A REVIEW OF PRACTICE DEVELOPMENT IN NURSING
AND MIDWIFERY IN THE REPUBLIC OF IRELAND AND THE
DEVELOPMENT OF A STRATEGIC FRAMEWORK

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A MESSAGE FROM THE MINISTER FOR HEALTH AND CHILDREN

I am delighted to welcome the publication of the *Review of Practice Development in Nursing and Midwifery in the Republic of Ireland and the Development of a Strategic Framework*.

While policies have developed in key areas of nursing and midwifery practice, a national approach to practice development has not occurred. With the development of new nursing and midwifery roles, organisation redesign and the introduction of new practice models, this document is timely.

Previously the *Examination of the Changes in the Professional Role of the Nurse Outside Ireland: A report prepared for the Commission on Nursing (1998)* recommended that national debate and consultation should occur in order to establish a framework for practice development with particular reference to levels and scope of professional practice. The publication of this *Review* and *Strategic Framework* document represents the culmination of significant debate and consultation on the part of a range of key stakeholders. It also provides specific actions to achieve the goal of ensuring integrated practice development approaches and thinking in nursing and midwifery practice.

One of the key messages coming from this work is how practice development can be used as a sustainable methodology to focus on the development of cultures within the workplace that can promote and support practice improvement and innovation. The relationship between practice development and learning and the importance of work-based learning, both in and from practice, is identified. Central to the recommendations are the concepts of patient-centredness and increased multidisciplinary activity, hallmarks of quality practice in a modern health system. I remain convinced that a collaborative approach between those using health services and those providing them, will help to bring about and sustain ongoing improvements in Irish healthcare.

I wish to record my appreciation of the National Steering Group and all those who contributed to the completion of this *Review* and development of this *Strategic Framework*. It provides a genuine step forward to guide the further advancement of practice development in Ireland.

*Mary Harney TD*
Minister for Health and Children
FOREWORD

The Nursing Policy Unit of the Department of Health and Children are very pleased to produce this strategic document which sets a policy direction for practice development within the professions of nursing and midwifery in Ireland.

Practice development has as its explicit intent, the development of an ethos that can sustain continuous processes of practice improvement and innovation with a focus on the development of person-centred cultures. To date the full potential of Practice Development has often been under-utilised. Practice development focuses on people, practice and the redesign of clinical services in order to bring about sustainable changes in workplaces. This document identifies how practice development can provide a sustainable methodology to transform the culture and context of care to deliver a real person-centred care culture within the context of national health policy.

For the first time, data has been collected and collated which has enabled a comparison of practice development activity in Ireland with the international evidence. I would like to acknowledge the practice development work already undertaken by a range of people across the health system and hope that the recommendations contained in this document will be a useful resource to build upon that work.

I would like to thank the Steering Group and Expert Group members for the experience and knowledge that they provided in our discussions. Their commitment to ensuring that practice developments in nursing and midwifery care in Ireland would be underpinned and supported by a sound framework was evident in all our deliberations. I would like to particularly acknowledge the contribution made by Ms. Mary McCarthy, former Chief Nursing Officer in the Department of Health & Children and former Chairperson of the Steering Group, for initiating the project. I would like to record my appreciation for the significant work undertaken by Ms. Mary Day, former Nurse Advisor, Ms. Sheila Sugrue, Nurse/Midwife Advisor and Dr. Malachy Feely, Nurse Advisor in ensuring completion of this Review and the development of the Strategic Framework. The assistance provided by the staff in the Nursing Policy Unit was considerable. In addition, I would like to thank Professor Brendan McCormack from the University of Ulster for completing this review and providing expert advice throughout the period of the project itself.

Finally I would like to thank everyone who made submissions, participated in focus groups or telephone interviews or contributed in any way to the project.

This Review of Practice Development in Nursing and Midwifery in the Republic of Ireland and the Development of a Strategic Framework provides a rich resource to support the ongoing transformation of the health care system.

Sheila O’Malley
Chief Nursing Officer
Department of Health & Children
EXECUTIVE SUMMARY

Background
Practice development is a term that has been used to describe particular approaches to supporting and promoting change in health care. The Nursing Policy Unit of the Department of Health & Children commissioned Professor Brendan McCormack, Professor of Nursing Research/Postgraduate Tutor, Institute of Nursing Research/School of Nursing, University of Ulster, to complete a review of practice development in Ireland that would contribute to the development of a strategic framework to support the ongoing transformation of the health and social care system.

Methodology
The study was underpinned by a method of systematic review of a diverse range of evidence called Realist Synthesis. Realist Synthesis is underpinned by the philosophy of realism to evaluate and synthesise multiple sources of evidence without applying strict hierarchical frameworks that determine the ‘worth’ of different types of evidence, i.e. all evidence is of equal value in the review process and findings.

Purpose
The purpose of the review was to identify how practice development activity in Ireland compares with the international evidence and from the information gained, develop a strategic framework for practice development in Ireland.

Methods
A four stage collaborative approach with key stakeholders was adopted. In addition, the findings of each stage were reviewed by a National Steering Group:

1. Stage 1: Analysis of the ‘grey literature’ relating to PD work in Ireland
2. Stage 2: Telephone interviews with a representative sample of key-stakeholders
3. Stage 3: Focus groups with a sample of key stakeholders
4. Stage 4: Expert Group with National and International experts

Findings
Stage 1: Analysis of the ‘grey literature’ provided insights into existing practice development activity in Ireland, including the confusion that relates to both the positioning and meaning of practice development in relation to practice, education and learning. A total of 651 different activities were identified in the papers reviewed. The majority of these suggested a technical approach to practice development is generally being applied, which is reflective of the stage of development of practice development in Ireland.

Stage 2: Telephone interviews examined a number of key areas:

a. Stakeholder Understandings of Practice Development: Among many stakeholders there is a clear understanding about what practice development is, the key processes involved and organisational and cultural considerations that shape the way the different approaches to practice development operate in reality. However, whilst stakeholders had these understandings, they also believed that differences existed between the understandings espoused and how these understandings were able to operate in reality.

b. Relationship Between Espoused Understandings of Practice Development and its Operationalisation: Overall, the data suggests that a number of challenges exist that prevent the broad range of practice development methodologies to be utilised in practice. Competing demands and a lack of understanding of practice development often mitigates against true practice development activity.
c. The Relationship between Practice Development and Learning: There was a unanimous view among interviewees that currently, there exists too much of an emphasis placed on training and classroom-based teaching and that this detracted from the facilitated learning and development that could/should happen in practice.

d. Facilitation: The range of facilitation expertise available varied considerably. There was unanimous recognition of the need for facilitation in practice development. Many felt however, that it is the invisible part of practice development, that it doesn't get documented (as only the specific activities get documented [in a technical way]) and that its role is poorly understood. Emancipatory facilitation is considered to be poorly understood generally. Emancipatory facilitators draw on knowledge and experience from a variety of sources to holistically inform facilitation of practice, taking account of knowledge of self; learning styles; the individual and their context; interpersonal processes; group theory and processes; systems, organisations and power; and change theory and processes (Royal College of Nursing, 2006). The need for capacity building was identified.

e. Practice Development Outcomes: Outcome measurement is problematic and currently is poorly understood and operationalised. However, some people identified how accreditation frameworks have provided a drive to be more systematic in evaluation of practice developments and that accreditation frameworks and corporate objectives provide useful frameworks for demonstrating practice development outcomes.

Stage 3: Focus groups with a sample of key stakeholders: There was largely a shared understanding of practice development among focus group participants, which reflected the views expressed in the individual interviews. The views of practice development expressed were consistent with the international literature/evidence. However, it was suggested that these perspectives were not held outside of stakeholders directly involved in practice development. The need for clarity of role was emphasised and many of the issues regarding ‘role confusion’ were endorsed. The demands placed on the practice development co-ordinators role due to a lack of role clarity was considered to be a key factor in limiting the potential to demonstrate the effectiveness of the role in the context of practice development relative to practice, education and research.

Stage 4: Expert Group with National and International experts: A workshop with a group of nationally and internationally recognised ‘experts’ in practice development theory and practice was held in order for all the data to be critically reviewed and considered in the context of developing a strategic framework. The purpose statement, strategic objectives and key activities in each strategic objective area were developed collaboratively with the expert group and were used to shape the final strategic direction.

Vision for Practice Development in Ireland
The outputs from this commissioned work identified a vision for practice development in Ireland that would:

- Put the patient and carer experience at the centre.
- Have clearly defined coordination roles.
- Be integrated with national initiatives and strategic priorities.
- Have local areas of work and national programmes.
- Have a national framework with key result areas / outcomes.
- Be facilitated by experts in facilitating clinicians in practice.
- Have leaders advocating its merits based on clear evidence of success.
- Be linked with the work of Higher Education Institutions/Centres for Nursing/Midwifery Education and be multidisciplinary in practice.
**Strategic Framework**

Eight strategic objectives and four strategic themes for action are identified to support the further advancement of practice development in Ireland. The purpose statement, strategic objectives and key activities in each strategic objective area are identified and used to shape the final strategic direction and framework in the Report and link with the strategic themes for action:

1. Patient/carer experience and outcomes
2. Individual and team effectiveness
3. Systems effectiveness
4. Infrastructure

Supporting the continued improvement of the patient experience through ensuring delivery of safe and effective person centred care in a transforming healthcare context is central to this framework.

**Policy Direction**

This strategic framework provides guidance and a strategy for the future development of practice development and the professions of nursing and midwifery in Ireland. It identifies how practice development can provide a sustainable methodology to transform the culture and context of care to deliver a real person-centred care culture within the context of national health policy. It clearly states the centrality of patients’ and carer’s experiences in relation to practice development activities (both in informing the need for practice development initiatives and in the conduct of practice development work). It further identifies the importance of multidisciplinary activity involving a wide range of key stakeholders in supporting the development of person-centred practice cultures and enabling effective emancipatory facilitation models of engagement to be realised. A number of recommendations are made to support the implementation of the strategic framework:

1. Establish a National Working Group to develop the programmes of work.
2. Establish a *consultative group* of key stakeholders, experts in the field of practice development, who can be liaised with for the development of action plans.
3. Develop a sub-group of the National Working Group to co-ordinate the evaluation of the strategy within an agreed time-frame.
GLOSSARY

Accreditation is the formal recognition of a body's competence to conduct a specific activity such as testing, inspection or certification. This recognition is based on compliance with International and European standards. Compliance with these standards requires organisations to demonstrate competence, impartiality and integrity ([http://www.inab.ie/media/INABBrochure.pdf](http://www.inab.ie/media/INABBrochure.pdf)). The accreditation process determines, in the public interest, the technical competence and integrity of organisations offering testing, inspection, calibration and certification services (often known collectively as evaluation services or conformity assessment services) ([http://www.inab.ie/media/ea-briefing-for-regulators.pdf](http://www.inab.ie/media/ea-briefing-for-regulators.pdf)).

CNE: Centre for Nursing Education.
CNME: Centre for Nursing and Midwifery Education.
CME: Centre for Midwifery Education.
CNMs: Clinical Nurse Managers.
CMMs: Clinical Midwife Managers.
CEO: Chief Executive Officer.
DoN: Director of Nursing.
DoM: Director of Midwifery.

Emancipatory Practice Development is a particular method of practice development that supports healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflect the perspectives of service users. It draws on knowledge and experience from a variety of sources to holistically inform facilitation of practice, taking account of knowledge of self; learning styles; the individual and their context; interpersonal processes; group theory and processes; systems, organisations and power; and change theory and processes (Garbett R. and McCormack B. 2004).

Focus groups are specific groups used as a means of gathering information to increase understanding about group experiences / understanding of a particular subject area. Such groups generally involve small numbers who participate in a collective facilitated discussion of defined duration.

Grey literature is a term used variably by the intelligence community, librarians, and medical and research professionals to refer to a body of materials that cannot be found easily through conventional channels ([http://en.wikipedia.org/wiki/Gray_literature](http://en.wikipedia.org/wiki/Gray_literature)).

HE: Higher Education.
HEIs: Higher Education Institutions.
Holistic care is an all encompassing approach that addresses the physical, psychological, emotional, social, spiritual aspects of an individual’s care.
HSE: Health Service Executive.
KRAs: Key Result Areas
NMPDUs: Nursing and Midwifery Planning and Development Units.
MPDC: Midwife Practice Development Co-ordinator.
NPDC: Nurse Practice Development Co-ordinator.
**Outcome measurement** is a process in which evaluation of the results of an activity, plan, process, or program and their comparison with the intended or projected results occurs (http://www.businessdictionary.com/definition/outcome-measure.html).

**Person centred care** is about respecting and valuing each individual as a unique being with rights, and engaging with them in a way that promotes their dignity, sense of worth and independence. It is care focussed on the person, where ‘person’ refers to both service users and teams who provide care services.

**Practice development (PD)** “is a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflect the perspectives of service users” [Garbett & McCormack (2004:9)]

**Realist Synthesis** is a new methodology for undertaking systematic reviews of evidence underpinning complex social interventions (practice development is considered to be a complex social intervention because of the multiple methods involved and its focus on people and processes). Realist synthesis draws on the principles of realistic evaluation and is underpinned by the philosophy of realism to evaluate and synthesise multiple sources of evidence (Pawson, 2006) without applying strict hierarchical frameworks that determine the ‘worth’ of different types of evidence, i.e. all evidence is of equal value in the review process and findings.

**Technical Practice Development** (tPD): In tPD the focus is on reaching an end-point already identified, such as the implementation of clinical guidelines to ensure more effective care within an organisation, or developing the competence of practitioners in some new aspect of care. The assumption underpinning tPD is that, armed with the technical skill and knowledge then practice will be developed and so a major focus in tPD is on the provision of information (in the form of guidelines and procedures), teaching and skills training.
1. INTRODUCTION

Practice development as an approach to sustainable practice change, has been growing in momentum internationally in recent years. It is clear that developing services that focus on the needs of individuals whilst focusing on clinical and cost effectiveness are at the heart of most government’s modernisation programmes. The rights of individuals to safe and effective, high quality health and social care permeate all policy documents. Despite the fact that these ambitions are upheld in policy, the provision of effective person-centred care cannot be assumed. Focusing as it does on the development of effective, person centred workplace cultures, practice development has a major role to play in filling this gap, and supporting modernisation and reform. Practice development focuses on people, practice and the redesign of clinical services in order to bring about sustainable changes in workplaces. To date its potential has been under-utilised. This strategy sets a policy direction for practice development.
2. THE NURSING, MIDWIFERY AND HEALTHCARE POLICY CONTEXT

There have been huge changes in the career structures, in education and in the strategic direction of the nursing and midwifery profession in Ireland in the 10 years since the publication of the Commission of Nursing in 1998. Aligned with this in 2003 the Government announced the most extensive reform programme for the Health System in over 30 years.

Changes in the organisation and delivery of services (Department of Health and Children 2001a) has focused on establishing systems, structures and processes that ensure the potential for innovation and transformation of services, whilst at the same time ensuring clear lines of accountability in the system. Patient safety and quality are central to the delivery of healthcare. The Report of the Commission on Patient Safety and Quality Assurance agreed that the vision or framework around which the Irish health system should be based on:

“Knowledgeable patients receiving safe and effective care from skilled professionals in appropriate environments with assessed outcomes”

(Department of Health & Children 2008,p. 3).

Underpinning this framework are values of openness, patient centredness, learning, effectiveness and efficiency, good governance, leadership, evidence-based practice, accountability and patient/family involvement.

Significant developments have occurred in health and social care reform in Ireland which impact on working practices and processes. The importance of a safe, effective, quality service cannot be over emphasised. Nurses and midwives have a key role in the delivery of healthcare in a rapidly changing healthcare arena. The strategic direction for the future of service development and the development of nursing and midwifery services as a future component of the health service is clearly identified in a range of documents (See Appendix 1).

A key focus in the policy and strategic direction of health systems in Ireland is that of integrated patient care and ensuring that a patient’s journey through the health system is as seamless as possible (Department of Health and Children 2001b) whilst at the same time ensuring that this journey is safe (Department of Health and Children 2008). The Health Services Executive’s (HSE) Transformation Programme 2007-2010 outlines 6 Transformation Priorities and sets out the mission and vision for the future of health service delivery (Appendix 2). The challenge is to ensure an integrated service across all stages of care so that the patient journey is a seamless one. This underscores the need to ensure that we have individuals with the right mix of skills and competencies to achieve the goals of the Transformation Programme. Accreditation systems and the development of national standards are key components of this strategic direction (http://www.hiqa.ie/functions_hcq_accred.asp)

Nursing and midwifery in Ireland has been addressing and responding to these strategic intentions, ensuring it is at the forefront of developments. Thirty five per cent of the total workforce in health are nurses and are therefore a real force in the future healthcare delivery as the largest individual professional grouping within the health service.

1 Whilst a significant focus of this framework document relates to nursing and midwifery practice development, health care professionals are increasingly working within a multidisciplinary/interdisciplinary context with an increased emphasis on patient-centredness. It is important that practice development activities involve and encompass the wider health team in the context of supporting the delivery of integrated practice development within and across services.
The Commission on Nursing “Blue Print for the Future” (Government of Ireland 1998) provided a comprehensive review of the Nursing and Midwifery profession in Ireland and made a wide range of recommendations in relation to the development of nursing and midwifery in Ireland, including regarding the development of nursing practice development roles and related responsibilities:

“Nursing practice development co-ordinators have also been appointed to help ensure the optimum learning environment for student nurses on clinical placement, in addition to other nursing practice functions”

(Government of Ireland 1998, p. 77)

The implementation of this recommendation has resulted in the development of a range of practice development type roles at various levels in organisations. In addition, the Report of the Expert Group on Midwifery and Children’s Nursing Education (2004, p. 11) recommended:

“Midwife/Nurse Practice Development Co-ordinators and Clinical Placement Co-ordinators support students and the development of the clinical learning environment in agencies where students are undertaking midwifery and children’s nursing placements.”

Since the publication of the Report of the Commission on Nursing there have been significant changes in the career structures, education and the overall strategic direction of the nursing and midwifery profession. Nursing and midwifery education in Ireland has gone through a radical change process in 10 years being transformed from an apprentice model to a diploma model and now to a degree programme. An Bord Altranais has responded to these changes through provision of a range of Requirements and Standards Documents that provide guidance for the development of flexible, innovative, practice-oriented registration programmes for third level institutions and for health care institutions involved in the education and training of nurses and midwives and responsibilities identified therein. The graduation of the first nurses from the degree programmes in general, intellectual disability and psychiatric nursing took place in 2006 and in 2010 the first graduates from the undergraduate midwifery programme will take place and integrated children’s/general nursing programmes will graduate in 2011. The National Council for the Professional Development of Nursing and Midwifery and the Nursing and Midwifery Planning and Development Units (NMPDUs) have had a significant role in developing the professional role of nurses and midwives in a changing healthcare environment. The creation of a clinical career pathway for nurses and midwives across specialist areas, in management and research has been instrumental in the delivery of quality nursing and midwifery care to patients. The Scope of Nursing and Midwifery Practice Framework for Nursing and Midwifery (2000) (www.nursingboard.ie) has provided the framework to enable role expansion within the profession. Nurses and midwives are expanding their role in many areas of practice. For example:

- the introduction of prescriptive authority for nurses and midwives from a range of areas such as care of the older person, chronic disease, palliative care, maternity services, mental health, intellectual disability and many more has impacted on practice in a positive manner.
- the development of forensic nursing services for victims of sexual assault will ensure provision of timely, sensitive and high standards of care for persons who present to the health service as a result of a sexual assault.

The Draft Nurses and Midwives Bill (http://www.dohc.ie/other_health_issues/nurses_and_midwives), the European Working Time Directive (Government of Ireland 2004, Department of Health & Children 2004) and the review of the workforce planning strategy (Department of Health & Children/Health Service Executive
Working Group on Workforce Planning in the Public Health Service 2007) all have implications for the way that
the nursing and midwifery workforce of the future responds to an ever changing and developing healthcare
system. Systems and processes will need to be in place in order to:

- create conditions that empower nurses and midwives to work in new ways
- ensure effective utilisation of nursing and midwifery service specific skills and knowledge relative to
  patient / client need
- ensure developments encompass holistic care and
- explore roles in a multidisciplinary context

Nurses and midwives therefore face the challenge of embracing new methods of care delivery, including
increased multidisciplinary/interdisciplinary ways of working that will provide safe and quality services that
are truly person-centred.

So as new roles are developed, organisations redesigned, increased emphasis on patient safety and new
practice models are introduced, it is opportune to explore and examine how practice development can provide
a sustainable methodology to transform the culture and context of care to deliver a real patient-centred care
model.
3. WHAT IS PRACTICE DEVELOPMENT?

The most often cited definition of practice development is that of Garbett & McCormack (2004:29) which suggested that:

*Practice development is a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflect the perspectives of service users.*

This definition makes explicit the interconnected relationships between strategies and processes that enable the development of knowledge and skills, the facilitation of practice and culture change and the adoption of rigorous evaluation processes. It also highlights the importance of practice development being a continuous process.

**Developing Person-centeredness in Critical Care through Practice Development in an Acute Hospital Setting**

A team of critical care nurses identified that there was a need to improve the way they provided continuity of care to patients in a large Regional Intensive Care Unit. The staff identified that they delivered good individualised care and their quality monitoring reports affirmed this. However, they also felt that their approach to assessment of care needs and the care system in operation hindered the provision of more person-centred care to patients and families. Over a period of 18-months the nursing team worked with a facilitator to address this issue. They engaged in a number of evaluation activities (values clarification, observations of practice, care stories [with patients and families] and review of routine audit data) to identify how they could become more person-centred. They analysed this data using a published framework for person-centred nursing and identified where they needed to make improvements. An external facilitator worked with the nurses and the multidisciplinary team to make significant changes to their model of care, work organisation method as well as processes they used to engage with patients and families. A continuous collaborative evaluation demonstrated that patients and families felt that care and services were more consistent with the values expressed in the patient information leaflets, and the team carried on making changes with the intent of always trying to improve how person-centred they were as a team.

Practice development is a systematic approach that aims to help practitioners and healthcare teams to look critically at their practice and identify how it can be improved. Its purpose is to develop effective workplace cultures that have embedded within them person centred processes, systems and ways of working. Unique to practice development is its explicit person centred focus. Person centred care is about respecting and valuing each individual as a unique being with rights, and engaging with them in a way that promotes their dignity, sense of worth and independence. This is the essence of caring, fundamental to nursing and midwifery, and core to health and social care business. The delivery of effective healthcare depends on front line staff. It is they who create the climate and culture within which patients are cared for.

Staff involved in practice development, such as Practice Development Co-ordinators, Practice Development Facilitators etc. help frontline staff to get underneath the surface of daily routine, to critically reflect on the values and beliefs they hold about patient care. Teams are challenged to consider if the behaviours, systems and processes used in practice, are consistent with person centred values. They are enabled to identify what needs to change and the part they need to play in effecting improvement. Key to this is the development of

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2 A range of vignettes obtained from nurses and midwives working in the Irish health system (unless otherwise stated) are provided as examples of the experiences and views encountered in the development of this strategic framework. Information provided has been written in a manner to maintain the anonymity of people and services.
evidence from practice, and the implementation of evidence into practice. The importance of this is referred to in the Report of the Commission on Patient Safety and Quality Assurance:

“This places continuing demands on multi-disciplinary teams delivering care to ensure that they are informed of best practice, have the flexibility to respond to new developments and put systems in place to monitor and evaluate the care provided so that high quality care in accordance with best practice is delivered”

(Department of Health & Children 2008, p. 2)

The increased self awareness fostered in staff through use of processes that enable them to take control of their own practice, integrated work-based learning, and the development of new knowledge, skills and ways of working are vital to achieving sustainable change.

**Personal Reflection from a Facilitator**

I have seen how individuals are growing and developing since the programme has started. Leaders have emerged, who I hope, will be the champions for change in the future. It has, I feel, unleashed an appetite for further development and growth in some of the participants. What for me has been surprising, has been how the non-nursing staff have embraced the programme and how willing and eager they are to become change agents, while acknowledging that challenging practices that are not person-centred will be very daunting and difficult, they are on the most part committed to the programme and believe in the process.

Looking back over the programme notes and evaluations from each programme day, I can see evidence that there is a shift in the culture of the group to a more person-centred way of working and thinking. There are good examples of where practice has changed. Attitudes and behaviours are changing slowly, how older people are spoken about is changing, the focus is on the person first and then patient. For some of the participants it was the first time they actually had a meaningful conversation with the people they have been looking after for years. The participants themselves are reflecting more on their practice, some are struggling with the programme and the challenges it is presenting. They have articulated how difficult it is at times for them and how conscious they now are of role modelling good practice. There is a greater emphasis on participation, choice and inclusion in decision making and practice has become more thoughtful.

Staff who in the past felt they had no voice, have now, through the development of reflective skills begun to challenge the culture and status quo. We have examples of care staff who in the past would never have been consulted with regards to care delivery, but who now are actively becoming involved in influencing a shift in the culture and the development of more person-centred ways of working. They feel a new sense of purpose. For some of the participants there is an appetite for more development.

There is evidence of development both on professional and personal levels. There is a motivation to embrace change and increased confidence and morale amongst some of the participants. There is a growing sense of self-belief and confidence. I have observed that some of the participants have shifted from self interest to looking at more of a shared vision with the people with whom they are working. There is a growing sense of confidence among some of the participants that they have the ability to further develop a culture where person-centred care is the norm. The ongoing challenge will be to keep the momentum and motivation sustained in the current climate of change and uncertainty.
4. WHY IS PRACTICE DEVELOPMENT IMPORTANT IN THE CURRENT HEALTHCARE CONTEXT?

The modernisation of health and social care services is aimed at improving health outcomes, raising the quality of service delivery and improving the patient experience across the pathway of care. These aspirations are underpinned by principles of quality, safety, effectiveness, efficiency, equity, access, and patient participation. To address this challenging agenda, various targets, change management tools and service improvement techniques have been introduced, which seek to place the patient at the centre of the process. The common denominator across all of these initiatives is the predominant focus on improving systems and processes. Practice development on the other hand, whilst using systematic processes, focuses specifically on developing people and transforming their practice to achieve effective person centred care. Both approaches are necessary for clinical and cost effectiveness.

Practice development with its focus on person centred care has a key role to play in reform. It has the potential to translate complex organisational and strategic agendas into practical reality for staff and patients, engaging staff with the larger vision by creating links with their own aspirations. Sustainable change requires local healthcare teams to become innovators, accepting responsibility for learning and developing their own practice, rather than simply engaging in short term projects or responding to perceived external demands. With its emphasis on facilitating work-based learning, staff empowerment, evidence collation and implementation, and fostering positive team relationships, practice development has a key role to play in achieving sustainable change.

5. PRACTICE DEVELOPMENT – THE EVIDENCE

In 2006, NHS Quality Improvement Scotland and NHS Education Scotland commissioned the first ever systematic review of the evidence underpinning practice development. This systematic review was undertaken by McCormack et al in 2007 (McCormack et al 2007 a, b, c, d). The study was underpinned by a method of systematic review of a diverse range of evidence called Realist synthesis3 (Pawson et al., 2004) and drew on practice development publications and ‘grey literature between the period 2000 – 2005. In providing a background to this strategic framework, the synthesised evidence from this systematic review was utilised. A hand search of papers published in the journal Practice development in Healthcare© between the period 2006 – 2008 was also undertaken to identify new sources of evidence. No new evidence was uncovered that challenged or further developed the issues raised in the systematic review. Thus a new literature review was not conducted, but instead the findings from the systematic review by McCormack et al (2007 a, b, c, d) was used as the evidence-base to underpin the study.

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3 Realist synthesis is a new methodology for undertaking systematic reviews of evidence underpinning complex social interventions (practice development is considered to be a complex social intervention because of the multiple methods involved and its focus on people and processes). Realist synthesis draws on the principles of realistic evaluation and is underpinned by the philosophy of realism to evaluate and synthesise multiple sources of evidence (Pawson, 2006) without applying strict hierarchical frameworks that determine the worth of different types of evidence, i.e. all evidence is of equal value in the review process and findings.

4 The Practice development in Healthcare journal is the only internationally peer-reviewed multidisciplinary journal that has a specific focus on practice development and thus it was deemed appropriate to focus a hand search on this key resource.

1. There is no evidence to suggest the primacy of multidisciplinary over unidisciplinary practice developments. However, consistent with other developments in contemporary healthcare delivery, the review suggests a general sense of multidisciplinary being ‘better’. However, the key issue is that the decision should reflect the overarching intent/desired outcomes of the development work itself.

2. The involvement of managers in practice development is crucial to its successful implementation and the sustainability of outcomes. However, the evidence would suggest mixed-support from managers for practice development work. This can be attributed to a lack of understanding of practice development in a healthcare world that is driven by short-term-ism and practice cultures that continue to be suspicious of managers. The connection of practice development with service/systems developments, set within a modernisation agenda is key to the future development of effective services.

3. There is universal acceptance of the need for service user engagement in practice development work. However, there is little evidence of this happening in a proactive way currently and most involvement is representative of ‘consultation’ rather than involvement. There is a need for further research, development and training to be undertaken with practice developers and service users in order to develop meaningful engaged relationships.

4. The evidence continues to suggest that practice developers in ‘formal’ roles continue to experience isolation and role ambiguity. The expertise required by practice developers to undertake particular roles is largely unknown and unrecognised. There is a need to develop a greater understanding of the particular knowledge, skills and expertise needed to operate in differing practice development roles. Clarity about ‘what is in and what is out’ of specific practice development projects is needed in order to maximise available expertise and evaluate outcomes. However, there is also a need to discontinue the dominant focus on practice development roles per se and instead develop transferable principles for the facilitation of practice development within and across organisations.

5. Collaborative relationships with Higher Education Institutions (HEIs) can provide an important means of reducing isolation for practice developers, but also a way of extending the potential for systematic and rigorous processes to be adopted. However, the principles upon which such relationships are established are crucial to the success of such collaborations.

6. If practice development processes and outcomes are to be sustained beyond the life of particular project timeframes, then there is a need to embed practice development activities in learning strategies. Therefore practice development and learning are inextricably linked. There is no evidence in the practice development literature of ‘traditional education’ processes having a direct impact on practice. Reflective learning strategies and in particular ‘action learning’ appear to have more to offer sustainability. There is a need for further evaluative research in this area.

7. There is consensus in the data that effective practice development requires the adoption of participatory methodological approaches. No one methodology is favoured and thus promoting one as a favoured methodology would not help to advance practice in this field. The diversity of approaches appears to enable new knowledge about effective processes to emerge.
8. There is growing consensus concerning the practice development methods that are effective in ensuring participatory engagement and in bringing about changes in the culture and context of practice. The complexity of practice development militates against the correlation of any one method with outcomes. Further research is needed to advance the development and testing of these methods in order to inform outcome measurement.

9. There is no available funding model for practice development. The majority of funding is focused on the resourcing of practice development roles. However, as we move more towards an integrated methodology where the emphasis is on particular methods rather than roles per se, then costing models need to be developed. Based on the evidence arising from this review, it should be possible to devise a funding model to match the methodologies and methods identified.

10. Outcome measurement in practice development is complex and does not lend itself to traditional methods of outcome evaluation. The evidence suggests that outcome measurement needs to be consistent with the espoused values of ‘participation and collaboration’ where data collection and analysis is an integral component of the development itself. A wide range of outcomes are evident from published practice developments and there is a need for the replication of these in further studies. In addition, consideration needs to be given to the ‘stable’ methods of practice development through scientific measures as separate activities from theory generating and knowledge development activities.

McCormack et al (2007c) identified key issues that need to be addressed in order for practice development to have a desired impact:

1. Decisions about practice development being uni or multi-disciplinary should reflect the overarching intent/desired outcomes of the development work itself.

2. The involvement of managers is crucial to the successful implementation of practice development processes and the sustainability of outcomes.

3. There is universal acceptance of the need for service user engagement in PD work.

4. Practice developers in ‘formal’ roles need to have skills in expert holistic facilitation.

5. Collaborative relationships with Higher Education Institutions (HEIs) can provide an important means of reducing isolation for practice developers, but also a way of extending the potential for systematic and rigorous processes to be adopted.

6. If processes and outcomes are to be sustained beyond the life of particular project timeframes, then there is a need to embed practice development activities in learning strategies. Therefore practice development and learning are inextricably linked.

7. Effective practice development requires the adoption of three key methodological principles – collaboration, inclusion and participation.
8. There are a number of methods that are effective in ensuring participatory engagement and in bringing about changes in the culture and context of practice. These are:
   - Agreeing ethical processes
   - Analysing stakeholder roles and ways of engaging stakeholders
   - Person-centredness
   - Clarifying the development focus
   - Clarifying values
   - Clarifying workplace culture
   - Collaborative working relationships
   - Continuous reflective learning
   - Developing a shared vision
   - Developing critical intent
   - Developing participatory engagement
   - Developing shared ownership
   - Developing a reward system
   - Evaluation
   - Facilitating transitions
   - Generating new knowledge
   - Giving space for ideas to flourish
   - Good communication strategies
   - Implementing processes for sharing and disseminating
   - High challenge and high support
   - Knowing ‘self’ and participants
   - Use of existing knowledge

9. Outcome measurement in practice development is complex and does not lend itself to traditional methods of outcome evaluation. Outcome measurement needs to be consistent with the espoused values of ‘participation and collaboration’ where data collection and analysis is an integral component of the development itself.

In summary, practice development has as its explicit intent, the development of cultures that can sustain continuous processes of practice improvement and innovation with a focus on the development of person-centred cultures. The explicit intention is the empowerment of all practitioners to take responsibility for the quality of their practice, develop practice and learn about the processes involved. It is a facilitated and continuous process and the methods involved are most effective when they are embedded into everyday practice.
Person-centred Nursing Developments in Genito-Urinary Medicine (GUM) Clinic (adapted from McCormack et al, 2008)

The Department of Genitourinary Medicine (GUM) aims to provide a quality sexual health service. Services include diagnosis, treatment, contact tracing and counselling for patients affected by or concerned about sexually transmitted infections including HIV and AIDS. Following the collection of evaluation data a workshop using claims, concerns and issues was used to develop an action plan for the unit to take forward. The staff within the clinic were interested in developing therapeutic relationships with patients as often they work with the same patient group for many years. In order to develop more person-centred practice, staff felt they needed more time to foster their nurse patient relationships. During a busy clinic with many “drop in” patients this was not easy. Two main strands of work developed. The first strand involved dividing the nurses into two teams and within those teams each nurse took responsibility for providing a key worker role. This role involved reviewing the patient’s clinical notes, ensuring all tests had been reported and the results relayed to the patient. To do this the nurse telephoned the patient, introducing themselves if the patient did not already know them, and explained the key worker role to them. This meant that any outstanding issues for the patient were addressed and they knew the name of the nurse responsible for their care at the clinic. The nurse-patient conversations in this setting tended to reflect attributes of the care environments in that it was a busy environment with short amounts of time for nurse-patient interaction. Analysis showed nurses tended to remain with patients with few interruptions and took an overview of the tests and the process for reporting back results.

The second strand of work stemmed from the large number of daily telephone inquiries to the clinic from anxious patients. The steady stream of calls was taking the nurses out of the consulting room and leaving patients alone. A pilot project of the nurse triage system was introduced. A nurse was allocated this role for the duration of the day, a private room and telephone were provided and the receptionist provided clinical notes for the nurse while the caller was on the line.

At further ward leader days (action learning) and through one to one working with the leader this work was then linked back to a model of person-centred nursing. Whilst several staff development issues were identified to enable these developments such as developing interpersonal skills and exploring risk taking and innovation, it was the caring processes with patients that the team chose to focus on. Dedicated and planned time allowed the nurses to consider and work with the patient’s values and beliefs. By doing so the nurses were then able to develop more meaningful engagements with patients and, linked with the development of their interpersonal skills, to listen to and hear the patient’s voice.
Stage 1: Analysis of the ‘grey literature’ relating to practice development work in Ireland

National Steering Committee Review

Stage 2: Telephone interviews with a representative sample of key stakeholders

National Steering Committee Review

Composite analysis of all data

Stage 3: Focus groups (n = 2) with a sample of key stakeholders

Strategy writing

National Steering Committee Review

Stage 4: Expert Group discussion and framework agreement

Finalised Strategy

Figure 1: Strategy Development Framework
6. STRATEGY DEVELOPMENT METHODOLOGY

In the development of a strategy for practice development in Ireland, it was important to gain an understanding of how existing practice development work compares with the international evidence, as summarised in section 5. In order to answer the question – “How does practice development activity in Ireland compare with the international evidence?” a four stage collaborative approach with key stakeholders was adopted (Figure 1) (See Appendix 7 for list of Contributors to the Strategy Development). In addition, the findings of each stage were reviewed by a National Steering Group (Appendix 3).

Stage 1: Analysis of the ‘grey literature’ relating to PD work in Ireland: In this stage health care providers, the National Council for the Professional Development of Nursing and Midwifery and all universities were written to and requested to provide details of the practice development work they were engaged in/supporting. A framework for reporting their activity was provided (Appendix 4). However, whilst many organisations made use of this framework, many submitted a variety of report styles and formats with varying degrees of detail. Reports were submitted by hard copy or email to the Nursing Policy Division, Department of Health and Children. The time period for reporting varied between submissions so a decision was made to restrict the reviewing period to between 2005-2007, as this reflected the period when many advancements in the methodology of practice development were made. A total of 28 reports were returned from the above organisations. Each report was reviewed using the following approach:

- overview of the paper
- detailed read to identify issues of significance
- identification of themes

Stage 2: Telephone interviews with a representative sample of key-stakeholders: In this stage the issues generated from Stage 1 were explored further with key stakeholders through telephone interviews. Key stakeholders were defined as people who are actively involved (directly or indirectly) with enabling practice development to be realised in health care settings. A list of stakeholder groupings was formulated and from this list the names of stakeholders representing these groupings was developed. Each selected participant was written to and invited to participate (n = 20). Each participant was offered a range of dates and times to be interviewed. Interviews were scheduled to last for 30 minutes. Seventeen stakeholders participated in the interviews. Reasons for not participating as agreed were largely to do with changes in circumstances preventing participating at the agreed time and inability to agree a new time because of the time-frame of the project. An interview schedule was formulated based on the issues derived from Stage 1 of the project and the findings from the systematic review. Participants were provided with the report of stage 1 in advance of the telephone interview. Each interview was audio-recorded using a ‘two-way telephone conversation recorder’. In addition, notes in the form of concept maps were made by the interviewer for each interview conducted and examples of good practice highlighted/noted.

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5 Grey Literature is the term used for documents and ephemeral material issued in limited amounts outside the formal channels of publication and distribution. It is difficult to estimate how much Grey Literature is produced since Copyright Laws indicate only the volume of conventional literature published commercially. Examples of Grey Literature include: scientific and technical reports, government documents, theses, patent documents etc. (Source: http://www.biblio.uottawa.ca/content-page.php?g=en&s=rgn&c=srclitgris).
Data were analysed using the following approach:
1. reading of each concept map
2. combining the concept maps of each interview for each interview question
3. identifying key themes from step 2
4. listening to audio recordings for evidence of the theme
5. extraction of data exemplars to illustrate the theme

Stage 3: Focus groups with a sample of key stakeholders:
Two focus groups were held following a preliminary analysis of the telephone interview data and a topic list was developed based on the telephone interview findings. The same approach to the identification of stakeholders as per the telephone interviews was adopted. Ten stakeholders participated in focus group 1 and 18 stakeholders participated in focus group 2. Each focus group lasted for 2 hours.

Stage 4: Expert Group with National and International experts:
A workshop with a group of nationally and internationally recognised ‘experts’ in practice development theory and practice was held in order for all the data to be critically reviewed and considered in the context of developing a strategic framework. The expert group (Appendix 5) undertook the following activities:

- Reviewed the summary evidence reported and discussed the implications of this for strategy development and strategic priorities.
- Creatively developed a strategy ‘purpose statement’.
- Agreed strategic objectives to realise the strategy purpose.
- Identified themes for actioning the strategic objectives.
- Prioritised activities in each theme.
- Discussed ideas for taking the strategy forward.

The purpose statement, strategic objectives and key activities in each strategic objective area were used to shape the final strategic direction.
A Practice Development Co-ordinator at Work
The management of acutely ill patients in a Special Care Mental Health Unit has posed difficulties for other patients and staff caring for them. There is both anecdotal and research evidence that current containment methods are contentious and emotive and little evidence or agreement regarding its efficacy. A practice development project was established to address the issue, with the intention of:

1. developing a shared vision and philosophy of care for patients in the Special Care Unit’s (SCU);
2. enhance leadership skills of multidisciplinary staff working in the SCU; and
3. improve the quality of care provided.

An Action Research project was established by the Nursing Practice Development Co-ordinator (NPDC) and co facilitated by the NPDC and a Higher Education Institute, (HEI). The project started by:

a. finding out about the needs of patients and multidisciplinary staff;
b. undertaking a training needs analysis;
c. evaluation of patient and staff satisfaction;
d. evaluation of staff attitudes; and
e. an audit of the experiences of acutely-ill patients.

These findings were then used to form action learning sets, introduce clinical supervision and provide ongoing support for staff as well as support changes in clinical practice.
7. SUMMARY OF FINDINGS

Stage 1 Findings
The findings from Stage 1 of the strategy development suggested that there was limited evidence of the practice development work reported reflecting the principles of practice development articulated earlier, with few of the papers reporting activity directly focusing on person-centredness, cultural change or facilitation. A total of 651 different activities were identified in the papers reviewed and the majority of these reflected a technical approach to practice development (tPD) (Manley and McCormack 2004).

Technical Practice Development (tPD)
In tPD the focus is on reaching an end-point already identified, such as the implementation of clinical guidelines to ensure more effective care within an organisation, or developing the competence of practitioners in some new aspect of care. The assumption underpinning tPD is that, armed with the technical skill and knowledge then practice will be developed and so a major focus in tPD is on the provision of information (in the form of guidelines and procedures), teaching and skills training. Yet there are many barriers to developing practice, not least the fact that situations everywhere are different, with each setting posing greater or lesser barriers to implementation. Knowledge and skills acquired may not be realised in practice for a number of reasons, but largely associated with the practice culture not being conducive to change. Although staff may identify with and plan to implement interventions on a study day or in a meeting, often when they return to their clinical areas a host of barriers frustrate them. Not least of these is that they are thrust back onto the same ‘hamster-wheel’ where the burden of day-to-day care may provide little opportunity to practice newfound skills.

Suggesting that the evidence provided largely reflects a technical approach to practice development should not be seen as a negative view of practice development, but instead reflects the stage of development of practice development in Ireland. Further, a key issue to bear in mind is the presentation of the information provided. The information was diverse in its presentation and lacking detail. Thus whilst an area of work might have an intent of being emancipatory, this was not articulated as it was often the specific activity that was listed rather than it being recorded from a developmental perspective.

The grey literature did provide some insights into existing practice development activity in Ireland:

1. There was limited relationship between the theoretical and methodological frameworks promoted in contemporary practice development literature and the evidence provided in this grey literature.
2. There is some confusion about the place of practice development alongside other activities (such as those of training activities) and this needs to be clarified.
3. The relationship between practice development and other learning activities was unclear. McCormack et al (2007b and c) were unable to identify any clear relationship between training and formal education activities and practice development outcomes (in terms of more person-centred care etc.) yet the majority of activity reported in this grey literature is training and formal education oriented.
4. There was limited evidence of ‘facilitation’ as an explicit activity.
5. Outcome measurement was poor and largely focused on counting the number of people attending courses and training programmes

These themes were explored further in the telephone interviews in order to tease out the issues raised and to gain perspectives from the different stakeholders involved.
Stage 2 Findings
The themes are underlined in the findings section and presented against each question discussed in the interviews.

1. Stakeholder Understandings of Practice Development
There were diverse understandings of practice development among the interviewees and whilst some understandings did reinforce the technical nature of practice development as illustrated in the grey literature, others did articulate understandings that were emancipatory in intent:

“we can say that introduction of a guideline is practice development, but really, is the introduction of that guideline around the whole development of how, say, tissue viability is managed and all that … so I think sometimes people doesn’t necessarily describe things in the right way … people pick out the isolated thing that they do and don’t describe the whole package of development …”

“its very much about looking at developing practice, improving practice, very much working from a bottom-up approach where you are working with and alongside staff, identifying deficiencies or areas for improvement and then working together through action learning, audits or action research to actually develop and improve practice and then measuring the outcomes for practice … but the emancipatory approach includes this but also starting from the point of shared vales and beliefs and taking staff on a journey to make these real in practice”

Both these quotes illustrate a depth of understanding of practice development, its methodology and some of the inherent processes involved in working in an emancipatory way.

Most people felt that practice development is still ‘new’ in Ireland and that it has come about because of changes to the education and training of nursing and midwifery students (i.e. the move to Higher Education Institutions [HEI]). In midwifery the role of practice development was introduced in 2006 as recommended in the Report of the Expert Group on Midwifery and Children’s Nursing Education, as part of the change agenda when introducing the BSc in Midwifery. The role is very new and is in place in the maternity units associated with the BSc in Midwifery. It was seen as a communicative process with a focus on ‘clinical practice’. The majority saw practice development as being about working with people ‘on the ground” “it’s a practical thing, people becoming intolerant of practice and want to change it.” Interviewees identified many of the elements of practice development that are written about in the literature, such as changing culture and context, empowerment of staff, improving practice, facilitating staff to develop practice, focusing on ‘care’, developing skills and competence, developing patient-centred care.

However, whilst many of those interviewed held these understandings they also suggested that the technical aspects of practice development dominate the Irish nursing and midwifery landscape. For some, this was a result of the ‘challenge of demand for quick outcomes and remedies’

“… people do try to practice with emancipatory-type beliefs in their practice development and are focused on trying to transform the context for care and become less preoccupied with the whole idea around clinical guidelines and procedures and so on. People do try to work with people’s values and beliefs and the evidence that comes from practice…, but the pressure comes from leaders who want outcomes automatically. Everyday… there is a demand for a new set of outcomes and a quick remedy for problems, so practice development gets pulled all over the place …”

6 The final question asked interviewees to consider what they would like to see as the central focus of a PD strategy in Ireland.
For others it was because of the way practice development was introduced to Irish nursing and midwifery (i.e. as a result of the entry of nursing and midwifery to Higher Education Institutions), a response to practice issues, and the particular expertise/previous experiences of staff in practice development roles.

Interviewees (n=5) who articulated an understanding of different practice development methodologies held the view that different methodologies (such as technical, emancipatory, transformational) should not be polarised, but where possible these should be integrated into practice development strategies and frameworks:

“... There is more than one model of practice development. I very much support the emancipatory approach but also feel there is room for technical approaches and I don't see them as a hierarchy … mmm, I also see the risk of boxing practice development under a particular label. For me practice development is around a very effective change process to improve patient outcomes … particular processes of practice development work depends on the levels of development within an organisation, the level of development of the individual nurses and midwives and obviously the level of risk as well …”

Overall, it could be summarised that among many stakeholders there is a clear understanding about what practice development is, the key processes involved and organisational and cultural considerations that shape the way the different approaches to practice development operate in reality. However, whilst stakeholders had these understandings, they also believed that there did exist differences between the understandings espoused and how these understandings were able to operate in reality.

### Working Collaboratively

In the South-East of Ireland, practice development staff work with clinical staff and other stakeholders to set standards for practice. When this has been done, baseline audits are undertaken, including the establishment of patient experience and journeys through the service over time. Specific issues from these audits are then worked up into action plans for practice change. Staff teams work with a facilitator to identify and agree the plan of action and agree individual responsibilities. Guidelines to support the new practices are produced and continuously evaluated through local audit. “Changing practice in this way takes time and a key issue in its success is the involvement of clinical staff in taking responsibility for a particular aspect of the practice almost like the change in practice being divided in a jigsaw puzzle, with each person taking responsibility for each piece of the puzzle collectively being responsible for the practice changing as a whole”.

2. Relationship Between Espoused Understandings of Practice Development and its Operationalisation

The idea that practice development activity is driven by a ‘top-down’ managerial agenda was seen to conflict with its intent. Competing demands and a lack of understanding of practice development often mitigates against true practice development activity.

A key example of this raised by most interviewees was the dominant focus on the development of policies and procedures:

“… and then what happened in (hospital name) was that for about the next three years, the main thrust was in the development of policies …”
Whilst everyone agreed that this was important work, there was a strong sense that there was a lot of re-inventing of wheels happening, with the same policies, guidelines and procedures being developed in different parts of the country. Some people suggested that they spent between 80-90% of their time working on policies and guidelines, leaving little time to work with staff in clinical areas.

Practice development should be about working with people ‘on the ground’ but the reality is that this is not always the case due to other commitments of people in practice development roles:

“… my understanding of practice development is that they [PD staff] should be out there supporting nurses to develop practice and to change practice, but for a number of reasons I don’t really see that happening … dipping in and out is what I see happening …!”

Currently the Practice Development Co-ordinators role is often largely about supporting degree students and coordination rather than facilitating developments in practice with staff. However, many people interviewed felt that there is a lot of facilitated development happening in practice but the challenge is getting people to describe it/write about it in detail. This view may serve to explain why so little non-technical practice development was articulated in the grey literature, i.e. that it is happening but that it is presented as ‘concrete lists’ rather than articulated processes. Most people felt that the Clinical Placement Co-ordinator and Practice Development Co-ordinator roles need to be separated out as this is a key cause of role ambiguity and confusion. Some people had developed strategies to deal with this, such as having some staff who prioritised supporting students whilst others focused on practice development work, developing project plans that are negotiated with the practice development committee and having a systematic approach to planning projects with clinical staff. The need for Directors of Nursing and Midwifery (DoN/Ms) to have an understanding of different practice development methodologies was seen as paramount by many interviewees. A better understanding of practice development would enable staff in lead positions to adopt different methodologies and use different sources of evidence to demonstrate effectiveness/outcomes.

Overall, the data would suggest that a number of challenges exist that prevent the broad range of practice development methodologies to be utilised in practice. Largely these challenges can be summarised as ‘competing agendas’ that require decisions to be made about what activities are prioritised. Activities that are seen to produce ‘quick’ and ‘tangible’ results are seen to be given priority, without due consideration for the longer-term implications and options. Nobody disagreed with the importance of guidelines and policies, however, the majority felt that the writing and re-writing of the same/similar policies and guidelines in different organisations was not a good use of resources and detracted from the real development activities needed to make these policies and guidelines real in practice. The role of the ‘Practice Development Co-ordinator’ epitomises the balancing of competing agendas and there is clearly a need to identify how these roles can have the greatest development impact in organisations.
Role of Director of Nursing/Midwifery in relation to Practice Development.

The current health care environment presents challenges to nurses and healthcare professionals in relation to contemporary technological, medical and social advances, which requires us to deliver healthcare within a different clinical, social and ethical framework. These challenges require nurse managers in particular to have a sound knowledge of the therapeutic milieu, clinical competence and expertise and nursing’s influence on the health systems within which we practice. As Director of Nursing I need to practice within this contemporary framework. I must analyse care practices within my practice area (Older Adult Services) and must find constructive ways to improve future performance and to drive the agenda for quality assurance within a person-centred model of care delivery. In order to operationalise this agenda, as Director of Nursing and team leader I must have the vision and set realistic goals for the healthcare team to achieve this. By promoting a practice development framework the team is motivated to develop a shared value system, and they are enabled to utilise evidence-based solutions to enhance care practices within the Older Adult care setting.

3. The Relationship between Practice Development and Learning

In general, the relationship between practice development and other learning activities is unclear. However, given the emphasis placed on training and formal education activities in stage 1, the relationship between practice development and learning was explored in the telephone interviews. There was a unanimous view among interviewees that currently, there exists too much of an emphasis placed on training and classroom-based teaching and that this detracted from the facilitated learning and development that could/should happen in practice. Staff in formal practice development roles appear to have a broad range of responsibilities for teaching and learning, from orientation programmes for staff through to a broad range of training programmes specific to aspects of nursing and midwifery practice.

There was also an equally unanimous view that the training and teaching activities were poorly evaluated beyond the monitoring of attendance and evaluating uptake of training activities. Some interviewees suggested that there is an overlap in activities between education departments (providing professional development) and practice development departments. Many suggested that these should be working along a ‘continuum’ of knowledge acquisition to knowledge implementation and generation. However, overall, education is seen as only one small part of the practice development process – “an element of the circuit”

“we do a lot of in-service training as part of a package, so there’s a reason for it. So if we are doing perineal suturing, it is not a suturing workshop, it is because we are developing midwives to do something as part of a practice development initiative … so the relationship between the training and practice development activity is that it is just one little circuit in the continuum of practice development …”

Some interviewees identified that there is a gap between clinical practice and higher education (HE) and that there is a lack of involvement of staff from Higher Education Institutes in practice development. Some participants listed a range of innovations and initiatives that are practice development oriented, represent complex programmes of work but without any input from HE partners. Others suggested that when there is a dominant focus on teaching and training then the focus is often not specific enough in terms of what practitioners need to do their job effectively.

Practice Developers working in a facilitative way in practice were seen as the key to transforming general learning into specifically applied learning in practice.
Development and delivery of a Module of Professional Development for Community General Nurses in the Public Health Nursing services in the North West

This programme was developed to meet a specific professional development need for Registered General Nurses/Midwives who had been working in community for many years. These nurses had extensive experience in clinical practice and had been provided with regular, clinically focused updates. However they had not had the opportunity to focus on their own professional development as community nurses and to be informed in the theory and principles underpinning community nursing and primary care. Following an application by the Community Nursing Practice Development Co-ordinator, (NPDC) the initiative was supported by funding from the National Council for the Professional Development of Nursing and Midwifery. The NPDC established a steering group, which also included the Directors of Public Health Nursing and the Directors of the Centre for Nursing and Midwifery Education from both Local Health Office Areas. The programme was developed and delivered by the CNME Specialist Co-ordinators and the NPDC, with other speakers from local and national PHN services, from the NMPDU and other agencies. The programme was set at level 8 and comprised 11 taught days, 2 practice experience days and a ½ day for assessed presentation of case studies. It was developed and delivered jointly by the two services and the two CNMEs in this rural dispersed area. The collaborative working between the services and the CNMEs, initiated and facilitated by the NPDC, ensured that the programme met both professional development and service needs, that it was delivered in a location and a schedule that allowed the service managers to release staff to attend all sessions and to liaise with other services to facilitate participants’ practice experience days. Participants also evaluated the programme very positively. There was high attendance and completion rate for the assessment was 93.75%. (15/16) There is a waiting list for further programmes.

4. Facilitation

The practice development literature holds ‘facilitation’ central to enabling engagement in emancipatory and transformational processes. However, it is true to say that the literature also confuses facilitation with the need for ‘facilitators’, i.e the formalising of facilitation knowledge and skills into a particular role function. The intention of the telephone interviews was to explore whether facilitation was considered important or not to practice development, as the presentation of the evidence in stage 1 did not place much emphasis on facilitation. The telephone interviews revealed a unanimous recognition of the need for facilitation in practice development and this is also evidenced in the previous sections of the findings in stage 1. Many people felt however, that it is the invisible part of practice development, that it doesn’t get documented (as only the specific activities get documented [in a technical way]) and that its role is poorly understood:

“Facilitation can be a bit nebulous … there can be a cultural thing around facilitation in Ireland …. I don’t hear many nurses say I facilitated x or y to happen as there is a culture here of liking people to take ownership for what they have done … you won’t tend to hear the practice development coordinators saying ‘I facilitated that to happen’. You will hear them say I gave them that information and I gave them this and they came together and they really did it themselves … there is a cultural way in the way we describe things”

The range of facilitation expertise available varies considerably and some interviewees felt that people are placed in formal facilitation roles without any training/development in facilitation or with limited support for the challenges of being a facilitator in complex change situations. In addition, as highlighted in previous findings, facilitators in formal practice development roles get ‘dragged into’ activities that are not facilitative (such as committee attendance) and this limits their ability to be effective. Some people felt that capacity (i.e. having access to facilitators) is a key issue and that Clinical Nurse Managers/Clinical Midwife Managers (CNMs/
CMMs) should have a facilitation focus in their roles, and demonstrate partnership working between different departments (e.g. NMPDU, PD Departments). Emancipatory facilitation is considered to be poorly understood generally and is not appreciated.

**Emancipatory Facilitators**

Emancipatory facilitators draw on knowledge and experience from a variety of sources to holistically inform facilitation of practice, taking account of knowledge of self; learning styles; the individual and their context; interpersonal processes; group theory and processes; systems, organisations and power; and change theory and processes (Royal College of Nursing, 2006)

“There is a lack of capacity in emancipatory facilitation … there is a lack of capacity to be able to facilitate the kind of development work that is needed. But the approach is often denigrated by leaders who don’t understand it and that doesn’t help …”

Facilitators feel ill prepared to use emancipatory approaches or how to evaluate them. Overall however, the importance of facilitation is recognised in practice development. There is a sense that a lot of it is happening but it is ‘hidden’, but it is also recognised that there is a need to build facilitation capacity and expertise.

**An Emancipatory Facilitator at Work**

Working with a group of PD facilitators during a programme day session the group identified the need to develop a set of principles that represents the beliefs they now have about their practice as it is in transition from task orientated approaches to care to a culture of person-centeredness. The starting point agreed by the group for this activity was to use a PD process known as ‘Claims, Concerns and Issues’ (CCI) to identify claims about current developments, what concerns still remain for the group and what actions are necessary to overcome these concerns.

The outcome of the CCI exercise was an extensive list of positive developments in their care practices which surprised most of the group, some concerns remaining about challenges mainly concerning resistance by a small group of colleagues to fully engage in the work and a number of action plans to address identified challenges. The next step was to develop draft principles from the CCI exercise and this was undertaken in the form of a creative poster that contained building blocks in the shape of a house. Each block represented their agreed principles of person-centred care and encompassed information gained from conversations with their patients and families, their colleagues, their agreed common values and beliefs about their care and their knowledge of PD and person-centred care philosophy.

The exercise had great significance to the group for two reasons; it afforded them the opportunity to take the initiative to review their developments and act on concerns together, and to share the information in a format that demonstrated their growing skills in creative thinking and reflection. The PD process the group carried out underlined the principles of emancipatory practice development facilitation.

**5. Practice Development Outcomes**

It was suggested from stage 1 that outcome measurement focuses on measuring the direct relationship between knowledge inputs and knowledge acquisition, with little evidence of outcomes (for individuals, teams, organisations) being evaluated. The telephone interviews supported this hypothesis with all interviewees agreeing that outcome measurement is problematic and currently is poorly understood and operationalised. A range of reasons why this is the case were offered, including, lack of understanding of and expertise in using
evaluation methodologies, an over reliance on audit data without acting on audit findings, lack of available outcomes frameworks for practice development, not enough time to do systematic evaluation and lack of proactive planning of evaluations:

“... one of the areas of practice development that we could improve upon is outcome measurement ... and that is probably an area that we could nationally improve upon ... and I would like to see a national strategy that will include how practice development is evaluated ...“

“I think a lot of it to be quite honest is about, where do the professions see practice development in their roles and as practice development gets a lower profile rather than a higher profile, so if we can raise that culture and that agenda then I think we can foster that culture of outcomes, audit and re-evaluation...”

However, some people (n=3) identified how accreditation frameworks have provided a drive to be more systematic in evaluation of practice developments and that accreditation frameworks and corporate objectives provide useful frameworks for demonstrating practice development outcomes. Others described initiatives to integrate reflection with evaluation plans but that much more work needed to be done in this area.

**Evaluating Practice Developments – An Example**

In a national practice development programme, processes and outcomes are being evaluated within a framework of cooperative inquiry primarily drawing upon reflective dialogue data between the External Facilitators, Internal Facilitators, Programme Participants and the Programme Leaders; interview data with all participants and records of developments. In addition, a number of ‘tools’ are being used to systematically evaluate the processes and outcomes of the development activity and the existence and growth of person-centred practice. Data are being collected at three time-points in the lifetime of the programme. These tools have been developed as components of previous research and development in person-centred practice and have established validity and reliability data. The project leaders and lead facilitators all act as co-researchers in the collection and analysis of data. Thus the framework has the added benefit of developing evidence gathering and research skills among the programme team and the programme participants. Data collected using some of the tools are analysed at a local level only and the data used to inform the development of local action plans, whilst other data are analysed at a local level to inform the development of action plans and at a national level to inform the effectiveness of processes and outcome achievement across the programme as a whole. However, all data is analysed using a participatory approach with programme participants, programme facilitators and programme leaders. In addition to this data, stakeholder perceptions of the programme have been gleaned through a questionnaire with key stakeholders. The notes from the programme days across all the sites detailing learning evaluations and feedback to Directors have also been collated. Within the team, notes and reflective accounts have been collated.

**Stage 3: Findings**

There was largely a shared understanding of practice development among focus group participants and this understanding reflected the views expressed in the individual interviews. The views of practice development expressed were consistent with the international literature/evidence and were highly consistent with the views of participants in the telephone interviews. However, when asked how widely held these perspectives were outside of stakeholders directly involved in practice development, the overall view was that it wasn’t. Reasons for this included:
• Dominance of guideline development activity
• Lack of support from other stakeholders
• Practice development and education being ‘lumped together’
• Limited understanding among managers
• Practice development not high on the agenda in organisations
• Practice development not being located in the wider organisational context and thus CEOs not understanding its potential and actual contribution to organisational effectiveness

The issue of guideline and policy development as the key focus of practice development activity was continually emphasised as one reason why other aspects of practice development were not happening, similar to the telephone interviews. The focus groups largely supported the idea of a national approach to guideline and policy development, an approach that coordinated their development and that provided frameworks and core content that only needed to be adopted locally. Whilst some national standards (such as HIQA Standards [residential care standards]) are being introduced there are few examples of nationally coordinated standards and guideline development and focus group members suggested that it would require a “massive culture change” to make this happen. Others felt that the ‘bulk’ of the work on standards and guideline development has been done and that in the context of practice development a key opportunity is emerging to adopt a national practice development implementation plan.

The need for clarity of role (i.e. distinguish between practice development, education, student support and quality improvement) was emphasised and many of the issues regarding ‘role confusion’ were endorsed. Like in the individual interviews, the grey area between professional and practice development was discussed. All participants felt that the existence of such a grey area was problematic and didn’t help with achieving the intentions of either. However, the view that this was a ‘territorial issue’ was also expressed and that there is a need to develop different understandings of what ‘learning and development’ are about and that with the development of such understandings new approaches to partnership working could emerge. The demands placed on the practice development co-ordinators role due to a lack of role clarity was considered to be a key factor in limiting the potential to demonstrate the effectiveness of the role in the context of practice development.

However, the key issue for focus group members was not the need for role clarity for its own sake, but in order to enable those in formal practice development roles/leaders of practice development to be able to develop Key Result Areas (KRAs) that they can systematically work to and evaluate effectiveness against.

Across both focus groups, the need for practice development to be integrated into pre-registration and post-registration curricula was emphasised. Many participants felt strongly that there were ample opportunities now for service providers and higher education institutions to work together to develop integrated models of learning that are based on the key principles underpinning practice development. Whilst the lack of role clarity that exists for Practice Development Co-ordinators was acknowledged, it was also felt that having student connections and responsibilities provided an important opportunity to legitimise the role and contribution of practice development to the advancement of nursing and midwifery expertise. However, the need for academic staff in higher education institutions to value practice development and understand their contribution to it needs to be addressed. Focus group members expressed the need to develop much more sophisticated research cultures in practice. For many, practice development offered a vehicle for achieving this agenda but recognised that to achieve this there is a need for collaborative and productive relationships between higher education staff and practice developers. The Department of Health & Children is planning to undertake a Strategic Review of the BSc in Nursing, which may present an opportunity to include practice development on the curriculum.
**Stage 4: Findings**

A workshop with a group of nationally and internationally recognised ‘experts’ in practice development theory and practice was held in order for all the data to be critically reviewed and considered in the context of developing a strategic framework. The purpose statement, strategic objectives and key activities in each strategic objective area were developed collaboratively with the expert group and were used to shape the final strategic direction.

<table>
<thead>
<tr>
<th>Summary of Findings from all Stages of Data Collection and Analysis</th>
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<tbody>
<tr>
<td>• Whilst the technical-rational approach to bringing about changes in practice dominates, there is an understanding of and an intent to operate within a more collaborative, inclusive and participatory methodology among key stakeholders.</td>
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<tr>
<td>• Good examples of practice developments that span the breadth of methodologies exist. However, it is clear that the detail of this work is not being articulated in organisational reports and operational plans and thus it is in danger of being ‘invisible’.</td>
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<tr>
<td>• There appears to be confusion about how practice development and education programmes can co-exist. The confusion can be attributed to a lack of clarity about the purpose and contributions of each to knowledge, skills and expertise development and the most effective methods for bringing about culture change.</td>
</tr>
<tr>
<td>• Role confusion exists, particularly regarding the ‘formal’ roles that have responsibility for practice development, (such as the Practice Development Coordinator Role) and how these roles interface with other organisational and strategic roles.</td>
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<td>• Most people acknowledge that facilitation expertise in the context of practice development is limited and that there is a great deal of work to be done in this area.</td>
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<tr>
<td>• Capacity building is essential and needs to be a key focus of future developments.</td>
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<tr>
<td>• Having agreed national Key Result Areas (KRAs) for practice development work that are strategically appropriate and consistent with national policy directions would help to maximise the impact of practice development.</td>
</tr>
<tr>
<td>• Evaluation (and outcome evaluation in particular) needs further development and there is a need for stronger relationships between practice developers and researchers in HEIs/CNMEs to be created.</td>
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</table>
8. VISION FOR PRACTICE DEVELOPMENT IN IRELAND

There was a unanimous view that practice development needed to adopt a more proactive approach and be less focused on reacting to problems. This view would reflect a desire for practice development to shift its focus from addressing boundaried practice issues to one that is concerned with facilitating culture change in practice settings from a multidisciplinary/interdisciplinary perspective involving a range of stakeholders. All interviewees were able to articulate a vision for practice development in Ireland. Based on the analysis of the literature, responses of interviewees, focus group and Expert Group, in the future, practice development in Ireland would:

- Put the patient and carer experience at the centre.
- Have clearly defined coordination roles.
- Be integrated with national initiatives and strategic priorities.
- Have local areas of work (context specific culture change) and national programmes (e.g. National approach to policy and guideline development).
- Have a national framework with Key Result Areas (KRAs) that make the importance of person-centredness explicit.
- Be facilitated by experts in facilitating clinicians in practice.
- Have leaders advocating its merits based on clear evidence of success.
- Be linked with the work of HEIs/CNMEs and seen as important to the delivery of nursing and midwifery excellence.
- Work towards being a multidisciplinary activity.
- Have clearly demonstrable outcomes linked to organisational, corporate and national priorities.

Person-centred Care

“It is very exciting to be part of the development of nursing in Ireland at the moment. The expansion of my role into practices such as medication prescribing and ‘head to toe’ assessment means that I am able to provide more holistic care to patients. Nurses are at the forefront of modernising services and we need to ensure we take every new opportunity available to us that enables us to deliver effective person-centred care.”
9. STRATEGY

In this section the strategic themes for taking practice development forward in Ireland are articulated. These are derived from the review of the data undertaken in stage 4 of the methodology. The purpose statement, strategic objectives and key activities in each strategic objective area were developed collaboratively with the expert group and are used to shape the final strategic direction.

10. PURPOSE OF STRATEGY

Continue to improve the patient’s experience ensuring safe and effective person centred care in a changing healthcare context.

11. STRATEGIC OBJECTIVES

1. Develop a transformational healthcare culture in the workplace.
2. Enable the development of effective healthcare teams to work across the patient pathway.
3. Identify, capture and monitor Key Result Areas [KRAs] for three groups to support delivery of person centred care:
   - patient /carers experience and outcomes
   - individual and team effectiveness
   - systems effectiveness
4. Work with professional bodies to support and develop a National system that enables and recognises work based learning linked to the nursing/midwifery/healthcare staff career pathways/structures, individual effectiveness and team effectiveness.
5. Identify the skill-set necessary for staff to learn in and from practice, implement evidence in practice and provide safe and effective care.
6. Facilitate partnerships at a strategic level between all stakeholders (including Nurse / Midwife Managers, Practice Development Co-ordinators and teams, CNMEs, NMPDUs, General Managers, multidisciplinary teams, service users etc.) to enable the strategic objectives to be achieved and evaluated within specified timeframes.
7. Modernise healthcare curricula, building in the potential for practice development and shared learning opportunities.
8. Facilitate a national (virtual) practice development collaborative.

Strategic Themes

These eight strategic objectives map onto four (4) strategic themes for action:

1. Patient/carer experience and outcomes
2. Individual and team effectiveness
3. Systems effectiveness
4. Infrastructure
12. STRATEGIC THEMES FOR ACTION

12.1 Patient and Carer Experience and Outcomes

This theme reflects the need for all practice development to be underpinned by a systematic approach to patient and carer engagement at all its stages. Practice development needs to:

- reflect the expressed needs of patients and carers
- adopt methods that maximise opportunities for patient and carer participation
- evaluate the effectiveness of engagement processes and outcomes arising

OPERATIONAL OBJECTIVES

12.1.1 Develop patient focused practice development Key Result Areas.

12.1.2 Develop methodologies, tools and processes for evaluating patient and carer-centred outcomes in conjunction with service and education providers.

12.1.3 Establish practice development programmes to develop patient-centredness.

12.1.4 Incorporate partnership working with patients/carers in all practice development work.

12.1.5 Focus the development and evaluation of practice in the five dimensions of patient experience (derived from key themes in international ‘patient experience’ and effectiveness literature):

- Safety and effectiveness
- Information and choice
- Privacy and dignity
- Patient/carer involvement
- Environment

12.2 Individual and Team Effectiveness

This theme focuses on the development of knowledge, skills and expertise in undertaking practice development work. The evidence suggests the need to develop facilitation and work-based learning expertise and infrastructures. In addition, issues of role-clarity, role boundaries and role development need to be addressed as well as skill and competency development with clinicians that will enable practice to be developed across existing role and geographical boundaries. Having a robust and inclusive approach to individual and team effectiveness such as 360° feedback and accreditation frameworks will enable such effectiveness to be realised set within principles of collaboration, inclusion and participation.

OPERATIONAL OBJECTIVES

12.2.1 Make explicit the practice development and facilitation skill set needed at every level of the practice development framework.

12.2.2 Pilot a model of work-based learning across a range of services, focusing on practice development and facilitation skills at different levels and including professional and academic accreditation.

12.2.3 Identify opportunities for combining practice development and continuous professional development in organisations in collaboration with a range of service providers, including CNMEs, NMPDUs etc.
Identify Key Result Areas and standards for team effectiveness.

Identify generic competencies for staff to work across specific patient pathways (integrated care) as roles expand in response to patient/client need and the health system transformation programme taking note of principles identified in the Department of Health & Children’s discussion paper\(^7\), and related guidance documents, in relation to role expansion.

Develop self assessment tools for individuals and teams that will enable action planning against the competencies and standards.

Help to build teams across professional boundaries and geographical locations (hospital, primary, community and continuing care).

Implement a nationally coordinated and locally implemented 360° role evaluation with existing practice development co-ordinators and practice development facilitators in line with this strategic framework.

Work in partnership with organisations that have responsibility for professional development and professional regulation in the implementation of these areas of activity.

12.3 Systems Effectiveness

In order for practice development processes and outcomes to be embedded in the culture of organisations, there is a need to develop the organisational system for practice development. Successful practice development is considered to be so when it is an integral part of an organisation’s strategic direction and governance framework.

OPERATIONAL OBJECTIVES

In planning practice developments that bring about workplace culture change, a systematic analysis of individual workplaces should be taken in order to ensure that the development methods utilised are context specific.

Organisations should develop a shared set of practice development values and beliefs that are consistent with this strategy’s strategic purpose and that would inform methodologies utilised.

Establish a shared governance process in organisations for enabling and maintaining practice developments and that will operationalise the established patient/carer and individual/teams KRAs.

\(^7\) The Department of Health & Children has established a Steering Group in relation to Role Expansion.
12.4 Infrastructure
A range of infrastructure issues were raised in the data informing this strategy. The need for role clarity among stakeholders is central, as is the importance of developing collaborative, inclusive and participatory frameworks with providers of professional development and education. Having staff with the requisite knowledge, skills and expertise to facilitate a wide-range of development activities and underpinned by a range of methodologies is also key. Practice development informed by such methodologies adopts an inclusive and participatory approach to evaluation and thus a clear evaluation framework needs to be developed.

OPERATIONAL OBJECTIVES

2.4.1 A review of practice development roles (including job descriptions) should take place in organisations in order to develop the skill sets available to support practice development across organisations in line with this strategic framework.

2.4.2 Develop an infrastructure to support Workbased Learning, critical reflection, facilitation, research and evaluation by utilising untapped resources in organisations e.g. CNME’s, HEIs etc. and refocusing their role in a collaborative process with the Practice Development Unit and evaluate the outputs from this.

2.4.3 Revisit education requirements and standards by meeting with An Bord Altranais to explore how existing practice development standards in pre-registration education can be enhanced and built upon.

2.4.4 Explore ‘Shared Learning’ and joint working opportunities by introducing mechanisms where interdisciplinary and multidisciplinary team members can work together on specific projects but also focus on the sharing of modules across disciplines in relation to the implementation of this strategic framework in practice.

2.4.5 In developing a virtual National Practice Development Collaborative, explore how this could happen in collaboration with Northern Ireland in delivering an All-Ireland collaboration.

2.4.6 In evaluating practice development activities, develop a realist evaluation template in order to capture the diversity of evidence produced.
13. POLICY DIRECTION FOR PRACTICE DEVELOPMENT

Practice development as an approach to sustainable practice change has been growing in momentum internationally in recent years. The development of this strategic framework has provided an opportunity to explore and examine how practice development can provide a sustainable methodology to transform the culture and context of care to deliver a real person-centred care culture. The need to focus on the key strategic themes arising from the data underpinning this strategy in order to achieve such a culture is paramount. Thus for this culture to be developed, patient’s and carer’s experiences need to be held central to practice development activities (both in informing the need for practice development initiatives and in the conduct of practice development work); a broad perspective of effectiveness needs to be understood by key stakeholders that takes into account individual and team effectiveness; organisational systems need to support the development of person-centred practice cultures and the infrastructure needs to be developed that enables effective emancipatory facilitation models of engagement to be realised.

The National Steering Group recommends the following processes in order to implement the strategy:

1. Establish a National Working Group (See Appendix 6) of key stakeholders within a defined timeframe to develop the programmes of work drawing upon the evidence base collected during the strategy development phases. These programmes of work will include an implementation plan outlining key actions, on a cost neutral basis, and identify:
   a. Who is responsible for each action?
   b. Anticipated timeframes to achieve actions
   c. Budgetary source, if indicated (within current budgetary allocations)

2. Establish a ‘consultative group’ of key stakeholders, experts in the field of practice development, who can be liaised with for the development of action plans towards implementation: such a group would serve to provide a critical community that can engage with the strategy implementation, drawing on ways of working consistent with practice development principles and that enables a systematic collaborative approach to strategy implementation and review to be realised.

3. Develop a sub-group of the National Working Group to coordinate the evaluation of the strategy within an agreed time-frame. The effectiveness of this strategy needs to be evaluated. A participatory, inclusive and programmatic approach to evaluation needs to be adopted, drawing on mixed-methods approaches to evaluation and incorporating key stakeholder perspectives. The evaluation of ‘impact’ of the strategy implementation needs to be a key consideration.
REFERENCES


Department of Health & Children/Health Service Executive Working Group on Workforce Planning in the Public Health Service (2007) http://www.dohc.ie/working_groups/wpphs/


McCormack B Wright J Dewer B Harvey G Ballintine K, (2007c) A realist synthesis of evidence relating to practice development: interviews and synthesis of data. Practice Development in Health Care 6: (1) 56-75


APPENDIX 1
Examples of National Influencing Strategies, Reviews and Reports

## APPENDIX 2

**HSE Six Transformation Priorities**

- Develop integrated services across all stages of the care journey.
- Configure Primary, Community and Continuing Care services so that they deliver optimal and cost effective results.
- Configure hospital services to deliver optimal and cost effective results.
- Implement a model for the prevention and management of chronic illness.
- Implement standards based performance measurement and management throughout the HSE.
- Ensure all staff engage in transforming health and social care in Ireland.

(Health Service Executive 2006, p. 11)
## APPENDIX 3

Members of National Steering Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td><strong>Chairperson</strong> (until October 2007)</td>
<td>Nursing Policy Unit&lt;br&gt;Department of Health &amp; Children</td>
</tr>
<tr>
<td>Ms. Mary McCarthy&lt;br&gt;Chief Nursing Officer</td>
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<tr>
<td><strong>Chairperson</strong> (February 2008 – date)</td>
<td>Nursing Policy Unit&lt;br&gt;Department of Health &amp; Children</td>
</tr>
<tr>
<td>Ms. Sheila O’Malley&lt;br&gt;Chief Nursing Officer</td>
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</tr>
<tr>
<td>Ms. Elizabeth Adams&lt;br&gt;Director of Nursing&lt;br&gt;Deputy Nursing Services Director</td>
<td>Office of the Nursing Services Director, Health Services Executive</td>
</tr>
<tr>
<td>Ms. Kay Beggan&lt;br&gt;Director of Nursing</td>
<td>Vergmont Mental Health Services&lt;br&gt;HSE Dublin Mid-Leinster representing Mental Health Nurse Managers Ireland</td>
</tr>
<tr>
<td>Dr. Gary Brown&lt;br&gt;Head of Department of Nursing &amp; Health Care Studies</td>
<td>Tralee Institute of Technology representing the Institutes of Technology</td>
</tr>
<tr>
<td>Ms. Sibeal Carolan&lt;br&gt;Nurse Practice Development Co-ordinator</td>
<td>The Adelaide &amp; Meath Hospital incorporating the National Children’s Hospital representing the Dublin Academic Teaching Hospitals</td>
</tr>
<tr>
<td>Ms. Deirdre Corrigan&lt;br&gt;Director of Services</td>
<td>Cheeverstown House, Templeogue, Dublin representing the Nurse Managers Association for Intellectual Disability</td>
</tr>
<tr>
<td>Ms. Mary Cotter&lt;br&gt;Specialist Co-ordinator / Interim Director of the Centre for Nurse Education</td>
<td>Centre for Nurse Education, The Adelaide &amp; Meath Hospital incorporating the National Children’s Hospital representing the Irish Nurses Organisation</td>
</tr>
<tr>
<td>Ms. Ina Crowley&lt;br&gt;Practice Development Co-ordinator for Practice Nurses</td>
<td>Nursing and Midwifery Planning and Development Unit, HSE West</td>
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* Replaced by Ms. Annette Cuddy
* Replaced by Ms. Áine Lynch
<table>
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<tr>
<th>Name</th>
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<tbody>
<tr>
<td><strong>Ms. Annette Cuddy</strong></td>
<td>Nursing and Midwifery Planning and Development Unit, HSE West representing the Office of the Nursing Services Director, Health Services Executive</td>
</tr>
<tr>
<td>Assistant Director of Nursing and Midwifery</td>
<td></td>
</tr>
<tr>
<td><strong>Ms. Aisling Culhane</strong></td>
<td>Psychiatric Nurses Association</td>
</tr>
<tr>
<td>Research and Development Advisor</td>
<td></td>
</tr>
<tr>
<td><strong>Ms. Mary Day</strong></td>
<td>Nursing Policy Unit, Department of Health &amp; Children</td>
</tr>
<tr>
<td>Director of Nursing (2008 – date)</td>
<td></td>
</tr>
<tr>
<td><strong>Ms. Mary Durkin</strong></td>
<td>Sligo General Hospital representing SIPTU Nursing</td>
</tr>
<tr>
<td>Clinical Nurse Manager 3</td>
<td></td>
</tr>
<tr>
<td><strong>Dr. Naomi Elliot</strong></td>
<td>School of Nursing and Midwifery, Trinity College Dublin representing the Irish Universities Association</td>
</tr>
<tr>
<td>Lecturer</td>
<td></td>
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<tr>
<td><strong>Dr. Malachy Feely</strong></td>
<td>Nursing and Support Staff Policy Unit, Department of Health &amp; Children</td>
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<tr>
<td>Nurse Advisor</td>
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<tr>
<td><strong>Mr. Paul Gallagher</strong></td>
<td>St. James Hospital representing the Dublin Academic Teaching Hospitals</td>
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<tr>
<td>Director of Nursing</td>
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<tr>
<td><strong>Ms. Patricia Healy</strong></td>
<td>Nursing and Midwifery Planning and Development Unit, Tullamore</td>
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<tr>
<td>Practice Development Facilitator (Midwifery)</td>
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<td>10 Resigned from Steering Group March 2009</td>
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<tr>
<td><strong>Ms. Carol Hillard</strong></td>
<td>Our Lady’s Hospital for Sick Children, Crumlin, Dublin</td>
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<tr>
<td>Nurse Practice Development Co-ordinator (Paediatrics)</td>
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<tr>
<td><strong>Ms. Jenny Hogan</strong></td>
<td>National Council for the Professional Development of Nursing &amp; Midwifery</td>
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<tr>
<td>Professional Development Officer</td>
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<tr>
<td>Ms. Hannah Kent</td>
<td>University College Hospital, Galway</td>
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<tr>
<td>Ms. Áine Lynch</td>
<td>The Adelaide &amp; Meath Hospital incorporating the National Children's Hospital, Dublin Academic Teaching Hospitals</td>
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<tr>
<td>Ms. Mairead Lyons</td>
<td>Connolly Hospital, Blanchardstown representing Irish Nursing and Midwifery Practice Development Co-ordinators Association</td>
</tr>
<tr>
<td>Ms. Mary F. McCarthy</td>
<td>HSE Dublin North East representing the Directors of Nursing and Midwifery Planning and Development Units</td>
</tr>
<tr>
<td>Ms. Martina McGuinness</td>
<td>Mental Health Services, HSE-Dublin Mid-Leinster</td>
</tr>
<tr>
<td>Ms. Louise McMahon</td>
<td>Dublin South Hospital Group, National Hospitals Office, HSE</td>
</tr>
<tr>
<td>Ms. Ann Louise Mulhall</td>
<td>Coombe Woman and Infant's University Hospital, Dublin representing the Association of Centres of Nursing and Midwifery Education</td>
</tr>
<tr>
<td>Ms. Imelda Noone</td>
<td>St. Brendan’s Hospital, Dublin</td>
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<tr>
<td>Dr. Siobhán O’Halloran</td>
<td>Office of the Nursing Services Director, Health Services Executive</td>
</tr>
<tr>
<td>Ms. Andrea O’Reilly</td>
<td>Bru Chaoimhin, Cork St., Dublin 8</td>
</tr>
<tr>
<td>Ms. Mary Owens</td>
<td>Mallow General Hospital representing the Irish Association of Directors of Nursing &amp; Midwifery</td>
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11 Resigned from Steering Group December 2008
12 Replaced Ms. Sibeal Carolan
13 Replaced Mr. Jimmy Walsh in 2009
14 Represented by Ms. Liz Adams and Ms. Annette Cuddy
<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td><strong>Ms. Julie Pryce</strong></td>
<td>St. John of God North East Services, St. Mary’s, Drumcar, Dunleer, Co. Louth</td>
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<tr>
<td>Nurse Practice Development Co-ordinator (Intellectual Disability)</td>
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<tr>
<td><strong>Dr. Anne Marie Ryan</strong></td>
<td>An Bord Altranais</td>
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<tr>
<td>Chief Education Officer</td>
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<tr>
<td><strong>Ms. Philippa Ryan Withero</strong></td>
<td>The Adelaide &amp; Meath Hospital incorporating the National Children’s Hospital</td>
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<tr>
<td>Acting Nurse Practice Development Advisor</td>
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<tr>
<td><strong>Ms. Sheila Sugrue</strong></td>
<td>Nursing Policy Unit</td>
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<tr>
<td>Nurse / Midwife Advisor</td>
<td>Department of Health &amp; Children</td>
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<tr>
<td><strong>Ms. Bernadette Toolan</strong></td>
<td>HSE Mid-Western Regional Maternity Hospital</td>
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<tr>
<td>Midwifery Practice Development Co-ordinator</td>
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<tr>
<td><strong>Ms. Catherine Tunney</strong></td>
<td>Nursing and Midwifery Planning and Development Unit, HSE Dublin North East</td>
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<tr>
<td>Regional Practice Development Officer for Public Health Nursing</td>
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<tr>
<td><strong>Mr. Jimmy Walsh</strong></td>
<td>The Association of Centres of Nursing and Midwifery Education</td>
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<tr>
<td>15 Director Regional Centre of Nurse Education, The Adelaide &amp; Meath Hospital incorporating the National Children’s Hospital</td>
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<tr>
<td><strong>Ms. Sandra Walsh</strong></td>
<td>Nursing Policy Unit</td>
</tr>
<tr>
<td>Assistant Principal Officer</td>
<td>Department of Health &amp; Children</td>
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</tbody>
</table>

15 Replaced by Ms. Ann Louise Mulhall in 2009
APPENDIX 4
Data Collection Framework for Practice Development Initiatives

1. Title
2. Background Information
3. Summary
4. Methods Used
5. Evaluation/Outcomes Measured (if completed)
## APPENDIX 5

Membership of Expert Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td><strong>Ms. Mary Day</strong></td>
<td><strong>Mater Misericordiae Hospital, Dublin</strong></td>
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<tr>
<td>Director of Nursing</td>
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<tr>
<td><strong>Dr. Jan Dewing</strong></td>
<td><strong>Honorary Research Fellow University of Ulster, Visiting Professor SNMIH University of Wollongong NSW Australia</strong></td>
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<tr>
<td>Independent Consultant Nurse</td>
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<tr>
<td><strong>Ms. Liz Henderson</strong></td>
<td><strong>Northern Ireland Cancer Network</strong></td>
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<tr>
<td>Network Nurse Director</td>
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<tr>
<td><strong>Ms. Geraldine Hynes</strong></td>
<td><strong>Practice Development Degree Programme, Royal College of Surgeons of Ireland, Dublin</strong></td>
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<td>Lecturer</td>
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<td><strong>Prof. Kim Manley</strong></td>
<td><strong>Royal College of Nursing, London</strong></td>
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<tr>
<td>Manager – Resources for Learning &amp; Improving/Lead for Quality and Standards</td>
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<tr>
<td><strong>Ms. Mary McCarthy</strong></td>
<td><strong>Nursing Policy Unit Department of Health &amp; Children</strong></td>
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<tr>
<td>Former Chief Nursing Officer</td>
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<tr>
<td><strong>Prof. Brendan McCormack</strong></td>
<td><strong>Institute of Nursing Research/School of Nursing, University of Ulster</strong></td>
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<tr>
<td>Professor of Nursing Research/Postgraduate Tutor</td>
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<tr>
<td><strong>Ms. Sheila O’Malley</strong></td>
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<td>Chief Nursing Officer, (Chair National Steering Group 2008 – date)</td>
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<td><strong>Dr. Theresa Shaw</strong></td>
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<td>Nurse / Midwife Advisor</td>
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APPENDIX 6
National Working Group

Draft Aims
To develop programmes of work drawing upon the evidence base collected during the review of practice development in nursing and midwifery in Ireland and the development of the strategic framework.

Draft Terms of Reference

1. To prepare a comprehensive operational plan for the implementation of the findings from the Report of the Review of Practice Development in Nursing and Midwifery in Ireland and the Development of a Strategic Framework. Preparation of this plan will be supported by reference to the following:
   a. Patient and carer centredness and engagement
   b. Quality and safety
   c. Evidence based practice
   d. Integration
   e. Partnership / collaboration
   f. Transformation
   g. Capacity building
   h. Use of existing expertise
   i. Interdisciplinary and multidisciplinary working
   j. Shared learning
   k. Local and national linkages
   l. Communication
   m. Evaluation

2. To develop programmes of work outlining key actions, on a cost neutral basis, including identifying:
   a. Who is responsible for each action?
   b. Anticipated timeframes to achieve actions
   c. Budgetary source, if indicated (within current budgetary allocations)

3. To identify existing supports that nursing and midwifery can utilise in ensuring implementation of the practice development framework.

4. To coordinate the evaluation of the strategy.

5. To report to the Nursing Policy Unit, Department of Health & Children.

In carrying out its terms of reference, the National Working Group shall take into account the Strategic and Operational Objectives identified in the Report of the Review of Practice Development in Nursing and Midwifery in Ireland and the Development of a Strategic Framework.
## APPENDIX 7

### Contributors to the Strategy Development

<table>
<thead>
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<th>Patricia Healy</th>
<th>Joan Phelan</th>
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<td>Elizabeth Heffernan</td>
<td>Sharon Phelan</td>
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<td>Naomi Bartley</td>
<td>Liz Henderson</td>
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<td>Kay Beggan</td>
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<td>Rose Bennett</td>
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<td>Mary Boyd</td>
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<td>Garry Brown</td>
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<td>Helen Byrne</td>
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<td>Sibeal Carolon</td>
<td>Teresa Lally</td>
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<td>Peter Donnelly</td>
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<td>Mairéad Durkan</td>
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<td>Dr Naomi Elliot</td>
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<td>Susan Hawkshaw</td>
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