

National Council for the Professional Development of
Nursing and Midwifery

Nursing and Midwifery
Research Priorities
for Ireland



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Professional Development
of Nursing and Midwifery

An Chomhairle Náisiúnta d'Fhorbairt
Ghairmiúil an Altranais agus
an Chnáimhseachais

JUNE 2005

Mission Statement of the National Council

The Council exists to promote and develop the professional role of nurses and midwives in order to ensure the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

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National Council for the Professional Development of
Nursing and Midwifery

Nursing and Midwifery **Research Priorities** for Ireland

by

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Foreword

The National Council is pleased to present this report which identifies nursing and midwifery priorities in Ireland. Changes in the provision of healthcare are having an impact on the demands made on the healthcare providers, and have resulted in shorter stays in acute services, quicker access to hospital services and greater emphasis on the importance of community care. A significant factor in support of such changes is the use of nursing and midwifery expertise. A focused plan to develop a substantiated body of knowledge that has high social relevance and can be used to guide patient care and professional decision making in nursing and midwifery services is needed. This report which has identified nursing and midwifery research priorities provides such a focus.

Nursing and midwifery research in Ireland is occurring but at a developmental phase. The identification of priority issues for nursing and midwifery research is welcome and will support advancement of health services in Ireland. Research priorities are identified in relation to clinical, managerial and educational issues for both nursing and midwifery.

This study was commissioned by the National Council through the Health Research Board in response to a recommendation in the national Research Strategy for Nursing and Midwifery in Ireland. A team of researchers from the School of Nursing, Midwifery and Health Systems, University College Dublin conducted the study with project governance from a steering group representing both the National Council and the Department of Health Nursing and Midwifery Research Committee.

I wish to thank the many individuals and organisations who contributed to this report, including study participants, researchers, commissioners and those involved in project governance. Particular thanks are extended to my colleagues Sarah Condell, Research Development Officer, Kathleen Mac Lellan who chaired the steering group and the researchers, Therese Meehan, Mary Kemple, Michelle Butler, Jonathon Drennan, Maree Johnson and Pearl Treacy.

Yvonne O'Shea
Chief Executive Officer

Research Acknowledgements

On behalf of my research colleagues I wish to acknowledge the many people who have contributed to the work of this study. Firstly, and especially, in relation to this Delphi survey of nursing and midwifery research priorities for Ireland, I wish to recognise the foresight of Bridin Tierney who, as the first research officer at An Bord Altranais from 1981-1985, attempted to conduct a Delphi survey of nursing research priorities for Ireland.

Appreciation is extended to Dr. Marie Carney and to the staff of the School of Nursing, Midwifery and Health Systems, University College Dublin for their support of this study, and particularly to those who travelled far and wide around the country explaining the study to nurses and midwives and encouraging them to participate. Gratitude is extended to the directors of nursing and to the directors of midwifery, and their assistants, in hospitals all around Ireland who welcomed the research assistants into their hospitals and did everything possible to assist them and to facilitate the participation of nurses and midwives in the study. I also wish to thank all the many nurses and midwives who took an interest in the study; their interest and enthusiasm for the study and for nursing and midwifery research has been greatly appreciated.

Most importantly, I wish to thank the nurses and the midwives who participated in this study, particularly for the time they took to think about the most important issues for nursing and midwifery research in Ireland and for completing the questionnaires. I trust that the findings of the study will be useful to them as they continue their commitment to providing the best possible care for the patients, the clients, the mothers and their babies.

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May 2005

Executive summary

This study has been conducted in order to identify research priorities for nursing and midwifery in Ireland. It represents an important step in the advancement of health services in Ireland and builds on the notable developments in nursing and midwifery in the country over recent years. The study has emerged directly from research strategy initiatives undertaken by the Nursing Policy Division of the Department of Health and Children. These initiatives led to the publication in January 2003 of *A Research Strategy for Nursing and Midwifery in Ireland: Final Report*.

The primary recommendation of the Research Strategy was that work should be undertaken at an early date to identify and prioritise the most important nursing and midwifery issues – in the areas of clinical practice, management and education – consistent with the wider healthcare agenda, which require a research base. Accordingly in 2004 the Department of Health and Children requested the National Council for the Professional Development of Nursing and Midwifery (National Council) to initiate a study to identify nursing and midwifery research priorities for Ireland. The study was subsequently commissioned by the National Council through the Health Research Board under the following terms of reference:

- To review the relevant national and international literature regarding research priorities for nursing and midwifery and set this in the context of research and development for health in Ireland.
- Using a robust methodology, to ascertain the research priorities and subsequent ranking for Irish nursing and midwifery from key stakeholders representing the totality of nursing and midwifery in Ireland.
- To provide an interim and final report, the latter of which should clearly identify short-term, medium-term and long-term priorities for nursing and midwifery research, including clinical, managerial and educational issues.

The team of researchers engaged in this study had available a considerable body of professional literature, mostly from international sources, on the concept of research priorities. This literature was reviewed comprehensively and was used as a guiding context for the study. It confirmed firstly the crucial importance of setting research priorities. Given the many and diverse health-related research topics that could be addressed, choices must be made. Available funding must be allocated to topics that have the highest potential impact on healthcare outcomes. Hence most developed countries have set national priorities for healthcare research that are directly linked to their particular healthcare needs.

The literature revealed secondly that 'value of research' is a central concept in considering approaches to setting research priorities. The 'value of research' approach suggests that priority topics must be specifically focused on health system burdens and needs and that stakeholders within the health system should be consulted in any priority setting exercise. It is of note that in the most influential studies reviewed the priorities identified have been linked carefully to national healthcare priorities.

The literature revealed finally that by far the most common approach to setting research priorities for nursing and midwifery is the Delphi survey of nurses' or midwives' views of what they think are the most important and most urgent problems that need to be addressed through research. This approach has been used widely for local, regional and national studies and for research by specialist practice groups because it is a relatively straightforward and effective method of making group decisions and is both time-effective and cost-effective.

It was therefore decided that the methodology for this study of research priorities for nursing and midwifery in Ireland would encompass a three-round, decision Delphi survey to identify and rate the importance of clinical, managerial and educational research issues, followed by a one-day discussion group workshop to identify timeframes within which research on the issues should be conducted. It was decided that this design would best allow for a national representative sample of informed nurses and midwives to reach majority consensus on research priorities within the designated time period and budget. In order to obtain the views of service users on nursing and midwifery research priorities, a small number of service users were included at the discussion group workshop stage of the study. The study was conducted over a nine-month period, from May 2004 through January 2005.

The basic Delphi survey comprises a series of paper and pencil questionnaires. On the round 1 questionnaire, convenience samples of 780 nurses and 142 midwives contributed over 5,000 statements of clinical, managerial and educational issues requiring research. The samples were demographically representative of nurses and midwives in professional employment in Ireland who were also knowledgeable about research; almost 80 per cent had completed a research module and 50 per cent had completed a research dissertation. In the analyses twenty-four nursing and twenty-six midwifery research issues were identified, each defined by specific examples. High response rates were achieved for the round 2 and round 3 questionnaires on which nurses and midwives rated the importance of their respective research issues using a 7-point importance rating scale. At a subsequent discussion workshop, participants rated the issues in relation to timeframes and in the light of the national health strategy and the health service reform programme.

Of the twenty-four priority issues for nursing research identified in the survey, five were rated high priority for research in the short term: three clinical issues, 'outcomes of care delivery', 'staffing issues in practice' and 'communication in clinical practice'; and two managerial issues, 'recruitment and retention of nurses' and 'nursing input into health policy and decision making'. Similarly, of the twenty-six priority issues for midwifery research identified in the survey, six were rated high priority for research in the short term: three clinical issues, 'satisfaction with care', 'care in labour' and 'preparation for practice'; one managerial issue, 'promoting woman-centred care'; and two educational issues, 'promoting the distinctiveness of midwifery' and 'promoting research/research-based practice'.

Research-based practice is a key factor in providing high quality, cost-effective and efficient health services. It is imperative, in moving towards meeting the health strategy requirement of transparent and evidence-based decision making, that the nursing and midwifery professions demonstrate the scientific evidence upon which their practice is based. Setting research priorities is central to the development of evidence-based practice.

The research priorities identified for nursing and midwifery in Ireland reflect the priorities identified in other European countries and in North America. They suggest research programmes that target the health service concerns identified in the national health agenda, such as the need to identify protocols and procedures that improve patient and client care outcomes and to examine and test solutions to workforce problems.

The findings of this study provide a firm basis for the development of nursing and midwifery research programmes that can further strengthen the professions' ability to extend health-related knowledge and help address important national healthcare problems and needs which are in urgent need of solutions.

1

Introduction

The professions of nursing and midwifery, together, constitute the largest professional group of healthcare providers in Ireland (Department of Health and Children 2002) and, as such, significantly influence the therapeutic quality and cost-effectiveness of the health services. The development of depth in nursing and midwifery scientific knowledge, which is needed to guide these services, requires systematic targeting of nursing and midwifery research endeavours and resources. There are many clinical phenomena, as well as managerial and educational issues, of interest to nurses and midwives. Therefore a focused plan is needed in order to develop a substantiated body of knowledge that has high social relevance and can be used to guide patient care and professional decision making in nursing and midwifery services. The identification of priority issues for nursing and midwifery research provides the appropriate focus for these undertakings.

In Ireland nurses and midwives are highly respected occupational groups, recognised widely for their professional commitment and services to society (Chavasse 1980). The Health Service Executive National Service Plan (2005) and national health documents such as: *Quality and Fairness: A Health System for You* (Department of Health and Children 2001a), *Primary Care – A New Direction* (Department of Health and Children 2001b) and *The National Health Promotion Strategy 2000–2005* (Department of Health and Children 2000) guide for the development of nursing and midwifery. Nurses and midwives provide essential services in every section of the health service, often on a twenty-four-hour basis. They are therefore centrally committed to performing their part in meeting the national health-service goals of fair access, responsive and appropriate care delivery, high performance and better health for everyone. Nurses and midwives are especially central to the goal of responsive and appropriate care delivery. This is because their professional responsibilities position them where they have the greatest influence on meeting the objectives of this goal – that is to say, the patient is placed at the centre of care delivery, appropriate care is delivered in the appropriate setting, and the recommended configurations of service are ones that will enhance the capacity to deliver timely and appropriate care.

The identification of priority issues for nursing and midwifery research is particularly pertinent to the health service goal of high performance. This has been demonstrated unequivocally in the United States of America (US) (US Department of Health and Human Services 1993, 1998, 2003). The central purposes of nursing and midwifery research are essentially the same as the health service goal of high performance, in other words the development of evidence-based standards to support best patient care and the continuous improvement of care embedded in daily practice. As professional disciplines, nursing and midwifery are committed to promoting best practice based on scientific research that is designed to examine and test their procedures, protocols and approaches to patient and client care, as well as the educational processes that support such care. In setting priorities for their research, nurses and midwives seek to identify the issues within the current, ongoing context of the health services that are most in

need of scientific examination and testing. The nurses and midwives who identify these issues are closely involved in all levels of health services, and the educational programmes which support them: thus they are well placed to identify the issues which are most important for nursing and midwifery in the context of national health policy.

The development of knowledge to support the national health strategy is closely associated with the health-related scientific research that is funded through the Health Research Board and non-government funding agencies. The structure for funding nursing and midwifery research, and for testing the use of knowledge to enhance service outcomes, is provided by the Department of Health and Children in collaboration with the Health Research Board as outlined in *Making Knowledge Work for Health: A Strategy for Health Research* (Department of Health and Children 2001c). The setting of priorities for nursing and midwifery research will serve to appraise the Department of Health and Children and the Health Research Board, and other possible funding agencies such as the Health Service Executive, the National Council and An Bord Altranais, of the research issues that nurses and midwives judge likely to have the highest potential impact on health service outcomes.

This study represents a significant step in the advancement of health services in Ireland and builds on the recent, significant developments in nursing and midwifery in the country. Bridin Tierney (1986), as the first research officer at An Bord Altranais, conducted a study to identify nursing research priorities for Ireland. Unfortunately, the study was not completed. Ten years later the importance of funding a study to identify nursing and midwifery priorities for Ireland was again highlighted (Ni Mhaolrunaigh 1996). Following the publication of *Report of the Commission on Nursing: A Blueprint for the Future* (Government of Ireland 1998), wide-ranging changes in the nursing and midwifery professions and their roles in the health services were implemented. In particular, the nursing policy division at the Department of Health and Children convened a research strategy committee to prepare a strategy for the development of nursing and midwifery research in Ireland for the short-term, medium-term and long-term (Department of Health and Children 2003b).

The overall aims of *A Research Strategy for Nursing and Midwifery in Ireland: Final Report* (Department of Health and Children 2003b) were to develop an initiative which would contribute effectively to 'knowledge development; the health and social gain of the population; policy formulation and ongoing development; and analysis of health, nursing and midwifery issues' (p.16). The vision of the research strategy report echoes the belief of many nurses and midwives that recipients of nursing and midwifery care deserve research-based practice. Research, as defined in the research strategy report, is 'The process of answering questions and/or exploring phenomena using scientific methods; these methods may draw on the whole spectrum of systematic and critical inquiry' (p.16).

The primary recommendation of the strategy is to identify and prioritise the most important nursing and midwifery clinical practice, management and education issues, consistent with the wider healthcare agenda, which require a research base. Accordingly, in 2004, the Department of Health and Children devolved responsibility to the National Council to call for proposals for a study to identify nursing and midwifery research priorities for Ireland, which the National Council commissioned through the Health Research Board.

Terms of reference

This study was guided by the terms of reference set forth by the National Council for the Professional Development of Nursing and Midwifery:

- To review the relevant national and international literature regarding research priorities for nursing and midwifery and set this in the context of research and development for health in Ireland.
- Using a robust methodology, to ascertain the research priorities and subsequent ranking for Irish nursing and midwifery from key stakeholders representing the totality of nursing and midwifery in Ireland.
- To provide an interim and final report, the latter of which should clearly identify short-term, medium-term and long-term priorities for nursing and midwifery research, including clinical, managerial and educational issues.

In addition, when commissioned to undertake this research, the researchers were requested by the funding body to attempt to capture the service users' views on nursing and midwifery research priorities.

Project governance

A steering committee was set up which represented both the National Council and the Department of Health Nursing and Midwifery Research Committee. The members of the steering committee were:

Mr Colum Bracken

Ms Sarah Condell

Ms Mary Godfrey

Ms Annette Kennedy

Ms Mary McCarthy

Ms Anne Marie Ryan

Dr Denis Ryan

The steering committee was chaired by Dr Kathleen Mac Lellan and met with the project team four times. The final report was brought to the National Council meeting and the Department of Health Nursing and Midwifery Research Committee June 2005.

Following the commissioning process, a team from the School of Nursing, Midwifery and Health Systems, University College Dublin, led by Dr Therese Meehan conducted the study. The researchers were Ms Mary Kemple, Dr Michelle Butler, Mr Jonathan Drennan, Dr Maree Johnson and Dr M. Pearl Treacy.

2

Review of literature

A considerable body of literature on the concept of research priorities exists and will serve as a guiding context for this study. The literature is reviewed under several headings in this chapter. Firstly, the concept of setting research priorities is examined and then different approaches to setting research priorities are reviewed. The Delphi survey as an approach to setting research priorities is examined in some detail. This is followed by a review of the literature on setting research priorities for nursing and then for midwifery. Finally, the literature review is drawn together in a summary which leads to the research questions addressed in this study.

Setting research priorities

It is widely recognised that scientific research is a key factor in the provision of effective and efficient health services (Department of Health and Children 2001c, U.S. Department of Health and Human Services 2005). Setting research priorities for health service professions is central to providing the greatest health benefits to the population in question within budget constraints and with respect for equity considerations (Larson 1993, Fleurence and Torgerson 2004). Health professions, naturally and necessarily, practice in collaboration with one another and engage in multidisciplinary research to examine the multiplicity of factors that influence their combined effectiveness in providing health services (Burnette et al 2003, Wilkerson 2004, U.S. Department of Health and Human Services 2005). The need for collaborative research among nurse and midwife researchers and with researchers from other disciplines is a given in the setting of nursing and midwifery research priorities (Ropka et al 1994). At the same time, each profession provides a distinctive service and contribution to this collaboration and is responsible for conducting the research needed to determine how it can contribute its greatest possible therapeutic value within budgetary constraints.

Scientific research is very costly and the funding available for research is always limited. Given the importance, diversity and large quantity of health-related research topics that could be addressed, choices must be made for each professional group and for the health service as a whole (Larson 1993, Edwards 2001). Available funding must be allocated to topics that have the highest potential impact on healthcare outcomes (U.S. Department of Health and Human Services 2005). Making such choices for funding is commonly called setting research priorities. Most developed countries have set national priorities for healthcare research which are directly linked to their particular healthcare needs (Chang 2000). Within countries, most health professions have set research priorities for their distinctive areas of practice, which are clearly linked to national healthcare priorities.

The setting of priorities for health services research emerged in the US in the mid-1970s (Fox 1976). Nursing was one of the earliest healthcare professions to set research priorities beginning, also in the US, with a landmark national study of clinical practice research priorities by Lindeman in 1975. Nurses saw clearly that their priorities had to fall within the purview of the nursing profession while also responding to the broad demands of health service needs. The setting of nursing research priorities was aimed at enhancing the contribution of nurses to health services through encouraging targeted programmes of research that could provide data with greater potential to improve practice outcomes and to better inform health policy (Ropka et al 1994).

These developments in the US were commensurate with a national readiness amongst nurses to set priorities for research. Bloch (1990) has emphasised the importance of national readiness amongst nurses as a prerequisite for setting nursing research priorities, including nursing education established at the university level, strong nursing leadership, well-qualified nurse researchers, involvement of the nursing community, and government support and funding for nursing research. Most importantly, Bloch emphasised that nurse researchers must be ready to focus on clinical practice-oriented research rather than on characteristics of nurses, social sciences and nursing education. Knowledge developed from studies in clinical practice-oriented areas also strengthens the theoretical knowledge base of each professional discipline (Burnette et al 2003). Professions with the strongest theoretical and research bases provide the greatest contribution to the collaborative provision of health services.

Approaches to setting research priorities

Economists argue that because funds for research and the provision of services come from the same limited health system budget, some measure of health system 'value of research' must be used to determine research priorities (Fleurence and Torgerson 2004, p. 2). 'Value of research' can be measured by the effect that the research is likely to have on relieving the burden of disease in the health system, by the impact of change in clinical practice that is likely to occur as a result of the research and by complex models of value of information analysis. This approach suggests that priority topics must be specifically focused on health system burdens and needs and that stakeholders within the health system should be consulted in any priority setting exercise. Elements of this approach are evident in the process undertaken to identify nursing research priorities in the US in the 1980s, where nurse scientists at the National Institutes of Health, the government funding agency, collaborated not only with nursing colleagues but also with colleagues in related disciplines (Hinshaw et al 1988). Priority areas for research, identified from the nursing literature, from smaller regional and specialist nursing priority studies and from nursing conference discussions, were considered in consultation with colleagues in related healthcare disciplines within the government funding agency. High priority nursing topics were tied directly to high priority areas on the national list of disease burdens, for example care of low-birth-weight infants and care of HIV-positive patients and their families. These are topics where nursing research could have, and has had, a significant impact on the quality, as well as the cost-effectiveness of care (US Department of Health and Human Services 1998, 2003).

If the 'value of research' approach is taken in nursing research priority studies, it must be carried through and the priority topics linked directly to burdens and needs of the health system. In a nursing research priority-setting study undertaken in the United Kingdom (UK), priorities were identified by key nurse researchers in consultation with key medical, health policy and academic researchers and through a wide-ranging consultative process incorporating the views of key members of professional and statutory nursing organisations, funding agencies, and nurses in practice, management, education and research roles (Kitson et al 1997). But, the priorities identified remained very broad. For example, it is not clear how the priority topics 'informal carers' and 'nurse-led systems of care', identified under the theme of care and caring practice, may contribute specifically to relieving the disease burden in the National Health Service. In a recent study designed to identify nursing and midwifery research priorities for England and Wales, Ross et al (2004) also appear to take a broad 'value of research' approach but do not link the priorities to health system needs. Study participants included a wide range of stakeholders, including medical doctors, allied health professionals, research commissioners, policy makers, educators, managers and researchers, as well as nurses and midwives. Priorities were also identified from an analysis of the professional literature, and from focus groups with service users. However, it is not made clear how research on 'continuity of care' or 'staff capacity and quality', referred to as priority areas, could contribute directly to addressing National Health Service healthcare priorities. In fact, the findings are so broad that the nursing and midwifery professions are not differentiated from one another.

It is also not clear that seeking the views of a wide range of non-nursing and midwifery stakeholders through the use of questionnaires or focus groups is a necessary part of a priority-setting exercise. Hinshaw et al (1988) emphasise that it is the privilege and responsibility of nurses to identify nursing research priorities, as it is the privilege and responsibility of members of other health professions to identify their research priorities. In the Hinshaw et al (1988) and Kitson et al (1997) priority-setting approaches, a small number of representatives of health policy and other health professions met with the researchers to consider the study or the results. In the Ross et al (2004) study, participation of a large number of non-nursing and non-midwifery stakeholders was sought. However, several representatives from government organisations, policy makers and members of non-nursing and non-midwifery professional organisations declined to participate in the study either because they thought that their perspective was not relevant to the study or that their involvement would be inappropriate. The great majority of studies designed to identify nursing research priorities do not include non-nursing stakeholders in the data collection process. It appears that most researchers assume that knowledgeable and experienced nurses and midwives who work closely with members of other health professions and who are engaged directly and indirectly in providing their distinctive services to patients and clients are best placed to actually identify the health service needs that their professions are able and responsible to meet. When the views of members of other health professions, funding agencies and health policy advisors are sought, this is done on a consultative basis once the research has been completed.

Most studies designed to identify research priorities for nursing and midwifery do not include the views of service users. However, it has been argued that service users have an important role to play in the research process by providing personal perspectives of the experience of illness and grounding researchers in the purposes of their work (Rhodes et al 2001). The inclusion of service users in research has become part of government policy in the UK (National Health Service Executive 1998). However, Rhodes et al (2002) observe that a common misunderstanding of service users involvement in research is that their views are sought during the data collection process through interviews and focus groups. In fact, the most widely adopted model of service user involvement in research is the presence of a small number of user representatives on a steering or advisory group. The findings of a study of service users' involvement in research support this model (Rhodes et al 2002). Only one study of nursing and midwifery research priorities which included service users in the sample was identified (Ross et al 2004). Service user data were collected through focus groups and particular prominence was given to how they viewed nursing and midwifery services. However, only 25 per cent of the projected sample actually participated in the focus groups and they clearly did not represent the population of service users. While it is important to acknowledge the value of service users views, these findings suggest that it may not be the best approach to include them in a study sample.

Approaches to setting research priorities for nursing and midwifery vary depending on the level of research development, the resources available to support research, the level of strategic planning, and the philosophical approaches regarding who should be involved, and how they should be involved, in setting priorities. By far the most common approach to setting research priorities for nursing and midwifery is the Delphi survey of nurses' or midwives' views of what they think are the most important and most urgent problems that need to be addressed through research. This approach has been used widely for local, regional and national studies and for research by specialist practice groups because it is a relatively straightforward and effective method of making group decisions and is both time-effective and cost-effective (McKenna 1994, Powell 2003).

The Delphi survey

The Delphi survey, also known as the Delphi technique or method, originated in the US in the 1940s as an attempt to predict horse racing outcomes (Lindeman 1975). Dalkey and Helmer (1963) first described its use in scientific research in an experiment devised to obtain the most reliable possible consensus of opinion from a group of experts about the course of future events, and to thereby solve a problem of national importance. This was achieved by administering a series of focused questionnaires to individual experts, interspersed with selective feedback of information, until a degree of consensus on the future events was reached. The researchers concluded that even though the process required refinement, it was very effective. The process became widely used as a predictive tool in industrial, social and educational planning and was subject to extensive analysis and refinement (Linstone and Turoff 1975). The Delphi survey is adaptable to a wide range of problem situations where a consensus of opinion and decision is required, especially in situations where priorities must be set and policies formulated (Tichy 2001). It has

been used extensively for decision-making by health professionals (Couper 1984, McKenna 1994).

The essential format of the Delphi survey, a series of paper and pencil questionnaires, has been subject to many variations but follows a basic set of steps (Couper 1984, Hasson et al 2000). Generally, the first questionnaire (round 1) consists of an open-ended question asking the participants to think carefully about the problem area and state solutions. For example, many nursing research priority studies follow Lindeman (1975) and request that the participants list up to five burning questions about the practice of nursing that need to be addressed through research. The responses are subject to content or thematic analysis and are collated by the researchers and formulated into statements that are used to construct a second, closed-ended questionnaire. On this questionnaire (round 2) the participants are asked to rate the importance of each statement on a 5 to 7-point Likert-type rating scale, and are sometimes asked to make written comments on the statements. The participants' ratings are analysed using descriptive statistics to get a mean importance rating and a measure of variability of the rating for each statement, and any written comments are recorded. The third questionnaire is the same as the second questionnaire except that for each statement, the mean, sometimes the measure of variability and any written comments are included. This feedback provides each participant with the collective group opinion for each statement. The participants are then asked to rate each statement again (round 3), taking into consideration the feedback of group opinion from questionnaire 2. This process may be repeated in a fourth questionnaire (round 4) if the scope of the study allows. The study results consist of a listing of statements or questions about the area of concern ranked in order of priority.

The Delphi survey is a particularly useful method of collecting and aggregating the ideas and judgements of a large group of geographically dispersed individuals in a time- and cost-efficient manner (Hardy et al 2004). It fosters the honest expression of views and equitable decision-making by study participants because they are normally anonymous to one another. Each participant has an equal opportunity to present ideas, to make judgements and to consider the judgements of others without being influenced by peer group pressure or by more outspoken or powerful individuals (Whitman 1990). Thomas (1976, p. 384) has likened the process to a 'quiet, thoughtful conversation, in which everyone gets a chance to listen'. This can create a highly motivating environment for the study participants (Dalkey 1972), encouraging them to reflect on new ideas and opinions and share responsibility for deciding the outcomes of a study (McKenna 1994, Williams and Webb 1994).

The Delphi survey process is flexible within certain methodological constraints. It can allow for the inclusion of small or large samples of study participants, ranging from 10 to 1,685 (Williams and Webb 1994). The number of participants varies in relation to the scope of a problem and the resources available for the study (Powell 2003). For a homogeneous group a small sample is usually sufficient, but for a heterogeneous group a large sample is usually required. Large heterogeneous samples can be accommodated and produce results which are highly consistent (Couper 1984). At the same time, a large sample may reduce questionnaire response rates and threaten the reliability of the study. Originally, Delphi survey participants were experts on the survey subject; however they are now commonly identified more broadly as persons who are particularly knowledgeable about the subject (Martino 1983, Powell 2003). The representativeness of a sample may depend on its size or on the subject expertise of the participants, depending on the circumstances of an individual study.

Methodological issues arise with regard to the Delphi survey questionnaires. The round 1 open-ended question can generate a large number of widely divergent statements. Hardy et al (2004) have pointed out that many statements may be poorly phrased and ambiguous and can reduce the validity of the data. The process of analysing and categorising the data can be very difficult and time-consuming and there appears to be no clear guidelines on how this should be accomplished. The validity and reliability of the process relies on the conceptual skill and the integrity of the researchers. On the importance rating questionnaires the number of statements and their rating varies across studies. Hardy et al used 112 statements and maintained a good response rate across questionnaire rounds with a sample of thirty participants. However, usually a much smaller number of statements are used to create a questionnaire of reasonable length and to encourage a good response rate, particularly in a large sample of participants. Couper (1984) has suggested that generally twenty-five statements is a practical number. The Likert-type rating scales which accompany the statements may have from five to nine rating points. Although the data from these scales are theoretically considered ordinal data, they are treated as interval data in most studies. Higher-point scales provide more interval-like data and allow for greater discrimination of ratings.

Although consensus is the aim of the original Delphi survey, there are no definitive rules for how it

should be established and there are variations across studies on how it is achieved (Crisp et al 1997). Responses on the round 3 questionnaires usually show convergence of opinion (Linstone and Turoff 1975) and a reduction in the dispersion of the participants' ratings (Powell 2003). This suggests that decreases in the statistical indicators of variability of ratings across rounds could provide a measure of consensus (Williams and Webb 1994). In several studies, per cent agreement on the final rating of items is used as a measure of consensus, however there are wide variations in percentages considered acceptable, ranging from 51 per cent (McKenna 1994) to 100 per cent (Williams and Webb 1994). Hardy et al (2004) used a 7-point rating scale and set the criterion for determining consensus on a statement as 85 per cent of ratings falling within a 2-point bracket on the scale. Crisp et al question the value of numerical consensus and argue instead that the stability of responses across questionnaires is a more reliable indicator of consensus.

Two main variations of the conventional Delphi survey have been identified: the policy Delphi survey and the decision Delphi survey (Crisp et al 1997). The policy Delphi survey serves as a forum for developing ideas and analysing policy issues. The decision Delphi survey serves to create a future reality rather than just predicting it. It is an effort to transfer an important field of activity 'from a pattern of accidental development through uncoordinated decisions toward a pattern of broad discussion among all involved... and thus toward goal-oriented and well-considered management' of the activity (Rauch 1979, p. 159). The decision Delphi survey differs from the conventional Delphi survey in that the sample is usually large, 'big enough to cover all aspects of the topic' (Rauch 1979, p. 160) and is composed of knowledgeable participants who are directly involved with the topic of concern, rather than a small number of experts. A goal of the researchers is to 'stimulate the participants and encourage them to identify with the questions' (Rauch 1979, p. 164). It is accepted that some participants will know one another and may share information about their participation in the study. A high questionnaire response rate is considered particularly important and 'reminding procedures', involving direct and indirect persuasion, are employed to foster high response rates (Rauch 1979, Dillman 2000, Tichy 2001). In addition, because the decision Delphi survey is not strictly concerned with prediction, consensus is not considered to be of paramount importance (Rauch 1979). These characteristics are consistent with the purposes and methods of many Delphi surveys designed to set nursing and midwifery research priorities even though this type of Delphi survey is usually not identified.

The many advantages of the Delphi survey relate to its flexibility and adaptability to different research needs and situations, but these characteristics also lead to certain limitations (Keeney et al 2001, Powell 2003). The Delphi survey has been widely criticised for not having precisely established methodological guidelines. McKenna (1994) has suggested that it may be more accurately considered a research approach rather than a specific method and, as such, can be susceptible to several threats to internal validity. Care must be taken that the participants actually are the most knowledgeable persons on the topic at hand. Any limitations in their ability to express their knowledge clearly and accurately on the round 1 questionnaire or any misreading in the analyses of this content and its translation into statements for questionnaire 2 pose threats to the content validity of the questionnaires. These threats can be compounded by the lack of specific guidelines for conducting this process.

Sackman (1975) has suggested that anonymity amongst participants may encourage a lack of accountability in their responses. A substantial time commitment is required on the part of researchers to facilitate high questionnaire response rates (Jairath and Weinstein 1994, Williams and Webb 1994). Any decrease in the participants' motivation to complete questionnaires accurately across the rounds, as well as loss of participants from the survey with the administration of each questionnaire, will also pose threats to internal study validity and the reliability of the study findings. In addition, Sackman has argued that the Delphi survey discourages the expression of dissenting opinions and that claims to consensus of opinion may not be valid. There is no agreement on how to best demonstrate level of consensus (Crisp et al 1997), and Greatorex and Dexter (2000) have argued that it is inevitable that this decision is subjective and will vary from study to study. Moreover, Whitman (1990) contends that it is not clear whether the degree of consensus reached represents true agreement based on considered opinion or is a consequence of a tendency to conform. Overall, the flexibility of the Delphi survey requires that sound scientific research principles are applied to all the steps involved in its use to ensure that, to the greatest extent possible, the study results are valid and reliable.

Setting research priorities for nursing and midwifery

Concern with setting nursing research priorities was first raised at a meeting of the American Nurses' Association Council of Nurse Researchers in 1974 because that body recognised the government research funding agency's concern that research of the health professions be related to major health priorities (Lindeman 1975). Since that time over one hundred studies designed to identify nursing and midwifery research priorities have been reported worldwide. In most studies nursing and midwifery have been treated as separate disciplines and their research priorities determined separately.

Nursing

Most studies designed to set nursing research priorities focus on specialist nursing practice, for example mental health (Ventura and Waligoru-Serafin 1981, Davidson et al 1997, Pullen et al 1999), palliative care (Cawley and Webber 1995, Chang and Daly 1998), oncology (Oberst 1978, Bakker and Fitch 1998, McIlpatrick and Keeney 2003, Cohen et al 2004), rehabilitation (Gordon et al 1996), long term care (Haight and Bahr 1992) and care of children (Broome et al 1996, Schmidt et al 1997) and public health nursing (Albrecht and Perry 1992, Misiner et al 1994). Many studies concern local or regional geographic areas such as a specific medical centre (Fitzpatrick et al, Davidson et al 1997), New York State (Shortridge et al 1989), Western Australia (Bartu et al 1991) and Northern England (Bond and Bond 1982). Several national studies focus on specialist nursing practice areas, for example in the US, critical care (Lewandowski and Kositsky 1983, Lindquist et al 1993), care of children (Hinds et al 1994), and emergency nursing (Bayley et al 2004); in Hong Kong, critical care (Lopez 2003); and in New Zealand, mental health nursing (Hardy et al 2004). In addition, some studies focus on priorities for nursing administration (Henry et al 1987, Lynn and Cobb 1994, Lynn et al 1999) and for nursing education (Bullock and Grayson 1995, Misener et al 1997).

The majority of these studies were 3-round Delphi surveys, while a few were cross-sectional surveys where priority areas were identified from the literature, by brainstorming or consultation with a range of stakeholders. Most studies include samples of 100-300 participants who were well informed in relation to the particular study focus, but some specialist studies draw on small samples of less than forty clinical experts or experienced researchers. Study limitations included concerns about the selection of expert participants and low questionnaire response rates. Most studies indicate that some degree of consensus was achieved in setting the priorities and all indicate clear directions for future research.

Some clinical specialist studies identified more than fifty specific patient concerns. Common clinical practice concerns across the studies were symptom management (especially in relation to pain), anxiety and stress, effectiveness of nursing interventions and outcomes of nursing care, nurse-patient communication, patient participation in decision-making, and patient education. Concerns with conditions of practice included staff-patient ratios, stress and staff turnover, reasons for and effects of nursing shortages, ways to retain nurses in practice and professional role development. Nursing administration priorities included concerns with the effects of patient care environments on patient outcomes and nurses' ability to provide effective care, skill mix, influence of informatics, measures of nursing intensity and patient acuity, models of nursing care, and use of research in practice. Nursing education priorities included concerns with teaching nursing competencies, research competencies and leadership skills.

It is of particular note that one regional study has been conducted to identify nursing and midwifery research priorities in Ireland. McCarthy et al (2005) used a multi-method design to identify nursing and midwifery research priorities for the Health Service Executive Southern Area. Priority areas were developed through analysis of practice documentation and in focus groups with seventy nurses and midwives employed in clinical, management and education positions. These data were used to formulate topics for an importance-rating questionnaire which was completed by 474 nurses and midwives. Priority areas for research were assessment and management of clinical practice, health promotion, transition from hospital to home, nursing education, quality of services, and support services. The highest priority topics requiring immediate research were the impact of staff shortages on the retention of nurses and midwives, stress and bullying in the workplace, quality of life for chronically ill patients and their carers, the assessment and management of pain, cardiopulmonary resuscitation decision-making, skill mix and staff burnout, transitional care for patients discharged early from hospital, and promoting healthy lifestyles.

Increasing attention has been given to identifying global regional and international nursing research

priorities (Hirschfeld 1998, Tierney 1998). In 1995 the Nordic countries (Norway, Sweden, Finland, Iceland, Denmark) collaborated in a conference discussion to identify the following common nursing research priorities: promoting health and well-being across the life span, symptom management, care of the elderly, cost-effectiveness evaluation, restructuring healthcare systems, and self-care and self-management of health and illness (Tierney 1998). In 2004, Castrillon Agudelo reported six nursing research priority areas shared by Latin-American countries (Brazil, Colombia, Chile, Ecuador, Honduras, Mexico, Peru): the work process of nursing, nursing actions related to health promotion, recovery and rehabilitation of health, advancement of knowledge specific to nursing practice, nursing interventions, and the formation of human resources in nursing. In a recent summary of global nursing research priorities compiled by Sigma Theta Tau International (2005), the top priorities shared by a number of countries included health promotion and disease prevention, targeting infectious diseases, patient safety including measures of nursing-sensitive outcomes, improvement and impact of nursing interventions on outcomes, evidence-based practice, and care of the older person. Hinshaw observed in 1997 that some priorities across countries are similar, for example health promotion, risk reduction, and care of the elderly and persons with chronic illnesses. However, Hinshaw also noticed some striking differences related to the types of prevalent illnesses and health concerns. There are also great differences between countries in levels of professional and research development. International research priorities are undoubtedly important in an increasingly globalised world, nonetheless Bloch (1990) and Chang (2000) have stressed that good priority setting must take place for each country within the national context and in relation to the country's health needs and problems.

Eight studies and two reports on national nursing research priorities have been identified. As noted, Lindeman reported a Delphi survey to identify clinical nursing research priorities for the US in 1975. Questionnaires were sent to a panel of 419 nurses and fourteen non-nurses from nursing and research agencies. The panel identified over 2,000 topics and rated the 150 most frequently mentioned topics in a 3-round process of iteration. The fifteen highest-rated patient-care topics included identification of valid and reliable indicators of high-quality patient care, nursing interventions related to stress, care of the aged, pain management, and patient education in self-care. The fifteen highest-rated topics of professional significance were increasing the utilisation of research in practice, effective implementation and evaluation of changes in practice, establishing the relationship between clinical nursing research and the quality of patient care, and the development of physiological and psychological assessment procedures needed to improve patient care.

Thirteen years following the Lindeman (1975) study, nurses at the US National Center for Nursing Research at the National Institutes for Health conducted an updated evaluation of research priorities. Topics were identified from a review of nursing literature and research priorities were identified in speciality practice and regional research priority studies (Hinshaw et al 1988). These were analysed by experienced nurse researchers at a specially convened conference. Seven clinical research priorities were identified in order of importance and were staged in terms of short-range to long-range needs. Stage I focused on care of low birth-weight infants and their mothers and on the care of HIV patients and their families, both with emphasis on prevention. Stage II focused on long-term care, symptom management and development of information systems. Stage III focused on health promotion and an examination of technology dependency across the life span.

In the UK, Kitson et al (1997) sought to identify nursing research priorities by inviting representatives of professional and statutory nursing organisations, funding agencies, and other concerned groups to identify general themes under which research priorities could be organised. Four themes were identified and, for each theme, an expert nurse group from clinical practice, research, academia and strategic management (total n=60) identified seven to ten specific preliminary research topics. For each theme, three top topics were identified as follows: for the theme of care and caring practices: patient perspectives, informal carers and nursing interventions; for the theme of healthcare environment: empowerment, inequalities and alliances; for the theme of organisations and management of care: nurse practitioners, pathways/case mix/managed care; for the theme of healthcare workforce: teamwork, cost-effectiveness of nursing skill mix and identifying the added value of nursing.

Ross et al (2004) identified priorities for nursing research funding for two countries of the UK, England and Wales. Data were collected from thirty-two service users using focus groups, from sixty-four nursing and other stakeholders using semi-structured telephone interviews, and from analysis of the literature. Five priority areas for research were identified: appropriate, timely and effective interventions; individualised services; continuity of care; staff capacity and quality; and user involvement and participation.

To identify nursing research priorities for Spain, Moreno-Casbas et al (2001) began by selecting twenty-four practice problems at a nursing conference using the nominal group technique. These problems were then rated on a 5-point importance scale in a 2-round Delphi survey by a wide-ranging panel of 189 nurses. Ten clinical research priorities were identified, including continuity and co-ordination of nursing care, quality of nursing care, impact of invasive techniques and treatments on patients' quality of life, needs of primary care givers, and quality of life among older people.

In Taiwan, Republic of China, Yin et al (1999) used consensus group idea-writing to identify national nursing research priorities. At a conference, 195 nurses from hospitals (84%) and education (16%) were asked to describe the research topics that they thought should be of highest priority for practice, management and education. The topics were analysed and reported back for total group discussion where 148 topics were selected. These were reduced to twenty-six topics prioritised as clinical (n=14), educational (n=4), and management (n=8). The highest rated clinical topics were quality of care, care of the elderly, infectious diseases, patient education, and women's and children's health. The highest rated topic for education was role preparation, and for management the highest rated topics included cost analyses, personnel administration and effectiveness and productivity.

French et al (2002) identified research priorities for hospital-based nursing practice in Hong Kong using a 3-round Delphi survey. In round 1, a panel of 195 purposively selected clinical nurse managers were asked to identify common practice issues that required research. Six hundred items were received from 135 respondents collapsed into sixty-five categories, and rated on importance in two Delphi iterations using an eleven-point scale which yielded forty-five final clinical practice priorities. The top ten ordered priorities were nurse-patient communication, competency in resuscitation, medicines administration, nursing documentation, pain management, wound management, pressure sore prevention and management, risk management and infection control.

In Korea, Kim et al (2002) used a 2-round Delphi survey and 1-day workshop to identify nursing research priorities. A national representative sample of 1,047 nurses were asked to identify important problems for research. The 310 respondents identified 1,013 research problems. Twenty-nine research areas were categorised and rated on a 7-point rating scale in the second round of the survey. These data were then prioritised by a group of sixty-five nurse experts, at a 1-day discussion workshop, who also took into consideration the topics of 706 research articles published in a Korean research journal. Advanced practice nursing was identified as the highest priority, followed by nursing interventions, clinical competence, quality and effectiveness of nursing care and standardised nursing tasks.

Of these eight studies, four employed a Delphi survey, three employed group meetings two of which considered information derived from literature reviews, and one employed focus groups and semi-structured interviews. Purposive sampling was used in all studies. Target samples ranged from 80 to 1,250 and respondent samples ranged from 60 to 452. Delphi questionnaires ranged from 20 broad items to 149 specific items and questionnaire response rates ranged from 21 per cent to 78 per cent. Nurse participants' education ranged from basic training to doctoral education and samples included nurses in practice, management and education, and two studies drew on data from non-nurses. Most of the studies gave high priority to specific clinical practice concerns but, in only one study were priorities linked specifically to the national health needs. Some priorities gave specific direction for nursing research endeavours, for example care of the elderly and needs of primary care givers. Other priorities seemed somewhat formless, for example empowerment, inequalities and alliances, and staff capacity and quality.

In addition, national nursing research priorities are reported for Chile and Thailand. In an overview of the development of nursing in Chile, Lange and Campos (1998) suggested twenty-three nursing research priorities for their country. Clinical priorities predominate and include: promotion of healthy lifestyles; women's, family and rural health; drug abuse prevention among young people; and long-term care of the elderly. Priorities for management included cost-effectiveness and continuity of nursing care, and for education, the type of nurses needed and areas of training that require emphasis. Hinshaw (1997) reported that nurse educators in Thailand identified a number of nursing research priorities including prevention, management and rehabilitation for health problems with emphasis on quality of life; self-care and self-reliance of individuals, families and communities; health promotion for vulnerable populations; and prevention and modification of health risk behaviours related to specific chronic diseases.

Midwifery

For midwifery, the identification of research priorities has been based on consultative and research approaches. The International Council of Midwives conducted a workshop at its Triennial Congress in

2002 to identify international midwifery research priorities (Renfrew et al 2003). It included thirty-five participants from the US, UK, Malawi, Japan, Australia, China, Denmark, Germany, India, Israel, Malta and Zimbabwe. Emphasis was placed on the need for international midwifery research to address important issues in women's health, and that such research is of high quality, culturally sensitive, and mutually respectful. Priority areas identified were defining midwifery and midwifery care, the prevention of caesarean birth and other interventions, preventing maternal and infant mortality and morbidity, HIV/AIDS, infant feeding, violence against women, and workforce planning.

In 2001 in Canada, researchers interested in midwifery were invited to a 'National Invitational Workshop on Midwifery Research' to begin discussions about priorities and strategies for carrying out a national programme of research. Midwifery research was defined as 'research by midwives, for midwives, or about midwives or midwifery care, framed by the particular purposes, values and skills of midwifery' (British Columbia Centre of Excellence for Women's Health (BCCEWH) 2002, p. 8). Priorities were identified based on areas of midwifery-related research with which they were involved and research considered to be important for the future. Priorities were developed in four thematic areas: a midwifery model of care including the notion of informed choice, midwifery practice issues, mapping midwifery demographics across the country and midwifery policy. Priorities included clinical studies to contribute to evidence-based practice, evaluation of midwifery practice, the sustainability and growth of the profession of midwifery, the relationship between midwifery and healthcare policy, evaluation of midwifery education programmes, and birthing women's experiences of midwifery care.

Raisler (2000) undertook a systematic literature review of 140 studies and 161 papers concerning midwifery care or practice published in the US between 1984 and 1998. The aim of the review was to describe the current state of midwifery care research in order to contribute to building a research agenda. Six major areas were identified: midwifery management of care, structure of care, midwifery practice, midwife-physician comparisons, place of birth, and care of vulnerable populations

A systematic consultation study conducted in the UK by Ross et al (2004), to identify priorities for funding midwifery as well as nursing research is reviewed under the nursing heading above. However, midwifery is not differentiated from nursing in this study and it is not clear how many midwives or midwifery service users or other midwifery stakeholders participated in the study. It must be assumed that the identified priority topics – appropriate, timely and effective interventions; individualised services; continuity of care; staff capacity and quality; and user involvement and participation – relate to midwifery, although the topics relate only in a very general sense.

One 3-round Delphi survey of midwifery research priorities conducted in the UK has been reported (Sleep et al 1995). A 2.5 per cent sample of practising midwives (n=875) and a 2.5 per cent sample of student midwives (n=109) were randomly selected from national populations. Data from questionnaire 1, on which participants were asked to submit up to five important issues related to midwifery that require research, were analysed and sorted into 149 specific topics. On questionnaire 2, the 149 topics were grouped within categories or themes and participants were asked to rate the topics within each category or theme in order of importance. The fifty-seven highest rated topics were used to construct questionnaire 3 and the participants were asked to rate each topic on a 6-point Likert-type scale. Twenty top priority topics were identified, including specific aspects of foetal monitoring, preparation for pregnancy and childbirth, systems of care, midwifery management, midwife roles, management of labour, midwife satisfaction, maternal satisfaction and postnatal care. Specific examples of each priority were also presented.

Overall, midwifery research priorities both nationally and internationally are well identified in the literature. Across consultations and studies midwives agree on similar areas of concern and on specific priorities. In the area of maternal and child health priorities, the focus is on preventing mortality and morbidity, HIV/AIDS, infant feeding and violence against women. Midwifery models of care are also an area of concern, including the priorities of management of care, preventing caesarean birth and other interventions, vulnerable populations, and structures and systems of care. In the area of aspects of midwifery care, common priorities are antenatal and postnatal care and care during labour, mothers' experience of midwifery care, mothers' choice and satisfaction regarding care and preparation for pregnancy and childbirth. Priorities in the area of professional issues include defining midwifery and evaluation of midwifery care, the sustainability and growth of midwifery, workforce planning, midwifery education and the influence of midwifery on health policy.

Summary

Scientific research is central to effective and efficient health services. Setting research priorities for the health service professions, particularly for the largest professional grouping of nursing and midwifery, is key to providing the greatest health benefits to the population within budget constraints. While the health service professions practise in collaboration with one another and engage in multidisciplinary research, each profession provides a distinctive service to society and is responsible for conducting the research needed to determine how it can maximise its unique contribution to disease prevention and health promotion. The nursing and midwifery professions in Ireland are well prepared and ready to identify their research priorities. Through this endeavour they seek to enhance their contribution to the health services by encouraging targeted programmes of research to provide data to improve patient and client care outcomes and to better inform health policy.

This study to identify nursing and midwifery research priorities for Ireland is set within the context of the many nursing and midwifery research priority studies which have been conducted worldwide at local, national and international levels. Value for research is a central concept in considering approaches to setting research priorities and it is of note that in the most influential studies reported, the priorities identified have been linked carefully to national healthcare priorities. The majority of studies have employed the Delphi survey design and the literature suggests that this is the most appropriate design for use in this study.

3

Methods

The study design was a three-round, decision Delphi survey (Rauch 1979) to identify and rate the importance of clinical, managerial and educational research issues, followed by a one-day discussion group workshop to identify timeframes within which research on the issues should be conducted. It was determined that this design would best allow for a national representative sample of informed nurses and midwives to reach majority consensus on research priorities within the designated time period and budget. In order to obtain the views of service users on nursing and midwifery research priorities, a small number of service users were included at the discussion group workshop stage of the study. Data entry was double-checked and data were analysed using SPSS Version 11.0 for Windows. The study was conducted over a nine-month period, from May 2004 through January 2005.

Research questions

- What are the overall short-term, medium-term and long-term research priorities, related to clinical, managerial and educational issues for nursing in Ireland?
- What are the overall short-term, medium-term and long-term research priorities, related to clinical, managerial and educational issues for midwifery in Ireland?

In addition, the views of a small group of service users on nursing and midwifery research priorities were sought.

Population and sample

The population of nurses in professional employment in Ireland was estimated to be 41,000, based on review of the Department of Health and Children Personnel Census for 2002, and estimates of nurses employed in private healthcare agencies and practices, as well as those employed in third-level education. The population of midwives employed in midwifery practice was estimated to be 2,400, based on a survey of midwives completed by Higgins (2003) for the Irish Nurses' Organisation. For the purposes of this study, these estimates represented the population of nurses and midwives in Ireland at the time of this study.

Following the principles outlined by Sackman (1975) and Rauch (1979), sample selection was based on the assumption that all nurses and midwives currently employed in nursing and midwifery (clinical, management, education) were well informed about the issue of inquiry for this study and had expert

knowledge of the nursing and midwifery issues in Ireland that need to be addressed through research. All nurses and midwives in professional employment in Ireland were invited and encouraged to participate in the study. However, it was not possible to know in advance how many would respond to the call for study participants.

Given the importance of the study to all nurses and midwives in Ireland, representative samples of the population of nurses and midwives – that is, samples with the distribution of the key characteristics similar to the known populations – were sought. Particular emphasis was placed on estimating from the existing population data, proportional numbers of nurses and midwives employed in clinical, managerial and educational roles; proportional numbers of nurses employed in the An Bord Altranais registration areas of general, psychiatric, intellectual disability, children's and public health nursing; and proportional numbers of nurses and midwives employed in the eight area health boards (the organisational structure in place at the time of the study). Estimates were made based on figures given in the Department of Health and Children Personnel Census for 2002. Initial sample size estimates were 1,028 nurses and 360 midwives.

In addition, over-sampling was planned where relative percentages for some characteristics were small. It was planned to include all advanced nurse practitioners, an additional 15 per cent of clinical nurse specialists, an additional 15 per cent of public health nurses, and an additional 25 per cent of educators, with a subsequent proposed nurse sample of 1,539. Recommended methods of follow-up of survey participants were employed to foster high questionnaire response rates (Dillman 2000). The potential response of the first Delphi questionnaire was estimated to be 70 per cent, or 1,077 nurses and 252 midwives (including over-sampling strategies), with a similar distribution of key characteristics of nurses and midwives as outlined in the population.

Procedures

Recruitment of participants

Convenience samples of nurses and midwives were sought countrywide over a ten-week period, initially through advertising in professional journals and newsletters. This included the distribution of approximately 40,000 fliers enclosed with a mailing of personally addressed copies of the *World of Irish Nursing* and *Psychiatric Nursing*. Invitations to participate were included in the *An Bord Altranais Newsletter* and the *National Council for the Professional Development of Nursing and Midwifery Newsletter*, sent to all nurses and midwives on the professional registers, as well as on the websites of these organisations. Posters and flier invitations to participate were distributed, by post and electronically, to all health board nursing and midwifery planning and development units, community care areas and third-level educational institutions, along with requests that they be distributed widely to all nurses and midwives employed in these organisations. Personal letters of invitation to participate were sent, through the National Council, to approximately 1,400 clinical nurse and midwifery specialists and to all actual and pending advanced nurse practitioners. Invitations to participate were also distributed by post and electronically to speciality nursing and midwifery organisations. All advertisements and personal invitations included telephone, e-mail and postal details of the research co-ordinator.

After five weeks of advertising, it was estimated that most, if not all, nurses and midwives in professional employment would have received information about the study and an invitation to participate. However, only 500 responses had been received, considerably lower than the anticipated number. Exploration of this situation revealed that many nurses and midwives still remained unaware of the study. In addition, some who were aware of the study were very hesitant about becoming involved, indicating that they believed they were not knowledgeable enough about research to participate.

To address this problem sixteen nurse and midwife research assistants were employed to visit large, and some smaller, hospitals in all areas of Ireland where nurses and midwives could be met with personally. Directors of nursing and midwifery at the hospitals were contacted and they arranged for assistant directors and clinical practice co-ordinators to accompany the research assistants on visits to nursing and midwifery wards and units to meet with nurses and midwives personally to explain the study to them and invite and encourage them to participate. In all, the research assistants visited forty-eight hospitals. Personal contact was also made with public health nurses and community midwives by telephone, post and at personal meetings. Subsequently, a total of 1,695 nurses expressed their willingness to participate

in the study, 156 more than the projected total nurse sample of 1,539, and 337 midwives, 85 more than the projected sample of 252. These volunteers formed the initial study sample.

A small number of users of nursing and midwifery services were also invited to participate in the study so that their views on the nursing and midwifery research priorities could be obtained. They were invited to participate in the workshop discussion group stage of the study, where their participation and completion of questionnaires gave them the opportunity to rate the importance of the research priorities and to indicate the timeframe within which they thought the research should be conducted.

A total of five user organisations were identified as sources of service user participants and samples of ten nursing and ten midwifery service users were sought. Invitations to participate were sent to the Irish Patients' Association, Children in Hospital Ireland, Mental Health Ireland, the National Association for Mentally Handicapped in Ireland, and Cuidiú – Irish Childbirth Trust. Information on the work of these organisations is included in Appendix 1. Five service users volunteered to participate in the workshop, two from Children in Hospital Ireland, one from the National Association for Mentally Handicapped in Ireland, and two from Cuidiú – Irish Childbirth Trust.

In order to increase the user sample, all of the above organisations were contacted a second time and each was asked to invite four members to complete the same questionnaire handed out at the discussion group workshop. In addition, a sixth organisation, representing mental health service users (GROW), was invited to participate and agreed to forward questionnaires to four of its members. Questionnaires were sent to the organisations and volunteer participants were sought within each organisation. User participants were asked to complete the questionnaires and to mail them directly back to the researchers. In a letter accompanying the questionnaire, participants were given contact details for two of the researchers and advised to contact them during working hours if they wished to discuss any aspect of the questionnaire. Over a period of nine weeks organisations were further contacted by telephone and e-mail and asked to encourage members to complete and return questionnaires. This resulted in an additional fourteen service users completing questionnaires.

The final sample of service users included ten nursing service users, one from GROW, three from Children in Hospital Ireland, two from National Association for Mentally Handicapped in Ireland, and four representing a combination of these organisations; and nine midwifery service users from Cuidiú – Irish Childbirth Trust.

Protection of human subjects

The study proposal was reviewed and approved by the University College Dublin Research Ethics Committee, Human Research Ethics Sub-committee. All nurses and midwives who volunteered to participate received a letter welcoming them to participate in the study and a consent form (Appendix 2) with their copy of Questionnaire 1. In the letter, they were asked to read the consent form prior to completing Questionnaire 1 and to contact the project co-ordinator if they had any questions about the study. On the consent form it was stated clearly that their completion of Questionnaire 1 implied their informed consent to participate in the study.

Delphi survey questionnaires

The Delphi survey consisted of three rounds for both nursing (general, mental health, intellectual disability, children's and public health) and midwifery respondents. In the discussion group workshop, a Timeframe Questionnaire was used. Separate questionnaires were developed for nursing and midwifery. Demographic Data Questionnaires (Appendix 3) were used to collect data on the key characteristics of the samples and served as a basis for comparing characteristics across responses to the three questionnaires.

Round 1: Questionnaire 1, for nursing and for midwifery (Appendix 4), were open-ended questionnaires with separate sections for clinical, managerial and educational statements. Participants were asked to state in any or all of the sections, up to five of the most important issues, problems, concerns, topics, and questions for nursing, or midwifery, in Ireland that need to be addressed through research. Participants were also asked to indicate whether they considered each issue stated to be moderately important, very important, or extremely important. It was emphasised that no more than five statements in total were requested.

Round 2: Questionnaire 2, for nursing and for midwifery, were developed from the responses received in

round 1 (Appendix 5). The issues derived from the thematic analysis of Questionnaire 1 were placed under clinical (Nursing = 10, Midwifery = 11), managerial (Nursing = 5, Midwifery = 8) or educational (Nursing = 9, Midwifery = 7) headings in random order. In order to give each issue more specific definition, it was accompanied by its most frequently occurring examples. Linked to each issue was a 7-point Likert-type rating scale on which respondents were asked to rate the importance of each research issue presented. The scale ranged from 1 (low importance) to 7 (high importance).

Round 3: Questionnaire 3, for nursing and for midwifery, were based on the same format as Questionnaire 2 with the issues listed in the same order, but incorporated two additional pieces of information (Appendix 6). Firstly, participants were presented with the mean score of each research issue from round 2. Secondly, participants were given the opportunity to also rate the most frequently occurring examples of each issue. The examples were listed separately beneath each issue, in random order and with a 7-point, numbered Likert-type rating scale. Participants were asked to consider again how important they thought each issue was for research, but to also take time to consider the mean group importance rating for the issue from Questionnaire 2. Then, taking into consideration both their own idea of the importance rating, and also the mean group rating from Questionnaire 2, they were asked to again circle the number that best represented how important they thought the issue was for research. At the end of the questionnaire, participants were asked to indicate if they would be interested in attending a 1-day meeting to receive feedback on the group importance ratings on Questionnaire 3 and to have the opportunity to discuss and reflect upon the feedback and complete a further rating of the issues.

Discussion group workshop

The final stage of the data collection was designed to determine the timeframe; (short-term, medium-term, or long-term) within which research on the priority issues should be conducted. The process of making these decisions was completed in the discussion group workshop.

The four-and-a-half-hour workshop commenced with a presentation of the study and results through round 3 of the Delphi survey, followed by an overview presentation of the national health strategy, outlined in *Quality and Fairness: A Health System For You* (Department of Health and Children 2001a) and the *Health Service Reform Programme* (Department of Health and Children 2003a). Time was then given to questions and discussion. Participants formed discussion groups – thirteen nurse groups and three midwife groups – and a specially prepared group facilitator moderated each group. Each participant received a copy of the Timeframe Questionnaire containing all of the research priority issues. The group leader moderated the groups' review and discussion of each research priority issue. When all of the issues had been discussed, each participant independently rated the timeframe (short-term, medium-term or long-term) within which she or he thought research on each issue should be conducted, using the Timeframe Questionnaire.

Service users attended the same discussion group workshop. Two user groups participated, one of nursing service users and the other of midwifery service users. The process followed was as set out for the nurse and midwife groups, with participants attending the research overview and national health strategy and health service reform programme presentations, followed by participation in their nursing user or midwifery user discussion group. A facilitator was assigned to each group and participants initially discussed the study and the questionnaire topics and then completed a ranking of the issues on the round 3 questionnaire. This was followed by further discussion and completion of a Timeframe Questionnaire to rate the research timeframes for the priority issues.

Timeframe Questionnaire: Research Timeframe Questionnaires, one for nurses and one for midwives (Appendix 7), were developed based on the same format as Questionnaire 2. Each issue was linked to a 3-point rating scale, with 1 representing short-term (within 3 years), 2 representing medium-term (within 3–5 years), and 3 representing long-term (more than 5 years). Following a group discussion of the issues, participants were asked to complete the questionnaire individually and to check the number that represented the timeframe within which they thought research on the issue should be conducted.

Analysis of questionnaires

The Delphi survey consisted of three rounds. Round 1 was an open-ended questionnaire which requested

respondents to identify five research priorities in either clinical, managerial or educational areas of nursing or midwifery. Rounds 2 and 3 were closed-ended importance-rating questionnaires. For the discussion group workshop, a closed-ended timeframe rating questionnaire was used.

Round 1: Review of Questionnaire 1 revealed that the majority of respondents did not limit themselves to making five statements. Many used all the space available to them, stating up to fifteen issues, problems, concerns, topics, and questions for research in Ireland, bringing the total number of issues submitted to more than 5,000. These items encompassed a very diverse range of issues related to all aspects of nursing and midwifery in Ireland. Clinical, managerial and educational statements were retained within the sections under which they were submitted and the data within each section were analysed separately.

Coding and thematic analyses were guided by the process outlined by Krippendorff (2004). All nursing and midwifery statements were coded by two of the researchers. The researchers (n=5) independently examined the coded data to identify themes and then met together to re-examine the codes and themes, continuing to re-examine any discrepancies in their analyses until agreement was achieved. The resulting codes from recurring themes were categorised into discrete broad issues for nursing and for midwifery. The diversity of the issues submitted on Questionnaire 1 for both nursing and midwifery required that the final issues were quite broad. For nursing, ten clinical, five managerial and nine educational issues were identified. For midwifery, eleven clinical, eight managerial and seven educational issues were identified. For each broad issue, examples of the most frequently occurring themes were identified in order of precedence, that is according to the frequency with which they were stated combined with their degree of importance (moderate, very, or extremely important) indicated on the questionnaire. The issues and their most frequently occurring examples were used to construct the nursing and midwifery importance rating questionnaires.

Rounds 2 and 3: Each of the issues in their respective sections (clinical, managerial, educational) was presented to participants on a 7-point Likert scale with categories ranging from 'low importance' to 'high importance'. Data for each issue were analysed using descriptive statistics (mean, standard deviation, percentage), and inferential statistics (ANOVA and chi-square) were used to test for differences between respondents to the three questionnaires on demographic and key characteristics.

Timeframe Questionnaire: Each of the issues was presented to participants on a 3-point timeframe rating scale for short-term, medium-term and long-term. Data were analysed using frequency counts of short-term, medium-term and long-term ratings for each issue. When the frequencies were examined it was observed that most of the issues had low long-term frequency ratings and that greater discrimination of timeframe ratings would be achieved if the medium-term and long-term frequencies were merged. Thus, in the final analyses the data were collapsed into short-term (within 3 years) and medium-to-long-term (more than 3 years).

Determination of consensus: Consensus that a research issue was of a high priority was determined according to the following three criteria: 1) the issue had a mean score of 6.0 or higher on the 7-point scale; 2) the issue showed a decrease in standard deviation scores from round 2 to round 3 indicating a shift towards group consensus in the importance rating across the rounds (a standard deviation score of less than 1.0 represented a distribution of scores closer to the mean and lower variability on group importance rating in round 3); and 3) 80 per cent of the respondents rated the priority at 6.0 or higher on a 7-point scale, indicating that the issue was of high priority. Because of the high importance rating scores of the majority of the issues, the cut-off point for consensus that an issue was a high priority was set at 80 per cent. Issues which fell outside the above criteria were deemed to be important but of a lower priority. Mean priority scores were grouped into three levels of priority, according to the 7-point scale as follows: high priority 6.0 to 7.0, medium priority 5.0 to 5.9, and low priority 4.9 or less.

Determination of high priority issues for research: Issues considered high priority for research were those which met all criteria for consensus that an issue was of high priority and were rated as requiring research in the short term.

4

Results

In this chapter the results of the Delphi survey and the discussion group workshop are reported in several sections. Firstly, the participant response rates are presented and the samples are compared to the populations of nurses and midwives in professional employment in Ireland. In order to demonstrate the representativeness of the samples and the external validity of the results, the profiles of the respondents over the three rounds of the survey are presented. This is followed by a presentation of the results of round 2 of the survey in comparison to the results of round 3. The results of round 3, the final round of the survey, are then presented in relation to the consensus that was achieved on the identification of nursing and midwifery research priorities for Ireland. The results of round 3 are presented separately for nursing and for midwifery. Finally, timeframes are presented within which research related to the priorities should be initiated.

Response rates and demographic data

In this section the response rates and demographic profiles of the samples used in the three rounds of the survey are presented. Information is presented also on how the samples compare to the populations of nurses and midwives in Ireland currently employed in professional practice. The profiles of the samples and how the samples changed over the three rounds of the Delphi survey are also outlined. These data are presented in order to demonstrate the representativeness of nurse and midwife samples used in the study.

Response rates

Of the 1,695 nurses and 334 midwives who volunteered to participate, 780 (47%) nurses and 142 (42%) midwives completed and returned Questionnaire 1. Every effort was made to achieve the highest possible response rate. One week after questionnaires were posted 'reminding procedures' were commenced following Dillman's (2000) tailored design for fostering high response rates. Participants who had not returned their questionnaires were contacted by telephone up to three times, at weekly intervals, to request their completion and return of the questionnaires. Of the 780 nurses and 142 midwives who returned Questionnaire 1, 701 (90%) nurses and 121 (85%) midwives returned Questionnaire 2. Of the 701 nurses and 121 midwives who returned Questionnaire 2, 600 (86%) nurses and 98 (81%) midwives returned Questionnaire 3. Of the 600 nurses and 98 midwives who returned Questionnaire 3, 303 nurses and 51 midwives volunteered to attend the discussion group workshop held in Dublin. On the day of the workshop, 122 nurses (20% of Questionnaire 3 participants) and 26 midwives (27% of Questionnaire 3 participants) attended.

Demographic profile of the participants

Nurses: The demographic profile of the nurse participants across the three questionnaires is shown in Table 4.1 (39 of the 780 participants provided incomplete demographic data). The majority were female, employed full-time, employed in general nursing and had been qualified for an average of seventeen years. Most had pursued third-level education with 51 per cent holding a bachelor's degree and almost 20 per cent a master's degree. The majority were knowledgeable about research with almost 80 per cent having completed a research module and 50 per cent having completed a research dissertation. There were no significant differences in demographic characteristics among those who completed the questionnaires over the three rounds. Of the 122 nurses who participated in the group discussion workshop, 70 were in clinical practice, 33 in management and 19 in education. Seventy-five were employed in general nursing, 9 in psychiatric nursing, 13 in intellectual disability nursing, 4 in children's nursing, and 14 in public health nursing. They represented all Health Boards.*

Table 4.1: Demographic profile of nurse participants to Questionnaires 1, 2 and 3

Characteristic	Questionnaire 1 (n=741)	Questionnaire 2 (n=701)	Questionnaire 3 (n=600)	Significant differences between rounds [†]
Age (M, SD)	39.6 (8.2)	39.6 (8.2)	39.5 (8.2)	ns ¹
Years Qualified (M, SD)	17.2 (8.5)	17.2 (8.3)	17.2 (8.5)	ns ¹
Gender (% , n)				ns²
Female	91.7 (674)	91.7 (637)	91.9 (547)	
Male	8.3 (61)	8.3 (58)	8.1 (48)	
Current Employment (% , n)				ns²
General	58.7 (435)	58.5 (410)	59.5 (357)	
Psychiatry	9.6 (71)	9.7 (68)	10.0 (60)	
Intellectual Disability	7.2 (53)	7.6 (53)	7.3 (44)	
Sick Children's	5.4 (40)	5.3 (37)	5.0 (30)	
Public Health	6.6 (49)	6.6 (46)	6.7 (40)	
Other	12.6 (93)	12.4 (87)	11.5 (69)	
Professional Qualifications* (% , n)				ns²
General	86.8 (643)	86.4 (606)	85.8 (515)	
Psychiatric	16.3 (121)	16.4 (115)	15.8 (95)	
Intellectual Disability	7.3 (54)	7.6 (53)	7.5 (45)	
Sick Children's	10.5 (78)	10.7 (75)	10.5 (63)	
Midwifery	27.1 (201)	26.4 (185)	27.0 (162)	
Tutor	7.7 (57)	8.0 (56)	8.2 (49)	
Other	34.4 (255)	33.5 (235)	33.0 (198)	
Academic Qualifications* (% , n)				ns²
Diploma	49.3 (365)	50.2 (352)	49.8 (299)	
Higher Dip/Postgrad Dip	32.9 (244)	32.7 (229)	32.7 (196)	
Bachelor's Degree	50.2 (372)	51.1 (358)	51.0 (306)	
Master's Degree	19.7 (146)	19.4 (136)	18.7 (112)	
PhD	0.9 (7)	1.0 (7)	1.2 (7)	
Other	13.6 (101)	13.4 (94)	12.3 (74)	
Work Status (% , n)				ns²
Full-time	77.9 (575)	77.3 (540)	76.6 (458)	
Part-time	13.8 (102)	14.0 (98)	14.5 (87)	
Job-sharing	5.7 (42)	6.0 (42)	6.4 (38)	
Other	2.6 (19)	2.7 (19)	2.5 (15)	
Research Experience (% , n)				ns²
Research Module	78.9 (585)	79.7 (554)	79.2 (471)	
Research Dissertation	56.8 (407)	57.1 (388)	57.1 (331)	
Participated in research	42.0 (290)	42.0 (274)	42.8 (239)	

*Participants may hold a number of professional and academic qualifications

[†]ns = not significant; ¹ANOVA; ²Chi-square

*On 1 January 2005 the Health Service Executive took over full responsibility for running Ireland's health services. Health Service Executive areas have replaced the former Health Boards. However, the term Health Board is retained for this study because it was conducted prior to this change.

Midwives: The demographic profile of the midwife participants across the three questionnaires is shown Table 4.2 (fourteen of the 142 participants provided incomplete demographic data). The majority were female, employed full time and had been qualified for an average of nineteen years. Forty-four per cent held a bachelor's degree and 28 per cent a master's degree. Most were knowledgeable about research with 70 per cent having completed a research module and 50 per cent having completed a research dissertation. There were no significant differences in demographic characteristics of midwives who completed the questionnaires over the three rounds. Of the 26 midwives who participated in the workshop, 14 were in clinical practice, 5 in management and 7 in education. They represented the Eastern, North-Eastern, South-Eastern, Southern, Mid-Western, and Western Health Boards.

Table 4.2: Demographic profile of midwife participants to Questionnaires 1, 2 and 3

Characteristic	Questionnaire 1 (n=128)	Questionnaire 2 (n=121 ¹)	Questionnaire 3 (n=98 ²)	Significant differences between rounds [†]
Age (M, SD)	41.32 (7.70)	41.54 (7.97)	41.44 (8.00)	ns ³
Years Qualified (M, SD)	19.09 (7.81)	19.28 (8.12)	19.28 (8.27)	ns ³
Gender (% n)				
Female	96.9 (124)	96.3 (105)	95.5 (84)	ns ⁴
Male	3.1 (4)	3.7 (4)	4.5 (4)	ns ⁴
Current Employment (% n)				
Midwifery	100 (128)	100 (109)	100 (88)	ns ⁴
Professional Qualifications* (% n)				
General	97.7 (125)	97.2 (106)	96.6 (85)	ns ⁴
Psychiatric	1.6 (2)	1.8 (2)	2.3 (2)	ns ⁴
Intellectual Disability	1.6 (2)	0.9 (1)	1.1 (1)	ns ⁴
Sick Children's	6.3 (8)	6.4 (7)	5.7 (5)	ns ⁴
Midwifery	98.4 (126)	97.2 (106)	97.7 (86)	ns ⁴
Tutor	18 (23)	17.4 (19)	14.8 (13)	ns ⁴
Other	28.9 (37)	27.5 (30)	27.3 (24)	ns ⁴
Academic Qualifications*(% n)				
Diploma	38.3 (49)	39.4 (43)	38.6 (34)	ns ⁴
Higher Dip/Postgrad				
Dip	33.6 (43)	36.7 (40)	36.4 (32)	ns ⁴
Bachelor's Degree	43.8 (56)	45 (49)	43.2 (38)	ns ⁴
Master's Degree	28.1 (36)	28.4 (31)	28.4 (25)	ns ⁴
PhD	0 (0)	0 (0)	0 (0)	ns ⁴
Other	17.2 (22)	13.8 (15)	12.5 (11)	ns ⁴
Work Status (% n)				
Full-time	75.8 (91)	77.1 (84)	76.1 (67)	ns ⁴
Part-time	11.7 (15)	10.1 (11)	11.4 (10)	ns ⁴
Job-sharing	10.9 (14)	11.9 (13)	12.5 (11)	ns ⁴
Other	1.6 (2)	0.9 (1)	0 (0)	ns ⁴
Research Experience (% n)				
Research Module	71.1 (91)	75.2 (82)	76.1 (67)	ns ⁴
Research Dissertation	50 (64)	52.3 (57)	50 (44)	ns ⁴
Participated in research	39.1 (50)	43.1 (47)	39.8 (35)	ns ⁴

*Participants may hold a number of professional and academic qualifications

¹Demographic data available only for 109 participants

²Demographic data available only for 88 participants

[†]ns = not significant; ³ANOVA; ⁴Chi-square

Analysis of the key characteristics of participants was undertaken to ascertain their representativeness to the nursing and midwifery populations. Table 4.3 shows the data for nurse and midwife areas of employment (clinical, managerial and educational). The nurse sample was over-represented in education and management and under-represented in clinical, although approximately 60 per cent of the sample that completed Questionnaire 3 were employed in clinical nursing. Population estimates are not available for midwives. Approximately 50 per cent of the midwifery sample were in a clinical practice position and, compared to the nurse sample, midwives were over-represented in education.

Table 4.3: Area of employment of nurse and midwife participants – comparisons to population

Area of Employment	Nursing (%)			
	Population (n=41,000)	Q1 (n=780)	Q2 (n=701)	Q3 (n=600)
Clinical	79.0	60.1	59.3	59.2
Management	20.0	27.8	28.3	27.7
Education	1.0	12.1	12.4	13.1
Area of Employment	Midwifery (%)			
	Population (n=2,400)	Q1 (n=142)	Q2 (n=121)	Q3 (n=98)
Clinical	Not known	51.6	50.4	50.0
Management	Not known	25.0	25.7	26.1
Education	Not known	23.4	23.9	23.9

Table 4.4 shows that general and mental health nurses were under-represented in the sample when compared to the population and children’s nurses were slightly over-represented when compared to the population. The proportions of intellectual disability nurses and public health nurses were similar to the population proportions.

Table 4.4: Proportions of areas of current employment* according to An Bord Altranais Nurse Register divisions – comparisons to population

Division of Current Employment	Population %	Questionnaire 1* % (n=780)	Questionnaire 2* % (n=701)	Questionnaire 3* % (n=600)
General	69.0	58.7	58.5	59.5
Mental Health	16.0	9.6	9.7	10.0
Intellectual Disability	8.0	7.2	7.6	7.3
Children’s	2	5.4	5.3	5.0
Public Health	5	6.6	6.6	6.7

*Approximately 12% indicated ‘Other’ sub-speciality as area currently employed.

Table 4.5 shows that nurses were proportionally represented from each of the Health Boards except for the North-West which was slightly under-represented. However, for all other regions, the proportions of nurses replying to the survey were similar to the proportions employed in each region. Estimates of population proportions of midwives for each of the Health Boards is not known. The proportions varied across rounds in a number of Health Boards.

Table 4.5: Nursing and midwifery participants’ employment by Health Board*– comparisons to populations

HSE Region	Nursing (%)				Midwifery(%)			
	Population (n=41,000)	Q 1 (n=780)	Q2 (n=701)	Q3 (n=600)	Population (n=2,400)	Q 1 (n=142)	Q2 (n=121)	Q3 (n=98)
Eastern	38	39.0	38.1	37.4	not known	45.7	45.4	45.8
Mid West	8.0	7.2	7.4	7.2	known	5.2	6.7	7.3
Midland	6.0	5.1	4.9	4.9		0.9	0.8	1.0
North East	7.0	8.1	8.2	8.4		8.6	8.4	9.4
North West	7.0	4.4	4.4	4.5		4.3	1.7	1.0
South East	9.0	8.9	9.2	9.1		9.5	10.1	11.5
Southern	14.0	14.5	14.9	15.3		13.8	14.3	13.5
Western	11.0	12.8	12.9	13.1		12.1	12.6	10.4

*Since 1 January 2005 comparable to Health Service Executive.

Comparisons of Delphi round 2 and round 3

In round 1 of the Delphi survey clinical, managerial and educational issues requiring research were identified and these were used to construct the questionnaires for round 2 and round 3. In this section, the results of round 2 are compared to the results of round 3. The means, standard deviations (SD) and rankings of priority issues were compared from round 2 to round 3 to identify changes in mean scores and related rankings across rounds and changes in SD scores as indicators of emerging consensus.

Nurse comparisons

The mean importance ratings and related rankings for clinical, managerial and educational issues are shown in Table 4.6. The SD scores for all issues were lower on round 3 except for *physical care concerns*, indicating movement towards group consensus on the ranking of the remaining issues.

Clinical: The highest ranked issue on round 2, *communication in clinical practice* was ranked 3rd on round 3, while *outcomes of care delivery* ranked 3rd on round 2, moved to the highest rank on round 3. Three issues retained the same relative ranking across the rounds: *staffing issues in practice* ranked 2nd, *ethical concerns* ranked 7th and *nurses' attitudes to specific patient/client groups* ranked 10th. Most issues moved up or down one place in ranking, except for *physical care concerns* which moved down three places on round 3. The SDs for *physical care concerns* and *nurses' attitudes to specific patient/client groups* were relatively high, indicating greater variability in their importance ratings.

Managerial: The issue of recruitment and retention of nurses retained the highest ranking across all rounds. The remaining issues all changed rank by one place either up or down across rounds. All SD scores decreased across rounds by several decimal points.

Educational: *Research and evidence-based practice* moved from 3rd rank on round 2 to the highest rank on round 3, and also had the lowest SD on round 3, indicating the highest level of consensus for this rating. The two lowest rated issues, *models of course delivery* and *recruitment and retention related to nurse education* remained the same across rounds. The other issues moved up or down 2 rankings across the rounds. All SD scores decreased across rounds by several decimal points.

Table 4.6: Comparison of the 24 nursing issue ratings for round 2 and round 3

Issue	Rank Round 2	Mean (SD) Round 2	Rank Round 3	Mean (SD) Round 3
Clinical				
Communication in clinical practice	1	6.24 (1.12)	3	6.24 (0.95)
Staffing issues in practice	2	6.21 (1.17)	2	6.25 (0.95)
Outcomes of care delivery	3	6.18 (1.03)	1	6.27 (0.92)
Nursing practice roles	4	6.10 (1.16)	5	5.90 (0.99)
Quality assurance in practice	5	6.03 (1.07)	4	5.99 (0.88)
Physical care concerns	6	6.00 (1.16)	9	5.79 (1.24)
Ethical concerns	7	5.94 (1.24)	7	5.82 (1.02)
Psychological care concerns	8	5.82 (1.24)	6	5.83 (0.99)
Specialist and advanced practice roles	9	5.74 (1.25)	8	5.80 (1.05)
Nurses' attitudes to specific patient/client groups	10	5.48 (1.54)	10	5.48 (1.30)
Managerial				
Recruitment and retention of nurses	1	6.26 (1.15)	1	6.26 (0.93)
Roles of nurse managers	2	5.98 (1.22)	3	6.03 (0.99)
Nurse input in health policy and decision making	3	5.91 (1.27)	2	6.17 (0.94)
Health and safety in practice	4	5.86 (1.24)	5	5.95 (1.06)
Quality assurance and standards of care	5	5.77 (1.17)	4	5.86 (0.90)
Educational				
Career planning and professional/educational development	1	5.95 (1.16)	2	6.01 (0.97)
Outcomes and effectiveness of education	2	5.93 (1.14)	3	5.98 (0.93)
Research and evidence-based practice	3	5.92 (1.16)	1	6.08 (0.88)
Educational needs analysis	4	5.88 (1.22)	6	5.81 (1.01)
Undergraduate/pre-registration clinical learning	5	5.78 (1.23)	4	5.92 (1.05)
Professional appraisal and staff development	6	5.72 (1.28)	7	5.81 (1.05)
Clinical education links between service and academic organisations	7	5.69 (1.23)	5	5.86 (1.00)
Models of course delivery	8	5.64 (1.37)	8	5.68 (1.07)
Recruitment and retention related to nurse education	9	5.54 (1.33)	9	5.64 (1.13)

Midwife comparisons

The mean importance ratings and related rankings for the clinical, managerial and educational issues are shown in Table 4.7. For most issues, the SD scores decreased from round 2 to round 3, indicating a move toward consensus. However, for some issues SD scores increased, indicating increased variability and lower consensus in the importance rating of these issues.

Table 4.7: Comparison of the 26 midwifery issue ratings for round 2 and round 3

Issue	Rank Round 2	Mean (SD) Round 2	Rank Round 3	Mean (SD) Round 3
Clinical				
Models of care	1	6.50 (0.83)	5	6.20 (0.93)
Preparation for practice	2	6.29 (1.15)	3	6.25 (1.04)
Clinical supervision	3	6.26 (1.04)	6	6.17 (0.90)
Care in labour	4	6.14 (1.22)	2	6.26 (1.15)
Continuing professional education	5	6.09 (1.18)	7	5.98 (1.09)
Breastfeeding	6	6.09 (1.37)	8	5.87 (1.37)
Communication	7	6.01 (1.35)	4	6.23 (1.13)
Satisfaction with care	8	5.99 (1.23)	1	6.33 (0.78)
Health promotion	9	5.93 (1.12)	9	5.83 (1.01)
Human resource management	10	5.74 (1.41)	10	5.74 (1.35)
Management grades	11	4.74 (1.73)	11	4.61 (1.56)
Managerial				
Promoting woman-centred care	1	6.51 (0.79)	1	6.47 (0.70)
Barriers to autonomy	2	6.23 (1.10)	5	5.87 (1.09)
Sources of stress	3	6.11 (1.22)	2	6.13 (1.16)
Management culture	4	6.09 (1.28)	6	5.61 (1.24)
Workforce planning	5	5.98 (1.31)	4	5.91 (1.21)
Developing midwifery practice	6	5.91 (1.24)	3	6.09 (1.06)
Change management	7	5.70 (1.35)	7	5.58 (1.24)
Levels of management	8	5.69 (1.42)	8	5.25 (1.31)
Educational				
Student midwife learning/education	1	6.39 (0.82)	4	6.17 (0.95)
Promoting the distinctiveness of midwifery	2	6.31 (1.03)	1	6.33 (0.66)
Continuing education	3	6.11 (1.01)	2	6.23 (0.77)
Promoting research/evidence-based practice	4	6.05 (1.03)	3	6.21 (0.88)
Support for midwives working with students	5	6.03 (1.10)	5	6.11 (1.07)
Midwifery curriculum	6	5.83 (1.14)	6	5.79 (1.03)
The role of the midwife tutor	7	5.74 (1.25)	7	5.62 (1.25)

Clinical: Most notable are the changes in the highest ranking issues. In round 2, *models of care* was ranked highest but moved to 5th rank in round 3. *Satisfaction with care* was ranked 8th in round 2, but moved to the highest rank in round 3. In addition in round 3, the SD for this issue was relatively low, indicating good consensus for this rating. *Preparation for practice* was ranked 2nd in round 2, but moved to 3rd place in round 3. *Care in labour* moved from 4th place in round 2, to 2nd place in round 3. Several issues moved up or down, two or three places, in ranking across the two rounds. The three lowest ranked issues, *health promotion*, *human resource management* and *management grades*, remained the same across the rounds. The SDs decreased in round 3 for all the issues except *breastfeeding*, which remained the same, and *models of care*, which increased. The SD for *management grades* remained relatively high, indicating higher variability in the rating of this issue.

Managerial: *Promoting woman-centred care* was ranked highest in round 2 and round 3 and, in both rounds, showed a low and decreasing SD, indicating increasing consensus for this rating. The two lowest ranked issues, *change management* and *levels of management*, also retained the same ranking across both rounds. For all issues, the SDs decreased across the two rounds, indicating an increasing consensus in the ratings.

Educational: *Student midwife learning/education* was ranked highest in round 2, but fell to 4th rank in round 3. However for this issue, the SD increased in round 3 indicating a slight increase in the variability of this rating. *Promoting the distinctiveness of midwifery* moved up from 2nd rank in round 2 to the

highest rank in round 3. In addition, the SD for this issue decreased considerably in round 3, indicating a good level of consensus for this rating. In round 3, *continuing education* moved from 3rd rank to 2nd rank, while *promoting research/evidence-based practice* moved from 4th rank to 3rd rank. For both issues, the SDs decreased considerably, indicating increasing consensus for the rating of these issues. The lowest rated issues, *midwifery curriculum* and the *role of the midwife tutor* remained the same across both rounds.

Results of Delphi round 3

In this section the results of the final round of the survey are reported together with the level of consensus that was achieved in the identification of the nursing and midwifery research priorities. Results are reported according to clinical, managerial and educational research priorities and the timeframes within which research related to the priorities should be initiated are also reported.

Nursing

For Research Question 1, the results concern the overall short-term, medium-term and long-term research priorities, related to clinical, managerial and educational issues for nursing in Ireland.

Clinical issues: Table 4.8 shows the three most important clinical issues for research and their three highest rated examples. All three issues, *outcomes of care delivery*, *staffing issues in practice* and *communication in clinical practice*, received mean importance scores greater than 6.0 on the 7-point scale and were rated as a high priority by at least 80 per cent of participants. *Outcomes of care delivery* was identified as the highest clinical research priority. The three highest ranked examples of *outcomes of care delivery* were 'evaluation of care delivery', 'patient/client assessment' and 'effectiveness of patient/client education'. *Staffing issues in practice* was identified as the second highest clinical research priority, and its three highest rated examples were 'nurses' stress and health concerns', 'staffing levels' and 'patient/client dependency levels'. The third highest ranked clinical research priority was *communication in clinical practice*, with 'communication with patients/clients and their relatives', 'communication among nurses' and 'communication with other health professionals' rated as its three highest examples. These three highest ranked issues were also identified as requiring research within a short-term timeframe.

Table 4.8: The 3 highest ranked nursing clinical research priorities with their 3 highest rated examples

Order of priority	Nursing clinical issues and examples
*1	Outcomes of care delivery
	Evaluation of care delivery
	Patient/client assessment
	Effectiveness of patient/client education
*2	Staffing issues in practice
	Nurses' stress and health concerns
	Staffing levels
	Patient/client dependency levels
*3	Communication in clinical practice
	Communication with patient/clients and patient/clients' relatives
	Communication among nurses
	Communication with other health professionals

*High priority for research in the short term

Table 4.9 shows the final priority ranking for all ten clinical issues according to mean importance scores, consensus percentage achieved, SD scores and timeframe rating (short term or medium-to-long term). It also shows the rankings of the examples of each research priority issue. Seven clinical issues, although identified as priority areas for research, received a lower mean importance rating and thus were ranked as lower priority for research. In addition, these issues received lower indications of group consensus on the mean importance rating. Four were identified as requiring research in the short term and two in the medium-to-long term. *Nurses' attitudes to specific patient/client groups* showed the lowest mean importance rating and thus was ranked as the lowest priority clinical issue for research. This issue also showed the highest SD score, indicating lower group consensus, and was identified as requiring research in the medium-to-long term.

Table 4.9: Final priority ranking, consensus¹ level, and timeframe ratings for 10 nursing clinical issues

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
*1	Outcomes of care delivery	85.7%	6.27 (0.92)	Short
(1)	Evaluation of care delivery		6.24 (0.99)	
(2)	Patient/client assessment		6.09 (1.06)	
(3)	Effectiveness of patient/client education		6.04 (0.98)	
(4)	Risk assessment		5.96 (1.07)	
(5)	Patient/clients' perceptions of nursing care		5.89 (1.13)	
*2	Staffing issues in practice	83.4%	6.25 (0.95)	Short
(1)	Nurses' stress and health concerns		6.30 (0.98)	
(2)	Staffing levels		6.28 (0.99)	
(3)	Patient/client dependency levels		6.14 (1.03)	
(4)	Skill mix		6.09 (1.04)	
(5)	Staff turnover rate		6.07 (1.11)	
(6)	Non-nurses delivering nursing care		5.88 (1.27)	
*3	Communication in clinical practice	84.3%	6.24 (0.95)	Short
(1)	Communication with patient/clients and patient/clients' relatives		6.31 (0.96)	
(2)	Communication among nurses		6.26 (1.08)	
(3)	Communication with other health professionals		6.05 (1.05)	
(4)	Communication with the public		5.87 (1.10)	
(5)	Communication with people from other cultures		5.90 (1.14)	
4	Quality assurance in practice	77.0%	5.99 (0.88)	Short
(1)	Nursing documentation		6.23 (0.96)	
(2)	National standards and guidelines for patient/client care		6.09 (1.00)	
(3)	Therapeutic effects of nursing interventions		5.98 (1.00)	
(4)	Clinical audit		5.97 (1.08)	
(5)	Research utilisation		5.90 (1.03)	
5	Nursing practice roles	72.2%	5.90 (0.99)	Short
(1)	Clinical decision making		6.12 (0.99)	
(2)	The nursing role in multidisciplinary team		6.02 (1.10)	
(3)	Scope of nursing practice		5.90 (1.17)	
(4)	Nursing care planning		5.83 (1.17)	
(5)	Relationships between nurses in practice and nurses in management		5.83 (1.30)	
(6)	Relationships between nurses and healthcare assistant		5.25 (1.50)	
6	Psychological care concerns	69.9%	5.83 (0.99)	Short
(1)	Care of mentally ill patient/clients		5.90 (1.16)	
(2)	Effects of caring for patient/clients with disabilities		5.84 (1.15)	
(3)	Effects of crowded patient/client care areas		5.74 (1.25)	
(4)	Interactions with families and communities		5.71 (1.11)	
(5)	Impact of psychological interventions		5.67 (1.05)	
7	Ethical concerns	67.2%	5.82 (1.02)	Short
(1)	Ethical issues related to patient/client informed consent and confidentiality		5.96 (1.14)	
(2)	Care of older people		5.96 (1.15)	
(3)	Timing of care delivery		5.42 (1.22)	
(4)	Patient/clients' transitions from hospital to community care		5.94 (1.15)	
8	Specialist and advanced practice roles	69.1%	5.80 (1.05)	Medium-long
(1)	Impact of specialist and advanced practice Nurses' roles on patient/client care and patient/client outcomes		5.90 (1.09)	
(2)	Preparation for specialist and advanced practice nurse roles		5.74 (1.18)	
(3)	Development and evaluation of Clinical Nurse Specialist and Advanced Nurse Practitioner roles		5.89 (1.02)	
(4)	Impact of specialist and advanced practice Nurses' roles on other nurses' roles		5.74 (1.21)	
(5)	Responsibilities of specialist and advanced practice nurses		5.67 (1.18)	
(6)	Specialist and advanced practice nurses' relationships with staff nurses		5.64 (1.33)	

Table 4.9: Final priority ranking, consensus¹ level, and timeframe ratings for 10 nursing clinical issues (continued)

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
9	Physical care concerns	70.2%	5.79 (1.24)	Medium-long
(1)	Patient/client hygiene		5.46 (1.50)	
(2)	Patient/client involvement in care		6.00 (1.15)	
(3)	Intravenous cannulation and administration		5.16 (1.55)	
(4)	Infection control		6.00 (1.34)	
(5)	Wound care		5.81 (1.42)	
(6)	Environmental resources available to support physical care concerns		5.71 (1.32)	
(7)	Pain and symptom management		6.16 (1.22)	
10	Nurses' attitudes to specific patient/client groups	57.0%	5.48 (1.30)	Medium-long
(1)	Attitudes to elderly people		5.61 (1.36)	
(2)	Attitudes to patient/clients with disabilities		5.52 (1.44)	
(3)	Attitudes to patient/clients from other cultures		5.41 (1.37)	

*High priority for research in the short term

¹Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

Managerial issues: Table 4.10 shows the three most important managerial issues for research and their three highest rated examples. Two issues: *recruitment and retention of nurses* and *nursing input into health policy and decision making* received mean scores greater than 6.0 on the 7-point scale and were rated as high priority by at least 80 per cent of participants. For the highest rated issue, *recruitment and retention of nurses*, the three highest rated examples were 'morale in nursing', 'nurse retention' and 'staffing for high dependency patients/clients'. For the second highest rated issue, *nursing input into health policy and decision making*, two of the three examples, 'nurses' influence on health policy' and 'inclusion of nurses in decision making' received highest ratings. The third highest rated issue, *role of nurse managers*, also achieved a mean importance score of greater than 6.0 but did not achieve 80 per cent consensus.

Table 4.10: The 3 highest ranked nursing managerial research priorities with their 3 highest rated examples

Order of priority	Nursing managerial issues and examples
*1	Recruitment and Retention of Nurses
	Morale in nursing
	Nurse retention
	Staffing for high dependency patients/clients
*2	Nursing input into health policy and decision making
	Nurses' influence on health policy
	Inclusion of nurses in decision making
	Nurses' knowledge of the effects of health policy on practice
3	Role of nurse managers
	Nurse managers' leadership abilities
	Nurse managers' communication and relationships with nurses providing patient/client care
	Nurse managers' planning and management of change

*High priority for research in the short term

Table 4.11 shows the final priority ranking for all five managerial issues according to mean importance scores, consensus percentage achieved, SD scores and timeframe rating (short term or medium-to-long term). It also shows the rankings of the examples related to each research priority issue. The two issues of *health and safety in practice* and *quality assurance and standards of care*, although identified as priority areas for research, received a lower mean importance rating and thus were ranked as lower priority for research. In addition, these issues received lower indications of group consensus on the mean importance rating. All of the managerial issues were identified as requiring research in the short term of less than three years.

Table 4.11: Final priority ranking, consensus¹ level, and timeframe ratings for 5 nursing managerial issues

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
*1	Recruitment and retention of nurses	82%	6.26 (0.93)	Short
(1)	Morale in nursing		6.24 (1.10)	
(2)	Nurse retention		6.21 (1.04)	
(3)	Staffing for high dependency patients/clients		6.04 (0.98)	
(4)	Bullying by managers		6.04 (1.18)	
(5)	Management of skill mix		5.95 (1.05)	
(6)	Stress amongst managers		5.89 (1.24)	
*2	Nursing input into health policy and decision making	80.0%	6.17 (0.94)	Short
(1)	Nurses' influence on health policy		6.09 (1.05)	
(2)	Inclusion of nurses in decision making		6.05 (1.11)	
(3)	Nurses' knowledge of the effects of health policy on practice		5.92 (1.10)	
3	Role of nurse managers	78.3%	6.03 (0.99)	Short
(1)	Nurse managers' leadership abilities		6.26 (1.02)	
(2)	Nurse managers' communication and relationships with nurses providing patient client care		6.24 (0.97)	
(3)	Nurse managers' planning and management of change		6.20 (1.02)	
(4)	Nurse managers' education for management positions		6.08 (1.09)	
(5)	Nurse managers' changing roles and responsibilities		5.93 (1.09)	
4	Health and safety in practice	70.5%	5.95 (1.06)	Short
(1)	Management of patient/client aggression toward nurses		6.12 (1.06)	
(2)	Nurses' ability to cope with patients'/clients'/relatives' aggressive behaviour		6.07 (1.07)	
(3)	Effects on nurses of heavy manual workloads		5.83 (1.25)	
5	Quality assurance and standards of care	69.1%	5.86 (0.90)	Short
(1)	Impact of nursing interventions		5.97 (0.92)	
(2)	Research utilisation		5.88 (0.99)	
(3)	National guidelines for practice		5.86 (1.05)	
(4)	Cost-effectiveness of nursing practice		5.49 (1.16)	

¹Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

*High priority for research in the short term

Educational issues: Table 4.12 shows the three most important educational issues for research and their three highest rated examples. Two issues, *research and evidence-based practice* and *career planning and professional/educational development* received mean scores greater than 6.0 on the 7-point scale. However, no issue achieved the 80 per cent consensus required to consider it as a high research priority. *Research and evidence-based practice* was identified as the highest educational research priority. The three highest rated examples for this issue were 'use of research to improve practice', 'dissemination of research information in practice' and 'nurse researchers' availability to practitioners'. For the issue *career planning and professional/educational development*, the three highest rated examples were 'importance of continuing education for practice', 'time and financial support for continuing education' and 'educational guidance for nurses'. The third issue, *outcomes and effectiveness of education*, although identified as priority for research, received a lower mean importance rating and thus was ranked as a lower priority for research.

Table 4.12: The 3 highest ranked nursing educational research priorities with their 3 highest rated examples

Order of priority	Nursing educational issues and examples
1	Research and evidence-based practice
	Use of research to improve practice
	Dissemination of research information in practice
	Nurse researchers' availability to practitioners
2	Career planning and professional/ educational development
	Importance of continuing education for practice
	Time and financial support for continuing education
	Educational guidance for nurses
3	Outcomes and effectiveness of education
	Linking of theory to practice
	Recognition of professional learning
	Impact of post-graduate education on practice

Table 4.13 shows the final priority ranking for all nine educational issues according to mean importance scores, consensus percentage achieved, SD scores and timeframe rating (short term or medium-to-long term). It also shows the rankings of the examples related to each research priority issue. Although all the issues were identified as priority areas for research, they received lower mean importance ratings and thus were ranked as lower priority for research. In addition, these issues received lower indications of group consensus on the mean importance rating. The issue of *recruitment and retention related to nurse education* was the lowest rated educational issue with only 62 per cent of the sample rating it as a priority issue. Only the highest rated issue, *research and evidence-based practice*, was identified as requiring research in the short term, with all the remaining issues identified as requiring research in the medium-to-long term of more than three years.

Table 4.13: Final priority ranking, consensus¹ level, and timeframe ratings for 9 nursing educational issues

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
1	Research and evidence-based practice	78%	6.08 (0.88)	Short
(1)	Use of research to improve practice		6.13 (0.90)	
(2)	Dissemination of research information in practice		6.09 (0.95)	
(3)	Nurse researchers' availability to practitioners		5.80 (1.09)	
(4)	Role-related research responsibilities		5.72 (1.06)	
2	Career planning and professional/ educational development	77%	6.01 (0.97)	Medium-long
(1)	Importance of continuing education for practice		6.20 (0.97)	
(2)	Time and financial support for continuing education		6.05 (1.13)	
(3)	Educational guidance for nurses		6.02 (1.07)	
(4)	Structured pathways for professional development		5.97 (1.08)	
3	Outcomes and effectiveness of education	75.3%	5.98 (0.93)	Medium-long
(1)	Linking of theory to practice		6.15 (0.96)	
(2)	Recognition of professional learning		6.11 (0.99)	
(3)	Impact of post-graduate education on practice		6.00 (1.03)	
(4)	Career pathways of degree-educated nurses		5.80 (1.16)	
4	Undergraduate/pre-registration clinical learning	70.6%	5.92 (1.05)	Medium-long
(1)	Students' learning experiences in the clinical environment		6.08 (1.08)	
(2)	Clinical placements		6.02 (1.08)	
(3)	Who should teach students in clinical areas		5.85 (1.20)	
(4)	Lecturers' roles in clinical areas		5.62 (1.26)	
5	Clinical education links between service and academic organisations	68%	5.86 (1.00)	Medium-long
(1)	Educational role of nurses in clinical practice		5.95 (1.02)	
(2)	Collaboration between service and academic organisations		5.85 (1.14)	
(3)	Clinical skills of lecturers		5.82 (1.22)	
(4)	Content and structure of all levels of clinical education		5.80 (1.04)	
6	Educational needs analysis	69.1%	5.81 (1.01)	Medium-long
(1)	Need for courses to meet changing needs		5.92 (1.17)	
(2)	Education in areas of specialist practice		5.90 (1.06)	
(3)	Knowledge of pharmacology and knowledge of medication responsibilities		5.86 (1.18)	
(4)	Management education needs analysis		5.71 (1.20)	
7	Professional appraisal and staff development	68.9%	5.81 (1.05)	Medium-long
(1)	Regular assessment of specialist area competencies		5.74 (1.13)	
(2)	Mandatory periodic reassessment of knowledge and skills and related staff development		5.73 (1.17)	
(3)	Regular assessments of practice competencies		5.73 (1.13)	
8	Models of course delivery	60.7%	5.68 (1.07)	Medium-long
(1)	Availability of courses outside major centres		5.99 (1.23)	
(2)	Modular frameworks to support flexible learning		5.75 (1.20)	
(3)	Need for distance learning and e-learning opportunities		5.61 (1.32)	
9	Recruitment and retention related to nurse education	62%	5.64 (1.13)	Medium-long
(1)	Qualities and abilities of people recruited into nursing		5.83 (1.19)	
(2)	Staff retention related to level of education		5.63 (1.18)	
(3)	How to attract people into undergraduate nursing education		5.50 (1.25)	

¹Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

CONCLUSIONS: nursing research priorities

Table 4.14 summarises the clinical, managerial and educational research priorities for nursing and presents them in relation to their priority-level rank order, level of sample consensus on importance ratings on round 3, mean importance ratings (used to determine rank order), SDs as indicators of the variability of importance ratings and the timeframe within which research on each of the priorities should be conducted. Five nursing issues met all the criteria for being considered high priority for research: three clinical issues, *outcomes of care delivery*, *staffing issues in practice* and *communication in clinical practice*; and two managerial issues, *recruitment and retention of nurses* and *nursing input into health policy and decision making*. The highest priority clinical issue for research was *outcomes of care delivery*, the highest priority managerial issue for research was recruitment and retention of nurses and the highest priority educational issue was *research and evidence-based practice*. However, the educational issue did not meet the criteria for being considered high priority because consensus on the importance rating of this issue did not reach 80 per cent.

Taking all the nursing issues together, the highest priority issue requiring research in the short term was the clinical issue of *outcomes of care delivery* (M=6.27). The second highest issue overall requiring research in the short term was the managerial issue of *recruitment and retention of nurses* (M=6.26). The third and fourth highest priority issues, respectively, requiring research in the short term were the clinical issues of *staffing issues in practice* (M=6.25) and *communication in clinical practice* (M=6.24). The fifth highest priority issue overall requiring research in the short term was the managerial issue of *nursing input into health policy and decision-making* (M=6.17). None of the educational issues met all the criteria for being included in the highest priority grouping.

Seven of the ten clinical priority issues were identified as requiring research in the short term. All the managerial priority issues were identified as requiring research in the short term. Only one of the nine educational priority issues was identified as requiring research in the short term. Some research issues showed a mean importance rating of greater than 6.0 on the 7-point scale, but they were not included in the highest priority grouping because the consensus of their mean importance ratings was less than 80 per cent.

Table 4.14: Nursing clinical, managerial and educational research priorities by rank, consensus, mean importance rating and timeframe

Issue/Example	Rank ¹	Consensus ² (%)	Mean (SD)	Timeframe
Clinical				
*Outcomes of care delivery	1	85.7%	6.27 (0.92)	Short
*Staffing issues in practice	2	83.4%	6.25 (0.95)	Short
*Communication in clinical practice	3	84.3%	6.24 (0.95)	Short
Quality assurance in practice	4	77.0%	5.99 (0.88)	Short
Nursing practice roles	5	72.2%	5.90 (0.99)	Short
Psychological care concerns	6	69.9%	5.83 (0.99)	Short
Ethical concerns	7	67.2%	5.82 (1.02)	Short
Specialist and advanced practice roles	8	69.1%	5.80 (1.05)	Medium-long
Physical care concerns	9	70.2%	5.79 (1.24)	Medium-long
Nurses' attitudes to specific patient/client groups	10	57.0%	5.48 (1.30)	Medium-long
Management				
*Recruitment and retention of nurses	1	82.0%	6.26 (0.93)	Short
*Nursing input into health policy and decision making	2	80.0%	6.17 (0.94)	Short
Role of nurse managers	3	78.3%	6.03 (0.99)	Short
Health and safety in practice	4	70.5%	5.95 (1.06)	Short
Quality assurance and standards of care	5	69.1%	5.86 (0.90)	Short
Education				
Research and evidence-based practice	1	78.0%	6.08 (0.88)	Short
Career planning and professional/ educational development	2	77.0%	6.01 (0.97)	Medium-long
Outcomes and effectiveness of education	3	75.3%	5.98 (0.93)	Medium-long
Undergraduate/pre-registration clinical learning	4	70.6%	5.92 (1.05)	Medium-long
Clinical education links between service and academic organisations	5	68.0%	5.86 (1.00)	Medium-long
Educational needs analysis	6	69.1%	5.81 (1.01)	Medium-long
Professional appraisal and staff development	7	68.9%	5.81 (1.05)	Medium-long
Models of course delivery	8	60.7%		Medium-long
Recruitment and retention related to nurse education	9	62.0%	5.64 (1.13)	Medium-long

¹Research priorities are ranked within category ²Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

*High priority for research in the short term

Midwifery

For Research Question 2, the results concern the overall short-term, medium-term and long-term research priorities, related to clinical, managerial and educational issues for midwifery in Ireland.

Clinical issues: Table 4.15 shows the three most important clinical issues for research and their three highest rated examples. Four issues, *satisfaction with care*, *care in labour*, *preparation for practice*, and *communication* received mean importance scores greater than 6.0 on the 7-point scale and were rated as a high priority by at least 80 per cent of participants. However, only the first three issues were identified as requiring research in the short term of three to five years and met all criteria for being considered high priority for research. *Satisfaction with care* was identified as the highest clinical research priority. The three highest rated examples of *satisfaction with care* were 'providing women with a choice in relation to maternity care', 'national review of maternity services' and 'organisation of maternity care'. *Care in labour* was identified as the second highest clinical research priority and its three highest rated examples were 'perineal care', 'Cardiotocograph (CTG) monitoring' and 'vaginal examinations'. The third highest clinical research priority was identified as *preparation for practice*, and its three highest rated examples were 'updating midwives' skills', 'responding to emergencies' and 'student preparation-theory/clinical balance'.

Table 4.15: The 3 highest ranked midwifery clinical research priorities with their 3 highest rated examples

Order of priority	Midwifery clinical issues and examples
*1	Satisfaction with care
	Providing women with choice in relation to maternity care
	National review of maternity services
	Organisation of maternity care
*2	Care in labour
	Perineal care
	Cardiotocograph (CTG) monitoring
	Vaginal examinations
*3	Preparation for practice
	Updating midwives' skills
	Responding to emergencies
	Student prep-theory/clinical balance

*High priority for research in the short term

Table 4.16 shows the final priority ranking for all eleven clinical issues according to mean importance scores, consensus percentage achieved, SD scores and timeframe rating (short term or medium-to-long term). It also shows the rankings of the examples of each research priority issue. The fourth highest clinical research priority was identified as *communication* and, as already mentioned, was rated as a high priority by at least 80 per cent of participants but required research in the medium-to-long term of more than three years. Seven clinical issues, although identified as priority areas for research, received a lower mean importance rating and thus, were ranked as lower priority for research. In addition, these issues received lower indications of group consensus on the mean importance rating. Five were identified as requiring research in the short term and two in the medium-to-long term. The issue of *management grades* showed a particularly low mean importance rating and also showed a much lower indication of group consensus on this rating.

Table 4.16: Final priority ranking, consensus¹ level, and timeframe ratings for 11 midwifery clinical issues

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
*1	Satisfaction with care	81.6%	6.33 (0.78)	Short
(1)	Providing women with choice in relation to maternity care		6.38 (0.73)	
(2)	National review of maternity services		6.26 (1.00)	
(3)	Organisation of maternity care		6.20 (0.87)	
(4)	Perceptions of role of midwife		6.06 (1.12)	
(5)	Transcultural issues		6.04 (0.91)	
*2	Care in labour	86.7%	6.26 (1.15)	Short
(1)	Perineal care		6.02 (1.26)	
(2)	Cardiotocograph (CTG) monitoring		5.96 (1.34)	
(3)	Vaginal examinations		5.93 (1.25)	
(4)	Perineal suturing		5.92 (1.29)	
(5)	Epidural use		5.57 (1.35)	
*3	Preparation for practice	80.6%	6.25 (1.04)	Short
(1)	Updating midwives' skills		6.45 (0.85)	
(2)	Responding to emergencies		6.43 (1.24)	
(3)	Student preparation-theory/clinical balance		6.12 (1.04)	
(4)	Student preparation-theory/practice balance		5.84 (1.26)	
(5)	Preparing students to give bad news		5.53 (1.29)	
4	Communication	82.7%	6.23 (1.13)	Medium-long
(1)	Record-keeping		6.16 (1.27)	
5	Models of care	77.6%	6.20 (0.93)	Short
(1)	Midwife-led care		6.63 (0.77)	
(2)	Midwifery support for women in the community		6.51 (0.78)	
(3)	Autonomy and the midwife		6.49 (0.74)	
(4)	Normal midwifery versus medical model		6.38 (0.97)	
(5)	Advanced practice/extended practice roles		6.25 (1.06)	
(6)	Medicalisation of childbirth		5.37 (1.80)	
6	Clinical supervision	78.6%	6.17 (0.90)	Short
(1)	Evidence-based/research-based practice		6.36 (1.00)	
(2)	Midwifery supervision		6.13 (0.92)	
(3)	Writing policy/guidelines		6.05 (1.11)	
(4)	Dealing with litigation		5.92 (1.15)	
7	Continuing professional education	78.6%	5.98 (1.09)	Short
(1)	Importance of continuing professional education		6.07 (1.11)	
(2)	In-service training		5.97 (1.22)	
8	Breastfeeding	72.4%	5.87 (1.37)	Medium-long
(1)	Establishing breastfeeding		6.22 (1.26)	
(2)	Uptake of breastfeeding		6.05 (1.29)	
(3)	Teat versus cup/syringe feeding		5.09 (1.53)	
(4)	Role of lactation consultants		4.95 (1.66)	
(5)	Diet and breastfeeding		4.93 (1.62)	
9	Health promotion	66.3%	5.83 (1.01)	Short
(1)	Resources for/effectiveness of antenatal education		5.93 (1.08)	
(2)	Parent preparation		5.91 (1.21)	
10	Human resource management	63.3%	5.74 (1.35)	Short
(1)	Staff retention		6.20 (1.24)	
(2)	Recruitment and selection of staff		5.97 (1.35)	
11	Management grades	26.5%	4.61 (1.56)	Medium-long
(1)	Clinical midwife manager numbers		4.72 (1.58)	

*High priority for research in the short term

¹Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

Managerial issues: Table 4.17 shows the three most important managerial issues for research, and the three highest rated examples of the first two issues and the two examples of the third issue. The issues, *promoting woman-centred care*, *sources of stress*, and *developing midwifery practice* received a mean score of 6.0 or more on the 7-point scale. However, only the highest rated issue, *promoting woman-centred care*, was rated as being of high priority by more than 80 per cent of participants. It was also

identified as requiring research in the short term. For this issue, the three highest rated examples were 'development of woman-centred care', 'quality of midwifery care' and 'outcomes and cost-effectiveness of midwifery-led care'. The second highest rated issue, *sources of stress*, included four highly rated examples, 'support for staff from management', 'factors leading to increased workload', 'burnout' and 'bullying', and was identified as requiring research in the short term. The third highest rated issue, *developing midwifery practice* included only two lower rated examples, 'what is the role of the advanced midwife practitioner?' and 'evaluation of the clinical midwife specialist role', and was identified as requiring research in the medium-to-long term.

Table 4.17: The 3 highest ranked midwifery managerial research priorities with their 3 highest rated examples

Order of priority	Midwifery managerial issues and examples
*1	Promoting woman-centred care
	Development of woman-centred care
	Quality of midwifery care
	Outcomes and cost effectiveness of midwifery- led care
2	Sources of stress
	Support for staff from management
	Factors leading to increased workload
	Burnout
3	Developing midwifery practice (2 examples in total)
	What is the role of the Advanced Midwife Practitioner?
	Evaluation of the Clinical Midwife Specialist role

*High priority for research in the short term

Table 4.18 shows the final priority ranking for all eight managerial issues according to mean importance scores, consensus percentage achieved, SD scores and timeframe rating (short term or medium-to-long term). It also shows the rankings of the examples of each research priority issue. Five managerial issues, although identified as priority areas for research, received a lower mean importance rating and thus, were ranked as lower priority for research. Two of these were identified as requiring research in the short term and three in the medium-to-long term.

Table 4.18: Final priority ranking, consensus¹ level, and timeframe ratings for 8 midwifery managerial issues

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
*1	Promoting woman-centred care	88.8%	6.47 (0.70)	Short
(1)	Development of woman-centred care		6.49 (0.85)	
(2)	Quality of midwifery care		6.41 (0.86)	
(3)	Outcomes and cost effectiveness of midwifery-led care		6.24 (0.95)	
(4)	Community and domiciliary models		6.21 (0.96)	
(5)	Responsiveness of midwifery care		6.15 (0.96)	
(6)	How well women are prepared for motherhood		6.02 (1.05)	
(7)	Midwifery prescribing		5.96 (1.13)	
(8)	Privacy and impact on outcomes of care		5.74 (1.27)	
(9)	Ward design		5.18 (1.56)	
2	Sources of stress	78.6%	6.13 (1.16)	Short
(1)	Support for staff from management		6.28 (1.09)	
(2)	Factors leading to increased workload		6.24 (1.11)	
(3)	Burnout		6.18 (1.14)	
(4)	Bullying		6.13 (1.30)	
3	Developing midwifery practice	76.5	6.09 (1.06)	Medium-long
(1)	What is the role of the Advanced Midwife Practitioner?		5.86 (1.18)	
(2)	Evaluation of the Clinical Midwife Specialist role		5.79 (1.33)	

*High priority for research in the short term

¹Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

Table 4.18: Final priority ranking, consensus¹ level, and timeframe ratings for 8 midwifery managerial issues (continued)

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
4	Workforce planning	71.4%	5.91 (1.21)	Medium-long
(1)	Appropriate staffing levels		6.14 (1.33)	
(2)	Recruitment and retention		6.09 (1.39)	
(3)	Appraisal/personal development planning		5.98 (1.24)	
(4)	Staffing		5.94 (1.50)	
(5)	Staff rotation		5.79 (1.34)	
(6)	Fair allocation of work		5.70 (1.47)	
(7)	Supporting and developing managers		5.65 (1.42)	
(8)	Rostering		5.52 (1.44)	
(9)	Dependency		5.44 (1.44)	
5	Barriers to autonomy	70.4%	5.87 (1.09)	Short
(1)	Proper recognition and remuneration for role and responsibilities		6.08 (1.25)	
(2)	Challenges as a result of medical model in maternity care		6.02 (1.00)	
(3)	Promoting autonomy at management level		5.89 (1.21)	
(4)	Fear of litigation		5.56 (1.39)	
6	Management culture	63.3%	5.61 (1.24)	Short
(1)	Do staff feel valued?		6.15 (1.26)	
(2)	Showing appreciation		6.06 (1.27)	
(3)	Management/staff communication		6.03 (1.16)	
(4)	Staff/management relations		5.81 (1.22)	
(5)	Leadership role models		5.71 (1.28)	
(6)	Management style		5.68 (1.27)	
(7)	Approaches to appraisal		5.65 (1.30)	
7	Change management	61.2%	5.58 (1.24)	Medium-long
(1)	Audit of standards of care		5.74 (1.29)	
(2)	Managing change		5.65 (1.27)	
(3)	Patient and staff risk analysis		5.64 (1.31)	
8	Levels of management	44.9%	5.25 (1.31)	Medium-long
(1)	Need for new specialist posts		5.78 (1.40)	
(2)	Clinical knowledge and skills required for management		5.77 (1.30)	
(3)	Importance of clinical midwife management role		5.59 (1.37)	
(4)	Need for clinical skills co-ordinator		5.50 (1.59)	
(5)	Midwife/manager ratios		5.27 (1.54)	
(6)	Appointment to management positions		5.21 (1.45)	
(7)	Management hierarchy		4.81 (1.64)	

*High priority for research in the short term

¹Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

Educational issues: Table 4.19 shows the three most important educational issues for research and their three highest rated examples. Two of these issues, the highest rated *promoting the distinctiveness of midwifery* and the third highest rated *promoting research/research-based practice* were identified as requiring research in the short term. Promoting the distinctiveness of midwifery included three highly rated examples, 'promotion of midwifery to the public', 'encouraging midwives to develop own practice', and 'focus on normal in midwifery education despite medical model'. Two examples of *promoting research/research-based practice* were also highly rated, 'exploring the use of evidence-based practice' and 'enabling midwives to undertake local research and publish'.

Table 4.19: The 3 highest ranked midwifery educational research priorities with their 3 highest rated examples

Order of priority	Midwifery educational issues and examples
*1	Promoting the distinctiveness of midwifery
	Promotion of midwifery to the public
	Encouraging midwives to develop own practice
	Focus on normal in midwifery education despite medical model
2	Continuing education
	Access to continuing education for midwives
	Content of continuing education for midwives
	Developing appropriate post-graduate education
*3	Promoting research/research-based practice
	Exploring the use of evidence-based practice
	Enabling midwives to undertake local research and publish
	Various approaches to promoting research- based practice

*High priority for research in the short term

Table 4.20 shows the final priority ranking for all seven educational issues according to mean importance scores, consensus percentage achieved, SD scores and timeframe rating (short term or medium-to-long term). It also shows the rankings of the examples of each research priority issue. Four midwifery educational research issues received a mean score of 6.0 or more on the 7-point scale and were rated as high priority by at least 80% of participants. The second and fourth highest issues, *continuing education* and *student learning/education*, while showing mean scores greater than 6.0 on the 7-point scale and being rated as a high priority by 80 per cent and over of participants, were identified as requiring research in the medium-to-long term of more than three years. The three highest rated examples of *continuing education* were 'access to continuing education for midwives', 'content of continuing education for midwives', and 'developing appropriate post-graduate education'. For the issue, *student learning/education*, the three highest rated examples were 'providing adequate support for student midwives in the clinical area', 'preparation of students for midwifery-led models' and 'improving practice skills'. Three educational issues, although identified as priority areas for research, received a lower mean importance rating and thus were ranked as lower priority for research, two identified as requiring research in the short term and one in the medium-to-long term.

Table 4.20: Final priority ranking, consensus¹ level, and timeframe ratings for 7 midwifery educational issues

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
*1	Promoting the distinctiveness of midwifery	85.7%	6.33 (0.66)	Short
(1)	Promotion of midwifery to the public		6.47 (0.78)	
(2)	Encouraging midwives to develop own practice		6.36 (0.86)	
(3)	Focus on normal in midwifery education despite medical model		6.26 (0.97)	
2	Continuing education	81.6%	6.23 (0.77)	Medium-long
(1)	Access to continuing education for midwives		6.17 (0.91)	
(2)	Content of continuing education for midwives		6.11 (0.86)	
(3)	Developing appropriate post-graduate education		6.03 (0.98)	
(4)	Measures other than courses to support learning amongst clinical staff		6.02 (0.79)	
(5)	Adequacy of in-service education		5.93 (1.13)	
(6)	Motivating staff to attend continuing education		5.80 (1.29)	
*3	Promoting research/research-based practice	83.7%	6.21 (0.88)	Short
(1)	Exploring the use of evidence-based practice		6.22 (0.94)	
(2)	Enabling midwives to undertake local research and publish		6.03 (1.04)	
(3)	Various approaches to promoting research-based practice		5.86 (1.07)	

Table 4.20: Final priority ranking, consensus¹ level, and timeframe ratings for 7 midwifery educational issues (continued)

Rank	Issue/Example	Consensus ¹ (%)	Mean (SD)	Timeframe
4	Student learning/education	82.7%	6.17 (0.95)	Medium-long
(1)	Providing adequate support for student midwives in the clinical area		6.31 (0.86)	
(2)	Preparation of students for midwifery-led models		6.22 (0.99)	
(3)	Improving practice skills		6.14 (1.05)	
(4)	Preparing students for the transition to midwife		6.13 (0.91)	
(5)	Relating theory to practice for midwifery students		5.93 (1.16)	
(6)	Students' experience of the clinical learning environment		5.86 (1.19)	
(7)	Role of independent midwives in the community in midwifery education		5.74 (1.20)	
(8)	Student assessment		5.67 (1.08)	
(9)	Direct entry midwifery programmes		5.61 (1.48)	
(10)	Barriers to preceptorship		5.56 (1.20)	
(11)	Promoting reflection among students		5.36 (1.34)	
5	Support for midwives working with students	77.6%	6.11 (1.07)	Short
(1)	Midwives and teaching workloads		5.98 (1.13)	
(2)	Effectiveness for induction programmes for overseas midwives		5.85 (1.25)	
(3)	Experience of midwives/support in assessing students		5.81 (1.19)	
(4)	Value of preceptorship programmes		5.68 (1.29)	
6	Midwifery curriculum	66.3%	5.79 (1.03)	Medium-long
(1)	New approaches to midwifery education		5.74 (1.04)	
(2)	Theory/practice gap in midwifery education		5.73 (0.98)	
(3)	Curriculum content		5.69 (1.12)	
(4)	Balance between theory and practice and academic requirements in midwifery education		5.64 (1.24)	
(5)	Aims of the midwifery curriculum		5.64 (1.25)	
7	Role of the midwife tutor	62.2%	5.62 (1.25)	Short
(1)	Making better use of clinical midwives in education in small hospitals		5.97 (1.13)	
(2)	The Lecturer/Practitioner role and provision of student support		5.77 (1.13)	

*High priority for research in the short term

¹Percentage rating the issues as a high priority (6.0 or above on a 7-point scale)

CONCLUSIONS: midwifery research priorities

Table 4.21 summarises the clinical, managerial and educational research priorities for midwifery and presents them in relation to their priority-level rank order, level of sample consensus on importance ratings on round 3, mean importance ratings (used to determine rank order), SDs as indicators of the variability of importance ratings, as well as the timeframe within which research on each of the priorities should be conducted. Six midwifery issues met all the criteria for being considered high priority for research: three clinical issues, *satisfaction with care*, *care in labour* and *preparation for practice*; one managerial issue, *promoting woman-centred care*; and two educational issues, *promoting the distinctiveness of midwifery* and *promoting research/research-based practice*. The highest priority clinical issue for research was *satisfaction with care*, the highest priority managerial issue for research was *promoting woman-centred care*, and the highest priority educational issue for research was *promoting the distinctiveness of midwifery*.

Taking all of the midwifery issues together, the highest priority issue requiring research in the short term, was the managerial issue of *promoting woman-centred care* (M=6.47). The second highest issue overall requiring research in the short term was the educational issue of *promoting the distinctiveness of midwifery* (M=6.33), followed closely in third ranking by the clinical issue of *satisfaction with care* (M=6.33). The fourth and fifth highest issues respectively requiring research in the short term were the clinical issues of *care in labour* (M=6.26) and *preparation for practice* (M=6.25). The sixth highest issue overall requiring research in the short term was the educational issue of *promoting research/research-based practice* (M=6.21).

Eight of eleven clinical priority issues were identified as requiring research in the short term. Four of the eight managerial priority issues were identified as requiring research in the short term, and four of the seven educational priority issues were identified as requiring research in the short term. Some research issues showed a mean importance rating of greater than 6.0 on the 7-point scale, but they were not included in the highest priority grouping because the consensus of their mean importance ratings was less than 80 per cent.

Table 4.21: Midwifery clinical, managerial and educational research priorities by rank, consensus, mean importance rating and timeframe

Issue/Example	Rank	Consensus (%)	Mean (SD)	Timeframe
Clinical				
*Satisfaction with care	1	81.6%	6.33 (0.78)	Short
*Care in labour	2	86.7%	6.26 (1.15)	Short
*Preparation for practice	3	80.6%	6.25 (1.04)	Short
Communication	4	82.7%	6.23 (1.13)	Medium-long
Models of care	5	77.6%	6.20 (0.93)	Short
Clinical supervision	6	78.6%	6.17 (0.90)	Short
Continuing professional education	7	78.6%	5.98 (1.09)	Short
Breastfeeding	8	72.4%	5.87 (1.37)	Medium-long
Health promotion	9	66.3%	5.83 (1.01)	Short
Human resource management	10	63.3%	5.74 (1.35)	Short
Management grades	11	26.5%	4.61 (1.56)	Medium-long
Management				
*Promoting woman-centred care	1	88.8%	6.47 (0.70)	Short
Sources of stress	2	78.6%	6.13 (1.16)	Short
Developing midwifery practice	3	76.5%	6.09 (1.06)	Medium-long
Workforce planning	4	71.4%	5.91 (1.21)	Medium-long
Barriers to autonomy	5	70.4%	5.87 (1.09)	Short
Management culture	6	63.3%	5.61 (1.24)	Short
Change management	7	61.2%	5.58 (1.24)	Medium-long
Levels of management	8	44.9%	5.25 (1.31)	Medium-long
Education				
*Promoting the distinctiveness of midwifery	1	85.7%	6.33 (0.66)	Short
Continuing education	2	81.6%	6.23 (0.77)	Medium-long
*Promoting research/research-based practice	3	83.7%	6.21 (0.88)	Short
Student learning/education	4	82.7%	6.17 (0.95)	Medium-long
Support for midwives working with students	5	77.6%	6.11 (1.07)	Short
Midwifery curriculum	6	66.3%	5.79 (1.03)	Medium-long
Role of the midwife tutor	7	62.2%	5.62 (1.25)	Short

*High priority for research in the short term

Service users: nursing

The results of the service users' ratings of the clinical, managerial and educational issues for research presented below are shown in table format, including means, SDs and timeframes for research to be conducted, in Appendix 8. Because the service users completed their ratings on only one occasion, at the discussion workshop, no data on the level of consensus amongst participants on the importance ratings could be collected. Some indication of consensus on the importance ratings or, on the other hand, the variability of the ratings, is suggested by SD scores.

Clinical issues: Nine of the ten priority clinical research issues demonstrated mean importance for research ratings of 6.0 or more on the 7-point scale, indicating that they were rated as highly important. Mean importance ratings ranged from 6.00 to 6.71. In addition, most of the examples included under each issue demonstrated importance ratings of 6.0 or more on the 7-point scale. The issue rated of highest importance for research was *communication in clinical practice*. The particularly low SD of 0.48 associated with this rating indicates a high level of consensus for this rating. Three examples of this issue, 'communication with patient/clients', 'patient/clients' relatives', and 'communication with people from other cultures', also demonstrated particularly high importance rating scores.

The issue rated of second highest importance for research was *psychological care concerns*, which was also associated with a low SD of 0.53, indicating a high level of consensus for this rating. The three highest rated examples of this issue were 'interactions with families and communities', 'care of mentally ill patients/clients' and 'effects of caring for patients/clients with disabilities'. The issues rated of third and fourth highest in importance were respectively *outcomes of care delivery* and *physical care concerns*, both also showing fairly high levels of consensus for these rating. The three highest rated examples of *outcomes of care delivery* were 'evaluation of care delivery', 'patient/clients' perceptions of nursing care' and 'effectiveness of patient/client education'. The three highest rated examples of *physical care concerns* were 'pain and symptom management', 'infection control' and 'wound care'.

Of the remaining six issues, all demonstrated a mean importance rating of 6.0 or above on the 7-point scale, except for the issue rated lowest priority for clinical research, *specialist and advanced practice roles*, with a mean rating of 5.71. The mean ratings for all of these issues and most of their examples were associated with relatively low SD scores, indicating fairly high levels of consensus for these ratings. Nine of the ten priority issues for clinical nursing research were rated as requiring research in the short term.

Managerial issues: The five priority managerial research issues all demonstrated mean importance for research ratings of 6.0 or more on the 7-point scale, indicating that all were rated as highly important. Mean importance ratings ranged from 6.0 to 6.29. In addition, several of the examples included under each of the issues demonstrated importance ratings of 6.0 or more on the 7-point scale. The issue rated of highest importance for research was *nursing input into health policy and decision-making*. One example of this issue, 'including all nurses in decision making' was also rated as highly important. The issue rated as second highest importance was *quality assurance and standards of care*, and one example of this issue, 'national guidelines for practice', was also rated as highly important. The remaining three issues were all rated at the same level of priority. The SDs associated with the mean ratings for all of the issues were less than 1.0 indicating a fairly high level of consensus for these ratings. Three of the five issues were identified as requiring research in the short term.

Educational issues: Three of the nine educational research issues demonstrated mean importance for research ratings of 6.0 or more on the 7-point scale, indicating that they were rated to be highly important. Mean importance ratings ranged from 6.14 to 6.43. The issue rated of highest importance was *professional appraisal and staff development*. The three examples of this issue, 'regular assessment of specialist area competencies', 'mandatory periodic reassessment of knowledge and skills and related staff development' and 'regular assessments of practice competencies', also demonstrated high priority ratings. The issue rated as second highest priority was research and *evidence-based practice*, followed closely by the issue rated third highest priority, *recruitment and retention related to nurse education*. Three examples of research and evidence-based practice, 'use of research to improve practice', 'dissemination of research information in practice', 'role-related research responsibilities' also received high ratings. Likewise, the three examples of *recruitment and retention related to nurse education*, 'staff retention related to level of education', 'qualities and abilities of people recruited into nursing' and 'how to attract people into undergraduate nursing education', received high ratings.

The remaining six educational research issues received a lower mean importance rating and thus, were ranked as lower priority for research. The SDs associated with the mean ratings for all of the issues were less than 1.0 indicating a fairly high level of consensus for these ratings. Five of the nine issues were identified as requiring research in the short term.

Taking all of the nursing issues together, as they were rated by the service users, the highest priority issues for research, requiring research in the short term were the clinical issues of *communication in clinical practice* (M=6.71), *psychological care concerns* (M=6.57) and *outcomes of care delivery* (M=6.50). Two clinical issues tied for fourth highest overall ranking, the issues of *physical care concerns* and *quality assurance in practice* (both: M=6.43, SD=0.78). Two issues followed one another very closely for the fifth and sixth overall rankings, the educational issue of *education and staff development* (M=6.43, SD=0.78) and the clinical issue of *ethical concerns* (M=6.43, SD=0.95). Nine of the ten clinical research priorities, three of the five managerial research priorities and five of the nine educational research priorities were identified as requiring research in the short term of within three years.

Service users: midwifery

Clinical issues: Four of the eleven clinical midwifery issues demonstrated mean importance ratings of 6.0 or more on the 7-point scale, indicating that they were rated as highly important. Mean importance ratings ranged from 6.17 to 6.86. In order of priority these were *care in labour*, *breastfeeding*, *satisfaction with care* and *models of care*. The SDs associated with these issues ranged from 0.38 to 0.75, indicating high levels of consensus for these ratings. Examples of the issue of *care in labour*, 'perineal suturing', 'perineal care', 'cardiotocograph (CTG) monitoring' and 'vaginal examinations' were also rated highly.

The issue rated of second highest importance for research was *breastfeeding*. This issue was also associated with a low SD of 0.55, indicating a high level of consensus for this rating. The two highest rated examples of this issue were 'establishing breastfeeding' and 'uptake of breastfeeding'. These issues had SDs of 0.45 and 0.70 respectively, indicating a high level of consensus for these ratings.

The issue rated of third highest importance for research was *satisfaction with care*. The SD for this issue was 0.75, indicating a high degree of consensus for this rating. The four highest rated examples of this issue were 'providing women with choice in relation to maternity care', 'national review of maternity services', 'organisation of maternity care' and 'transcultural issues'. The SDs for these issues ranged from 0.83 to 1.13, indicating moderate consensus. The issue rated of fourth highest importance for research was *models of care*, with a relatively low SD of 0.55, suggesting a high degree of consensus for the rating. The four highest rated examples of this issue were 'midwife-led care', 'normal midwifery versus medical model', 'medicalisation of childbirth', and 'midwifery support for women in the community'. The SDs for these examples ranged from 0.86 to 1.65, indicating moderate to lower consensus for these ratings. The four issues ranked highest for clinical research were all considered to require research in the short term.

Of the seven remaining clinical issues, the mean importance ratings ranged from 4.57 to 5.86, indicating low to medium priority. The lowest rated clinical issue was *management grades*. In addition, of the six remaining issues, five were considered to require research in the medium-to-long term, the exception being *preparation for practice* which was considered to require research in the short term.

Managerial issues: Two of the eight managerial issues received mean rating scores of 6.0 or more on the 7-point scale, indicating that they were rated highly important. These two issues in order of priority were *promoting woman-centred care* and *sources of stress*. The SDs for these issues were 0.53 and 0.78 respectively, indicating high levels of consensus. The highest rated examples for *promoting woman-centred care* were 'development of woman-centred care', 'community and domiciliary models', 'quality of midwifery care', 'outcomes and cost effectiveness of midwifery-led care', 'how well women are prepared for motherhood' and 'responsiveness of midwifery care'. The SDs for these examples ranged from 0.44 to 0.66, indicating high consensus for these ratings.

The issue rated of second highest importance was *sources of stress*. The SD for this issue was SD 0.78, indicating a high degree of consensus for this rating. The examples of this issue, 'burnout', 'bullying' and 'support for staff' were also rated to be of high importance. For the six remaining managerial issues, the mean importance ratings ranged from 5.14 to 5.71, with the issue of *management culture* receiving the lowest priority rating. The SDs for these issues ranged from 0.51 to 1.38, indicating high to moderate consensus on the importance ratings across the issues. The two highest priority issues were considered to require research in the short term and the remaining issues to require research in the medium-to-long term.

Educational issues: Three of the seven educational issues, *continuing education*, *promoting the distinctiveness of midwifery* and *student midwife learning/education*, had the same mean importance scores of 6.0. The SDs for these issues ranged from 1.00 to 1.15, indicating moderate levels of consensus for these ratings. The issues were placed in priority order according to their SD scores with the lowest SD

indicating the highest priority. The three highest rated examples of *continuing education* were 'content of continuing education for midwives', 'access to continuing education for midwives' and 'motivating staff to attend continuing education'. The SDs for these examples ranged from 0.60 to 0.97, indicating high to moderate consensus for these ratings. Highly rated examples of the issue *promoting the distinctiveness of midwifery* were 'focus on normal in midwifery despite medical model' and 'promotion of midwifery to the public' and their SD scores indicated a moderate degree of consensus for these ratings.

The third highest ranked issue was *student midwife learning/education*. Highly rated examples of this issue were 'role of independent midwives in the community in midwifery education' and 'preparation of students for midwifery-led models' and the low SDs of 0.44 and 0.50 indicated a high degree of consensus on the ratings. Other highly rated examples were 'improving practical skills', 'direct entry midwifery programmes', 'preparing students for the transition to midwife', 'relating theory to practice for midwifery students', 'student assessment', and 'providing adequate support for student midwives in the clinical area'. Of the four remaining issues, the mean importance scores ranged from 5.43 to 5.86, indicating a medium priority rating. The lowest rated priority issue was role of the midwife tutor. Two issues, *promoting the distinctiveness of midwifery* and *student midwife learning/education* were considered to require research in the short term and the remaining issues to require research in the medium-to-long term.

Taking all of the midwifery issues together, as they were rated by the service users, the highest priority issues for research, requiring research in the short term, were the clinical issues of *care in labour* (M=6.86), and *breastfeeding* (M=6.50). Two managerial issues tied for the third highest overall ranking, the issues of *promoting woman-centred care* and *sources of stress* (both: M=6.43). Three educational issues tied for the fourth highest overall ranking, *continuing education*, *promoting the distinctiveness of midwifery* and *student midwife learning/education* (M=6.00). Five of the eleven clinical research priorities, two of the eight managerial research priorities and two of the seven educational research priorities were identified as requiring research in the short term of within three years.

5

Discussion

The identification of nursing and midwifery research priorities for Ireland represents a major step in the development of the scientific knowledge required to guide the practice of the country's largest group of healthcare professionals. As well as representing 40 per cent of the healthcare workforce, nurses and midwives are widely recognised for their continuous attentiveness to patients during times of illness or health-related need. Thus, nurses' and midwives' methods and approaches to practice have the greatest potential to foster healing and health in society. Although nurses and midwives work in close collaboration with other health professionals, they offer their own very distinctive services. It is imperative for the nursing and midwifery professions, and for the people of Ireland whom they serve, that their services are research-based. Research priorities point the way to ensuring that the most important aspects of their services are examined and enhanced through scientific research and that the research-bases of the professions are reinforced and augmented on an ongoing basis. Advancement of nursing and midwifery knowledge in Ireland will also contribute to the global understanding of nursing and midwifery practice.

There are two major assumptions that underpin any study of research priorities. First is the belief that research issues, applicable to nurses and midwives, can be prioritised and a consensus can be reached about such prioritisation. That is, some research topics can be clearly identified as being more important than others, and some should be addressed sooner rather than later. Second is the imperative that those who use the knowledge gained from research – that is clinicians, managers and educators – play a vital role in the development of the list of research issues applicable to their practice. In essence, the users of the knowledge should be the creators of the priorities for research and knowledge development; in other words, they should set the research agenda.

These two challenges were addressed in this research by the production of priority listings of the most important research issues for nursing and midwifery and by the engagement of large numbers of clinicians, managers and educators in determining those issues. A representative sample of the population of nurses and midwives, with similar proportions of key characteristics to the known population, was sought. An initial publicity campaign using posters and flier invitations distributed electronically and by post to all Health Board nursing and midwifery planning and development units, community care areas and third-level educational institutions, resulted in a limited response from the nursing and midwifery community. However, further individualised invitations to participate, delivered at unit and ward level at institutions within Health Boards with the support of directors of nursing and midwifery, and via other personal meetings in the community-at-large, resulted in a total of 1,695 nurses agreeing to participate in the study, 156 more than the initial projection of 1,539. Similarly, a total of 337 midwives agreed to participate, 85 more than the projected sample of 252.

Distribution of Questionnaire 1 to these samples resulted again in a limited response. Only 47 per cent of nurses and 42 per cent of midwives who had volunteered to participate in the study returned Questionnaire 1, despite the extensive use of 'reminding procedures' (Dillman 2000). Questionnaire recipients were contacted by telephone up to three times to request the return of the completed questionnaires but many cited work pressures as well as other personal commitments as reasons for not responding. The initial response rates were however within the range of initial response rates of other national Delphi surveys of nursing and midwifery research priorities. While they were less than the 52 per cent response rate achieved in the US (Lindeman 1975) and the 50 per cent response rate achieved in the United Kingdom (Sleep et al 1995), they were greater than the 38 per cent response rate achieved in Spain (Moreno-Casbas et al 2001). Furthermore, it should be noted that this study represents the largest study of this kind in nursing and midwifery reported in the national and international literature. This level of engagement of the nursing and midwifery community, in itself, represents a unique contribution to nursing and midwifery knowledge.

Despite the low response rate to Questionnaire 1, the key characteristics of the nurse sample, and by comparison the midwife sample, indicate that the research priorities were identified by a reasonably representative sample of nurses and midwives. Furthermore, the demographic profile shows that almost 80 per cent of the nurses and more than 70 per cent of the midwives had completed a research module, and around 50 per cent had completed a research dissertation. These findings show that the research priorities were identified by nurses and midwives who were knowledgeable about research and lend strength to the validity of the study questionnaires.

The nurses and the midwives who completed Questionnaire 1 demonstrated that they were truly committed to participation in the study through their high response rates to Questionnaire 2 (nurses 90 per cent; midwives 85 per cent) and Questionnaire 3 (nurses 86 per cent; midwives 81 per cent). Even though the response rates were lower for Questionnaire 3, this should be considered in the light of the similar decreases in respondents across rounds encountered invariably in Delphi surveys. In addition, Questionnaire 3 was considerably longer than Questionnaire 2 because both issues and examples were rated, thus increasing the number of statements from 24 to 122 for nurses and from 26 to 126 for midwives. The nurse sample was reasonably representative of the population, even though for nursing, clinicians were under-represented by 20 per cent and managers over-represented by 8 per cent; clinicians constituted a substantial 60 per cent of the sample, which was sufficient to determine research priorities reflective of clinical practice. The number of educators in the sample is appropriate considering the initial plan to over-sample educators by 25 per cent. Although the population parameters for midwives were not known, the sample proportions were similar to the nurse sample, except for educators who were considerably over-represented in the midwifery sample. The nurse sample was representative across the Health Boards, except for the North West area, which was slightly under-represented. The midwifery population parameters across the Health Boards were not known, but the distribution of the midwife sample was similar to the nurse sample, except that the Midland area appears to be under-represented and, by association, the North West area was under-represented. In terms of nurses' employment in the An Bord Altranais divisions of the Register, children's nurses were slightly over-represented while general and mental health nurses were under-represented. However, almost 70 per cent of the sample consisted of general and mental health nurses, which ensured that their views were well represented. The high response rates to Questionnaires 2 and 3 and the overall representativeness of the samples strengthened the external validity of the study.

Once a sufficient and appropriate number of nurses and midwives were recruited as participants, the steps of the study design were implemented to identify the research priorities, to rate them in order of importance and to achieve consensus on their importance. A three-round, decision Delphi survey, based on the work of Rauch (1979), allowed the researchers to assist the nurse and the midwife participants in identifying and rating the importance of clinical, managerial and educational research topics for nursing and midwifery. In the first round of the survey, participants were asked to generate the priority issues. This approach is used in most studies, although it has been criticised because it can generate large numbers of ambiguous and poorly phrased statements (Hasson et al 2000). In some national studies priorities have been generated from the literature (Hardy et al 2004) or in conference discussions (Yin et al 2000). However for this study to identify priorities for Ireland, it was logically necessary to draw on the considerable knowledge of the Irish nurses and midwives themselves and the questionnaire method, rather than a conference, ensured that all the nurses and midwives had the opportunity to participate. A very large number of priority statements were generated, most were clearly worded and many identified the same issues. The analysis of this data and the formulation of priority statements was found to be a manageable task.

In most Delphi surveys three rounds of questionnaires have been used, except where the priority issues have been identified from the literature or in conference discussion, in which cases two rounds are used. Normally, three rounds are necessary to allow for feedback of group ratings to participants. In some studies, the participants' individual ratings are fed back to them and they are invited to comment in writing on the priority issues (Hasson et al 2000, Powell 2003), but this is not essential and in this study would have been unmanageable because of the large samples. In several studies, participants' consensus has been assumed with the completion of one round of group feedback. Although it has been suggested that a greater number of rounds may improve consensus, this has not been demonstrated (Couper 1984, Crisp et al 1997).

There is, in fact, no agreement about how to best judge when participants' consensus on the importance of priority issues has been achieved, with criteria ranging from 51 per cent (McKenna 1994) to 100 per cent (Williams and Webb 1994). In this study, guidelines suggested by (Hardy et al 2004) were followed and clear criteria were established for determining consensus. Because of the high importance ratings of the majority of issues, the criterion for consensus that an issue was high priority was set at 80 per cent. In addition, to be considered high priority an issue required a mean importance score of 6.0 or higher on the 7-point scale, and a decrease in SD scores from round 2 to round 3 indicating a decrease in the variability of participants' rating. Perusal of the final priority ranking tables shows that these criteria discriminated well between levels of consensus and mean priority ratings. For nursing, three clinical issues and two managerial issues were identified as high consensus, high priority. The remaining clinical and managerial issues and all of the educational issues, a total of nineteen, were identified as lower consensus, medium priority. For midwifery, three clinical issues, one managerial issue and two educational issues were identified as high consensus, high priority and the remaining twenty issues identified as lower consensus, medium priority.

The discussion group workshop to identify, for each priority issue, the short-term, medium-term or long-term timeframe within which research on each issue should be conducted, was designed especially to meet the needs of this study. In previous research, identification of timeframes has not been addressed specifically. Studies generally imply that a direct relationship is assumed between the importance rating of priority issues and the timeframe within which research should be conducted, with the highest priority issues addressed in the short-term. The inclusion of timeframe ratings in this study was designed to link high priority issues to pressing healthcare needs where nurses and midwives could have a significant impact. While this concern is clearly evident in all of the national studies reviewed, only Hinshaw et al (1988) directly linked high priority issues to national needs where nursing could have an impact. And this was done through discussion meetings with health policy and colleague stakeholders.

Because all healthcare research is interwoven with health policy, national health needs and health service developments, it was judged necessary to facilitate the participants' understanding of current health service needs and health service developments prior to the completion of the Timeframe Questionnaire. The workshop was attended by nurses and midwives who were representative of the participants who completed Questionnaire 3 with regard to clinical, managerial and educational roles; and employment in An Bord Altranais divisions of the Register and Health Board location. For confidentiality reasons, workshop participants were not identified by their study identification numbers and their demographic profiles were not identified.

The workshop presentation of the national health strategy and the health service reform programme generated high levels of discussion in the workshop groups in relation to the appropriate research timeframe for each issue. Initially, the participants tended to think that research related to all issues should be conducted in the short term. But, following a discussion of the issues in relation to one another, and in relation to the national health strategy and health service needs, relative timeframes for research on the different issues were recognised. However, when the data were analysed it was observed that most issues had received low long-term ratings and that clearer discrimination between timeframes would be achieved if the medium-term and long-term categories were merged into one medium-to-long term category. Thus, the timeframe categories were revised to short-term (within three years) and medium-to-long term (more than three years).

For nursing, research should be conducted in the short term for all five high priority issues: *outcomes of care delivery, staffing issues in practice, communication in clinical practice, recruitment and retention of nurses, and nursing input into health policy and decision making* (see Table 4.14). For four clinical, five managerial and one educational medium priority nursing issues, research should also be conducted in the short term but this research would logically take second place to that of the high priority issues. For

midwifery, the relationship between the priority of issues and the timeframe for research is not so straightforward (see Table 4.21). Research should be conducted in the short term for six of the high priority issues: *satisfaction with care; care in labour; preparation for practice; promoting woman centred care; promoting the distinctiveness of midwifery, and promoting research/research-based practice*. Research should be conducted in the medium-long-term for three of the high priority issues: *communication, student learning/education, and continuing education*. While these results may indicate that these issues are of high priority for research, they are also more enduring issues that need to be examined over time. Here, again, for some medium priority issues, research should be conducted in the short term but these would also be secondary to the high priority issues.

Nursing issues for research

Scope of issues

In answering Research Question 1, three high priority clinical issues and two high priority managerial issues which require research in the short term were identified. Group consensus on the importance of these issues ranged from 84 per cent to 86 per cent, and it is significant that four of these issues are focused directly on issues concerning patient and client care. The highest priority issue, *outcomes of care delivery* relates directly to the effectiveness of nursing practice; one example of this issue, 'evaluation of care delivery', gives specificity to this issue. Two additional examples, 'patient/client assessment' and 'risk assessment' relate directly to patient safety and can be linked to the important nursing concept of patient surveillance, or observation necessary to ensure that patients are rescued quickly if their conditions deteriorate (Clarke and Aiken 2003). Another example of the care delivery outcome issues, 'effectiveness of patient/client education', is widely recognised to be extremely important in assisting patients and clients to understand illnesses and health needs and to engage in self-care. *Outcomes of care delivery* are intimately dependent upon the second high priority issue, *communication in clinical practice*. The examples of this issue demonstrate the importance of communication in all aspects of practice. The clinical issue, *staffing issues in practice* and the managerial issue, *recruitment and retention of nurses* are clearly related to one another, and this is especially evident in the similarities between the examples of both issues. The additional high priority issue, the managerial issue *nursing input into health policy and decision making*, relates closely to the four issues discussed above on a broad level. The examples of this issue demonstrate an important link between direct patient and client care and health policy. How health policy influences the nurses' ability to practice and the importance of nurses' input into healthcare decision-making at a national level is highlighted in this study.

Also in answer to Research Question 1, the following medium priority issues were identified: seven clinical issues, three managerial issues and nine educational issues. Group consensus on the importance of these issues ranged from 70 per cent to 77 per cent, with the exception of nurses' attitudes to specific patient/client groups which achieved only 57 per cent consensus. The clinical practice issues include a range of concerns. The issues, *physical care concerns, psychological care concerns, and nurses' attitudes to specific patient/client care groups* again focus directly on the complexities of patient care. These, in turn, relate to the broader issue of quality assurance in practice. It is not surprising that, at a time of rapid change and development in the scope of nursing practice, the issues of *nursing practice roles and specialist and advanced practice roles* were identified. It is also not surprising, in a national and global environment so concerned with human rights and abuses and the nature of life and death, that the issue of ethical concerns was identified. A range of medium-priority clinical issues, *quality assurance in practice, nursing practice roles, psychological care concerns and ethical concerns*, were identified as requiring research in the short term, while the remaining issues were identified as requiring research in the medium-to-long term.

The three medium-priority managerial issues, *role of nurse managers, health and safety in practice and quality assurance in standards of care*, achieved group consensus of importance ranging from 69 per cent to 78 per cent. The issues are somewhat distinct from one another, although links can be seen between the issue of *role of nurse managers* and the high priority clinical issue of *nursing practice roles*, and also between the management and clinical concerns with quality assurance. Although only five managerial issues were identified, three were rated medium-priority, all were identified as requiring research in the short term.

All nine educational issues were identified as medium priority, and eight of these were identified as

requiring research in the medium-to-long term. Group consensus on the importance of all nine issues ranged from 62 per cent to 78 per cent. The nine issues cover a range of distinctive educational concerns. *Research and evidence-based practice* received the highest rating in the medium-priority range. Significantly, it was also the only educational priority rated as requiring research in the short term. The issue of *recruitment and retention related to nurse education* echoes clinical concern with the same issue and is also linked to the issue of *career planning and professional/educational development*. The examples given for *models of course delivery* and *educational needs analysis* indicate concerns with flexibility in the offerings of education programmes and the need to extend the scope of educational topics in relation to the changing scope of practice. *Outcomes and effectiveness of education and professional appraisal and staff development* both relate to the need for evaluation of educational approaches. The issue of *clinical education links between service and academic organisations* points to the need to investigate the educational effects of the recent move of all basic nursing education from service to third-level settings.

While the overall scope of the nursing issues is broad, it is very clear that they represent the view that patient and client clinical care come first on the nursing research agenda. The largest number of issues are clinical issues and the three highest priority, highest consensus issues are clinical issues. The five managerial issues, except for the role of nurse managers themselves, relate clearly to the provision of a supportive environment for clinical practice and patient or client care.

Comparison with international literature

The highest priority clinical nursing issue for research identified in this Irish study, *outcomes of care delivery*, has also been identified in other national studies. Kim et al (2002) identified effectiveness of nursing care as the second of five top priority issues for research in Korea. Lindeman (1975) identified evaluating processes used to provide nursing care in terms of patient outcomes as the ninth in a listing of fifteen priority issues for research in the US, and two additional priorities also related to outcomes of care delivery. Ross et al (2004) identified, from the literature, outcomes of specific clinical interventions and incorporated this issue into a major priority area they termed appropriate, timely and effective interventions. In addition, examples of this issue are also identified as priorities for research in other countries. The example, 'evaluation of care delivery', was identified as a priority by Lindeman, and in the research priorities identified by French et al (2002) for Hong Kong. The example, 'risk assessment', is identified as the ninth priority and the example, 'patient education', as the twelfth of forty-five priorities identified for nursing research in Hong Kong.

The second highest priority issue identified in this study, *staffing issues in practice*, is not reflected exactly in other national studies but it could be part of broader concepts, such as 'staff capacity and quality' identified by Ross et al (2004) in the UK. Examples of this issue, such as skill mix, are identified in the UK by Kitson et al (1997) and in Hong Kong by French et al (2002). Another example of this issue, 'nurses' stress', is also identified by French et al and by Lindeman (1975). The third highest priority issue identified in this study, *communication in clinical practice*, is reflected in the highest of forty-five research priorities identified by French et al, nurse/patient communication. Effective means of communication is also identified as a high priority in the Lindeman study.

The issue of *quality assurance in practice* also achieved a high priority rating in Korea (Kim et al 2002) and the highest priority ranking in the list of research priorities identified for Spain (Moreno-Casbas et al 2001). The medium priority issue of *nursing practice roles* is identified as a research priority in other national studies in relation to its examples, such as, clinical decision making and scope of practice (Lindeman 1975). The related medium priority issue of *specialist and advanced practice roles* is identified as a priority in the US by Lindeman and is identified as a very high priority issue in the UK (Kitson et al 1997) and in Korea (Kim et al 2002). The medium priority issue of *ethical concerns* is also identified as a high priority for nursing research in Hong Kong (French et al 2002).

The highest priority managerial issue identified in the current study, *recruitment and retention of nurses*, is identified as a workforce planning priority in the UK by Kitson et al (1997) and Ross et al (2004). The second highest managerial issue, *nursing input into health policy and decision making*, is also identified as a high priority by Kitson et al. Examples of management issues are also evident as priorities in other studies, for example, relationships with other caregivers and family members (Moreno-Casbas et al 2001) and research utilisation (Lindeman 1975).

The highest priority educational issue in the present study, *research and evidence-based practice*, is also identified in other national studies (Lindeman 1975, Kitson et al 1997, Moreno-Casbas et al 2001), but is identified as a clinical or management issue. In most national research priority studies specific educational issues are prominent but are implied in some clinical priorities.

One other national nursing research priority study, for the Republic of China, was designed particularly to identify clinical, managerial and educational research priorities for nursing research (Yin et al 2000). Priority issues were identified through a process of group idea writing and analysis by 195 nurses from a large medical centre and from educational agencies. Clinical issues identified focused mainly on specific disease processes and symptoms, but several priority issues are very similar to this Irish study. Quality of care was the fourth highest clinical priority in the present study and the highest rated of fourteen clinical priorities in the Chinese study. In the present study 'effectiveness of patient education' was a highly rated example of the highest priority clinical issue, *outcomes of care delivery*, and, in the Chinese study, patient education was rated as the fourth highest clinical priority. In the present study, 'care of older people' and 'nurses' attitudes to older people' were identified as examples of two medium priority issues, whereas in the Chinese study, care of the elderly was rated the second highest clinical priority. In the present study, 'pain and symptom management' and 'infection control' were identified as two examples under the medium priority issue of pain and symptom management, whereas in the Chinese study, infection control achieved the third highest priority rating and pain management the ninth highest priority rating.

In the Chinese study (Yin et al 2000), eight managerial priorities were identified but these did not include the highest rated Irish managerial priority, *recruitment and retention of nurses*. The second highest Irish managerial priority, *nursing input into health policy and decision making*, may be similar to three of the Chinese priorities: economic evaluation/cost analysis, national health system effects and nursing status/standing. The issue of ethical values was identified as a managerial priority in the Chinese study and *ethical concerns* was identified as a clinical priority in the present study. Four education issues were identified as priority issues for research in the Chinese study compared to nine educational issues in the present study. The four Chinese priorities issues were also identified in the present study: role preparation, education for practice, trends in nursing education and continuing education.

Two high priority issues appear in national studies which are not emphasised in this current Irish study. One is nursing interventions, which is prominent in all other national studies. It is possible that the highest rated clinical issue in this study, *outcomes of care delivery*, encompasses this issue from an interventions outcomes perspective. The other high priority issue identified in most other national studies which is not clearly identified in this study is symptom management. Although this appears as an example under *physical care concerns*, it is given much less prominence compared with other national studies.

The analysis of the results of the current study in relation to the results of other national nursing research priority studies is by no means exhaustive. A very wide range of research priority issues has been identified worldwide. In some studies, such as those conducted by Kitson et al (1997) and Ross et al (2004) a very broad approach is taken to identifying research priorities and includes managerial issues. Kim et al (2002) also take a broad approach and include educational issues. Lindeman (1975), Moreno-Casbas et al (2001) and French et al (2002) take a clinical approach to identifying research priorities, an approach which is more likely to identify specific aspects of clinical patient care.

The research priorities identified in the one regional study conducted in Ireland (McCarthy et al 2005) are very similar to the priorities identified in this national study. High-priority specific topics, requiring immediate research, identified by McCarthy et al included the impact of staff shortages on retention of nurses and midwives, stress and bullying in the workplace and skill mix and staff burnout, all issues or examples of issues which have been identified as high priority in this study. 'Pain and symptom management' is identified in this study as an example of *physical care concerns*, which was rated as medium priority. 'Transitional care for patients from hospital to home' is reflected in this study as an example of *ethical concerns* and, a further priority identified by McCarthy et al, cardiopulmonary decision making, could also be viewed as an ethical issue. However, 'promoting healthy lifestyles' was not identified as a priority issue in this study. Additional priorities identified by McCarthy et al are also encompassed within the priorities identified in this study.

Midwifery issues for research

Scope of issues

In answer to Research Question 2, three high priority clinical issues, one high priority managerial issue and two high priority educational issues which require research in the short term were identified. Group consensus on the importance of these issues ranged from 80 per cent to 88 per cent. The managerial issue, *promoting woman-centred care*, and the educational issue, *promoting the distinctiveness of midwifery*, achieved consensus levels of 88 per cent and 86 per cent respectively, the highest consensus of importance in the study. The closely related issue, *care in labour*, achieved a consensus of 86 per cent. The additional high priority, high consensus issues related to differing concerns; one clinical issue, *satisfaction with care*, and one educational issue, *promoting research/research-based practice*.

Also in answer to Research Question 2, one high priority clinical issue, *communication*, and two educational issues, *student learning/education* and *continuing education*, were identified as requiring research in the medium-to-long term. Group consensus on the importance of these issues ranged from 81 per cent to 83 per cent. It is of note that the issue of communication refers only to the example of record-keeping. The examples associated with *student learning/education* demonstrate a wide range of concerns related to this issue; this is also the case for the issue of *continuing education*.

Further, in answer to Research Question 2, seventeen medium priority issues were identified: seven clinical, seven managerial and three educational. Group consensus on the importance of the clinical issues ranged from 63 per cent to 78 per cent, with the exception of *management grades* which achieved a consensus level of only 27 per cent. The only example of this issue is 'clinical midwifery manager numbers'. This issue had the lowest mean importance rating in the study, a relatively high SD and is rated as requiring research in the medium-to-long term. These data indicate that it is of low importance, but that there is also little consensus on its importance. One other issue, *breastfeeding*, was rated as requiring research in the medium-to-long term. Five clinical medium priority issues were rated as requiring research in the short term: *models of care*, *clinical supervision*, *continuing professional education*, *health promotion* and *human resource management*. However, *health promotion and human resource management* achieved consensus levels of only 63 per cent. Overall, these issues represent a broad spectrum of research concerns.

For the seven medium priority managerial issues, consensus of importance ranged from 61 per cent to 79 per cent, with the exception of *levels of management* which achieved consensus of only 45 per cent and had a low mean importance rating. This issue is rated as requiring research in the medium-to-long term. It appears similar in its topic and ratings to the low-rated clinical issue of *management grades*. Three additional issues are rated as requiring research in the medium-to-long term: *developing midwifery practice*, *workforce planning and change management*. Three medium priority issues, *sources of stress*, *barriers to autonomy* and *management culture* are rated as requiring research in the short term. The examples related to these issues suggest that the concerns underlying them are related to one another. These medium priority research issues all appear to be related to factors influencing the midwives' ability to practice as professional individuals in healthcare organisations.

For the three medium priority educational issues, two issues, *support for midwives working with students and role of the midwife tutor*, were rated as requiring research in the short term. These are closely related to concerns about student education, as is the third issue, *midwifery curriculum*, rated as requiring research in the medium-to-long term.

While the overall scope of the midwifery issues is also broad, predominant issues for research emerge. Midwives believe that research is needed to help illustrate the distinctiveness of midwifery and to promote woman-centred care. In addition, several issues relate to midwifery education and to organisational management concerns.

Comparison with international literature

The four high consensus, high priority issues identified for clinical midwifery in this study, *satisfaction with care*, *care in labour*, *communication* and *preparation for practice*, are also found in the studies conducted by Sleep et al (1995), Raisler (2000), the Canadian study (BCEWH 2002), and Ross et al

(2002). The top three examples for the issue of *satisfaction with care* were 'satisfaction in relation to providing choice', 'the organisation of maternity care' and 'perceptions of the role of the midwife'. Sleep et al (1995) identified two similar topics in their top twenty topics, satisfaction, audit and choice in relation to using research in practice and satisfaction, audit and choice in relation to giving women choices. Women's experience of birth and midwifery care was an issue also identified by Raisler (2000) and in Canada by the BCCEWH (2002). Also related to satisfaction with care or, more specifically, seeking to provide services which meet with the expectations of different users of those services, Ross et al (2002) identified user involvement and participation as a priority area for research.

Issues relating to *care in labour* and the highest three examples of care in labour sub-topics – perineal care, CTG monitoring and perineal suturing – are to be found in the studies reported by Renfrew et al (2003), Sleep et al (1995), BCCEWH (2002), and Raisler (2000). The ICM (Renfrew et al 2003) identified the prevention of caesarean birth and other interventions as a priority for research internationally. Sleep et al identified a range of research themes concerned with care in labour in their top twenty items, including the safety and effectiveness of birth in water in the second stage of labour, midwives' role in preventing instrumental delivery in the second stage of labour, management of obstetric emergencies throughout labour, and the rationale for induction in the first stage of labour. Specifically relating to the high priority issues identified in this study, Sleep et al identified priorities in relation to foetal monitoring, continuous foetal monitoring and its effects on care, and the significance of meconium stained liquor, and suturing or not suturing the perineum.

A range of clinical priority areas are identified by BCCEWH (2002) in Canada, including home versus hospital birth outcomes, studies of vaginal breech birth and the efficacy of alternative methods to induce labour. Raisler (2000) identified a range of studies relating to the processes and outcomes of intrapartum care, including pain management. Ross et al (2002) also identified appropriate, timely and effective health interventions as a priority area for research. Here they link interventions to the physical and mental health needs of individuals, their carers and their families. In addition, communication is identified as an important theme by Ross et al, a priority area relating to individualised services, where they refer, in particular, to communication within the clinical encounter.

Aspects of the issue *preparation for practice* and the highest rated examples of this issue, 'updating midwives' skills', 'responding to emergencies' and 'student preparation and theory/clinical balance', are only to be found in the study reported by Sleep et al (1995) who identified midwives' ability to respond to recent changes, such as home birth, water birth and midwife-led care, in their top twenty priorities.

Research topics similar to *promoting woman-centred care*, the only midwifery management issue to achieve a group consensus of 80 per cent, are found in the research conducted by Ross et al (2002), BCCEWH (2002), Sleep et al (1995) and Raisler (2000). Ross et al identified research priority areas concerned with individualised services, for example the evaluation of user-centred models of care. In relation to their priority area, user involvement and participation, Ross et al emphasise the need for meaningful engagement with service users through representation, participation and consultation. Patient-centred services is also an important theme identified in the Ross et al priority areas concerned with appropriate and effective interventions. One particular topic, identified in the Canadian study (BCCEWH 2002), was 'what do women want from midwifery care?' As previously mentioned, two themes relating to satisfaction, audit and choice were identified by Sleep et al. Raisler identified studies that evaluated midwifery practice, including the outcomes achieved in the provision of care for women from vulnerable groups.

The additional final high priority issues identified for midwifery education are *promoting the distinctiveness of midwifery*, *promoting research/research-based practice*, *student learning/education*, and *continuing education*. Reflecting the emphasis on clinical aspects of midwifery in the studies of midwifery priorities reviewed, few topics are to be found that relate to midwifery education. The International Confederation of Midwives includes education as only one aspect of workforce planning in its list of international midwifery research priorities (Renfrew et al 2003). The Canadian study (BCCEWH 2002) includes only one research priority that is focused specifically on midwifery education, the evaluation of educational programmes, and there is no education-focused priority featured in the Sleep et al (1995) top twenty priorities. Raisler's (2000) systematic literature review includes only midwifery care research.

Each of the studies reviewed concludes with recommendations to continue to develop the midwifery research agenda. These include creating a national research agenda and consultation and debate with clinical, policy and research communities (Raisler 2000); pressing for midwifery representation on funding

agencies, lobbying for increased finance to support education and training to develop research skills, enhancing opportunities for midwives to gain experience on research teams, developing research scholarships and fellowships (Sleep et al 1995); ring-fencing funding for nursing and midwifery research in research commissioning and research capacity building (Ross et al 2004); establishing a national midwifery research network, and establishing a regular and ongoing electronic forum for communication between network members (BCCEWH 2002).

Examination of the international literature helps to provide further insight into how the priorities identified for midwifery research in Ireland could be developed further towards specific research questions. In relation to midwifery clinical research priorities, the number of issues identified and the similarity of issues found in relation to satisfaction with care and care in labour suggests that these issues are important across countries, that it is likely that research is being conducted in these areas (thus facilitating comparative research), and provides further support for their utility as research priorities. This is also true of the research priority identified for management, *promoting woman-centred care*.

There is a range of differences between the priorities identified in this study and those identified in other countries. Two key differences were noted in this comparison. Firstly, few priorities were identified for midwifery management and midwifery education in other countries. This may have happened in this study had the research team not been specifically asked to identify separate priorities for midwifery practice, midwifery management and midwifery education. Secondly, little support was found for two of the clinical priorities that were identified in this study: *communication and preparation for practice*. Nonetheless, these two topics were rated as being of high importance across the two rating rounds of the Delphi survey. A range of different approaches is identified across countries towards the establishment of research concerned with the different research priorities identified. Several, or all, of those identified could be considered in the Irish context.

Service users

Consideration of the views of service users about the health services at-large and the services provided by healthcare professionals has received increasing attention in recent years. It is becoming widely acknowledged that service users have an important role to play in providing personal perspectives on the experience of illness and health service issues which need to be addressed through research. While service users have been included as participants in some studies (Ross et al 2004), it is generally considered most effective to include service users in an advisory capacity on a research steering committee or advisory group (Rhodes et al 2002). The inclusion of service users as participants in this study was suggested at commissioning stage of the study.

While service user participation in this study does present some feedback in relation to the priorities set by the nurses and the midwives, it is clear that there are gaps in the users' perspectives in their response to the priorities ranking exercise. This may have been due to the professional language used in the questionnaires which was necessary from a professional perspective. Bearing these limitations in mind service user participants exhibited a moderate to high degree of agreement on the importance of some issues, particularly in terms of clinical research priorities.

It is notable that mean scores of 6.0 or more and moderate or high levels of agreement were more likely to be achieved on issues related directly to clinical practice. These issues would have been visible and, therefore, had more meaning as care issues for service users. This was reflected in the service users' rating as high priority, nursing issues such as *communication in clinical practice, psychological care concerns, outcomes of care delivery, physical care concerns and ethical concerns*; and likewise, midwifery issues such as *care in labour and breastfeeding*. On the other hand, issues which were focused on professional concerns or were more related to indirect care were less likely to be ranked highly by service users. This was reflected in the service users' rating as lower priority, nursing issues such as *specialist and advanced practice roles, models of course delivery, outcomes and effectiveness of education and career planning and professional/educational development*; and, likewise, midwifery issues such as *management grades, human resource management, workforce planning, change management, barriers to autonomy and role of the midwife tutor*.

A number of limitations affected the participation and the outcomes of service users' in this study. Many organisations were unable to commit to workshop attendance because of other demands on their volunteer staff and this greatly affected their participation. The participation of service users was planned

to take place at the face-to-face discussion group workshop stage because this allowed for discussion and guidance by a group facilitator. The completion of the postal questionnaire was difficult for the participants, because they did not have the benefit of completing the questionnaire in a group format with a facilitator present. The difficulty this engendered should not be underestimated and telephone calls to the researchers reflected problems in this respect. The participants considered the language used for some of the issues to be professional or technical language that they did not always understand and, therefore, could not comment on.

In some of the service user organisations members were already participating in other research studies and, although this study sought only small numbers of user participants, the fact that other research was ongoing caused confusion. The participants in the workshops experienced difficulty commenting on priorities which they did not develop and indicated that some areas of concern were not reflected in the priorities, for example, the needs of children in hospital. In the light of these factors and the small sample size, the ratings by service users of nursing and midwifery research priorities and of the timeframes in which research should be conducted should be viewed with caution.

Different approaches to including the perspectives of service users could be considered in future research priority studies. For example a developmental or grounded theory approach could be used to give service users the opportunity to identify their own priorities for research in terms of nursing and midwifery care delivery. These data could then be used to develop research priorities from the perspective of the service users and could provide data for comparison and integration with the findings of this study. Another approach could be to include a range of service users on a steering or advisory committee for a study.

Study findings in relation to national healthcare needs

The broad purpose of this research is to contribute to fulfilling the vision of *A Research Strategy for Nursing and Midwifery in Ireland*, that is, to help 'focus attention on the primacy of research in developing nursing and midwifery knowledge, that will contribute to the achievement of health and social gain for individuals and the population' in Ireland (Department of Health and Children 2003b, p. 16). The final step in this research endeavour is to suggest how the research priorities which have been identified for nursing and midwifery in Ireland can be used to enhance the contribution of nurses and midwives to the health services. The highest priority issues that have been identified suggest targeted programmes of research that could provide data with greater potential to improve patient and client care outcomes and to inform health policy.

The national and international shift towards health outcomes and quality outcomes is a move that has been embraced by nurses within the Irish health service. The high priority of outcomes of care delivery relates directly to the national goal of high performance care delivery that supports best patient care and safety (Department of Health and Children 2001a). In view of the size and influence of the nursing workforce, a programme of research designed to examine the effectiveness of different approaches to patient care and nursing interventions, for example in areas such as diabetes case-finding and management and enhanced methods of risk assessment of acutely ill patients, could have a significant impact on the effectiveness of essential health services and their costing.

Staffing issues and the recruitment and retention of nurses and midwives have been rated high priority issues for nursing and midwifery research. A programme of research designed to seek solutions to these serious workforce problems (Department of Health and Children 2001a), for example the development and testing of 'magnet' workplaces and the testing of innovative skill mixes, could lead to breakthroughs in addressing this problem. In addition, several research priorities concern the auditing of the quality of nursing and midwifery care, as well as patient and client care risk assessment. Auditing the quality of healthcare services and risk assessment are also identified as national health service concerns (Department of Health and Children 2001a).

The attention given in recent years to extending the scope of nursing and midwifery practice, not into medicine, but rather in ways that would allow nurses and midwives to serve society to their full potential, suggests several potentially fruitful programmes of research. Nursing and midwifery practice roles and specialist and advanced practice roles have been identified as priority areas for nursing and midwifery research. Research in other countries suggests that advanced nurse practitioners can work in community practices and in collaboration with other health professionals to decrease the disease burdens associated with low-birth-weight infants and the effects of chronic illness so prevalent in society (Department of

Health and Children 2001a). Testing programmes of care delivered by clinical nurse specialists and advanced nurse practitioners could help to address health service concerns with the need to ensure early detection of cancer (Department of Health and Children 2001a). In fact there are many areas where the effectiveness of advanced nurse practitioners in improving quality of care and decreasing costs could be examined.

Several of the high priority areas for nursing and midwifery research could be linked to government strategies to better utilise the nurses and the midwives in the health service (Department of Health and Children 2001a). As the Health Service Reform Programme brings about changes in the health service structures there will be many opportunities for nurses and midwives to develop and test new roles and new patterns of practice in hospitals and in the broader community.

Summary

This study, designed to identify nursing and midwifery research priorities for Ireland, has been commissioned and completed at an auspicious juncture in the development of these professions in Ireland. Nurses and midwives in Ireland are highly respected occupational groups, recognised widely for their professional commitment and services to society. Since at least 1980 (Chavasse 1980), they have been actively involved in the scientific and research-related development of their professions. The *Report of the Commission on Nursing* (Government of Ireland 1998) fostered significant additional growth and potentially far-reaching developments. One of the most important developments has been the clear articulation of a research strategy. The completion of this study fulfils a primary recommendation of this research strategy.

This study has identified twenty-four priorities for nursing research and twenty-six priorities for midwifery research which will serve to guide the development of nursing and midwifery knowledge and further enhance the contribution of these professions to society. A Delphi survey approach, with the addition of a group discussion workshop, proved to be an effective and efficient method of identifying the research priorities and the timeframe within which these priorities should be addressed. The samples of nurses and midwives who participated in the study were generally representative of the nurses and the midwives in professional employment in Ireland, and high response rates were achieved from the samples that completed the rating questionnaires. High consensus, high priority issues were identified for nursing and midwifery research to be conducted in the short term. Medium priority issues were also identified for research to be conducted in the short or medium-to-long term.

Most significantly, the nursing and midwifery research priorities identified in this study related closely to several national healthcare problems and needs. The findings of the study provide a firm basis for the development of nursing and midwifery research programmes that can further strengthen the professions' ability to extend health-related knowledge and help address important national healthcare problems and needs which are in urgent need of solutions.

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Appendix 1 - Service Users Organisations

Service User (Consumer Group) Organisations Surveyed

General Care:

Irish Patients Association

Description: The Association does not distinguish between a patient suffering from a physical or mental illness, or an acute or chronic illness. Its aims are to: place the patient at the centre of health care; improve the quality and service they receive; improve the cost effectiveness and the availability of service; protect the rights of present and future patients. The Association learns from the experience of patients and carers, assists them where possible, and works in partnership with the system to ensure that these needs are met. It sits on many policy and advisory bodies, and provides lecture and conferences. Often a first point of contact by media, nationally and internationally.

Mental Health:

Mental Health Ireland

Description: Mental Health Ireland aims to promote positive mental health and to actively support persons with a mental illness, their families and carers by identifying their needs and advocating their rights.

GROW

Description: GROW is a Mental Health Organisation which helps people who have suffered, or are suffering, from mental health problems. Members are helped to recover from all forms of mental breakdown, or indeed, to prevent such happening. GROW, founded in Australia in 1957 by former mental sufferers, has a national network of over 130 Groups in Ireland. Its principal strength is the support members give each other from their own experience in matters to do with mental health. GROW is grant aided by all of the Health Boards and by the Department of Health and Children. GROW is a voluntary organisation with a small number of paid employees.

Learning Disability:

National Association for the Mentally Handicapped in Ireland (N.A.M.H.I.)

Description: NAMHI is a voluntary organisation of those who work on behalf of people with mental handicap; is non-sectarian and non-political; is a multi-disciplinary body involving, among others, parents, doctors, nurses, teachers, psychologists, therapists, administrators, training personnel, family members and friends of people with mental handicap. NAMHI represents its member organisations and people they serve – people with mental handicap. By providing a central forum, NAMHI enables its member organisations to identify priorities and to formulate nationally agreed policies. NAMHI can present, in a coherent way, the views of its members to Government departments and statutory bodies. In this way, NAMHI can influence the decision making process so as to provide improved supports and services for Irish people with mental handicap.

*Sick Children:***Children in Hospital Ireland**

Description: Promotes the welfare and wellbeing of all sick children by drawing attention to their need for emotional security. Supports parents before, during and after a child's stay in hospital. Programmes and activities include: provision of play and recreation by trained hospital play volunteers; information and advice service; education programmes aimed at school and college students, parents, health and other professionals; annual public lecture; research relating to providing for the needs of sick children and their parents; awareness-raising projects.

*Midwifery/Maternity:***Cuidiú Irish Childbirth Trust**

Description: A parent-to-parent community-based voluntary support group and their motto is 'Education and Support for Parenthood'. Their aim is to provide information to parents, which allows them to make informed choices about childbirth, breastfeeding and parenthood – from infancy right up to adolescence.

Appendix 2 - Welcome Letter and Consent Form

Invitation to Nurses to Participate in Research – Consent Form

My name is Dr. Therese Meehan. I am leading a research team at the School of Nursing and Midwifery, University College Dublin. The team has been chosen to conduct the study: 'Research Priorities for Nursing and Midwifery in Ireland'. I am inviting you to take part in this research. The purpose of this study is to identify the short-term, medium term and long-term research priorities related to clinical, managerial and educational issues for nursing and midwifery in Ireland.

You have been chosen to participate in this research, along with 1,540 other nurses, because you are currently employed in nursing clinical practice, management or education.

If you agree to participate in this research you will be asked to complete a demographic information form and two questionnaires. The demographic information form and the first questionnaire are enclosed with this invitation to participate. On the first questionnaire you are asked to write up to five topics, problems, issues or questions related to nursing practice, management or education in Ireland – which you think are most urgently in need of investigation through research. You are asked to return the demographic information form and the first questionnaire in the enclosed stamped addressed envelope within two weeks. You will receive the second questionnaire about the middle of August 2004. This questionnaire will contain up to 150 questions about nursing topics, problems or issues that have been developed from participants' responses on the first questionnaire. You will be asked to rate how important you think each question, topic, problem or issue is for nursing research in Ireland. This questionnaire may take approximately 1½ hour to complete. You will be asked to return it in an enclosed stamped addressed envelope by the middle of September 2004.

Also, if you agree to participate you may be asked to attend a 1-day workshop in Dublin in November. The purpose of this workshop will be to review and discuss how the questions on the second questionnaire were rated and to conduct a final rating of the questions.

There are no known risks to you from taking part in this research, and no direct benefits to you. However, it is hoped that the research will benefit the nursing profession in Ireland by identifying the most important questions and topics for research and focusing nursing research efforts.

All information obtained during this research will be kept strictly confidential. All information collected from you will be stored in a locked file. Each nurse who participates in the research will be given a code number and only code numbers will identify questionnaires. The Principal Investigator and Research Co-ordinator will be the only persons who can link your code number to your name. The code number-name key will be kept in a separate locked file. Your responses on the questionnaires will be anonymous to other research participants. Identifying information about you will not be used in any reports of the research. Upon completion of the research, all demographic data forms and questionnaires will be destroyed.

Your participation in this research is voluntary. You are free to refuse to take part or to withdraw at any time without giving a reason.

If you have any questions about the research, please contact Dr. Therese Meehan at 01 716 7401 or e-mail Therese.Meehan@ucd.ie, or the Research Co-ordinator, Ms. Mary Kemple at 01 716 7273 or e-mail Mary.Kemple@ucd.ie

**YOUR COMPLETION OF THE STUDY QUESTIONNAIRES
WILL SIGNIFY YOUR CONSENT TO PARTICIPATE IN THE STUDY**

Therese. C. Meehan, RGN, Ph.D.
Principal Investigator

1st June 2004

Invitation to Midwives to Participate in Research – Consent Form

My name is Dr. Therese Meehan. I am leading a research team at the School of Nursing and Midwifery, University College Dublin. The team has been chosen to conduct the study: 'Research Priorities for Nursing and Midwifery in Ireland'. I am inviting you to take part in this research. The purpose of this study is to identify the short-term, medium term and long-term research priorities related to clinical, managerial and educational issues for nursing and midwifery in Ireland.

You have been chosen to participate in this research, along with 360 other midwives, because you are currently employed in midwifery clinical practice, management or education.

If you agree to participate in this research you will be asked to complete a demographic information form and two questionnaires. The demographic information form and the first questionnaire are enclosed with this invitation to participate. On the first questionnaire you are asked to write up to five topics, problems, issues or questions related to midwifery practice, management or education in Ireland – which you think are most urgently in need of investigation through research. You are asked to return the demographic information form and the first questionnaire in the enclosed stamped addressed envelope within two weeks. You will receive the second questionnaire about the middle of August 2004. This questionnaire will contain up to 30 questions about midwifery topics, problems or issues that have been developed from participants' responses on the first questionnaire. You will be asked to rate how important you think each question, topic, problem or issue is for midwifery research in Ireland. This questionnaire may take approximately a ½ hour to complete. You will be asked to return it in an enclosed stamped addressed envelope by the middle of September 2004.

Also, if you agree to participate you may be asked to attend a 1-day workshop in Dublin in November. The purpose of this workshop will be to review and discuss how the questions on the second questionnaire were rated and to conduct a final rating of the questions.

There are no known risks to you from taking part in this research, and no direct benefits to you. However, it is hoped that the research will benefit the midwifery profession in Ireland by identifying the most important questions and topics for research and focusing midwifery research efforts.

All information obtained during this research will be kept strictly confidential. All information collected from you will be stored in a locked file. Each midwife who participates in the research will be given a code number and only code numbers will identify questionnaires. The Principal Investigator and Research Co-ordinator will be the only persons who can link your code number to your name. The code number-name key will be kept in a separate locked file. Your responses on the questionnaires will be anonymous to other research participants. Identifying information about you will not be used in any reports of the research. Upon completion of the research, all demographic data forms and questionnaires will be destroyed.

Your participation in this research is voluntary. You are free to refuse to take part or to withdraw at any time without giving a reason.

If you have any questions about the research, please contact Dr. Therese Meehan at 01 716 7401 or e-mail Therese.Meehan@ucd.ie, or the Research Co-ordinator, Ms. Mary Kemple at 01 716 7273 or e-mail Mary.Kemple@ucd.ie

**YOUR COMPLETION OF THE STUDY QUESTIONNAIRES
WILL SIGNIFY YOUR CONSENT TO PARTICIPATE IN THE STUDY**

Therese. C. Meehan, RGN, Ph.D.
Principal Investigator

1st June 2004

Appendix 3 - Demographic Data Questionnaire

Code:

NURSING & MIDWIFERY RESEARCH PRIORITIES FOR IRELAND Demographic, Academic and Professional Profile

Please answer the following questions as they apply to you and your employment. Where indicated please tick the appropriate box.

Researcher
Use Only

- | | |
|---|----|
| <p>1. What is your age _____ years</p> | Q1 |
| <p>2. Please indicate your Gender:</p> <p style="padding-left: 20px;">Female.....[]₁</p> <p style="padding-left: 20px;">Male.....[]₂</p> | Q2 |
| <p>3. In which of the following settings do you primarily work? .</p> <p style="padding-left: 20px;">Nursing.....[]₁</p> <p style="padding-left: 20px;">Midwifery.....[]₂</p> <p style="padding-left: 20px;">Psychiatric Nursing.....[]₃</p> <p style="padding-left: 20px;">Intellectual Disability Nursing.....[]₄</p> <p style="padding-left: 20px;">Sick Children’s Nursing.....[]₅</p> <p style="padding-left: 20px;">Public Health Nursing.....[]₆</p> <p style="padding-left: 20px;">Other.....[]₇ (Please specify) _____</p> | Q3 |
| <p>4. Please specify your current grade (e.g. Staff Nurse/Midwife; CNM II; College Lecturer; Clinical Nurse Specialist etc.)</p> <p style="padding-left: 20px;">Current Grade _____</p> | Q4 |
| <p>5. Please indicate the professional qualifications you currently hold (select as many as apply)</p> <p style="padding-left: 20px;">RGN.....[]₁</p> <p style="padding-left: 20px;">RPN.....[]₂</p> <p style="padding-left: 20px;">RNMH.....[]₃</p> <p style="padding-left: 20px;">RSCN.....[]₄</p> <p style="padding-left: 20px;">RM.....[]₅</p> <p style="padding-left: 20px;">RNT.....[]₆</p> <p style="padding-left: 20px;">Others.....[]₇ (Please specify) _____</p> | Q5 |
| <p>6. Please indicate the academic qualifications you currently hold (select as many as apply and please specify)</p> <p style="padding-left: 20px;">Diploma.....[] (Please specify) _____</p> <p style="padding-left: 20px;">Higher/Postgraduate Diploma.....[] (Please specify) _____</p> <p style="padding-left: 20px;">Bachelor’s Degree.....[] (Please specify) _____</p> <p style="padding-left: 20px;">Master’s Degree.....[] (Please specify) _____</p> <p style="padding-left: 20px;">PhD.....[] (Please specify) _____</p> <p style="padding-left: 20px;">Others.....[] (Please specify) _____</p> | Q6 |

<p>7. Do you work?:</p> <p>Full-time (39 hours per week)[]₁</p> <p>Part-time (less than 39 hours per week).....[]₂</p> <p>Job-shared (worked week on or week off or less)...[]₃</p> <p>Other.....[]₄ (Please specify) _____</p>	<p>Q7</p>
<p>8. Have you completed a research course module at <u>either undergraduate or postgraduate</u> level</p> <p>Yes.....[]₁</p> <p>No.....[]₂</p>	<p>Q8</p>
<p>9. Please indicate <u>how many years</u> professional experience you have had since completing your first professional registration (across all areas where you have worked)</p> <p>Years qualified _____</p>	<p>Q9</p>
<p>10. The following questions relate to your research activities <u>since completing</u> your first professional qualification (select as many as apply):</p> <p><u>Have you completed</u></p> <p>a) a research dissertation as part of an academic award?</p> <p>Yes.....[]₁</p> <p>No.....[]₂</p> <p>b) participated in a scientific research project</p> <p>Yes.....[]₁</p> <p>No.....[]₂</p>	<p>Q10</p> <p>10a</p> <p>10b</p>

Appendix 4 - Questionnaire 1

30th June 2004

Dear Nurse,

We wish you a very warm welcome to participate in this study to identify nursing and midwifery research priorities for Ireland. This study is extremely important and your participation is greatly valued. You will play an important role in helping to fulfil a recommendation of the *Research Strategy for Nursing and Midwifery in Ireland*, which is in turn a recommendation of the Commission on Nursing.

You will find enclosed an implied consent form, two questionnaires and a stamped, addressed envelope in which to return the questionnaires. The implied consent form is for you to read and keep. It outlines the details of the study and your rights as a study participant. Your completion and return of the questionnaires implies your consent to participate in the study.

On Questionnaire 1 you are asked to identify up to five important nursing problems, concerns, topics, issues or questions related to nursing practice, nursing management and nursing education that you think need to be addressed through research. We have given some directions to help you complete the questionnaire. As you will see, we are asking you to write up to five statements in total. But, if you have only one or two, or three or four statements to write we will welcome those just as much.

You don't have to complete Questionnaire 1 alone. You are free to discuss your ideas with your nursing friends and colleagues. You could even get a little group together where you work to help you think about and talk over ideas.

A demographic data form, composed of ten brief questions, is also attached to Questionnaire 1. Please return Questionnaire 1, including the demographic data form, to us **as soon as possible** in the enclosed stamped, addressed envelope. At the latest, please return it as close as possible to **Friday, 30th July**.

If you have any questions (or mislay anything we have sent you) or if we can help you in any way, please do not hesitate to contact us.

Thank you for your time and effort.

Therese Meehan, RGN, PhD.
Principal Researcher
01 716 7401

Mary Kemple, RGN, RM, MSc.
Research Co-ordinator
01 716 7273



**School of Nursing and Midwifery
University College Dublin
National University of Ireland**

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Nurse Questionnaire 1

Dear Study Participant:

The purpose of this questionnaire is to identify for Ireland the most important **nursing practice, nursing management and nursing education** problems, concerns, topics, issues and questions that need to be addressed through research.

Directions: Please take some time to think about the nursing problems, concerns, topics, issues and questions that you face in your daily work that the profession needs more information about. What questions about clinical practice, management and education do we need better answers to? What gaps are there in the knowledge that we need for clinical practice, management and education? What information do we need to enhance our clinical practice, management and education?

Please state below and over, in one sentence, **up to five** important problems, concerns, topics, issues or questions that you think the nursing profession in Ireland needs more information about. You may wish to focus your statements under one section or spread them over all three sections. Please note that you are only required to write up to a total of five statements across all three sections.

Then for each statement, tick in the columns to the right how important you think it is that we conduct research in this area: moderately important, very important or extremely important.

Nursing Practice-Related problems, concerns, topics, issues and questions.	Level of Importance ✓		
	Moderate	Very	Extremely

please turn pages over →

Nursing Management-Related problems, concerns, topics, issues and questions.	Level of Importance √		
	Moderate	Very	Extremely

Nursing Education-Related problems, concerns, topics, issues and questions.	Level of Importance √		
	Moderate	Very	Extremely

30th June 2004

Dear Midwife,

We wish you a very warm welcome to participate in this study to identify nursing and midwifery research priorities for Ireland. This study is extremely important and your participation is greatly valued. You will play an important role in helping to fulfil a recommendation of the *Research Strategy for Nursing and Midwifery in Ireland*, which is in turn a recommendation of the Commission on Nursing.

You will find enclosed an implied consent form, two questionnaires and a stamped, addressed envelope in which to return the questionnaires. The implied consent form is for you to read and keep. It outlines the details of the study and your rights as a study participant. Your completion and return of the questionnaires implies your consent to participate in the study.

On Questionnaire 1 you are asked to identify up to five important midwifery problems, concerns, topics, issues or questions related to midwifery practice, midwifery management and midwifery education that you think need to be addressed through research. We have given some directions to help you complete the questionnaire. As you will see, we are asking you to write up to five statements in total. But, if you have only one or two, or three or four statements to write we will welcome those just as much.

You don't have to complete Questionnaire 1 alone. You are free to discuss your ideas with your midwifery friends and colleagues. You could even get a little group together where you work to help you think about and talk over ideas.

A demographic data form, composed of ten brief questions, is also attached to Questionnaire 1. Please return Questionnaire 1, including the demographic data form, to us **as soon as possible** in the enclosed stamped, addressed envelope. At the latest, please return it as close as possible to **Friday, 30th July**.

If you have any questions (or mislay anything we have sent you) or if we can help you in any way, please to not hesitate to contact us.

Thank you for your time and effort.

Therese Meehan, RGN, PhD.
Principal Researcher
01 716 7401

Mary Kemple, RGN, RM, MSc.
Research Co-ordinator
01 716 7273



School of Nursing and Midwifery
 University College Dublin
 National University of Ireland

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Midwifery Questionnaire 1

Dear Study Participant:

The purpose of this questionnaire is to identify for Ireland the most important **midwifery practice**, **midwifery management** and **midwifery education** problems, concerns, topics, issues and questions that need to be addressed through research.

Directions: Please take some time to think about the midwifery problems, concerns, topics, issues and questions that you face in your daily work that the profession needs more information about. What questions about clinical practice, management and education do we need better answers to? What gaps are there in the knowledge that we need for clinical practice, management and education? What information do we need to enhance our clinical practice, management and education?

Please state below and over, in one sentence, **up to five** important problems, concerns, topics, issues or questions that you think the midwifery profession in Ireland needs more information about. You may wish to focus your statements under one section or spread them over all three sections. Please note that you are only required to write up to a total of five statements across all three sections.

Then for each statement, tick in the columns to the right how important you think it is that we conduct research in this area: moderately important, very important or extremely important.

MIDWIFERY PRACTICE-RELATED problems, concerns, topics, issues and questions.	Level of Importance ✓		
	Moderate	Very	Extremely

please turn pages over →

Midwifery Management-Related problems, concerns, topics, issues and questions.	Level of Importance ✓		
	Moderate	Very	Extremely

Midwifery Education-Related problems, concerns, topics, issues and questions.	Level of Importance ✓		
	Moderate	Very	Extremely

Appendix 5 - Questionnaire 2

October 12th 2004

Dear Nurse,

We thank you again for your participation in this study to identify nursing and midwifery research priorities for Ireland. Your role in helping to identify the nursing priorities is extremely important and greatly valued.

All the problems, concerns, topics, issues and questions related to nursing practice, nursing management and nursing education which were identified on Questionnaire 1 have been analysed and grouped according to general topics. These topics were then used to construct Questionnaire 2. For each topic on Questionnaire 2, the most frequently occurring examples of the topic are also included. On the enclosed copy of Questionnaire 2, you are asked to rate the importance of each topic, following the directions at the top of the first page. There are 10 clinical practice topics, 5 management topics, and 9 education topics.

We ask that you please complete and return Questionnaire 2 **as soon as possible** in the enclosed stamped, addressed envelope, by **October 22nd**. If you do not receive this by October 22nd, please complete and return it anyway, as soon as you possibly can. Your completion of Questionnaire 2 is extremely important for the success of the study.

We plan to hold a meeting of study participants in Dublin on Monday 29th November from 11:00am until 3:00pm. The purpose of the meeting is to present participants with feedback on the results from Questionnaire 2. Participants who attend the meeting will have the opportunity to discuss and reflect upon the results of Questionnaire 2 and to rate the importance of each topic again on a third questionnaire.

We need as many nurses as possible to attend the meeting. A light lunch will be provided and a subsistence allowance of €20 will be paid. All travel expenses for attending the meeting will be reimbursed at the public transportation rate. Please tick the box at the end of Questionnaire 2 to indicate if you would be interested in participating in the meeting.

If you have any questions (or mislay anything we have sent you) or if we can help you in any way, please do not hesitate to contact us.

Thank you for your time and effort.

Therese Meehan, RGN, PhD.
Principal Researcher
01 716 7401
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Research Co-ordinator
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School of Nursing and Midwifery
 University College Dublin
 National University of Ireland

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Nurse Questionnaire 2

Dear Study Participant:

The purpose of Questionnaire 2 is to rate the level of importance for each of the **nursing practice, nursing management** and **nursing education** topics identified from the results of Questionnaire 1. There are 10 practice topics, 5 management topics, and 9 education topics.

Directions: Take a few moments to read over the topics. These are broad topics and, to provide you with an understanding of what each topic includes, particular examples are given. Reflect on each topic and the examples given, and consider how important you think the **topic** is. Then, using the accompanying rating scale, **circle the number** that best represents how important you think the **topic** is.

Nursing Practice – 10 Topics

Please circle the number that best represents how important you think the topic is

Nurses’ attitudes to particular patient groups (*patients with disabilities, patients from other cultures, elderly patients*).

Low Importance 1 2 3 4 5 6 High Importance 7

Nursing practice roles (*scope of practice; care planning; relationships among different practice and management levels and with health care assistants; role in multidisciplinary team; clinical decision making*).

Low Importance 1 2 3 4 5 6 High Importance 7

Specialist and advanced practice roles (*influence on other nurse roles; role preparation; development and evaluation of CNS and ANP roles; practice responsibilities; relationships with staff nurses, impact of roles on care and patient outcomes*).

Low Importance 1 2 3 4 5 6 High Importance 7

Outcomes of care delivery (*changing approaches to caring for patients; evaluation of care delivery; patient assessment; risk assessment; effectiveness of patient education; patients’ perceptions of nursing care*).

Low Importance 1 2 3 4 5 6 High Importance 7

Please circle the number that best represents how important you think the topic is.

Communication in clinical practice (*with patients and patients' relatives; with other health professionals; with the public; with people from other cultures; among nurses*).

Low Importance								High Importance
1	2	3	4	5	6	7		7

Physical care concerns (*patient hygiene; wound care; infection control; intravenous cannulation and administration; pain and symptom management; environmental resources; patient involvement in care*).

Low Importance								High Importance
1	2	3	4	5	6	7		7

Ethical concerns (*ethical issues related to patient informed consent and confidentiality, care of older persons, timing of care delivery, and patients' transitions from hospital to community care*).

Low Importance								High Importance
1	2	3	4	5	6	7		7

Quality assurance in practice (*therapeutic effects of nursing interventions, nursing documentation, clinical audit, research utilisation, national standards and guidelines*).

Low Importance								High Importance
1	2	3	4	5	6	7		7

Psychological care concerns (*effects of crowded patient care areas; interactions with families and communities; care of mentally ill patients; impact of psychological interventions; effects of caring for patients with disabilities*).

Low Importance								High Importance
1	2	3	4	5	6	7		7

Staffing issues in practice (*patient dependency levels, staffing levels, staff turnover rate, skill mix, non-nurses delivering nursing care; nurses' stress and health concerns*).

Low Importance								High Importance
1	2	3	4	5	6	7		7

Nursing Management – 5 Topics

Please circle the number that best represents how important you think the topic is.

Health and safety in practice (*management of patient aggression and violence towards nurses; nurses' ability to cope with patients' or relatives' aggressive behaviour; effects of heavy manual workloads on nurses*).

Low Importance 1 2 3 4 5 6 High Importance 7

Quality assurance and standards of care (*effectiveness of nursing interventions; cost-effectiveness of nursing practices; national guidelines for practice; research utilisation*).

Low Importance 1 2 3 4 5 6 High Importance 7

Nursing input into health policy and decision making (*nurses' knowledge of effects of health policy on practice; inclusion of all nurses in decision making; nurses' influence on health policy*).

Low Importance 1 2 3 4 5 6 High Importance 7

Roles of nurse managers (*changing roles and responsibilities; leadership abilities; communication and relationships with nurses providing patient care; education for management positions, planning and management of change*).

Low Importance 1 2 3 4 5 6 High Importance 7

Recruitment and retention of nurses (*nurse retention and morale, management of skill mix, staffing for high dependency patients, bullying by managers; stress amongst managers*).

Low Importance 1 2 3 4 5 6 High Importance 7

Nursing Education – 9 Topics

Please circle the number that best represents how important you think the topic is.

Research and evidence-based practice (*dissemination of research information in practice; use of research to improve practice; nurse researchers' availability to practitioners; role-related research responsibilities*).

Low Importance	1	2	3	4	5	6	7	High Importance
-------------------	---	---	---	---	---	---	---	--------------------

Clinical education links between service and academic organisations (*educational role of clinical nurses; collaboration; clinical skills of lecturers; content and structure of clinical education; teaching methods*).

Low Importance	1	2	3	4	5	6	7	High Importance
-------------------	---	---	---	---	---	---	---	--------------------

Undergraduate/pre-registration clinical learning (*who should teach students in clinical areas, clinical placements; teaching methods; lecturers' roles in clinical areas; students' learning experiences in the clinical environment*).

Low Importance	1	2	3	4	5	6	7	High Importance
-------------------	---	---	---	---	---	---	---	--------------------

Career planning and professional development (*structured pathways for professional development; educational guidance; time and financial support for continuing education; importance of continuing education for practice*).

Low Importance	1	2	3	4	5	6	7	High Importance
-------------------	---	---	---	---	---	---	---	--------------------

Educational needs analysis (*courses to meet changing needs; knowledge of pharmacology and medication responsibilities; education in areas of specialist practice; management education*).

Low Importance	1	2	3	4	5	6	7	High Importance
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Please circle the number that best represents how important you think the topic is.

Professional appraisal and staff development

(mandatory periodic reassessment of knowledge and skills and related staff development; regular assessments of practice competence; specialist area competencies).

Low Importance 1 2 3 4 5 6 7 High Importance

Recruitment and retention related to nurse education *(qualities and abilities of people recruited into nursing; how to attract people into undergraduate education; retention related to level of education).*

Low Importance 1 2 3 4 5 6 7 High Importance

Models of course delivery *(modular frameworks to support flexible learning; need for distance learning and e-learning opportunities; availability of courses outside major centres).*

Low Importance 1 2 3 4 5 6 7 High Importance

Outcomes and effectiveness of education *(linking theory to practice; impact of post-graduate education on practice; recognition of professional learning; career pathways of degree-educated nurses).*

Low Importance 1 2 3 4 5 6 7 High Importance

Meeting of study participants on Monday, 29th November (see accompanying letter)

I am interested in participating in the meeting: Yes No

Thank you for completing Questionnaire 2

Please return it in the enclosed stamped, addressed envelope as soon as possible.

October 12th 2004

Dear Midwife,

We thank you again for your participation in this study to identify nursing and midwifery research priorities for Ireland. Your role in helping to identify the midwifery priorities is extremely important and greatly valued.

All the problems, concerns, topics, issues and questions related to midwifery practice, midwifery management and midwifery education which were identified on Questionnaire 1 have been analysed and grouped according to general topics. These topics were then used to construct Questionnaire 2. For each topic on Questionnaire 2, the most frequently occurring examples of the topic are also included. On the enclosed copy of Questionnaire 2, you are asked to rate the importance of each topic, following the directions at the top of the first page. There are 0 clinical practice topics, 0 management topics, and 0 education topics.

We ask that you please complete and return Questionnaire 2 **as soon as possible** in the enclosed stamped, addressed envelope by **October 22nd**. If you do not receive the this by October 22nd, please complete and return it anyway, as soon as you possibly can. Your completion of Questionnaire 2 is extremely important for the success of the study.

We plan to hold a meeting of study participants in Dublin on Monday, 29th November from 11:00am until 3:00pm. The purpose of the meeting is to present participants with feedback on the results from Questionnaire 2. Participants who attend the meeting will have the opportunity to discuss and reflect upon the results of Questionnaire 2 and to rate the importance of each topic again on a third questionnaire.

We need as many midwives as possible to attend the meeting. A light lunch will be provided and a subsistence allowance of €20 will be paid. All travel expenses for attending the meeting will be reimbursed at the public transportation rate. Please tick the box at the end of Questionnaire 2 to indicate if you would be interested in participating in the meeting.

If you have any questions (or mislay anything we have sent you) or if we can help you in any way, please to not hesitate to contact us.

Thank you for your time and effort.

Therese Meehan, RGN, PhD.
Principal Researcher
01 716 7401
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Mary Kemple, RGN, RM, MSc.
Research Co-ordinator
01 716 7273
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School of Nursing and Midwifery
University College Dublin
National University of Ireland

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Midwife Questionnaire 2

Dear Study Participant:

The purpose of Questionnaire 2 is to rate the level of importance for each of the **midwifery practice**, **midwifery management** and **midwifery education** topics identified from the results of Questionnaire 1. There are 11 practice topics, 8 management topics, and 7 education topics.

Directions: Take a few moments to read over the topics. These are broad topics and, to provide you with an understanding of what each topic includes, particular examples are given. Reflect on each topic and the examples given, and consider how important you think the **topic** is. Then, using the accompanying rating scale, **circle the number** that best represents how important you think the **topic** is.

Midwifery Practice – 11 Topics

Please circle the number that best represents how important you think the topic is

Breastfeeding (*for example: diet and breastfeeding; establishing breastfeeding; teat versus cup/syringe feeding; uptake of breastfeeding; role of lactation consultants*).

Low Importance 1 2 3 4 5 6 7 High Importance

Preparation for practice (*for example: responding to emergencies in midwifery; student preparation - theory/clinical balance; student preparation - breaking bad news; updating midwives' skills; gap between theory and practice*).

Low Importance 1 2 3 4 5 6 7 High Importance

Human resource management (*for example: recruitment and selection of staff; staff retention*).

Low Importance 1 2 3 4 5 6 7 High Importance

Continuing professional education (*for example: importance of continuing education for practice; in-service training*).

Low Importance 1 2 3 4 5 6 7 High Importance

Please circle the number that best represents how important you think the topic is.

Care in labour (for example: perineal suturing; Cardiotocograph (CTG) monitoring; perineal care; vaginal examinations; epidural use).

Low Importance 1 2 3 4 5 6 7 High Importance

Health promotion (for example: resources for and effectiveness of antenatal education; parent preparation).

Low Importance 1 2 3 4 5 6 7 High Importance

Clinical supervision (for example: writing policy/guidelines; dealing with litigation; midwifery supervision; evidence-based / research-based midwifery practice).

Low Importance 1 2 3 4 5 6 7 High Importance

Communication (for example: record keeping).

Low Importance 1 2 3 4 5 6 7 High Importance

Satisfaction with care (for example: national review of maternity services; organisation of maternity care; transcultural issues; choice; perceptions of the role of the midwife).

Low Importance 1 2 3 4 5 6 7 High Importance

Models of care (for example: advanced practice/extended practice roles; midwifery support in the community/postnatal support in community/ community midwifery; autonomy and the midwife; midwife-led care; normal midwifery versus medical model/ medicalisation of childbirth).

Low Importance 1 2 3 4 5 6 7 High Importance

Management grades (for example: clinical midwife manager numbers).

Low Importance 1 2 3 4 5 6 7 High Importance

Please circle the number that best represents how important you think the topic is.

Midwifery Management – 8 Topics

Barriers to autonomy (for example: challenges as a result of the medical model; fear of litigation; promoting autonomy at management level; proper recognition and remuneration for role and responsibilities).

Low Importance 1 2 3 4 5 6 7 High Importance

Change management (for example: managing change; patient and staff risk analysis; audit of standards of care).

Low Importance 1 2 3 4 5 6 7 High Importance

Levels of management (for example: nurse/manager ratios; management hierarchy; clinical knowledge and skills required for management; appointment to management positions; importance of Clinical Midwifery Management role; need for specialist posts; need for clinical skills coordinator).

Low Importance 1 2 3 4 5 6 7 High Importance

Management culture (for example: management/staff communication; do staff feel valued; management style; staff/management relations; leadership role models; showing appreciation; approaches to appraisal).

Low Importance 1 2 3 4 5 6 7 High Importance

Sources of stress (for example: support for staff from management; bullying; burnout; factors leading to increased workload).

Low Importance 1 2 3 4 5 6 7 High Importance

Workforce planning (for example: staffing; rostering; staff rotation; appropriate staffing levels; appraisal/ personal development planning; supporting and developing managers; fair allocation of work; recruitment and retention; dependency).

Low Importance 1 2 3 4 5 6 7 High Importance

Please circle the number that best represents how important you think the topic is

Promoting woman-centred care (for example: development of woman-centred care, outcomes and cost-effectiveness of midwifery-led care; community and domiciliary models; quality of midwifery care; how well women are prepared for motherhood; ward design, privacy and impact on outcomes of care; responsiveness of midwifery care; midwifery prescribing).

Low Importance 1 2 3 4 5 6 7 High Importance

Developing midwifery practice (for example: evaluation of the Clinical Midwife Specialist role; what is the role of the Advanced Midwife Practitioner).

Low Importance 1 2 3 4 5 6 7 High Importance

Midwifery Education – 7 Topics

Please circle the number that best represents how important you think the topic is.

Continuing education (for example: access to continuing education; content of continuing education; other measures to support learning among clinical staff; adequacy of in-service education; motivating staff to attend; developing appropriate post-graduate education).

Low Importance 1 2 3 4 5 6 7 High Importance

Midwifery curriculum (for example: curriculum content; new approaches to midwifery education; aims of the midwifery curriculum; theory/practice gap; balance between theory and practice and academic requirements).

Low Importance 1 2 3 4 5 6 7 High Importance

Promoting the distinctiveness of midwifery (for example: focus on normal despite medical model; encouraging midwives to develop own practice; promotion of midwifery to the public).

Low Importance 1 2 3 4 5 6 7 High Importance

Please circle the number that best represents how important you think the topic is

The role of the midwife tutor (*for example: the lecturer/practitioner role and the provision of student support; making better use of clinical midwives in small hospitals*).

Low Importance 1 2 3 4 5 6 7 High Importance

Promoting research/evidence-based practice (*for example: exploring the use of evidence-based practice; promoting local research; enabling midwives to do research and publish; targeting research on specific practice issues; various approaches to promoting research-based practice*).

Low Importance 1 2 3 4 5 6 7 High Importance

Student midwife learning/education (*for example: providing adequate support for students in the clinical area; relating theory to practice; preparing students for the transition to midwife; student assessment; improving practical skills; direct entry midwifery programmes; experience of the clinical learning environment; promoting reflection; barriers to preceptorship; preparation for midwifery-led models; independent midwives in the community*).

Low Importance 1 2 3 4 5 6 7 High Importance

Support for midwives working with students (*for example: teaching workloads; effectiveness of induction programmes for overseas midwives; assessing students; value of preceptorship programmes*).

Low Importance 1 2 3 4 5 6 7 High Importance

Meeting of study participants on Monday, 29th November (see accompanying letter)

I am interested in participating in the meeting: Yes No

Thank you for completing Questionnaire 2

Please return it in the enclosed stamped, addressed envelope as soon as possible.

Appendix 6 - Questionnaire 3

17th November, 2004

Dear Nurse,

We are very pleased to have received a response of over 80% to Questionnaire 2. We greatly appreciate your participation in the study and your support. We also appreciate the interest several participants have expressed in having the opportunity to rate the examples which appeared with each topic. This has led us to extend the study to include one further questionnaire.

The enclosed Questionnaire 3 provides you with the opportunity to rate the importance of the topics again, taking into account the average importance rating from all participants on Questionnaire 2. It also provides the opportunity to rate the importance of the examples listed under each topic.

We ask that you please complete Questionnaire 3 **as soon as possible** and return it in the enclosed stamped, addressed envelope, by **November 25th**. If you do not receive this by November 25th, please complete and return it anyway, as soon as you possibly can. Your completion of Questionnaire 3 will help strengthen further the results of the study.

To accommodate this additional questionnaire, we have moved the time for the meeting of study participants from Monday, 29th November to **Monday, 17th January 2005**. Participants who attend the meeting will receive feedback on Questionnaire 3, have the opportunity to discuss and reflect upon the feedback, and will do a further rating of the importance of each topic as well as the topic examples.

We still need as many midwives as possible to attend the meeting. A light lunch will be provided and a subsistence allowance of €20 will be paid. All travel expenses for attending the meeting will be reimbursed at the public transportation rate. Please tick the box at the end of Questionnaire 3 to indicate if you would be interested in participating in the meeting.

If you have any questions (or mislay anything we have sent you) or if we can help you in any way, please to not hesitate to contact us.

Again, thank you very much for your time and effort.

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**School of Nursing and Midwifery
University College Dublin
National University of Ireland**

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Nurse Questionnaire 3

Dear Study Participant:

The purpose of Questionnaire 3 is to:

- 1) rate again the level of importance for each of the nursing practice, nursing management and nursing education broad topics, and
- 2) to give you the opportunity to rate the importance of the topic examples by themselves.

Each broad topic appears in bold print together with its average importance rating given by all nurses who completed Questionnaire 2.

Beneath each broad topic, its examples are listed so they can be rated separately.

The questionnaire will take you approximately 30 minutes to complete.

Directions: Take a few moments to reconsider each broad topic together with the average importance rating it was given by nurses who completed Questionnaire 2. Again **circle the number** that represents how important you think the broad topic is for research, taking into consideration the average group rating from Questionnaire 2. Then, consider the examples listed below the broad topic and **circle the number** that represents how important you think each example is for research.

Questions are on both sides of pages

Nursing Practice – 10 Broad Topics with their Examples

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Nurses' attitudes to specific patient/client groups Average group rating on Questionnaire 2 = 5.5	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Attitudes to elderly people</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Attitudes to patient/clients with disabilities</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Attitudes to patient/clients from other cultures</i>	Low Importance 1 2 3 4 5 6 7 High Importance

/over page

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Nursing practice roles Average group rating on Questionnaire 2 = 6.1	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Relationships between nurses and health care assistant</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Scope of nursing practice</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>The nursing role in multidisciplinary team</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Clinical decision making</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nursing care planning</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Relationships between nurses in practice and nurses in management</i>	Low Importance 1	2	3	4	5	6	High Importance 7

/over page

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Specialist and advanced practice roles Average group rating on Questionnaire 2 = 5.7	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Impact of specialist and advanced practice nurses roles on patient/client care and patient/client outcomes</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Preparation for specialist and advanced practice nurse roles</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Development & evaluation of Clinical Nurse Specialist & Advanced Nurse Practitioner roles</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Impact of specialist and advanced practice nurses roles on other nurses' roles</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Responsibilities specialist and advanced practice nurses</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Specialist and advanced practice nurses relationships with staff nurses</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Outcomes of care delivery Average group rating on Questionnaire 2 = 6.2	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Patient/client assessment</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Effectiveness of patient/client education</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Risk assessment</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Patient/clients' perceptions of nursing care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Evaluation of care delivery</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Communication in clinical practice Average group rating on Questionnaire 2 = 6.2	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Communication with the public</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Communication with patient/clients and patient/clients' relatives</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Communication with people from other cultures</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Communication with other health professionals</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Communication among nurses</i>	Low Importance 1 2 3 4 5 6 7 High Importance

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Physical care concerns Average group rating on Questionnaire 2 = 6.0	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Patient/client hygiene</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Patient/client involvement in care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Intravenous cannulation and administration</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Infection control</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Wound care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Environmental resources available to support physical care concerns</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Pain and symptom management</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Ethical concerns Average group rating on Questionnaire 2 = 5.9	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Ethical issues related to patient/client informed consent and confidentiality</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Care of older people</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Timing of care delivery</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Patient/clients' transitions from hospital to community care</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Quality assurance in practice Average group rating on Questionnaire 2 = 6.0	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Therapeutic effects of nursing interventions</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Research utilisation</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>National standards and guidelines for patient/client care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nursing documentation</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Clinical audit</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Psychological care concerns Average group rating on Questionnaire 2 = 5.8	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Impact of psychological interventions</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Effects of crowded patient/client care areas</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Interactions with families and communities</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Care of mentally ill patient/clients</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Effects of caring for patient/clients with disabilities</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Staffing issues in practice Average group rating on Questionnaire 2 = 6.2	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Staff turnover rate</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Skill mix</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Staffing levels</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurses' stress and health concerns</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Patient/client dependency levels</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Non-nurses delivering nursing care</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Nursing Management – 5 Broad Topics with their Examples

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Health and safety in practice Average group rating on Questionnaire 2 = 5.9	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Effects on nurses of heavy manual workloads</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurses' ability to cope with patient/clients' or relatives' aggressive behaviour</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Management of patient/client aggression and violence towards nurses</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Quality assurance and standards of care Average group rating on Questionnaire 2 = 5.8	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Cost-effectiveness of nursing practices</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>National guidelines for practice</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Impact of nursing interventions</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Research utilisation</i>	Low Importance 1 2 3 4 5 6 7 High Importance

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Nursing input into health policy and decision making Average group rating on Questionnaire 2 = 5.9	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Nurses' influence on health policy</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Nurses' knowledge of effects of health policy on practice</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Including all nurses in decision making</i>	Low Importance 1 2 3 4 5 6 7 High Importance

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Roles of nurse managers Average group rating on Questionnaire 2 = 6.0	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurse Managers education for management positions</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurse Managers communication and relationships with nurses providing patient/client care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurse Managers changing roles and responsibilities</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurse Managers leadership abilities</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurse Managers planning and management of change</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are						
Recruitment and retention of nurses Average group rating on Questionnaire 2 = 6.3	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Staffing for high dependency patient/clients</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Morale in nursing</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Management of skill mix</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Bullying by managers</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Nurse retention</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Stress amongst managers</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Nursing Education – 9 Broad Topics with their Examples

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Research and evidence-based practice Average group rating on Questionnaire 2 = 5.9	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Use of research to improve practice</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Dissemination of research information in practice</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Role-related research responsibilities</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Nurse researchers' availability to practitioners</i>	Low Importance 1 2 3 4 5 6 7 High Importance

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Clinical education links between service and academic organisations Average group rating on Questionnaire 2 = 5.7	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Educational role of nurses in clinical practice</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Content and structure of all levels of clinical education</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Collaboration between service and academic organisations</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Clinical skills of lecturers</i>	Low Importance 1 2 3 4 5 6 7 High Importance

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Undergraduate/pre-registration clinical learning Average group rating on Questionnaire 2 = 5.8	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Who should teach students in clinical areas</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Lecturers' roles in clinical areas</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Students' learning experiences in the clinical environment</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Clinical placements</i>	Low Importance 1 2 3 4 5 6 High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Career planning and professional/ educational development Average group rating on Questionnaire 2 = 6.0	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Time and financial support for continuing education</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Structured pathways for professional development</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Importance of continuing education for practice</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Educational guidance for nurses</i>	Low Importance 1 2 3 4 5 6 High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Educational needs analysis Average group rating on Questionnaire 2 = 5.9	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Knowledge of pharmacology and knowledge of medication responsibilities</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Education in areas of specialist practice</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Need for courses to meet changing needs</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Management education needs analysis</i>	Low Importance 1 2 3 4 5 6 7 High Importance

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Professional appraisal and staff development Average group rating on Questionnaire 2 = 5.7	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Regular assessment of specialist area competencies</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Mandatory periodic reassessment of knowledge and skills and related staff development</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Regular assessments of practice competencies</i>	Low Importance 1 2 3 4 5 6 7 High Importance

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Recruitment and retention related to nurse education Average group rating on Questionnaire 2 = 5.6	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Qualities and abilities of people recruited into nursing</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>How to attract people into undergraduate nursing education</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Staff retention related to level of education</i>	Low Importance 1 2 3 4 5 6 7 High Importance

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are
Models of course delivery Average group rating on Questionnaire 2 = 5.6	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Need for distance learning and e-learning opportunities</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Modular frameworks to support flexible learning</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Availability of courses outside major centres</i>	Low Importance 1 2 3 4 5 6 7 High Importance

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**School of Nursing and Midwifery
University College Dublin
National University of Ireland**

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Midwife Questionnaire 3

Dear Study Participant:

The purpose of Questionnaire 3 is to:

- 1) rate again the level of importance for each of the midwifery practice, midwifery management and midwifery education broad topics, and
- 2) to give you the opportunity to rate the importance of the topic examples by themselves.

Each broad topic appears in bold print together with its average importance rating given by all midwives who completed Questionnaire 2.

Beneath each broad topic, its examples are listed so they can be rated separately.

The questionnaire will take you approximately 30 minutes to complete.

Directions: Take a few moments to reconsider each broad topic together with the average importance rating it was given by nurses who completed Questionnaire 2. Again **circle the number** that represents how important you think the broad topic is for research, taking into consideration the average group rating from Questionnaire 2. Then, consider the examples listed below the broad topic and **circle the number** that represents how important you think each example is for research.

Questions are on both sides of pages

Midwifery Practice – 11 Broad Topics with their Examples

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Breast feeding Average group rating on Questionnaire 2 = 6.0	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Diet and breastfeeding</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Role of lactation consultants</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Uptake of breastfeeding</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Teat versus cup/syringe feeding</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Establishing breastfeeding</i>	Low Importance 1 2 3 4 5 6 7 High Importance

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Preparation for practice Average group rating on Questionnaire 2 = 6.3	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Responding to emergencies in midwifery</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Student preparation - gap between theory and practice</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Updating midwives' skills</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Preparing students to break bad news</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Student preparation - theory/clinical balance</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Human resource management Average group rating on Questionnaire 2 = 5.7	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Staff retention</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Recruitment and selection of staff</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Continuing professional education Average group rating on Questionnaire 2 = 6.0	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Importance of continuing education for practice</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>In-service training</i>	Low Importance 1 2 3 4 5 6 High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Care in labour Average group rating on Questionnaire 2 = 6.1	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Perineal suturing</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Epidural use</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Vaginal examinations</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Cardiotocograph (CTG) monitoring</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Perineal care</i>	Low Importance 1 2 3 4 5 6 High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Health promotion Average group rating on Questionnaire 2 = 5.9	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Resources for and effectiveness of antenatal education</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Parent preparation</i>	Low Importance 1 2 3 4 5 6 High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Clinical supervision Average group rating on Questionnaire 2 = 6.3	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Dealing with litigation</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Evidence-based / research-based midwifery practice</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Midwifery supervision</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Writing policy/guidelines</i>	Low Importance 1 2 3 4 5 6 High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Communication Average group rating on Questionnaire 2 = 6.0	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Record keeping</i>	Low Importance 1 2 3 4 5 6 High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Satisfaction with care Average group rating on Questionnaire 2 = 6.0	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Organisation of maternity care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Perceptions of the role of the midwife</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Providing women with choice in relation to maternity care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>National review of maternity services</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Transcultural issues</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Models of care Average group rating on Questionnaire 2 = 6.5	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Midwifery support for women in the community</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Midwife-led care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Medicalisation of childbirth</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Autonomy and the midwife</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Advanced practice/extended practice roles</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Normal midwifery versus medical model</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Management grades Average group rating on Questionnaire 2 = 4.7	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Clinical midwife manager numbers</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Midwifery Management – 8 Broad Topics with their Examples

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Barriers to autonomy Average group rating on Questionnaire 2 = 6.2	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Promoting autonomy at management level</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Proper recognition and remuneration for role and responsibilities</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Fear of litigation</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Challenges as a result of the medical model of maternity care</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Change management Average group rating on Questionnaire 2 = 5.7	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Audit of standards of care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Patient and staff risk analysis.</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Managing change</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Levels of management Average group rating on Questionnaire 2 = 5.7	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Clinical knowledge and skills required for management</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Need for clinical skills co-ordinator</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Appointment to management positions</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Management hierarchy</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Need for specialist midwifery posts</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Midwife/manager ratios</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Importance of Clinical Midwifery Management role</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Management culture Average group rating on Questionnaire 2 = 6.0	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Staff/management relations</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Management/staff communication</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Approaches to appraisal</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Do staff feel valued?</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Management style</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Leadership role models</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Showing appreciation</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Sources of stress Average group rating on Questionnaire 2 = 6.1	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Bullying</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Burnout</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Factors leading to increased workload.</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Support for staff from management</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Workforce planning Average group rating on Questionnaire 2 = 6.0	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Appropriate staffing levels</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Supporting and developing managers</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Staffing</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Fair allocation of work</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Staff rotation</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Rostering</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Dependency</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Recruitment and retention</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Appraisal/ personal development planning</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Promoting woman-centred care Average group rating on Questionnaire 2 = 6.5	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Responsiveness of midwifery care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>How well women are prepared for motherhood</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Community and domiciliary models</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Quality of midwifery care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Outcomes and cost-effectiveness of midwifery-led care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Midwifery prescribing</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Privacy and impact on outcomes of care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Development of woman-centred care</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Ward design</i>	Low Importance 1	2	3	4	5	6	High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Developing midwifery practice Average group rating on Questionnaire 2 = 5.9	Low Importance 1 2 3 4 5 6 7 High Importance
<i>What is the role of the Advanced Midwife Practitioner?</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Evaluation of the Clinical Midwife Specialist role.</i>	Low Importance 1 2 3 4 5 6 7 High Importance

Midwifery Education – 7 Broad Topics with their Examples

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Continuing education. Average group rating on Questionnaire 2 = 6.1	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Measures other than courses to support learning among clinical staff</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Motivating staff to attend continuing education</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Adequacy of in-service education</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Developing appropriate post-graduate education</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Content of continuing education for midwives</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Access to continuing education for midwives</i>	Low Importance 1 2 3 4 5 6 7 High Importance

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Midwifery curriculum Average group rating on Questionnaire 2 = 5.8	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Theory/practice gap in midwifery education</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>New approaches to midwifery education</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Balance between theory and practice and academic requirements in midwifery education</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Aims of the midwifery curriculum</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Content of midwifery curriculum</i>	Low Importance 1 2 3 4 5 6 High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Promoting the distinctiveness of midwifery. Average group rating on Questionnaire 2 = 6.3	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Focus on normal in midwifery education despite medical model</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Encouraging midwives to develop their own practice</i>	Low Importance 1 2 3 4 5 6 High Importance 7
<i>Promotion of midwifery to the public</i>	Low Importance 1 2 3 4 5 6 High Importance 7

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
The role of the midwife tutor Average group rating on Questionnaire 2 = 5.7	Low Importance 1 2 3 4 5 6 7 High Importance
<i>The lecturer/practitioner role and the provision of student support</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Making better use of clinical midwives in midwifery education in small hospitals</i>	Low Importance 1 2 3 4 5 6 7 High Importance

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.
Promoting research/evidence-based practice Average group rating on Questionnaire 2 = 6.1	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Exploring the use of evidence-based practice.</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Enabling midwives to undertake local research and publish</i>	Low Importance 1 2 3 4 5 6 7 High Importance
<i>Various approaches to promoting research-based practice</i>	Low Importance 1 2 3 4 5 6 7 High Importance

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Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Student midwife learning/education Average group rating on Questionnaire 2 = 6.4	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Students experience of the clinical learning environment</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Relating theory to practice for midwifery students</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Barriers to preceptorship</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Promoting reflection among students</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Improving practical skills</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Direct entry midwifery programmes</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Student assessment</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Preparing students for the transition to midwife</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Providing adequate support for student midwives in the clinical area</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Role of independent midwives in the community in midwifery education</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Preparation of students for midwifery-led models</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Rate both Topic and Examples	Importance for research: Circle the number that represents how important you think the <u>topic</u> and <u>examples</u> are.						
Support for midwives working with students Average group rating on Questionnaire 2 = 6.0	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Experience of midwives /support in assessing students</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Effectiveness of induction programmes for overseas midwives</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Value of preceptorship programmes</i>	Low Importance 1	2	3	4	5	6	High Importance 7
<i>Midwives and teaching workloads</i>	Low Importance 1	2	3	4	5	6	High Importance 7

Thank you for completing Questionnaire 3

Please return it in the enclosed stamped, addressed envelope as soon as possible.

Meeting of study participants on Monday 17th January 2005.

I am interested in participating in the meeting: Yes No

Appendix 7 - Research Timeframe Questionnaires



School of Nursing and Midwifery
University College Dublin
National University of Ireland

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Nursing Research Timeframe Questionnaire

The purpose of this Questionnaire is to determine the appropriate timeframe for research to be conducted on the broad research priority topics for **nursing practice (10)**, **nursing management (5)** and **nursing education (9)**, which have been identified in this study. For each topic, you are asked to indicate whether you think research on the topic should be conducted in the short-term (within 3 years) medium-term (within 3-5 years) or long-term (more than 5 years).

Directions: Take a few moments to read over the broad topics as well as the examples included under each topic. Consider each **topic** in light of the Irish national health strategy and any other factors that you think influence the timeframe within which research on the **topic** should be conducted. Then, tick the time frame box next to the topic, which you think is most appropriate.

Nursing Practice – 10 Broad Topics

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Nurses' attitudes to specific patient/client groups, (for example: patient/clients with disabilities, patient/clients from other cultures, elderly people).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Nursing practice roles, (for example: scope of practice; care planning; relationships between practice and management; relationships with health care assistants; role in multidisciplinary team; clinical decision making).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Specialist and advanced practice roles (for example: impact on other nurses' roles; role preparation; development and evaluation of Clinical Nurse Specialist and Advanced Nurse Practitioner roles; practice responsibilities; relationships with staff nurses, impact of roles on patient/client care and patient/client outcomes).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Topic	Timeframe For each topic, place a tick in the timeframe which you think is most appropriate		
<p>Outcomes of care delivery (for example: changing approaches to caring for patient/clients; evaluation of care delivery; patient/client assessment; risk assessment; effectiveness of patient/client education; patient/clients' perceptions of nursing care).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Communication in clinical practice (for example: communication with patients/clients and patients'/clients' relatives; communication with other health professionals; communication with the public; communication with people from other cultures; communication among nurses).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Physical care concerns (for example: patient/client hygiene; wound care; infection control; intravenous cannulation and administration; pain and symptom management; environmental resources; patient/client involvement in care).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Ethical concerns (for example: ethical issues related to patient/client informed consent and confidentiality, care of older people, timing of care delivery, patient/clients' transitions from hospital to community care).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Quality assurance in practice (for example: therapeutic effects of nursing interventions; nursing documentation; clinical audit; research utilisation; national standards and guidelines for patient/client care).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Psychological care concerns (for example: effects of crowded patient/client care areas; interactions with families and communities; care of mentally ill patient/clients; impact of psychological interventions; effects of caring for patient/clients with disabilities).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Staffing issues in practice (<i>for example: patient/client dependency levels, staffing levels, staff turnover rate, skill mix, non-nurses delivering nursing care; nurses' stress and health concerns</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Nursing Management – 5 Broad Topics

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Health and safety in practice (<i>for example: management of patient/client aggression and violence towards nurses; nurses' ability to cope with patient/clients' or relatives' aggressive behaviour; effects of heavy manual workloads on nurses</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Quality assurance and standards of care (<i>for example: impact of nursing interventions; cost-effectiveness of nursing practices; national guidelines for practice; research utilisation</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Nursing input into health policy and decision making (<i>for example: nurses' knowledge of effects of health policy on practice; inclusion of all nurses in decision making; nurses' influence on health policy</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Roles of nurse managers (<i>for example: changing roles and responsibilities; leadership abilities; communication and relationships with nurses providing patient/client care; education for management positions, planning and management of change</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Topic	Timeframe For each topic, place a tick in the timeframe which you think is most appropriate		
Recruitment and retention of nurses <i>(for example: nurse retention; morale in nursing; management of skill mix, staffing for high dependency patient/clients, bullying by managers; stress amongst managers).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Nursing Education – 9 Broad Topics

Topic	Timeframe For each topic, place a tick in the timeframe which you think is most appropriate		
Research and evidence-based practice <i>(for example: dissemination of research information in practice; use of research to improve practice; nurse researchers' availability to practitioners; role-related research responsibilities).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Clinical education links between service and academic organisations <i>(for example: educational role of nurses in clinical practice; collaboration; clinical skills of lecturers; content and structure of all levels of clinical education).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Undergraduate/pre-registration clinical learning <i>(for example: who should teach students in clinical areas, clinical placements; teaching methods in clinical practice; lecturers' roles in clinical areas; students' learning experiences in the clinical environment).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Career planning and professional/ educational development <i>(for example: structured pathways for professional development; educational guidance; time and financial support for continuing education; importance of continuing education for practice).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Topic	Timeframe For each topic, place a tick in the timeframe which you think is most appropriate		
Educational needs analysis (<i>for example: courses to meet changing needs; knowledge of pharmacology and medication responsibilities; education in areas of specialist practice; management education</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Professional appraisal and staff development (<i>for example: mandatory periodic reassessment of knowledge and skills and related staff development; regular assessments of practice competence; regular assessment of specialist area competencies</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Recruitment and retention related to nurse education (<i>for example: qualities and abilities of people recruited into nursing; how to attract people into undergraduate education; retention related to level of education</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Models of course delivery (<i>for example: modular frameworks to support flexible learning; need for distance learning and e-learning opportunities; availability of courses outside major centres</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Outcomes and effectiveness of education (<i>for example: linking of theory to practice; impact of post-graduate education on practice; recognition of professional learning; career pathways of degree-educated nurses</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Thank you for completing this Questionnaire

Please return it to your group facilitator



**School of Nursing and Midwifery
University College Dublin
National University of Ireland**

Study to Identify Nursing and Midwifery Research Priorities for Ireland

Midwifery Research Timeframe Questionnaire

The purpose of this Questionnaire is to determine the appropriate timeframe for research to be conducted on the broad research priority topics for **midwifery practice (11)**, **midwifery management (8)** and **midwifery education (7)**, which have been identified in this study. For each topic, you are asked to indicate whether you think research on the topic should be conducted in the short-term (within 3 years) medium-term (within 3-5 years) or long-term (more than 5 years).

Directions: Take a few moments to read over the broad topics as well as the examples included under each topic. Consider each **topic** in light of the Irish national health strategy and any other factors that you think influence the timeframe within which research on the **topic** should be conducted. Then, tick the time frame box next to the topic, which you think is most appropriate.

Midwifery Practice – 11 Broad Topics

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Breastfeeding (<i>for example: diet and breastfeeding; establishing breastfeeding; teat versus cup/syringe feeding; uptake of breastfeeding; role of lactation consultants</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Preparation for practice (<i>for example: responding to emergencies in midwifery; student preparation - theory/clinical balance; student preparation - breaking bad news; updating midwives' skills; gap between theory and practice</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Human resource management (<i>for example: recruitment and selection of staff; staff retention</i>).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Continuing professional education <i>(for example: importance of continuing education for practice; in-service training).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Care in labour <i>(for example: perineal suturing; Cardiotocograph (CTG) monitoring; perineal care; vaginal examinations; epidural use).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Health promotion <i>(for example: resources for and effectiveness of antenatal education; parent preparation).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Clinical supervision <i>(for example: writing policy/guidelines; dealing with litigation; midwifery supervision; evidence-based / research-based midwifery practice).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Communication <i>(for example: record keeping).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Satisfaction with care <i>(for example: national review of maternity services; organisation of maternity care; transcultural issues; choice; perceptions of the role of the midwife).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Models of care <i>(for example: advanced practice/extended practice roles; midwifery support in the community/postnatal support in community/ community midwifery; autonomy and the midwife; midwife-led care; normal midwifery versus medical model/ medicalisation of childbirth).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Management grades <i>(for example: clinical midwife management numbers).</i>	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Midwifery Management – 8 Broad Topics

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Barriers to autonomy (for example: challenges as a result of the medical model; fear of litigation; promoting autonomy at management level; proper recognition and remuneration for role and responsibilities).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Change management (for example: managing change; patient and staff risk analysis; audit of standards of care).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Levels of management (for example: nurse/manager ratios; management hierarchy; clinical knowledge and skills required for management; appointment to management positions; importance of Clinical Midwifery Management role; need for specialist posts; need for clinical skills co-ordinator).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Management culture (for example: management/staff communication; do staff feel valued; management style; staff/management relations; leadership role models; showing appreciation; approaches to appraisal).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Sources of stress (for example: support for staff from management; bullying; burnout; factors leading to increased workload).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Workforce planning (for example: staffing; rostering; staff rotation; appropriate staffing levels; appraisal/ personal development planning; supporting and developing managers; fair allocation of work; recruitment and retention; dependency).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Promoting woman-centred care (for example: development of woman-centred care, outcomes and cost-effectiveness of midwifery-led care; community and domiciliary models; quality of midwifery care; how well women are prepared for motherhood; ward design, privacy and impact on outcomes of care; responsiveness of midwifery care; midwifery prescribing).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Developing midwifery practice (for example: evaluation of the Clinical Midwife Specialist role; what is the role of the Advanced Midwife Practitioner).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Midwifery Education – 7 Broad Topics

Topic	Timeframe		
	For each topic, place a tick in the timeframe which you think is most appropriate		
Continuing education (for example: access to continuing education; content of continuing education; other measures to support learning among clinical staff; adequacy of in-service education; motivating staff to attend; developing appropriate post-graduate education).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)
Midwifery curriculum (for example: curriculum content; new approaches to midwifery education; aims of the midwifery curriculum; theory/practice gap; balance between theory and practice and academic requirements).	Short-term (within 3 years)	Medium-term (within 3-5 years)	Long-term (more than 5 years)

Topic	Timeframe For each topic, place a tick in the timeframe which you think is most appropriate		
<p>Promoting the distinctiveness of midwifery (<i>for example: focus on normal despite medical model; encouraging midwives to develop own practice; promotion of midwifery to the public</i>).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>The role of the midwife tutor (<i>for example: the lecturer/practitioner role and the provision of student support; making better use of clinical midwives in small hospitals</i>).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Promoting research/evidence-based practice (<i>for example: exploring the use of evidence-based practice; promoting local research; enabling midwives to do research and publish; targeting research on specific practice issues; various approaches to promoting research-based practice</i>).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Student midwife learning/education (<i>for example: providing adequate support for students in the clinical area; relating theory to practice; preparing students for the transition to midwife; student assessment; improving practical skills; direct entry to midwifery programmes; experience of the clinical learning environment; promoting reflection; barriers to preceptorship; preparation for midwifery-led models; independent midwives in the community</i>).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>
<p>Support for midwives working with students (<i>for example: teaching workloads; effectiveness of induction programmes for overseas midwives; assessing students; value of preceptorship programmes</i>).</p>	<p>Short-term (within 3 years)</p>	<p>Medium-term (within 3-5 years)</p>	<p>Long-term (more than 5 years)</p>

Thank you for completing this Questionnaire

Please return it to your group facilitator

Appendix 8 - Service User Ratings of Nursing and Midwifery Research Priorities and Timeframes

Nursing Service Users: Ten clinical issues importance ratings and timeframe ratings (n=10)

Rank	Issue/Example	Mean (SD)	Timeframe
1	Communication in clinical practice	6.71 (0.48)	Short
(1)	Communication with patient/clients and patient/clients' relatives	6.80 (0.42)	
(2)	Communication with people from other cultures	6.60 (0.51)	
(3)	Communication among nurses	6.40 (0.99)	
(4)	Communication with the public	6.40 (0.84)	
(5)	Communication with other health professionals	6.10 (0.73)	
2	Psychological care concerns	6.57 (0.53)	Short
(1)	Interactions with families and communities	6.60 (0.51)	
(2)	Care of mentally ill patient/clients	6.50 (0.70)	
(3)	Effects of caring for patient/clients with disabilities	6.44 (1.01)	
(4)	Impact of psychological interventions	6.20 (0.78)	
(5)	Effects of crowded patient/client care areas	6.20 (1.13)	
3	Outcomes of care delivery	6.50 (0.83)	Short
(1)	Evaluation of care delivery	6.70 (0.48)	
(2)	Patient/clients' perceptions of nursing care	6.60 (0.51)	
(3)	Effectiveness of patient/client education	6.50 (0.70)	
(4)	Patient/client assessment	6.40 (0.51)	
(5)	Risk assessment	6.00 (0.81)	
4	Physical care concerns	6.43 (0.78)	Short
(1)	Pain and symptom management	6.60 (0.69)	
(2)	Infection control	6.50 (0.70)	
(3)	Wound care	6.20 (1.03)	
(4)	Patient/client hygiene	6.10 (0.87)	
(5)	Patient/client involvement in care	6.00 (0.81)	
(6)	Environmental resources available to support physical care concerns	5.50 (1.78)	
(7)	Intravenous cannulation and administration	5.00 (1.41)	
5	Ethical concerns	6.43 (0.97)	Short
(1)	Ethical issues related to patient/client informed consent and confidentiality	6.50 (0.70)	
(2)	Patient/clients' transitions from hospital to community care	6.40 (0.96)	
(3)	Care of older people	6.20 (1.39)	
(4)	Timing of care delivery	6.10 (0.99)	
6	Quality assurance in practice	6.43 (0.78)	Short
(1)	National standards and guidelines for patient/client care	6.60 (0.69)	
(2)	Nursing documentation	6.30 (0.82)	
(3)	Research utilisation	6.20 (0.78)	
(4)	Therapeutic effects of nursing interventions	6.20 (0.63)	
(5)	Clinical audit	6.00 (0.81)	
7	Nurses' attitudes to specific patient/client groups	6.29 (0.75)	Short
(1)	Attitudes to patient/clients with disabilities	6.60 (0.51)	
(2)	Attitudes to elderly people	6.50 (0.52)	
(3)	Attitudes to patient/clients from other cultures	6.10 (0.73)	

**Nursing Service Users: Ten clinical issues importance ratings and timeframe ratings (n=10)
(continued)**

Rank	Issue/Example	Mean (SD)	Timeframe
8	Staffing issues in practice	6.00 (0.81)	Short
(1)	<i>Nurses' stress and health concerns</i>	6.20 (0.78)	
(2)	<i>Skill mix</i>	6.20 (0.91)	
(3)	<i>Staffing levels</i>	6.10 (0.87)	
(4)	<i>Patient/client dependency levels</i>	6.10 (0.73)	
(5)	<i>Staff turnover rate</i>	5.80 (0.91)	
(6)	<i>Non-nurses delivering nursing care</i>	5.00 (2.00)	
9	Nursing practice roles	6.00 (0.63)	Medium-long
(1)	<i>Scope of nursing practice</i>	5.89 (0.78)	
(2)	<i>The nursing role in multidisciplinary team</i>	5.89 (1.05)	
(3)	<i>Clinical decision making</i>	5.78 (0.83)	
(4)	<i>Nursing care planning</i>	5.78 (0.83)	
(5)	<i>Relationships between nurses in practice and nurses in management</i>	5.78 (1.30)	
(6)	<i>Relationships between nurses and health care assistant</i>	5.33 (1.32)	
10	Specialist and advanced practice roles	5.71 (0.75)	Short
(1)	<i>Impact of specialist and advanced practice nurses roles on patient/client care and patient/client outcomes</i>	6.40 (0.84)	
(2)	<i>Development & evaluation of Clinical Nurse Specialist and Advanced Nurse Practitioner roles</i>	5.80 (1.03)	
(3)	<i>Responsibilities specialist and advanced practice nurses</i>	5.78 (0.66)	
(4)	<i>Preparation for specialist and advanced practice nurse roles</i>	5.60 (1.17)	
(5)	<i>Specialist and advanced practice nurses relationships with staff nurses</i>	5.40 (1.07)	
(6)	<i>Impact of specialist and advanced practice nurses roles on other nurses' roles</i>	5.10 (0.99)	

Nursing Service Users: Five managerial issues importance ratings and timeframe ratings (n=10)

Rank	Issue/Example	Mean (SD)	Timeframe
1	Nursing input into health policy and decision making	6.29 (0.95)	Medium-long
(1)	<i>Including all nurses in decision making</i>	6.00 (0.81)	
(2)	<i>Nurses' influence on health policy</i>	5.90 (1.10)	
(3)	<i>Nurses' knowledge of effects of health policy on practice</i>	5.90 (1.10)	
2	Quality assurance and standards of care	6.14 (0.69)	Short
(1)	<i>National guidelines for practice</i>	6.10 (1.10)	
(2)	<i>Impact of nursing interventions</i>	5.80 (0.91)	
(3)	<i>Research utilisation</i>	5.80 (0.91)	
(4)	<i>Cost-effectiveness of nursing practices</i>	5.70 (1.56)	
3	Health and safety in practice	6.00 (0.81)	Short
(1)	<i>Nurses' ability to cope with patient/clients' or relatives' aggressive behaviour</i>	6.30 (0.82)	
(2)	<i>Effects on nurses of heavy manual workloads</i>	6.10 (0.99)	
(3)	<i>Management of patient/client aggression and violence towards nurses</i>	6.10 (1.10)	
4	Roles of nurse managers	6.00 (0.57)	Medium-long
(1)	<i>Nurse Managers communication and relationships with nurses providing patient/client care</i>	6.20 (0.78)	
(2)	<i>Nurse Managers education for management positions</i>	6.00 (0.81)	
(3)	<i>Nurse Managers leadership abilities</i>	5.90 (0.73)	
(4)	<i>Nurse Managers planning and management of change</i>	5.80 (0.63)	
(5)	<i>Nurse Managers changing roles and responsibilities</i>	5.60 (0.96)	
5	Recruitment and retention of nurses	6.00 (0.57)	Short
(1)	<i>Staffing for high dependency patient/clients</i>	6.50 (0.52)	
(2)	<i>Morale in nursing</i>	6.20 (0.91)	
(3)	<i>Management of skill mix</i>	6.20 (0.78)	
(4)	<i>Nurse retention</i>	6.20 (0.91)	
(5)	<i>Bullying by managers</i>	6.10 (1.10)	
(6)	<i>Stress amongst managers</i>	5.70 (1.05)	

Nursing Service Users: Nine educational issues importance ratings and timeframe ratings (n=10)

Rank	Issue/Example	Mean (SD)	Timeframe
1	Professional appraisal and staff development	6.43 (0.78)	Short
(1)	<i>Regular assessment of specialist area competencies</i>	6.20 (0.91)	
(2)	<i>Mandatory periodic reassessment of knowledge and skills and related staff development</i>	6.20 (0.91)	
(3)	<i>Regular assessments of practice competencies</i>	6.20 (1.03)	
2	Research and evidence-based practice	6.14 (0.90)	Short
(1)	<i>Use of research to improve practice</i>	6.40 (0.84)	
(2)	<i>Dissemination of research information in practice</i>	6.30 (0.67)	
(3)	<i>Role-related research responsibilities</i>	6.00 (0.81)	
(4)	<i>Nurse researchers' availability to practitioners</i>	5.90 (0.73)	
3	Recruitment and retention related to nurse education	6.14 (0.69)	Short
(1)	<i>Staff retention related to level of education</i>	6.10 (0.73)	
(2)	<i>Qualities and abilities of people recruited into nursing</i>	6.00 (0.81)	
(3)	<i>How to attract people into undergraduate nursing education</i>	6.00 (0.81)	
4	Clinical education links between service and academic organisations	5.86 (0.90)	Medium-long
(1)	<i>Clinical skills of lecturers</i>	6.10 (0.87)	
(2)	<i>Educational role of nurses in clinical practice</i>	5.80 (0.78)	
(3)	<i>Collaboration between service and academic organisations</i>	5.80 (0.63)	
(4)	<i>Content and structure of all levels of clinical education</i>	5.50 (0.52)	
5	Undergraduate/pre-registration clinical learning	5.86 (1.06)	Short
(1)	<i>Who should teach students in clinical areas</i>	6.00 (0.86)	
(2)	<i>Students' learning experiences in the clinical environment</i>	6.00 (0.86)	
(3)	<i>Clinical placements</i>	5.89 (0.92)	
(4)	<i>Lecturers' roles in clinical areas</i>	5.56 (1.01)	
6	Educational needs analysis	5.86 (0.69)	Short
(1)	<i>Knowledge of pharmacology and knowledge of medication responsibilities</i>	6.10 (0.87)	
(2)	<i>Education in areas of specialist practice</i>	6.10 (0.73)	
(3)	<i>Need for courses to meet changing needs</i>	6.10 (0.73)	
(4)	<i>Management education needs analysis</i>	5.33 (0.86)	
7	Models of course delivery	5.86 (0.69)	Medium-long
(1)	<i>Modular frameworks to support flexible learning</i>	5.50 (1.50)	
(2)	<i>Availability of courses outside major centres</i>	5.50 (1.58)	
(3)	<i>Need for distance learning and e-learning opportunities</i>	5.40 (1.50)	

**Nursing Service Users: Nine educational issues importance ratings and timeframe ratings (n=10)
(continued)**

Rank	Issue/Example	Mean (SD)	Timeframe
8	Outcomes and effectiveness of education	5.86 (0.69)	Medium-long
(1)	<i>Linking of theory to practice</i>	6.33 (0.70)	
(2)	<i>Impact of post-graduate education on practice</i>	6.11 (0.60)	
(3)	<i>Recognition of professional learning</i>	5.89 (0.78)	
(4)	<i>Career pathways of degree-educated nurses</i>	5.89 (0.78)	
9	Career planning and professional/ educational development	5.71 (0.75)	Medium-long
(1)	<i>Importance of continuing education for practice</i>	6.00 (0.81)	
(2)	<i>Structured pathways for professional development</i>	5.80 (0.91)	
(3)	<i>Educational guidance for nurses</i>	5.80 (0.78)	
(4)	<i>Time and financial support for continuing education</i>	5.70 (0.82)	

Midwifery Service Users: Eleven clinical issues importance ratings and timeframe ratings (n=9)

Rank	Issue/Example	Mean (SD)	Timeframe
1	Care in Labour	6.86 (0.38)	Short
(1)	<i>Perineal suturing</i>	6.22 (1.09)	
(2)	<i>Perineal care</i>	6.11 (1.36)	
(3)	<i>Cardiotocograph (CTG) monitoring</i>	6.00 (1.11)	
(4)	<i>Vaginal examinations</i>	6.00 (1.11)	
(5)	<i>Epidural use</i>	5.89 (1.05)	
2	Breastfeeding	6.50 (0.55)	Short
(1)	<i>Establishing breastfeeding</i>	6.78 (0.45)	
(2)	<i>Uptake of breastfeeding</i>	6.67 (0.70)	
(3)	<i>Role of lactation consultants</i>	5.89 (0.92)	
(4)	<i>Diet and breastfeeding</i>	5.67 (1.87)	
(5)	<i>Teat versus cup/syringe feeding</i>	4.11 (1.83)	
3	Satisfaction with care	6.29 (0.75)	Short
(1)	<i>Providing women with choice in relation to maternity care</i>	6.44 (1.13)	
(2)	<i>National review of maternity services</i>	6.33 (0.86)	
(3)	<i>Organisation of maternity care</i>	6.22 (0.83)	
(4)	<i>Transcultural issues</i>	6.11 (0.92)	
(5)	<i>Perceptions of the role of the midwife</i>	5.22 (1.92)	
4	Models of care	6.17 (0.75)	Short
(1)	<i>Midwife-led care</i>	6.56 (0.88)	
(2)	<i>Normal midwifery versus medical model</i>	6.33 (0.86)	
(3)	<i>Medicalisation of childbirth</i>	6.11 (1.61)	
(4)	<i>Midwifery support for women in the community</i>	6.11 (0.92)	
(5)	<i>Autonomy and the midwife</i>	6.00 (1.65)	
(6)	<i>Advanced practice/extended practice roles</i>	5.56 (1.23)	
5	Clinical Supervision	6.17 (0.90)	Short
(1)	<i>Evidence based/research based practice</i>	6.36 (1.00)	
(2)	<i>Midwifery supervision</i>	6.13 (0.92)	
(3)	<i>Writing policy guidelines</i>	6.05 (1.11)	
(4)	<i>Dealing with litigation</i>	5.92 (1.15)	
6	Preparation for practice	5.86 (0.69)	Short
(1)	<i>Student preparation - gap between theory and practice</i>	6.11 (0.78)	
(2)	<i>Student preparation - theory/clinical balance</i>	6.11 (0.60)	
(3)	<i>Updating midwives' skills</i>	6.11 (0.78)	
(4)	<i>Preparing students to break bad news</i>	5.78 (1.92)	
(5)	<i>Responding to emergencies in midwifery</i>	5.56 (1.42)	
7	Communication	5.71 (0.95)	Medium-long
(1)	<i>Record Keeping</i>	5.33 (1.22)	
8	Continuing Professional Education	5.71 (0.95)	Medium-long
(1)	<i>Importance of Continuing education and practice</i>	6.33 (1.11)	
(2)	<i>In-service training</i>	5.67 (1.00)	

**Midwifery Service Users: Eleven clinical issues importance ratings and timeframe ratings (n=9)
(continued)**

Rank	Issue/Example	Mean (SD)	Term
9	Human Resource Management	5.57 (1.27)	Medium-long
(1)	<i>Staff retention</i>	6.00 (1.11)	
(2)	<i>Recruitment and selection of staff</i>	5.78 (1.48)	
10	Health Promotion	5.43 (0.97)	Medium-long
(1)	<i>Resources for and effectiveness of antenatal education</i>	5.88 (1.12)	
(2)	<i>Parent Preparation</i>	5.63 (0.74)	
11	Management Grades	4.57 (0.78)	Medium-long
(1)	<i>Clinical midwife manager numbers</i>	3.78 (1.39)	

Midwifery Service Users: Eight managerial issues importance ratings and timeframe ratings (n=9)

Rank	Issue/Example	Mean (SD)	Timeframe
1	Promoting woman-centred care	6.43 (0.53)	Short
(1)	<i>Development of woman-centred care</i>	6.78 (0.44)	
(2)	<i>Community and domiciliary models</i>	6.56 (0.52)	
(3)	<i>Quality of midwifery care</i>	6.50 (0.53)	
(4)	<i>Outcomes and cost effectiveness of midwifery-led care</i>	6.33 (0.50)	
(5)	<i>How well women are prepared for motherhood</i>	6.22 (0.66)	
(6)	<i>Responsiveness of midwifery care</i>	6.22 (0.66)	
(7)	<i>Privacy and impact on outcomes of care</i>	6.00 (0.86)	
(8)	<i>Midwifery prescribing</i>	5.78 (1.20)	
(9)	<i>Ward design</i>	5.44 (2.29)	
2	Sources of Stress	6.43 (0.78)	Short
(1)	<i>Burnout</i>	6.44 (1.01)	
(2)	<i>Bullying</i>	6.00 (1.00)	
(3)	<i>Support for staff from management</i>	6.00 (1.50)	
(4)	<i>Factors leading to increased workload</i>	5.89 (1.26)	
3	Developing Midwifery Practice	5.71 (1.38)	Medium-long
(1)	<i>What is the role of the Advanced Midwife Practitioner?</i>	5.11 (2.20)	
(2)	<i>Evaluation of the Clinical Midwife Specialist role</i>	5.00 (2.17)	
4	Workforce Planning	5.57 (0.97)	Medium-long
(1)	<i>Fair allocation of work</i>	6.22 (1.30)	
(2)	<i>Recruitment and retention</i>	6.22 (0.83)	
(3)	<i>Appropriate staffing levels</i>	5.89 (1.26)	
(4)	<i>Staff rotation</i>	5.89 (1.53)	
(5)	<i>Staffing</i>	5.67 (1.41)	
(6)	<i>Dependency</i>	5.67 (1.22)	
(7)	<i>Rostering</i>	5.56 (1.74)	
(8)	<i>Appraisal/personal development planning</i>	5.22 (1.09)	
(9)	<i>Supporting and developing managers</i>	5.11 (1.05)	
5	Levels of Management	5.25 (1.31)	Medium-long
(1)	<i>Need for specialist posts</i>	5.78 (1.40)	
(2)	<i>Clinical knowledge and skills required for management</i>	5.77 (1.30)	
(3)	<i>Importance of CNM III role</i>	5.59 (1.37)	
(4)	<i>Need for clinical skills co-ordinator</i>	5.50 (1.59)	
(5)	<i>Midwife/manager ratios</i>	5.27 (1.54)	
(6)	<i>Appointment to management positions</i>	5.21 (1.45)	
(7)	<i>Management hierarchy</i>	4.81 (1.64)	
6	Barriers to Autonomy	5.33 (0.51)	Medium-long
(1)	<i>Challenges as a result of medical model in maternity care</i>	5.67 (1.32)	
(2)	<i>Proper recognition and remuneration for role and responsibilities</i>	6.56 (0.72)	
(3)	<i>Fear of litigation</i>	4.78 (2.27)	
(4)	<i>Promoting autonomy at management level</i>	4.67 (1.73)	

Midwifery Service Users: Eight managerial issues importance ratings and timeframe ratings (n=9)
(continued)

Rank	Issue/Example	Mean (SD)	Timeframe
7	Change Management	5.14 (1.21)	Medium-long
(1)	Audit of standards of care	5.44 (1.42)	
(2)	Managing change	5.11 (1.53)	
(3)	Patient and staff risk analysis	5.00 (1.93)	
8	Management Culture	5.14 (1.06)	Medium-long
(1)	Management/staff communication	6.00 (1.32)	
(2)	Showing appreciation	5.78 (1.48)	
(3)	Do staff feel valued?	5.67 (1.41)	
(4)	Staff/management relations	5.44 (1.59)	
(5)	Management style	5.00 (1.22)	
(6)	Approaches to appraisal	4.89 (1.05)	
(7)	Leadership role models	4.67 (1.32)	

Midwifery Service Users: Seven educational issues importance ratings and timeframe ratings (n=9)

Rank	Issue/Example	Mean (SD)	Term
1	Continuing Education	6.00 (1.00)	Medium-long
(1)	<i>Content of continuing education for midwives</i>	5.89 (0.60)	
(2)	<i>Access to continuing education for midwives</i>	5.89 (0.92)	
(3)	<i>Motivating staff to attend continuing education</i>	5.78 (0.97)	
(4)	<i>Adequacy of in-service education</i>	5.67 (0.70)	
(5)	<i>Developing appropriate post-graduate education</i>	5.67 (1.32)	
(6)	<i>Measures other than courses to support learning among clinical staff</i>	5.67 (1.22)	
2	Promoting the distinctiveness of midwifery	6.00 (1.15)	Short
(1)	<i>Focus on normal in midwifery education despite medical model</i>	6.22 (1.20)	
(2)	<i>Promotion of midwifery to the public</i>	6.22 (1.09)	
(3)	<i>Encouraging midwives to develop their own practice</i>	5.78 (1.48)	
3	Student midwife learning/education	6.00 (1.00)	Short
(1)	<i>Role of independent midwives in the community in midwifery education</i>	6.78 (0.44)	
(2)	<i>Preparation of students for midwifery-led models</i>	6.67 (0.50)	
(3)	<i>Improving practical skills</i>	6.44 (1.01)	
(4)	<i>Direct entry midwifery programmes</i>	6.33 (0.70)	
(5)	<i>Preparing students for the transition to midwife</i>	6.33 (1.00)	
(6)	<i>Relating theory to practice for midwifery students</i>	6.11 (0.92)	
(7)	<i>Student assessment</i>	6.11 (1.05)	
(8)	<i>Providing adequate support for student midwives in the clinical area</i>	6.00 (1.11)	
(9)	<i>Students' experience of the clinical learning environment</i>	5.67 (1.22)	
(10)	<i>Barriers to preceptorship</i>	5.67 (0.86)	
(11)	<i>Promoting reflection among students</i>	5.67 (1.11)	
4	Midwifery Curriculum	5.86 (0.90)	Medium-long
(1)	<i>New approaches to midwifery education</i>	6.11 (0.92)	
(2)	<i>Theory/practice gap in midwifery education</i>	6.00 (0.70)	
(3)	<i>Content of midwifery curriculum</i>	5.78 (0.97)	
(4)	<i>Aims of the midwifery curriculum</i>	5.67 (1.50)	
(5)	<i>Balance between theory and practice and academic requirements in midwifery education</i>	5.33 (1.32)	
5	Support for midwives working with students	5.57 (0.78)	Medium-long
(1)	<i>Effectiveness or induction programmes for overseas midwives</i>	6.11 (1.26)	
(2)	<i>Midwives and teaching workloads</i>	5.89 (1.16)	
(3)	<i>Experience of midwives/support in assessing students</i>	5.56 (1.23)	
(4)	<i>Value of preceptorship programmes</i>	5.33 (1.22)	
6	Promoting research/evidence-based practice	5.57 (1.13)	Medium-long
(1)	<i>Exploring the use of evidence-based practice</i>	6.00 (1.18)	
(2)	<i>Various approaches to promoting research-based practice</i>	5.56 (1.33)	
(3)	<i>Enabling midwives to undertake local research and publish</i>	5.11 (1.45)	

**Midwifery Service Users: Seven educational issues importance ratings and timeframe ratings (n=9)
(continued)**

Rank	Issue/Example	Mean (SD)	Term
7	The role of the midwife tutor	5.43 (1.13)	Medium-long
(1)	<i>Making better use of clinical midwives in midwifery education in small hospitals</i>	5.78 (1.30)	
(2)	<i>The Lecturer/Practitioner role and the provision of student support</i>	5.67 (1.22)	



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