff			
DATE	SESSION TIMES	ATTENDEES	Plan for day
15th Jan	11am-12pm 12pm-1pm 2pm-3pm 3pm-4pm	Everyone (RGN, PHN, ADPH, DPHN) to attend one of the four sessions	1. Research Questionnaire on usefulness of Form I completed by Management and Nursing Staff 2. If people wish to be interviewed or give their opinions orally as well as completing the questionnaire, I will welcome all input 3. Form 2 distributed to all nursing staff requesting same 4. Talk on Form 2 to all staff requesting it and also to ADPHNs 5. Nurses advised that form 2 must be completed in next 11 weeks 6. Talk with ADPHNs to refresh on Form 3 if needed
31st March(11 WEEKS) Form 2 and / or Form 3 to be completed			
DATE	SESSION TIMES	ATTENDEES	Plan for day
31st March	11am-12pm 12pm-1pm	All nursing staff who completed Form 2	1. Research Questionnaire on usefulness of Form 2 completed by Management and Nursing Staff that used Form 2 2. If people wish to be interviewed or give their opinions orally as well as completing the questionnaire, I will welcome all input 3. Research Questionnaire on usefulness of Form 3 to be completed by ADPHNs and DPHN 4. Close of research and thanks to all 5. Everyone informed about expected date of publishing of research and data 6. Staff and Area will be mentioned in acknowledgements when research is published

PowerPoint Presentation Made on Day of research Lunch





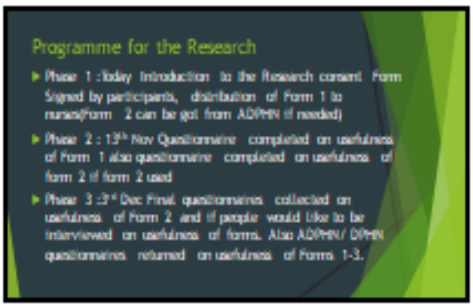





Document two
If further advice, guidance or support is required, and a plan of action is needed to address the issue, then document two is used.


Document two completed in advance of the site visit by APHN
Staff will have thought through what exactly their issue is
Document issue between themselves
Document what solutions have been tried by them to date.
Document at least 2 suggestions for resolution of issue
Submitted to ADPHN at least 7 days before site visit


Leading to Safer and improved practice
Less risk of litigation
More job satisfaction
Better staff retention


Programme for the Research
Phase 1 :Today Introduction to the Research consent Form Signed by participants, distribution of Form 1 to nurses(Form 2 can be got from ADPHN if needed)
Phase 2 : 13th Nov Questionnaire completed on usefulness of Form 1 also questionnaire completed on usefulness of form 2 if form 2 used
Phase 3 :2nd Dec Final questionnaires collected on usefulness of Form 2 and if people would like to be interviewed on usefulness of forms. Also ADPHN/ DPHN questionnaires returned on usefulness of Forms 1-3.


Completion of Research
Documentation of findings
Acknowledgement of staff involved in the research in Doctoral Thesis

Appendix J

Plain Language Statement

DUBLIN CITY UNIVERSITY

Plain Language Statement

I. My name is Sheila Geoghegan, I work as a lecturer with UCD on the Public Health Nursing Programme and I am currently studying on a Doctoral Programme in Education and Leadership at Dublin City University& St Patricks College. Part of my course is to undertake a research project. My own study involves examining if a suite of documents introduced into Public Health Nursing can assist with early identification of work issues and assist with timely intervention to resolve or improve the issue and provide staff with support/ when they are experiencing difficulty Also it is hoped that this suite of documents will contribute to prevention of situations developing where patient care is compromised or staff's wellbeing being put at risk.

II. Details of what involvement in the Research Study will require

I hope to use an Action Research approach to the study. Action research suits situations where practitioners explore issues in their own surroundings; therefore, making their findings much more likely to be used in practice (Freitas & Higgins, 2000). Action research is the most closely aligned to the needs of the practitioner. In this method, the researcher collects the views of the practitioners (Nursing staff and Management) who have used the suite of documents, she then collates this information and makes changes to the documents according to staff recommendations and then the researcher relaunches the new and altered documents again in another cycle of Action Research to research if the altered documents fulfil their purpose or not of

1. ***Assisting with early recognition of work issues and /or contribute to timely identification of work situations where there is a need to support staff?***
2. ***Prevent escalation of issues and lead to better outcomes*** (like prompter correction of issues leading to better client outcomes, increase in staff wellbeing, more job satisfaction, better staff retention and a reduction in the risk of litigation)?
3. ***Assist in improving practice?***

To begin the research the author will introduce the documents through a talk and PowerPoint presentation and then look for volunteers to use the documents and complete an anonymous questionnaire which can take approx. 10 minutes and some may also like to take part in interviews or focus groups which will take up to half an hour each. The same volunteers will be involved in the second cycle of Action research again answering the questionnaire and interview or focus group if they wish to. All participants' identity will remain anonymous and data collected will remain confidential. However, confidentiality can only be guaranteed within the limitations of the law.

III. Potential risks or Benefits to participants from involvement in the Research Study (if greater than that encountered in everyday life)

There are no risks or benefits attached to being involved in the research project

iV. Arrangements to be made to protect confidentiality of data, including that confidentiality of information provided

All participants identity will remain anonymous and data collected will remain confidential. However, confidentiality can only be guaranteed within the limitations of the law.

V. Advice as to whether or not data is to be destroyed after a minimum period

All data collected will be stored on an encrypted computer with two logon passwords that is owned and used solely by the researcher. Data collected will be stored on this computer for the minimum period when the until the study is complete and will then be destroyed. All hard copy data will be shredded at this stage also.

VII. Statement that involvement in the Research Study is voluntary

Involvement in the study is voluntary and the participants may withdraw from the Research Study at any point.

If participants have concerns about this study and wish to contact an independent person, please contact:

***The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000, e-mail* rec@dcu.ie**

My own contact details are below and I am happy to answer any questions you may have

Yours Sincerely

Sheila Geoghegan

Director Of Public Health Nursing

Kildare West Wicklow Area

Beech House,

Naas

Co Kildare

Mobile Phone No. 087 9188151

Email sheila.geoghegan@hse.ie

Appendix K

Consent Form for the Research Participants

LIN CITY UNIVERSITY

Informed Consent Form for Nurses

I. Research Study Title

Improving practice in Public Health Nursing

II. Clarification of the purpose of the research

The researcher has developed three documents which form part of an annual practice review for RGNs and PHNs working in public health nursing. S/he wishes to examine if using these documents can improve nursing practice.

***Document One was developed to assist nurses** reflect on their practice and acknowledge their achievements and discuss any issues they have. It also assists them to look at their professional learning needs and helps them develop a learning plan and future career plan for themselves.*

***Document Two** (If Used) was developed to give nurses an opportunity to discuss any clinical issues they may be having in their practice with nursing management, so management can assist them in resolving the issue in a timely manner.*

***Document Three** (If used) was developed for use when an issue arises that is affecting clinical practice. It assists the nurse/ ADPHN to identify the issue and it gives them the tools to approach the issue in a professional manner and make a plan for resolution of same.*

III. Confirmation of particular requirements as highlighted in the Plain Language Statement

Requirements may include involvement in interviews, completion of questionnaire, audio/video-taping of events. Getting the participant to acknowledge requirements is preferable, e.g.

Participant – please complete the following (Circle Yes or No for each question)

I have read the Plain Language Statement (or had it read to me)	*Yes/No*
I understand the information provided	*Yes/No*
I have had an opportunity to ask questions and discuss this study	*Yes/No*
I have received satisfactory answers to all my questions	*Yes/No*
I am aware that my interview will be audiotaped	*Yes/No*

IV. Confirmation that involvement in the Research Study is voluntary

I may withdraw from the Research Study at any point.

V. Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations

VI. Any other relevant information

For example:

- *if the sample size is small, advice to participants that this may have implications for privacy/anonymity*
- *if participants are in a dependent relationship with any of the researchers, a clear statement that their involvement/non-involvement in the project will not affect their ongoing assessment/grades/management*

Statement of Investigator's responsibility:

I have explained the nature, purpose, procedures, benefits, risks of, or alternatives to, this research study. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Statement of Research Participants responsibility:

I confirm that I have read and understood the Information Leaflet about this study. I have had the opportunity to ask questions about the study and all my questions have been answered to my satisfaction. I believe I understand what will happen if I agree to be part of this study.

I have read, or had read to me, this Consent form. I have had the opportunity to ask questions about the Consent form and all my questions have been answered to my satisfaction.

I freely and voluntarily agree to be part of this research study, which respects my legal and ethical rights. I am aware that my identity will remain anonymous and data collected will remain confidential. However, confidentiality can only be guaranteed within the limitations of the law. (ie., it is possible for data to be subject to subpoena, freedom of information claim or mandated reporting by some professions).

I am also aware that I may withdraw at any time, without giving reason, and without this decision affecting my future treatment or medical care. I have received an Information Sheet and am aware that I will be given a copy of this Consent form.

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project

Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Two Tools to access Practice Environments

(1)Heather Laschingers Tool to Assess for Work Effectiveness

(2) Lakes 2002 the practice environment scale of the nursing work index

Heather Laschingers Tool to Assess for Work Effectiveness

Table 4. Increasing Work Effectiveness Using Kanter's Model of Empowerment

Sources of Power	Strategies to Empower
Opportunity	Job enrichment, rotation, redesign Create new job ladders as alternatives to upward success definition, i.e., advances in skill rather than status Define tasks and knowledges needed for each job Performance appraisal to track progression
Lines of information	Seek out and ask for information Create alternate sources more informative than boss Share information to build trust and cooperation Communicate and celebrate successes Take credit for your ideas, communicate
Lines of support	Build relationships with peers Build relationships with superiors Build relationships with subordinates Build cross-functional relationships Build relationships outside own area Give recognition for achievements at any level to foster pride in work Excel in own function to get support Support innovation, risk-taking behavior
Lines of supply	Be aware of/and use traditional power sources Increase discretionary power, i.e., allow autonomy Negotiate expanded role Influence decisions that impact on job Bring in resources from outside unit to enable work, distribute as rewards, give prestige

(This was used as part of the scoping out exercise in Cycle Two with Nursing Staff)

This Tool was developed by Laschinger and it is a follow onto Roseabeth Kanter's 1977 work which recognizing the universal importance of the quality of the nurse practice environment,

Lakes 2002 the practice environment scale of the nursing work index

Nurse Participation in Hospital Affairs	
23	Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).
6	Opportunity for staff nurses to participate in policy decisions.
17	Opportunities for advancement.
21	Administration that listens and responds to employee concerns.
11	A chief nursing officer who is highly visible and accessible to staff.
5	Career development/clinical ladder opportunity.
28	Nursing administrators consult with staff on daily problems and procedures.[b]
27	Staff nurses have the opportunity to serve on hospital and nursing committees.
15	A chief nurse officer equal in power and authority to other top level hospital executives.
Nursing Foundations for Quality of Care	
31	Use of nursing diagnoses.[c]
22	An active quality assurance program.
25	A preceptor program for newly hired RNs.
26	Nursing care is based on a nursing, rather than a medical, model.
30	Patient care assignments that foster continuity of care, i.e., the same nurse cares for the patient from one day to the next.
18	A clear philosophy of nursing that pervades the patient care environment.
29	Written, up-to-date nursing care plans for all patients.
14	High standards of nursing care are expected by the administration.
4	Active staff development or continuing education programs for nurses.
19	Working with nurses who are clinically competent.
Nurse Manager Ability, Leadership, and Support of Nurses	
10	A nurse manager who is a good manager and leader.
20	A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician.
7	Supervisors use mistakes as learning opportunities, not criticism.[c]
3	A supervisory staff that is supportive of the nurses.
13	Praise and recognition for a job well done.
Staffing and Resource Adequacy	
12	Enough staff to get the work done.
9	Enough registered nurses to provide quality patient care.
1	Adequate support services allow me to spend time with my patients.
8	Enough time and opportunity to discuss patient care problems with other nurses.
Collegial Nurse–Physician Relations	
16	A lot of teamwork between nurses and physicians.
2	Physicians and nurses have good working relationships.
24	Collaboration (joint practice) between nurses and physicians.

Appendix M

Prompt Sheet for use in Patients Focus Groups Cycle 1

Prompt Questions for Patients Focus Group

Cycle 1

Appendix M

Flexible Prompt Guide for Cycle one for scoping out how to improve practice

Cycle 1 Patients

One very important thing that I would really like to say is that there is no right or wrong answer. This is really a conversation about thoughts and impressions. As you know, I am gathering information about looking at ways to improve nursing practice in community nursing and I am interested in your views and opinions on how we could achieve this. There are areas that I would like to explore; however, I'd really like to understand your views and feelings so please add anything you wish at any time.

Have you had issues with nursing poor practices in the last year?
What caused it?
Have you reported any issue or had to speak to someone about an issue in the last year?
What caused it?
How would you rate your satisfaction with the Nursing service? Has this changed in recent years/ times?
For the better / worse?
Why?
How would you rate the level of support you received?
Has this changed in recent years/ times?
For the better / worse?
Why?
Does the service meet your needs?
Has this changed in recent years/ times?
For the better / worse?
Why?
Do you find the service flexible if your needs change?
Has this changed in recent years/ times?
For the better / worse?
Why?
How would you rate the waiting time from when you made initial contact until you engaged with a Nurse?
How would you rate the communication between you and your Nurse?
Has this changed in recent years/ times?
For the better / worse?
Why?
Do you feel you are treated in a respectful and courteous manner?
Has this changed in recent years/ times?
For the better / worse?
Why?
How would you rate the respect for your privacy and confidentiality during your involvement with the Nursing service?
Has this changed in recent years/ times?
For the better / worse?
Why?
Has the service changed since you first began using it?
If so is this for the better or the worse.
If for the better what caused it
If for the worse what caused it
Are you happy with your present service?

If not, then why not?
What would you change to improve things?
What do you like about the service?
Are there any other comments you would like to make about the service?

Appendix N

Prompt Sheet used in Nurses Focus Group/ Interviews Cycle 2

Prompt Sheet for use in Nurses Focus Groups / Interviews Cycle 2

Prompt Questions for Nurses Focus Group/ Interviews

Cycle 2

Appendix N

Flexible Prompt Guide for Cycle one for scoping out how to improve practice

Cycle 2 Nursing staff

One very important thing that I would really like to say is that there is no right or wrong answer. This is really a conversation about thoughts and impressions. As you know, I am gathering information about looking at ways to improve nursing practice in community nursing and I am interested in your views and opinions on how we could achieve this. There are areas that I would like to explore; however, I'd really like to understand your views and feelings so please add anything you wish at any time.

Have you had issues with poor practices in the last year? (No need to give me specific incidents)
What caused it?
Do you use clinical errors or omissions as learning opportunities?
Is there a blame culture in the organisation?
Have you reported any patient –related incidents in the last year?
What caused it?
Has there been a reoccurrence of any type of incident which involved a patient in the last year?
What do you see as the commonest cause of practice issues?
What do you think we need to do differently to prevent them reoccurring again?
Are there policies in place to maintain best practice?
Has patient opinion on service delivery been sought?
If yes - how has patient opinion been sought?
What do you see as the commonest cause of practice issues?
What do you think we need to do differently to prevent them reoccurring again?
Do you and your managers ensure that policies are in place to maintain best practice?
Were any incidents related to a lack of competency?
If so was the nurse offered or did s/he seek to update or develop a competency?
Do staff have opportunity to engage in CPD?
Do you feel if they had an issue with practice that they would go to the manager?
Do you feel you have enough ongoing support?
Do you feel staffing levels are sufficient?
If no, does this affect practice?
Have caseload increased in recent years?
Why?
Do you have to ration care?
Why?
Have you missed care?
Why?
Have many staff left in the last year
Why
Do you like your job?
Does it give you job satisfaction?
Do you feel you want to stay/ leave?
Why?
Can you access caseload review?
Can you access reflective practice?
Have you used it?
Do you have access to reflective practice?
Do you have access to CPD?
Do you have access to career planning?

Would you like to develop further in your career?
Would you stay with this organisation?
Do you know what the future development plans for the organisation are?
Have you looked at these when considering your own career pathway?

Is there recognition for a job well done here?
Is there good team work?
Is there good team support?
Is there a good work atmosphere?
Have many staff left
Why?

Is there provision for family friendly policies in work?
Is there access to occupational health?
Is there access to staff health support systems?
Are you happy here?
Do you feel you are competent in your present job?
Do you think we could improve practice delivery?
How?
Is there anything else that you would like to add?

How does it feel to talk through these issues now?

Prompt Sheet used in Nursing Management Focus Group/ Interviews Cycle 2

Prompt Questions for Nursing Management Focus Group/ Interviews

Cycle 2

Appendix N

Flexible Prompt Guide for Cycle one for scoping out how to improve practice

Cycle 2 DPHN/ADPHNs

One very important thing that I would really like to say is that there is no right or wrong answer. This is really a conversation about thoughts and impressions. As you know, I am gathering information about looking at ways to improve nursing practice in community nursing and I am interested in your views and opinions on how we could achieve this. There are areas that I would like to explore; however, I'd really like to understand your views and feelings so please add anything you wish at any time.

Have you had issues with poor practices in the last year? (No need to give me specific incidents)
What caused it?
Do you use clinical errors or omissions as learning opportunities?
Is there a blame culture in the organisation?
Have you reported any patient –related incidents in the last year?
What caused it?
Has there been a reoccurrence of any type of incident, which involves a patient in the last year?
Are there policies in place to maintain best practice?
Has patient opinion on service delivery been sought?
If so- how was patient opinion sought?
What do you see as the commonest cause of practice issues?
What do you think we need to do differently to prevent them reoccurring again?
Were any incidents related to a lack of competency?
If so was the nurse offered or did s/he seek to update or develop a competency?
Do staff have opportunity to engage in CPD?
Do staff have the opportunity to get support and if so from whom?
Do you feel staffing levels are sufficient?
If no, does this affect practice?
Have caseload increased in recent years?
Why?
Is there rationing of care?
Has there ever been missed care that you are aware of?
Have many staff left in the last year
Why
Was there an exit interview
Did this reveal anything?
Was there job satisfaction?
Do you like your job?
Does it give you job satisfaction?
Can you access caseload supervision?
Do you feel supported in your job?
Do you have access to reflective practice?
Do you have access to CPD?
Do you have access to career planning?
Would you like to develop further in your career?
Would you stay with this organisation?
Do you know what the future development plans for the organisation are?
Have you looked at these when considering your own career pathway?
If you had a problem would you approach your manager?
Is the manager available to assist you if you need to discuss an issue?

Is there recognition for a job well done?
Is there god team work?
Is there good team support?
Is there good working relationships on your own team?
Is there provision for family friendly policies in work?
Is there access to occupational health?
Is there access to health support systems?
Are you happy here?
Do you feel you are competent in your present job?
Do you think we could improve practice delivery?
How?
Is there anything else that you would like to add?

How does it feel to talk through these issues now?

Appendix O

Questionnaire for Staff Using Document 1, 2 and 3

Three Questionnaires were developed (One for each document and also the patient survey found in Appendix D). Staff questionnaires were circulated via the post and email with an explanatory letter included.

Questionnaire for Staff Using Document 1

Research Questionnaire to be Completed by Nursing Staff After Using Document One		
Statement	**Rating Circle One**	**Additional Information**
Date:		
Researcher's Name:	Sheila Geoghegan	
Participant's Name:	(If you wish to write it)	
HSE CHO / Area Location:		

Please take a moment to complete this questionnaire. Your feedback provides data that allows us to accurately assess the quality and effectiveness of this suite of documents. All responses are confidential.

Evaluate this program on the topics listed below using a 1 to 5 Rating Scale

Rating Scale - 1 = Strongly Disagree and **5 = Strongly Agree**. Circle the appropriate number

This document has given me the opportunity to recognise and acknowledge **my most important achievements** in work during the last year?	**Disagree Agree** **1 2 3 4 5**	
Document One has given me the opportunity to recognise **things that did not go so well** for me in the last year?	**Disagree Agree** **1 2 3 4 5**	
I believe recognising both areas in my practice is important	**Disagree Agree** **1 2 3 4 5**	
Areas that I have done well in are my strengths and are areas I like and am very competent in and could go on to develop further in	**Disagree Agree** **1 2 3 4 5**	

I have noted these areas and put them in a future plan for myself	**Y/N**	
Things that have not gone so well are areas that need my attention	**Disagree Agree** **1 2 3 4 5**	
I have noted these areas and decided what to do about them?	**Disagree Agree** **1 2 3 4 5**	
These areas are related to • lack of competency in work area • lack of time • staff shortage • complex case • conflict with patient • conflict with colleagues • conflict with ADPHN • others not pulling their weight • personal matter • Other _____ (please state)	**Y/N**	

Research Questionnaire to be Completed by Nursing Staff After Using Document One		
Statement	**Rating Circle One**	**Additional Information**
Rating Scale - 1 = Strongly Disagree and **5 = Strongly Agree**. Circle the appropriate number		
Have you discussed these issues with ADPHN and decided what to do?	**Y / N**	
Completing document one, has given me the opportunity to discuss with my APHN the clinical issue(s) that I need advice or support on?	**Disagree Agree** **1 2 3 4 5**	
This document has assisted me to improve / resolve the clinical issue(s)	**Disagree Agree** **1 2 3 4 5**	
Have you competed your personal development plan for next year?	**Y /N/**	
Have you put in your mandatory training requirements for next year?	**Y / N**	
Have you put in the areas that you think you need an update in for your present practice?	**Y / N**	
Have you put in any topics you would like ADPHN/DPHN to arrange **local** talk/update on?	**Y / N**	
This document has assisted me to **think about** my future career	**Disagree Agree** **1 2 3 4 5**	
This document has assisted me to **plans for** my future career	**Disagree Agree** **1 2 3 4 5**	If so name one of your plans
Is there a different area of work you would like to work in?	**Y / N**	
Have you mentioned this to ADPHN to record it, in case an opportunity came up locally?	**Y / N**	

Research Questionnaire to be Completed by Nursing Staff After Using Document One		
Statement	**Rating Circle One**	**Additional Information**
Rating Scale - 1 = Strongly Disagree and **5 = Strongly Agree**. Circle the appropriate number		
This document has given me the time and space to discuss and examine my practice?	**Disagree Agree** **1 2 3 4 5**	
This document has given me the time and space to look at my continuous professional development?	**Disagree Agree** **1 2 3 4 5**	
Engaging with ongoing professional development has led to improvements in my practice	**Disagree Agree** **1 2 3 4 5**	If yes, please name improvement(s)
Engaging in continuous professional development has led to improvements in patient care	**Disagree Agree** **1 2 3 4 5**	If yes, please name improvement(s)
Engaging in continuous professional development can lead to new career opportunities if I want it to	**Disagree Agree** **1 2 3 4 5**	
Did using this document help you or your practice in any way?	**Y / N**	If yes, please name one way
Do you feel this form is worth introducing into Community Nursing?	**Yes/ No**	If YES**,** why is it worth introducing in your opinion If NO, why is it not worth introducing in your opinion
If yes, how often do you think it should be used (Tick Box)	**Every 6 Months** ☒ **Annually** ☒ **Every Second Year** ☒ **Other** ☒	If other, please state time frame.

Do you have any additional comments regarding changes you would make to the form?
Comments

Thank you for taking part in my survey

You can email it to me at **sheila.geoghegan@hse.ie**

Questionnaire for Staff Using Document 2

Research Questionnaire to be Completed by Nursing Staff After Using Document Two		
Statement	**Rating Circle One**	**Additional Information**
Rating Scale - 1 = Strongly Disagree and **5 = Strongly Agree**. Circle the appropriate number		
This document has assisted me in notifying my ADPHN that I am having issues in my work area?	**Disagree Agree** **1 2 3 4 5**	
This document has assisted me in identify-ing exactly what the issue was prior to ADPHN visit?	**Disagree Agree** **1 2 3 4 5**	
This document has assisted me (and other staff at Primary Care Centre) to discuss the issue and explore solutions to it prior to ADPHN visit?	**Disagree Agree** **1 2 3 4 5**	
Things improved as a result of using this form	**Disagree Agree** **1 2 3 4 5**	
The issue has been resolved	**Disagree Agree** **1 2 3 4 5**	
While the issue has not resolved, things have improved and discussing the issue has helped me	**Disagree Agree** **1 2 3 4 5**	
If discussing the issue has helped you, in what way has it helped you? Please comment		

Research Questionnaire to be Completed by Nursing Staff After Using Document Two		
Statement	**Rating Circle One**	**Additional Information**
Rating Scale - 1 = Strongly Disagree and 5 = Strongly Agree. Circle the appropriate number		
Using Document Two has led to earlier / prompter correction of issue(s)	**Disagree Agree** **1 2 3 4 5**	
Using Document Two has led to Improvement in my practice	**Disagree Agree** **1 2 3 4 5**	
Using Document Two has led to better patient care delivery	**Disagree Agree** **1 2 3 4 5**	
Using Document Two has led to less risk of litigation	**Disagree Agree** **1 2 3 4 5**	
Using Document Two has helped me to feel heard and / or supported by management with my issue	**Disagree Agree** **1 2 3 4 5**	
By discussing/ improving/ correcting my practice issues, it has assisted me to feel better and worry less and this has improved my feeling of wellbeing	**Disagree Agree** **1 2 3 4 5**	
Using Document Two to discuss/ improve/ correct my practice issues has led to better job satisfaction	**Disagree Agree** **1 2 3 4 5**	
I feel using Document Two to discuss, improve or correct practice issues leads to staff feeling more supported.	**Disagree Agree** **1 2 3 4 5**	
I feel using Document Two to discuss, improve or correct practice issues leads to staff feeling more valued	**Disagree Agree** **1 2 3 4 5**	
I feel that staff who feel supported and valued are more loyal to their employer and more likely to stay in their present job	**Disagree Agree** **1 2 3 4 5**	

I feel that by staff reporting their own clinical issues and seeking help with it, it eradicates the blame culture associated with management identifying clinical issues.	**Disagree Agree** **1 2 3 4 5**	
Would you recommend this form to other staff in a similar situation to yourself?	**Y / N**	If yes, why would you recommend it?

Comments:

Do you have any additional comments regarding changes you would make to the form?

Do you have any additional comments you would like to make?

Questionnaire for Staff Using Document 3

Questionnaire for ADPHNs / DPHN who completed Document 3 (Identification & Resolution of Clinical Issues)		
Statement	**Rating Circle One**	**Additional Information**
Has Document 3 assisted you to identify the issue that was interfering with practice delivery?	Disagree Agree 1 2 3 4 5	
Has Document 3 to identify the issue for resolution?	Disagree Agree 1 2 3 4 5	
Has Document 3 assisted you to clarify what needed to change?	Disagree Agree 1 2 3 4 5	
Has Document 3 assisted you to clarify the goals required?	Disagree Agree 1 2 3 4 5	
Has Document 3assisted you to agree the specific steps to be taken to resolve the issue?	Disagree Agree 1 2 3 4 5	
Has Document 3 assisted you to Identify the method and the measure that will be used to evaluate progress?	Disagree Agree 1 2 3 4 5	
Has Document 3 assisted you to set a time plan to meet to assess progress and provide feedback to the employee?	Disagree Agree 1 2 3 4 5	
Has Document 3 assisted you to Identify employees and employer's responsibilities in the plan?	Disagree Agree 1 2 3 4 5	

Has Document 3 assisted you to be able to approach the issue in a professional manner?	Disagree Agree **1 2 3 4 5**	
Has Document 3 assisted you to support the staff member throughout correction of the issue?	Disagree Agree **1 2 3 4 5**	
	Rating Scale - 1 = Strongly Disagree and **5 = Strongly Agree**. Circle the appropriate number for each statement	
Any additional comments		

Thank you for taking part in my survey

You can email it to me at sheila.geoghegan@hse.ie

Appendix P

Indicative Content of Focus Group/ Interview Questions for Nursing Staff/ Nursing Management

Indicative Content of Focus Group/ Interview Questions for Nurses

Indicative Content of Focus Group/ Interview Questions for Nurses

Re Training		Have you attended the training regarding the introduction and use of the suite of documents? Have you used the documents? Where did you access the documents
Document 1	Has the patient been given the opportunity to voice their opinion on service delivery and their satisfaction/ dissatisfaction with same. Have any issues arose.	Has document 1 brought any practice issues to nursing management's attention? Has there been changes made to correct any reported practice issue due to using document 1 Has the document led to earlier recognition of issues? Has there been poor patient outcomes in any of the patient reported issue Has the document assisted with earlier recognition of the issues
Document 2	A broad range of skills and competencies are required by PHN staff to provide multi-faceted care within the community. Are there any areas where staff are experiencing difficulty with their caseload and require support or advice? Are staff competencies and essential education up to date and is more training required	Does this document give staff the opportunity to look at and recognise their achievements during the past year? Does the document give staff the opportunity to examine where things have not gone so well? Does it provide them with the opportunity to ask for advice or support? Also, does it allow time for ADPHN and staff member to look at updating competencies or planning new learning which is pertinent to both their present position and future career development? Does it entice staff to career plan?
Document 3	Clinical issues arising and/ or help or support needed.	Do this document assist management with early recognition of work issues Do this document assist management

		with early recognition of work situations where staff need support or advice before it impacts on patient care? From managements perspective does this document give timely notice of work issues and / or Areas where support is needed thus aiding early resolution
Document 4	Need to develop appropriate and timely plan of action to correct the issue or support the staff member	Does this document assist management to develop appropriate plan of action to correct the issue or support the staff member? If not, what changes would you make?
	Has the use of the documents lead to better outcomes for staff, patients and the HSE	Has using the documents led to 1. Improved practice 2. Increased staff wellbeing, 3. Improved job satisfaction 4. Improved staff retention 5. Improved patient outcomes 6. Reduced risk of litigation
Overall Assessment		

Indicative Content of Focus Group/ Interview Questions for Nursing Management

Indicative Content of Focus Group/ Interview Questions for Nurse Managers

Document No.	Research issues (antecedent data)	Evolving research question
Document 1	Has the patient been given the opportunity to voice their opinion on service delivery and their satisfaction/ dissatisfaction with same. Have any issues arose.	Has cognizance been taken of patients view re satisfaction with service delivery. Has there been areas noted where work issues have contributed to poor service delivery. If so, has the document assisted with early recognition of the issues and prompt intervention to correct them
Document 2	A broad range of skills and competencies are required by PHN staff to provide multi-faceted care within the community. Are there any areas where staff are experiencing difficulty with their caseload and require support or advice? Are staff competencies and essential education up to date and is more training required	Does this document give staff the opportunity to look at and recognise their achievements during the past year also to look at where things have not gone so well? Does it provide them with the opportunity to ask for advice or support? Also, does it allows time for ADPHN and staff member to look at updating competencies or planning new learning which is pertinent to both their present position and future career development?
Document 3	Clinical issues arising and/ or help or support needed.	Do this document assist staff with early recognition of work issues and /or contribute to timely identification of work situations where they need to seek support or advice before it impacts on patient care?
Document 4	Need to develop appropriate and timely plan of action to correct the issue or support the staff member	Does this document assist in developing appropriate plan of action to correct the issue or support the staff member? Is the document appropriate to this use
Overall Assessment	Has the use of the documents lead to better outcomes for staff, patients and the HSE	Has using the documents led to 1. Improved practice 2. Increased staff wellbeing, 3. Improved job satisfaction 4. Improved staff retention 5. Improved patient outcomes 6. Reduced risk of litigation

Appendix Q

Interview Questions for Staff Using Document 1, 2 and 3

Three sets of interview questions were developed (One for each document and also the patient survey found in Appendix D)

Interview Questions for Staff Using Document 1

Interview Questions for Document One Users

- **Has this document given you the opportunity to recognise your achievements during the last year?**
- **Has this document given you the opportunity to recognise things that did not go so well for you in the last year?**
- **Do you need to develop or update any existing competencies?**
- **Have you added these to your personal development plan(PDP)?**
- **Do you need to develop new competencies for your present job**
- **If yes, have you added these to your PDP?**
- **Are there areas that you would like to develop further in, or do some courses in, in the coming year?**
- **Are there areas where you could use these skills more in the future?**
- **Have you noted these areas and put them into a future PDP?**
- **What action now needs to be taken by you to accomplish this?**
- **Do you like your present job?**
- **What kind of work or job would you like to be doing in one/two/five years' time?**
- **With this in mind what sort of training/experiences would benefit you and your job in the coming year?**
- **Do you have a personal plan for your future development**
- **Do you think you need one?**
- **Why**
- **Has the document allowed you and ADPHN to discuss updating your competencies or planning new learning which is pertinent to your present position and future career development?**
- **Do you think this document has made it easier for you to plan your educational updates? Why?**
- **Do you think this document has made a difference to you planning your future career? Why?**
- **Have you any issues in your clinical practice?**
- **Did the document give you the opportunity to discuss these issues?**
- **Have you set, agreed solutions with ADPHN and implemented them?**
- **Did things improved?**
- **Did the issue resolve?**
- **Would you normally report an issue to your line manger**
- **Has this document given you the opportunity to talk to your ADPHN/DPHN about any issues you need advice or support on?**
- **Has using this document feel helped you to feel heard?**
- **Has using this document led to an improvement in staff wellbeing?**
- **Has using this document led to feeling supported in your work?**
- **Has using this document led to better patient outcomes?**
- **Has using this document led to an improvement in practice?**
- **Would you recommend this form to others?**
- **Why?**
- **Are there changes you would recommend making to the document?**

Interview Questions for Staff Using Document 2

Interview Questions for Document Two Users

- **Has using this document led to early reporting of an issue?**
- **Has this document assisted you in notifying your ADPHN that you are having issues in your work area?**
- **Has this document assisted you in identifying exactly what this issue is prior to ADPHN visit?**
- **Had you tried to solve it yourself?**
- **Did you discuss it with others colleagues?**
- **Has completing document two given you the opportunity to discuss the issue with the ADPHN**
- **Has the issue improved / resolved as a result of this?**
- **Was there learning in this?**
- **Has it been easier to report your issues to ADPHN while using this form? Would you recommend this form to other staff in a similar situation to yourself?**
- **Did you get improvement or resolution to your issue?**
- **Has using this document led to an improvement in job satisfaction?**
- **Has using this document led to staff feeling less stressed?**
- **Has using this document feel helped you to feel heard?**
- **Has using this document led to an improvement in staff wellbeing?**
- **Has using this document led to feeling supported in your work?**
- **Has using this document reduced the risk of burn out?**
- **Have changes to patient service delivery taken place as a result of review of with this form?**
- **Has using this document led to better patient outcomes?**
- **Has using this document led to an improvement in practice?**
- **Has using this document led to fewer complaints?**
- **Has using this form led to less incidents occurring?**
- **Has using this document led to less risk of litigation?**
- **Would you recommend this form to others?**
- **Why?**
- **Are there changes you would recommend making to the document?**

Interview Questions for Staff Using Document 3

Document Three Interview Questions

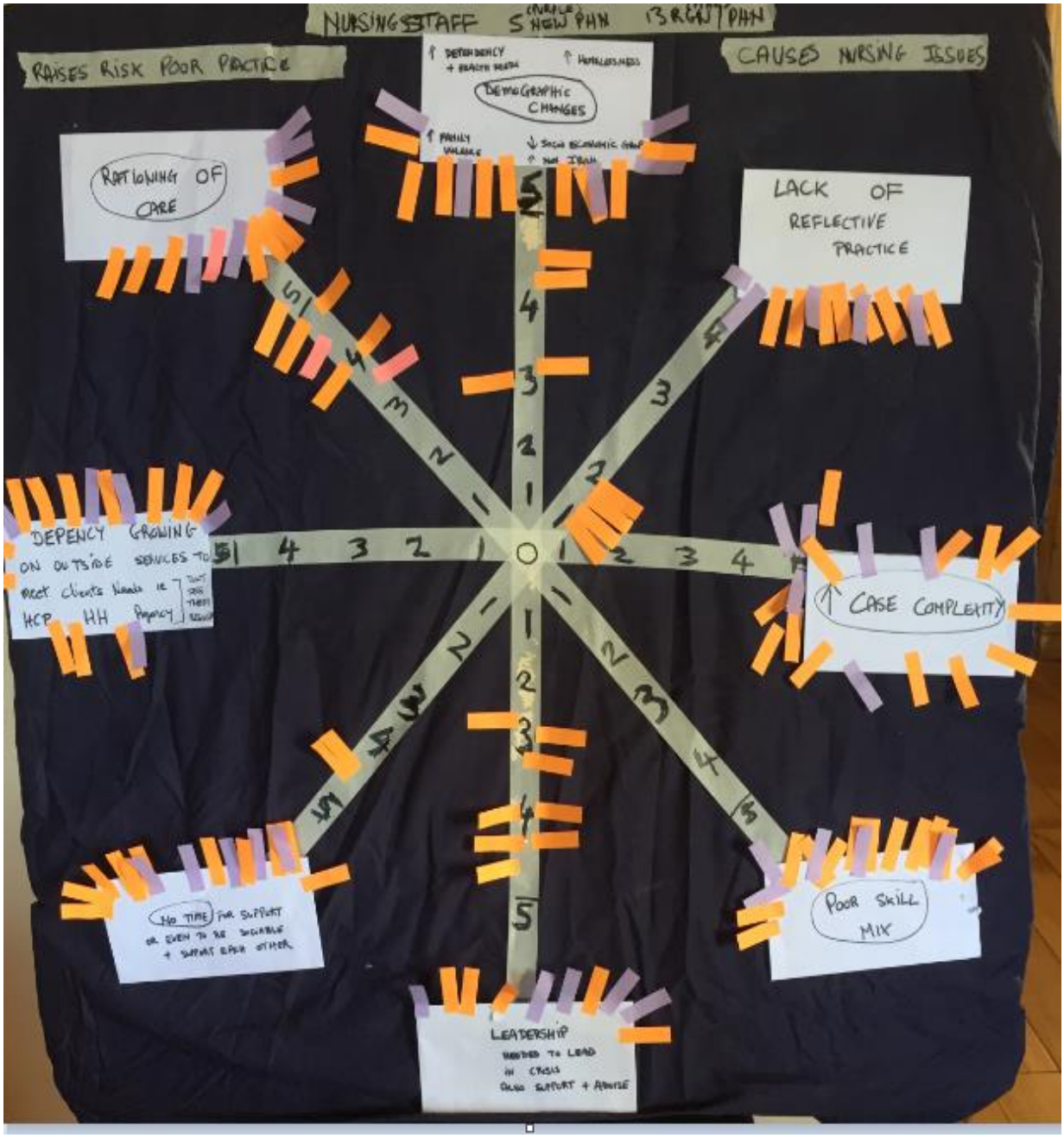
1. **There was an issue that you and the DPHN discussed?**
2. **Were you aware there was an issue before the ADPHN approached you?**
3. **Did anything change lately that is now acting as a predisposing factor for the issue?**
4. **Had you tried to solve it yourself?**
5. **What did you do?(if you want to say)**
6. **Did you discuss it with others colleagues?**
7. **Did you discuss it with your line manager?**
8. **Has completing document three with the line manager given you the opportunity to discuss the issue**
9. **Did you formulate an action plan to help resolve the issue together?**
10. **Do you feel that Document Three made it clear what the expected level of work / performance standard is?**
11. **Does the document bring clarity as to what the nursing staff role and the managers role is in the remedy of the**
12. **Were you happy with this plan?**
13. **Did the issue improved / resolved as a result of this?**
14. **Was there learning in this?**
15. **Have you completed the plan yet?**
16. **When do you hope to complete it?**
17. **Do you think Doc Three was successful in helping you resolve your issue?**
18. **Is this document appropriate for this use?**
19. **Would you use it again?**
20. **Would you recommend it to colleagues to use if they had an issue?**
21. **Did you feel it helped resolve/improve the issue?**
22. **Did Document three make the process easier to approach or not?**
23. **Are you happy with the outcome?**
24. **Would you use it again?**
25. **Why?**
26. **Would you recommend it to colleagues to use if they had an issue?**
27. **Why?**
28. **Are there changes you would recommend making to the document?**
29. **Has using these documents lead to improved practice?**
30. **Has using these documents lead to increase in staff wellbeing?**
31. **Has using these documents lead to better patient outcomes?**
32. **Has using these documents lead less complaints or litigation ?**

Appendix R

Photograph of Socrates Wheel and Graph of Findings in Nursing Focus Groups In Cycle 2

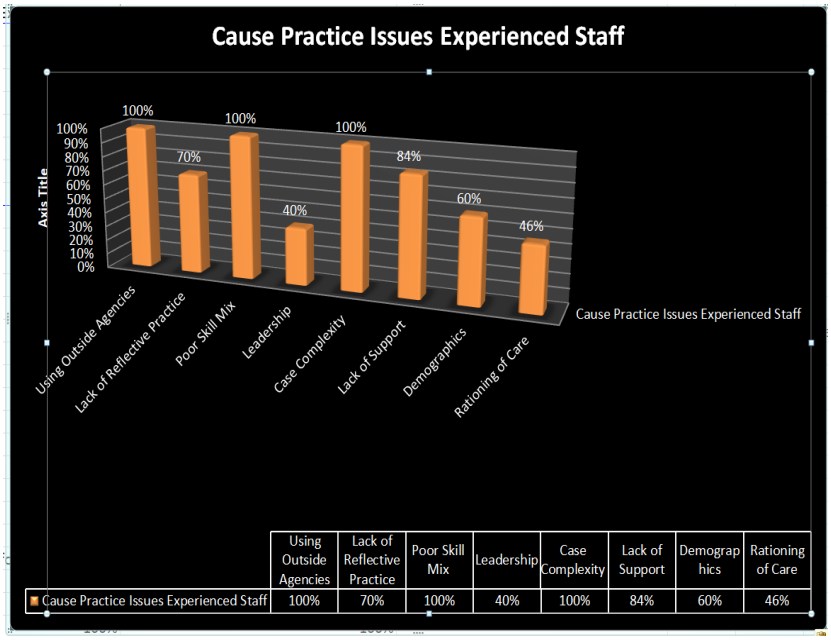
Causes of Practice Issues

Photograph of Socrates Wheel Used in Nursing Focus Groups



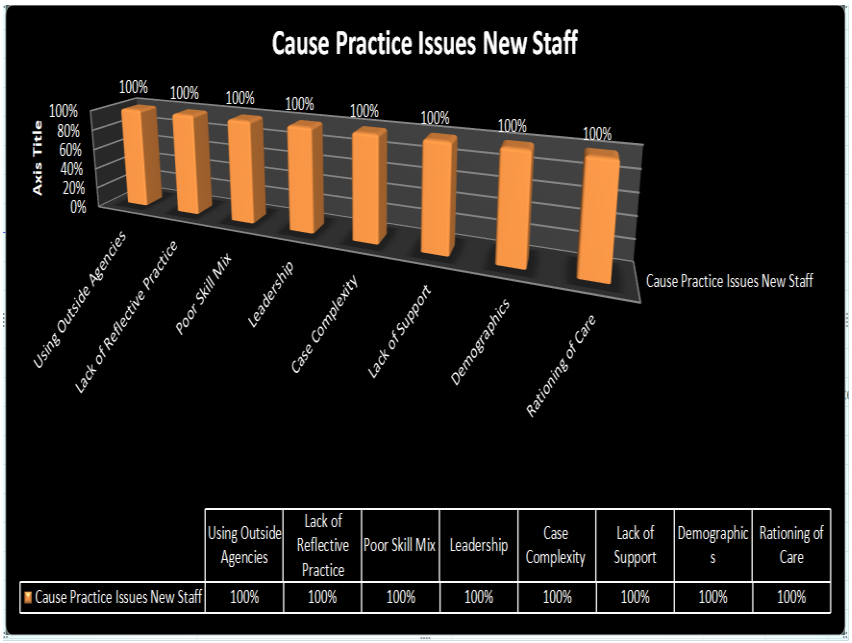
Nursing Staff Socratic Wheel Naming and Rating the Factors that Predisposed to and Caused Practice Issues

Photograph Socratic Wheel used in biggest focus group for the nurses. This identifies the causes of practice issue. The purple stickers represent 5 novice nurses and the orange stickers represent 13 experienced nurses in the photograph above. Results of this are found in diagram 4.1 and 4.2 in thesis and also in the 2 diagrams on next page in Appendix. Comparisons between management and nursing groups are found in diagram on next page 327.



	Using Outside Agencies	Lack of Reflective Practice	Poor Skill Mix	Leadership	Case Complexity	Lack of Support	Demographics	Rationing of Care
Cause Practice Issues Experienced Staff	100%	70%	100%	40%	100%	84%	60%	46%

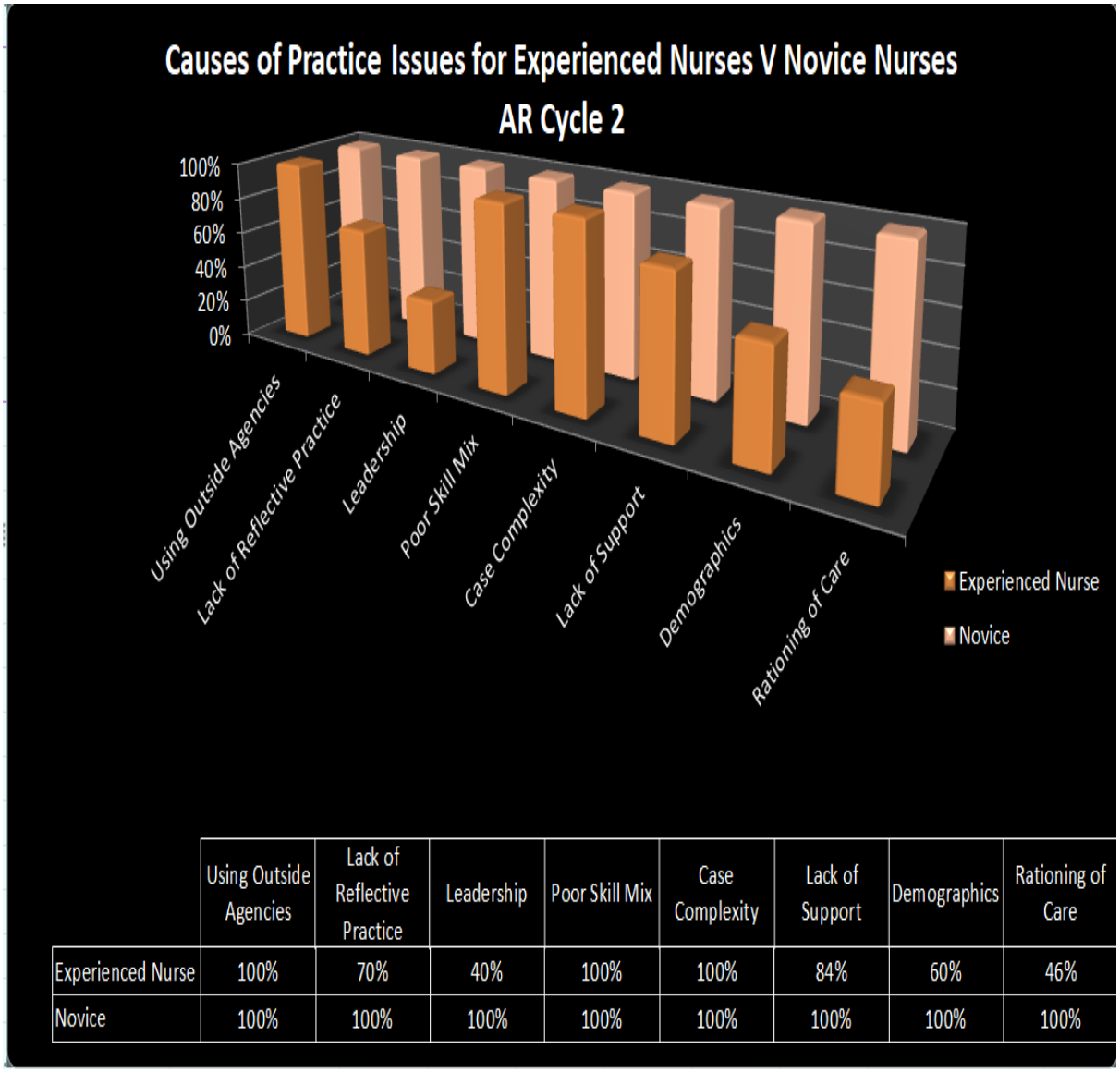
Causes of Practice Issues in Experienced Nurses Opinion



	Using Outside Agencies	Lack of Reflective Practice	Poor Skill Mix	Leadership	Case Complexity	Lack of Support	Demographics	Rationing of Care
Cause Practice Issues New Staff	100%	100%	100%	100%	100%	100%	100%	100%

Causes of Practice Issues In Novice Nurses Opinion

Diagrammatical representation comparing the findings of the causes of Practice Issues in Novice Nurses and Experienced nurses
AR Cycle 2



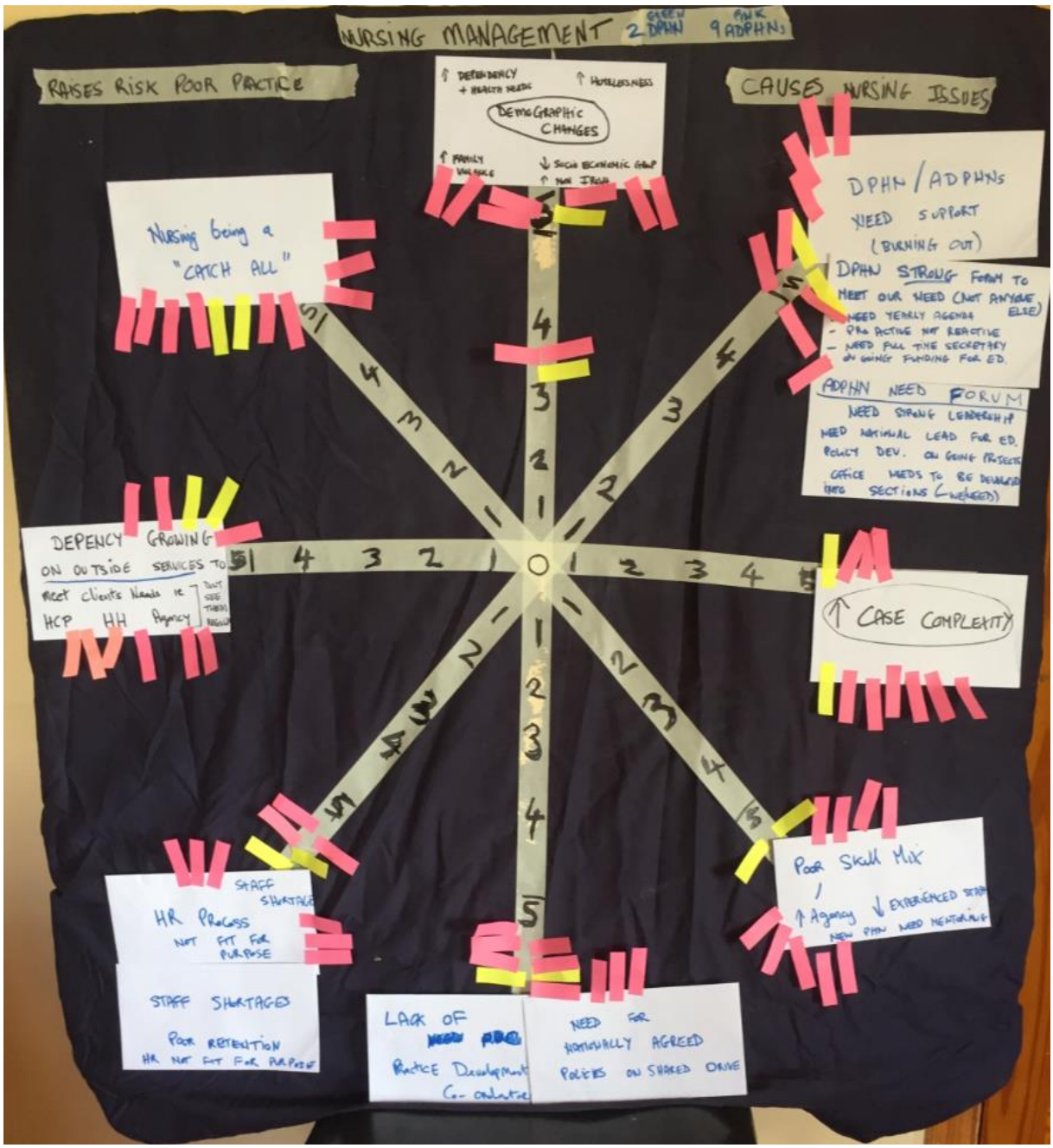
	Using Outside Agencies	Lack of Reflective Practice	Leadership	Poor Skill Mix	Case Complexity	Lack of Support	Demographics	Rationing of Care
Experienced Nurse	100%	70%	40%	100%	100%	84%	60%	46%
Novice	100%	100%	100%	100%	100%	100%	100%	100%

Appendix S

Photograph of Socrates Wheel and Graph of Findings in ADPHNs/ DPHNs Focus Groups in Cycle 2

Causes of Practice Issues

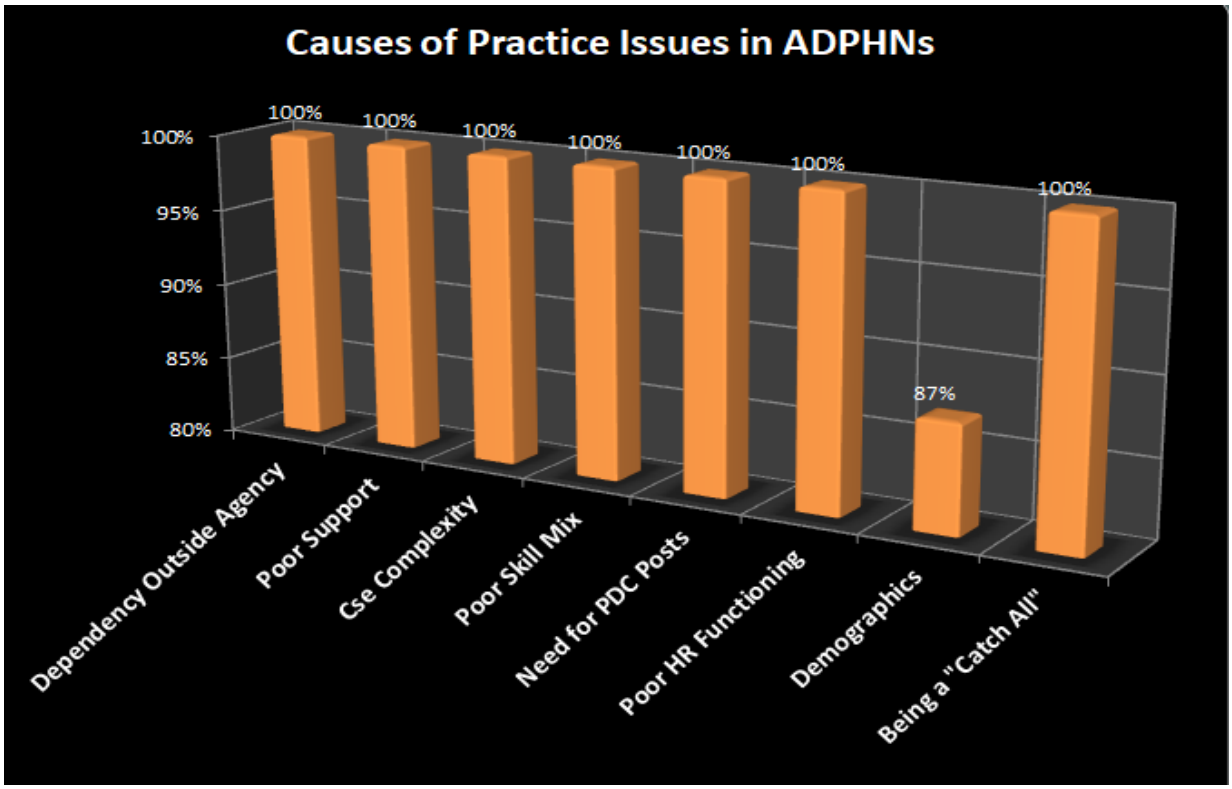
Photograph of Socrates Wheel Used in Nursing Management Focus Groups



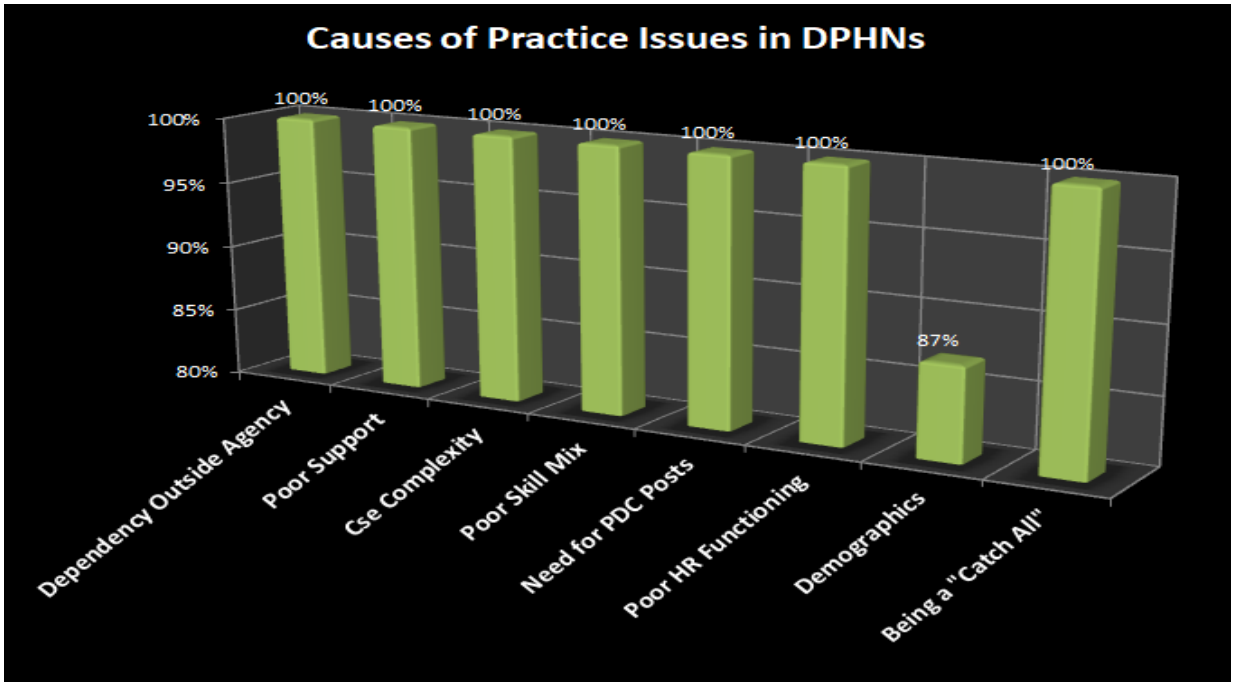
Nursing Managements Socratic Wheel Naming and Rating the Factors that Predisposed to and Caused Practice Issues

Photograph above of Socratic Wheel used in Nursing Management focus group to identify the causes of practice issues for them. The pink stickers represent 9 ADPHNs and the yellow stickers represent the 2 DPHN's. This information was then put into diagram 4.4 and 4.5 in thesis and diagrams on following pages in this Appendix show causes of practice issues in ADPHN and DPHNs on next page and their comparisons between both groups on page 332

Diagrammatical representation comparing the findings of the causes of Practice Issues in DPHNs and ADPHNs

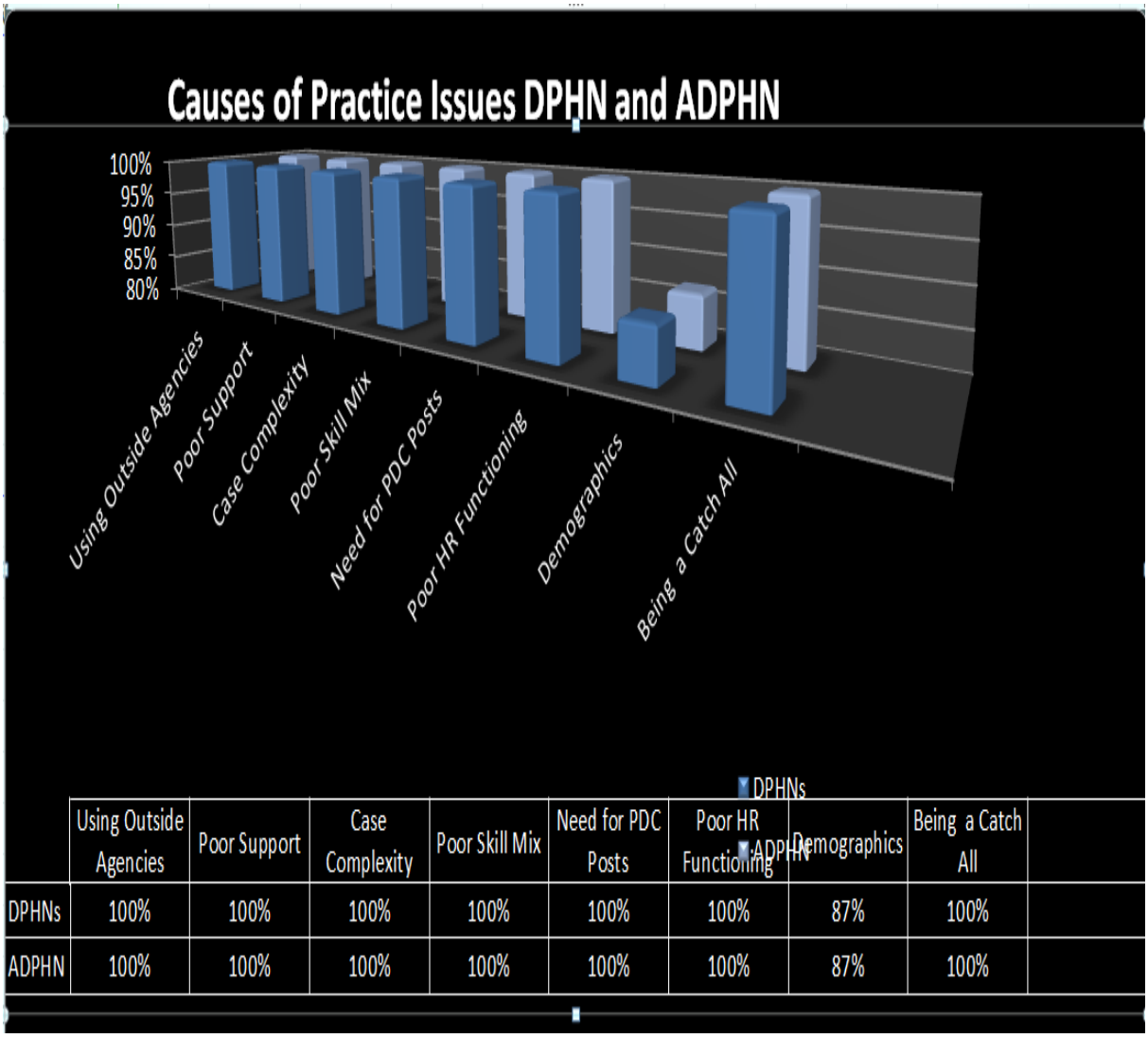


Causes of Practice Issues in ADPHNs Opinion



Causes of Practice Issues DPHNs Opinion

Diagrammatical representation comparing the findings of the causes of Practice Issues in DPHNs and ADPHNs

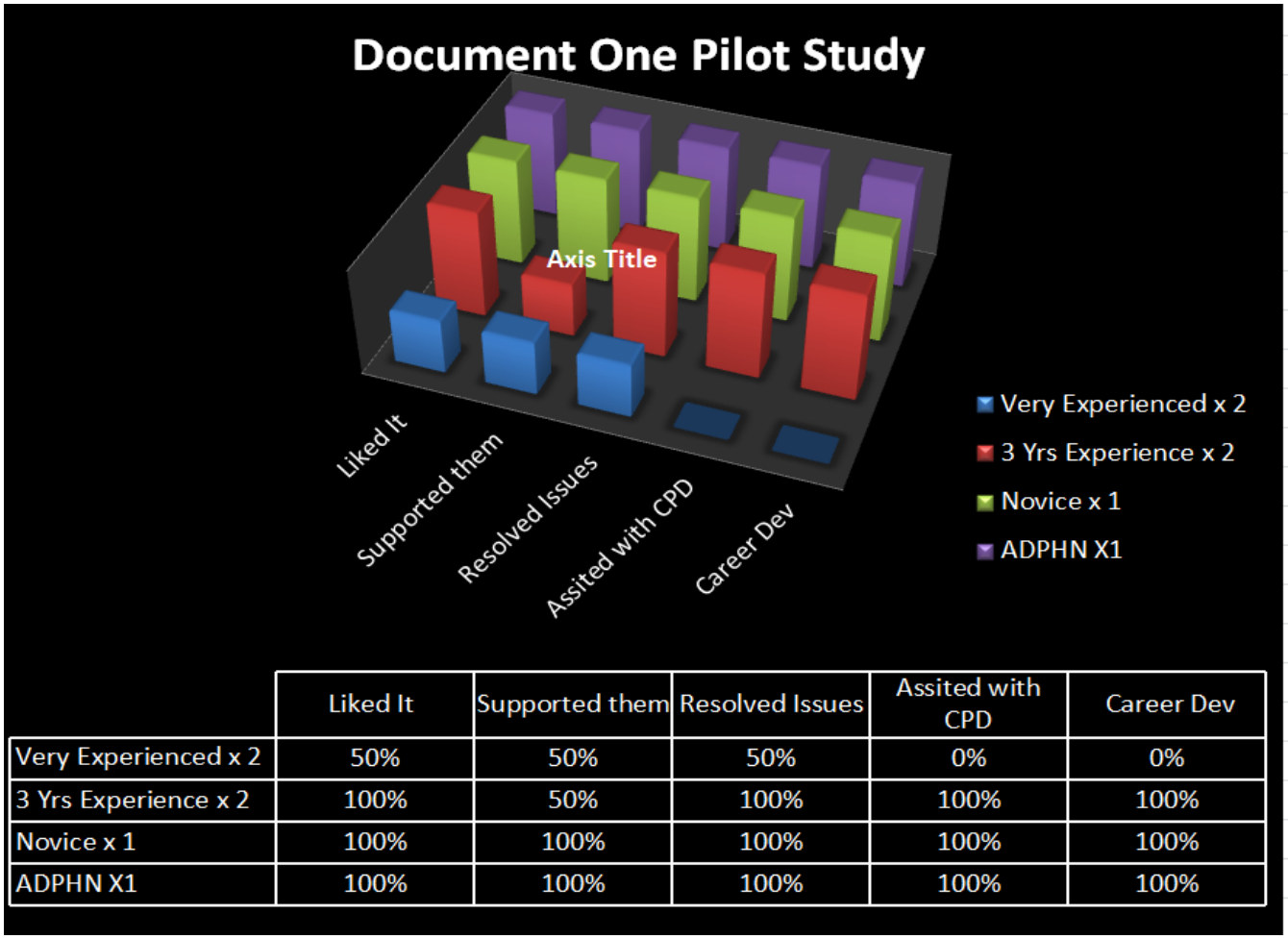


	Using Outside Agencies	Poor Support	Case Complexity	Poor Skill Mix	Need for PDC Posts	Poor HR Functioning	Demographics	Being a Catch All
DPHNs	100%	100%	100%	100%	100%	100%	87%	100%
ADPHN	100%	100%	100%	100%	100%	100%	87%	100%

Appendix T

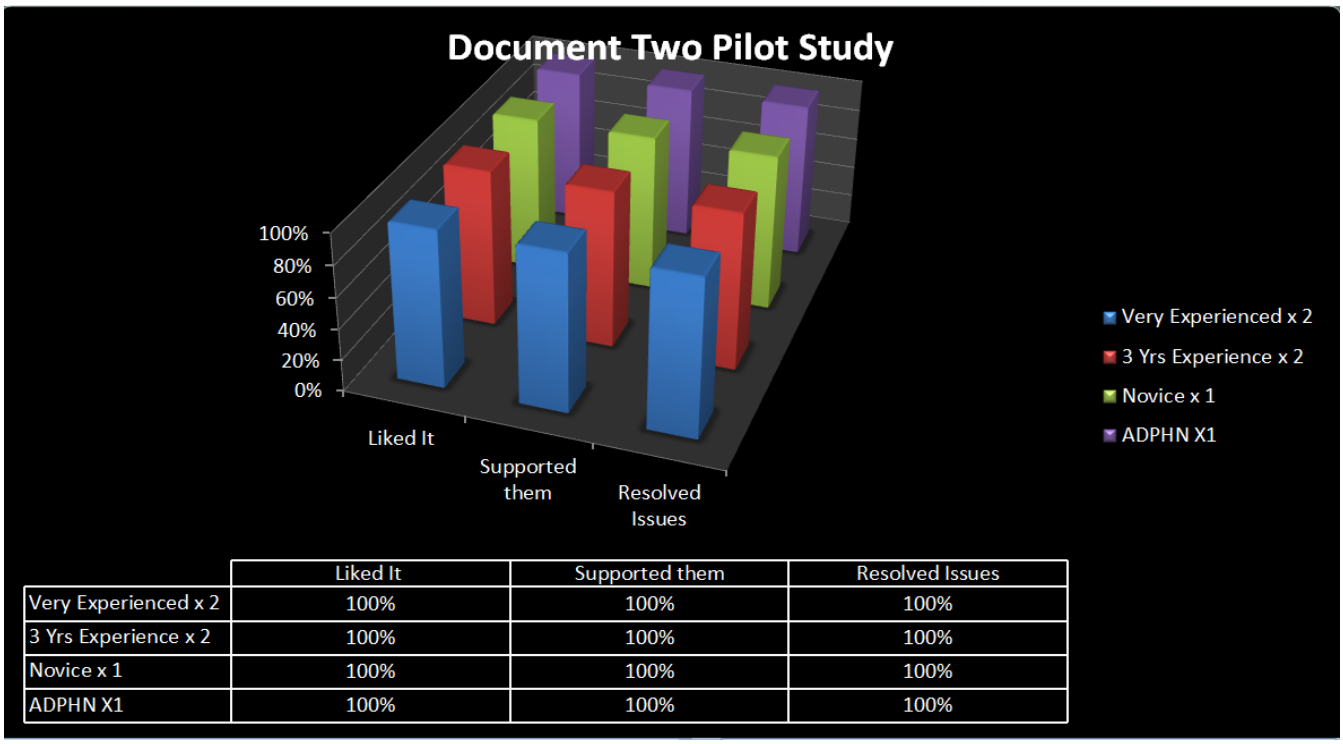
Findings from Pilot Study

Cycle 3



	Liked It	Supported them	Resolved Issues	Assited with CPD	Career Dev
Very Experienced x 2	50%	50%	50%	0%	0%
3 Yrs Experience x 2	100%	50%	100%	100%	100%
Novice x 1	100%	100%	100%	100%	100%
ADPHN X1	100%	100%	100%	100%	100%

Figure 5.1 Results of Pilot Study on Document One



	Liked It	Supported them	Resolved Issues
Very Experienced x 2	100%	100%	100%
3 Yrs Experience x 2	100%	100%	100%
Novice x 1	100%	100%	100%
ADPHN X1	100%	100%	100%

Figure 5.2 Results of Pilot Study on Document Two

Appendix U

Findings Post Use of Document 1

Cycle 4

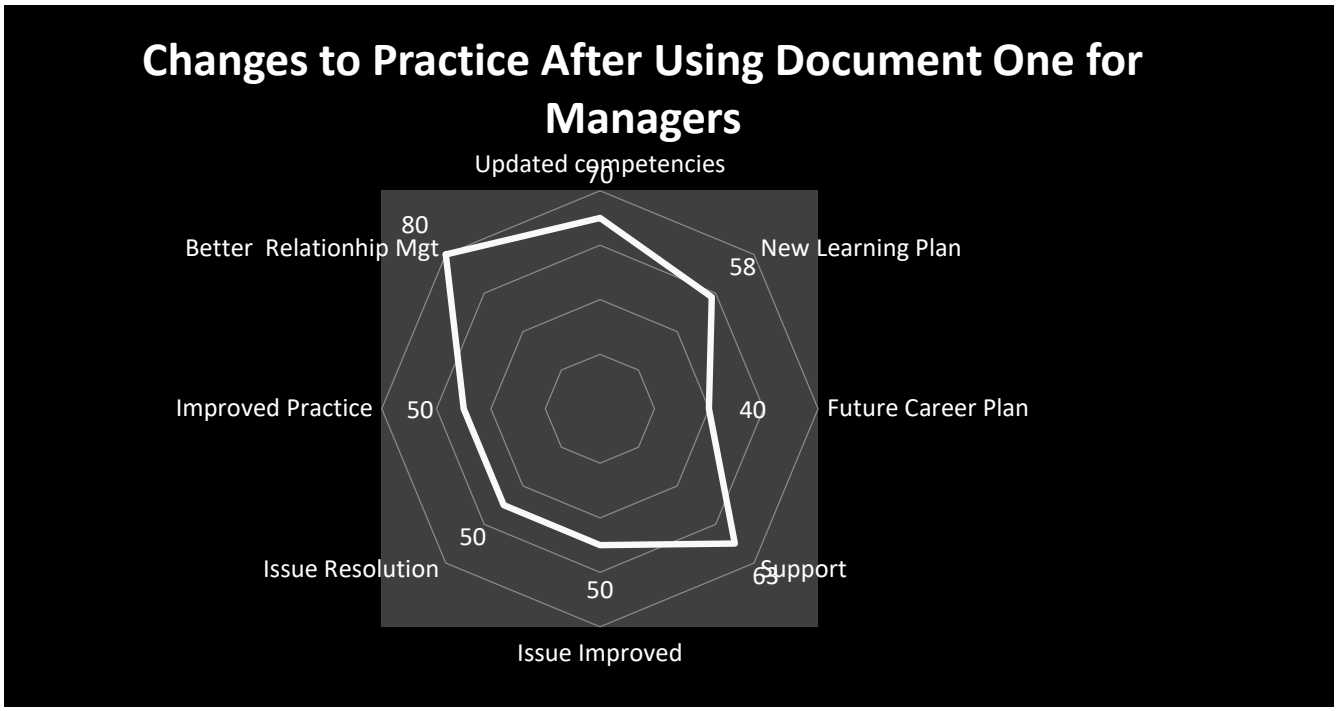


Figure 5.3 Changes to Practice after using Document One as Observed by Mangers

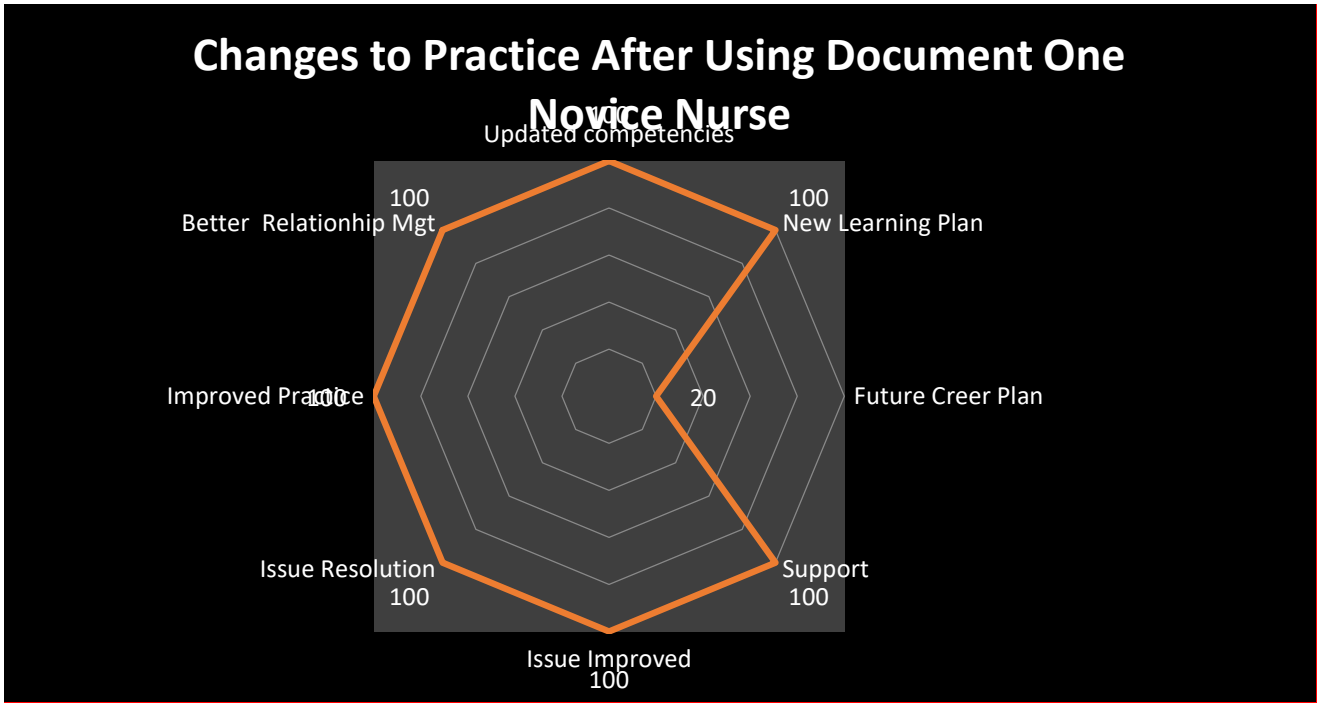


Figure 5.4 Changes to Practice after using Document One for Novice Nurses

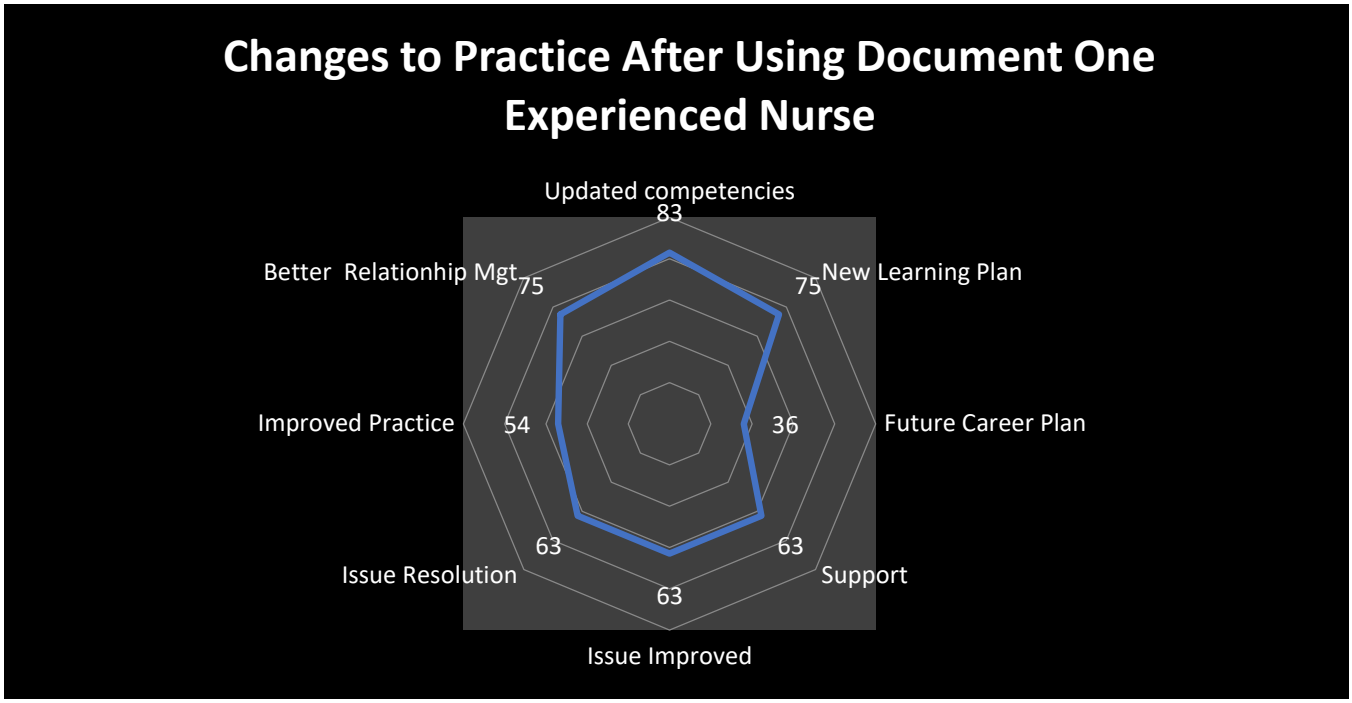


Figure 5.5 Changes to Practice after using Document One for Experienced Nurses

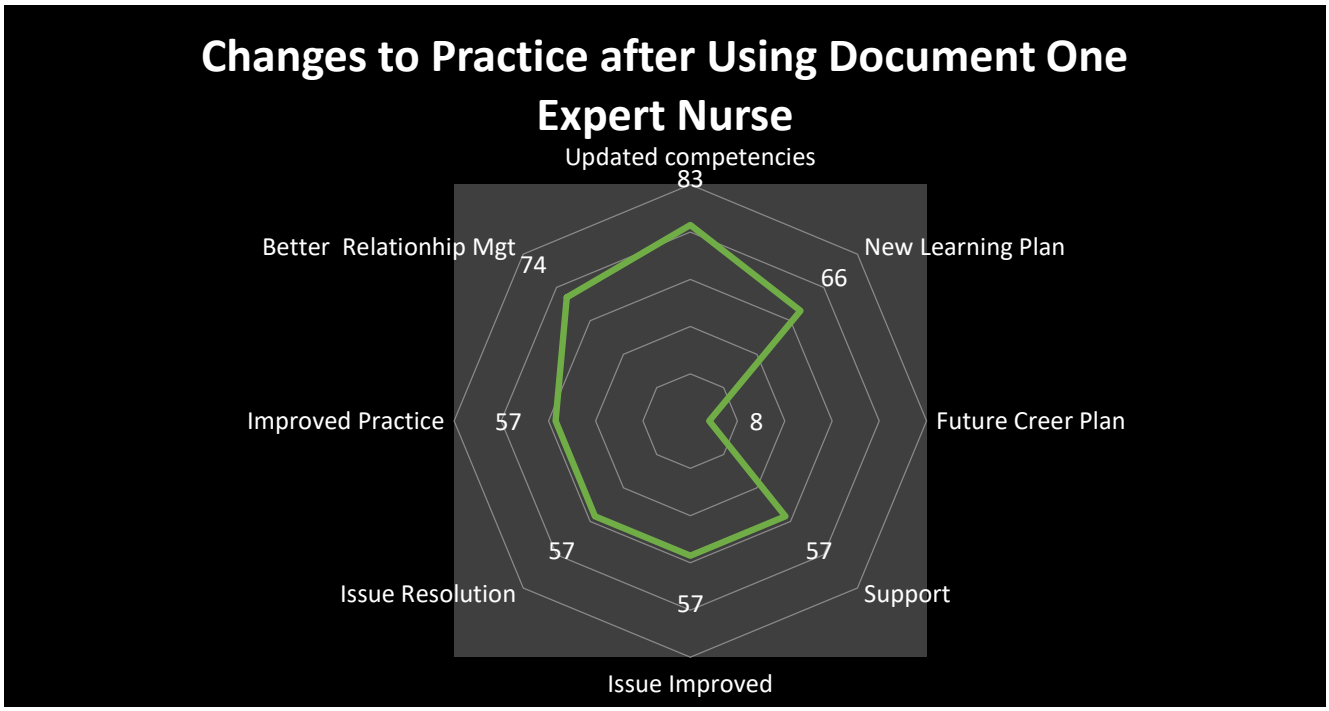


Figure 5.6 Changes to Practice after using Document One for Expert Nurses

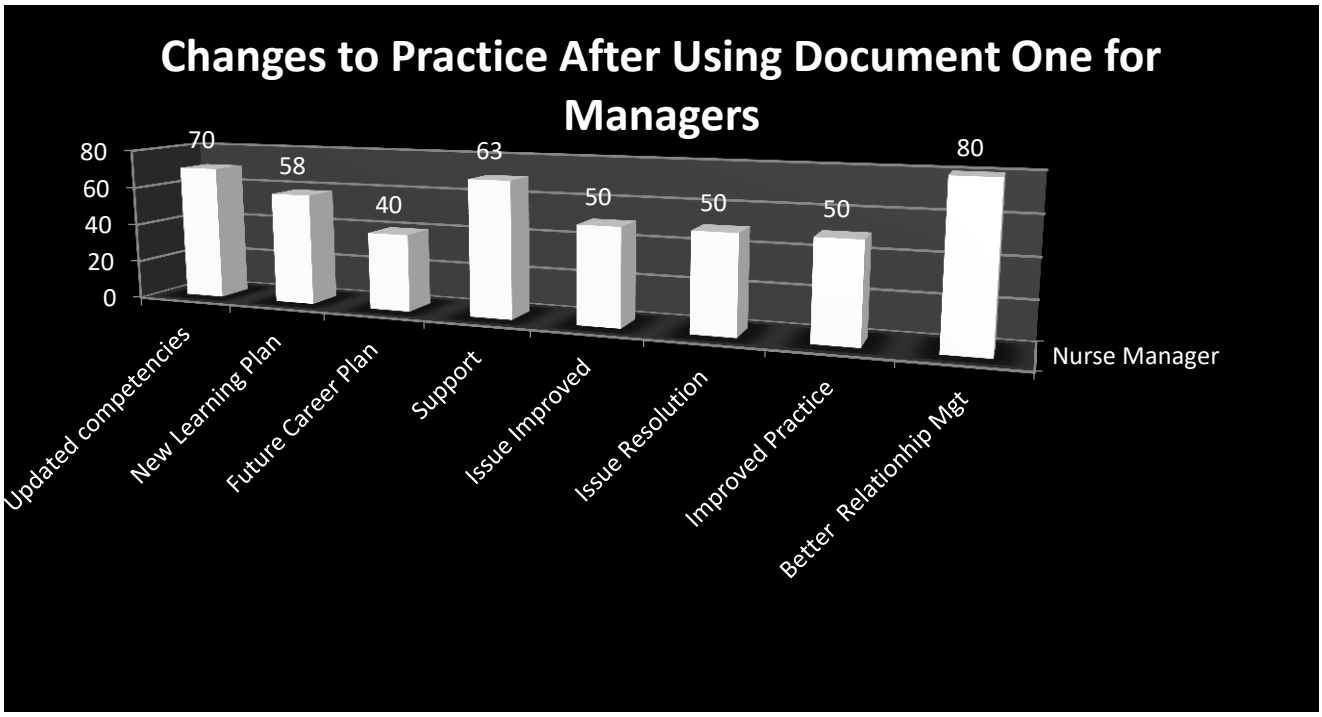
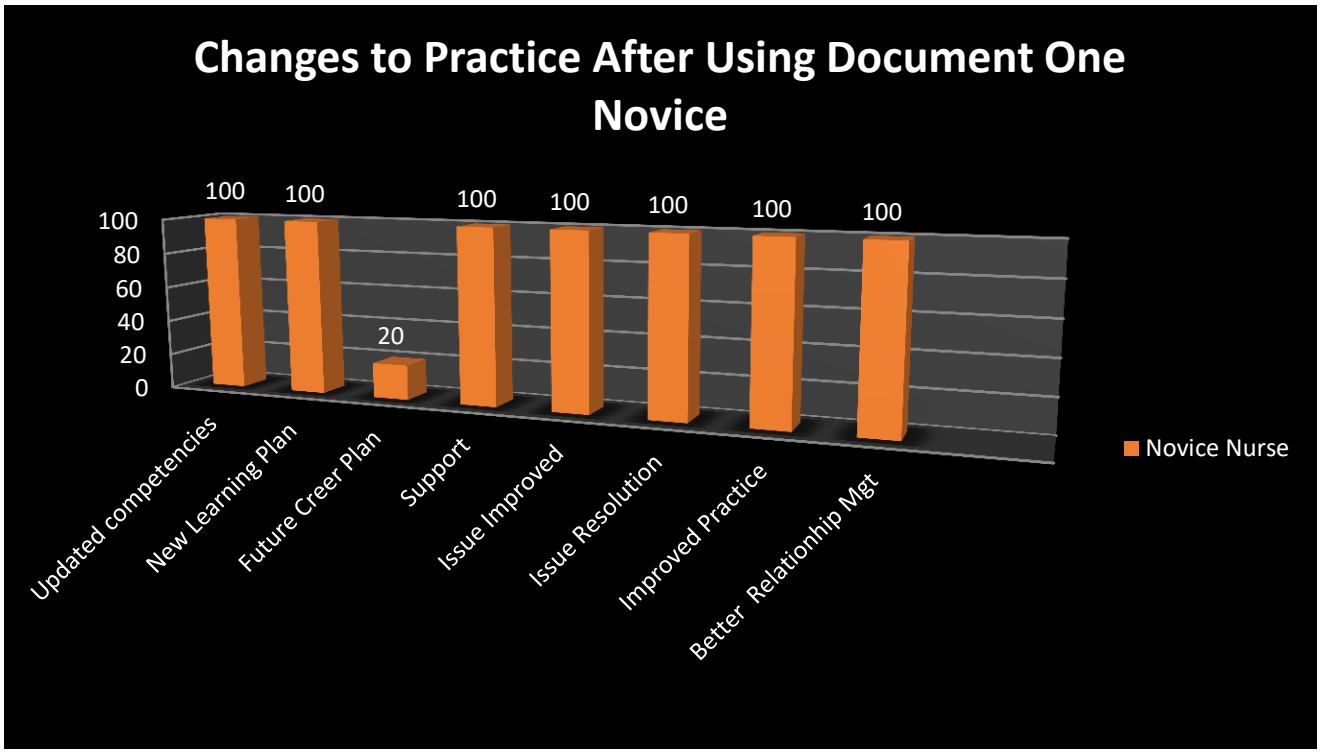


Figure 5.3 Changes to Practice after using Document One for Mangers



Changes to Practice after using Document One for Novice Nurses

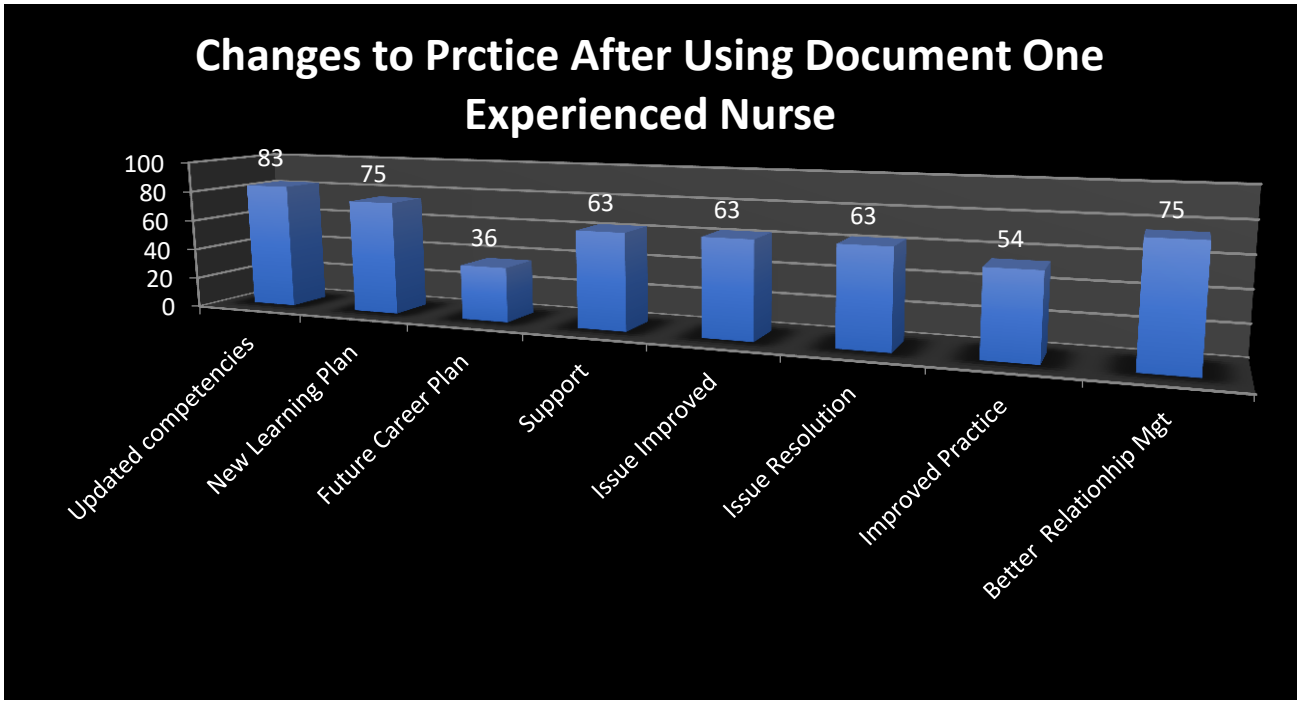
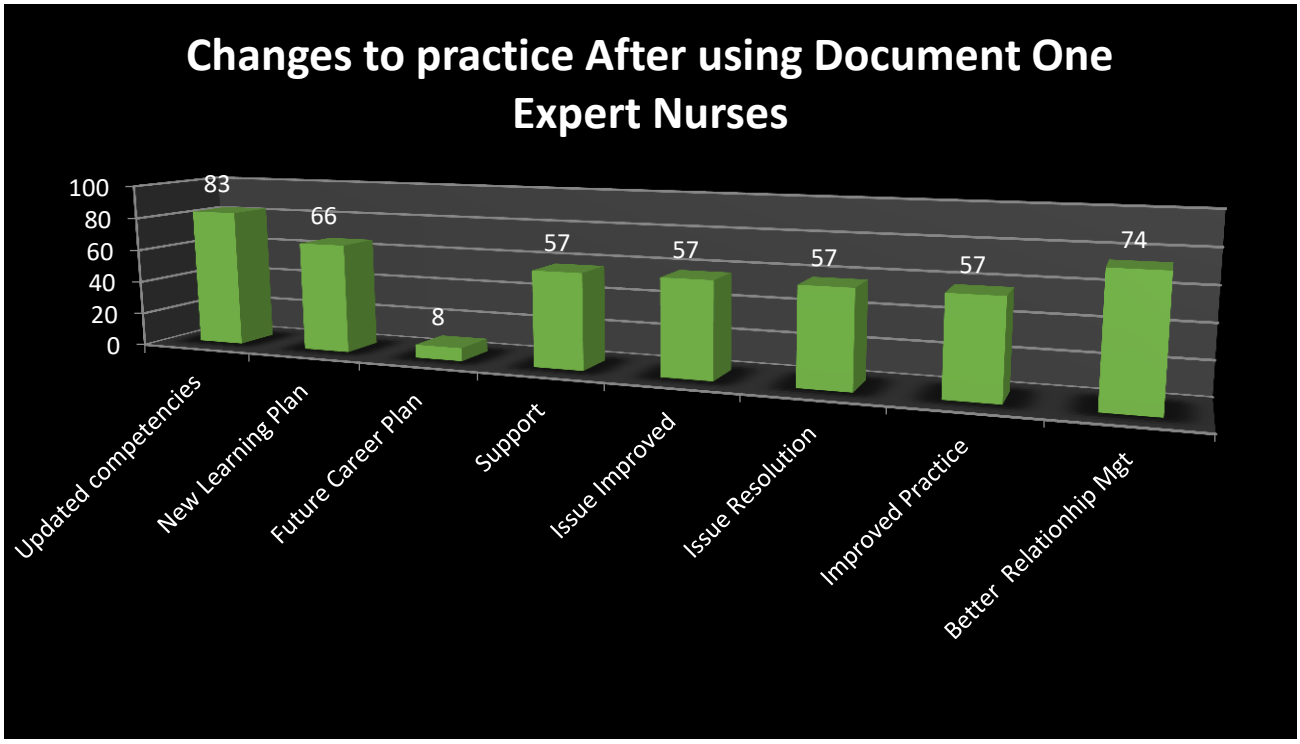


Figure 5.5 Changes to Practice after using Document One for Experienced Nurses

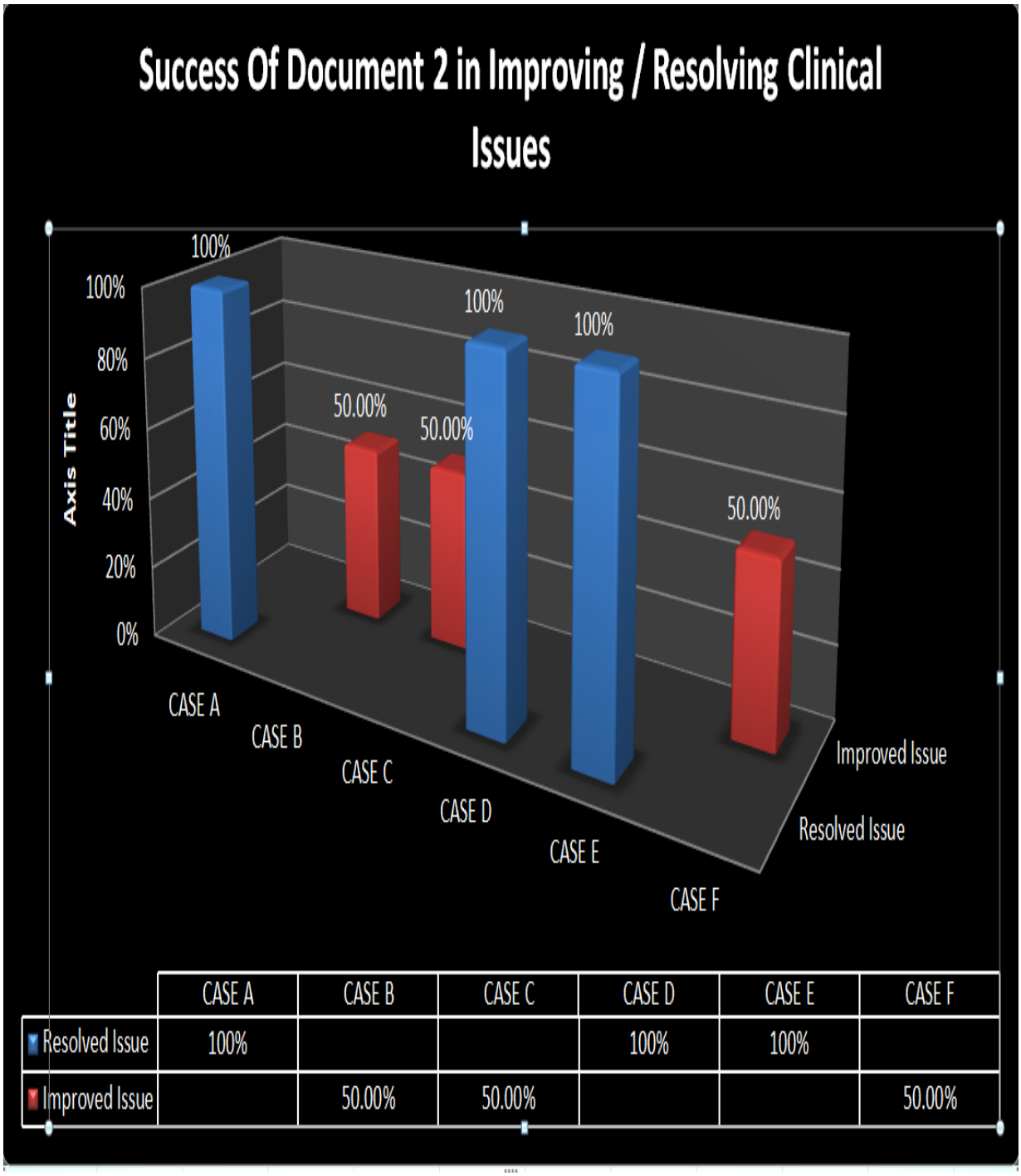


Changes to Practice after using Document One for Expert Nurses

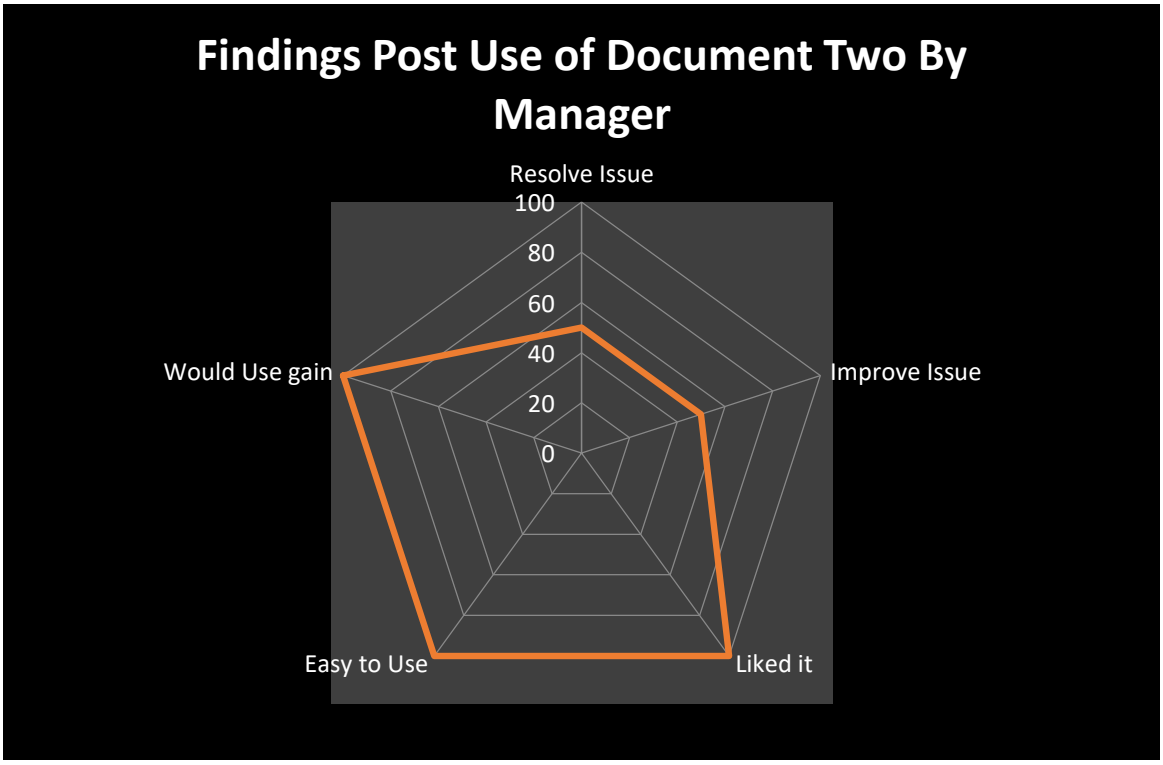
Appendix V

Findings when Documents 2 was Used by Research Group

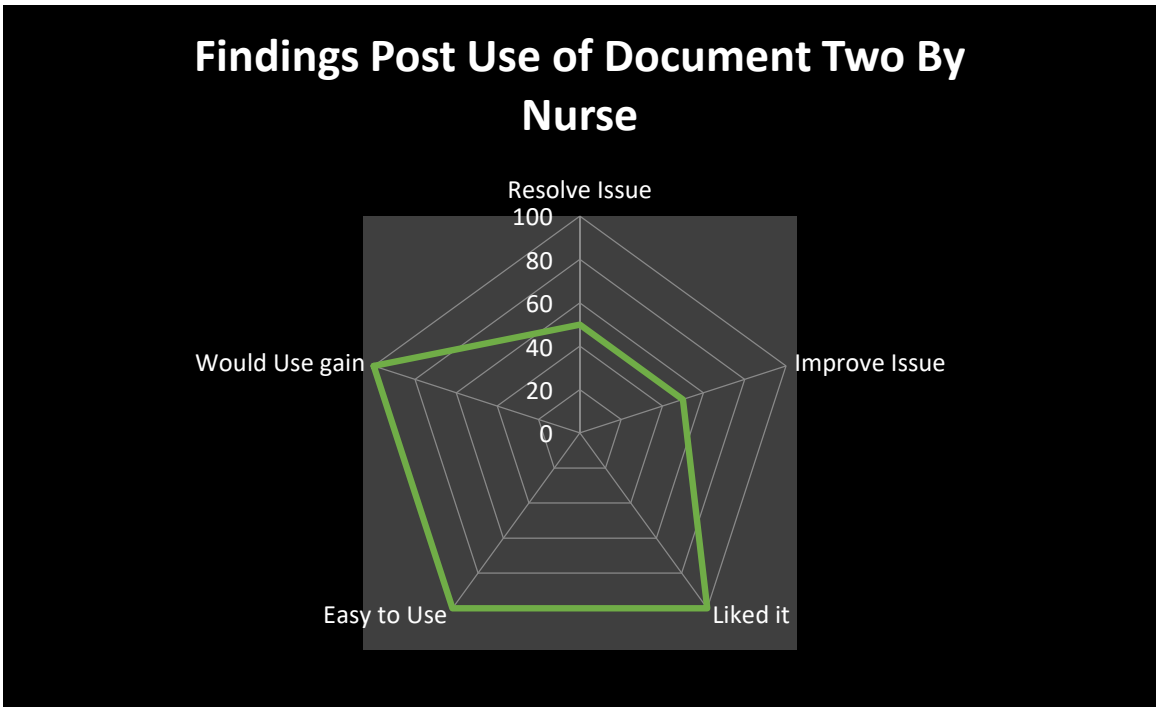
Cycle 4



Success of Document Two in Improving or Resolving Clinical Issues



Findings From Manager Post Use of Document Two

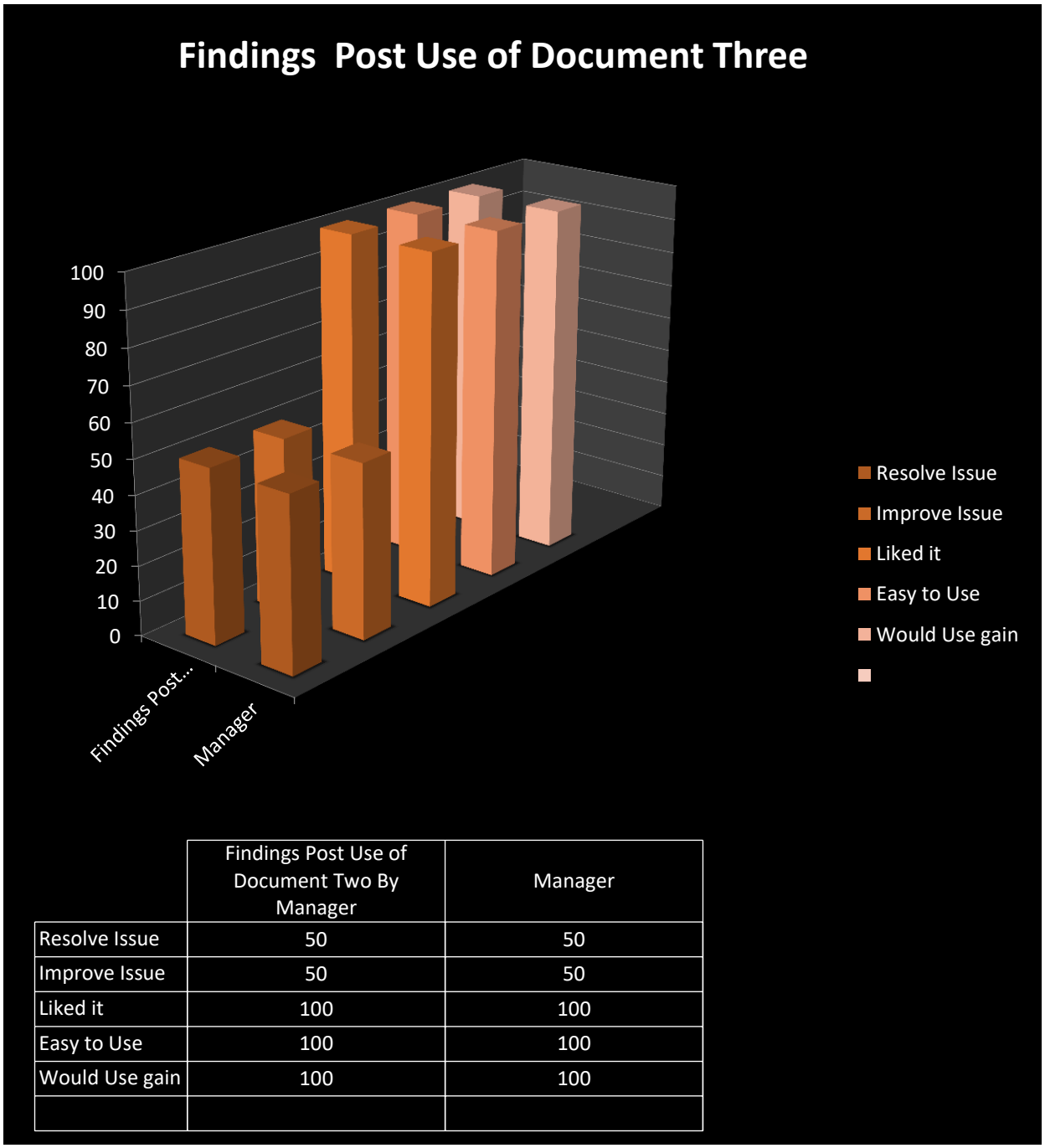


Findings From Nurse Post Use of Document Two

Appendix W

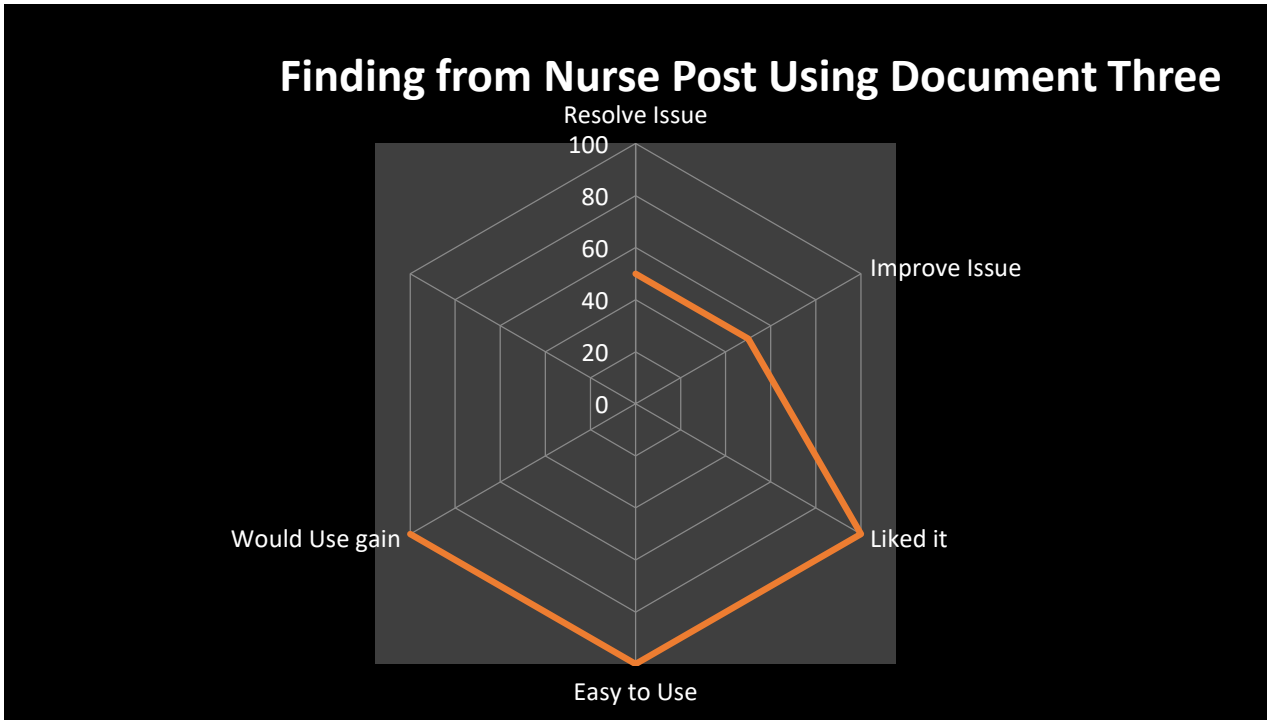
Findings when Documents 3 was Used by Research Group

Cycle 4

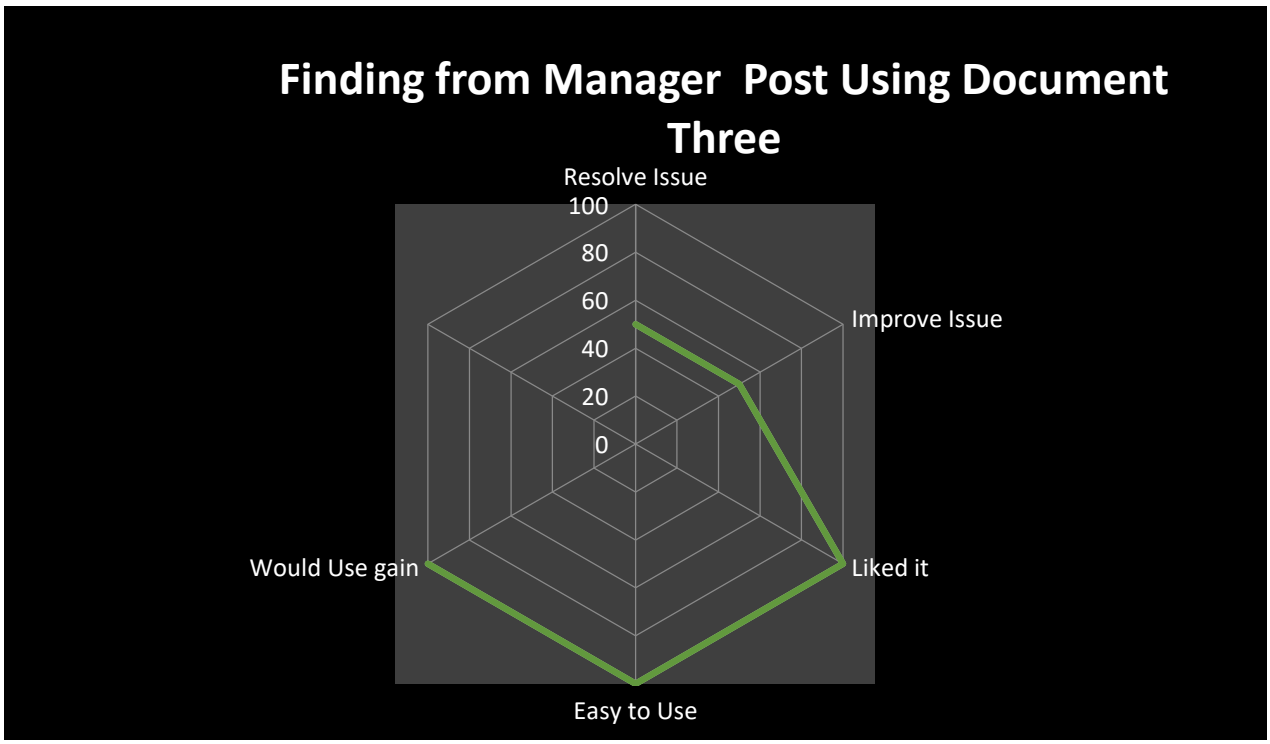


	Findings Post Use of Document Two By Manager	Manager
Resolve Issue	50	50
Improve Issue	50	50
Liked it	100	100
Easy to Use	100	100
Would Use gain	100	100

Success of Document Three in Making Identifying and Making a Plan to Resolve Clinical Issues



Success of Document Three for Nurses to Resolve Clinical Issues



Success of Document Three for Managers to Resolve Clinical Issues

Appendix X

Sample of Entry from Code Book Kept Throughout Research

ode Label	Definition	Description	Qualifications or exclusions	Examples
Lack of Support	*Demonstrating anxiety about lack of the provision of time by manager or colleague to give time regularly to support*	*Anxious about lack of time by manager colleague to support nurse in her practice review and advice on rationing of care and discuss any practice issues or worries the nurse has*	*Expressed as feelings between manager and nurse mainly but also expressed as feeling between colleagues particularly in novices staff.*	*'We used to be able to discuss a case when we needed advice on it now it's all rush and we can hardly talk to each other. I really feel sorry for the new girls as they are really under pressure, they are thrown in at the deep end and they should have someone to help them. We are used to making decisions alone, but they find it difficult really difficult…'.*
Poor Skill Mix	*Having enough nursing staff with the right knowledge and skills, in the right place, at the right time to provide safe and quality care to patients and service users.*	*Expressed as staff being replaced by other staff who do not possess the same qualification, thus they are not able to carry out the same duties as staff member they are replacing on nursing caseload.*	*Poor skill mix often refers to replacing PHN with RGN. When PHN is away on Maternity leave the neighbouring PHN covers her area increasing her work load x 1.5 plus takes on governance of both areas as the 1.0 wte PHN missing is usually replaced by 0.5 wte RGN only workload increases dramatically*	*'You need to replace like with like, if you don't, the patient loses out as they don't get the service. So, no service or reduced service is getting more common place'.* *'There is a bigger Risk of missing vulnerable families when you're cross covering two area … you don't have time to see them or do anything right as it should be… It's all firefighting '.*

Code Label	*Definition*	*Description*	*Qualifications or exclusions*	*Examples*
Rationing of Care	*Nurses unable to meet all care needs so they resort to prioritised patients for care delivery according to patient acuity of condition and patient medical and nursing needs.*	*These add additional dimensions and further responsibilities to PHNs workload when there are CCD on caseload Staffs are constantly updating skills to remain competent practitioners with these cases in particular. Even when competent there is a so much work to be covered and staff worry re missing care particularly with these patients. There is the constant fear of being unable to cope any more with the present staff quota and present complexity of the whole caseload*	*There is a prioritization document developed and patients are ranked 1-4 according to this, Grade 1 are essential care calls and must be completed and the prioritisation vary up to grade 4 where care can be delayed. However this document is only made for use in the short term and not to be used as an ongoing document to assist with staffing issues*	***'Im now using the prioritisation document almost on a weekly basis to decide who to see, or rather who not to see…and on these days patients who are terminally ill, on sick nursing or new born screenings is all I get to see, no one else gets a call and there are some very chronic patients I need to see and I'm always fearful of missing a child neglect or child abuse or a family violence but I just can't get to them on a regular basis I should be doing because there are no sta***

Appendix Y

Sample of Entry from Journal/ Diary Kept Throughout Research

Analytic Memos/ Journal Entry
Where difficulty with site access for research
(Findings documented in Journal)

Diary Notes re Access to sites

1. Access to Research Sites

There were two proposed research sites at the onset of this inquiry. Initially, when I approached the sites prior to securing access there were some issues, and the following reflections illustrate the process of my meeting with the DPHN and my subsequent field notes and reflections.

Field note Entry from Reflective Diary 14* Dec 2017 Speaking with DPHN and her management team in initial site, I sought to use, I suddenly realised this was my place for the foreseeable future and that in keeping with the principles of participatory research; I had relinquished any control I may have had in the conduct of an alternative research inquiry. By moving from fellow DPHN to lecturer and researcher, I was now an 'outsider' waiting to be invited in; potential co-researchers are powerful and I am powerless and I still had not gotten past the 'gatekeepers' to potential co-researchers. According to Coghlan and Brannick (2010) there is the absolute demand in action research for authentic relationships between the action researcher (AR) and the principal people involved, as to how the co-researchers understand the process and significant potential action. We discussed my potential AR and I answered relevant questions about it. While they did find issues in the research and I took notes on these issues, so as I could make changes to the documents, they were basically happy but they felt it was a lot of work and they were too short staffed and unable to cooperate, I perceived that the DPHN had to prioritise the changes she participated in. Participating in research was not one of them as she could not see the value I seen in the research.

When we met, I re-iterated that they or their teams were not obliged to participate in the research. Naturally, in the interests of true participation, it is very important that potential co-researchers engage of their own free will, otherwise the exercise is useless. Because of this meeting and my subsequent meeting with the DPHN and her team, it became very necessary quite early in the research for me to reframe my thinking and my plans by seeking an alternative research setting. I was conscious that time was short and I was concerned that I was without a site for inquiry. I was overwhelmed by this prospect and turned to my action research colleagues, supervisors and fellow lecturers for support. They assisted me to move on, to reconceptualise this 'problem' as an opportunity and not see it as a loss. They advised to document the finding, which incidentally were all reflective of my research beliefs that started me out on my research journey initially and now that I was witnessing it first-hand perhaps not in a way I would have liked but nonetheless unbeknownst to them they were reflecting my research theory. My critical friends advised me to document it as a finding in my diary, make the suggested changes to the document and move-on and by doing so, I would engage in a potentially more fruitful inquiry. I reflected on their advice and moved on. Also, hard as it was to accept action research is voluntary, open to change (Herr and Anderson 2005, Reason 2006) and transparent and fair and if I chose this site I might not have honoured all of these requirements needed for the process of accurate and cooperative research. I was still disappointed and turned to a model of structured reflection, for clarity of thinking and realised that until then, I had interpreted the issue as personal

failure. The question, ‘how were others feeling and what made them feel that way?’, brought me back to the reflective notes I had recorded after our meeting together and the words that the DPHN and her team used to convey her feelings resounded with me:

‘I can’t do it...I have to think about the patients and the nurses, we are too short staffed and can’t afford the time’. She sounded exhausted, flattened, and seemed under considerable strain. At that point, I realised that this was not about me! I needed useful critical dialogue between participants if this research was to be successful and this was not possible here. While the DPHN supported the research in principle, explanations offered for non-participation were ‘problems’ that this was not a desirable start to any research project, that required staff to accept action research as voluntary process to assist them identify and solve their own clinical issues. It also required all involved to have the time and capacity to be open to change (Herr and Anderson 2005, Reason 2006). I now know when I am further removed from the discussions that I chose wisely because if I pursued the site I might not have honoured all of the requirements needed for the process of accurate and cooperative research.

I was reminded of my belief in the importance of the research inquiry and question, and with this understanding, I moved on. I was concerned about potentially causing further anxiety to the DPHN; however, I was happier and my fears were someway allayed when she suggested that we could work together in the future. However, later in the research, having moved back to my peer group I seen them in a new light, I see their pressure and their need to make decisions regularly around what way to ration their work time and their staff work time also.

Access Gained

When access was gained, I was so glad I had pursued other sites. I felt that while not all results may have been what I desired, I honoured all of the requirements needed for the process of accurate and cooperative research. In addition, I felt the staff did not know me as they would have in the other areas and it gave me a better chance not to influence how they participated in the research

Appendix Z

Debriefing Material

Director of Public Health Nursing Office

Kildare West Wicklow

Beech House

Naas

Co. Kildare

Date

Dear Nurse

Thank you for your participation in this research on investigating if the introduction of a suite of documents could *Improve Practice in Public Health Nursing*

Current research has found that (specify findings). Your participation was important in helping researchers understand the (specify).

Final results will be available from the investigator, Sheila Geoghegan, by March 1, 2021. You may contact me at the telephone or email address below to receive an email copy of the final report. All results will be grouped together; therefore individual results are not available. Your participation, including your name and answers, will remain absolutely confidential, even if the report is published.

If you have any additional questions regarding this research, please contact (information above).

Sheila Geoghegan

Director of Public Health Nursing Kildare West Wicklow

Tel 087 9188151

Email sheila.geoghegan@hse.ie