A Snapshot of Public Health Nursing and Community Registered General Nursing in Ireland

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Foreword

It gives me great pleasure to publish this report; A Snapshot of Public Health Nursing and Community Registered General Nursing in Ireland. This report is significant as it is the first Irish Nurses and Midwives Organisation baseline survey to capture Public Health Nurses’ (PHNs) and Community Registered General Nurses’ (CRGNs) perceptions of working in the community environment and the quality of care provided to their patients/clients over the past year.

Ireland is not unique in searching for new and innovative ways of providing effective, efficient and financially viable health care; reducing the reliance on acute services and transiting services to the community. The new model of care outlined in the *Programme for Government* (2013) identifies primary care as the main channel for health service delivery reducing the over reliance on acute services. Governments throughout the world have undertaken this type of health system reform, focused on delivering service in the community, in response to economic, political, ideological or epidemiological processes. It is recognised worldwide that nursing and midwifery delivers the highest proportion of direct patient/client care. Therefore, nursing and midwifery undoubtedly exerts considerable influence over whether, in reality, the change advocated by health policy makers can actually be achieved. In response to escalating costs and a vision to improve and protect the health of the population by providing a safe, high quality, accountable and sustainable health care system, the health reform agenda has evolved towards community services. PHN and CRGN are key components in leading, planning, developing, delivering and evaluating many elements of the Government’s commitments.

In total 632 PHNs and CRGNs responded to the INMO online survey, which was launched in March 2013 – a 52% response rate. The questionnaire covered four main themes, employment, working environment, patient/client care and job satisfaction. While aspiring to deliver appropriate, safe and high quality nursing and midwifery care to patients/clients, PHNs and CRGNs are confronted by reduced staffing levels due to the moratorium, significant variation in caseloads, increasing workloads, an ageing and growing population, widening gaps in health status, escalating demands due to the shift from acute to community care, inadequate technical and administrative support. In addition, the on-going changes in policy direction, for example, the shift towards the management of chronic diseases without appropriate resourcing, is causing a significant additional burden on an already overstretched service.

I wish to express my sincere appreciation to all PHNs and CRGNs for taking the time to share their perspectives and experiences of delivering nursing and midwifery services in the community. Their contribution is invaluable in relation to highlighting key concerns and identifying appropriate and realistic solutions. In every aspect of community health services the contribution of PHNs and CRGNs is fundamental. This report will form a vital part of the INMO strategic plan to address issues and engage with Government, the Health Service Executive and key policy makers to support safe and appropriate nursing and midwifery services in the community.

Finally, I wish to acknowledge the staff of the Professional Development Centre and Library under the direction of Elizabeth Adams with particular appreciation to Aileen Rohan, Niamh Adams, Sheila Normanly and Linda Doyle with the support of their colleagues Jean Carroll, Marian Godley, Muriel Haire, Rhona Ledwidge, Edel Reynolds and Helen O’Connell.

Liam Doran
General Secretary, Irish Nurses and Midwives Organisation
Section 1: Introduction

1.1 Introduction

Public health nurses (PHNs) have traditionally provided the core nursing and midwifery care in the community, with community registered general nurses (CRGNs) in more recent times, supporting and contributing to community services. Since their establishment, their role in delivering patient/client care in the community has evolved; and more significantly, the environment - both societal and political - in which they work to provide nursing and midwifery service to patients/clients has changed. The move to a primary care model and the reconfiguration of services has had major implications for the future of nursing and midwifery in the community. An Expert Advisory Group established by the Office of the Nursing and Midwifery Services Director, Health Service Executive (HSE) recently examined public health nursing services in Ireland, seeking the views of Directors of Public Health Nursing and Assistant Directors of Public Health Nursing (2012). However, there is little information regarding the views of PHNs and CRGNs and their contribution to the new model of care, and the role and functions that they will be expected to provide. While the Government of the day produces new strategies and policy documents, it is the nurses and midwives in the community who are continually adapting to reform in order to implement these changes. These changes have increasingly led to both over extension of the PHN and CRGN role, as well as confusion surrounding role definition.

Against this background, the Irish Nurses and Midwives Organisation (INMO) sought to gather information from its PHN and CRGN members regarding their current working environments, roles, working arrangements and perceptions of the type of nursing and midwifery care they are required to provide in the community. This survey forms part of this information gathering process. In particular, the survey aims to:

- Gather information regarding the current status of PHN and CRGN work environments
- Elicit the views of PHNs and CRGNs regarding several key areas related to community nursing.

The report begins in Section 2 by providing a short history of community nursing and a brief look at the policy documents surrounding community nursing and midwifery. Section 3 provides a demographic profile of the nurses and midwives working in the community based on the survey responses. Section 4 provides an overview of staffing in the area of community nursing and the subsequent caseload and workload issues. The working relationships and team working environment is also discussed. The views of PHNs and CRGNs regarding patient/client care is discussed in Section 5. Section 6 looks at their satisfaction with the job. The opportunities and challenges facing PHNs and CRGNs are listed in Section 7, and the final section, Section 8, provides a brief conclusion to the report.

1.2 Methodology

The online survey (Appendix 1) was developed through SurveyMonkey.com based on the Royal College of Nursing’s (RCN, United Kingdom) annual survey The Community Nursing Workforce in England (2012). In addition, the Report of the Irish RN4CAST Study 2009 - 2011: a nursing workforce under strain (Scott, Kirwan, Matthews, et al., 2013) informed the survey development.

According to the personnel census from the Health Service Executive (2013), there are 1,521 PHNs employed in Ireland. There are no separate numbers available for CRGNs, as they are not listed separately, either in the personnel census, nor with An Bord Altranais agus Cnáimhseachais na hÉireann (the Nursing and Midwifery Board of Ireland, NMBI). Within the membership system of the Irish Nurses and Midwives Organisation, 729 email addresses are listed for PHNs and 483 are listed for CRGNs. All of these members were sent an invitation to complete the survey online.

The survey was further publicised on INMO websites. A rotating icon was placed on the homepage of http://www.inmo.ie in two locations and fixed icons were placed within the Your Career, Workshops and Section pages. A fixed icon was placed on the homepage of http://www.nurse2nurse.ie. In addition, posters and a covering letter were sent to all health centres in Ireland inviting further participants.
The survey was launched on 8 March 2013 and closed on the 12 April 2013. A final reminder email was sent on the 9 April 2013 to encourage additional respondents. More than half of the 1,212 PHNs and CRGNs on the INMO membership system took part in the survey. A total of 632 questionnaires (52% response rate) were received and analysed using both statistical and thematic analysis. Response numbers can vary where there were multiple answer possibilities.
Section 2: An Overview of Community Nursing

In Ireland, PHNs have traditionally been the core of community nursing and midwifery services. However, the role of public health nursing has been the subject of increasing discussion both nationally and internationally over recent years, particularly in light of changing models of health service delivery that are being implemented in response to changing patient/client needs. The CRGN, on the other hand, has developed in an ‘ad hoc’ manner and there is very little research available on this role within community services in Ireland.

2.1 A Short History of Community Nursing and Midwifery in Ireland

The Poor Relief (Ireland) Act 1851 marked the formal introduction of community nursing and midwifery as separate from hospital based nursing in Ireland (Parliament of Great Britain, 1851). The Act made provision for district midwifery services. Community nursing and midwifery services were also provided by voluntary and religious orders. In 1915 the Notification of Births (Extensions) Act 1915 (Parliament of Great Britain, 1915) allowed for the employment of nurses to provide home health promotion services to children less than five years of age and in 1924 a school health service was introduced and included nurses who were referred to as public health nurses. However, it wasn’t until 1960 that a separate register for public health nursing was established by An Bord Altranais (succeeded by An Bord Altranais agus Cnáimhseachais na hÉireann, Nursing and Midwifery Board of Ireland). This new category represented an amalgamation of existing domiciliary nursing, community midwifery services and voluntary district nursing services. Educational courses were introduced by An Bord Altranais at this time for those already in the community, in addition to those nurses and midwives who aspired to become a public health nurse. The courses ranged from two to six months duration, depending on whether or not the nurse or midwife was already working in a community nursing service.

The current concept of public health nursing is derived from a Department of Health Circular issued in 1966. The circular provided a very broad outline of the aim of the public health nursing service, which was that PHNs would be: “available to individuals and to families in each area throughout the country, more specifically, … to provide such domiciliary midwifery services as may be necessary; general domiciliary nursing, particularly for the aged; and at least equally important, to attend to the public health care of children from infancy to the end of the school going period” (Department of Health, 1966, para. 7).

Up until the late 1970s PHNs were the only nurses and midwives employed in the community. However, following a review of community nursing services in 1979 and falling PHN numbers, CRGNs were introduced on a temporary basis. Since then the role has been developed in an ‘ad hoc’ way and there is no mandatory education, training, or induction and no career path, nor opportunity for advancement. Following recommendations made in the Report of the Commission on Nursing (Government of Ireland, 1998), some CRGNs have been employed permanently in the community alongside PHNs, while others continue to be employed on a temporary basis. Moreover, studies indicate that there is little equity in the distribution of the CRGN in the community (Hanafin and Cowley, 2005).

The Department of Health and Children (DOHC) circular which defines the role of the CRGN states: “The CRGN will be expected to maintain a high standard of nursing care, to share responsibility with the community nursing team for the management of nursing care and the patients’ environment and to maintain a high standard of professional and ethical responsibility. To liaise closely with and support the PHN service as part of a community nursing team in accordance with a care plan developed with a PHN” (DOHC, 2000).

2.2 Roles of PHNs and CRGNs

The PHN’s role is traditionally described as ‘generalist’ and a role that covers all patient/client types from the ‘cradle to the grave’, with caseloads including all age ranges from newborns to the older person. The role has been described as “health promoter, manager and clinician” (Hanafin, 1997). PHNs in Ireland currently work as part of a multidisciplinary team and provide a generalist nursing service to a broad range of patient/client groups including children, older people, new mothers, families, those who are terminally ill, those with complex disabilities, refugees and members of the travelling community.
The CRGN works alongside the PHN in a role that has been developed in an ‘ad hoc’ manner without any clear plan. The primary focus of the CRGN work is on individual patient/client, usually the older person care. Hanafin, Houston and Cowley (2002) observed that registered general nurses were undertaking the hands on care of the older person and the public health nurse managed the caseload.

According to the recent report by the Irish Longitudinal Study on Ageing, public health and community nursing services are strongly concentrated in the older age groups. (Mc Namara, Normand and Whelan, 2013)

2.3 Population of Ireland

Results from the Census 2011 (Central Statistics Office, 2012), show that the population of Ireland is continuing to increase, although at a slower rate than in previous years. Over the past decade, the birth rate in Ireland has increased by 27% from 57,854 in 2001 to 73,424 in 2010. Significantly though, results show that the number as well as the proportion of the population in the older age groups is increasing rapidly. The number of people aged over 65 years has increased by approximately 24% in the period from 2003-2012. Each year the total number of people over the age of 65 grows by around 20,000. Population predictions state that the population over 65 will more than double over the next 30 years, with evident implications for health service planning and delivery.

2.4 Health Policy in Ireland

Ireland, similar to other countries, has been involved in health service reform for decades, in particular, since the publication of the National Health Strategy, *Quality and Fairness: A Health System for You* (DOHC, 2001b) and the National Primary Care Strategy document *Primary Care: A New Direction* (DOHC, 2001a). These documents outline a model of health service delivery that aims to match the needs of patients/clients with the skills and competencies available from within an interdisciplinary primary care team of health and social care professionals. It is envisaged that all individuals will enrol with a primary care team and a GP within the team. The broad skill mix of a team will enable each team member to work to their maximum professional capacity.

The new model of care outlined in the *Programme for Government* (Government of Ireland, 2013) identifies primary care as the main channel for health service delivery, with a reduction in what is seen as an over reliance on the acute health services. It states that the current system is unfair to patients, often does not meet their needs in a timely manner and does not deliver value for money. In order to achieve this new model, there will be an emphasis on local access to healthcare, delivered as close as possible to people’s homes and through the grouping of community healthcare professionals into multidisciplinary teams and networks consistent with a Primary, Community and Continuing Care (PCCC) reconfiguration framework. This model reflects a shift in focus from acute to community-based care, a trend that is occurring at global level. The Department of Health published its *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015* (2012a), in which the details for the reform of the current model of delivering healthcare are described. Along with reforming the current model of delivering healthcare, there will also be significant developments in the administration of health financing with the new programme *Money Follows the Patient* (Department of Health, 2013) to be implemented. This is a key element for universal health insurance and is a system that will provide a fairer and more transparent basis for funding hospital services. It will drive greater efficiency in the delivery of services and will ultimately support the provision of quality care in the most appropriate setting.
Section 3: Employment and Working Environment

This section presents the quantitative results from the questionnaire. It describes the demographic profile of the respondents as well as their employment details, working environment and patient/client groups.

3.1 Demographic Profile of Respondents

Although the survey targeted PHN and CRGNs, a number of titles and grades fell under the surveys’ remit. Two-thirds of respondents (66%, n=404) could be strictly defined as PHNs, whilst 24% (n=147) were Staff Nurses, or CRGNs. The remainder of the participant group consisted of the following: Assistant Directors of Public Health Nursing (6.69%, n=41), Directors of Public Health Nursing (0.82%, n=5), Advanced Nurse Practitioners (0.33%, n=2), Clinical Nurse Managers 1 (0.82% n=5) and 2 (0.16%, n=1), and Clinical Nurse Specialists (1.31%, n=8). (Table 1). The vast majority of respondents (98%, n=608) were female.

Table 1 - Official grade category

<table>
<thead>
<tr>
<th>What is official grade category?</th>
<th>Response Percent</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Nurse</td>
<td>65.90%</td>
<td>404</td>
</tr>
<tr>
<td>Registered Staff Nurse (Community RGN)</td>
<td>24.00%</td>
<td>147</td>
</tr>
<tr>
<td>Assistant Director of Public Health Nursing</td>
<td>6.70%</td>
<td>41</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>1.30%</td>
<td>8</td>
</tr>
<tr>
<td>Clinical Nurse Manager 1 (CNM1)</td>
<td>0.80%</td>
<td>5</td>
</tr>
<tr>
<td>Director of Public Health Nursing</td>
<td>0.80%</td>
<td>5</td>
</tr>
<tr>
<td>Advanced Nurse Practitioner</td>
<td>0.30%</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Nurse Manager 2 (CNM2)</td>
<td>0.20%</td>
<td>1</td>
</tr>
</tbody>
</table>

answered question 613
skipped question 19
3.2 Contract Status

The breakdown for permanent versus temporary positions showed just under 8% (n=47) of respondents on temporary contracts (Figure 1). Total respondents = 614.

*Figure 1 - Contract status*

The majority (36%, n=188) of respondents have been in their current position between 5 and 10 years. The next highest category are those over 10 years in their current post at 27% (n=144). A total of 24% (n=128) of respondents reported being in their current position for less than five years. Only 7% (n=35) and 6% (n=31) respectively reported being in their current position less than one year or over 20 years (Figure 2). Total respondents = 526.

*Figure 2 - Length of time in current position*
3.3 Grades and Acting Roles

The majority of respondents (58%, n=305) were at the highest point on their pay scale grade. A total of 12% (n= 62) of respondents were at the starting point of their grade, and 30% (n=154) at the mid-point. Total respondents = 521.

More than 11% (n=70) of respondents indicated that they were in ‘acting up’ positions. Total respondents = 618. Respondents were then asked a secondary question as to the longevity of their ‘acting up’ status in months and/or years. Of the sample who answered this section 49 respondents had worked an average of 8 months only. However, 58 respondents noted that their ‘acting up’ roles had stretched into a category of years and months. An average of slightly over 4 years was spent performing such roles (Figure 3). Only 30% (n=26) of those indicating ‘acting up’ were being paid for the position (Figure 4).

Figure 3 - Acting up position

![Figure 3 - Acting up position](image)

In addition to your official grade category, are you acting up into another grade position?

- Yes: 11.3%
- No: 88.7%

Figure 4 - Payment for acting up position

![Figure 4 - Payment for acting up position](image)

Are you getting paid for this acting position?

- Yes: 30.2%
- No: 69.8%
3.4 Hours Worked, Overtime and Weekends

Respondents were requested to provide details of contracted working hours and their experience working overtime.

Respondents were questioned as to whether overtime was paid or unpaid by their employer, and to clarify, if paid, how much overtime they would complete in an average week. A total of 95% (n=455) of respondents indicated that there was 'no paid overtime' at their place of work. Of the remaining 5% (n=24) who did receive payment, the average number of paid overtime hours per week was six. Total respondents = 479.

Respondents were then asked how much unpaid overtime they worked in an average week (outside of contracted hours), with 82% (n=403) of respondents stating that they regularly worked unpaid overtime. Due to the variation in week-to-week working practice, an average number of hours unpaid overtime worked per week could not be accurately calculated. However, respondents noted regularly working through breaks and lunch, and continuing to work well after their shifts had officially finished. Anything from 0.5 to 15 hours of unpaid overtime was being noted on a regular basis.

Half of respondents (50%, n=244) said they had worked weekends in the past year, with an average of 4 weekends per year worked, amounting to 1,891 weekends in total.

3.5 Work Location

The HSE regional breakdown of respondents is illustrated below in Figure 5.

*Figure 5 - Work location by HSE region*

A total of 41% (n=202) of respondents noted their area as predominantly urban, 24% (n=118) as equally urban and rural, and nearly 35% (n=169) as predominantly rural (Figure 6). Total respondents = 490.
The majority of respondents (71%, n=313) noted that they worked from a health centre base, with the remainder working from primary care centres. Total respondents = 444.

3.6 Care Groups in Receipt of PHN/CRGN Services

The survey captured the care groups in receipt of the professional services of PHNs and CRGNs. Unsurprisingly with Ireland’s notably high percentage of older population, Older Persons featured as the largest of the care groups at 91% (n=427).

The Palliative/End of Life Care group was similarly high at 84% (n=396), with Chronic Disease featuring with 77% (n=363) of respondents. Disability Services were seen by 70% (n=331). Child and Family Health with Health Promotion and Community Development at 76% (n=359) and 72% (n=339), respectively. Finally Nurse/Midwife Led Clinic Service and School Health took 51% and 37%. All ‘Other’ forms of standard care accounted were noted as only 17 % (Table 2). Total respondents = 471.

Table 2 - Care group categories

| Which of the following fall under your remit? Please tick all that apply to you. |
|---------------------------------|----------|---------|
| Answer Options                  | Response Percent | Response Rate |
| Older Persons Health            | 90.7%   | 427     |
| Palliative Care/End of Life Care| 84.1%   | 396     |
| Chronic Disease Management      | 77.1%   | 363     |
| Child and Family Health         | 76.2%   | 359     |
| Health Promotion and Community Development | 72.0% | 339 |
| Disability Service              | 70.3%   | 331     |
| Nurse/Midwife Led Clinic service| 50.7%   | 239     |
| School Health                   | 36.9%   | 174     |
| Other                           | 17.2%   | 81      |

answered question 471
skipped question 161
Section 4: Workload and Staffing

This section addresses the number one concern of all of the survey respondents – the issue of staffing and the knock on effect that it has with caseload, workload and leave.

4.1 Staffing Levels

As staffing levels are the number one concern of nurses and midwives working in the community, the survey asked about staffing level changes in the past 12 months (Table 3).

<table>
<thead>
<tr>
<th>Table 3 - Staffing level changes in the past year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Answer Options</strong></td>
</tr>
<tr>
<td>Yes - staffing levels have decreased</td>
</tr>
<tr>
<td>Yes - staffing levels have increased</td>
</tr>
<tr>
<td>No change in staffing levels</td>
</tr>
<tr>
<td>Not sure / don't know</td>
</tr>
</tbody>
</table>

The moratorium on recruitment has been in place since March 2009 (HSE, 2012) and official Department of Health statistics show that the number of nursing staff employed by the HSE has reduced from a high of 39,006 in 2007 to 34,736 in 2013 (Department of Health, 2012b, p.46). A closer investigation of the figures for primary and community care, show that there has been an approximate 14% reduction in nursing staff in this area in the period from 2009-2013 (HSE, 2013, p.12).

Respondents were further questioned on changes to staffing levels within their own specific teams. The majority of respondents, 67% (n=256) noted a recruitment freeze, as would be expected in light of the recruitment moratorium. This understandably resulted in 51% (n=196) of respondents commenting on an expansion of their roles, wherein they, or their teams, were expected to cover wider areas. Redistribution/Redeployment of staff also featured highly (38% n=144) and merged or restructured services counted for 21% (n=79).  One survey respondent commented:

"...with the moratorium on recruitment; no relief for pregnancy, maternity, sick and annual leave; and the fact that positions where PHNs/CRGNs have retired have not been filled, ultimately the service is stretched beyond limit." - Survey Respondent.

Voluntary redundancies and severance were noted by 23% (n=87). A specific ban on the use of agency staff was noted by 19% (n=72). The reduction of opportunities to access clinical supervision/mentoring was identified as a concern by a significant number of respondents (38%, n=145). In addition, 10% (n=39) noted actual service closures (Table 4). Total respondents = 382.
4.2 Caseload

Responses indicate that there is significant variation in the population numbers and caseloads. However, the majority of respondents who answered this question indicated that they worked in areas with a population up to 5,000 (n=116). Hanafin and Cowley (2005) found that the mean average size of population per public health nurse was 1:4000. This is a significant increase in the ratio since 1995 when the average was found to be 1:3000.

The importance of this data relates to the method of determining the workload of PHNs and CRGNs. PHNs have for a long time argued against the current approach that is dominated by population numbers rather than population needs or ‘vertical equity’ as this latter approach is often referred to (Hanafin, Houston and Cowley 2002; Institute of Community Health Nursing, 2007). Certainly the ‘numbers’ approach would be at odds with the aspirations of the Primary Care Strategy (DOHC, 2001a), which stresses the importance of a population health needs approach. It would seem, however, that despite these assertions in the Primary Care Strategy and subsequent documents - including the Health Services Executive (2008) Population Health Strategy - that PHNs are still being allocated according to population numbers. Certainly going forward, if the primary care and population health strategies are to be realised, the historic practice of allocating nursing and midwifery services and other resources based on population numbers must be discarded in favour of a population health needs approach.

4.3 Workload

Staffing issues including the recruitment freeze, redeployment and expansion of the nurse and midwife roles have had a huge impact on the workload of respondents. Compounding these issues are large amounts of documentation and an increased demand on health services.

A total of 70% (n=321) of respondents felt that they do not always have enough time to deliver the required level of care to meet patient/client needs, and 87% (n=410) stated that their workload had increased in the past year.

Although no national standard workload measurement tool exists, 79% (n=362) of respondents reported using a locally agreed assessment tool for patients/clients. (Table 8).

---

**Table 4 - Reasons for nursing staffing levels changes within your team**

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment freeze with vacancies left unfilled</td>
<td>67.0%</td>
<td>256</td>
</tr>
<tr>
<td>Role expansion (eg. staff cover wider areas)</td>
<td>51.3%</td>
<td>196</td>
</tr>
<tr>
<td>Fewer opportunities for access to clinical supervision/mentoring</td>
<td>38.0%</td>
<td>145</td>
</tr>
<tr>
<td>Redistribution/redeployment of staff</td>
<td>37.7%</td>
<td>144</td>
</tr>
<tr>
<td>Redundancies/voluntary severance</td>
<td>22.8%</td>
<td>87</td>
</tr>
<tr>
<td>Services merged or restructured</td>
<td>20.7%</td>
<td>79</td>
</tr>
<tr>
<td>Agency use ban</td>
<td>18.8%</td>
<td>72</td>
</tr>
<tr>
<td>Other</td>
<td>15.9%</td>
<td>61</td>
</tr>
<tr>
<td>Service closures</td>
<td>10.2%</td>
<td>39</td>
</tr>
</tbody>
</table>

answered question: 382
skipped question: 250
The increased pressures of workload and staffing have been cited by a number of respondents as having a negative effect on their working environment and job satisfaction.

4.4 Relief Cover

A knock on effect of difficulties with staffing levels results in issues around relief and cross cover. The response to whether relief staff are available to cover sick leave, holidays or similar, a staggering 87% (n=400) replied in the negative (Figure 7). Total respondents = 461.

Figure 7 – Availability of relief staff

Cross cover is continually cited by respondents as a major burden on workload, with nearly 47% (n=241) of respondents stating that they “often” provide cover for nursing colleagues (Table 5). Total respondents = 515.

“Increases in workload, staff burnout and unhappiness in the workplace has a negative impact on patient care.” - Survey Respondent.

“Staff leaving on maternity / sickness / moved to other areas are not being replaced adding extra strain on staff / workloads already working in the community.”
- Survey Respondent.
Table 5 – Cover provided to nursing colleagues

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often</td>
<td>46.8%</td>
<td>241</td>
</tr>
<tr>
<td>Always</td>
<td>28.3%</td>
<td>146</td>
</tr>
<tr>
<td>Sometimes</td>
<td>16.3%</td>
<td>84</td>
</tr>
<tr>
<td>Never</td>
<td>4.9%</td>
<td>25</td>
</tr>
<tr>
<td>Rarely</td>
<td>3.7%</td>
<td>19</td>
</tr>
</tbody>
</table>

answered question | 515
skipped question | 117

4.5 Team Work

There are many benefits associated with team working, including an enhanced patient/client centred and responsive service, a more cost effective service that supports and promotes job satisfaction amongst health professionals. (Forum on Teamworking in Primary Healthcare, 2000, p.15). Multidisciplinary care teams are an essential component of working in the community sector. A total of 70% (n=334) of respondents said other allied health professionals were assigned to their bases (Figure 8). Total respondents = 480.

PHNs and CRGNs reported liaising with community multidisciplinary healthcare professionals in all areas of specialities, hospital-based professionals and services, and community-based social services professionals and groups. Respondents detailed the types of professionals assigned to their base as follows: Occupational Therapist (80%, n=259), Physiotherapist (77%, n=247), Speech and Language Therapist (76%, n=248), Dietitian/Nutritionist (48%, n=154) (Table 6). Total respondents = 324.

Figure 8 – Availability of allied health professionals
Table 6 - Allied health professionals assigned to your base

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapist</td>
<td>79.9%</td>
<td>259</td>
</tr>
<tr>
<td>Speech and Language Therapist</td>
<td>76.5%</td>
<td>248</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>76.2%</td>
<td>247</td>
</tr>
<tr>
<td>Dietitian/Nutritionist</td>
<td>47.5%</td>
<td>154</td>
</tr>
<tr>
<td>Other</td>
<td>42.6%</td>
<td>138</td>
</tr>
<tr>
<td>answered question</td>
<td></td>
<td>324</td>
</tr>
<tr>
<td>skipped question</td>
<td></td>
<td>308</td>
</tr>
</tbody>
</table>

This data reiterates the generalist nature of the PHN’s and CRGN’s role, but more importantly points to the fact that PHNs, because of their breadth and depth of knowledge regarding the health and social needs of populations, are uniquely placed to play a key role in the implementation of changing models of service delivery.

When asked about access to teams and team contribution the results were mixed (Table 7). A total of 36% (n=166) stated that they never had difficulty accessing multidisciplinary teams or agencies, while 46% (n=217) reported experiencing problems. Similarly, 44% (n=205) of respondents reported problems attending or contributing to team meetings, while 43% (n=200) had no difficulty. When asked about joint work and whether colleagues were always available when joint visits were required, 37% (n=171) did not have any issue; however, 45% (n=209) had difficulty accessing colleagues for these visits. Total respondents = 475.

A few respondents commented that while they were working in Primary Care Centres, it was in name only and the working relationships with other health professionals were still the same.

“The Primary Care Team are physically in the same building but the culture of working together has to be fostered and not just expected to happen without nurturing it.” - Survey Respondent.

These mixed results indicate that the full benefits of team working may not be felt throughout the community sector. Many of the respondents suggest that communication may be an inhibitor to successful team work. Communication was listed by the Forum on Teamworking in Primary Healthcare as a barrier to successful team working. Other barriers included were, competing demands, diverse lines of management and personality factors (2000, p. 17).
### Question 29: team working

Please indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I never have difficulty accessing multidisciplinary teams/agencies</td>
<td>27</td>
<td>139</td>
<td>84</td>
<td>177</td>
<td>40</td>
<td>467</td>
</tr>
<tr>
<td></td>
<td>5.8%</td>
<td>29.8%</td>
<td>18%</td>
<td>37.9%</td>
<td>8.6%</td>
<td></td>
</tr>
<tr>
<td>I can always attend and contribute to team meetings</td>
<td>30</td>
<td>170</td>
<td>64</td>
<td>176</td>
<td>29</td>
<td>469</td>
</tr>
<tr>
<td></td>
<td>6.4%</td>
<td>36.2%</td>
<td>13.6%</td>
<td>37.5%</td>
<td>6.2%</td>
<td></td>
</tr>
<tr>
<td>Colleagues are always available when joint visits are required</td>
<td>18</td>
<td>153</td>
<td>82</td>
<td>173</td>
<td>36</td>
<td>462</td>
</tr>
<tr>
<td></td>
<td>3.9%</td>
<td>33.1%</td>
<td>17.7%</td>
<td>37.4%</td>
<td>7.8%</td>
<td></td>
</tr>
<tr>
<td>There is an open culture and shared learning for near misses and incidents</td>
<td>19</td>
<td>147</td>
<td>127</td>
<td>137</td>
<td>44</td>
<td>474</td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>31%</td>
<td>26.8%</td>
<td>28.9%</td>
<td>9.3%</td>
<td></td>
</tr>
<tr>
<td>There are enough staff to ensure safe effective patient centred care</td>
<td>4</td>
<td>28</td>
<td>69</td>
<td>230</td>
<td>141</td>
<td>472</td>
</tr>
<tr>
<td></td>
<td>0.8%</td>
<td>5.9%</td>
<td>14.6%</td>
<td>48.7%</td>
<td>29.9%</td>
<td></td>
</tr>
</tbody>
</table>

*answered question: 475
skipped question: 157*
Section 5: Patient/Client Care

“Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings” (International Council of Nurses, 2010).

Maintaining a high standard of patient-centred care is core to all community and public health nurses. Nationally, the Health Information and Quality Authority (HIQA) has developed the National Standards for Safer Better Healthcare (2012), which provide a national framework for good governance, patient safety and quality of care. These national standards apply to all healthcare services provided or funded by the HSE. They are monitored by HIQA and are the precursor to a new licensing system to be introduced for all hospitals in 2015. The HSE’s Quality and Patient Safety Directorate also strives to ensure standards of patient care and safety. Tables 8 and 9 provide full survey results concerning questions on patient/client care.

5.1 Levels of Patient/Client Care

Throughout the survey results, respondents expressed the importance of person-centred patient/client care to their work. However, many felt frustrated that they could not give patients/clients the level of care required due to a number of issues.

“I love my job but would love to spend more time with the patients reassuring them, educating them and caring for them 100% of the time” - Survey Respondent.

Higher volumes of patient/client care are continuing to move into the community. A total of 96% (n=449) of respondents agreed that nurses and midwives were now caring for patients/clients with more complex needs compared to a year ago. Less time with patients/clients means that there is an increased risk that the quality of patient/client care will suffer. Total respondents = 467.

Many respondents expressed a high level of anxiety over the reduced services available to patients/clients and impacts of health cuts affecting the standard of patient/client care. One respondent stated: “We are not meeting client needs, not implementing any of the health strategies effectively, not providing quality, timely, effective care. We are a crisis service in crisis.” - Survey Respondent.

5.2 Patient/Client Safety

Patient/client safety is high on the Government’s agenda, as evidenced by the development of the Patient Safety First Initiative, and is an important topic internationally. The World Health Organization (WHO) has launched a programme entitled “Safer Primary Care” as a result of research which showed that a “significant proportion of safety incidents captured in hospitals had originated in the earlier levels of care” (Safer Primary Care Expert Working Group, 2012, p.3).

Only 7% (n=32) of survey respondents felt that there was enough staff to ensure safe patient/client care. Total respondents = 472. Many respondents stated their concern over the safety of patients/clients, with one respondent stating: “The cuts are creating a very dangerous environment for both clients and nurses.”

Other respondents said: “We need more staff to safely and adequately deliver a high quality service to our clients.”

“There is an increase in work load with a decrease in resources. It is not sustainable. It leaves patients and staff open to risk.” - Survey Respondent.

“Community services are at breaking point. It is now a very dangerous, stressful place to work. It is impossible to enjoy patient contact as each contact is rushed and the services when identified by PHNs are not there to meet patient needs.”
“The staffing levels are dangerously low. I feel it only a matter of time before there is a dangerous incident.”

“The PHN can no longer provide a safe, competent, client centred service to the multiplicity of client groups.”

5.3 Documentation and IT Infrastructure

A recurring theme is that PHNs and CRGNs spend large amounts of time on administrative duties at the expense of patient/client care and that secretarial support should be available to deal with non-nursing issues.

“If a client requires more than 5 hours care per week they’d require a secretary to fill in all the forms they have to fill in - and try and pick a suitable agency from a list provided by HSE. What do they know about the agencies?” – Survey Respondent.

The need to enhance the administrative support to PHNs has been flagged in reports for decades, including in The Commission on Nursing (Government of Ireland, 1998). One survey respondent stated that “It is essential to have secretarial backup”. This view was echoed by another respondent who advocated “development of support services e.g. clerical staff”. The need for administrative support was identified by another respondent who envisaged the “PHN doing less admin work” and again by another respondent who stated “I would like there to be additional support in the community i.e…..secretarial support” and yet another who indicated the requirement for “more administration and clerical support”.

Good record-keeping or documentation is an essential role of any nursing practice (An Bord Altranais, 2002). Written care plans are a key part of the record keeping process. Results from the survey suggest that care plans are not always developed for patients/clients. More than 40% (n=183) of respondents stated that they did not have a written up-to-date care plan for each patient/client (total respondents = 458), and 63% (n=290) of respondents stated that they did not complete their patient/client-related paperwork on time. Total respondents = 462.

A follow on to documentation is an improvement in ICT systems, which is urgently needed across non-acute areas, such as primary and community care, where it remains poorly developed. This issue has been raised previously (DOHC, 2001a; Directors of Public Health Nursing, 2006), however progress appears to be slow to date with only a patchwork of information systems and varying degrees of quality and comprehensiveness. However, the current systems do not support delivery of the efficient, integrated and timely information required for ease of usage by PHNs and CRGNs in the community and the implementation of the reforms.

“…the lack of any coherent ICT strategy means the community is decades behind the acute services in this area.” - Survey Respondent

5.4 Health Promotion

Health promotion is an essential element in encouraging better health and PHNs and CRGNs in the community are ideally placed to offer this service. Health promotion goes beyond just health care and PHNs and CRGNs have to collaborate with other sectors to assist better the determinants of health. The International Council of Nurses (ICN) states in their fact sheet, ICN on Mobilising Nurses for Health Promotion, (2000) that nurses and midwives can make a difference in the health and wellbeing of people by reducing obstacles and helping people tackle the different health determinants such as shelter, food, education and social issues.
Many of the survey respondents highlighted the fact that the health promotion role of their job was deteriorating due to health service cuts. A number of respondents described the community health service as a “fire brigade” service, with staff only dealing with emergencies. Others described a lack of health promotion material available to them. One PHN stated:

“The role of the public health nurse is becoming more about nursing the acutely ill and losing the role of health promotion. The capacity of public health nurses to reach the healthy population with health promotion is being decreased by lack of staff and resources.” – Survey Respondent.

5.5 Management of Chronic Disease

The HSE is developing integrated chronic disease management programmes to improve patient/client access and care in an integrated manner across service settings to produce the best health outcomes, enhanced clinical decision making and the most effective use of resources. Guidelines are being developed for priority programmes relevant to primary care such as stroke, heart failure, asthma, diabetes and chronic obstructive pulmonary disease. According to the Office of the Nursing and Midwifery Services Director, HSE (2012), the planned introduction of National Clinical Care Programmes into primary care is an opportunity for the PHN to contribute positively to this development. Unfortunately, 81% (n=380) of survey respondents did not feel that services could cope with the shift towards management of chronic diseases in the community. Total respondents = 469.

“The PHN service is under extreme pressure with the volume of referrals received from the acute services. A lot of these referrals are also inappropriate (no medical card, no direct nursing needs and not over 65 years).” – Survey Respondent.

5.6 Shift from Acute to Community Care

Probably the most significant policy change affecting nursing and midwifery in the community has been the shortening the length of stay of patients in hospitals and the continuing shift from hospital to community-based care. Respondents were not opposed to this policy direction in theory, but questioned the resources allocated to support it. One respondent stated; “In theory it is fantastic. In principle, so much more could be provided in community setting including investigations to relieve pressure on acute services. However, the key issue is that Primary Care needs to be resourced and the PHN model of care is working. Why change it, just resource it.”

This shift to community-based care has meant that PHNs and CRGNs are also providing post-acute care services, which some believe has directed the nursing and midwifery resource away from health promotion, illness prevention and community development (Nursing and Midwifery Planning and Development Unit for HSE areas of Counties Dublin, Kildare, and Wicklow, 2006). Also, while this shift has been embedded in a range of policy documents - the Primary Care Strategy (DOHC, 2001a), the Transformation Programme (HSE, 2007), the more recent Programme for Government (Government of Ireland, 2013) and Future Health (Department of Health, 2012a) - ambiguity still remains about the role of PHNs and CRGNs within these new structures. In fact, there are concerns about the ‘distinct’ nature of public health nursing in the community being lost within the new structures (Clarke, 2004).

“Community nursing service was never developed to allow the transition from acute to community service...despite this the transition is happening” - Survey Respondent.

Several reports, including the Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020 (HSE, 2007), have indicated that there should be reductions in the average length of time people stay in hospital. The Review found that many patients/clients were being kept in hospital for too long and in excess of 900 acute beds were occupied due to excessively long hospital stays. Community services are now dealing with patients/clients with more complex needs. Nearly all (97%, n=458) respondents agreed that patients/clients were being discharged from hospital more quickly than before. (Table 9).
One respondent stated: “…poor discharge planning, not seamless as it should be, patients being discharged too early without adequate resources to meet needs. Poor liaison from hospital”.

5.7 Community Services under Pressure

Despite a Government commitment of more than €400 million for community based services to support older people to remain in their homes and communities, PHNs and CRGNs continue to stress that more investment is needed if the acute to community shift is going to become a reality and if the community service is able to meet a future rise in demand.

“People in community have increased needs which cannot be met by community as there are not adequate services to care for people in their own homes i.e. Home Helps/HCA.”
- Survey Respondent

An overwhelming number of respondents (84%, n=387) indicated that they felt the current community health nursing service was already at capacity and would be unable to cope with further services moving from the acute to the community sector. They stated that there must be investment in the community services in order to ensure they have the capacity not only to cope but to deliver quality care for all patients/clients. Total respondents = 462.

“We are constantly prioritising the already prioritised and this type of on-going, constant organising and re-organising is mentally draining. The battle to advocate for clients within a system that is measured in financial terms only and highly bureaucratic is soul destroying.” – Survey Respondent.

“Our service in my opinion is like a fire fighting service. Cases are always having to be re-prioritised.”
- Survey Respondent.

“The PHN can no longer provide a safe, competent, client centred service to the multiplicity of client groups.” – Survey Respondent.

“Very difficult to provide safe care to clients. Essential call prioritised and all other PHN role is being lost.” – Survey Respondent.

Only 15% (n=71) of respondents (Total respondents = 464) were of the opinion that new community health services were being developed to meet the needs of the sector. The effects of the Government’s moratorium on recruitment was widely felt, with only 3% (n=15) of respondents (Total respondents = 465) agreeing with the statement “more community health staff are being employed to meet the needs in the community”.

“People in community have increased needs which cannot be met by community as there are not adequate services to care for people in their own homes i.e. Home Helps/HCA.”
- Survey Respondent
Table 8 - Survey question 27: patient care

Question 27: patient care
Please indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I always have time to deliver the required level of care to meet my patient's needs</td>
<td>12</td>
<td>65</td>
<td>61</td>
<td>234</td>
<td>87</td>
<td>459</td>
</tr>
<tr>
<td></td>
<td>2.6%</td>
<td>14.2%</td>
<td>13.3%</td>
<td>51%</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>My workload has increased in the past year</td>
<td>260</td>
<td>150</td>
<td>41</td>
<td>14</td>
<td>6</td>
<td>471</td>
</tr>
<tr>
<td></td>
<td>55.2%</td>
<td>31.9%</td>
<td>8.7%</td>
<td>3%</td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>The amount of time I spend with each patient has reduced in the past year</td>
<td>144</td>
<td>201</td>
<td>64</td>
<td>38</td>
<td>12</td>
<td>459</td>
</tr>
<tr>
<td></td>
<td>31.4%</td>
<td>43.8%</td>
<td>13.9%</td>
<td>8.3%</td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>I never delay first visits/assessments/appointments due to workload</td>
<td>59</td>
<td>118</td>
<td>67</td>
<td>154</td>
<td>55</td>
<td>453</td>
</tr>
<tr>
<td></td>
<td>13%</td>
<td>26%</td>
<td>14.8%</td>
<td>34%</td>
<td>12.1%</td>
<td></td>
</tr>
<tr>
<td>All my patients are assessed using a locally agreed assessment tool</td>
<td>140</td>
<td>222</td>
<td>50</td>
<td>36</td>
<td>10</td>
<td>458</td>
</tr>
<tr>
<td></td>
<td>30.6%</td>
<td>48.5%</td>
<td>10.9%</td>
<td>7.9%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>I have a written up to date care plan for each patient</td>
<td>46</td>
<td>133</td>
<td>96</td>
<td>148</td>
<td>35</td>
<td>458</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>29%</td>
<td>21%</td>
<td>32.3%</td>
<td>7.6%</td>
<td></td>
</tr>
<tr>
<td>I always complete patient-related paperwork on time</td>
<td>28</td>
<td>79</td>
<td>65</td>
<td>210</td>
<td>80</td>
<td>462</td>
</tr>
<tr>
<td></td>
<td>6.1%</td>
<td>17.1%</td>
<td>14.1%</td>
<td>45.5%</td>
<td>17.3%</td>
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</table>

answered question 474
skipped question 158

Table 9 - Survey question 28: patient care

Question 28: patient care
Please indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are being discharged from hospital more quickly than before</td>
<td>377</td>
<td>81</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>471</td>
</tr>
<tr>
<td></td>
<td>2.6%</td>
<td>14.2%</td>
<td>13.3%</td>
<td>51%</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>I am dealing with patients with more complex needs than previously</td>
<td>380</td>
<td>69</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>467</td>
</tr>
<tr>
<td></td>
<td>81.4%</td>
<td>14.8%</td>
<td>3%</td>
<td>0.6%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>New community health services are being developed to meet needs in the community</td>
<td>28</td>
<td>43</td>
<td>72</td>
<td>174</td>
<td>147</td>
<td>464</td>
</tr>
<tr>
<td></td>
<td>6%</td>
<td>9.3%</td>
<td>15.5%</td>
<td>37.5%</td>
<td>31.7%</td>
<td></td>
</tr>
<tr>
<td>More community health staff are being employed to meet needs in the community</td>
<td>6</td>
<td>9</td>
<td>24</td>
<td>140</td>
<td>286</td>
<td>465</td>
</tr>
<tr>
<td></td>
<td>1.3%</td>
<td>1.9%</td>
<td>5.2%</td>
<td>30.1%</td>
<td>61.5%</td>
<td></td>
</tr>
<tr>
<td>I am investing more time in stopping people going to hospital in the first place</td>
<td>46</td>
<td>127</td>
<td>122</td>
<td>108</td>
<td>58</td>
<td>461</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>27.5%</td>
<td>26.5%</td>
<td>23.4%</td>
<td>12.6%</td>
<td></td>
</tr>
<tr>
<td>I am confident that community nursing can cope with more services moving from the acute sector</td>
<td>13</td>
<td>21</td>
<td>41</td>
<td>158</td>
<td>229</td>
<td>462</td>
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<tr>
<td></td>
<td>2.8%</td>
<td>4.5%</td>
<td>8.9%</td>
<td>34.2%</td>
<td>49.6%</td>
<td></td>
</tr>
<tr>
<td>I am confident that we can adequately cope with the shift towards management of chronic diseases in the community</td>
<td>9</td>
<td>25</td>
<td>55</td>
<td>177</td>
<td>203</td>
<td>469</td>
</tr>
<tr>
<td></td>
<td>1.9%</td>
<td>5.3%</td>
<td>11.7%</td>
<td>37.7%</td>
<td>43.3%</td>
<td></td>
</tr>
</tbody>
</table>

answered question 477
skipped question 155
Section 6: Job Satisfaction

Although some respondents stated how much they enjoyed their job in the community, there is some contradiction as the majority of PHNs and CRGNs reported widespread demoralisation linked to increased workloads, excessive working hours and poor pay and promotion prospects – all features of the work environment of the nurses and midwives in community services in Ireland. This phenomenon is not limited to the community sector. The recent Report of the Irish RN4CAST Study 2009 - 2011: a nursing workforce under strain also reported moderate to high levels of burnout and low levels of job satisfaction throughout the acute hospital sector. It was also noted that many respondents to the RN4CAST expressed dissatisfaction with their jobs as opposed to their career. (Scott, Kirwan, Matthews, et al, 2013). Shields and Ward (2001) demonstrate that nurses are attracted to and remain at their place of employment when opportunities exist that allow them to advance professionally, to gain autonomy and to participate in decision making, while being fairly compensated. In the Irish context, none of these are visible in the majority of community environments. Tables 10 and 11 provide full survey results concerning questions on job satisfaction.

6.1 Planning and Pay

Nurses and midwives have an important contribution to make in health services planning and decision making. PHNs and CRGNs in the community have very close interaction with patients/clients and their families, mostly in their own home environment, and are ideally placed to interpret both individual health care needs and wider community health needs. Unfortunately, over half those surveyed responded that they did not have the opportunity to participate in any policy decision making. Furthermore, given the current economic situation and the impact of austerity measures on the health budget, it is not surprising that nurses and midwives in the community feel they are not adequately paid for their work. Between all the additional cuts and levies, the salary for nurses and midwives has dropped approximately 14% in the past few years.

6.2 Flexibility

With the majority of PHNs and CRGNs in the community female, it is reassuring to know that family friendly options are available to staff. Nearly 61% (n=287) of respondents stated that they had flexibility in their work. However, this flexibility did not extend to taking annual leave, where 44% (n=207) of respondents said that taking annual leave could be an issue. (Table 10).

Several other respondents mentioned the stress they felt when returning from annual leave. “Returning from annual leave is traumatic as workload has accumulated in your absence. My PHN colleagues will have done primary visits and essential clinical work during my holiday time. It often happens that on return from annual leave another PHN then takes annual leave and the cycle of covering for PHN colleagues continues and non-essential work gets deferred.” - Survey Respondent

6.3 Education and Career Development

In making decisions regarding career progression for PHNs, the challenge is to ensure that the planning, organising and delivery of nursing and midwifery care meets the needs of the community and that service providers have the requisite skills and experience to respond appropriately to the needs of individuals, families and communities. A constant theme running through all the literature and surveys regarding CRGNS is the lack of mandatory training and skills competency. It is essential that educational pathways for CRGNs are established.
The Nurses and Midwives Act 2011 (Government of Ireland, 2011) states that nurses and midwives have to maintain professional competence and that their employer should facilitate its maintenance. It is therefore encouraging to see that almost three-quarters of respondents have been facilitated to attend all the mandatory training necessary for nursing in the community. That said, several respondents commented that mandatory training was the only thing that they were given the opportunity of attending. One respondent commented: “I have not been afforded the opportunity to partake in one professional development activity apart from mandatory training in the past 13 years”.

Nearly half of the respondents also stated that they were not facilitated to take study leave when needed, while the other half said that they were facilitated, or it was dependent on circumstances. However, taking a broader look at skills in the community, over two-thirds of respondents stated that they did not have career development or clinical ladder opportunities. The National Council for the Professional Development of Nursing and Midwifery (NCNM) report, Agenda for the Future Professional Development of Public Health Nursing stated that: “Apart from the need to develop closer links with a greater understanding of the respective roles of the various nurses and midwives now working in the community, there is also a need to examine the continuing professional development requirements of the public health nursing team, including the community based general nurses” (2005, p. 20).

This was reflected in the survey with one CRGN commenting: “… There is no clear role description and career opportunities for RGNs in Community. No educational pathway for RGNs in the Community to prepare staff for the different working environments. Lack of acknowledgement of the increased responsibility of managing a community caseload, thus the need for better preparation for staff to work in the community.”

Similar views are found in the study by Magee and Dunne (2009) who stated that there is evidence in literature from multiple sources recommending that the CRGN have their professional development needs met and formal education to carry out the role and this view was expressed and endorsed by the CRGNs.

6.4 Satisfaction

The qualitative section of the survey showed a strong, negative response regarding the job satisfaction of PHNs and CRGNs from respondents. Responses showed that they felt they were working in extremely difficult situations and environments – both physically and emotionally, for example: “Working in very poor infrastructure – just a small inadequate prefab. There is no caretaker so all maintenance issues take up the time of the PHN, ie calling for oil, ordering stock etc.”

Over 80% (n=375) agreed that they felt drained at the end of the working day and respondents said: “I can honestly say I’ve had enough”; “If I had a choice and was younger I would head off on a plane where my experience and qualifications would be recognised and appreciated”.

Over 46% (n=214) of respondents did not feel that management were listening or responding to their concerns. (Table 11). “The situation is sad beyond belief. What we are offering as a service is a shambles. Frightened older people wondering what they will be left with. Who will help them. The few nurses on the ground being stretched at every turn. The paperwork is amassing and there is barely enough hours in the day to get the work done. Health and safety – what's that? Our own lives outside our work is everyday more and more impacted by what we have to take home with us. The endless paperwork that we just can’t reach during the working day. The anxiety of worrying all the time about ‘things’ that are being missed because there is little or no time to assess, assimilate and act appropriately.” – Survey Respondents.
However despite these negative statements, there was a glimmer of positivity with their career choice and actual job with 65% (n=304) stating that they could create a relaxed atmosphere with their patients/clients. Furthermore 72% (n=342) agreed that they could accomplish many worthwhile things in their job. The overall sentiment being, that while their work environment is difficult and their job satisfaction and morale are low, they still happy with their career choice and caring for patients/clients. While seeming to be at odds with the general qualitative statements, 61% (n=290) disagreed that they were unhappy in their job. Even while working under difficult circumstances, their commitment to their patients/clients is apparent. (Table 11).

Table 10 - Survey question 30 job satisfaction

<table>
<thead>
<tr>
<th>Question 30 job satisfaction</th>
<th>Please indicate how strongly you agree or disagree with the following statements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer Options</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>I have flexibility in my work</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>8.5%</td>
</tr>
<tr>
<td>I have the opportunity to participate in policy decisions that affect my working environment</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>3.2%</td>
</tr>
<tr>
<td>I have career development/clinical ladder opportunities</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2.1%</td>
</tr>
<tr>
<td>I am adequately paid</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>1.5%</td>
</tr>
<tr>
<td>I have been facilitated to attend all mandatory training I need</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>16.3%</td>
</tr>
<tr>
<td>Taking annual leave is never an issue</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>7.8%</td>
</tr>
<tr>
<td>I have adequate resources to allow me to deliver appropriate care to my patients</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>1.9%</td>
</tr>
<tr>
<td>I am facilitated to take study leave when needed</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>4.3%</td>
</tr>
</tbody>
</table>

answered question 475
skipped question 157
Table 11 - Survey question 31 job satisfaction

<table>
<thead>
<tr>
<th>Question 31 job satisfaction</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel drained at the end of the working day</td>
<td>186</td>
<td>189</td>
<td>59</td>
<td>32</td>
<td>7</td>
<td>0</td>
<td>473</td>
</tr>
<tr>
<td></td>
<td>39.3%</td>
<td>40%</td>
<td>12.5%</td>
<td>6.8%</td>
<td>1.5%</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>I can create a relaxed atmosphere with my patients</td>
<td>44</td>
<td>260</td>
<td>88</td>
<td>55</td>
<td>11</td>
<td>9</td>
<td>467</td>
</tr>
<tr>
<td></td>
<td>9.4%</td>
<td>55.7%</td>
<td>18.8%</td>
<td>11.8%</td>
<td>2.4%</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td>I am unhappy in my job</td>
<td>38</td>
<td>44</td>
<td>96</td>
<td>190</td>
<td>100</td>
<td>3</td>
<td>471</td>
</tr>
<tr>
<td></td>
<td>8.1%</td>
<td>9.3%</td>
<td>20.4%</td>
<td>40.3%</td>
<td>21.2%</td>
<td>0.6%</td>
<td></td>
</tr>
<tr>
<td>I can accomplish many worthwhile things in my job</td>
<td>90</td>
<td>252</td>
<td>64</td>
<td>45</td>
<td>21</td>
<td>1</td>
<td>473</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>53.5%</td>
<td>13.5%</td>
<td>9.5%</td>
<td>4.4%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>I feel management listens and responds to employee concerns</td>
<td>18</td>
<td>108</td>
<td>107</td>
<td>119</td>
<td>95</td>
<td>22</td>
<td>469</td>
</tr>
<tr>
<td></td>
<td>3.8%</td>
<td>23%</td>
<td>22.8%</td>
<td>25.4%</td>
<td>20.3%</td>
<td>4.7%</td>
<td></td>
</tr>
</tbody>
</table>

answered question: 474
skipped question: 158
Section 7: Key Concerns

This survey has identified a number of key concerns which are having a negative impact on the working environment of PHNs and CRGNs across the country. Improving the working environment for nurses and midwives is a key factor in improving quality of care. The recent Report of the Irish RN4CAST Study states that “improving the nurse work environment is important both for the advancement of the health care quality and patient safety agenda in Ireland and for reducing burnout levels and increasing job satisfaction among nurses.” (Scott, Kirwan, Matthews, et al., 2013, p. 3).

The World Health Professional Alliance (WHPA) Positive Practice Environment Campaign is internationally recognised across numerous professional groups, with a focus on improving the quality of health services and patient care by promoting best practices for healthcare workers and creating tools for achievement.

The Positive Practice Environment guiding checklist is designed as a reference tool to enable employers, government bodies and professional bodies to assess the quality of the working environment and develop strategies to address problematic areas (ICN, 2010). In this section, the key concerns from the survey are discussed in the context of the Positive Practice Environment characteristics.

The International Council of Nurses states: “Patients and the public have the right to the highest performance from health care professionals and this can only be achieved in a workplace that enables and sustains a motivated well-prepared workforce” (Positive Practice Environment Campaign, ICN, 2010).

For more information about the Positive Practice Environment Campaign or to view the checklist of characteristics visit http://www.ppecampaign.org/.

7.1 Professional Recognition

Measuring employee satisfaction and acting on outcomes is one of the characteristics identified for a positive workplace. Although some respondents stated that they were happy in their job, respondents felt extremely demoralised and undervalued. Patient care is at risk as a result. By promoting staff surveys as a monitoring of health and wellbeing, this issue can be better understood and addressed appropriately.

Reward contribution and performance is another characteristic of PPEs. However, due to the current austerity measures and many cutbacks experienced by respondents, this appears to be not being met. As discussed earlier, 95% (n=455) of respondents were not paid for overtime and only 30% (n=26) of respondents in ‘acting up’ positions were receiving payment. This will have an effect on the retention of staff in the long-term.

7.2 Management Practices

Communication is identified as an issue, with many respondents highlighting poor communication, for example 46% (n=217) stated they had difficulty accessing teams. For a workplace to thrive as a PPE, open communication and teamwork should be encouraged. This can be achieved by establishing and supporting alliances across different health care professionals.

7.3 Support Structures

The need for clerical support was identified by many respondents, as well as the excessive amounts of documentation required on a daily basis. It was clear that respondents were concerned about the impact this would have on patient/client care. Another issue arising from the survey was the reduced access to equipment and supplies experienced by respondents. Providing adequate equipment, supplies and support staff is essential.
to ensure a positive workplace environment. It is apparent from the survey results that this issue requires attention. Offering employment security and work, predictability, is an essential characteristic also, which, with so much cross cover being expected of respondents, is an area which also needs to be addressed. In addition, it seems that the lack of support structures is affecting the amount of health promotion work, which is a key role for most respondents, being undertaken in the community.

7.4 Education

For a working environment to thrive, support for professional development and career advancement is essential. As discussed earlier, almost three-quarters of respondents have been facilitated to attend mandatory training. However, many respondents were pessimistic about their career development opportunities.

7.5 Occupational Health and Safety

Staffing issues remain a major concern in the community sector as discussed earlier in the report. The current moratorium on recruitment and extensive cross cover requirement, as a result of uncovered leave, is causing much distress to PHNs and CRGNs across the country. Concerns have been raised by respondents regarding safe staffing levels. An important key characteristic of a PPE is adherence to safe staffing levels.

The caseload and workload of the majority of the respondents is adversely affected by the staffing issues. Further issues arising from the increased speed at which patients are discharged from acute settings are compounding this problem, as is an overall reduction in services due to budget cuts. According to the ICN: “If heavy workloads remain unaddressed or are perceived to be unreasonable, staff can feel exploited and demotivated” (International Council of Nurses, 2008, p.19). According to the PPE framework, positive working environments adopt occupational safety and wellness polices.
Section 8: Conclusions

The aim of this survey was to gather information regarding the current status of the work environment of PHNs and CRGNs and elicit their views regarding several key areas related to community nursing and midwifery. It is disheartening to see the same concerns reoccurring here that have already been outlined in previous studies. This survey clearly noted the frustration of those working in the community. Some of the issues voiced included the lack of staff, huge caseloads, masses of paperwork with no support, difficulties with working in multidisciplinary teams with other health care professionals with waiting lists, ambiguity of roles for both the PHN and the CRGN, and cuts to vital services.

Nevertheless, it must be emphasised that Ireland has a dynamic and committed community nursing and midwifery workforce. Despite all the challenges that make the job much more difficult, PHNs and CRGNs are committed to their patients/clients and feel they can achieve many worthwhile outcomes for their patients/clients. They are an experienced and well educated community workforce, which is a very valuable resource for the implementation of new primary care structures.

In order to ensure that quality care is available for all patients/clients, it is essential to have quality safe workplaces and positive practice environments for nurses and midwives. The success of the Government’s primary care strategy depends largely on PHNs and CRGNs, but in order to meet growing demand, they need adequate resources in order to achieve the required outcomes. It is difficult to see how the primary care plans can live up to expectations without considerable investment in community health services and community staff.
References


Parliament of Great Britain, 1851. *Poor Relief (Ireland) Act 1851*.


APPENDIX 1: Questionnaire

Community review - Your Work, Your Perspectives

Introduction

This short survey (15 minutes approximately) is aimed at public health nurses (PHNs) and community registered general nurses (CRGNs).

This is the INMO’s first baseline study to capture your perceptions of working in the community environment and the quality of care provided to patients over the past year (from January 2012).

The aim of the survey is to identify your key issues within your current community working environment.

Your Employment

1. **What is your official grade category?**
   - Advanced Nurse Practitioner
   - Assistant Director of Public Health Nursing
   - Clinical Nurse Manager 1 (CNM1)
   - Clinical Nurse Manager 2 (CNM2)
   - Clinical Nurse Specialist
   - Director of Public Health Nursing
   - Public Health Nurse
   - Registered Staff Nurse (Community RGN)
   - Other (please specify)

2. **Are you**
   - Female
   - Male

3. **Are you**
   - Permanent
   - Temporary

4. **In addition to your official grade category, are you acting up into another grade position?**
   - Yes
   - No

If yes, please list grade
Community review - Your Work, Your Perspectives

Your Employment

5. How long have you been in the acting position?

- Months
- Years

6. Are you getting paid for this acting position?
- Yes
- No

7. Which HSE region do you work in? Choose one of the following below:
- HSE Dublin North East
- HSE Dublin Mid-Leinster
- HSE South
- HSE West

8. What area do you work in? Choose one of the following below:
- Carlow and Kilkenny
- Cavan and Monaghan
- Clare
- Cork North
- Cork North Lee
- Cork South Lee
- Cork West
- Donegal
- Dublin North
- Dublin North Central
- Dublin North West
- Dun Laoghaire
- Dublin South City
- Dublin South East
- Dublin South West
- Galway Kerry
- Kildare and West Wicklow
- Laois and Offaly
- Limerick
- Longford and Westmeath
- Meath
- Roscommon
- Sligo and Leitrim
- Tipperary North
- East Limerick
- Tipperary South
- Waterford
- Wexford
- Wicklow

9. How long have you been in your current position?
- Less than 1 year
- Less than 5 years
- 5-10 years
- Over 10 years
- Over 20 years

10. What point are you on your scale of pay?
- Starting point
- Mid point
- Top of scale

11. How many contracted hours do you normally work per week?
- Number of hours

12. In an average week, approximately how much PAID overtime would you do?
- Hours
13. In an average week, approximately how much UNPAID overtime would you do? 
   Hours

14. In the past year, how many weekends did you work? 
   Number of weekends worked

15. Is relief nursing staff available to cover sick leave, holidays etc? 
   ○ Yes 
   ○ No 
   Other (please specify)

16. How often in the past year have you provided cover for nursing colleagues? 
   ○ Never 
   ○ Rarely 
   ○ Sometimes 
   ○ Often 
   ○ Always

Your Working Environment

17. Is the area you work predominantly urban or rural? 
   ○ Predominantly urban 
   ○ Equally urban and rural 
   ○ Predominantly rural

18. What is the approximate population of the area you cover? 

19. Where are you based? 
   ○ Health Centre 
   ○ Primary Care Centre 
   Other (please specify)

20. Including yourself, how many nursing colleagues (all grades) work in your health centre/primary care team? 

21. How many other non-nurse grade colleagues (eg. health care assistants, home helps) provide nursing care in your health centre/primary care team?
Community review - Your Work, Your Perspectives

Your Working Environment

22. Looking solely at nurses, has there been any change to staffing levels in your health centre in the last 12 months (since January 2012)?
- Yes - staffing levels have increased
- Yes - staffing levels have decreased
- No change in staffing levels
- Not sure / Don’t know

23. Are there allied health professionals assigned to your base?
- Yes
- No

24. If your answer is “yes”, what allied health professionals are assigned to your base?
- Occupational Therapist
- Physiotherapist
- Speech and Language Therapist
- Dietitian/Nutritionist
- Other (please specify)

25. If there has been a change in nursing staffing levels, what changes have occurred within your team in the last 12 months. Tick all that apply.
- Recruitment freeze with vacancies left unfilled
- Redundancies/voluntary severance
- Redistribution /redeployment of staff
- Services merged or restructured
- Agency use ban
- Service closures
- Role expansion (eg. staff cover wider areas)
- Fewer opportunities for access to clinical supervision/mentoring
- Other (please specify)
Community review - Your Work, Your Perspectives

Patient Care

26. Which of the following fall under your remit? Please tick all that apply to you.

- Child and Family Health
- School Health
- Older Persons Health
- Disability service
- Chronic disease management
- Palliative Care/End of Life Care
- Health Promotion and Community Development
- Nurse/Midwife Led Clinic service

Other (please specify)

27. Please indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>I always have time to deliver the required level of care to meet my patient’s needs</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My workload has increased in the past year.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount of time I spend with each patient has reduced in the past year.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I never delay first visits/assessments/appointments due to workload.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All my patients are assessed using a locally agreed assessment tool.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a written up to date care plan for each patient.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I always complete patient related paperwork on time.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community review - Your Work, Your Perspectives

Patient Care

28. Please indicate how strongly you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are being discharged from hospital more quickly than before</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am dealing with patients with more complex needs than previously</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New community health services are being developed to meet needs in the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More community health staff are being employed to meet needs in the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am investing more time in stopping people going to hospital in the first place</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am confident that community nursing can cope with more services moving from the acute sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am confident that we can adequately cope with the shift towards management of chronic diseases in the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Team Working

29. Please indicate how strongly you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>I never have difficulty accessing multidisciplinary teams/agencies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can always attend and contribute to team meetings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleagues are always available when joint visits are required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is an open culture and shared learning for near misses and incidents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are enough staff to ensure safe effective patient centred care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community review - Your Work, Your Perspectives

Job Satisfaction

30. Please indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have flexibility in my work.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have the opportunity to participate in policy decisions that affect my working environment.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have career development/clinical ladder opportunities</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am adequately paid.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have been facilitated to attend all mandatory training I need.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Taking annual leave is never an issue.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have adequate resources to allow me to deliver appropriate care to my patients.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am facilitated to take study leave when needed.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

31. Please indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel drained at the end of the working day</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I can create a relaxed atmosphere with my patients</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am unhappy in my job.</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>I can accomplish many worthwhile things in my job.</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>I feel management listens and responds to employee concerns.</td>
<td>○</td>
<td>○</td>
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</tr>
</tbody>
</table>
Community review - Your Work, Your Perspectives

If you have any further comments to make, please do so below.

32. **Community services under pressure**

33. **Acute to Community Shift**

34. **Capacity to meet future patient need**

35. **Impact of cuts**

36. **Any other comments.**

Acknowledgement

The INMO wishes to thank the Royal College of Nursing, United Kingdom for their advice and generosity for sharing their experience regarding their annual survey, the Community Nursing Workforce in England (2012).

In addition, the Report of the Irish RN4CAST Study 2009-2011: a nursing workforce under strain (Scott, Kirwan, Matthews, et al., 2013) was instrumental in informing the development of the Questionnaire.
A Snapshot of Public Health Nursing and Community Registered General Nursing in Ireland