CHILDREN'S NURSING - MEETING THE NEEDS OF CHILDREN?

by

PATRICIA SUSAN PRICE

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ABSTRACT

Rodgers' evolutionary model of concept analysis was used to develop definitions of children's nursing and their special needs, from which the inherent qualities of children's nurses were extrapolated and tested in a variety of ways. Firstly selectors of children's nursing students evaluated the suitability of six hypothetical candidates, in a self administered postal questionnaire. There was some agreement on the identified pre-requisite qualities.

Secondly a content analysis of 25 job descriptions for newly qualified children's nurses, using NUD*IST was undertaken, to determine English NHS Trusts' expectations. Across the sample there was agreement on the role of the children's nurse, confirming the definition derived from the concept analysis. There was less agreement between trusts in the manner in which these expectations were expressed.

New regulations for nurse education were introduced during the time of this study and the government published new standards for children's health services. Therefore a final concept analysis of children's nursing at the start of the 21st century was undertaken. A number of implications for children's nursing selection and further development of the identified qualities of potential students were identified. The definition of children's nursing should continue to be debated as the role develops and becomes increasingly expressed in terms of competencies.

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INTRODUCTION

The United Kingdom (UK) is unusual in having a specific preparation for different branches of nursing at the point of initial registration with the statutory body, a position that it has maintained since the introduction of registration in 1919. In the mid 1980s the direct entry route into training as a children's nurse was closed, meaning that those who wished to become children's nurses were required to have an initial registration, before applying to train as a children's nurse.

The implementation of the recommendations of Project 2000 (UKCC 1986) re-established a direct route into children's nursing. This changed the profile of new recruits, restoring access to anyone from school leavers through to more mature candidates, the vast majority with no previous caring or nursing experience. This change raised a number of questions in relation to the qualities selectors would look for in these potential child branch students and the expectations their employer, the NHS, would have of them when they first entered employment.

When entry to children's nursing training had followed an initial registration, often followed by a period of employment nursing children, selectors could make a decision based on a range of evidence of a nurse's suitability to undertake further training as a children's nurse. Without this data, and selecting from novices, there were questions about the characteristics selectors might look for, whether there would be agreement and how selectors might identify them

during the application process.

Answering these questions required the establishment of which inherent characteristics a novice candidate for children's nursing might be required to demonstrate. If children's nursing is different from other branches of nursing then these qualities needed to come from a definition of children's nursing that demonstrated its special attributes. Whilst many children's nurses describe what they do, there are a number of others, such as the government, the statutory body who sets and regulates standards for education and practice and professional organisations, who have a stake in children's nursing and could therefore contribute to a definition.

Such bodies would be unlikely to become involved in survey based research being undertaken by a solo researcher, however; they all publish literature in relation to children's nursing. Concept analysis was therefore the framework of choice. As a literature based process for determining the attributes of a concept, it was used to develop a definition of children's nursing using the publically available literature from these stakeholders.

Using of Rodgers' evolutionary model of concept analysis (Rodgers 2000a), on the available literature, with its specific recognition of influence of the context and the consequent dynamism of concepts, led to a possible definition of children's nursing at the beginning of the 21st century as

> the delivery of nursing care following an assessment of the child and based on their special needs. Children's nursing occurs in a range of settings as part of a multi-

> disciplinary package of care and where possible involves the child and parents in the planning and delivery of that care. Children's nursing utilises a range of specific technological, psychological and educational knowledge and skills to ensure that children's needs are met and they are able to achieve their potential.

This definition clearly demonstrated that the focus of children's nursing is on the special needs of the child. The concept of special needs is used in a range of settings and publications as a shorthand, as though there is agreement on what the needs are and the ways in which they differ to those of other groups. A second concept analysis facilitated the development of a definition of children's special needs as:-

> "those which are different from others undergoing a similar experience because they are specifically related to the individual child's stage of development." (Price 1994, 230).

This definition was then applied to the experience of children when they require nursing to demonstrate the personal qualities, knowledge and skills that children's nurses would need and how these were different to those needed to care for people in other age groups with similar nursing problems. From these statements of knowledge, skills and personal qualities it was then possible to extrapolate a range of qualities that would be inherent, that is, existing in the potential children's nurse, and identifiable during the first stage of the selection process.

Using the information derived from the concept analysis, a survey, of the English institutions offering the Dip HE Child Branch, was undertaken using a self administered postal questionnaire. In a new methodology, designed to test the level of agreement selectors demonstrated in relation to the identified qualities and the ways in which they would be displayed during the application process. Part of the questionnaire included six hypothetical

child branch applications which the respondents were required to rate on their acceptability for interview, giving the reason for their decision. Following a content analysis of responses there was some support for the inherent qualities of the child branch student derived from the concept analysis of the literature.

However, the perspectives of other stakeholders are also relevant. Children's nurses entering employment following a Project 2000 programme were different to those who had undertaken the second registration route, having no previous qualified nursing experience. To establish whether there was any agreement among the employers regarding the skills and attributes required of newly qualified children's nurses two surveys of English NHS trusts were undertaken, one in 1998 and the second in 2002. The second survey attempted to determine whether the role changed and whether the employers expectations matched the definition of children's nursing.

A request for a D grade staff nurse job description generated two samples, each of 25 from 1998 and 2002 representing the same trusts. A content analysis of the job descriptions was undertaken using QRS NUD*IST, a computer based qualitative content analysis programme. Although across the whole sample there was agreement on the role of these newly qualified children's nurses, individual trusts had a variety of expectations, with only limited change between the two samples, over the four year gap. Elements of the definition of children's nursing, derived from the concept analysis were found in all the job descriptions.

Finally, during the time that the studies reported in this thesis were in progress, the effectiveness of Project 2000 in preparing nurses for registration, fitness for practice and meeting the requirements of the employer, fitness for purpose had been reviewed. Following publication of the UKCC's commission on pre-registration nursing education (UKCC 1999), changes in pre-registration nursing education were implemented in the Fitness for Practice programmes (The Stationery Office 2000a). The statutory bodies for nursing were reviewed and restructured, the DoH contracted with the Quality Assurance Agency to review all nursing programmes, requiring the development of benchmark statements about children's nursing (QAA 2001) and the DoH published the children's National Service Framework (DoH 2003a). Such change from a range of stakeholders had the potential to change the definition of children's nursing. A final concept analysis was undertaken, leading to the definition of children's nursing as

> The delivery of nursing care following an assessment of the child and their family and based on their special needs. Children's nursing occurs in a range of settings as part of a multi-disciplinary package of care and where possible involves the child and parents in the planning and delivery of that care. Children's nursing utilises a range of child focussed technological, psychological and educational knowledge and skills to ensure that children's needs are met, that they gain independence and they are able to achieve their potential.

The implications for further study identified by this thesis focussed on

- the potential for further development of the inherent characteristics of children's nursing students through retrospective review of the application forms of those who were successful and using these qualities to assist the selection of child branch students and possibly reduce the attrition from such programmes.
- the value of continuing to define children's nursing, as the role develops and job roles become increasingly phrased in terms of competencies, which should be focussed on meeting the needs of children and their families.

CHILDREN'S NURSING - A CONCEPT ANALYSIS

INTRODUCTION

The notion of employing nurses specifically trained to care for children emerged, in the UK, alongside the establishment of children's hospitals in the second half of the 19th century. While professional registration for nurses was being established children's nurses were successful in getting their particular training recognised and a separate part of the register was established. This decision made the UK different from almost every other country that registers nurses, a situation currently maintained. Particularly during the later part of the 20th century government reports and policy decisions have made the case for the status quo, with statements such as "children have special needs" (HMSO 1976, para 16.19), and children's nursing calls for "special skills" (HMSO 1972, para 283).

Whilst there are a significant number of published papers describing what children's nurses do in practice, and a range of terms, from reference to the parts of the Professional Register or titles such as children's nurse, there are limited numbers of attempts to distill the common denominator of children's nursing, to define the attributes of children's nursing that makes it different no matter where it is practised.

CHOICE OF METHODOLOGY

In deciding on an appropriate methodology to distill the common denominator of children's nursing a number of approaches were considered.

The use of a Delphi study was considered, however, such a study "deliberately targeting expert opinion" (Lindsay 2004, 38), could have been seen as biassed in favour of those who have a strong support for children's nursing and a possibly vested interest in maintaining the status quo. Other forms of survey methodology had the potential advantage of allowing access to significant numbers of children's nurses, both in education and practice. To ensure a sufficient sample, including nurses from around the country and in a variety of organisational settings self-completion questionnaires would have been the most suitable instrument. The practice of children's nursing is, however, influenced by a range of other stakeholders such as employers, other health care professions, the government through its policies, reports and standards and the statutory bodies that regulate the profession. Accessing opinion from this wider body and bringing together a significant sample could not have been guaranteed, which may have skewed any eventual findings. These organisations do, however, put their requirements and expectations into the public arena through a range of publications.

Rodgers (Rodgers 2000a) and Walker and Avant (1995) state if those involved in discussing a concept have different understandings of it, it is difficult to undertake further enquiry or compare findings focussed on the concept under discussion. Concept analysis is one approach that is stated to have the ability to enable clarification of a concept such as children's nursing

and determine its characteristics. Described as a process to determine the "selected properties of objects to be studied" (Hardy 1974, cited Rodgers 2000, 9) concept analysis is a methodology used by a number of disciplines outside nursing, such as psychology (Rodgers and Knafl 2000). Its use in nursing, over the last twenty years, is documented by a number of authors (eg Morse et al 1996; Paley 1996; Walker and Avant 1995).

Walker and Avant define concept analysis as "a strategy that allows us to examine the attributes or characteristics of a concept" (Walker and Avant 1995, 37), with concepts being something "expressed by a word or a term" (Walker and Avant 1995, 38). They state the purpose as being able to "clarify those overused vague concepts that are prevalent in nursing" with the intention of ensuring that everyone who "uses the term will be speaking of the same thing" (Walker and Avant 1995, 38). Such a process is essentially literature based and would enable the inclusion of data from the whole range of stakeholders, using publically available publications. For this reason concept analysis was chosen as the framework to facilitate the definition of children's nursing.

Choice of concept analysis framework

Writing in 1996 Morse et al stated that the most "frequently used process" for concept analysis is based on an approach developed in the 1960s by Wilson (Morse et al 1996, 257). Wilson's approach was adapted by nurses and established as an 8-step procedure (Walker and Avant 1995; Morse et al 1996).

"1. Select a concept
2. Determine the aims or purpose of analysis
3. Identify all uses of the concept that you can discover
4. Determine the defining attributes
5. Construct a model case
6. Construct borderline, related, contrary, invented and illegitimate cases
7. Identify antecedents and consequences
8. Define empirical referents" (Walker and Avant 1988; 1995)

Morse et al, however, criticise Walker and Avant's adaptation, believing that it has made concept analysis "appear to be set of easily followed steps" (Morse et al 1996, 260) that have led to a lack of rigour and producing "trivial and insignificant results" (Morse 1995, 32), lacking ability to be applied in practice. Other authors see Walker and Avant's approach as having "rigid divisions" with particular difficulties associated with constructing the cases which are required as hypothetical examples of the concept (Endacott 1997, 71).

Rodgers in her discussion of concept analysis believes that existing models have led to the development of concepts, "characterised by a rigid set of conditions" and "presenting a static view of the world" (Rodgers 1994, 23), that fail to acknowledge the potential for change both over time and in different contexts (Rodgers 1994). For Rodgers concepts are subject to continuous change and through taking account of the cycle of evolution of a concept Rodgers states that is it is possible to see "what is common in the existing use of the concept" (Rodgers 1994, 26).

In a critique of this model of the analysis process, as originally presented by Rodgers in 1993, Morse et al see the link with the context of the concept as being limiting and "restricted to a

single situation" (Morse et al 1996, 260). Such criticism appears to be addressed by Rodgers' later writing, where the notion of context is clarified, by requiring the analyst to ask questions such as "Is the concept used differently in different situations? By different people?" (Rodgers 2000a, 91), and thereby clarifying that analysis can look at a number of situations.

As table 1 (below) demonstrates a number of authors have particularly chosen Rodgers' evolutionary method of concept analysis because of its ability to capture both the different contexts for the use of the concept and the dynamic nature of a particular concept under analysis. Although most frequently used for concepts such as family centred care (Hutchfield 1999), partnership (Gallant, Beaulieu and Carnevale 2002) and grief (Cowles and Rodgers 1991, cited Morse et al 1996) the evolutionary model has also been used to look at roles. For example Naumanen-Tuomela undertook a study of the expertise of occupational health nurses (Naumanen-Tuomela 2001) and Elcock the role of the lecturer practitioner (Elcock 1998).

Author	Concept analysed	Rationale for chosen method
Endacott (1997)	Need	Walker and Avant "felt to restrict" (471), Rodgers used as it "proposes a cyclical model enabling the analysis to reflect the dynamic, changing nature of the concepts" (472).
Robinson, McKenna (1998)	Loss	Combination of approaches to "enable greater breadth and pluralism" (780)

Author	Concept analysed	Rationale for chosen method
Elcock (1998)	Lecturer practitioner	Rodgers as it enables clarification of "the current use of the concept, taking into account the contextual aspects .... and the temporal aspect (it is a role that is still evolving)" (1093)
Hutchfield (1999)	Family centred care	Hybrid model Rodgers "searches for meanings and common usage and acknowledges concepts as dynamic and changing over time, rather than finite" (1179)
Naumanen-Tuomela (2001)	Occupational Health Nurses	Rodgers's inductive evolutionary concept analysis model "which was chosen because of its flexibility and ability to take into consideration the changes in concepts over time" (258)
Schilling et al (2001)	Diabetes in children	Rodgers "Furthermore, this method is predicated on the idea that concepts change over time, either `by convention or by purposeful definition' (p. 81). In addition to varying over time, "this method stresses the belief that concepts are affected by contextual factors" (88-89).
Glaister (2001)	Healing	Walker Avant methodology "a clear concise method" (63)
Gallant et al (2002)	Partnership	Rodgers's inductive evolutionary concept analysis model "which was chosen because of its flexibility and ability to take into consideration the changes in concepts over time" (150)

Table 1 Examples of rationale for choice of concept analysis framework in nursing

Rodgers herself used the model to study health policy (Rodgers 1989, cited Rodgers 2000a). Rodgers developed and Naumanen-Tuomela and Elcock both used this methodology for its potential to enable the study of concepts which had evolved over a period of time and were still undergoing change (Elcock 1998). Children's nursing is such a concept, with its origins in the UK in the second half of the 19th century and its needs to respond to changes in health care knowledge, skills, attitudes and expectations as nursing moves into the 21st century. Mapping the distinct stages of Rodgers' evolutionary method of concept against the available data sources related to children's nursing in the United Kingdom demonstrates its suitability for the development of a definition of this phenomenon (table 3, 24), a phenomenon for which the questions need to be why is it needed, what does it involve and what is the purpose and consequence?

"Identify the concept of interest associated expressions (including surrogate terms)" (Rodgers 2000a, 85)

Rodgers states that the purpose of analysis is to explore the "idea or characteristics associated" with a concept (Rodgers 2000a, 85). To achieve this identification of the concept is a "crucial step" (Rodgers 2000a, 85), a process that may be complicated by the emergence of a wide range of terminology. Rodgers describes these potential additional terms as being surrogate, in that they may give expression to the same idea or one that is close to the concept under analysis. Referring to her own work in exploring health policy Rodgers also outlines the potential of this methodology for exploration of how a concept has developed over time, or been viewed from a range of disciplines making the use of this method suitable for application to children's nursing, a concept that has evolved over the last century. The

evolutionary model is also credited by Rodgers with the ability to expand the use of concepts and apply them to different and possibly new situations.

As previously stated the United Kingdom (UK) is one of very few countries that enables registration as a children's nurse although, as demonstrated later, registration is not mandatory for employment as a nurse looking after children. As a role it is described by a range of titles or references to the part of the professional register. In applying the evolutionary model to the concept of children's nursing the "surrogate terms" (Rodgers 2000a, 85) will therefore reflect expressions used in the UK by children's nurses and by those such as the professional associations and government policy makers. The surrogate terms are:- children's nurse, paediatric nurse, Registered Sick Children's Nurse (RSCN), child branch nurse, Registered Nurse Child. The range of surrogate terms also needs to include the formal registration titles used by the registering body, the Nursing and Midwifery Council (NMC):- Part 8: Nurses trained in the nursing of sick children or Part 15: First level nurses trained in children's nursing (Project 2000). To take account of both past and present day practice the concept for exploration is therefore children's nursing or paediatric nursing a term found in older contexts.

"Identify and select an appropriate realm (setting and sample) for data collection" (Rodgers 2000a, 85).

Setting

In preparing to undertake an analysis using the evolutionary model the researcher has to determine both the "time period" and the "disciplines or types of literature" (Rodgers 2000a,

87) that will be considered for inclusion in the total possible sample. Whilst Rodgers does not give any specific guidelines for choosing the time period she emphasises the importance of the goal of the analysis as directing the choices to be made.

Time period

Children's nursing, in the UK, has evolved since its beginnings in the late 19th Century and during the 20th century a number of government reports, for example The Report of the Committee on Nursing (HMSO 1972), have maintained a belief that children's nursing is different and calls for "special skills" (HMSO 1972, para 283). The present day concept of children's nursing, sits at the end of this evolution and has developed from it. The time period is therefore from the late 19th century to the end of the 20th century. Within this period the greater consideration will be given to the period of Project 2000 the point where there was possibly the largest change in expectations of children's nursing.

Significant sections of the analysis rely on government documents such as policy and reports and the requirements of the various statutory bodies charged with setting the standards for education and registration of nurses. In many cases such publications give decisions and requirements with limited reference to any of the evidence, discussion or debate that informed the decision making process. Some record of the background discussions may be found in the Public Record Office Archives, however records for the period of the most interest, the end of the 20th century are currently closed, many for a period of 30 years. Hence the analysis of some findings is descriptive of what was publically stated or required.

Disciplines

Rodgers states that familiarity with the literature can be used as a guide to determine the disciplines from which data will be drawn (Rodgers 2000a). Such familiarity enables the identification of seven stakeholders (disciplines) and a wide range of types literature for consideration (table 2).

Stakeholder	Type of literature / data source
The Government, through the Department of Health	• Government commissioned reports • Policy documents • Standards for the delivery of health services eg Welfare of Children and Young People in Hospital (DoH 1991) • Acts of Parliament and Statutory Instruments related to nursing regulatory bodies and training. • Health Service Circulars requiring implementation of government policy • NHS Recruitment publicity
The statutory body responsible for setting standards for registration, United Kingdom Central Council (UKCC) (1983-2002) and the General Nursing Council for England and Wales (GNC) (1919-1983).	• Comment and project activity related to changes to education and training of nurses for registration eg Project 2000 (UKCC 1986) • Guidelines for the content of education programmes leading to registration • Statements eg re the nature of nurse education, training and employment
English National Board (ENB), the statutory body responsible for approving and monitoring nursing education programmes (1983-2002)	• Policy • Guidelines and requirements • Curriculum guidelines • Surveys • Monitoring reports • Student recruitment and retention statistics

Stakeholder	Type of literature / data source
Professional associations such as the Royal College of Nursing (RCN)	• RCN Policy documents • Good practice guidance for employers and nurses • Responses to consultations • Commissions eg The Judge Report (RCN 1985)
Pressure groups such as Action for Sick Children (ASC) previously National Association for the Welfare of Children in Hospital (NAWCH)	• Information for parents • Charters • Voluntary guidelines for monitoring and commissioning children's health services
Individual professionals, authors of published papers and those in education, research and practice, in children's nursing and other disciplines	• Wide range of journals • Text books • Research reports • Also social sciences - psychology, sociology
Children and their families.	• Research studies and surveys looking at health care services, staying in hospital and the involvement of the family in the care of the child in hospital.

Table 2 Stakeholders and the potential range of literature available to be sampled

Sample for analysis

Rodgers (2000) outlines the process for determining the total sample of literature from which to select the actual data for analysis. She recommends searches of both computerised and printed databases. A sampling "design" can then be established (Rodgers 2000a, 88), to ensure an appropriate representation from each of the disciplines (stakeholders). Rodgers has a "general guide, at least 30 items from each discipline or 20 per cent of the total population (Rodgers 2000a, 88-89). Rodgers acknowledges that such processes may present the researcher with a large data sample.

Database searches based on a concept such as children's nursing, which has an history of over 100 years, have the potential to create a large data sample from each of the disciplines (table 2). Not all the disciplines considered for inclusion have data that can be accessed through such searches, which do not usually include government policy documents or statutory instruments in their data bases. In such situations Rodgers acknowledges the researcher can use "experience or knowledge" to include "landmark or classic sources" (Rodgers 2000a, 90), which may include those cited by others.

The sampling plan also has to take account of the fact that in determining the attributes of a concept such as children's nursing a number of disciplines (stakeholders) have an influence on each other. In the case of children's nursing, for example, it is the government that creates and enables parliamentary legislation in relation to the statutory bodies and the nature of the education and training required for registration as a children's nurse. The practice of nurses and other health care professionals may also be affected by developments in medical science and technology and research in other disciplines such as psychology. Such findings also influence the professional associations and pressure groups who may lobby for changes in practice. Many of these disciplines also make reference to "classic or landmark" texts (Rodgers 2000a, 90) and the historical base of the concept when writing about children's nursing.

The sampling plan is therefore structured to take account of these influences and the data divided into time bands chosen to reflect milestones in the development of the concept

towards its present characteristics. The use of time bands is an adaptation of the model developed by Rodgers as part of the process within this study to facilitate the management of the data.

The time bands are

- Late 19th Century to the introduction of regulation for nursing in 1919
- 1919 - 1959 from registration to the publication the report of the committee on The Welfare of Children in Hospital (The Platt Report) (MoH 1959), a landmark text
- 1960 - 1990 from the publication of the Platt Report up to Project 2000
- 1990 - 2000 the period when the recommendations of Project 2000 were fully implemented in England

The rationale for the selection of specific data will be included in the findings related to each time band.

"Collect data relevant to identify: a) the attributes of the concept: and b) the contextual base of the concept, including interdisciplinary, sociocultural and temporal (antecedents and consequential occurrences) variations." (Rodgers 2000a, 85).

At this point in the evolutionary model the researcher's purpose is the identification of the attributes, the characteristics of the concept, as they emerge from the data. Rodgers states that this part of the process also identifies data that relate to the "contextual features (antecedents, consequences and sociocultural and temporal variations)" (Rodgers 2000a, 91). Although Rodgers does not explicitly define what she means by the contextual features she outlines the questions that can be asked of the data. Applied to the concept of children's nursing they become:-

Antecedent	What happens before children's nursing occurs?
Consequences	What is happening when children's nursing occurs? What happens after..... or as a result of children's nursing?
Sociocultural/temporal	Are the expectations of children's nursing different in different situations and with different people?

Rodgers believes that the identification of the attributes in this way enables "a *real* definition" of the concept (Rodgers 2000a, 91) and also facilitates identification of situations that are expressions of the concept.

Although labelled as the evolutionary model it is not compulsory to undertake an historical review of the development of the concept on every occasion. The decision to undertake an analysis of children's nursing that included a review of its history was based on a) the fact that it was events in history that set the UK apart from other countries who register their nurses and b) particularly in the later part of the 20th century authors quite consistently refer back to events in the past, such as the Platt Report (MoH 1959) to support arguments based in the present, c) other nurse researchers may not be aware of the events and developments that shaped children's nursing in the UK.

Rodgers lays down a method for organising the literature and assuring a balance between disciplines, based on the usual principles of undertaking a literature review. For this study of

children's nursing influence of some of the identified disciplines will vary between time bands and this needs to be considered within each particular section. There will also be literature that reflects back on an earlier expression of the concept giving new insight into the context of the concept and which therefore has to be considered for inclusion.

"Analyze data regarding the above characteristics of the concept" (Rodgers 2000a, 85)

Rodgers cautions against the possibility of "jumping to conclusions" when undertaking the analysis of the data and the possibility that the researcher may wish to "validate his or her pre-existing views on the concept" (Rodgers 2000a, 94). She also encourages the researcher to delay the final analysis until all the potential data sources have been reviewed as a method of ensuring that all the concept's attributes have been identified. As with any similar approach to a collection of data Rodgers also believes it may be "desirable" to return to elements of the literature (Rodgers 2000a, 95) to look for other emerging attributes or confirm the basis of developing insights. As the process develops "labels" can be identified to describe the various "major aspects of the concept" (Rodgers 2000a, 95).

As the data for this analysis of children's nursing has been time banded there will be emerging themes and labels at the end of each period, with the potential for change over time and for some themes to disappear as new themes emerge from the data. Taking account of the historical context may also demonstrate differing expectations from different stakeholders and the response of children's nursing to developments in knowledge, medical science, the nature and structure of the health service, multi-disciplinary working and child and family

expectations.

"Identify an exemplar of the concept, if appropriate" (Rodgers 2000a, 85)

In the evolutionary method the purpose is to identify exemplars that "illustrate the characteristics of the concept" (Rodgers 2000a, 96). It is important, at this stage of the analysis for the researcher to be aware of any bias that may lead to exemplars that are too specific to particular settings. In other words exemplars should be sufficiently universal so as to be applicable across a range of settings. It is also possible at this stage in the analysis to find that the concept has areas which are still vague and in need of further development (Rodgers 1994).

In undertaking an analysis of children's nursing it should be possible to identify exemplars from a range of published examples. The identification of exemplars may also need to take into account the age range of the child who is the focus of the attributes, as they may be demonstrated differently. For example, if communication was determined to be an attribute, there would be a difference between caring for an infant when the focus of communication would be on the parents and caring for an adolescent where inclusion in discussions about their care may be identified as an attribute.

"Identify implications, hypotheses and implications for further development of the concept." (Rodgers 2000a, 85)

Rodgers states that "one of the most significant outcomes" of using the evolutionary model of concept analysis its ability to create a "solid conceptual framework" (Rodgers 2000a, 99)

and identify other areas for enquiry using a variety of different methods. This approach to concept analysis is not intended to provide the "definitive answer" to questions about the attributes of a concept (Rodgers 2000a, 97). Rather the results of such an inquiry are the starting point for further study which can be undertaken using a variety of different methods and approaches. As a result this understanding of concept analysis should lend itself particularly well to the determination of the attributes of children's nursing.

Table 3 overleaf summaries the evolutionary model of concept analysis and its proposed application to children's nursing.

Stages of Rodgers' model	Action required to apply to children's nursing
"Identify the concept of interest associated expressions (including surrogate terms)" (Rodgers 2000a, 85)	Concept of interest: children's nursing or paediatric nursing Possible surrogate terms include titles and references to parts of the professional register.
"Identify and select an appropriate realm (setting and sample) for data collection" (Rodgers 2000a, 85)	Setting: "time period to be examined and the disciplines or types of literature" (Rodgers 2000a, 87). Children's nursing in the UK started in late 19th Century, changes continue to occur at the time of the study. Sample: "selection of the sample to be used in the research" (Rodgers 2000a, 87) may also include "classic" or "landmark" texts (Rodgers 2000a, 90). A wide range of stakeholders and different forms of literature contribute to describing the concept.
"Collect data relevant to identify: a) the attributes of the concept: and b) the contextual base of the concept, including interdisciplinary, sociocultural and temporal (antecedents and consequential occurrences) variations." (Rodgers 2000a, 85)	Look for definitions, statements that "provide a clue to how the author defines the concept" ((Rodgers 2000a, 91) "Keep in mind the question "What are the characteristics?", "What is happening when (an instant of the concept) occurs?" "What happens before....?" and "What happens after ....., or as a result of (the concept)?" "Is the concept used differently in different situations? By different people?"(Rodgers 2000a, 91)
"Analyze data regarding the above characteristics of the concept" (Rodgers 2000a, 85)	"Each category of data (attributes, contextual information, references) is examined to identify major themes presented in the literature" (Rodgers 2000a, 94). What am I looking for? What are the characteristics of children's nursing?
"Identify an exemplar of the concept, if appropriate" (Rodgers 2000a, 85)	"A practical demonstration of the concept in a relevant context" (Rodgers 2000a, 96). Consider descriptions of practice from published papers and textbooks
"Identify implications, hypotheses and implications for further development of the concept." (Rodgers 2000a, 85)	To be developed when the analysis is completed. Consider possible ways to test elements of the concept.

Table 3 Rodgers' evolutionary model of concept analysis mapped against children's nursing

LATE 19TH CENTURY - 1919

The first time band for analysis is between the late 19th Century and activity leading to the setting up of the General Nursing Councils and the professional register in 1919. During this period there was a change in attitude towards children leading to the belief that sick children required admission to hospital in order to receive appropriate care. Expression of this belief underpinned the building of specialist children's hospitals and the beginning of a specific training for those who wished to nurse children.

Sample selection

The sample for this stage of the analysis was developed through database searches using the phrases:- children's nursing, paediatric nursing, paediatric nursing history, children's nursing history and looking for data sources relevant to the development of British nursing at this point in its history. Searches were also undertaken using the names of both people and institutions that were in existence at this time. These included Charles West, the founder of The Hospitals for Sick Children, Great Ormond Street and Catherine Wood one of the Lady Superintendents and author of some of the first British nursing texts on the nursing of children. Classic texts on the history of British Nursing were also included (eg Abel-Smith 1960).

Findings

Context

At the beginning of this time band one in three children lived to their first birthday (Burr 1989). Children were viewed as commodities owned by adults, and useful as "economic units" (Pringle and Naidoo 1975). Young children were employed in places such as cotton mills, where in 1833 out of 84,000 young people half were under the age of 14, and down coal mines where girls as young as six earned a living (Buchanan 1983). Children who were abandoned or orphaned were cared for in charitable institutions (Pringle and Naidoo 1975) but there were no hospital facilities for children who were sick, partially due to the fear that they would bring in infection (Bradley 1999). Children of the wealthy were cared for in their own homes (Bradley 1999).

With the spread of the "age of enlightenment" from Europe there was a change in society's attitude towards children, no longer viewed as commodities, they began to be seen as the future. With this change came a belief that, when they were ill, they needed specialist medical care and this philosophy led to the beginning of specialist children's hospitals. The first such hospital was opened in Paris in 1802 (Waterhouse 1962; Bradley 1999). England lagged behind these developments having, at that time, dispensaries treating children on an outpatient basis (Miles 1986a). Although the dispensaries had the benefit that children were treated and cared for in their own homes and therefore not separated from their parents there was insufficient supervision of the child during treatment and in the poorer families care was often given by siblings. There was also limited opportunity to undertake the study of the diseases

of children that would take treatment and medical science forward (Miles 1986a).

Dr Charles West is acknowledged as starting to change in this situation in the UK. He was convinced that despite the concerns, related to separating children from their families and the risks of spreading infection by bringing them together, children would be better cared for in a special hospital. West's work led to the opening of the first British specialist children's hospital, The Hospital for Sick Children, Great Ormond Street (GOS) in1852 (Saunders 1982; Miles 1986a; Watt and Mitchell 1995; Parker 1996). As with many hospitals before the founding of the National Health Service (NHS) in 1948 this was a charitable institution supported by philanthropists (Miles 1986a) and as probably the "most frequently researched" specialist children's hospital (Lindsay 2001, 20), is the source of much information about the early days of hospital based care for children.

West's stated purpose for the hospital reflected its philanthropic status, wanting to give care to children whose parents had "no leisure to tend them, no means to administer to their wants" (West 1854, cited Lindsey 2001, 21). To achieve this he set out his aims as being

> "1. To provide for the reception and maintenance and medical treatment of the children of the poor during sickness and to furnish them with advice, that is, the mothers of those who cannot be admitted to the hospital.
> 2. To promote the advancement of medical science generally with reference to the diseases of children and in particular, to provide for the more efficient instruction of student in this department of medical knowledge.
> 3. To disseminate among all classes of the community, but chiefly among the poor, a better acquaintance with the management of infants and children during illness by employing it as a school for the education and training of women in the special duties of children's nursing" (West cited Miles 1986a, 83).

Children considered eligible for admission were to be between the ages of two and twelve suffering from diseases as it was considered that for those below the age of two it was "undesirable to separate them from their parents" (Saxton 1981, 5). Between 1852 and 1890 a total of 38 children's hospitals were founded in the UK (Lindsay 2001), including Bristol, Edinburgh, Liverpool, Norwich, Manchester, Glasgow and Aberdeen and they adopted similar aims to those of Charles West (Downtown 1961; Miles 1986a).

"How to nurse sick children", the textbook used by the nurses at Great Ormond Street (GOS), was published in 1854 by Dr West (Watt and Mitchell 1995), a full five years before Florence Nightingale published her text "Nursing: what it is and what it is not". Although West's text was published in 1854 it was not until 1878 that training for children's nurses became well established, with the appointment of a Lady Superintendent of Nurses, Catherine Wood and nine pupil nurses (Glasper and Charles Edwards 2002a; Miles 1986a). Using the plan that West had set out in his text Wood (1888) stated her belief that "First that sick children require special nursing and second that sick children's nurses require special training" (Wood 1888, 507) and in so doing is credited with having established children's nursing training.

The concept of children's nursing late 19th century - 1919

The management committee, at GOS, set out their requirements in relation to nursing recruits to the hospital and in six papers in *The Nursing Record* Wood outlined her beliefs in relation to the training for and activity of children's nursing. By applying Rodgers' contextual questions to these sources it is possible to determine:-

What happens before children's nursing occurs?

As already described a child would have become physically ill with a disease and their family would not have had the time, knowledge or resources to care for them appropriately.

What is happening when children's nursing occurs?

One of the major characteristics of children's nursing, required by the employer, the requirement for close and careful observation of the child was also required by Wood. She describes the child in need of nursing as being very different from an adult, unable to describe what is wrong, and likely to react in an unco-operative way when strangers try to examine him. The children's nurse has to "always be on the watch for changes in its physical condition" and never leave the child alone (Wood 1888, 507) with the nurse able to "discern and interpret the minute variations" in the child's condition (Wood 1888, 508).

For Wood children's nursing required a mind trained to remember "every particular about her patients" (Wood 1888, 509) being able to report on the actions of medicines, the state of the child's appetite and the child's performance of daily functions. The more senior students were expected to develop the ability to observe symptoms and "reason upon changes" in the children in their care (Wood 1888, 509). Children's nursing also required the nurse to give all physical care to the child, such as feeding and washing, as well as carrying out treatments and the doctors orders.

Wood appeared to appreciate some of the emotional needs of the child that could be met by

children's nursing, stating that "play is as much a part of the treatment as physic" (Wood 1888, 508). She wished wards to have "ceaseless chatter and the careless distribution of toys" as they were "consistent with a well ordered children's ward" (Wood 1888, 508). Children's nursing also required nurses to develop "the mother's instinct, the grand self-sacrifice and self-forgetfulness that are the outcomes of a mother's love" (Wood 1888, 509). These statements can be see as expressing what might be described as the original concept of British children's nursing.

Tawney, a health visitor, started her writing on "The Nursing of Sick Children" stating "I must lay stress upon the differences which we, as nurses, find between the child and the adult" (Tawney 1909, 206). She does not appear to advocate a specialist training for children's nursing, but rather draws attention to the areas of knowledge, in relation to areas such as growth and development, that nurses require when caring for children. She particularly emphasises the importance of telling children the truth in relation to matters such as the taste of medicine, in order to maintain their trust. She indicates areas in which the children's nurse may be required to educate the mothers of children who have been ill. Such a belief reflects that of West who had seen education as one of the aims of his children's hospital. Evidence from some of the provincial children's hospitals, such as Norwich and Sheffield, demonstrates a similar belief in the role that they could play in educating visiting mothers (Lindsay 2001).

In a general statement about nursing as a vocation Hughes, also writing in 1909, mirrors some of Wood's beliefs. She advises those who wish to take up the vocation of nursing that they

would be trained to realise the importance of accuracy, obedience and attention to detail, “regularity, punctuality, consideration for fellow workers” and “ gentleness and sympathy”, accompanied by intelligent obedience to medical instruction” and knowledge of the reason for the doctors orders (Hughes 1909, 95-96).

What happens after ... or as a result of children’s nursing?

There is limited evidence to provide a definitive statement in relation to the expectations of having admitted a child to hospital for nursing. Amongst West’s aim he expressed a desire to

> "1. ..... to furnish them with advice, that is, the mothers of those who cannot be admitted to the hospital.
>
> 3. To disseminate among all classes of the community, but chiefly among the poor, a better acquaintance with the management of infants and children during illness by employing it as a school for the education and training of women in the special duties of children’s nursing” (West cited Miles 1986a, 83).

What he expected from this is not clear. Put into late 20th century terminology this might be considered as an early expression of the role of the children’s nurse in health education and promotion.

Are the expectations of children’s nursing different in different situations and with different people?

At this point in the development of the concept there are a limited number of stakeholders influencing children’s nursing. The main external group were the doctors who required the nurses to follow their instructions.

Table 4 summarises the context of children's nursing at the beginning of the 20th century.

Questions about the context	At the beginning of the 20th century
What happens before children's nursing occurs?	• Children are physically ill • Poorer parents do not have the knowledge or resources to provide the care
What is happening when children's nursing occurs?	• Physical care of the child is provided by nurses • Play is provided for children • Skilled observation and an ability to detect changes in the children being cared for are used • Detection of deviation from normal growth and development is noted • Knowledge of pharmacology is utilised • Children's emotional needs are understood and met through the use of play • Reasons for doctors orders are understand while carrying them out • Mothers receive some education in the care of their child • Substitution of a mother's love for that of the nurse using a mother's instinct
What happens after..... or as a result of children's nursing?	• Parents in particular mothers are educated in the care of their child
Are the expectations of children's nursing different in different situations and with different people?	Doctors • require the nurse to follow their orders

Table 4 The context of children's nursing at the beginning of the 20th century.

The attributes of the concept of children's nursing

Rodgers states that identifying the attributes of the concept "constitute a *real* definition" (Rodgers 2000a, 91). Having reviewed a sample of the literature describing children's nursing in this time band the concept of children's nursing can be defined as follows.

> Children's nursing is the hospital based provision of care for physically ill children of poorer parents, requiring a range of skills and abilities based on a knowledge of children's growth and development and response to pharmacological intervention, it requires the nurse to provide for the child's emotional state through the provision of play, to act as a mother substitute and gain the trust of the child who may be unco-operative and distressed, due to their stage of growth and development and level of understanding and to educate mothers in the care of their children.

A number of personal qualities of the children's nurse also emerge from the literature with the hospital management committee requiring those who would be delivering this first hospital based children's nursing service to have "patience", "a quickness of observation" and the ability to read "writing as well as printing". Those who wished to become children's nurses were also expected to be "acquainted with the principles of Christian religion" and be able to "repeat the Lord's prayer and Ten Commandments". Any one wishing to become a ward sister also had to be able "to write in a legible hand" and despite the impression from some authors that Victorian children's hospitals were not very aware of the needs of children there was "Instant dismissal to be given when a nurse caught striking a child, and also not being able to keep a child happy" (unknown source, cited Saxton 1981, 5)

- some education with the ability to read
- familiarity with Christianity
- an ability to keep children happy
- patience

CHILDREN'S NURSING 1919-1960

Three changes occurred in nursing and health care during the first half of the 20th century. The first was the development and enactment of legislation to regulate the nursing profession in 1919 creating two additional disciplines (stakeholders) who became involved in determining the nature of children's nursing. These were the government, through the development of legislation and secondly the regulatory body charged with creating the register. The second major change came after the Second World War with the establishment of the National Health Service (NHS) in 1948. No longer were children's nurses working for charitable institutions, rather they and the hospitals they worked were absorbed into a national service. Finally in the later part of the time band the understanding of the needs of children was beginning to change, leading to calls for changes in attitudes and practices in the care of children when they were admitted to hospital.

Sample selection

The sample for this stage of the analysis was again developed through database searches using phrases such as: registration, the General Nursing Council, children's nursing, paediatric nursing, children's nursing history, paediatric nursing history and children in hospital. Searches were also undertaken using the names of organisations such as Great Ormond Street Hospital for Children and people such as Bowlby and Robertson. Classic texts on the history of nursing (eg Abel-Smith 1960; Baly 1980), were also used. Copies of government reports such as the Report of the Committee on the Welfare of Children (The Platt Report) (MoH

1959) were also considered.

Findings

The beginnings of registration

The changes and developments that led to registration for nurses are generally viewed from two perspectives. For some (eg Rafferty 1995) it was about reconstruction of the class basis of the occupation and the wish of medical practitioners to gain control over what nurses did. For others impetus came from the lack of standardised training or assessment of capability meant the public and employers were unable to judge the competence of any of those who described themselves as nurses (eg Abel-Smith 1960) and the wish to professionalise nursing (Glasper and Charles-Edwards 2002a). The 1902 Midwives Act, which meant that all midwives had to undergo training and registration with the Central Midwives Board (Baly 1995) and the fact that in the 1901 census, out of 63,500 female nurses in England and Wales, less than half could be considered to have undergone some form of training (Abel-Smith 1960) led to formal proposals for the registration of nurses.

In 1903 and 1904 two bills advocating the registration of nurses were unsuccessfully presented to parliament (Pyne 1982). The government set up a select committee of the House of Commons, including representatives of the principal nursing organisations "that favoured registration" (Arton 1988, 24), that started work in 1905. Each year between 1905 and 1914 bills were unsuccessfully presented to the House of Commons until in 1914 a bill received a majority vote at its first reading only to subsequently be held up by the start of the First World

War (Pyne 1982).

At the beginning of the 20th century training for nurses was directed by the hospitals in which they were employed and varied considerably in expectation and length. Outside of parliament, between 1916-17 the children's hospitals were in discussion about admitting those who had completed a three year children's nursing training onto a supplementary register (Miles 1986b). According to Miles the children's hospitals were also agitating for agreement that nurses on this part of the register would only have to take two years in an adult hospital "for full qualification" (Miles 1986b, 135) an interesting reflection of their possible perception of their status.

In 1919 at the end of the First World War the Ministry of Health was created as part of a package of social reform (Dingwall et al 1988), part of the government plans for post war reconstruction. According to Dingwall et al (1988), although at this time there was no nationally organised health service it was essential for the government to be able to recognise a workforce that would be able to deliver this "new service efficiently" (Dingwall et al 1988, 86). Registration of nurses was seen by the Ministry of Health as an administrative answer to this dilemma and in 1919 following a series of conferences a bill was passed by parliament paving the way for the nursing councils (Baly 1995; Dingwall et al 1988).

What might have appeared as a victory for those who wished for registration was not in fact

the case. Any regulations that the nursing councils may have wished to develop were “subject to approval by the Minister” of Health (Dingwall et al 1988, 88) and unlike the midwives there was no power to make registration as a nurse a pre-condition of employment. The Nurses’ Registration Act established three General Nursing Councils (GNC) one for England and Wales, one for Scotland and one for Ireland. The Minister appointed nurse and lay members of the first council and in December 1919 the bill received royal assent (Baly 1980). Like the midwives before them nurses would now be required to undergo a specific training and registration with a statutory body, the General Nursing Council. The three GNCs were also to be responsible for approving the schools of nursing of which it was estimated there were “about 1500", a very different picture to the 24 centres for medical education (Dingwall et al 1988, 89).

Nursing historians such as Abel-Smith (1960) and Baly (1980), by taking details from contemporary publications, present a picture of argument and dispute amongst different groups of senior nurses about the specific make up of the register. During the lead up to nurses actually registering there had been a lobby for a comprehensive training for registered nurses which would have prepared nurses to care for all types of patients (Arton 1988). There was also a strong lobby, from the powerful matrons of the children’s hospitals, supported by the senior physician from Great Ormond Street Hospital for Sick Children (Arton 1988), for a separate register for children’s nurses.

As the rules set out by the General Nursing Councils (GNC) were subject to approval by

ministers they were able to direct the development the register (Dingwall et al 1988). Claiming that those who wished to bar admission to the register of any but "*bona fide"* nurses had interpreted the Act incorrectly, parliament amended the recommendations of the GNC. The reason for this amendment was that to refuse registration to "a good nurse because she trained in a nursing home or a special hospital, never dreaming she would be under a disability, was cruel and inconsistent" (Nursing Times 1923, 716, cited Abel-Smith 1960, 111).

The registers established by the General Nursing Councils, therefore, mirrored the different patterns of training and hospital provision available at the time. They were

> "1. a general part containing the names of all nurses who satisfied the conditions of admission to that part of the register;
> 2. a supplementary part containing the names of male nurses
> 3. a supplementary part containing the names of nurses trained in the care of persons suffering from mental diseases;
> 4. a supplementary part containing the names of nurses trained in the nursing of sick children
> 5. any other prescribed part" (Baly 1980, 161).

This pleased the children's nurses who wished to continue recruiting members. The development of the supplementary registers also pleased employers as they saw this as a way of reducing movement out of the less popular areas of nursing employment.

The setting up of different registers each with their own training syllabus reinforced the idea of specialist nurses, dividing nurses into those who focussed on the age of the patient, adult (general) and children's nurses, in comparison with mental health and, later, learning

disability nurses who focussed on the nature of the patients' problem. It also set the UK apart from other countries, a pattern maintained today. The register which had opened for admissions in 1921 listed 10,887 General Nurses and 191 Sick Children's Nurses by 1923 (Arton 1987).

The first council for England and Wales consisted of members appointed by government with two experienced children's nurses in their number (Arton 1988). It was members of this group who had responsibility for setting syllabuses for training. The initial syllabus for sick children's nursing and the requirements for a three year programme were published during 1921-22 (Bendall and Raybould 1969). The potential variety in training lengths was removed and from this point there was an national standard of expectation in relation to the subjects that nurses would be taught and the ways in which they were examined both in practice and theory.

The changing register

The Nurses Registration Act established the principle of a registered nursing workforce. The initial legislation was developed and amended throughout the 20th century in response to a variety of forces. At each point of change the legislation has remained subject to the approval of government ministers, the same people that were concerned with the delivery of health services.

Changes to the register in the 1940s resulted from government concerns over nursing

shortages and standards, a concern that has carried through to the present day, and the profession's concerns about the status of the qualified nurse. Pyne (1982) in his brief account of the history of the GNC highlights the fact that during the 1930s nursing journals had started to make reference to the need for assistant nurses, although no formal action was taken at that time such nurses started to find employment in those hospitals that were suffering staff shortages. At the start of the Second World War the Ministry of Health appealed for nurses to join the Civil Nursing Reserve and Baly notes that amongst those volunteering were "3000 assistants and 20,000 auxiliaries" (Baly 1980, 180). The Ministry of Health faced a dilemma in that there was no set standard for assistant nurses and a third grade of nurse had appeared - the auxiliary.

According to Abel-Smith there was support for formally recognising assistant nurses as they were often employed by hospitals through agencies who charged more for their services than the employers paid registered nurses (Abel-Smith 1960) and there was no set standard for assistants. The Royal College of Nursing (RCN), a professional association, was also concerned about the effect of the "unqualified" nurse on the profession and the fact that many students from the three year course left part way through their training to become higher paid assistant nurses. As Baly notes there was also a real dilemma for those in charge of hospitals, in that between 1941 and 1943 out of 11000 students who qualified only "*400 entered permanent hospital employment"* (Baly 1980, 182). The Horder Report commissioned and published by the RCN made recommendations a number of which were taken up by the government and made into the Nurses Bill 1943.

This new legislation enabled a second route to qualification as a nurse. The General Nursing Council was made responsible for maintaining a Roll of Assistant Nurses and following the recommendations of the Horder report three parts of the Roll were established. The qualification and title Enrolled Nurse was established. Abel-Smith notes with interest that these new parts of the register also coincided with areas of nursing "shortage" (Abel-Smith 1960, 171) general (adult), mental and learning disability nursing. The educational standards required for entry to the enrolled nurse programmes, the length of the programme and the level of learning and assessment were lower than for full registration. There were no Enrolled Nurses for children's nursing and although the rationale for this is not known, it may be that there were no shortages or that general nurses were being employed to nurse children to make up the shortfall. This creation of the enrolled nurses, according to Dingwall (1986), did not solve the dilemma of recruitment shortages or the costs of employing nurses following the establishment of the National Health Service on 5th July 1948.

Changes in health care and attitudes to children

Authors in the 1950s reflect changing patterns of child health. In 1911 22% of childhood deaths had been due to tuberculosis and by 1955 this had dropped to only 2%. Deaths from infectious diseases had fallen while deaths from cancer had increased from 1% in 1911 to 15% in 1955 (Griffith 1957). The length of hospital stays for children was, on average, 15 days in 1959.

Whilst the health of children was changing, attitudes to children in hospital had become

somewhat set. Child care experts of the 1920s and 1930s advocated "mechanistic" approaches to bringing up children (Connell and Bradley 2000, 33). This approach stressed the importance of strict schedules for caring and as little handling of the child as possible, so they "would learn to amuse themselves" (Connell and Bradley 2000, 33). There was also a strong belief that children adjusted better to hospital without family visits (Connell and Bradley 2000). This coupled with the beliefs that visitors would increase the risk of cross-infection (Burgess 1988; Burr 1989) and that nurses knew best how to care for a sick child (Burgess 1988) led to very limited visiting for children in hospital, as can be seen in surveys from the late 1940s, just after the start of the NHS.

Surveys of the visiting times in some London hospitals showed the following:-

> *"Guy's Hospital* Sundays 2-4
> *St Bartholomew's* Wednesday 2-3.30
> *St Thomas' hospital* first month no visits, but parents could see children asleep between 7-8pm
> *London Hospital* under three years old, no visits, but parents could see children through partitions. Over three years old, twice weekly."
> (Munro-Davies 1949 cited Robertson 1989, 8)

Following the Second World War, John Bowlby an acknowledged "expert in child psychiatry" (Alsop-Shields and Mohay 2001, 52) was asked by the United Nations to investigate the impact on children of separation from their parents, a situation that had existed for millions of children during the war. Bowlby published his findings and so doing produced a theory of attachment and separation and the impact of separation from the maternal figure on the future mental health of children. Although his work is criticised for lack of rigour, being based too much on institutionalised children and ignoring the role of carers other than mothers, it has

continued to influence discussion throughout the later part of the 20th century (eg Hall 1978; Alsop-Shields and Mohay 2001, 51).

James Robertson, a psychotherapist from the Tavistock Institute of Human Relations in London, also undertook work in relation to the separation of children from their parents. His film "A two year old goes to hospital", followed two year old Laura's 8 day stay in hospital. This "Classic film showing the suffering of a little girl in hospital" (Robertsonfilms 2003) was televised in 1953. Released at a time when parental visiting of children was extremely limited and children were separated from their parents "sometimes for weeks on end" (Miles 1986b, 136) it created a sense of unease (Burr 1989). Robertson's work was important because it demonstrated that, rather than settling down after a few days in hospital as health care workers believed, children went through a number of stages, "protest, despair and denial" (Robertson 1970, cited Hall 1978, 28) and that disturbed behaviour, as a consequence of these periods of separation may occur on the return home. The establishment in the form of paediatricians and children's nurses "vilified" Robertson when he went around the country showing his films, claiming that the film had been selectively edited and the nurses prevented from playing with Laura (Darbyshire 1994, 3).

In 1952, at the same time as Robertson was releasing his film, the General Nursing Council appeared to be taking account of similar developments in understanding of the role of psychology in the care of patients. They made additions to the syllabuses for both general (adult) and sick children's training, requiring the inclusion of psychological and sociological

aspects of life, the "human behaviour in illness and social aspects of disease" (Bendall and Raybould 1969, 181). Requiring students to learn about

> *"The basis of mental health* Security in the mother-child relationship, security in the family situation; love, consistency, discipline and freedom, recognition and praise. *Mother and child.* Beginnings of capacity to form human relationships, sucking, mothering, weaning, toilet training, effects of separation from the mother, rejection and over protection" (GNC 1952 cited, Robertson 1970, 119).

As a response to an increasing understanding of the role of parents in the care of their sick children integrated SRN/RSCN courses of training started in 1954 (Glasper and Charles-Edwards 2002b). This enabled nurses to qualify as State Registered Nurses (SRN), who cared for adult patients, as well as Registered Sick Children's Nurses (RSCN). These integrated programmes were developed against a background of discrimination against those who were only qualified children's nurses. Such singly qualified nurses were often unable to achieve promotion without the additional SRN qualification, a situation exacerbated by the recommendations of the Platt Report published in 1959 (see below), and additionally the Royal College of Nursing would not, at that time, allow them to become members (Glasper and Charles-Edwards 2002b). On reflection it seems strange that those involved in setting out such educational arrangements considered that including the care of a sick adult as part of a children's nurse's training would give them an insight into the role of the normally healthy family with children

At about the same time, and partly as a consequence of the work of Bowlby and Robertson and an increasing attention to the concerns of the consumers of the health service (Hawker 1985), the government called for a change to the arrangements for visiting children in

hospital. The Ministry of Health wrote twice to hospital management committees "recommending an increase in visiting facilities, but to little effect" (Robertson and Robertson 1989, 8). Details of parental visiting, published in the Nursing Times in March 1952, demonstrate the limited extent to which hospitals had embraced the concept of parental visiting (table 5). The rationale for the different approaches to visiting, such as avoiding upsetting the children, for the convenience of the parents but also for the medical and teaching staff present an interesting reflection of attitudes that people such as Robertson were determined to change (Pringle and Naidoo 1975).

Hospital	Visiting arrangements
Evelina Hospital for Sick Children, London	6.15pm to 6.45 pm weekdays 2pm-3pm Sundays Evening chosen as it was the time when children miss their parents most and is convenient for fathers. Also as a teaching hospital for doctors and nurses the wards are free of teaching rounds in the evenings (Wilcock 1952).
St Thomas's Hospital London	Two afternoons each week 2pm-3pm. Children admitted for tonsillectomy usually only stay 3 days so parents discouraged from visiting "because we find that these children barely have time to settle down and the visit of a mother or father is distressing to them" (Brown 1952, 259)
The Royal Liverpool Children's Hospital	Country branches - previously visiting one day a month, now weekly, two adults for one and half hours City branches - half an hour each week, parents could still see the ward sister for half an hour each day (Sabin 1952)

Table 5 Visiting times in some hospitals in 1952

In 1956 the government set up a committee to

"Make a special study of the arrangements made in hospital for the welfare of ill

> children ... and make suggestions which could be passed on to hospital authorities" (MoH 1959, para 1)

Their report acknowledged the role that Robertson's work in taking forward the work of the committee, in particular the BBC broadcasts of Robertson's films, had stimulated a large amount of correspondence to the committee (MoH 1959). This work along with a "growing readiness" to understand children's emotional needs, combined with the fact that the introduction of the NHS had given everyone access to health care and therefore created consumers, appear as the driving forces behind setting up the committee.

The "Platt Report", taking its name from Sir Harry Platt chair of the committee, was published in 1959 (MoH 1959) and has since been described as a "milestone" (DoH 1991, 1). The main focus of the committee's report was on welfare issues related to children in hospital and amongst many recommendations the report is best known for advocating the need for parental visiting, that children should be cared for on children's wards and that there should be education and play for children in hospital. The committee also recommended that more account should be taken of "the child's emotional and mental needs" (MoH 1959, 3) and that the education and training of those involved in caring for children should take this into account.

The Platt Report stated that children should be cared for by children's nurses and stated that the nurse in charge of the ward should be both "a Registered Sick Children's Nurse as well as SRN" (MoH 1959, 10). The rationale for this particular recommendation was not

published but it reinforced the career potential for those who had undertaken the integrated course (SRN/RSCN), as in hospitals where the recommendations were implemented they were eligible for promotion, a route potentially now closed to those with a single children's nursing qualification. The Platt report failed to recommend that all those involved in nursing children should be children's nurses (Smith and Long 2002).

The publication of the Platt Report led Jane Thomas, a mother, to write to James Robertson, for advice on how to encourage hospitals to implement the recommendations. Following his advice local groups of Mothers for Care of Children in Hospital were set up eventually merging to become the pressure group NAWCH, the National Association for the Welfare of Children in Hospital (Swanwick 1983; Action for Sick Children 2003). In 1962 NAWCH undertook a survey to "dispute government figures on unrestricted visiting to children's wards" which remained the focus of its campaigning through until 1986 (Action for Sick Children 2003, 1).

Although the Platt Report (MoH 1959) made reference to a range of health care professionals (radiographers, physiotherapists and lab technicians) who would be involved in the care of children in hospital there was no sense of a multi-professional team working directly together. The developing role of other professions involved in the care of children in hospital is reflected by the committee's reference to occupational therapists. Their preliminary training qualifying them "to a certain extent to organise play and recreation", while they were seen as being involved with individual children with little time to give to instructing "other helpers

in this important aspect of care" (MoH 1959, 11).

The Platt Report was also influential in other areas and is seen as leading to the introduction, in 1960, of an experimental programme leading to registration as a children's nurse for those nurses who were already SRNs and who wished to move into children's nursing or gain the appropriate qualification. This route to a second registration eventually became the main route into children's nursing until 1989 when the changes, introduced following the implementation of "Project 2000 - A new preparation for practice" (UKCC 1986), re-established a direct route into children's nursing. The rationale for the development of such a programme is not explained. The inference of such a decision is that there were significant numbers of non-children's nurses caring for children, particularly at the level of ward sister, therefore failing to meet the recommendations of the Platt Report (MoH 1959).

Children's nursing 1960

As this element of the analysis is focussed on the development of the concept, the suitable level of detail was determined through reading accounts of practice. These reflect the actuality of children's nursing better than the bland regulations or training curricula which may speak in idealised terms.

<u>What happens before children's nursing occurs?</u>

Children become ill and require medical or surgical treatment or nursing care that cannot be provided by the family or at home. Everyone is entitled to free health care as part of the

National Health Service, which is funded by the government, and therefore if needing hospital treatment will be admitted as an emergency case or from a waiting list for treatment.

What is happening when children's nursing occurs?

As can be seen from the outline analysis of the context in which children's nursing existed between 1919 and 1960, the focus of hospital care was on the physical needs of the child. Textbooks and nursing registration examination questions of the time underline this aspect of children's nursing, with questions such as

> "Write notes on:-
> (a) undescended testes;
> (b) prolapse of the rectum;
> (c) nasal catarrh;
> (d) knock knees." (GNC 1958)

set in the state examination, taken at the same stated time across the whole country. It is also of interest that among the members of the panel that set these state examination questions for nurses there were doctors, a situation that would not have been reversed for medical examinations.

Descriptions of nursing practice portray children's nursing as being undertaken within rigid daily routines and the allocation of specific tasks to be completed, rather than named children to be cared for thus ensuring that children did not become too attached to their nurses (Hawthorn 1974). In using this system, known as task allocation, children's nursing was no different to adult nursing of the time. Burgess (1988) in describing a typical day of the 1940s and 50s writes about children dressed in nightclothes, staying in bed and not being allowed

up to play until the afternoon with the children ready for bed by 5pm with lights out at 7. She also describes the "anxiety of parents" waiting to be let into the wards to look at their sleeping children (Burgess 1988, 69).

The rigidity of attitudes of nurses to children being visited in hospital is also found in popular literature. Darbyshire quotes from Margaret Drabbles novel "The Millstone" published in 1965 and set in a period of the "late 1950's-early 1960s" (Darbyshire 1994, 4) where a nurse explains to a mother wishing to visit her baby daughter that

> "I am afraid that for such small infants we don't allow any visiting at all. We really do find that it causes more inconvenience to staff and patients than we can possibly cope with. ... you must understand that it is of no practical use to visit such a young child" (Drabble 1965, 148-149, cited Darbyshire 1994, 4).

Other nurses, reflecting back on their experience, describe rounds of cleaning, preparation of bread and butter and baby feeding. At Great Ormond Street, one of whose original aims had been the education of mothers, up until the 1950s parents were only allowed to visit on Sundays. When daily visiting was instituted it was at tea time so that the parents could "help them clean their teeth" (Anon GOS 2003). Other writers describe the children's nurse of this period as "possessive" (Morgan 1967, 1711), substituting themselves for the parents, from whom the child may have been separated for up to a year (Morgan 1967, 1711). In places where restricted visiting was allowed there would be the hectic round of preparation, getting the children ready and the doctors rounds completed.

It can also be seen from commentary in later periods (eg Hawthorn 1974) that changes to the GNC syllabus that had been required in 1952 in relation to inclusion of learning on psychological and sociological aspects of life had failed to impact on the care of children on the wards. Hawthorn in her study started in 1968, 16 years after the curriculum change revealed a "fundamental lack of knowledge among the nursing staff of the children's emotional needs" (Hawthorn 1974, 184).

The introduction of the one year route to enable SRNs to undertake their RSCN training would imply that in some situations children were also being nursed by non-children's nurses.

What happens after ..... or as a result of children's nursing?

Robertson's work on children undergoing separation from their parents, as a result of experiences such as admission to hospital, leads to the conclusion that some children would have been traumatised. Following such experiences there would have been a period of disturbed behaviour or return to patterns of behaviour from earlier developmental stages (Robertson 1970). The parents of children diagnosed with long term medical problems, such as diabetes, must have received some form of training to enable them to continue the care of their child, how this would have been managed is not explicit.

Are the expectations of children's nursing different in different situations and with different people?

The standards for children's nursing were now nationally set by the General Nursing Council,

who in their syllabus required nurses to learn about

> *The basis of mental health* Security in the mother-child relationship, security in the family situation; love, consistency, discipline and freedom, recognition and praise. *Mother and child.* Beginnings of capacity to form human relationships, sucking, mothering, weaning, toilet training, effects of separation from the mother, rejection and over protection" (GNC 1952, cited Robertson 1970, 119),

however in practice nurses and doctors appeared to do everything possible to ensure that this learning did not enter into the practice in hospital.

The practice of children's nursing in 1960 has changed from that of 1919 and children's nursing can now be defined as follows:

> Children's nursing is the hospital based provision of care for physically ill children, requiring a range of skills and abilities based on a knowledge of children's growth and development and response to medical intervention. Children's nursing is routinised and rigid in its application and focussed on the completion of tasks, done to children who are separated from their parents, who are prohibited from visiting them. Children's nursing is regulated by a statutory body whose assessment requirements are focussed on the medical care of children.

CHILDREN'S NURSING - 1960-1990

This time band in the development of children's nursing in the UK covers a period between the publication of the "milestone" (DoH 1991,1) of the Platt Report (MoH 1959), through changes to the way in which parents were involved in the care of their children in hospital and to a point just before reshaping of pre-registration nursing education through Project 2000 (UKCC 1986; HMSO 1989). This time band also saw additional disciplines contributing to the shaping of children's nursing. In 1983 there were changes to nursing's statutory body with the emergence of national boards, one for each of the four countries, and lobbying and campaigning of the National Association for the Welfare of Children in Hospital (NAWCH) focussed particularly on parental visiting. By the end of this period children were also increasingly receiving care from nurses based in community settings

Sample selection

As with the preceding time bands searches were undertaken using a variety of terms including:- Project 2000, parental visiting, children's nursing, paediatric nursing. As, has already been stated, as the UK has an almost unique position in relation to registration as a children's nurse, the focus was on British texts.

Rodgers states that the researcher may use "experience or knowledge" related to the concept to guide the inclusion of "classic texts" (Rodgers 2000a, 90). As the researcher had undertaken her own training in children's nursing in 1980-1981 and was involved in clinical

practice and teaching children's nursing her personal experience and familiarity with the literature were used to guide data collection.

Findings

Government reports and policy

In 1970 the Secretary of State for Social Services announced the appointment of the Committee on Nursing. Their terms of reference reflected concerns about the training of nurses and midwives and how future workforce requirements of the health service could be met. The committee were required

> "To review the role of the nurse and midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service" (HMSO 1972, v).

The report, which became known as the Briggs Report after its chairman, was published in 1972 (HMSO 1972). The committee made recommendations covering issues such as reorganisation of the statutory bodies and educational programmes to measures for ensuring the continued staffing of the NHS, through increased recruitment of men and mature students (HMSO 1972). Almost as an afterthought the committee recommended possible changes to the statutory bodies for nursing, midwifery and health visiting.

The proposals for education maintained a register of two levels, with the first level, (certification) being completed within 18 months and the second level (registration), for the more able being completed after a further 18 months (HMSO 1972). From the way in which the statistics are reported it is difficult to determine the rationale for some of the committee's

findings and recommendations. However, of particular importance to this study is the committee's stated belief in the importance of paediatric nursing and their recommendation that, those so interested, "could take a substantial part of the course for the certificate in a children's hospital" (HMSO 1972, para 284) to work in a field of practice they described as requiring "special skill" (HMSO 1972, para 283).

"Hospital Facilities for children" (DHSS 1971), published during the time that the Committee on Nursing was debating its recommendations, gives an impression of a government unhappy with the extent to which previous recommendations relating to the care of children in hospital had been implemented. Apparently acknowledging a shortage of children's nurses the government recommends that "The nurse in charge ... should wherever possible be a registered sick children's nurse" (DHSS 1971). There are no figures published in this report but the statement that

> "any nurse who is in charge of a children's unit who is not specially trained ..... is given the opportunity ... if she so wishes, for post-registration training leading to the qualification of RSCN" (DHSS 1971, para 4d),

appears to imply that the government was concerned that not enough people were taking or being allowed to take this route to additional qualification, recommended by the Platt Report in 1959 (MoH 1959).

Four years after Briggs "Fit for the future: Report of the Committee on Child Health" known as the Court Report, was published (HMSO 1976). Described as another milestone (DoH 1991, i), its task was to review

> "the existing health services for children, judge how effective they are for the child and his parents, and to propose what the new integrated child health service should try to achieve and how it should, therefore, be organised and staffed" (HMSO 1976, 1).

The committee took written evidence from 138 organisations and 123 individuals and visited services providing care for children. They presented a picture of a country with over 1 million children in single parent families, 6% of children undergoing hospital admission annually with 18% of those receiving care on adult wards, only 50% of wards with unrestricted visiting and a focus on ill health rather than promoting health. They described a health service in which there was a disregard of government policy in that only "41% of registered and 22% of enrolled nurses working on children's wards had paediatric qualifications" and "an extra 700 RSCNs were needed immediately" (Hutt 1981, 1537).

Like many other government reports evidence for the findings and recommendations the committee made is not explicit, however, they repeated the call for children to be nursed by children's nurses and stated that such training should "further their understanding of a child's emotional, educational, social, psychological and physical needs" (HMSO 1976, 4) and include experience in community settings. The committee highlighted the fact "That hospital admission can be psychologically highly stressful for children" (HMSO 1976, para 12.40) and put forward measures, such as pre-admission visiting that could be implemented to help reduce the stress of waiting list admission. The committee especially highlighted their belief that *"children have special needs which they cannot articulate for themselves and that society has therefore a duty to ensure that these are identified"* and addressed (HMSO 1976, para 16.19). In as much as any such report could be described as slating the implementation of

previous policy this committee seemed angry that previous government recommendations had not been implemented and that there were "unacceptable deficiencies" in health services for children (HMSO 1976, para16.19). Like other similar reports this one fails to offer a clear distinction between children's nursing and other branches of nursing. The underlying theme appears to be that children have special needs and therefore require nurses that have been trained in a special way. The training of other professionals involved in the care of children, "physiotherapists, occupational therapists, speech therapists, dieticians" (HMSO 1976, para 18.64), was seen as possibly being behind that of other groups as "the need to examine the paediatric requirements of their discipline has only just begun" (HMSO 1976, para 18.64)

The Court Report findings were echoed in other studies such as that undertaken by the National Association for the Welfare of Children in Hospital (NAWCH). Despite both the Platt report and the DHSS circular in 1971 NAWCH was able to highlight the limited visiting allowed to children undergoing surgery, with particular problems in ear, nose and throat wards (ENT) which were usually adult environments. In their 1975 survey of 800 wards NAWCH found only 19% where 24 hour visiting was allowed and only 76% of wards where visiting was generally available on the day of a child's surgery. The situation in adult ENT wards, where many children received care, was worse with 57% of those wards not allowing children to be visited before surgery and 70% not allowing visiting after surgery (NAWCH 1977).

Robertson the producer of the film "A two year old goes to hospital" laid the blame for the failure to implement policy firmly with paediatricians and particularly nursing sisters and

tutors who "had neither the competence or the empathy" to cope with the new 1952 children's nursing syllabus (Robertson 1970, 119-120) that promoted acceptance of children's reliance on their families. Robertson blamed the GNC for not taking vigorous action to extend the training of nurse tutors and ward sisters and for in fact reducing the emphasis on learning about children's needs in the 1964 syllabus, in which "the word 'mother' no longer appears" (Robertson 1970, 121). Although he did not produce any evidence he claimed that nurse tutors, teaching about the nursing of children may have had "only eight weeks on a children's ward during general training" (Robertson 1970, 122). Robertson put his finger on the dilemma that any similar healthcare policy faces, in that it is only policy and it can not be enforced as "it is not possible to legislate on matters of professional judgement" (Robertson 1970, 100-101).

Hawthorn in her study "Nurse I want my Mummy" (Hawthorn 1974) had started collecting observational data on 9 children's wards in 1968. She concluded her findings "revealed a fundamental lack of knowledge among the nursing staff of the children's emotional needs" (Hawthorn 1974, 184). Ten years after the publication of the Platt Report Hawthorn claimed that some of the nurses in the study did not know why it had been recommended "that parents should either be able to live in with their young children or be able to visit them at any time" (Hawthorn 1974, 184). Whilst this was only a small study with seven days of observation in each setting combined with Robertson's work it reflects children's nursing in the 1970s as failing to move forward and lacking understanding of children and their needs. It is not known how much studies such as these would have influenced the findings of the Court Report and

its concern about children's special needs.

Although children's nursing during the 1970s may be portrayed as failing to take forward a range of recommendations it is also worth noting that the focus in all these reports was on the emotional needs of the child and their family. What these reports failed to address was the sociological impact on both health care workers and parents. For the nurses there was a withdrawal from some of the caring role when the parents were visiting and for some parents at least a sense that they had to stay with their child even though they may have preferred to go home (Hall 1978).

Allen and Murrell give an example of the theoretical preparation of general nursing students for their experience on a children's ward during the 1980s, part of the statutory requirement to have "a background understanding of paediatrics" (Allen and Murrell 1978, 172). In a typical example from one of the 8 sessions the student were required to undertake there was a continuing emphasis on the medical aspects of the care of children.

> **"Session V**
> Disorders of the gastro-intestinal tract, abnormalities of stools and vomit.
> *Resources*
> *Books* Diseases in Infancy and Childhood
> Essentials of Paediatric Surgery
> Baby Surgery
> *Cassettes/slides* Coeliacs
> Pyloric stenosis operation" (Allen and Murrell 1978, 173).

Other textbooks on nursing, intended for the general nurse, include sections related to the same experience on a children's ward. In a typical example, "Modern Nursing" (Hector 1976)

evidence of a need for nurses to understand of the role of parents in the care of the child in hospital is starting to emerge. Writing about the impact this has on the nurse Hector indicates that involving the parents in care changes the nurses' role, in that they become the people who only do the unpleasant things "like injections" (Hector 1976, 469).

Textbooks for children's nursing students and qualified nurses were also beginning to change during the 1970's and moving away from a strong medical focus, as the dust cover of Bates "Practical Paediatric Nursing" (1971) a classic children's nursing text of the time states "No attempt has been made to include disease processes. This book is essentially a nursing companion.." (Bates 1971). Bates also demonstrates a changing approach to the role of parents

> "A mother is usually the best person to understand and tolerate the behaviour of her own child, well or sick. When the task becomes beyond her scope, additional support of alternative arrangements have to be made" (Bates 1971, 85).

She also highlights that not all areas of healthcare were in line with the recommendations of the Platt Report (MoH 1959) stating "even today, less enlightened people restrict visiting" (Bates 1971, 88).

Although moving away from the medical focus the notion of the multi-professional team working together had not yet found its way into nursing texts such as this. For example Bates' discussion of physiotherapy for children focusses on what the nurse can do "in her (sic) absence" (Bates 1971, 406). Occupational therapists are discussed under the heading of "recreation" (Bates 1971, 93) and the social workers' role appears to focus purely on the

provision of financial assistance to parents. Bates also dedicates twenty two pages to children's nutrition without any mention of the role of the dietician.

During this period there were changes in the routes to qualification as a children's nurse. Singly qualified children's nurses were finding it increasingly difficult to gain employment and many were going on to undertake their SRN to "maintain their career prospects" (ABPN 1984, 3). The GNC for England and Wales decided to discontinue the three year route to children's nursing with the last intake in 1976, leaving the combined SRN/RSCN route or a one year programme after achieving the SRN as the route to qualification as a children's nurse. These combined courses themselves ceased in the early 1980s meaning that anyone who wished to enter children's nursing had to take the one year post registration programme. Within the statutory requirements for registration this development effectively turned any route to registration as a children's nurse into a four year training. Although this would appear to be a totally different position to that of any of the other registrations, which took only three, any nurses on these other registers who wished to gain a second registration would also have had to complete programmes totalling 4 years.

"The Report of the Committee on Nursing" (HMSO 1972), the Briggs Report, apart from recommending changes in nursing education had also proposed changes to the regulatory bodies for nursing and midwifery. In what Trevor Clay, the then general secretary of the Royal College of Nursing, described as an "eleventh hour dash" (Clay 1987, 73) before parliament was prorogued in 1979, legislation to bring changes to the statutory bodies was passed through

parliament. The Nurses, Midwives and Health Visitors Act 1979 (HMSO 1979) set up five new bodies. The General Nursing Councils and nine other bodies involved in midwifery, health visiting and post registration education in England, Wales, Scotland and Northern Ireland were replaced by a new statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and four National Boards, one for each country (NMC 2003b).

Clay (1987) presents a picture of the profession "split" by rivalries and "engrossed .. in tearing itself apart" and failing to sort themselves out before the act reached parliament (Clay 1987, 74), a situation that mirrored events leading up to the initial act setting up registration in 1919. Clay quotes one source as saying "I don't think we can in future afford to put our professional destiny quite so naively in the hands of the politicians" (Clay 1987, 74).

From the commentary of Dingwall et al (1988) it would seem that such infighting amongst the profession played into the hands of the civil servants in the Department of Health and Security. Dingwall et al claim that for the civil servants the 1970s were a good period for "this kind of legislative housekeeping" (Dingwall et al 1988, 213), and at a time when the government did not have a clear parliamentary majority such politically uncontroversial changes "could be kept on the shelf" ready for use (Dingwall et al 1988, 213). In the NMC history of self-regulation the statutory body has a different view of these changes seeing a government with a lack of will to find time for the legislation (NMC 2003b).

The Nurses, Midwives and Health Visitors Act 1979 (HMSO 1979) gave the United Kingdom Central Council (UKCC) the role of setting the "standard, kind and content" of programmes leading to registration, along with the function of setting training rules and competencies. The National Boards had, amongst other roles, the role of giving approval to courses of training for nursing, midwifery and health and ensuring that such courses met the requirements of the UKCC in relation to standards and content. Although the act received royal ascent in 1979 the new statutory bodies worked in shadow, developing policies, procedures and bringing together the functions of the preceding organisations until the transfer of statutory functions was completed in 1983. The UKCC like the GNC before it was funded by the registrants, the National Boards were funded by their different departments of health and were required to report to these departments on an annual basis.

1980s

Legislation, enacted to come into power at the same time as the UKCC took up its statutory functions, set out the requirements for programmes leading to registration. These requirements were entirely different in form from the previous arrangements. No longer were there prescriptive syllabi or detail (ENB 1985b), instead there was a list of competencies that were required for registration to be achieved "related to the care of the particular type of patients with whom she *(sic)* is likely to come in contact" (HMSO 1983a, 10) and therefore applicable to adult, children, mental health and learning disability nursing. This change built on the requirements of the EEC Nursing Directives, developed initially by the GNC, following its publication in 1977 (Quinn 1978). This move to expressing nursing through competencies was

described as “totally in line with changes being instituted in educational courses in other professional disciplines” (ENB 1985b, 4). Such legislative change is required to pass through parliament and its is unlikely that the government of the day would sponsor legislation that they did not feel fulfilled the requirements for staffing its health services.

A number of the requirements of the rules for registration, which became known as Rule 18, demonstrated the role of the nurse at this point in time. They were expected to gain the competence to “recognise situations that may be detrimental to the health and well-being of the individual”, a shift from a purely illness focus for nursing. The requirements also took the elements of the nursing process, a four stage approach to planning patient care and enshrined them in statute by requiring nurses to be competent in skills such as “carry out .... the comprehensive assessment”, “devise a plan of care based on the assessment”, “implement the planned programme”, and “review the effectiveness of the nursing care provided” (HMSO 1983, 10). There was also the requirement that nurses would be competent to “work in a team with other nurses and with medical and para medical staff and social workers” (HMSO 1983, 10), the role of the nurse in the multi-professional team was beginning to emerge. This requirement was also very clear in the ENB guidelines explaining the aims of the RSCN programme (ENB 1985a).

The inclusion of the nursing process in statutory requirements mirrored changes in clinical practice, where the implementation of this approach to the planning and delivery of care was being taken forward. Textbooks of this period, for example Lewer and Robertson (1983), were

also laid out using this approach. Instead of chapters entitled "Alimentary tract disorders" (Weller 1981), the child was moved to the centre of thinking with chapters such as "Nursing the acutely ill child and the child admitted for surgery" (Lewer and Robertson 1983).

Guidelines on the sick children's nursing programme produced for curriculum developers in 1985 set out the English National Board's (ENB) expectations in relation to the content of programmes leading to registration as a Registered Sick Children's Nurse (RSCN), now known as Part 8 of the Professional Register (HMSO 1983a). The ENB stated

> "there are major and important differences between providing nursing care for children and for adults. Firstly it must be accepted that children are children before they are patients and that their care must be provided within an appropriate environment and in a suitable style; secondly that ill health and/or separation from home may adversely affect growth and development." (ENB 1985a, 1).

These guidelines for the one year programme were intended to "enable the Registered General Nurse to become competent in the care of the child and their family. The five aims of the programme could be described as being the difference between the nursing of the physically ill adult and the physically ill child. There was also a requirement for the general nurse to gain experience with and learn about children who were handicapped. The general nurse was expected by the end of this 53 week programme to

> "Acquire the knowledge, practical skills, attitudes and competencies required to
> - assist parents to promote the healthy growth and development and to provide care for those who are sick;
> - recognise situations that may be detrimental to the health and well-being of infants, children and young people;
> - assess, plan for an provide effective care within an appropriate environment and in a suitable style for infants and children who are sick;
> - work in a team with the family and other nurses, medical and paramedical staff, social workers, school teachers and those responsible for play;
> - undertake the management of care of a group of sick children over a period of

time and organise the appropriate support services" (ENB 1985a,1)

The statutory focus was on growth and development, health promotion and care developed and delivered through the use of the nursing process. The role of the children's nurse in the multi-disciplinary team was also central.

Alongside these statutory developments there was continuing shortage of children's nurses. The government was so concerned that in 1980 the DHSS commissioned a study by the Institute of Manpower Studies to find out where the children's nurses were. The first stage, mailing all the RSCNs on the GNC register, was followed by more detailed study of a smaller sample, looking at qualifications (Hutt 1984a), likes and dislikes about the profession (Hutt 1984b), issues and problems (Hutt 1984c) and recommendations for the future (Hutt 1984d). Having completed this survey Hutt noted "A reluctance of managers to employ RSCNs in hospitals" (Hutt 1984c). Over twenty years after the Platt report and almost 10 years after the Court Report nursing managers without the RSCN qualification were described as "dismissive".. "they thought it of no importance and felt that anyone with an SRN could look after children" (Hutt 1984c). Hutt as part of this work developed a list of job attributes covering all aspects of the "job" (Hutt 1984b), identified through the use of repertory grid techniques. This is one of the few research based approaches to the activity of children's nursing.

Studies and commentary published during the 1980s continued to highlight concerns about the care of children and their families when they needed hospital care. For example Harris

(1981a, b, c, d, e) in a series of papers based on a study of 60 parents and children undergoing a short hospital stay for surgery (tonsillectomy or orchidopexy) highlighted parental concern over the lack of information with which to prepare their children (Harris 1981a). Further concerns of parents related to only being allowed to visit their child for an hour after an orchidopexy, and being unable to visit those children who had undergone tonsillectomy (Harris 1981b) due to staff concerns that a crying child might have a post-operative haemorrhage. (Harris 1981c). Finally in looking at the training of children's nurses Harris saw what she describes as deficiencies in the GNC curriculum, with what she states is limited required learning in relation to the needs of children (Harris 1981e). Interestingly Harris also notes that 18 years after the recommendation from Platt that the ward sister should have both SRN and RSCN qualifications, in 1981 only 57% of ward sisters did (Harris 1981e).

Children's nursing textbooks of the 1980s, as a data source, can be seen as presenting an idealised view of children's nursing and its connection with children's needs and those of their families, with phrases such as "a basic premise of the book is that the awareness of the needs of the individual child is as important as the assessment of his disease" (Adamson and Hull 1984, preface). Many texts of this period start with a focus on the normal children and their growth and development, references to government policy in relation to unrestricted visiting and the need to involve parents in care (eg Adamson and Hull 1984; Lewer and Robertson 1983), advocating the best practice.

This advocation of good practice, however, did not always carry through into actual practice

as publications from 1984, 1987 and 1988 demonstrate. For example a survey, entitled "Where are the children?" (Caring for Children in the Health Services 1987), examined regional statistics for children in hospital in England in 1984. The survey reported that 25% of children were still nursed in adult wards, and that district health authorities unable to provide details of where RSCN staff actually worked. In 1987 Fradd drew attention to a "new campaign" to "alert nurses and other staff to the importance of involving parents in the care of their children" (Fradd 1987, 16) again coming many years after the initial recommendations. Changes in attitudes to the visiting arrangements for children do not appear to have reached all areas as Lewer's 1988 text demonstrates when she states "some paediatric wards still restrict visiting after operations such as tonsillectomies" (Lewer 1988, 49).

Nursing texts also demonstrate a developing awareness of the team of professionals who could be involved in the care of children and their families. In 1981 Weller's anglicised version of the American Lippincott Manual of Paediatrics (Weller 1981) makes no reference to any other members of the health care team. Whilst by 1988 Lewer stresses that "communication must be just as effective between these different disciplines as it should be with the parents and children" (Lewer 1988, 50).

Other changes in children's nursing were also starting to emerge in the 1980s, with the development of children's community nursing services and a change from thinking only about the care of sick children to thinking about and promoting child health (Robbins 1987).

Defining children's nursing - 1990

Again a definition of children's nursing at this point in its development is facilitated through the use of the four questions that Rodgers recommends.

What is happening before children's nursing occurs ?

Children required nursing care for the same reasons as previously, either as an admission from the waiting list or as an emergency. Some children who had already undergone treatment or who had a long term problem may be discharged from a hospital setting to receive care from nurses in the community. For some children and their families contact with children's nursing may come from an identified need for health promotion and education.

What is happening when children's nursing occurs?

As previously, children's nursing requires the application of specific knowledge and nursing skills to the care of children who have undergone some form of medical treatment (ENB 1985a). Children's nursing, as with other branches of nursing is being expressed in terms of broad based competencies and the child's need for care is assessed using the nursing process (ENB 1985a). Children's nursing occurs in a hospital setting where there is nearly always access for their parents (ENB 1985a) and for some children that care may continue following discharge back into the community.

Children in hospital, increasingly, have access to play facilities and, probably to the disappointment of some children, schooling (ENB 1985a; Hutt 1984b). Nurses may give less

direct care or only be involved in those aspects of care that parents are unwilling or unable to undertake for their own child (eg Lewer and Robertson 1983; Hutt 1984b). Increasing understanding of the impact of admission to hospital on children means that more nurses are becoming involved in developing services such as pre-admission programmes (Price 1991). Understanding in other areas of care, such as the management of children's pain is also improving (Price 1990). Children's nursing is part of a multi-disciplinary approach to the care of sick children (ENB 1985a; Hutt 1984b; Lewer and Robertson 1983).

Children's nursing also involved the education and training of parents, particularly those whose children had long term or potentially life threatening problems, in the medical and nursing aspects of their child's treatment. Success in these areas of care increased the families independence and could reduce the requirement for regular admission to hospital.

What happens after .... or as a result of children's nursing?

Although all children would have been affected by being admitted to hospital the increasing use of pre-admission processes, the involvement of parents in care and shorter stays in hospital would have reduced the long term impact on the child's growth and development. For some families the fact that they could care for their child in the home setting with support from community nurses had the potential to improve their quality of life and reduce the impact on siblings.

Are the expectations of children's nursing different in different situations and with different

people?

The statutory expectations of children's nursing are now expressed in terms of broad based competencies. While the government is concerned that there are not enough children's nurses some non-RSCN nursing managers see little need for this specific qualification (Hutt 1984c).

Children's nursing in 1990 can therefore be defined as follows

> Children's nursing is the delivery of competency based care to physically ill or handicapped children and their families in either hospital or community settings. Children's nursing uses a range of skills and abilities adapted to the individual child and based on a knowledge of growth and development and a child's response to illness and treatment. The practice of children's nursing increasingly involves working within the multi-disciplinary team educating and involving parents in the care of their children.

CHILDREN'S NURSING 1990-2000

The 1990s saw one of the largest changes in nursing education since the introduction of registration in 1919. Work begun by the statutory body the UKCC, in the mid 1980s, to review nursing and midwifery training had reached the statute book in September 1989 putting into place a new way of training, at the higher level of Diploma of Higher Education and by 2002 almost half the registered children's nurses would have qualified through this route. Other changes during this decade were the relocation of nursing and midwifery education into institutions of higher education, increases in medical knowledge and the use of technology.

Sample selection

As with previous time bands searches were undertaken using a variety of terms including:- Project 2000, children's nursing, paediatric nursing. Again the researcher had been involved in nursing education at the start of this time band moving in 1995 to employment within the statutory processes for nursing and specifically children's nursing. As such the researcher's personal experience and familiarity with the literature was used to guide data collection, particularly in relation to statutory instruments and guidelines which do not appear in the standard literature searches.

Findings

Education - "Project 2000 A new preparation for practice" (UKCC 1986)

The Briggs Report (HMSO 1972), apart from recommending changes to the statutory bodies, had also proposed changes in the structure of nurse training. In 1984 the UKCC had taken the lead role for the statutory bodies (Green 1995) in setting up "Project 2000 - A new preparation for Practice" (UKCC 1986) and taking forward the work started by Briggs. The project team were to

> "determine the education and training required in preparation for the professional practice of nursing, midwifery and health visiting in relation to the projected health care needs in the 1990s and beyond and to make recommendations" (UKCC 1986, 3).

The project group of 20, the vast majority of whom were from nursing and midwifery education, were funded by the UKCC and a small research grant. There was also a representative of the government health departments. There were "criticisms" (Bradshaw 2001, 33) over the fact that nurses from clinical practice were not included in the project group. The group undertook over 40 formal meetings across the four countries of the UK and received responses from over 200 groups or individuals to proposals put forward in a series of project papers.

Reviewing and critiquing every nuance of the process that Project 2000 went through would be counter productive to this analysis of the statutory statements of what children's nursing is. As with many such government or statutory publications the rationale for changes are seldom fully detailed and from the point in time of the approval of the new legislation and approval of the new programmes there is no alternative route to registration. The main focus is therefore in the changes for those who wished to become children's nurses.

At the same time as the UKCC was undertaking its work in relation to Project 2000 the Royal College of Nursing (RCN) set up its own independent commission on nursing education (RCN 1985), publishing "The Education of Nurses: a new dispensation" (RCN 1985), known as the Judge Report, before the UKCC's recommendations in relation to Project 2000. In reviewing the position of nurse training in the 1980s, where students were employees and educational needs and patterns were subservient to the needs of the service the RCN commission concluded that people of an appropriate quality would not come forward to enter nursing unless things changed. Like the UKCC's later report the Judge Report proposed a three year programme leading to registration. The RCN commission proposed that the first year would be a foundation common to all students. Following this there would be opportunity to be educated in areas of specialism. In the third year it would be possible, amongst other options to take a paediatric programme. The rationale for maintaining different areas of practice at the point of registration is not explicit within the RCN report.

The UKCC proposals were for a common foundation programme, followed by a branch programme, which in the initial proposals also included midwifery, meaning all nursing students irrespective of their eventual branch specialisation would initially receive a common nursing education. The programme leading to registration would be both theoretical and practical, in institutional and non institutional settings "embedded in health not in illness" (UKCC 1986, 46). The final report "Project 2000: A new preparation for practice" (UKCC 1986) maintained a register for children's nursing with the statement that "There is no doubt that the nursing of children is a special area" (UKCC 1986, 49). The project team's reasoning

being for this decision being

> "that all children have specific age related needs and today's changing patterns of illness and disease in children and changes in family life give rise to complex emotional and behavioural problems" (UKCC 1986, 49).

The proposals were put out for public consultation and Sheila Barlow, vice chair of the Project 2000 working party and Director of Nursing Education at GOS, invited comments on the proposals stating that

> "people who understand the needs of children will be relieved to find within the proposals put forward by the Project 2000 working party recommendations that children require nurses with specific skills and knowledge to provide adequately for their care" (Barlow 1986, 61).

The use of the phrase the needs of children, as used in this statement, reflects back to reports such as Court (HMSO 1976) and in this way "needs" becomes almost a shorthand which requires no explanation, needs are something that are assumed, understood and agreed.

The changes proposed in Project 2000 were intended to enable preparation for the next century and as such were predictive, an attempt to change the focus of nursing away from the institutional settings towards the community. The rationale for not changing the United Kingdom's preparation for registration to a generic preparation as undertaken in other countries was later described, in pragmatic terms, as being based on questions of "whether a generic practitioner would be competent across the range of settings" (UKCC 2001, 22) and concern that employers would "misuse" the generic practitioner (UKCC 2001, 22). In 1986 there had also been concern that "a lack of professional development for generic nurses, particularly in mental health, learning disabilities and children's nursing, would have negative

effects on standards of care" (UKCC 2001, 22). It is impossible to determine the level of any government influence or pressure that may have been used to ensure that the new legislation, based on the Project 2000 proposals, met the needs of government policy in relation to the staffing of the health service. It is difficult to see a government that issues policy stating that children should be cared for by children's nurses making it even more difficult to combat the continuing shortages of appropriately qualified nurses.

Although the UKCC had undertaken a process of consultation with the public and the profession details of the internal debate, discussion and decision making processes leading to the changes in pre-registration nursing education were not published. As previously, changes in the requirements for programmes leading to registration required approval through parliament following a process of drafting and consultation by government lawyers, ministers and their civil servants. When the Nurses, Midwives and Health Visitors (Registered Fever Nurses Amendment and Training Amendment Rules) Approval Order (HMSO 1989) came into force the new statutory instrument established an 18 months common foundation programme followed by an 18 month branch programme (HMSO 1989).

As with the 1983 statute the requirements were stated in broad terms to be applied "to meet the nursing needs of individuals and of groups in health and in sickness in the area of practice of the branch programme" (HMSO 1989, 5), and expectations of the students' achievement had moved from competence to "outcomes". The new statutory instrument (HMSO 1989) did not just create change for children's nursing, through the re-introduction of a three year route

to registration as a children's nurse, there were also changes for mental health and learning disability nurses, as their previous three year programmes had in effect to be shortened to take account of the new statutory requirements for a common foundation programme. Nurses on all parts of the register were required to gain "the ability to function effectively in a team and participate in a multi-professional approach to the care of patients and clients" (HMSO 1989, 5).

In order to facilitate curriculum development and change to the new programmes the UKCC published "UKCC requirements for the content of Project 2000 programmes" (UKCC 1989), a circular that made the requirements explicit and stated that the Common Foundation Programme should:-

> "prepare the student to demonstrate: knowledge of the core subjects to a specified standard; application of core knowledge and skills during supervised and specified experience in practice settings related to patients and clients of different age, gender, class, disability, race, culture and creed in a variety of settings, with individuals, families, groups and communities; the development of problem solving, communication, observational caring and assessment skills and the application of these to responsible decision making" (UKCC 1989, 3).

The requirements for the branch programmes in adult, child, mental health and learning disability nursing had both common and distinct areas of knowledge and practice in the four branches, such as the use of nursing process terminology, nursing models and health promotion. The child branch became Part 15 of the UKCC professional register and once again became the same length as other programmes leading to an initial nursing registration. The new programmes were at a minimum of Diploma of Higher Education and although Project 2000 itself did not directly move nursing into higher education the requirements for

diploma level preparation meant that schools and colleges of nursing were required to establish links with both higher education institutions for access to teaching staff for pure physiology, psychology and sociology and systems for approving the credit worthiness of programmes (ENB 1993a).

In England the new programmes were rolled out over a period of about five years as the government released funding and the ENB gave approval to the new curricula. The initial 13 demonstration sites chosen for the implementation of these new programmes started admitting students in September 1989 with the first diplomates eligible for employment from summer 1992. There was initial anticipation that the days of children's nurses needing to be both adult and children's registered would be passed, however, concerns expressed at the time the first students were eligible for employment indicated that this might not be the case. As Fradd in her discussion of the "Evolution of the RSCN" stated "I am aware of students ... debating a second branch programme because local managers have indicated a reluctance to employ them" (Fradd 1992, 310).

To facilitate the development of the new programmes the English National Board (ENB) published "Creating Lifelong Learners: partnerships for Care" (ENB 1994a), guidelines for those involved in curriculum development in which the statutory requirements were translated into "Indicative content" for each of the four branches (ENB 1994a, 19). To give approval to such programmes the ENB required demonstration of the way in which the required theoretical and practical content would be covered in the curriculum, for example through the

presentation of a mapping of the curriculum against the UKCC and ENB requirements (ENB 1996, 1997).

As with similar projects the ENB process for development of the indicative content used a steering group and working group approach, involving representatives of practitioners, educationalists and officers of the Board. The publication also acknowledges the contributions of a substantial number of individual contributors to the final publication. Materials developed by the working group were also scrutinised by critical readers, representing the full range of stakeholders prior to their publication. The indicative content set out different requirements in relation to each of the branches of nursing which clearly demonstrated a range of expectations (Appendix 1).

Comparison of the requirements for the RSCN programme as made explicit in the ENB guidelines published in 1985 (ENB 1985a) with the requirements for the Project 2000 child branch programme published by the ENB (ENB 1994a) demonstrate that although the programme length had changed and the academic level had been raised there was limited change in the statutory expression of children's nursing. There was an acknowledgement of general changes in health care in relation to issues such as quality, audit, the need for life long learning and the increased complexity of technological nursing. There was also some modernisation of the phraseology and reference to more recent developments such as "the study of genetics", legislation related to child abuse, research, working within health care and skills required for and budgeting and contracting within health care (ENB 1994a, 19). The

really major change brought about by the implementation of the Project 2000 recommendations was the expectation that student learning would take place both in hospital and the community (UKCC 1986).

Figures published in the early 1990s give a picture of the world the child branch nurse would enter. Nearly 10% of children under the age of 5 “were admitted to hospital at least once in 1990" (Woodroffe at al 1993, 45) with an average stay across all admissions of 2 days, a figure that had slowly decreased over time (Action for Sick Children 1993). Figures gathered by Action for Sick Children also showed an increasing trend in the number of children admitted to hospital as day cases, almost doubled between 1987 and 1989 (Action for Sick Children 1993).

In 1994 the UKCC Professional Advisory Service was responding to queries from employers related to whether Project 2000 nurses could work with people outside of the area of registration (UKCC 1994). Interestingly, in their response, the UKCC used the example of a children’s nurse who would be able to give care to children in an Accident and Emergency department and give care to other patients under the supervision of an appropriately qualified nurse. It might be considered disappointing that this example was not turned around to consider the adult qualified nurse working with children an occurrence that was likely to be far more common.

In England the ENB were concerned about the shortages of children’s nurses and the impact that this would have on the training and supervision of students during their clinical

placements. The English National Board (ENB) although not able to require the employment of nurses with particular qualifications could set requirements for the environments in student nurses and midwives undertook their training. In 1988 the ENB echoed concerns from earlier reports (eg Hutt 1983) in stating:-

> "The Board has been concerned about the lack in paediatric units of sufficient numbers of Registered Sick Children's Nurses who are required for the supervision of learner nurses gaining experience in these units and for the provision of appropriate nursing care for sick children" (ENB 1988, 1)"

In 1989, 1992 and again in 1994 the ENB issued of circulars under the heading of

> "Guidelines for the shortened course for registered general nurses with experience in paediatric nursing leading to admission to Part 8 of the Professional Register" (ENB 1989a; 1992a; 1994)

Initially these guidelines had been seen as having a short life, however there was a continuing need to extend their life and the last reissue of the circular in 1998 also made reference to Adult nurses, being those qualified under the Project 2000 rules (ENB 1998d). The rationale for reissuing and updating these guidelines was based on a continuing demand from hospital managers for children's nurses to enable them to meet the recommendations set out by the Department of Health (ENB 1994). Between 1993 and 1997 3679 general nurses took either the shortened or one year route to registration as a children's nurse (ENB 1997a).

In 1997 the ENB "Standards for the approval of higher education institutions and programmes" (ENB 1997) underlined the importance of working within the multi-disciplinary team, for all nursing and midwifery programmes. The standards, against which all programmes were approved and monitored required "curriculum design and development

within an interprofessional/multi-agency and multi-cultural context" (ENB 1997, 24). The final report on achievement of these standards, issued before the closure of the ENB in 2002, demonstrated the increasing extent to which programmes were being delivered and managed within a multi-disciplinary context. In 1999/2000 the standard had been met by only 15.6 per cent of programmes rising to 81.4% in 2000/2001 (ENB 2002a).

During this decade the government also published its recommendations for the care of children in hospital. Launched in 1991 with the aim of bringing together good practice on meeting the "special needs of children" (DoH 1991, 16) in hospital "Welfare of Children and Young People in Hospital" (DoH 1991) made the recommendation, but critically not the requirement, in relation to the staffing of children's wards that

> "there are *at least two* Registered Sick Children's Nurses (RSCN) (or nurses who have completed the child branch of Project 2000) on duty **24 hours a day"** (DoH 1991, 33).

This appears to reflect the need for children's nurses to direct care which is somewhat less than all children being cared for by children's nurses. Burr (2001) describes the civil servant responsible for this publication as being under pressure to reduce this standard to one RSCN. Although the reason for this is not clear, it might be concluded that with the ongoing shortages of children's nurses (HMSO 2001) the government knew that it would not be able to meet its own target.

In 1993 the National Audit Commission undertook a review to "To investigate why (the well established principles for the care of the child in hospital) are not being met" (HMSO 1993,1). The report "Children first: A study of hospital services" (HMSO 1993) again highlighted the

shortages of children's nurses on the wards and noted that

> "The skills required to nurse the child are different, such as observation techniques and psychological support are different involving parents in care requires special skills in teaching and support" (HMSO 1993, 19).

The report highlighted a lack of strategies for the development of children's services and the need for these to be developed and the fact that despite government policy, in the centres of excellence visited by the National Audit Office, "Most wards are at times during the day staffed with only one RSCN or occasionally none at all" (HMSO 1993, 20)

In 1992 the Royal College of Nursing published "Paediatric Nursing - A philosophy of care" reprinted in full in the second edition of "Standards of care - paediatric nursing" (RCN 1994). In this philosophy the RCN "asserts the right of all children in all settings to be nursed by appropriately educated staff" (RCN 1994, 62). In setting such a standard for care the RCN, supported the recommendations of the DoH (DoH 1991) and stated that a children's nurse "should be on duty at all times in children's wards and departments" (RCN 1994, 9). Also as part of the Department of Health "initiative to improve children's services" (RCN 1994a, vii) the RCN published a framework for the development of Paediatric Home Care teams. Within the framework there was a clear statement that "Key providers of paediatric home care must be paediatric nurses with community training" (RCN 1994a, 21). The RCN, as a professional association, while it has the role of advocating what it considers to be best practice, has no authority to ensure compliance with its policies.

In 1996 Action for Sick Children published a "Quality review"(Hogg 1996). The review,

which built on previous work (Hogg 1989), brought together government policy and standards for the care of children in both hospital and community settings and linked to the DoH recommendations in relation to two children's nurses being on duty. As an independent audit tool, which carried no obligation for completion, it was not intended to provide a global picture of the state of the NHS, rather provide opportunity for organisations to measure themselves against published standards and expectations.

The concept of children's nursing 1990-2000

As with previous sections of this analysis there are a significant number of data sources describing what children's nurses do and Rodgers questions will be used to frame the context of the definition of children's nursing at the beginning of the 21st century.

What is happening before children's nursing occurs?

There is a threat to a child's developmental potential (UKCC 1989; ENB 1994) caused by a short or long term problem requiring care from a multi-disciplinary health care team of which children's nursing is one element (UKCC 1989; ENB 1994). The threat may be met by health education or promotion (UKCC 1989; ENB 1994), medical or nursing intervention which at least initially is beyond the capability of the family to deliver. The threat may be managed either in an institutional or non-institutional setting ie in hospital or in the child's home (UKCC 1989; ENB 1994).

What happens when children's nursing occurs?

Children's nursing utilises a range of "special skills" (HMSO 1993, 19) to meet the "special needs of children" (DoH 1991, 16; Barlow 1986; Price 1994). Using these skills children's nurses undertake an assessment of a child's nursing requirements using a knowledge of normal growth and development, this threat to development and the impact of any health care intervention. The planning and implementation of this package of care also considers the extent to which the child, if old enough, and the family wish or are able to be involved. Children's nursing may require the application of a range of technological or educational skills (HMSO 1993; Lawrence 1998; ENB 1994), may occur in either a hospital or a community setting such as the child's home and there may also be opportunities for health education and promotion.. The children's nurse may feel that they are required to act as the child or family's advocate (Long 1991). Children's nursing takes place within a multi-professional team approach (HMSO 1989), which is subject to change and development and new roles emerge (ENB 1994a).

What happens after .... or as a result of children's nursing?

The threat to children's growth and development is either mitigated or removed. For children who have a long term need for health care, both they if old enough and their parents will have been equipped with the skills and knowledge to take forward their care, knowing when it would be appropriate to seek professional assistance or advice. Health education and promotion has the potential to change the behaviour of children and their families, potentially reducing the need for professional health care and increasing the likelihood that they will

reach their full potential.

Are the expectations of children's nursing different in different situations and with different people?

In keeping with the DoH recommendations (DoH 1991) a qualification in children's nursing is not mandatory for employment nursing children. In some settings the nursing care of children may be directed by a children's nurse either in charge of the team or working some distance away. For some parents the extent to which they were able to be involved in their care may be surprising, either due to the lack of negotiation with the nurses, or from a lack of previous experience with a child requiring some form of care outside the home (Darbyshire 1994). Although with the increase in day surgery (Action for Sick Children 1993) some parents may have limited expectations of children's nursing, those families with children with a need for ongoing care may build up strong personal relationships with their children's nurses.

Children's nursing at the beginning of the 21st century can be defined as follows

> Children's nursing is the delivery of nursing care following an assessment of the child and based on their special needs. Children's nursing occurs in a range of settings as part of a multi-disciplinary package of care and where possible involves the child and parents in the planning and delivery of that care. Children's nursing utilises a range of specific technological, psychological and educational knowledge and skills to

ensure that children's needs are met and they are able to achieve their potential.

Conclusion

The final stage in the evolutionary model of concept analysis is the identification of "directions for further inquiry" (Rodgers 2000a, 98) achieved through the exploration of the implications. To this point this analysis has used a range of materials from a number of disciplines to develop a definition of children's nursing, exploring in outline its evolution and its essential elements no matter where it is practised.

A specific training for children's nursing came into being at the end of the 19th century as the practical expression of a belief that children were different and needed nurses with a specific set of knowledge and skills to meet their needs. Children's nursing has developed since that time and at the beginning of the 21st century there is still a specific part of the professional register for children's nurses because of the belief, stated in reports and government policy that children have special needs. The next stage in the development of this concept is to seek clarification of what indeed these special needs are, how they are different from the needs of other groups who require nursing and what impact they have on the nature of children's nursing.

THE NEEDS OF CHILDREN

Sections of this chapter have been published as

Price, S. 1994. The special needs of children. *Journal of Advanced Nursing* 20, 227-232

INTRODUCTION

The assumption underlying children's nursing in the United Kingdom, as demonstrated in the previous chapter of this study, is that children have special needs and that is why they require specially trained nurses. As already stated in the discussion of the Project 2000 proposals (67 onwards), the phrase special needs appears to be used almost as a shorthand, something that everyone should understand. Analysis of government reports and statutory documents, however, demonstrates that there are a range of different areas in which children may have needs, on occasions described differently at different times by the same body (table 6 below).Without a clear definition of the concept of children's needs and the way in which they are special, it is difficult to ensure that all those involved in discussing them have the same understanding of how they may be affected and appropriately met when a child has a need for nursing (Rodgers 2000a; Walker and Avant 1995).

The evolutionary model of concept analysis and the special needs of children

When Rodgers' evolutionary model of concept analysis is mapped against possible data sources for an analysis of the special needs of children, the requirement that the different contexts of the concept under analysis should be considered is found to be a suitable process

to move the definition of special needs from, what may be described as the normal child, to the child who is receiving nursing care, the focus of this study (table 7, 94).

"Identify the concept of interest associated expressions (including surrogate terms)" (Rodgers 2000a, 85)

As can be seen from the examples below (table 6) a number of different government reports (MoH 1959; HMSO 1976) and statutory publications (ENB 1985a; HMSO 1989; ENB 1989) make reference to a variety of needs of children.

Need	MoH 1959	HMSO 1976	ENB 1985a	HMSO 1989	ENB 1989
Physical	X	X	X	X	
Psychological		X	X	X	X
Social		X	X	X	
Emotional	X	X			X
Physiological					X
Intellectual			X		
Educational	X	X			
Spiritual				X	

Table 6 The different needs of children (Price 1994, 229)

Although Rodgers states that the emergence of what might be described as a range of terminology for the concept under review may complicate the process of analysis (Rodgers 2000a) the intention in this analysis is to produce a definition that can in practice be applied

to all areas of need, a definition that is specific in its expression of the way in which the need for an individual child may be special, no matter which disciplinary perspective. Rodgers also states that there may be a range of surrogate terms in the literature under review that give rise to ideas that are the same or close to the concept. The term "children with special needs" is used to refer to children who have been assessed as having particular learning difficulties under the provision of the Education Act 1981 (DoH 1991). These special needs, as a result of learning disability are not those under analysis. In the context of this study and the further development of the concept of children's nursing the focus of analysis is the "special needs of children".

"Identify and select an appropriate realm (setting and sample) for data collection" (Rodgers 2000a, 85)

The goal of this analysis is to define the way in which children's needs are special. As table 6 has already demonstrated there are a potentially wide range of different disciplines that contribute to the overall study of children's needs. There are also a range of nursing texts that apply the findings from the different disciplines to the care of children of different ages when they are in hospital. The sampling plan will, therefore, take account of the fact that within a study such as this it is not possible to be totally exhaustive and capture every nuance of all the different disciplines findings and expressions of the needs of children, as to attempt this would be to rewrite a developmental textbook rather than develop a working definition.

The time period and sample will therefore focus on the later part of the 20th century, as being concurrent with the developments in children's nursing that led it from being focussed on

routine and rigid patterns of care (see 50-51) and ignoring the role of parents to the more family centred practice of the beginning of the 21st century (87-88).

"Collect data relevant to identify: a) the attributes of the concept: and b) the contextual base of the concept, including interdisciplinary, sociocultural and temporal (antecedents and consequential occurrences) variations." (Rodgers 2000a, 85)

Rodgers proposes a number of questions that can be asked during this stage of the analysis. As can be seen, asking these questions will enable the impact of admission to hospital on children's special needs to be elucidated and considering the sociocultural context will ensure consideration of the different ages of children.

Antecedent	- What happens before children's special needs are met?
Consequences	- What is happening when children's special needs are met? -What happens after .... or as a result of meeting children's special needs?
Sociocultural/temporal	- Are the expectations of meeting children's special needs different in different situations and with different people?

The researcher's familiarity with the literature and the preceding analysis of children's nursing both highlight the importance of considering the consequences of not meeting children's needs. Such consideration will also assist in determining the specialness of these needs.

"Analyze data regarding the above characteristics of the concept" (Rodgers 2000a, 85)

As discussed previously (see 21) Rodgers cautions against jumping to conclusions too early in the analysis and failing to allow the concept's characteristics to "emerge from the data"

(Rodgers 2000a, 94). As there are a range of disciplines with the potential to contribute data that will facilitate the analysis of this concept it will be essential to determine the main themes from each, before drawing conclusions. If the definition of the concept is accurate and applicable to the context of children's nursing, it should also be applicable to the different disciplinary perspectives of children's needs (table 7, 94).

"Identify an exemplar of the concept, if appropriate" (Rodgers 2000a, 85)

If the concept has been adequately defined it should fit children from across the different age ranges. The identification of examples of the concept applied to children of different ages can be facilitated by the use of examples from nursing texts.

"Identify implications, hypotheses and implications for further development of the concept." (Rodgers 2000a, 85)

Having defined what is special about children's needs within the context of children's nursing, the next stage in the process is to determine what implications this may have and areas for further research.

Stages of Rodgers' model	Action required to apply to the special needs of children when they need nursing
"Identify the concept of interest associated expressions (including surrogate terms)" (Rodgers 2000a, 85)	Children's special needs when they require nursing
"Identify and select an appropriate realm (setting and sample) for data collection" (Rodgers 2000a, 85)	Setting: "time period to be examined and the disciplines or types of literature" (Rodgers 2000a, 87). Late 20th century. Sample: "selection of the sample to be used in the research" (Rodgers 2000a, 87) may also include "classic" or "landmark" texts (Rodgers 2000a, 90). A wide range of stakeholders and different forms of literature contribute to describing the concept. For example:- nursing theorists, needs theorists
"Collect data relevant to identify: a) the attributes of the concept: and b) the contextual base of the concept, including interdisciplinary, sociocultural and temporal (antecedents and consequential occurrences) variations." (Rodgers 2000a, 85)	Look for definitions, statements that "provide a clue to how the author defines the concept" (Rodgers 2000a, 91) "Keep in mind the question "What are the characteristics?", "What is happening when (an instant of the concept) occurs?" "What happens before....?" and "What happens after ....., or as a result of (the concept)?" "Is the concept used differently in different situations? By different people?"(Rodgers 2000a, 91)
"Analyze data regarding the above characteristics of the concept" (Rodgers 2000a, 85)	"Each category of data (attributes, contextual information, references) is examined to identify major themes presented in the literature" (Rodgers 2000a, 94). What am I looking for? What are the characteristics of children's special needs?
"Identify an exemplar of the concept, if appropriate" (Rodgers 2000a, 85)	"A practical demonstration of the concept in a relevant context" (Rodgers 2000a, 96). Consider descriptions of practice from published papers and textbooks
"Identify implications, hypotheses and implications for further development of the concept." (Rodgers 2000a, 85)	To be developed when the analysis is completed. Consider possible ways to test elements of the concept.

Table 7 Rodgers' evolutionary model of concept analysis mapped against the special needs of children when they need nursing

Findings

Rodgers' four questions related to the "contextual base of the concept" (Rodgers 2000a, 91) structure the findings of the analysis of the concept of the special needs of children within the context of children's nursing. As the findings related to the concept of children's nursing demonstrated, the answer to the question "What happens before children's special needs are met?", the antecedents of this concept, was demonstrated by researchers and campaigners such as Bowlby and Robertson. They argued that children's needs were not understood or being met, during experiences such as being cared for in hospital, leading to them being damaged by the experience, at least in the short term (Robertson 1970; Robertson and Robertson 1989).

The findings from the data, that demonstrate the consequences of meeting children's special needs can be divided into four areas. Understanding what is happening when their needs are met is based on a knowledge and understanding of growth and development and the nature of childhood. The impact of not meeting children's needs is demonstrated by data focussing on factors that may either help or hinder the achievement of an individual child's potential. Support for inclusion of data from these two areas and the link to the care of children when they are admitted to hospital comes from the importance that data, particularly in the form of nursing textbooks, place on students' understanding this area of the study of children. Such data sources also highlight the role that knowledge of factors such as age variations in normal pulse and respiratory rates and the impact of immaturity of physiological systems on medical treatment regimes such as fluid replacement play.

Rodgers also requires the researcher to consider the sociocultural and temporal perspective when analysing a concept. As already stated this requirement enables the definition of children's special needs to be focussed, particularly, on when they require nursing. Data sources presenting an understanding of human need can be mapped against children's needs and the impact of hospital admission on the potential for the child and family to be able to meet them.

Growth and development

The study of human growth and development has a range of dimensions (Wong 1995, 106), including both quantitative change ie growth and qualitative change ie development and the achievement of the person's potential (Sinclair and Dangerfield 1998). Sinclair and Dangerfield describe human growth and development as having a "unique pattern" being different from other mammals" (Sinclair and Dangerfield 1998, 2). Although the focus of this analysis is on children, up to the age of 18, it is recognised that elements of growth and development will continue and change over the whole of a person's life time (Orem 1991). UNICEF in its publication "First Call for Children" (UNICEF 1990) sets out a framework in which this growth, development and achievement of potential can be achieved. UNICEF states that children should be able to have contact with both parents, the rights of "association" (UNICEF 1990, 51) and access to education which will enable "the development of the child's personality, talents and mental and physical abilities to their fullest potential" (UNICEF 1990, 60).

The study of growth and development is usually divided into three areas, physical, intellectual and psycho-social. Physical growth and maturation are in most cases empirically tested and the findings based on simple measures such as weight and measurement. It is clear from table 8 (102) that physical growth is an important element of childhood and that it can be considered in a number of ways. The first element of physical growth relates to size (Sinclair and Dangerfield 1998). Such growth occurs within a recognised range of parameters, though these may change over time due to a number of factors. For example Hall in his account of the development of new growth charts reports that the previous standard the Tanner-Whitehouse chart is now out of date (Hall 1995). Citing the increases in breast feeding and the developments in artificial feeding Hall proposes that the accepted formula that the average baby gains between 140g (5oz) and 196 (7oz) per week in the first three months of life (Illingworth 1991) has changed with even more rapid growth in the early period, followed by "deceleration" (Hall 1995, 583). Such expectations of average normal growth and development enable the development of standardised charts against which serialised measurement and charting of the children's weight and height gain can be measured and monitored with a view to taking action if there is deviation from the anticipated norm.

The development of standardised measures also enables identification of areas where environmental and genetic factors may have an effect on children's growth. For example work on growth carried out in Liverpool, has shown "considerable average height difference between inner city children and those from the more affluent suburbs" (Sinclair and Dangerfield 1998, 29). Regular monitoring of physical growth, part of the role of the health

visitor, enables the early detection of problems such as faltering growth, a situation where a child may grow exceptionally slowly, possibly due to underlying illness, feeding problems or inappropriate energy intake (Cheek 2003). These standardised tests have also been adapted for different groups, for example Turkish children (Halliogou 2001) and can thereby take account of potential different genetic influences on growth.

Growth in size is accompanied by the growth and maturation of physiological and sensory systems. For example, digestive processes are immature at the point of birth and most do not begin functioning until around 3 months of age (Wong 1995). Infants are not able to successfully move from liquid feeds to solids until they have a properly co-ordinated swallowing reflex, their pancreas starts to mature and produce appropriate digestive enzymes and their tongue develops greater motility (gpnotebook 2003). Children's senses also develop along pre-determined pathways and there are accepted norms for the points at which the average child will achieve particular developmental milestones. Examples include the development of peripheral vision to 180^{0} between 6 months to one year of age (Wong 1995).

Development in gross and fine motor skills are also well documented and particularly observable in the younger child (table 8, 102). Examples of gross skills include being able to sit independently, achieved by 98% of normal children by the age of nine months and walking (Cheek 2003). Fine motor development skills include the achievement of a pincer grip towards the end of the first year enabling the child to pick up small items such as raisins and finger food (Wong 1995).

Unlike physical development plotting the intellectual and psycho-social changes throughout childhood can be more open to interpretation and conjecture as young children are unable to vocalise their thoughts and ideas. Developmental texts present what may possibly be described as classic theories whilst taking account of emerging developments coming to light through the creation of "innovative new ways of testing infants" (Coon 2000, 104), often facilitated by new technologies such as video recording.

Examples of developments include discussion of Piaget's theory of cognitive development. Although described as having shortcomings (Smith and Cowie 1988) Piaget's theory is also described as "one of the more influential" (Leather et al 2000, 33). From his study of children Piaget proposed four stages of cognitive development that occurred between the age of 0 and teenage years. Moving from simple reflex activity to understanding that objects are permanent, during the sensorimotor stage (birth to 2 years), to the egocentricity and thinking focussed on the observable of the preoperational period (2 -7 years) by about the age of 7. The further two stages of concrete operational (7-11) and formal operational (11-15) being described by Piaget as moving from the ability to sort and organise facts to abstract, flexible and adaptable thinking of the teenager (Leather et al 2000).

Piaget is criticised, amongst other things, for failing to provide what might be described as the full evidence on which his findings were based, such as quantitative data and lacking a standardised approach to interviewing his subjects (Smith and Cowie 1988). The development of more "sensitive" (Coon 2000, 104) ways to test babies reactions, such as the use of video

technology, have enabled the recording of reactions that researchers are interpreting as thinking in babies under a year of age (Coon 2000), something that Piaget's theory did not allow for.

In the area of moral development there are theorists such as Kohlberg, who studied under Piaget, and developed his stages of moral development based on studies of boys. He identified three levels each with two stages that he felt described the changes in a child's moral development. Moving from the first stage where they determine "the goodness or badness of an action" based on its consequences such as punishment (Wong 1995, 124) through to the final stage, said by Kohlberg to be around the age of 20 and only reached by a few, of behaviour determined by general rights and standards (Wong 1995). Woolfolk (1993) outlines some of the criticisms of Kohlberg's work, such as the lack of interrelater reliability, with concerns whether an evaluation of a child would be consistent between researchers. His work has also been challenged, as being based only on work with boys, by people such as Gilligan and her work identifying differences between boys and girls (Coon 2000).

Personality theorist Erikson set out his understanding of psycho-social development in the 1960s (Erikson 1963). With five stages between birth and the age of 18, with further stages in adult life, Erikson laid out a sequential process of development from trust and mistrust through to identity vs role confusion, as part of the process of resolving personal needs and those of society and culture. Developments and further study since then have looked at other areas of influence on the child such as parenting style (eg Baumrind 1991, cited Coon 2000),

feeding disturbances (Nagel and Jones 1992, cited Coon 2000) and the influence of peers (Wise 1994).

In keeping with the aim of not undertaking a totally exhaustive analysis of children's needs table 8 (overleaf) gives further examples related to each of the areas of growth and development with a specific focus on the period between birth and adolescence. As can be seen from the column "Developmental area" a number of different terms are used by different bodies to describe the same areas of development.

Developmental area	Areas of change	Examples of developmental change in children
Physical growth and maturation (Physical MoH 1959; HMSO 1976; ENB 1985a; HMSO 1989; UKCC 1989; DoH 1991) (Physiological ENB 1994)	**- growth** **- the senses** **- motor development**	Babies double birth weight by 4-7 months (Wong 1995) During adolescence "physical changes are rapid and profound" (Papalia and Olds 1991, 7) At birth the eye is "structurally incomplete" (Wong 1995, 291) Infants can distinguish their own mother's breast milk (Wong 1995) Infant able to sit unsupported at 7 months Able to throw a ball 70' by the age of 9
Intellectual (Intellectual ENB 1995a) (Educational MoH 1959; HMSO 1976)	**- cognitive** **- moral** **- memory** **- language**	Piaget's theory of Cognitive development (Coon 2000) Kohlberg's six stages of moral reasoning (Papalia and Olds, 1991) Development of recognition and recall 2 year old 80% correct in recognition tasks (Papalia and Olds, 1991) 6 year olds several thousand words
Personality/Social (psycho-social) (Emotional MoH 1959) (Psychological / Social HMSO 1976; ENB 1985a; HMSO 1989; UKCC 1989; ENB 1994) (Spiritual HMSO 1989)	**- self concept** **- expression of emotion** **- relationship with others**	Erikson's psycho-social theory - eight Eriksonian Crises during life (Papalia and Olds, 1991) Social smile 3-6 weeks Fear 5-7 months Peer group becomes central in middle childhood (Papalia and Olds, 1991) Achieving sexual identity in adolescence

Table 8 Areas of human growth and development (Papalia and Olds 1991; Wong 1995)

Factors influencing the development of children's potential

In looking at studies of children and young people in situations where the normal practices of child rearing have been compared with situations of deprivation, it can be demonstrated that there are certain conditions which enable children to develop more fully than others and thereby achieve their potential (table 9 below). There is evidence that children's development can be influenced by events in utero such as maternal rubella (German Measles) (Tookey and Peckham 1999) or toxoplasmosis (Turner 1999) and restrictions on children's movement can also impact on a child's motor development (Coon 2000).

In similar ways children's intellectual and psycho-social development is also influenced by external factors. For example, there is agreement that alterations to children's access to education and their social conditions can improve their intelligence (Hunt 1995, cited Coon 2000). Studies on children from Romanian orphanages where children received little or no attention from their carers have demonstrated their lack of development, particularly in relation to attachment (Chisholm et al 1993, cited Coon 2000). UK government programmes as Sure Start, which will receive £200 million funding between 2002-2006, are specifically focussed on the "Thousands of children living in disadvantaged areas" (DoH 2003, 1). Although there is currently limited evidence of the effectiveness of such schemes (Macintyre 2003) such a commitment is a demonstration of belief that they have the potential to produce improvements in "children's health, social, emotional and cognitive development" (DoH 2003, 1) and halt or reverse the impact of disadvantage.

Although growth and development are written about under these three main headings it is also important to note that lack of development in one area will influence development in others, such as the slow progress in learning language for children who are deaf. Table 9 (below) outlines some other examples of the influences that can impact on children's growth and development. This brief review of growth and development in childhood has demonstrated that this is a period of massive change. During this time there are a number of factors that have the potential to influence the extent to which a child may achieve their full potential. In other words to achieve successful growth and development requires the individual's needs to be met.

Developmental area	Areas of change	Examples of influences on the growth and development of children
Physical	**- Physical growth**	Genetic, racial background; living conditions; Calorie, food group, vitamin intake (Wong 95)
	- the senses	Maternal rubella during pregnancy may cause deafness for child (Tookey and Peckham, 1999), Chemotherapy (Russ 2001)
	- motor development	dependent on physiological maturation; poor environment not providing stimulation or opportunity for movement will delay development. (Dennis 1960 cited Papalia and Olds 1991)
Intellectual	**- cognitive**	Culture; educational system (Song and Ginsberg 1987 cited Papalia and Olds 1991)
	- moral	age, IQ, education, socio-economic status (Colby et al 1983 cited Papalia and Olds 1991)
	- memory	motivation to master skills; ways of approaching tasks; the nature of interactions surrounding an activity eg asking questions creates better memory that just commenting
	- language	affected by:- hearing impairment; mental handicap; parents/adults communication with the child; deprived environment (Wong 1995)
Personality/ Social (psycho-social)	**- self concept**	affected by:- the extent to which they felt loved; competence in completing tasks; attainment of ethical/moral standards; the influence they have on others (Coopersmith 1967 cited Papalia and Olds 1991)
	- expression of emotion	reaction of mothers eg babies of depressed mothers “at risk of various emotional and cognitive disturbances” (Papalia and Olds 1991, 152)
	- relationship with others	environment (Daniels and Plomin 1985 cited Papalia and Olds 1991); genetic influences; after effects of separation

Table 9 Factors influencing the development of children’s potential

Human needs

Within the context of children's nursing, in the UK, needs based approaches to the assessment and planning of nursing care have possibly had the greatest use. One of the most commonly used with children or adapted for use with children is the Activities of Living model developed by Roper, Logan and Tierney, originally published in 1980 and revised in 1985 and 1990 (Roper, Logan and Tierney 1990) and again in 2000. Other models used in the care of children originating in a similar needs based approach are Orem (eg Orem 1991) and Henderson (Henderson 1969). Although described by some commentators as having "a reductionist approach to human beings as a set of needs" (Meleis 1985, 173), the beliefs that these theorists held about the function of nursing have been seen "as not being bettered" (UKCC 1999, para 2.19). Maslow's hierarchy of human needs is seen as underpinning such approaches to nursing (Fawcett 1989).

Maslow's life was dedicated to the study of people who were "psychologically healthy" (Maslow 1987, xxxv). Prior to Maslow researchers generally focussed on separate elements of motivation such as biological factors and achievement. Maslow's work is described as synthesising these different fields of research and being one of the most popular theories of human motivation (Huitt 2003). In his Theory of Motivation and Personality he initially proposed five basic human needs that have to be met to enable personal development. The needs are often represented in a pyramid with the most essential, physiological at the base.

Self actualization

Esteem: to achieve, be competent, gain approval and recognition

Belonginess and Love: affiliate with others, be accepted

Safety/security: out of danger

Physiological: hunger, thirst, bodily comforts (Huitt 2003).

Maslow describes these needs as unconscious innate drives that are "more unconscious than conscious" (Maslow 1970, 54). Maslow proposes that the move from the physiological need to the need for self-actualization can be viewed as a progression. Giving an example of a person suffering from hunger Maslow describes how the satisfaction of this physiological need can become all consuming, pushing other needs “into the background” (Maslow 1987, 16) and influencing their whole philosophy. He suggests that the chronically hungry person may think that if only they were guaranteed food they would be happy and “never want anything more” (Maslow 1987, 17).

In later work Maslow added extra stages to the hierarchy rising from cognitive need to self-transcendence.

Self-transcendence: to connect to something beyond the ego or to help others find self-fulfilment and realize their potential.

Self-actualization: to find self-fulfilment and realize one's potential;

Aesthetic: symmetry, order, and beauty;

Cognitive: to know, to understand, and explore;

(Maslow and Lowery 1998 cited Huitt 2003)

Satisfaction of primary physiological need allows other needs to develop, and when each is satisfied the person moves on to satisfy the next. For example people living in a society that normally makes its members feel safe may not feel endangered and therefore no longer have any real safety needs. In between the two ends of the continuum of safety are potential intermediate points which may achieve satisfaction through such measures as fulfilling the need for secure employment, savings and insurance. At the top of the hierarchy of needs lies self actualisation a point at which needs may “vary greatly from person to person” (Maslow 1987, 22).

Such an apparently "strict temporal sequencing" is a criticism that Doyal and Gough (1991, 36) incorrectly level at this theory of human needs. Maslow (1970, 51) states quite clearly, that although such a hierarchy seems a "fixed order" "it is not nearly so rigid as we may have implied" (Maslow 1970, 51). In demonstrating the potential for flexibility in the order in which these needs are met Maslow provides examples of situations where satisfaction of a higher need may in fact predominate over a lower need. Such examples include those "innately creative people" (Maslow 1970, 52) whose drive to fulfil their creativeness is achieved despite the lower physiological and safety needs not being satisfied. There are also those who "give up everything" (Maslow 1970, 53) in order to be able to achieve a particular task. Maslow described such people as standing up for a cause "at great personal cost" (Maslow 1970, 53). Modern examples of aid workers, those working with refugees or providing food and shelter for the homeless could perhaps be seen in this category.

Within the Theory of Motivation and Personality it is also clear that a particular need does not have to be totally satisfied before the next need starts to appear. Maslow (1970) provides the example of a person who has the following levels of satisfaction of each of their five basic needs.

10% Self actualization
40% Self esteem
50% Love
70% Safety
85% Physiological (Maslow 1970).

This framework for the consideration of human need can be applied in a range of circumstances. For example Baker and Lane have demonstrated its application to the care of a child with cerebral palsy as a way to facilitate exploration of the psycho-social needs of a child and their family (Baker and Lane 1995).

Children's needs

The United Nations' Convention on the Rights of the Child states that "The child, for the full and harmonious development of his or her personality should grow up in an atmosphere of happiness, love and understanding" (UNICEF 1990, 44). In other words the authors confirm a relationship between children's potential development and the meeting of their needs.

In the early 1970's The Department of Health and Social Security in Britain commissioned Mia Kellmer Pringle to

> "Prepare a comprehensive document about the developmental needs of all children, about the ways in which these needs are normally met, and about the consequences for the emotional, intellectual, social and physical growth and development of children

> when, for one reason or another, these needs are not adequately met" (Pringle 1986, 8).

The publication The Needs of Children (1974; 1980; 1986) drew on the findings of the National Children's Bureau's National Child Development Study which started in 1958. This study followed 17,000 children born between 3-9 March 1958, through all stages of development. Data were collected from parents, schools attended by the children, a series of physical measurements such as height and weight and tests of intellectual attainment (Pringle 1986).

Pringle's statement that children's physical needs are "satisfactorily met" (Pringle 1986, 15) was based on her belief that over the "past forty years there has been a virtual revolution in children's physical development" (Pringle 1980, cited Pringle 1986, 7). This meant that the focus of her work was that of psycho-social development and the "measures likely to raise the general level of children's intellectual, educational, social and emotional development" (Pringle 1986, 31) a framework for expressing the needs of children in a way that is concurrent with that proposed by Maslow. Although Pringle makes no reference to Maslow she supports his rejection of the idea that needs always require satisfaction in "a hierarchical sequence" (Pringle 1986, 33). Using the framework of children's needs proposed by Pringle (1974; 1980; 1986) with its underpinning philosophy that needs are "inter-related and inter-dependent" (Pringle 1986, 33) creates a way in which to view the child as an individual, rather than a collection of different developmental areas.

In her discussion of intellectual, emotional and social and educational development Pringle

draws out a "four-fold classification" (Pringle 1986, 34) of children's needs which are seen as "interrelated" and "interdependent" (Pringle 1986, 33).

The need for love and security

The need for new experience

The need for praise and recognition

The need for responsibility

Although not acknowledged this categorisation would appear to be a development of earlier work by Thomas (1925 cited by Peplau 1952), “who suggested four main directive impulses: desires for security, for new experience, for affectional responses and for recognition” (Peplau 1952, 79). There are also echoes of this expression of children’s needs in the General Nursing Council syllabus issued in 1952, which required children’s nurses to learn about “security in the family situation; love, consistency, discipline and freedom, recognition and praise” (GNC 1952, cited Robertson 1970, 119). Pringle’s approach also enables the range of expressions of needs identified in table 6 (90) to be brought together.

Writers on need agree that failure to meet needs causes "stunted or distorted development" (Pringle 1986, 81). Fulfilment of these needs enables the child to achieve adequate growth and development in all areas, when these needs are not met there is potential for children to fail to develop to their full potential (Pringle 1974). Table 10 demonstrates that the meeting of children’s needs as proposed by Pringle should enable development to progress within normal parameters and that where these need are not met children will fail to achieve. There is a range of different experiences can satisfy these needs and enable development enabling

the child to move through the hierarchy in a manner matching that proposed by Maslow. For example there are a range of ways in which the child's need for new experience can be met such as play, the use of language and experience at school. Focussing on the area of play shows a whole range of developmental achievements such as body control, learning about objects and the expression of feelings which come from the satisfaction of physical, intellectual and psycho-social developmental needs. The role of others in satisfying a child's need for praise and recognition enables the child to develop the skills and confidence to face new challenges and tasks (table 10).

Need	Satisfied by	Meeting the need	Not meeting the need
Love and security	Relationships within the family with stability, unconditional love	Child can respond to affection, the need for self control, personal identity, self worth and moral values	Child unable to develop feelings for others, may have low levels of physical, intellectual and social development
For new experience	Play Language Experience at school	Child develops body control, learns properties of everyday objects, self expression, outlet for feelings develops powers of reasoning and judgement affected by their ability with language	Over stimulation - may have episodes of uncontrollable excitement, exhaustion, maladaptive behaviour. Under stimulation - boredom, frustration, or restlessness
Praise and recognition	Parents/teachers providing encouragement Parents/teachers understanding expectations of age and ability appropriate behaviour Praise for effort and not just achievement	Child develops self respect, confidence when faced with new situation, tasks or relationships	Child fails to develop self respect, lacks confidence in new situations May be satisfied with less than their best
Responsibility	Parents can provide help and encouragement to take increasing responsibility Schools can provide pupil centred regimes, ground rules for pupils and staff	Child develops values, standards, concerns and ambitions; understands responsibility	Fails to develop sense of values May end up in dead end jobs, bored and frustrated.

Table 10 The psycho-social needs of children (developed from Pringle 1986)

Children's special needs

The analysis of the concept, so far, enables a definition of the special needs of children as

> "those which are different from others undergoing a similar experience because they are specifically related to the individual child's stage of development." (Price 1994, 230).

Such a definition would fulfil the criteria of being applicable to all areas of need, from which ever disciplinary perspective was under consideration and acknowledges that other groups may also have special needs that are also related to their stage of development.

The appropriateness of this definition within the context of defining children's nursing can be demonstrated through the use of an exemplar. One of the differences between Rodgers evolutionary model of concept analysis and other methodologies is the requirement that exemplars "should be *identified* rather than constructed" (Rodgers 2000a, 96). Rodgers urges caution in the choice of exemplars implying that scenarios that are too detailed and complex could distract the reader, a better exemplar being one that she describes as "generic", that is applicable in a range of situations (Rodgers 2000a, 96). To move to a definition of the special needs of children within the context of nursing, it is necessary to determine the impact of hospital admission on children and their families.

The hospital experience of children

Admission to hospital for anyone will involve a whole range of new experiences and for children may challenge their need for love and security. For a child and their family this may

be “the first crisis” (Wong 1995, 1065), the first time that parents have had to devolve some of their autonomy over their child (Darbyshire 1994). A child’s reaction to illness and hospitalisation will potentially be influenced by different stresses at different points in their development (Wong 1995).

As table 11 (118) demonstrates as a child grows older their responses to the different effects of hospital admission will change and this will impact on some of their needs, in particular for new experience and love and security. For example children may display responses due to “separation anxiety” (Webber 1995, 50) ranging from the protest and despair of the toddler through to the response of the adolescent feeling the impact of being away from friends (Wong 1995) at the same time as feeling that they have increased parental involvement in what is happening to them (Muller et al 1992). For the toddler pain may “be seen as punishment” (Wong 1995, 1069), particularly for those children who have been admitted for waiting list surgery who may not have felt that there was anything wrong with them. Although the adolescent will usually understand the reason for the pain and contribute to the assessment of it they may feel that they are in some way losing control (Wong 1995). For the child with no previous experience of being in hospital there is also a whole range of unfamiliar activities and events to encounter.

For the adult responses to these events will be different. An adult may have particular family responsibilities, worry over their employment and how other family members will manage. They may also suffer from the lack of their usual routine (Roper et al 1990). Adults’ usually

fuller understanding of the implications of their admission and treatment may also create an anxiety in relation to medical tests and investigations (Roper et al 1990), a concern that would be felt by the parents of the younger child. As table 11 (118) demonstrates considering the impact of admission to hospital in this way it can be seen that linking the impact on the child's needs as defined by Pringle provides a framework through which an analysis of the ways in which children's nurses meet the developmental needs can be undertaken. Whilst in looking at the effect of admission it would appear that in the main two needs need consideration when the child requires nursing care it can be seen that the other two of Pringle's needs, for praise and recognition and responsibility also come into play.

Seeing the child as a whole with specific needs enables integration of the knowledge and skills required to meet specific needs. For example in table 11 (118) the experience of "separation anxiety" (Webber 1995, 50) when viewed from the perspective of the child undergoing a new experience enables thinking of all the child's needs. With the focus on meeting the child's needs the carer's knowledge of psycho-social development and the usual reactions to such events can be considered. Knowing the child's stage of intellectual development and ability to comprehend is also important in enabling explanation. Understanding physiological responses to the potential anxiety and distress and being able to compare these with the average all enable an holistic assessment, allowing the purpose of care to be when ever possible focussed on the positive aspects of the experience enabling growth, rather than on the negative which may hinder development.

Possible effect of admission	Need that may be influenced	Infant	Toddler (1-4years)	School Child (5-12)	Adolescent (13-18)	Adult
"Separation anxiety" (Webber 1995, 50)	New experience Love and security	Increases as the infant gets older	Protest, despair, detachment (Wong 1995) Upset by strangers (Wong 1995)	Fear of being away from family (Wong 1995)	Concern re separation from usual activities, friends (Wong 1995)	May be away from normal sources of support. Concern over employment, will family members manage.
"Reaction to bodily injury or pain" (Webber 1995, 52)	New experience Love and security	Treatment may require restrictions on movement, the use of noisy machines.	"Pain seen as punishment" (Wong 1995, 1069)	Able to locate pain eg stomach ache is a specific rather than a global term (Eland and Anderson 1977)	Able to explain why they have pain, may have concern over loss of control when in pain (Wong 1995)	Greater understanding of pain, able to communicate their pain to others.
"Unfamiliar activities" (Roper et al 1990, 113)	New experience Love and security	eg Food and bath type and time Normal activity eg naps may be affected	eg difficulty with noise, lights on at bed times lack of opportunity for usual rests, different bathroom, toilets,	May be unsure how to behave (Muller et al 1992). May be embarrassed by home rituals	Disruption to life, school work. Adolescents who are frequent attenders may become increasingly resentful	Lack of routine eg going out to work, caring for the family, monotony of surroundings (Roper et al 1990)

Possible effect of admission	Need that may be influenced	Infant	Toddler (1-4years)	School Child (5-12)	Adolescent (13-18)	Adult
"Loss of control" (Webber 1995, 51)	New experience Love and security	Infants usual cues for controlling their environment eg smiling may be missed (Wong 1995)	Restriction on activity. "Medical procedures usurp toddlers control over their world" (Wong 1995, 1068)	Moving to increasing choice may not like restrictions on activities, visitors, parental involvement in decision making may lead to feeling of loss of control (Muller et al 1992)		Anxiety over tests (Roper et al 1990)

Table 11 The experience of admission to hospital across the age range

Meeting children's needs when they require nursing

Parents, who will have developed a range of strategies for dealing with their children (Muller et al 1992, 228), can be seen as the "experts" (Sidey 1995, 36) in meeting their own child's needs. Based on their knowledge of the child as an individual, decisions on the ways in which a child's needs are usually met may vary between families and between different children in the family. When children are in the home their needs may be met by the child themselves, by a sibling, by the parent/s or by a combination of all parties. Admission to hospital means that a range of other people will be involved in making decisions about the care of the child.

Factors which influence the decision making process may depend on the age of the child and the nature of the need. From the point in time when a child is able to start making decisions the balance of influence of the different parties on the way in which the decision is made and the need is met will vary. If the example of the need for new experience through play is considered family members may all be involved in playing with an infant singly or in a group. For the adolescent new experience might be gained with peers or through parents introducing them to a new hobby or sport.

The person responsible for meeting the child's needs and the environment in which the needs require to be met will also vary. For example teachers and others who have contact with a range of children in specific settings whilst not necessarily being an expert for each individual child's needs have a wider frame of reference against which to judge a particular child's development. The ways in which knowledge from the particular frame of reference can be

used is also developed against both experience and evidence.

Who is involved in hospital?

When a child is admitted to hospital they have to deal with the effects of admission, the cause of their admission and also the fact that more people may become involved in deciding how their needs can be met. Each person, including the different health care professionals, may have a different idea about which needs exist, the priority of the need and the way in which they should be met. Although the extent to which parents are involved in the care of their children in hospital may vary (Muller et al 1992) it should be impossible to leave them out of any discussion of how children's needs are met at such a time.

Table 12 demonstrates how a common medical decision to treat a child with an antibiotic increases the number of people who are involved with the child and there may be a wide range of computations of the people who may be involved in ensuring that the child has the treatment. There are also a number of people who may be consulted on the child's response to such a treatment in relation to side effects and effectiveness. At the same time the child's daily routine of washing, eating and playing or going to school will be subject to a greater number of constraints than would probably occur when the child was at home or school, many of which will be created by those outside the immediate family.

Activity		Child	Parent/s	Nurse	Doctor	Others eg physio'
Deciding on medical treatment eg antibiotic					X	
Administration of medicine	Age dependent	X	X	X		X
Communication on effectiveness of treatment				X	X	X
		X		X	X	X
		X	X		X	X
			X		X	X
		X	X	X	X	X
		X			X	X
Daily routine eg feeding, washing, playing		X				
		X	X			
		X	X	X		
			X			
			X	X		
		X		X		

Table 12 The people involved in deciding how a hospitalised child's need may be met

Matching nursing care to the special needs of children

The impact of age on the needs of an individual and therefore their nursing care, is one of the underlying beliefs of a number of nursing theorists. For example in the "Basic Principles of Nursing Care" (Henderson 1969), prepared for the International Council of Nurses by Virginia Henderson, she points to the fact that nursing texts were being written around the "needs of persons according to age..." (Henderson 1969, 10). Henderson emphasised the importance of

taking account of “age, cultural background, emotional balance and his (the individual) physical and intellectual capabilities” (Henderson 1969, 10).

In the sixth edition of “Principles and practice of nursing”, her seminal text on nursing, Henderson (Henderson and Nite1997) provides examples of the knowledge and skills that are required to care for people of different ages and cultures. For example in highlighting some of the consequences of immaturity she outlines the requirements of a young child with “immature kidneys” (Henderson and Nite 1997, 568) and the impact of their need for care and control and monitoring of treatment regimes. As a consequence of their physiological immaturity young children have a “smaller margin of safety” and therefore the nurse should “plan careful weighing, recording and comparing of an ill infant’s daily weight” (Henderson and Nite 1997, 568). Doctors also need to know safe limits for prescribing any treatment, such as replacement fluids.

This focus on the different ages and cultures of people requiring nursing care is also expressed by British nursing theorists Roper, Logan and Tierney (1990), who state that “Taking account of a person’s age ... has always been recognised as important in nursing” (Roper et al 1990, 39). They further state that the application of their model for nursing should take account of where the person is on the “Lifespan” and “Dependence/independence continuum” (Roper et al 1990, 25). In their explanation of the activities of living and their impact on the need for nursing the authors consistently highlight the differences and similarities between the age groups.

Muller et al (1992) stated their belief that, particularly for children who are patients, psychological welfare is equally as important as physical well being and because of this these two areas "cannot be divorced" (Muller et al 1992, 232). Table 13 (125-126) provides an exemplar of the differences between children and adults who have diabetes, a condition chosen because it can affect people across the whole age range, may require different treatment and different educational strategies depending on the age of the person or the prescribed treatment. This table also demonstrates that the approach to classifying needs used by Pringle can be used as a framework for the care of children in hospital and can also be extended to encompass both the adult and the older person.

Physiologically the nature and the rationale for the treatment vary across the age range. For the child if they have diabetes that is not well controlled it can have consequences in relation to growth and delayed puberty (Diabetes UK 2001). In later life the concerns move towards reducing impact on other body systems such as the renal system and the circulatory system. The treatment regime is also different depending on the age at which the initial diagnosis of diabetes is made, with the younger age group usually requiring insulin injection and diet, while middle aged and older people may be able to gain control through diet and tablets alone.

For the young child the level of personal control is quite limited as it is the parents' responsibility to administer the insulin and they will also have control over the diet. For the adolescent the issue of taking over responsibility for insulin injections and a potentially different diet making them different to their peers is one of the main challenges. The diagnosis

of diabetes at this age may also impact on the potential career choices that are open to the adolescent.

For anyone affected by diabetes this is a new experience. In meeting the needs of patients who are newly diagnosed with this condition there are a range of responses, which may vary as the person gets older, needs to make life decisions and gains an increasing understanding of the impact of the diagnosis. Through consideration of the needs created by this new experience patients can be helped to understanding the initial diagnosis and the changes that may come throughout the rest of their life as a result of having diabetes. The importance of meeting the need for love and security may vary from the need to provide for the frightened child, through to the adult who may believe that this illness may affect those around them, their ability to be involved with and supporting them. As people get to take on increasing responsibility for their treatment there is also a potential need for praise as they learn to adapt and overcome problems.

Need which may be met		Infant/young child	Adolescent	Adult	Older person
Physiological	**Aim of treatment**	To prevent poor growth, delayed puberty, disability later in life ([5])		To gain optimum control and reduce the impact on other body systems	
	Physiology	Type 1 Insulin dependent - body no longer able to produce insulin ([1])			Type 2 - non insulin dependent in over 40s Body can still make some insulin but not enough OR does not work properly ([1])([6])
	Symptoms	Information provided by parents -polyuria, nocturia, thirst, weight loss Sudden onset ([4])([6])	Information from adolescent and parents or the adult patient -polyuria, nocturia, thirst, weight loss Sudden onset ([4]) ([6])		Usually gradual ([4]) Patient usually obese ([4])
	Treatment	Insulin injections and diet			Diet and/or Tablets
New experience **Love and security** **Responsibility** **Praise**	**Level of personal control**	Initially dependent on adults to administer insulin and provide an appropriate diet. Increasing level of personal control moving to self injection and diet choice ([6])	Able to inject, choose own diet. May rebel and not do glucose testing ([6])	Able to inject, choose own diet.	Usually able to regulate diet and/or tablets

Need which may be met		Infant/young child	Adolescent	Adult	Older person
	Health service provision	Should be referred to medical specialist in childhood diabetes ([3]) Children's dietician	Age 16 prepare to move to adult services ([1])	Adult services	
Responsibility **Praise**	**Education**	"The nurse will have to assess the most appropriate way to teach the child and family, taking into account their individual differences and needs" ([5])	Adolescent and parents receive education Increasing awareness of impact on future ([6])	Education for the patient, including other family members. Impact on work, lifestyle, sexual functioning ([4])	
	Comments	"Children with diabetes have special needs related to the fact that they are children" ([1], [2])			"Can be prevented by preventing obesity and promoting regular activity throughout childhood and adult life" ([2])

Table 13 Diabetes across the age range

[1] Diabetes UK (2001), [2] DoH (2001), [3] National Audit Office (2001), [4] Walsh (1997), ([5]) McEvilly et al (1995) ([6]) McEvilly (2003)

Implications

The final stage in the evolutionary model is to generate implications for further enquiry using different methods (Rodgers 2000a). The framework and processes of Rodgers evolutionary model of concept analysis have led to a definition of the special needs of children, which is congruent with the proposed definition of children's nursing, at the beginning of the 21st century. Through analysis of data sources and the use of an exemplar children's special needs have been demonstrated as being those related to their individual developmental stage. Such a definition is also congruent with the definition of children's nursing (87-8), as it can be applied to all settings in which children are nursed, the focus of knowledge of all the members of the multi-disciplinary team and the range of skills needed to ensure that children reach their potential.

As has been demonstrated the UK is distinctive in that people can chose to entering training to register as a children's nurse with no prior nursing experience and then go directly into employment as a children's nurse. If the definitions of children's nursing and the special needs of children are accurate then this could have a number of implications. Firstly, does this mean, that those who select child branch students choose people with specific qualities that enable them, following a period of education, to deliver care that meets children's special needs. Secondly do those who employ newly qualified children's nurses expect them to work in multi-disciplinary settings meeting the needs of children and their families through the delivery of planned care that utilises a range of scientific, technological, psychological, and educational skills?

SELECTING CHILDREN'S NURSING STUDENTS

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Price, S., Hicks, C. (2000). Qualities of candidates for child branch. *Paediatric Nursing,* 12 (7) 20-23

Price, S. (2002). The recruitment and retention of children's nurses. *Paediatric Nursing* 14 (6) 39-43.

INTRODUCTION

The first implication arising from the definition of children's nursing and the special needs of children is that those who select child branch students choose people with specific qualities to undergo training leading to registration and subsequent employment as a children's nurse. These definitions in themselves, however, say nothing about what these qualities may be or how they may be evidenced during the selection process.

Recruiting and selecting the appropriate people into nursing has been a consideration throughout the 20th century. For example in the 1970s The Report of the Committee on Nursing (The Briggs Report) (HMSO 1972), an official government commissioned report charged with considering ways in which to ensure that "best use is made of available manpower" in the NHS (HMSO 1972, v), devoted ten paragraphs to the "Point of entry"

(HMSO 1972, 82) into the profession. The 1980s saw the publication of Child et al's (1988) study "Selection for nurse training", commissioned by the DHSS to consider the development of materials to create job information checklists to help those who wished to become Registered General Nurses and Registered Mental Nurses decide on a career in nursing, and to make recommendations related to "pinpointing the limitations of interviews .... and make suggestions how the limitations might be overcome" (Child et al 1988, 6).

Candidates are required to meet the statutory requirements related to age and academic achievements, and those involved in selecting students also need to check their health and screen them for any convictions. Currently those who wish to undertake nursing programmes are required to choose the branch they wish to enter at the point of application a requirement of institutions contracts with the NHS, based on workforce planning. Institutions receive contracts for both numbers of groups of branch students and the number of students per group. This means that institutions do not have any room for manouevre to respond to demand for "extra" places and as a consequence for popular branches with small numbers there is potentially greater competition for places. As the data in the literature review demonstrates there is a significant reduction from the number of applications to the number of places available on the child branch.

Due to the way in which the application process works, it is difficult to be exact in relation to the numbers of individual students applying for the child branch. On a rough calculation however approximately 4000 applications were received for the entry to the Dip HE child

branch in England for a total of 1436 places in 2002 (NMAS 2003). For the adult branch the figures were approximately 11346 for 10357 places. This raises the question of what selectors look for when scrutinising applications to such an apparently popular programme as the child branch. Do they look for particular qualities to distinguish those who are the most suitable and is there any agreement on these qualities and the ways in which they may be demonstrated by candidates?

LITERATURE REVIEW

Much of what is written about the different methods of personnel selection relates to selection of one person for one post. In such situations the numbers of potential candidates may be quite limited and the methods employed can be focussed on the needs of one organisation with a particular role to fill. As figures from the admissions system presented in the literature review will demonstrate the selection of student nurses involves large numbers of candidates being selected for both entry to the profession and for future employment within the NHS a process that resulted in 14538 new nurses entering the register in 2002 (NMC 2002a)

Selecting nursing students

British data relating to the selection of preregistration nursing students is scarce (Land 1993), with the literature that is available usually focussing on the selection of qualified nurses. The limited evidence related to the selection of preregistration students usually focuses on the advantages and disadvantages of existing selection methods. This is the first study to look specifically at the selection of preregistration students who wish to become children's nurses.

The Briggs Report published in 1972 (HMSO 1972), in fulfilment of a remit to consider ways to ensure that "best use is made of available manpower" in the NHS (HMSO 1972, v), made recommendations in relation to recruitment and entry into nursing. The committee stated that nursing should consider applicants from "average intelligence to the highest" (HMSO 1972, para 259). They also recommended that the statutory bodies for nursing and midwifery should

"encourage further research on selection" and proposed consideration of "aptitude and motivation tests" (HMSO 1972, para 259 (e)). One of the nurse members of the committee, giving voice to one of the dilemmas of nursing selection, stated that for those who wished to enter nursing, predictions based on previous academic achievement could be "confounded" by the effect of motivation and aptitude and that the skill of nursing required qualities of "temperament, personality and character" (Collins 1972, 1593), which it was difficult to predict. Such statements can be seen as encapsulating the struggle between those who look for purely academic and objective tests against those for whom the personal qualities of the nurse are seen as equally significant.

Personal qualities were also considered important by the author of one of the classic nursing textbook of the 1970s. Hector (1976) presents a detailed list of the personal qualities that nurses should have, including "a liking for people", "physical health", "manual dexterity", "good average intelligence and an adequate education" and "integrity" (Hector 1976, 7-8).

In 1984, a year after the United Kingdom Central Council took over its functions, the Department of Health and Social Security funded the Nurse Selection Project, at the University of Leeds. The findings, published in a "more readable version" (Child et al 1988, vii) in 1988, report on the project that gained responses from 166 (73.7%) of a possible total of 225 nurse education institutions in existence at that time. Within the study the research team's sample included schools that offered the Registered Sick Children's Nursing programme, which at the time would have been accessed by those who were already qualified

as adult nurses.

From a review of the literature Child et al (1988) concluded that despite attempts to find a "personality 'type' applicable to nursing" " there was no consistent pattern of traits" (Child et al 1988, 3). The various studies that had been previously undertaken had a "lack of regard" in relation to the register the student wished to enter (Child et al 1988, 3). Child et al (1988) also cautioned that it would be "counter-productive" to only choose people with a particular personality as that would set the profession "in a particular mould" (Child et al 1988, 3), the "similar to me phenomenon" (Sears and Rowe 2003, 13).

Child et al (1988) used a postal questionnaire to request details of the qualities respondents looked for in the application forms of candidates who wished to undertake training leading to registration (Child et al 1988). The published details did not make explicit whether respondents would identify particular qualities from candidates' supporting information or from details provided in the reference. The research team derived 13 qualities from the data received in response to this open question (table 14 overleaf).

Qualities	% of institutions
Academic qualifications	75%
Work/employment experience and stability	50%
Presentation of form (neatness, legibility)	23%
Health	19%
Motivation/career intentions	19%
Evidence of "understanding of people" or "caring attitude"	19%
References	17%
Communication skills/literacy	17%
Interests and hobbies/other achievements	16%
Age	11%
Reliability/stickability/dependability	10%
Knowledge of/experience of nursing	10%
Unspecified "personal qualities"	9%

Table 14 Qualities looked for on the application form (Child et al 1988, 51)

As table 14 demonstrates, the highest level of agreement between respondents was on the importance of academic qualifications (75%) and work/employment experience (50%) with levels of agreement on other qualities falling below 25%. In the study respondents saw the application form as demonstrating a candidate's ability to "present information neatly, legibly, accurately" (Child et al 1988, 60). Other aspects of communication skills were considered to be the ability to be simple and accurate in the conveying of information. A candidate's health (19%) and the quality of the reference (17%) were the two final common criteria. Physical problems or indication of frequent sickness or absence were considered as weighing against a candidate. Respondents stated that references were considered in the light of both the

positive and the negative information they provided about candidates. Those involved in the selection of RSCN students also wanted evidence of "adaptability and emotional stability" (Child et al 1998, 61), though the methodology of the study did not allow elaboration of how this would be assessed from an application form.

All schools who looked for motivation (19%) considered it to be demonstrated through candidates' descriptions of why they wanted to be nurses, involvement in voluntary work or work involving caring. Evidence of commitment was apparently determined by the length of time that an applicant had been considering nursing as a career. Through semi-structured interviews with selectors the research team asked questions related to "Commitment to nursing and specialist interest" (Child et al 1988, 60). If a candidate wanted to enter one of the specialist registers (ie Registered Mental Nurse, Registered Nurse for the Mentally Handicapped, Registered Sick Children's Nurse (RSCN) those involved in selection for interview "liked to see sensible reasons" (Child et al 1988, 60) for the choice. Disappointingly the report provides no detail of what these sensible reasons may be, or who decided that they were in fact sensible.

All the schools of nursing involved in the study interviewed candidates before acceptance onto the programme and the research team also identified the qualities that selectors would look for during an interview (table 15). Table 15 shows a comparison of the information that selectors would anticipate gathering from the application form and during interviews. Although many of the same qualities were detailed the reasons why, for example 19% would

look for motivation on the application form while 60% would look for this at interview are not stated. It may be that there is a belief that such a quality was considered easier to assess in the face to fact situation.

Qualities looked for in selection	Form	Interview
Academic qualifications/ability	75%	60%
Work/employment experience and stability	50%	
Health	19%	27%
Motivation/career intentions	19%	60%
Communication skills/literacy	17%	60%
Interests hobbies/other achievements	16%	31%
Reliability/stickability/dependability	10%	17%
Knowledge of/experience of nursing	10%	28%
Unspecified ““personal qualities””	9%	
References	17%	
Age	11%	
Understanding/awareness of nursing		35%
Stable home background		16%
"Maturity (for age)"		14%
"Ability/desire to work with people (of all ages)		13%
Adaptable/flexible		5%
Self awareness		5%
Ability to cope with authority		4%
Practical ability		8%
Commitment		24%
Emotional stability		20%

Table 15 Qualities looked for on the application form and at interview

Although at interview some of the selectors in Child et al’s study were looking for qualities such as self awareness (5%), maturity (14%) and understanding of nursing (35%), the qualities looked for by the greatest number were those which are the most measurable such as academic qualifications looked for by 75% of selectors on the application form and 60% at interview. The only difference that the researchers could determine in the qualities required for entry to

the different registrations related to candidates' knowledge of the specialist area of nursing applied for. Institutions who ran the RGN/RSCN courses were considered as being able to be "'choosy' because applicants for the combined course were plentiful" (Child et al 1988, 59).

Child et al (1988) made a number of recommendations related to the selection of nursing students. The team recommended that if selectors were looking for different qualities for the different parts of the register then these should be made clear to the candidates and there should be agreement on the way in which they should be evidenced during selection to ensure consistency between selectors and their assessment of candidates. Child et al (1988) also recommended that selectors should "confine their criteria" to those which could be "precisely defined and clearly observed" (Child et al 1988, 112-113). For the limited number of schools who at the time of the study used other methods of assessment such as discussion groups or tests, there was again the recommendation for clear guidelines and "precisely defined criteria" so that selectors were aware of what was a "good or poor performance" (Child et al 1988, 114).

Child et al's study (1988) reported to the DHSS in 1987 two years before the Project 2000 courses started to admit students. By the time the findings and recommendations of the report were published the nursing and midwifery admissions system in England had been centralised, to mirror the processes used by the University and Colleges Admissions Service (UCAS). Implementation of the processes required by the Nurses and Midwives Central Clearing House (NMCCH) rolled out over a period of several years, starting with applications for the RSCN

programmes. There is no direct evidence to demonstrate the extent to which any of the recommendations of Nurse Selection Project were actually implemented in the development of the centralised system.

Selection for Project 2000 programmes

In reviewing this first step in the educational process leading to registration as a children's nurse, the focus will be on the Diploma programmes (Project 2000), as this was and still is the major route into nursing in England, with a total of 37314 application forms being handled during the 2001/02 applications cycle (NMAS 2003), in comparison with 6541 applications for degree programmes during that year (UCAS 2003).

The major change in nursing education that took place with the implementation of Project 2000 brought in a change to diploma level education. By the time students were being admitted to these programmes the NMCCH process, (now NMAS) was applicable to all students wishing to enter a pre-registration programme. Through this scheme candidates are able to make applications to up to four institutions any one year. The institutions chosen by the candidate receive a copy of the application form from which they make initial selection decisions of whether to reject or progress further.

There are no exact figures for the number of candidates applying for entry to the child branch at the time of this study. Statistics for 1997/8 and 1998/9, published by the Nursing and Midwifery Admissions Service (NMAS) who took over the administration of the application

process, for application forms received and applications for the child branch in 1997/8 and 1998/9 do, however, demonstrate the popularity of this branch of nursing (table 16) when compared with adult nursing. As not every applicant takes advantage of the opportunity to make four applications a simple reduction of the number of child branch applications to determine how many people actually applied is not directly possible.

Year	Adult branch		Child branch	
	Applications[1]	**Places[2]**	**Applications[1]**	**Places[2]**
1997/8	22142	Not available	9201	Not available
1998/9	40507	10138	15872	1439

Table 16 Applications to NMAS and number of places [1](NMAS 2001), [2] (ENB 2000b)

Harding (1999) reports on a survey undertaken by the University of the West of England to try and identify the qualities of the children's nurse that would be evident at the point of selection. Her survey underlines the dilemma faced by institutions in dealing with such numbers of the child branch as it was undertaken as a response to the fact that "the number of applications consistently exceeds the number of places available" (Harding 1999, 14).

Statutory requirements and regulations

In selecting students to enter programmes leading to nursing registration there are few national criteria. The minimum educational requirements are set in statute and as such are a legal requirement. At the beginning of this study the Nurses and Midwives Central Clearing House (NMCCH) was responsible for managing the application process for Diploma programmes

in England, a process now managed by Nursing and Midwifery Admissions Service (NMAS), under contract to the Department of Health (NMAS 2003). Applicants are required, by the vast majority of institutions, to apply for a particular branch programme a process dictated by the need to meet the contracted numbers for the different branches agreed between individual institutions and their local Workforce Development Confederations acting on behalf of the NHS.

The only statutory requirements for entrance to nursing education are age and academic achievement. The Nurses, Midwives and Health Visitors Approval Order 1983 No 873 (HMSO 1983) sets out both the age and educational requirements for entry to first level (registered nurse) training. At the point of entry into nursing education students must be “not less than seventeen and one half years of age the first day of the course” (HMSO 1983, 9). Entry requirements are based on "a minimum of five subjects at ordinary level A, B, C, grade in the General Certificate of Education of England and Wales or Grade 1 in the Certificate of Secondary Education" (HMSO 1983, 9), a standard that came into force from 1st January 1986 (HMSO 1983) . Equivalent grades are also stated for the different educational qualifications of Scotland and Northern Ireland and in 1989 the General Certificate of Secondary Education (GCSE), grades A-C, was added to the list. Institutions were also able to accept applications from those who were successful in the DC Test, “ an intelligence test intended for anyone wishing to undertake a Pre-Registration Nursing or Midwifery programme who does not satisfy the minimum statutory entry requirements.” (nursing-consultancy.com 2003). The UKCC, now the NMC, also have the power to set out "equivalent" qualifications or

"educational test" (HMSO 1983, 9) (full list appendix 2).

Up to the reintroduction of an initial registration route into children's nursing, with Project 2000, registered nurses who wished to move into this field of practice were able to use their initial nursing registration to satisfy the academic entry requirements for a post-registration children's nursing programme, a process which required the completion of an application form and usually an interview, subject to the constraints recognised by Child et al (1988).

There are two additional requirements to guide institutions in their selection of candidates. The first is the need to check the health of candidates (ENB 1996) and to check candidates for children's nursing, initially under the requirements of the Department of Health Circular "Protection of Children: Disclosure of criminal background of those with access to children (HC(88)9)" (ENB 1995, 27), a process since superceded by the Criminal Records Bureau. Selectors may also need to make decisions based on any convictions candidates may declare under the requirements of the Rehabilitation of Offenders Act 1974 as nursing and midwifery programmes are "exempt" and convictions "are never regarded as spent" (ENB 1995, 27). Educational institutions are able to set their own academic requirements above the statutory minimum, if they so wish and may stipulate specific subjects they require for entry. Some institutions may also specify whether a particular number of subjects should be passed at one attempt.

There is evidence from a number of sources demonstrating that an increasing emphasis on candidates' academic achievement started to develop following the introduction of Project

2000. Gilmore, in her rather uncritical review of literature related to pre-registration nursing and midwifery education (Gilmore 1999), highlights early concerns that the entry requirements for diploma level nursing education were "too low" (Gilmore 1999, chapter 6.1).

Comparison of the academic requirements set out in the Applicants Handbook for 1994 (ENB 1994b) and the Applicants Handbook 1995 (ENB 1995) offer some support for Gilmore's conclusions. Of the 59 institutions listed in 1994, five had increased their academic entry requirements by 1995. Three were more specific in relation to specific GCSEs required with two making reference to A levels. A reason for this move to more rigorous academic requirements was according to one institution "Due to the academic nature of the programme" (ENB 1994b, 95). This may have been due to institutions feeling that they needed to emphasise to potential candidates the change from certificate to diploma level outcomes for nursing programmes and the increased academic expectations that such changes entailed.

Scrutiny of the NMAS Applicant Handbook 2000 (NMAS 1999) shows a similar range of acceptable qualifications, with additions linked to new qualifications or changes of titles of awarding bodies such as "Edexcel (BTec) National Qualification" (NMAS 1999, 25). Although direct comparative analysis of all institutions is not possible, due to the institutional changes that have continued to take place, of 47 institutions offering pre-registration nursing programmes 37 set out specific requirements over and above the statutory minimum (NMAS 1999).

NMAS statistics present a changing picture of the entry academic qualifications of the national cohorts of students. Comparison of the percentage of students on adult and child branches across a sample of the possible qualifications demonstrates a number of trends between 1998 and 2002 (table.16). Interestingly despite higher expressed institutional requirements, the percentage of students with A levels was less in 2002 and an increasing number had access course qualifications (NMAS 1999), a trend that may reflect the increasing percentage of candidates over the age of 26, who are more likely to have completed an Access programme. Figures for the adult and child branch indicate that in 1998 37% of candidates accepted for the adult branch were over 26 a figure rising to 46% in 2002, with a similar rise in the child branch figures from 14% in 1998 to 37% in 2002.

	Child branch			**Adult branch**		
	A level	Access	BTec	A level	Access	BTec
1998	16.7	3.8	9.2	14.9	9.6	8.4
1999	15.7	4.4	10.0	13.7	9.8	7.8
2000	14.4	3.9	8.7	12.3	11.8	6.7
2001	14.5	5	8	11	14	5.3
2002	11.6	5.8	6.9	11.5	14.4	4.3

Table 17 Trends in some academic qualifications (developed from NMAS 2001, 2002, 2003)

One measure of the effectiveness the levels of educational requirements for candidates might be the level of attrition from programmes. There have been a small number of British studies of this aspect of selection, focussed on the researchers' personal institutions (eg Houltram

1996; Kevern et al 1999). The result from such studies may reflect particular aspects of a specific institution, making the results less generalisable across the total student nurse population. There are also difficulties on a more national basis as the definitions of attrition used by different organisations are not always compatible and there are insufficient data for those who leave for personal reasons, or who fail to cite any reason at all.

Data published by the ENB, up till its closure in 2002, tracked the attrition rates of nursing students related to the branch programme they were on. Figures demonstrate the discontinuation rate as a percentage of the population in training, ie across the cohorts represented in any three year cycle. In 1998-99 a total of 18% of children's nursing students discontinued their training a figure that is very comparable with that for the adult branch (17%) (ENB 1999). Data from 2000-01 demonstrate that this figure remains fairly static with 17% discontinuations for the child branch and 16% for the adult (ENB 2001). Some wastage is accepted by the DoH as part of the contracting process, with the requirement in England that student wastage should be reduced to 13% (Price 2002).

The evidence that is available related to reasons why nursing students may not complete their training does not make any distinction across the different branches. Indeed the National Audit Office (NAO) report, Educating and Training the Future Health Professional Workforce for England (National Audit Office 2001), states that understanding of the reasons for wastage are limited, though some responsibility is laid on the pressures in the NHS (National Audit Office 2001). Figures produced by the NAO indicate that clinical or academic failure were

responsible for 25% of the attrition which came in second place to leaving because of personal (including financial) problems (National Audit Office 2001). The NAO make no connection between these figures and the selection processes that led to the students being accepted in the first instance. The National Audit Office report (National Audit Office 2001) provides a clear example of this dilemma for nursing where just under a quarter of nursing students left for "reasons not specified in the survey" or "Not known" (National Audit Office 2001, 27).

References

As part of the NMCCH/NMAS process referees are requested to provide information about candidates under a number of criteria. Although these have been "compiled following consultation with the institutions" (ENB 1995, 117) there are no public details of the nature of the consultation or the methodology used to draw up this list. It might be assumed that the consultation revealed a common list of the personal attributes and qualities that would suit all types of pre registration student nurses. Such criteria might, therefore, be considered to reflect a national opinion of the attributes of future nurses.

1. "Communication
2. Initiative
3. Motivation/Commitment
4. Confidence
5. Potential to follow a personally and academically challenging education programme
6. Reliability
7. Sociability
8. Health and attendance record in the past two years of employment, college or in the capacity known to you.
9. Athletic/social/other interests." (ENB 1994b, 147; ENB 1995, 117)

There is nothing to indicate to the referee that there may be any potential differences between the different branches of nursing. Referees are informed that education for nursing and midwifery will be at University Diploma level and that

> "Nursing is a demanding career physically, emotionally and intellectually. It requires people who have the potential to work alongside others who are experiencing a wide range of physical and mental health difficulties and who may require extensive support and supervision in their everyday living" (ENB 1995, 117).

Table 18 sets out a comparison of information required from referees and applicants on the NMCCH form against qualities identified by respondents in Child et al (1988). This comparison indicates that ten years after Child's initial data collection and the change to Diploma level education, there are similar expectations of the qualities that candidates for nursing are expected to display (table 18 overleaf).

Qualities	Child et al		NMCCH
	Form	Interview	
Academic qualifications/ability (Child et al 1988) Potential to follow a personally and academically challenging education programme (ENB 1995a)	75%	60%	*
Work/employment experience and stability	50%		
Health	19%	27%	*
Motivation/career intentions (Child et al 1988) Motivation/commitment (ENB 1995a)	19%	60%	*
Evidence of “understanding of people”/“caring attitude”	19%		
Communication skills/literacy	17%	60%	*
Interests hobbies/other achievements Athletic/social/other interests	16%	31%	*
Reliability/stickability/dependability (Child et al 1988) Reliability (ENB 1995a)	10%	17%	*
Knowledge of/experience of nursing	10%	28%	
Unspecified ““personal qualities””	9%		
Initiative			*
Confidence			*
References	17%		
Age	11%		
Sociability			*
Reason for choosing the branch			*
Experience of multicultural society			*
Sensitive to changing health care requirements			*
Understanding/awareness of nursing		35%	
Stable home background		16%	
"Maturity (for age)"		14%	
"Ability/desire to work with people (of all ages)		13%	
Adaptable/flexible		5%	
Self awareness		5%	
Ability to cope with authority		4%	
Practical ability		8%	
Commitment		24%	
Emotional stability		20%	

Table 18 Comparison of Child et al (1988) and NMCCH reference qualities and institutional expectations (ENB1995, 117)

Dobson describes references as asking for “an assessment of an individual by a third party” (Dobson 1989, 455). Candidates for nursing are required to provided two references one of which must come from someone who can provide an academic reference, either from a school, college or a previous nursing school. For those without access to such sources of reference the first referee must be an employer (ENB 1995). The NMCCH’s request for details related to specific criteria creates a semi-structured format intended to guide referees in providing relevant information (Dobson 1989). By providing such a structure "following consultation with the institutions" (ENB 1995, 117) it is theoretically more possible for those involved in selection procedures to make comparisons between different applicants (Dobson 1989).

According to Dobson (1989) the provision of such subjective information about applicants can be of "considerable value". Land disagrees stating that it may be "bland and generalised" (Land 1993, 36). Personal experience, in the selection of applicants for interview, demonstrated that the quality and nature of references can vary considerably with some referees providing a one line response related to the requested headings while others give a much broader impression of a candidate’s suitability.

Dobson (1989) believes the "accuracy" of a first reference may also be "confirmed" (Dobson 1989, 465) by information independently provided by the second referee. The motives of the referee may, however, be more difficult to assess (Hughes 2002). They may, for example, hold particular views or beliefs about the nature of the job being applied for and these may

influence the nature of the reference or they may feel a sense of loyalty to their soon to be past student (Hughes 2002). As Land (1993) implies some referees may perceive nursing as a practical vocation with little need for academic ability and therefore more suitable for the less able.

Those involved in selecting students are unlikely to check on references, anticipating that the reference is provided by a person with a "sense of fair play" (Dobson 1989, 465), who will attempt to write a favourable assessment of the applicant. In selecting student nurses the amount of work required to undertake such additional scrutiny would be considered prohibitive due to the numbers of candidates involved. There are no reports examining at which point in the selection cycle information available in the reference is considered.

Biodata

Biodata is described as being hard or soft (Robertson and Smith 2001). Hard biodata being information that can be verified, such as examination results and previous occupations (Drakeley 1989; Crafts 1991). Drakeley (1989) sees hard biodata as having the potential to be both objective and systematic. These qualities, however, only apply to information that can be gained in the same way for all candidates, through the use of such tools as questionnaires. One of the underlying assumptions of biodata is that future behaviour and job performance can be predicted through its use (Crafts 1991).

Discussion of the uses of biodata focusses on measuring it against items that are considered

relevant for the job (Robertson and Smith 2001). The hard biodata requested on the NMCCH form is verifiable and seeks personal details eg date of birth, gender and educational achievements. One of the main purposes of this within the application system is to check that the candidates meet the statutory requirements of age and academic qualifications for entry to the profession. Admission to a nursing education programme is not permitted under statute before $17^{1}/_{2}$ (HMSO 1983) and the statutory minimum academic qualification must be achieved before the submission of the NMCCH/NMAS form (Appendix 2). This is the first point for the possible rejection of a candidate's application by those institutions who have specified particular subject requirements above the statutory minimum.

Soft biodata, is also used as part of the application process, in the form of "supporting information" that the candidate is required to supply (ENB 1995, 29). Soft biodata is described as more "abstract" and by allowing applicants to express their "aspirations", "motivation", "attitudes and expectations" (Drakeley 1989, 440), it them to demonstrate something of themselves apart from academic achievements. Information of this type would appear to be important to nursing education institutions, as shown by the NMCCH guidance to candidates,

> "Keep in mind the programme(s) for which you are applying and provide information that will help those considering your form to select you for interview.
>
> Give a brief history of your practical experience as it relates to your application. Include any voluntary or community work you have undertaken, as well as your current work and/or studies" (ENB 1995, 29)

A review of the Applicant Handbook for 1995 revealed four institutions who specifically referred the that information provided in this section of the application would be used as part

of the selection process, a situation mirrored in the 2000 edition of the handbook (NMAS 1999). Only one institution made specific reference to the need for applicants to highlight their reason for their choice of branch programme, activities which demonstrate their communication skills and any paid voluntary work (NMAS 1999). The dilemma faced by those who review this section of the application form is that there is no specific format for this section against which all candidates can be assessed.

The applicants' handbook provides a small description of the nature of the Common Foundation Programme (CFP), the first 18 months of the programme the purpose of which is to "develop your observational, communication and caring skills" (ENB 1995, 97) and an outline of the aims of the different branch programmes. From such statements it might be presumed that candidates are expected to demonstrate such skills which will then be developed an educational process. The handbook does not indicate the ways in which these skills might be assessed before the point of entry.

Crafts (1991) and Bowles (1995) suggest the soft biodata that candidates provide about themselves is dependent on their level of honesty and is more difficult to verify. This phenomenon of enhancing information is described as "fictionalization" (Asher cited Drakeley 1989, 440). Robertson and Smith (2001), in their review of recent literature related to statements in situations such as this, report that the higher the number of competency statements the more highly the quality of the candidate is rated. Personal experience in the selection of students has demonstrated that a candidate's description of time spent in a caring

environment, whether organised by the school or the candidate themselves, can seem far more impressive on paper than is actually the case in reality. The experience of the careers teachers and others who provide guidance to students on how to fill in these forms and make the best presentation that they can, can also influence the way in which this soft biodata is presented. Land (1993), however, is supportive of soft biodata proposing that looking for factors such as "experience in a caring profession, voluntary activities, leadership qualities and motivational factors, reliability and aptitude" could replace the need for further selection processes such as interviews which are simply designed to establish these facts" (Land 1993, 33).

Although candidates are encouraged to write about their experience and voluntary work, selectors may not always be aware of local circumstances which may impact on a candidate's access to such experience. For example there may be a number of candidates who live miles from any suitable or available caring experience. Others may find that there is significantly reduced opportunity, for example, concerns raised following the Allitt Inquiry (HMSO 1994) reduced the number of volunteers in some caring establishments. Mature students and those who have limited financial support may need to spend any available free time in more financially rewarding forms of employment, not directly related to caring, in order to support their studies.

Interviews

Evidence related to interviews as a selection method usually refers to job situations, which is different to that of a nursing candidate who is attempting to be selected for education rather than a specific set job and who because of the need to fill cohorts of students is not in direct competition with others, rather being considered for suitability for a particular programme of education and training.

Non-nursing literature is not supportive of the use of interviews as a method of selection. For example, Herriot (1987 cited Herriot 1989, 433) proposes that the term interview "is really a generic word" for a process that is either "dynamic" (Herriot 1989, 434) with little structure or by which all the candidates are asked the same set of questions (Herriot 1989). Land (1993) also cites various authors who are in agreement with Herriot that conducting interviews has little value. This would seem to be particularly so in nursing where, as Child et al (1988) reported, there appeared to be a lack of criteria for assessing candidates, as well as "little consistency" in who performed the interview (Land 1993, 34). In their review of personnel selection methods Robertson and Smith present a more optimistic view stating that interviews have been shown to have reasonable validity (Robertson and Smith 2001).

Child et al (1988, 5) state that "psychologists regard the interview as a naive approach", however, they acknowledge that at the time of their study "interviews remain the commonest method used in selection" (Child et al 1988, 5) as "The nursing profession, quite understandably, believes that entrants to training should be screened" (Child et al 1988, 1).

Interview processes do however require a significant input of time from those involved (Ehrenfeld and Tabak 2000; Hughes 2002).

Reporting on a survey, undertaken by 1993 survey by the British Market Research Board, SHL state that within the UK interviews are "widely used" (shlgroup 2001, 4). Anecdotally nursing, which is in the public sector appears, to conform to the norm (table 19) as demonstrated by a project commissioned by the DoH that specifically looked at "Good practice in recruiting and retaining students" (DoH 2000, 9). Seventeen providers of pre-registration nursing education responded to the survey, which collected data through telephone interview and "paper-based surveys" (DoH 2000, 9). Ninety percent of respondents to the DoH commissioned survey used face to face interviews. These were seen as a "key component in assessing a candidate's suitability" (DoH 2000, 28) with selectors using interviews to look at communication and interpersonal skills, motivation and confidence.

Assessment Method	**Private Sector n=350**	**Public Sector n=100**
Interview	98%	100%
Tests	65%	71%
Questionnaires	55%	42%
In-Tray	21%	39%
Group Exercise	34%	39%
Any Behavioural Simulation	46%	60%

Table 19 Methods of assessment (shlgroup 2001, 4)

Hek's study, published in 1994 demonstrated that some nursing applicants were involved in other selection activities. These included a mixture of discussion groups possibly combined with essays written on the day or submitted prior to interview. Land (1993a) in her study in the West Midlands reported that these were not really liked by prospective students, while those involved in running them were concerned about the more passive candidates and the fact there was less opportunity to assess interviewees' communication skills (Ehrenfeld and Tabak 2000).

shlgroup (2001) list three major types of interviews (table 20), the biographical interview that takes candidates through their past history, and the competency based interview that looks for candidates' previous behaviours to match against the requirements of the role. The third type, the situational interview, enables exploration of the way in which candidates would respond in particular situations. As table 20 demonstrates there are advantages and disadvantages to all of these with the biographical interview being difficult to match to specific job criteria, the competency based interview relying on a job analysis, something that might be difficult for those selecting students for the potentially vast number of future roles that nurses occupy.

Nature of interview	Advantages	Disadvantages
Biographical	Most common and is probably the one expected by candidates	Difficult to relate to particular job criteria which may allow the interviewers “biases and stereotypes” to influence the decision (shlgroup 2001, 6)
Competency	Directly related to the role Easier to rate responses against the requirements of the role	Relies on thorough job analysis Highly articulate candidates may be able to make “a credible case” and be overrated (shlgroup 2001, 7)
Situational	Standard questions and “highly relevant to the job” (SHL 2001, 8)	Possibly influenced by social desirability responses Formality of the interview process may feel “unfriendly and intimidating” (shlgroup 2001 8)

Table 20 Advantages and disadvantages of different types of interview

Herriot (1989, 434) cites Kinicki and Lockwood's (1985) findings of "interview impression". In such situations the interviewers are attracted to interviewees who reflect similar positions to those held by themselves. In nursing this impression has the potential to be further influenced by the fact that candidates will have reached this stage of the process on the basis of the suitability of their biodata, their biographical information, and will therefore have been considered to have exhibited satisfactory characteristics.

Despite such findings the change to Diploma level education for nurses did not appear to have altered the selection processes used by institutions. The NMCCH Applicants’ Handbook, published in 1995 when this study began, stated that they were "not aware of any institutions

prepared to make offers without first interviewing" (ENB 1995, 20). This is supported by Hek's study (1994) which demonstrated that all the responding institutions performed some sort of interview as part of the selection process for nursing students and the DoH study in 2002 (DoH 2002a).

Herriot (1989) proposes that the interview maintains its popularity as a selection tool for several reasons. Those who use this method believe in the value of the "face-to-face encounter" (Herriot 1989, 435). Through meeting with the potential students the interviewers feel that they can determine how they will fit into the particular organisation (Herriot 1989). Others believe in the value of providing opportunity for the candidate to ask questions. Candidates may also feel that they have the opportunity to see how they feel about the organisation (Herriot 1989; HR-Guide 2003).

Selecting child branch students

Before the implementation of the Project 2000 recommendations those who applied to undertake children's nursing training would have been at least 21 years of age, having had to complete their State Registered training first. The implementation of the recommendations of Project 2000 meant that once again there was a route to becoming children's nurse without the statutory requirement for an existing nursing registration.

The move to Project 2000 changed the age of the student of children's nursing. People were now apply at the point of leaving school, as they only needed to be $17^{1}/_{2}$ (HMSO 1983).

Statistics produced by NMAS the system administering student admissions show that in 1998 87% of the applicants for children's nursing were under the age of 25 with 81% of the accepted applicants in that age range, with 72% of applicants for adult nursing being under the age of 25 and 64% of the accepted applicants being under the age of 25. These statistics would appear to demonstrate that the child branch student population was overall younger than the adult population and it may be inferred that they would therefore have had less life experience and possibly less opportunity to work in some form of caring capacity. This situation remains constant, as demonstrated by the 2002 statistics produced by NMAS. These show that for that year 75% of applicants and 76% of accepted candidates for the child branch were under the age of 25, whilst 58% of applicants and 54% of accepted candidates for the adult branch were under the age of 25.

In the period following the legislative changes, required to bring in the Project 2000 programmes, there was an increase in the number of institutions offering children's nursing programmes with the ENB statistics demonstrating a 15% increase in the number of children's nursing programmes in England (ENB 1995a). Up until the development of these new programmes the main providers of children's nursing programmes had been those institutions linked to either discrete children's hospitals or large children's units. The new providers of children's nursing programmes did usually not have these links and tended to find placements for students on wards within a number of NHS trusts with smaller children's nursing provision.

For those involved in the selection of students to enter the child branch these changes and new developments had the potential to impact on the selection of students. No longer were selectors able to refer to a nurse's previous experience of caring for children in the NHS, and references from their current employer who, it could be anticipated would usually be able to provide support for their application and provide confirmation of the qualities that would make them suitable to become children's nurses. From the introduction of the child branch a sizable majority of those putting themselves forward for selection would be school leavers or people with no previous experience of nursing sick children in a hospital setting. For those selectors who worked in institutions new to the provision of children's nursing programmes there was potentially the added dimension of limited experience in selecting students for this field of nursing from amongst such potentially raw recruits.

Criteria for candidates for children's nursing programmes

As a group which has chosen to work with children and their families, children's nurses are described in terms which seem to imply that they are different to others and have particular characteristics. Watt and Mitchell (1995) believe that the qualities of children nurses have remained "unchanged" (Watt and Mitchell 1995, 23) since 1854, when Dr Charles West stated that anyone who had entered children's nursing "without a feeling of very earnest love to little children.... you have made a great mistake" (West 1854, cited by Watt and Mitchell 1995, 23).

As previously described during the concept analysis of children's nursing a number of people have commented on the qualities of children's nurses. The, perhaps, most famous statement of the qualities required of children's nurses is that of Catherine Wood, Lady Superintendent of the Hospitals for Sick Children, Great Ormond Street who described trainee children's nurses as requiring "Instruction in discipline, obedience, promptitude, order, method and cleanliness" (Wood 1888, 508). Wood also considered it necessary to develop in the nurse "the mother's instinct, the grand self-sacrifice and self-forgetfulness that are the outcomes of a mother's love" (Wood 1888, 509).

Writers in the 1980s presented their opinion of the qualities of children's nurses in a manner which is perhaps less vocational, but with a sense that feelings about the child and family remain important (table 21). These qualities relate to the personality of the nurse and a type of person and as such are statements of personal belief. If questioned the authors would probably claim that these qualities were self evident and those they had found through their own personal experience of children's nurses. There is no reference to any particular qualities or abilities that may be required to undertake any assessment of the child and family, work with other health care professionals, facilitate the educational role of the children's nurse or support any technical nursing skills.

Wood (1888, 508, 509)	Bendall (1987, 58)	Hainton (1981, 31)	Curtis (1983, 42)
"Obedience, promptitude, order, method, cleanliness." "The mother's instinct." "The grand self sacrifice." "Self forgetfulness."	"Special skills, knowledge and understanding"	"Genuine love of children. Deep sense of compassion. A sense of humour. Confidence to provide support for child and parents."	"Common sense. Insight. Warmth. Understanding. Compassion." "These qualities are for the most part inherent"

Table 21 The qualities of a children's nurse 1888-1980s

While Wood (1888) and Hainton (1981) make reference to mother and children there is little to distinguish the children's nurse from any other health care worker in Bendall (1987) and Curtis' (1983) writing.

Parental perspectives of the children's nurse

Table 21 highlights the qualities that children's nurses see in themselves and others. There are others, such as parents, who may have different expectations. As part of his study of parents with experiences varying between days and months of being on two wards in a Scottish hospital with their children, Darbyshire (1994) established a list of both the positive and negative qualities that parents attributed to the nurses involved in their care. Data for this study were collected through interviews described as "natural informal conversation" (Darbyshire 1994, 199) and focus groups. Table 22 demonstrates that parents see positive qualities as those which demonstrate acknowledgement of the recipients of care, such as explanations that parents could understand, being unhurried, interested and allowing parental involvement in care. On the negative side those nurses perceived as being bossy, not paying

attention to the children and patronising were not seen in a good light. In highlighting the personal qualities, the personal characteristics, of the nurse Darbyshire argues that the "professional and personal qualities of the nurse cannot be artificially separated as they are inextricably bound together" (Darbyshire 1994, 129), adding weight to the notion that the type of person who nurses children is important (table 22).

Positive Qualities	Negative qualities
Commitment (working beyond contracted hours)	
allowing parents to express their feelings	professional detachment - indifferent to the parents emotional needs
acknowledgement of parents' needs (as well as child's	lack of empathy from the nurses who were not mothers
supportive to parents	bossy
non-judgmental atmosphere	
socialising with children	Not paying attention to the child when undertaking a procedure
explanations they could understand	patronising, talking down
nurses who were genuinely interested in them and their child	
warm, friendly, unhurried relationships	busyness
being allowed to be involved in child's care and choosing level of involvement	ignoring parents
having parents and child's needs met	

Table 22 Parental opinions of the qualities of children's nurses (Darbyshire 1994)

Government reports and recruitment materials

The government, through the Department of Health and their Trusts are the major employer of children's nurses. Reports commissioned by them and the recruitment material they publish reflect their perspective of the qualities required by children's nurses to fulfil the requirements of the NHS.

The National Audit Commission through a "detailed examination of a number of study sites, the synthesis of published research and analysis of national data." (HMSO 1993, preface), identified "six principles which should underlie the care of sick children in hospital" "Child and family centred care" "Specially skilled staff", Separate facilities", Effective treatments", Appropriate Hospitalisation" and "Strategic Commissioning" (HMSO 1993, 7). Focussing specifically on staff who care for children the Commission stated that

> "- The skills required to nurse the child, such as observation techniques and psychological support, are different;
> - involving parents in care requires special skills in teaching and support" (HMSO 1993, 19)

This emphasis on both the person and the application of specific skills is also reflected in publications issued by NHS Careers, the body set up to recruit those who wish to train as nurses (NHS Careers 2001a, b, c, d). The NHS Careers publication identify differences between the four different branches of nursing (table 23 overleaf).

Communication skills are common for all branches, with the emphasis in children's nursing being on those that are non verbal, considered "vital" (NHS Careers 2001a), whilst for the adult nurse they are "fundamental" (NHS Careers 2001b). Children's nurses need to

"Minimise the impact of illness or hospital admission" while "Working with the parents" (NHS Careers 2001a), whilst the adult nurse has "Close contact with patients and their families" (NHS Careers 2001b). For learning disability nurses the emphasis is on "working in a range of social settings, including home, work and leisure activities" and ensuring that clients with learning disability "do not suffer discrimination" "You will be dealing with all age ranges" (NHS Careers 2001c). For the mental health nurse there are other challenges from working in "One of the most complex and most demanding areas of nursing" whilst having the ability "to spot a build up of tension and defuse it" (NHS Careers 2001d).

Children's nursing	**Adult nursing**
"understand how a healthy child develops" "Minimise the impact of illness or hospital admission" "Working with the parents" "There are special communications challenges associated with children's nursing" "needs to interpret behaviour and reactions intelligently" "need to be very intuitive and immensely reassuring" "Non verbal communication skills... vital" "Confident at handling the distress of parents" (NHS Careers 2001a)	"Working in a multi-disciplinary team" "Close contact with patients and their families" "You will learn how to assess, plan, implement and evaluate care for individual patients" "Presence of mind and flexibility to juggle the needs of individuals at the same time" "Communication skills are fundamental" "Personal skills to set people at their ease" (NHS Careers 2001b)
Learning disability nursing	**Mental health nursing**
"Emphasis on nursing in a range of social settings, including home, work and leisure activities" "Sensitive human interaction is the core skill. You will need to have great patience and highly developed, flexible communication skills" "You will sometimes need to be assertive to ensure people with a learning disability do not suffer discrimination" "You will be dealing with all age ranges" (NHS Careers 2001c)	"One of the most complex and most demanding areas of nursing" "The key role and challenge is to form therapeutic relationships" "Your main tool as a mental health nurse will be the strength of your personality and communication skills. You will need to empathise with the people you are dealing with and show warmth and care about them." the ability "to spot a build up of tension and defuse it" (NHS Careers 2001d)

Table 23 Specific skills for the different branches - NHS Careers

The careers information, the descriptions of children's nurses and the potential similarities and differences between them and other nurses relate to the qualified nurse, the end product of an educational process. They describe the behaviours a person will need to have developed and employ in that particular field of nursing practice.

Price (1994) in defining the special needs of children, developed a range of indicators, from both literature and personal experience, that demonstrated ways in which a nurse might meet the needs of a child as identified by Pringle (1974, 1980, 1986), used in the concept analysis and definition of children's nursing (87-8). Price's list also included the physiological needs of children (table 24). As has been argued earlier in defining the special needs of children when they require nursing, this framework enables the child to be seen as a whole and allows for consideration of the different areas of growth and development as they relate to the specific experience the child is undergoing.

Variable	Indicator
Physiological development	Nursing activities which indicate awareness of: the child's physiological state eg altered or normal; knowledge of the child's physiological development; appropriate physical health care
Psycho-social development	
Love and security	Facilitating the stability of relationships within the family; acknowledgement of the importance of routines and rituals; consistent expectations in respect of discipline.
Praise and recognition	Encouraging the development of: self respect, age appropriate behaviour. Rewarding of effort and achievement.
For new experience	Teaching the child to deal with change and new experiences through the use of age appropriate play; appropriate stimulation.
Responsibility	Encouraging the child to take responsibility for his/her own actions; the use of patient-centred regimes; helping the child understand his/her illness through education

Table 24 Indicators of nursing actions developed from Price (1994, 231)

Further testing and development of these indicators against the needs of a range of children make it possible to capture the qualities of children's nurses (table 25, 168; table 26, 170). These qualities can then be compared with those required by adult nursing, the other branch of nursing that is focussed on an age group rather than a general area of care (mental health and learning disability nursing) and determine which of these may be common to nurses caring across the age range and those that are specific to children's nurses (table 27, 172).

Table 25 (168) applies the indicators of nursing activities to the care of a baby with bronchiolitis, an acute viral infection affecting small children under the age of 2, "with one-fifth" requiring hospital admission (Peter 2003, 122). As the activities to meet the indicators

demonstrate the nurses caring for the young child have to have knowledge of the normal respiratory pattern of babies and young children and signs of respiratory distress. There is also a requirement for close monitoring in relation to maintaining respiratory function and hydration and practical skills in ensuring that the baby's nasal passages remain patent.

Apart from ensuring that the baby's physiological functioning is monitored the children's nurse's other role is the care of the family, which may also include older siblings (Peter 2003). Table 25 does not list every possible action that may take place, rather it demonstrates some from a range of activities focussed on the family and encouraging them be as involved as they wish in the care of their baby. The activities to achieve this will be varied partly depending on the parents' previous experience of illness in their children and their level of understanding and skill. There may also be opportunities such as health promotion that should be considered.

Variable	Indicator	Activities to meet indicator
Physiological development	Nursing activities which indicate application of knowledge of the child's physiological state eg altered or normal: activities which indicate knowledge of the child's physiological development; appropriate physical health care	Monitoring baby for; respiratory rate, rhythm, use of accessory muscles, cough, flared nares, temperature, intercostal or subcostal recession, patency of nasal passages, apnoea attacks, level of hydration, fatigue, positioning
Psycho-social development Love and security Praise and recognition For new experience Responsibility	Facilitating the stability of relationships within the family; acknowledgement of the importance of routines and rituals; consistent expectations in respect of discipline.	Encouraging/involving parents in the elements of care as baby's condition improves, reestablishing regimes eg bathing, feeding, playing, involvement of siblings in care. Friendly approach
	Encouraging- the development of self respect, the development of age appropriate behaviour. Rewarding of effort and achievement	Awareness of impact on siblings eg possible regression due to impact of baby's admission to hospital Encouraging parents awareness of any siblings
	Teaching the child to deal with change and new experiences through the use of age appropriate play; appropriate stimulation	Encouraging parents to reestablish play, acknowledging impact on any siblings of baby's admission
	Encouraging the child to take responsibility for their own actions; the use of patient centred regimes; helping the child understand their illness through education.	Encouraging parents in taking over responsibility for baby. Education to take baby home, information eg re impact of smoky atmosphere on baby's respiratory problems. Providing knowledge so that parents are aware of when they may need help in the future.

Table 25 Nursing actions which enable the meeting of a baby's needs with bronchiolitis (adapted and developed from Price1994; Carter1995; Peter 2003)

The care of a school child with diabetes is mapped against the indicators in table 26 As previously discussed diabetes is a chronic disorder which can affect people across the whole age spectrum (125-6), and is "an important cause of long term health problems" (Wong 1995, 1765).

One of the differences in care between this and other chronic disorders and acute illness such as bronchiolitis is the need for ongoing treatment, in this case injected insulin and diet. As shown in table 26 this difference requires not only care related to restoring and maintaining physiological functioning but also a broad range of education in relation to the disorder and the knowledge and skills required by both the parents and the child to manage the disorder. Knowledge of children's intellectual development, their physical dexterity and their sense of wishing to be involved in their care is essential. One of the keys to success is the provision of appropriate praise and encouragement and bringing an awareness of activities which can increase self esteem and support from peers to the child and families attention.

Variable	Indicator	Activities to meet indicator
Physiological development	Nursing activities which indicate application of knowledge of the child's physiological state eg altered or normal: activities which indicate knowledge of the child's physiological development; appropriate physical health care	If child is hospitalised - implementation and interpretation of appropriate monitoring strategies. Administration of medical prescription. Safe administration of insulin:- rotation of sites to ensure absorption of insulin, safe disposal of sharps Ensuring dietary needs are met.
Psycho-social development Love and security	Facilitating the stability of relationships within the family; acknowledgement of the importance of routines and rituals; consistent expectations in respect of discipline.	Involvement/support of family in the child's care. Enabling family to adapt management of the diabetes to reduce disruption of the family's life. Enabling parents to deal with the child who is an awkward eater.
Praise and recognition	Encouraging- the development of self respect, the development of age appropriate behaviour. Rewarding of effort and achievement	Encouraging child to take increasing responsibility for injections and dietary control. Increasing self esteem through involvement in activities eg Youth Diabetes Group. Friendly approach
For new experience	Teaching the child to deal with change and new experiences through the use of age appropriate play; appropriate stimulation	Teaching and assessment of injection and blood testing techniques, management of hypo/hyper glycaemia for both parents and child. Liaison eg with dietician.
Responsibility	Encouraging the child to take responsibility for their own actions; the use of patient centred regimes; helping the child understand their illness through education.	Encouraging children to carry their identification card and glucose tablets. Development and use of a range of teaching packages.

Table 26 Nursing actions which enable the meeting of a child's needs when they have diabetes (adapted and developed from Price 1994; McEvilly et al 1995)[1]

[1] Price, S (1999) The selection of students for children's nursing: the qualities expected of candidates. Nurse Education Today 19 227- 238

Table 27 gives a broad view of the different qualities needed to nurse children with diabetes and those which would be common with those required to nurse adults with the same medical diagnosis. One immediate distinction is the differing areas of knowledge in relation to the physiological functioning of their group of patients. Children's nurses, particularly when caring for the very young have to rely on their skills of observation and their ability to respond to parents concerns to a greater extent than adult nurses who in the majority of cases actually have a patient who can communicate and respond on their own behalf. For the children's nurse there is also a requirement to be able work with children and adults and adapt the care, advice, support teaching and guidance to make it understandable for such a wide age group. For the children's nurse the educational focus may be with the child, the family or with both, with a need to train them in injection techniques, the understanding of diet and recognition of signs of a lack of control of the diabetes. The combination of those who need such education for the adult may be more restricted, and the diabetic will potentially have far more autonomy than a young child whose care and treatment will be under the relative control of their parents.

Variable	Summary of nursing actions required to meet indicator	Nursing knowledge, skills and attitudes
Physiological development	If child is hospitalised - implementation and interpretation of age appropriate monitoring strategies. Administration of medical prescription. E.g. Safe administration of insulin:- rotation of sites to ensure absorption of insulin, E.g. monitoring baby's respiratory status	**Children's nursing** ability to observe, record and interpret observations according to the norm for the child's stage of physiological development **Common** Technical skills
Psycho-social development Love and security	Involvement/support of family in the child's care. Understanding of the dynamics of family. Enabling family to adapt management of the child who is in need of nursing in an age appropriate manner.	**Children's nursing** Able to work with and get on with parents and children. Able to work with adults and children at the same time. Age appropriate support for child and family based on stage of development **Common** Warm friendly.
Praise and recognition	eg Encouraging child to take increasing responsibility for injections and dietary control. Parental awareness of siblings	**Children's nursing** Knowledge of child's need for praise and encouragement **Common** Aware of total person, Able to stand back. Not always wanting to do thing for others
For new experience	eg for the diabetic child teaching and assessment of injection and blood testing techniques eg for the baby enabling parents to reestablish play	**Children's nursing** Understanding of child's intellectual development and learning needs **Common** Teacher, able to work in a team and understand the possible contribution of others.
Responsibility	Development and use of a range of age appropriate teaching packages for the child and parents in relation to the care of the child who is ill.	**Children's nursing** Teaching. Able to use age appropriate communication skills with children, adults and professionals. Knowledge of child's developing understanding of their body and its functions

Table 27 Summary of qualities, distinguishing children's nursing and those that would be common with nursing adults

From the initial table of indicators of nursing actions (table 24,166) and their mapping against the care of two different children (tables 25, 168; 26, 170) it is possible to extrapolate those characteristics which would be inherent, ie existing in candidates who would be successful in applying to become children's nurses (table 28, overleaf).

As children's nursing is a practice based profession requiring skills in areas such as injections, feeding and handling it would seem appropriate to consider that candidates would have some element of physical dexterity before they enter the profession. For nurses to be able to get on with children and their families as well as working in a multi-disciplinary team it would also seem appropriate that they have interpersonal skills and a wish to communicate with others. Some understanding of what nursing children may involve and a desire to work with children and their families would be expected in the candidate putting themselves forward for selection.

Variable	Nursing actions required for activity	On entry to nursing	Knowledge/skill gained through education
Physiological development	Technical skills, ability to observe, record and interpret observations according to the norm for the child's stage of development Understanding of physiological development	Physical dexterity Psychomotor skills Observational skills	Knowledge of normal physiological and psychological development and the relevance of deviation. Technological and nursing skills.
Psycho-social development Love and security	Able to work with and get on with both adults and children. Able to work with both adults and children at the same time. Warm friendly. Age appropriate support for child and family. Understanding of child development	Interpersonal skills Warm/friendly	Application of interpersonal skills to people of different ages
Praise and recognition	Aware of total person, Able to stand back. Not always wanting to do thing for others, Knowledge of child's need for praise and encouragement	Wanting to work with children and families. Some understanding of what nursing children involves	Confidence to enable others to be involved in their own care
For new experience	Teacher, able to work in a team and understand the possible contribution of others. Understanding of child's intellectual development and learning needs	Aware that others may also contribute to care	Knowledge of teaching techniques and the roles of other health care professionals
Responsibility	Teaching. Able to use age appropriate communication skills with children, adults and professionals. Knowledge of child's developing understanding of their body and its functions	Ability to communicate with children and their families	Ability to communicate with other professionals appropriately

Table 28 Inherent characteristics of candidates for children's nursing[3]

[3] Price, S (1999) The selection of students for children's nursing: the qualities expected of candidates. Nurse Education Today 19 227- 238

The combination of the qualities expected of students derived from the application of Pringle's classification of children's needs to the care A combination of these children based on the preceding analysis of nursing literature and based on the proposed definition of children's nursing and the special needs of children combined with those derived from Child et al (1988) and the NMCCH (ENB 1995) creates a list of the inherent characteristics, qualities of children's nurses (table 29). Some qualities will be anticipated as being common to all students of nursing and others will be those specific qualities which would enable selectors to make a positive decision to accept the candidate for children's nursing.

Common to all nursing student candidates	Communication skills	Interpersonal skills	Self aware	Friendliness	Academic ability
	Caring attitude	Motivation	Warmth	Reliability	Confidence
	Psychomotor skills/physical dexterity	Observational skills	Athletic/ social/ other interests	Voluntary/ community work	Knowledge of/ experience of nursing
	Sociability		Initiative		
Children's nursing candidates	Understanding what nursing children involves	Awareness of others contributing to care	Caring skills	Ability to work with people of all ages.	Motivation/ Wanting to work with child and family
	adaptability		emotional stability		

Table 29 Inherent qualities of children's nurses and qualities common to all nurses

Treece and Treece (1986) state that it is possible to undertake research without a hypothesis, as long as the researcher "clearly states the question to be answered" (Treece and Treece 1986, 153). If the qualities identified by the literature review are indeed those of candidates for

children's nursing, then they raise two questions:-

Do people who select child branch students look for the inherent qualities identified in the literature?

Is there agreement amongst selectors on these qualities and the ways in which they may be evidenced?

METHODOLOGY

Introduction

A survey of the English institutions offering the Diploma in Higher Education (Dip HE) child branch was undertaken to answer the questions:-

> Do people who select child branch students look for the inherent qualities identified in the literature?
>
> Is there agreement amongst selectors on these qualities and the ways in which they may be evidenced?

The choice of a postal questionnaire as the survey method was determined by the nature of the data considered appropriate answer the questions and the geographical distribution of the personnel who could be included in the sample. Two ways of testing agreement amongst institutions were designed, the first requiring respondents to list the qualities they looked and the second requesting responses to a number of hypothetical application forms, developed specifically for this survey. The use of a questionnaire also enabled the collection of data related to the number of applications received by the institutions and the number of places available on the branch programmes presenting an opportunity to consider whether institutions might be considered to be "choosy" (Child et al 1988, 59), and an opportunity for questions related to the methods used to select students once they had passed the initial paper based processes for selection.

The use of face to face survey methodologies was rejected as being time consuming in setting up interview appointments that may not always be kept, across a wide geographical area

which would have increased costs or required the reduction of the sample size to a point where the results may have been more difficult to generalise for the whole population (Newell 1993). A telephone survey would have required less travel and incurred less expense though, because of the numerical data that were required, would have again necessitated the arrangement of telephone appointments. Such a methodology would have meant the loss of the opportunity to test selectors responses to the different candidates developed in the format of a NMCCH/NMAS application form.

Survey method

As has been discussed previously by far the majority of potential children's nurses are admitted to Diploma level programmes leading to registration than through the degree routes. Focussing on institutions that provided the Diploma route to registration would, therefore, provide a larger potential sample. The wide geographical spread of these institutions, from Newcastle to Plymouth meant that the chosen survey method had to be cost effective both in time and financial outlay. The method of data collection for this survey also had to be capable of collecting data related to selection methods in use with potential Dip HE (Nursing) students and have the ability to collect data related to both the attitudes and opinions of those involved in the selection process. Postal questionnaires are described as having such advantages (eg McColl 1993; Oppenheim 1992; Parahoo 1993; ucl.ac.uk 2001).

Postal questionnaires have other advantages for the type of survey deemed the most practical (Newell 1993). They avoid interviewer bias (Oppenheim 1992; ucl.ac.uk 2003a) and all

respondents are asked exactly the same questions (Polit and Hungler 1985; Treece and Treece 1986). Questionnaires also allow respondents to answer at their own convenience (Parahoo 1993; Treece and Treece 1986), allowing for greater accuracy when information is required from records that may be held elsewhere (Parahoo 1993), such as the number of candidates applying for particular branches of nursing over a given period.

Oppenheim (1992) and others (eg Parahoo 1993; Treece and Treece 1986) cite disadvantages which need to be taken into account when using self-administered questionnaires, such as those sent by post. One significant disadvantage of such data collection methods is the reliance on the reading and comprehension of questions which makes them inappropriate for use by people with "poor literacy" (Oppenheim 1992, 102). This was not considered to be a disadvantage with the intended sample for this study as all the respondents were people whose usual routine of work involved the use of the written word and responses to questions. A second disadvantage of postal questionnaires is that the answers may be less spontaneous than in other methodologies as respondents have more time to consider their responses (ucl.ac.uk 2001). Again this was not considered a disadvantage as the respondents would be asked to consider a number of potential candidates for nursing and give an opinion on their suitability in a process designed to mirror their usual working practice and whose purpose was to receive a considered response to the candidates.

Oppenheim sees the fact that some respondents may not complete the questionnaire in the order in which it was set out as a possible disadvantage (Oppenheim 1992). This is

particularly so if later questions have the potential to influence the answers that might be given to earlier questions. This was not considered to be a disadvantage for this study as the two questions focussing on the qualities of candidates for the child branch were approached in different ways. The first requiring factual information and the second asking for decisions in relation to the specially created applications.

The absence of the researcher with the consequent lack of "opportunity to correct mis-understandings" (Oppenheim 1992, 102) is also seen as a disadvantage of postal questionnaires. As is recommended a pilot study was planned as a mechanism to indicate possible areas where a change of wording might ensure that questions were less likely to be open to misunderstanding. Research involving postal questionnaires may also suffer from poor response rates (Polit and Hungler 1985) and a policy to deal with this, including checking responses against a master list and determining dates for follow up postings was developed.

Treece and Treece (1986) consider the cost of printing and posting as a disadvantage of postal questionnaires. For this study such costs were, however, far less than would have been incurred in setting up appointments and travelling to the institutions, geographically spread between Newcastle upon Tyne and Plymouth, to conduct interviews. The ability to anticipate data collection within a defined period of time was a further advantage of using self administered postal questionnaires enabling planning of time for data analysis.

By presenting respondents with a postal questionnaire which requested numerical data and details of academic entry requirements which could be collated within the normal work schedules it was anticipated that the response rate would be increased.

Types of questions

In questionnaire design "most questions are either 'open' or 'closed'" (Oppenheim 1992, 112). Both types of questions have potential advantages and disadvantages when used in a postal questionnaire and these should be considered in the development of the research tool. The questionnaire for this survey needed to be able to capture both factual data such as numbers of students and attitudes and opinions on the qualities of candidates for children's nursing. There was therefore a need for both types of questions.

Closed questions

Facts and attitudes can both be explored through the use of closed questions (Oppenheim 1992). In closed questions the respondent is "limited" (Treece and Treece 1986, 280) in the response they can make by the options presented in the list of possible answers provided by the researcher. It is therefore important to ensure that an appropriately wide range of possible answers is made available.

Open questions

Open questions provide more freedom for the respondent, as they are able to use their own words to provide answers (Oppenheim 1992). This freedom may, however, produce data

which is difficult to analyse and which may loose some of its "richness" during that process (Oppenheim 1992, 112). The answers to such questions also have the potential to be influenced by the amount of space provided for the answer on the form and with a self-completion questionnaire there is no opportunity for the researcher to probe and discover more. Surveys using an interview methodology may increase the opportunity for probing but the data still have to be recorded and the interpretation of the response is reliant on the researcher, both for accurate recording and appropriate interpretation. For data on attitudes and opinions related to the selection of child branch students open questions would be the most appropriate as they would allow the collection of data without responses being affected by a prepared list of responses.

Question wording

Clarity of question wording is particularly important when the respondent cannot seek clarification of what is being asked (Polit and Hungler 1985). Drennan (2003) cites Conrad and Blair's (1996) description of lexical problems within questionnaire design, a problem that can occur when respondents fail to understand terms or phrases used within the questions. This is an important consideration in the development of a postal questionnaire (Polit and Hungler 1985). A question must mean the same to all respondents otherwise it "is unlikely to produce meaningful information" (Polit and Hungler 1985, 200). One purpose of a pilot study is to determine whether the respondents' answers indicate that they had interpreted the questions in the way anticipated by the researcher.

A number of other factors need to be taken into consideration when developing questions. Wording should be simple and avoid the use of "jargon" and "acronyms" (Oppenheim 1992, 129) and avoid ambiguous words or non-specific words (Oppenheim 1992) Double negatives and leading questions should be checked for (Treece and Treece 1986; Oppenheim 1992) and questions should also only ask one question at a time (Oppenheim 1992), so that the researcher is sure which of the options is the one that reflects the respondents intended answer. For example, the use of words such as dinner or tea may vary in meaning in different parts of the country (Oppenheim 1992). Words which are non-specific and unmeasurable such as better or worse are also not suitable for use (Treece and Treece 1986). Lexical problems may also occur during the analysis of responses, if respondents use their own jargon or job titles in a way that may confuse the analyst.

Social desirability

Many researchers highlight the problem of socially acceptable answers as a problem in the use of questionnaires (eg Treece and Treece 1986; Oppenheim 1992). This may be particularly so with factual questions (Oppenheim 1992) where the respondent wishes to impress the researcher. As the researcher would not be known to the respondents and the results were guaranteed to be anonymous the impact of social desirability was considered to be minimal.

Sample

In undertaking such a survey it is important that the respondents are representative of the whole population (Newell 1993). Oppenheim (1992) and others (eg Newell 1993; Reid and

Boore 1987) discuss a number of different methods by which the representativeness of the sample can be increased. Such discussions, however, usually centre around the development of large studies, with significantly larger populations that were available for this study.

Unlike Harding (1999) the sample chosen for this survey was a total population sample (Newell 1993) chosen to ensure total representativeness and reduce potential reliance on colleagues and allow generalisation of the findings across all providers of children's nursing education. A smaller sample would also have required determining which institutions were new or established providers of children's nursing education and the development of criteria to establish such facts and ensure inclusion within the sample.

At the time of this study colleges of nursing were merging and integrating with higher education institutions. The 1995 NMCCH Applicant Handbook (ENB, 1995) listed 43 institutions which offered the child branch spread across the whole of England from Newcastle on Tyne to Plymouth. Of these five were not considered suitable for inclusion in the survey because three did not select students directly for their child branch, leaving such decisions until the end of the common foundation programme half way through the course and one institution was awaiting validation of a new provision. The fifth, South Bank University School of Paediatric Nursing and Child Health (Great Ormond Street) only accepted applicants for children's nursing and would therefore not have been able to respond to a number of questions. This left a total potential sample of 38 institutions.

Increasing the response

An explanation of why particular respondents have been invited to participate in a survey is considered as one of the factors which can increase their motivation to respond (Oppenheim 1992; Reid and Boore 1987). Oppenheim (1992) includes the issue of anonymity in his discussion of approaching the respondents (Oppenheim 1992). True anonymity, for the respondents, makes it difficult for the researcher to check who has returned the questionnaire.

Oppenheim (1992) suggests that writing to a named person increases that potential for response. Many of the institutions included in this study advise that correspondence and inquiries should be directed to a post rather than a named person. The questionnaire and letter were, therefore, posted to the head of selection and recruitment in the institutions as at a time of great organisational upheaval it was anticipated that these departments would have possibly greater stability in personnel. The follow up mailing to institutions which had not replied by the first deadline included a second copy of the questionnaire, a measure that is seen to substantially increase the response rate (Edwards et al 2003).

Respondents were requested to give details of their name and institution. An assurance was given, on the front page of the questionnaire, that this information would not appear in the final report of the survey. The respondents were made aware that the purpose of collecting this information was to track which institutions had returned forms. They were also informed that the page with this information would be removed when that was done.

The questionnaire (see appendix 3)

The first two sections of the questionnaire asked questions related to all the branches of nursing offered by the institutions. The third section was entirely focussed on the likelihood of candidates being chosen to be interviewed for admission to the Dip HE child branch and utilised an application form approach, mirroring the practice of the admissions service (NMCCH/NMAS).

Section 1

Questions 1 - 6

The questions, in this section, required factual answers, which could be considered as not being threatening to the respondent whilst also being relevant (Reid and Boore 1987). Although requiring factual responses these questions were open questions. Respondents were asked to provided details of the data rather than pick from a range of numbers, particularly dealing with the potentially small numbers related to the child branch. It was considered that this would increase the reliability of the responses as these figures would probably have to be looked up in departmental records. These factual questions enabled the collection of a range of different data that would enable calculation of the proportionate reduction that had to take place between the total numbers of applicants and the number of places. Requiring factual data in relation to all branches offered by the institution would allow for comparisons to be drawn.

It was anticipated that data would confirm whether the responding sample was representative of the full range of institutions and data about the number of students would enable the researcher to determine whether institutions could be described as being able to be "choosy" (Child et al 1988, 59) about candidates.

1. How long has your college been running the Dip HE child branch?
2. Which of the following branches do you offer?

   Responses to this question would provide nominal data. At the time of data collection there was a statutory requirement that institutions should offer three of the four branches (ENB 1993).
3. How many groups for each branch do you admit each year and how many students are recruited for each?

   Data in response to this question would be interval/ratio. The move to Project 2000 had led to a move from regular intakes of students several times a year to twice yearly. Not all institutions offered the child branch for each intake during the year.
4. In total how many applications did you receive for each of the Dip HE branches in 1994?

   Responses to this question would also provide interval/ratio data enabling comparisons to be drawn between all the branches offered in an institution.
5. What are your criteria for selecting potential students for: Adult

   Academic qualifications

   Personal qualities

Space was provided for responses related to each of the four branches offered by the institution. Hek's (1994) study, published at the time that this questionnaire was being developed, had reported that less than 50% of the institutions responding to her study required maths or a subject demonstrating numeracy. Respondents were, therefore, required to indicate their institution's educational requirements as well as the personal qualities they would expect from prospective students. Through the use of an open question it was anticipated that respondents would present their own institutions' criteria, rather than attempt to match those presented by the researcher. The educational criteria listed by the institutions would also demonstrate whether they were being responsive to changes in statutory requirements that had been widened to take account of National Vocational Qualifications (appendix 2) and whether potential academic ability was being used as a mechanism to filter out candidates for over subscribed branches such as the child branch.

Personal qualities

Child et al (1988) in their study of student selection had used questionnaires to determine "what qualities are looked for in the application form" (Child et al 1988, 128). Responses from 67% of the 225 schools then in existence were presented. The institutions had not been asked to distinguish expectations of candidates for the different nursing registrations then in existence. With the introduction of Project 2000 it was possible for applicants to apply directly for children's nursing, something that had not been possible for a number of years. The choice of an open question was allowed respondents to reply in their own words. It was also anticipated that the qualities identified in response to this question would match the

characteristics derived from the literature and that other qualities would emerge from the data. (See 196 for discussion of the method of analysis for responses to this question)

Question 6

Child et al (1988) had anticipated that the introduction of the recommendations of Project 2000 would lead to a "reassessment of selection criteria and methods" (Child et al 1988, 115). The institution where the researcher was employed at the time of the implementation of Project 2000 had moved from individual interviews for students to group discussion, followed by a short individual interview and an information giving session. Therefore the question

> Has your selection process for students changed since the implementation of Project 2000?
>
> If yes please describe your previous system.

was intended to determine whether there had been changes in other institutions.

Section 2

Section two concentrated on the selection method and the personnel involved in selecting students. There is no statutory or advisory policy issued in relation to the processes for selecting nursing students, meaning that institutions are free to devise their own selection processes within the time frame required by the centralised admissions service. The purpose of asking respondents in question 9 whether the same method was used for all branches was to determine whether there was any link between ratio of applicants to places and the processes used. Within this section there was also the opportunity to explore the extent to

which students are chosen by representatives of their own branch of nursing.

The researcher's own experience indicated that institutions were currently using either individual interviews, discussion groups or a mixture of the two. Respondents were presented with a range of questions related to their chosen method of selecting students. The questions related to discussion groups were based on the expectation that a number of groups may be run simultaneously. These questions were deliberately factual in their quest for information as the respondents would possibly not have been involved in the choice of method for student selection. The use of this methodology did not lend itself to detailed study of the reasons for and attitudes towards the selection process chosen by the institution.

Child et al (1988) had indicated, that when they were undertaking their study, a wide range of personnel from both institutions and practice were involved in the student selection. Since that time anecdotal evidence had suggested that the restructuring of the NHS and the merger of nursing education institutions into higher education, had led to less direct involvement of NHS personnel in the selection of students. The questions were therefore structured in an attempt to determine the extent to which practising nurses were involved in the selection processes. If responses demonstrated that few or no practising nurses were involved in such processes the question could be raised of who was being selected - students or potential nurses. A filter question was used to send respondents to an open question should none of the options match their practice.

For these, and a number of other questions, visual analogue scales were used to record the response. Such scales are "typically" (Waltz et al 1991, 366) 100mm in length with only one variable being measured on each scale. Burns and Grove (1993) state that anchor words should be bipolar, such as "all" or "none" (Burns and Grove 1993, 380). Mead and Moseley (2001) see value in using strong labels so that when respondents are making decisions it is possible to be confident that they really mean it. Burns and Grove (1993) state that the anchor words should be placed at the end of the line not underneath, whilst other writers do not appear to conform to such conventions (eg Carter 1994). Mead and Moseley (2001) stress the importance of piloting the scaling with a population similar to that involved in the full study. The decision in designing the scales for use in this study was to use strong bipolar anchor points such as never and always, and not likely and very likely as the size of the total possible sample (38 institutions) would not allow for repeated testing of any different scales. There is no evidence that any particular scaling method is any better than any other (ucl.ac.uk 2001a).

Visual analogue scales are simple to use (Gift 1989). The use of a limited range of vocabulary means that people of all abilities should be able to use them satisfactorily. Also with the use of only two anchor words there is little opportunity for individual interpretation of the meaning of words (Gift 1989). Waltz et al (1991) indicate that such scales can easily be incorporated into mailed questionnaires. The respondent should be requested to draw a mark through the 100mm line. The distance is measured using a ruler from the left side of the line to a "specified place" on mark where it intersects the line (Waltz et al 1991, 366). Waltz et al (1991) describe the level of data obtained, through the use of visual analogue scales, as

interval, therefore enabling the use of parametric analysis where appropriate.

Section 3

Hypothetical candidates

The final section of the questionnaire was considered more "thought provoking" (Treece and Treece 1986, 290) and was focussed specifically on the selection of candidates who wished to enter the child branch and the reasons why an institution made decisions about their acceptability for interview. A range of candidates were specifically developed to test the theoretical inherent qualities derived from the literature. The number of hypothetical candidates presented for consideration by the respondents was limited to six in an attempt keep the length of the questionnaire and the time required for its completion practical for the respondents at a busy time in their own admissions cycle.

Six vignettes portrayed hypothetical candidates who were ranged in degrees of acceptability from most acceptable to not acceptable (see table 32, 197). The NMCCH format of a space for "supporting information" (ENB 1995, 29) and a reference was used with the intention of imitating the normal process of selecting candidates for interview. As far as the researcher is aware this methodology had not been used previously in any study related to the selection of Dip HE child branch students.

Gould describes the use of vignettes as “simulations of real events” (Gould 1996, 207), that allow manipulation of variables, and as such are suited to the study design which in this

section mirrored the normal decision making processes of student selection. Early nursing authors, for example Flaskerud (1976, cited Gould 1996), expressed concerns that vignettes would not be able to portray the "phenomenon of interest" (Gould 1996, 208). This was not considered a disadvantage for this study, as the methodology mirrored the actual process under scrutiny and, indeed, the supporting information provided by the student could be described as a personal vignette, the reality of the candidate.

Providing each institution with the same set of data from which to reach a decision was intended to enable a comparison across the whole sample. Inviting respondents to provide their own list of anticipated qualities without reference to actual candidates would have reduced the potential richness of the data and replicated the earlier question. Allowing respondents to describe or discuss candidates from their own institutions would not have allowed comparison across the sample and could, potentially, have required consideration by a large number of ethical committees and this might have reduced the number of responding institutions and increased the amount of time to collect the data.

Acceptability of candidates

The researcher's personal experience as admissions tutor for a pre-registration nursing course enabled the development of these candidates using the proposed characteristics. These characteristics were manipulated (table 30, 194 and 31, 195) to create six applications (appendix 3).

QUALITIES COMMON TO ALL NURSING STUDENTS	C1		C2		C3		C4		C5		C6	
	I	**R**	**I**	**R**	**I**	**R**	**I**	**R**	**R**	**R**	**I**	**R**
Communication skills		X	X					X		X		
Initiative	X		X	X	O		X	X	X		X	X
Potential to follow personally and academically challenging programme		X		X		O		X	X			O
Reliability	X		X	X	X	X	X	X	X	X	X	X
Sociability	X	X	X			X	X	X	X		X	
Athletic/social and other interests	X		X		X	X	X	X	X		X	X
Interpersonal skills		X		X		X						
Warmth								X				
Friendliness	X	X						X				
Confidence												
Observational skills												
Self aware				X	X							
Voluntary/community work	X		X				X		X			X
Knowledge of/experience of nursing	X				O		X	X	X			
Caring attitude	X	X	X							X		
Motivation/commitment												
Psychomotor skills/ physical dexterity	X		X			X					X	

Key **C** = candidate number **I** = supporting information **R** = reference
X = positive manipulation O = negative manipulation

Table 30 Qualities common to all student candidates

QUALITIES SPECIFIC TO CHILD BRANCH STUDENTS	C1		C2		C3		C4		C5		C6	
	I	R	I	R	I	R	I	R	I	R	I	R
Motivation/commitment eg reason for wishing to be a children's nurse	X	X	X	X	O	O	X	X	X	X	O	X
Understanding what nursing children involves			X		O		X	X	X		O	
Awareness of others contributing to care							X					
Caring skills	X	X		X						X		O
Ability to work with people of all ages	X	X		X			X		X	X		
Adaptability												
Emotional stability												
Motivation/wanting to work with children and families			X		X	O	X		X	X	X	

Key **C** = candidate number **I** = supporting information **R** = reference
X = positive manipulation O = negative manipulation

Table 31 Qualities specific to child branch students

Not every identified characteristic was manipulated in the supporting information as it would be unrealistic to anticipate that every candidate had elements of all characteristics or would manage to include them in their application. This also provided the opportunity to identify whether those involved in reviewing the applications were also interested in what was not said by or about a candidate. The number of negative manipulations in both the supporting information and reference were limited in keeping with personal experience of reading such applications and the fact that in reality candidates will be attempting to impress the selectors and referees usually attempt "fair play" (Dobson 1989, 465).

Child et al (1988) in their study of nurse selection had identified that some qualities of

candidates such as confidence, observational skills, adaptability or emotional stability were only looked for during the interview process. These qualities were therefore not entered into the manipulated variables. The variable of motivation/commitment was manipulated specifically in relation to the candidates' expressed aspirations to become a children's nurse. There were a number of competency statements included within the application forms such as "I have held various positions of responsibility" (Candidate 1).

Gould in her framework for critiquing vignettes proposes that the vignette and the questions that are posed in relation to it should be tested (Gould 196). This was undertaken by two expert witnesses, one a Director of Community and Child Health Studies at a southern university with responsibility for recruitment and retention of child branch students and the other a lecturer at a midland university with a long experience of selecting students for children's nursing programmes. Both experts were required to follow the processes as set out in the questionnaire (table 32 overleaf) as well as providing a descriptive ranking of acceptability. Numerical ranking based on the scores on the visual analogue scales was also applied to the candidates to distinguish between them within the descriptive ranking hierarchy.

Candidate	Descriptive Ranking	Numerical ranking
1	Moderately acceptable	4
2	Most acceptable	1
3	Not acceptable	6
4	Most acceptable	2
5	Moderately acceptable	3
6	Not acceptable	5

Table 32 Experts ranking of candidates.

Qualities of the candidates

For candidate 1, considered to be moderately acceptable, it was anticipated that selectors might question the relevance of her range of experience, in shadowing a midwife, a district nurse and being on a geriatric ward, to her expressed desire "to be a children's nurse". Candidate 2's statement about why she wished to become a nurse and her enjoyment in working with children was considered to make her a most acceptable candidate. The head teacher's statement about problem solving was seen as a positive recommendation of a good student who would be suitable for the potentially less supportive environment of higher education.

The use of terminology such as the "medical profession", from candidate 3, was seen as indicative of an applicant has no really clear idea of what nursing is about and its difference from other professions allied to medicine and indeed medicine itself. This combined with the fact that he had no caring experience and his headmaster implied that applying for nursing was a recent idea created a candidate who was believed to be not acceptable.

Candidate 4 in referring to his own experience and clearly stating where he thought he would wish to be employed when he qualified was considered to be a most acceptable candidate. The inclusion of the statement that "I believe that it is important for there to be male nurses, particularly for adolescent boys", had the potential to cause respondents to comment on why this might be. This was considered very pertinent at a time when a male professor of children's nursing was raising the question of whether post the Allitt Inquiry (HMSO 1994) and the case of Philip Donnolly, a male nurse who had abused children we had reached a time "where society considers a male in children's nursing so inappropriate that they are accused of abuse without even setting foot in a clinical area?" (Glaper and Campbell 1994, 18).

The inclusion of an experienced nursery nurse amongst the candidates reflected the reality of the application process, as a number of nursery nurses working with sick children in hospital do wish to move into nursing. The fact that Candidate 5 had acceptable but less usual academic qualifications and was currently planning to complete a GCSE in human biology before starting her training was seen as creating a moderately acceptable candidate. Candidate 6's concentration on her activities and the fact that she left any statement about being a nurse and specifically a children's nurse right to the end of her supporting information were intended to give an impression of a not acceptable candidate.

Respondents were requested to indicate "How acceptable would this applicant be for your college's child branch?" on a visual analogue scale with bi-polar points of Not acceptable and Very acceptable. They were also asked to "Please give reasons for your decision about the

acceptability of this applicant".

Further variables

In reality the selection process has to take account of two further variables. Selectors would consider an applicant's academic qualifications against both the statutory requirements (Appendix 2) and their own institution's specific requirements. The NMCCH and now the NMAS handbook for applicants details any additional institution specific requirements such the need for English Language, or the requirement for Mathematics or a Science. This checking is necessary as some candidates apply to institutions without the appropriate additional qualifications for entry. In an attempt to ensure that institutions own academic requirements did not influence decisions made about the hypothetical candidates respondents were asked to "please assume that all the candidates have achieved your entry requirements."

Secondly the NMCCH form also requires candidates to provide information related to sickness and absence "from employment or college you have had in the last two years" (ENB 1995, 29). This information was not included in the hypothetical applications, again with the intention of ensuring that respondents concentrated only on the supporting information and reference. In reality candidates are instructed to write their supporting information in their own handwriting. For clarity and ease of reproduction this information as well as that for the reference was word processed. It was anticipated that the questionnaire would take between 20 and 25 minutes to complete. Described by Treece and Treece (1986) as a suitable length for a self completion questionnaire.

The expectation was that the responses given to these applications would indicate whether there would be agreement on the inherent characteristics of potential child branch students and the evidence to support demonstration of that characteristic. There was also the possibility that other characteristics would emerge from the data.

Content Analysis

Questions 5 (7 main study) and 15 had been specifically designed to test the extent to which there was "agreement amongst those involved in selection on the inherent qualities characteristics of potential child branch students", and provide a quantitative "view of the whole population" (UNFPA 2001, 3). The development of the hypothetical candidates using a range of manipulated variables was not only intended to elicit a qualitative response to the theoretical inherent qualities, providing some "insight into attitudes" of the individual respondents (UNFPA 2001, 3) but also to determine the level of agreement, that is the strength of opinion across the sample and to enable ranking of the responses.

The method of analysis chosen for these questions had to present more than "quotable quotes" (Ashworth 1997, 215), it also needed to determine "the presence, frequency, intensity or nature of the selected characteristics" (Markoff et al 1977 cited by Waltz et al 1991, 299) as required to test the hypothesis. Content analysis is described as having such functions (Treece and Treece, 1986), as it enables the quantification of qualitative data (Webb 2001) leading to data that can be subjected to descriptive statistical analysis (Pearson 1997). It may also be possible to generalise findings as all respondents will have been asked the same question

(Pearson 1997). Cavanagh (1997), Waltz et al (1991) and Fielding and Lee (1998) describe content analysis as a suitable method for the analysis of recorded information in a wide variety of formats including, amongst others, books, plays, newspaper articles (Waltz et al 1991) and textbooks (Cavanagh 1997). The raw data generated in response to questions 5 (7 main study) and 15 would be in a written format and fulfilled the criteria for the "universe of content" (Waltz et al 1991, 301) (table 33 overleaf).

Waltz et al (1991) describe a series of steps which must be taken when undertaking content analysis. Table 33 (overleaf) demonstrates these steps and the processes which need to be considered at each point mapped against this study and the data from the two questions that would be subject to content analysis.

Step (Waltz et al 1991)	Process	This study
"Define the unit of content to be examined" (301). The written source.	May be the whole universe (ie all the material available) (Waltz et al 1991).	All the responses to questions Q5(7) related to the personal qualities of candidates and to the manipulated variables in Q15.
"Identify the characteristics or concepts to be measured" (302)	"what do I need to know about or learn from the content" (Waltz et al 1991, 302).	Need to know the qualities of candidates and the number of respondents referring to particular qualities demonstrated by the candidates.
"Select the unit of analysis to be employed" (302)	The use of words, phrases, themes (Waltz et al 1991). These may be gained from an initial scan of the written sources.	Collating responses into a word processed format would enable an initial sense of the ways in which the data could be split into units for analysis.
"Develop a sampling plan" (303)	Specific instructions eg the number of chapters from a book (Waltz et al 1991). May also be the whole universe (Waltz et al 1991).	In this study all the response would be considered in the analysis.
"Develop a scheme for categorising the content" (304) (also Cavanagh 1997)	Through the use of literature, theory, preliminary data analysis (Cavanagh 1997). Some may be predetermined and others emerge from the literature during the analysis (Moseley and Mead 1997)	The responses were to be matched against each other and then against the theoretical inherent qualities derived from the literature New qualities emerging from the data were to be entered into the analysis
"Develop explicit coding and storing instructions" (305)	In qualitative research these issues are important. Codes may need adjustment (Cavanagh 1997).	The data were to be matched against the theoretical inherent qualities and the manipulated variables

Step (Waltz et al 1991)	Process	This study
"Pretest the categories and coding instructions" (305) (also Cavanagh 1997)	Though the use of a small sample of the content to be analysed (Waltz et al 1991).	Categories determined by the theoretical inherent qualities and the new categories emerging from the data
"Revise coding rules" (Cavanagh 1997, 8)		To remain based on the theoretical qualities and emerging new qualities.
"Train coders .. establish an acceptable level of reliability" (306)	Training of other coders is not an issue for a solo researcher.	Training of other coders is not an issue for a solo researcher.
"Perform the analysis" (306)		sample size of 22 was suitable to enable a "cut and paste" process to be used (Webb 1999, 323)

Table 33 Steps in content analysis

Advantages/disadvantages of Content Analysis

The potential advantages (table 34) and disadvantages (table 35) of content analysis were evaluated taking into consideration the data to be used and the method of data collection and analysis that could be undertaken. Waltz et al's (1991) review of content analysis draws together the process, advantages and disadvantages of this methodology, with particular emphasis on its applicability to nursing research. As these two tables (34, 35) demonstrate this methodology, when matched against this study, had the potential to support the processes required to test the hypothesis.

Advantages (Waltz et al 1991)	This study
The use of existing information available at low cost	This was not existing information, however the provision of data was at no cost to the respondent
Study can be undertaken "without requiring subjects to do anything out of the ordinary" (309)	Qu 5/7 (the personal qualities) was based on the respondents listing their usual expectations. Qu 15 The design of this question deliberately mimicked the usual practices for decision making at this stage of the application process. The only additional requirement was the request to write down the reason for the decision.
"Information produced for non scientific purposes can be made usable for scientific inference" (310)	This was not a consideration for this study. It would be a consideration eg in using records of patient care.
"Available data sources cover long time frames" allowing for the study of trends (310)	Not a consideration for this study as its focus was an analysis of the expectations at the time of the study
Computerised approaches simplify categorising and coding procedures	"Sentence busting" (Burnard 1994, 35) utilising the capabilities of a word processing package could be used as a method of collating the results from both these questions, as a development of the cut and paste processes described by Webb (1999) as suitable for a sample of this size.
"Categorical schemes are generally developed after data are collected and thus do not constrain or bias the data" (310)	Qu 5/7 The themes were to be extracted from the data, provided in response to an open question. Qu 15 the content analysis would be focussed on responses to the manipulated variables. The opportunity to demonstrate other qualities thought important to institutions was created through the use of content analysis.

Table 34 Advantages of content analysis

Disadvantages (Waltz et al 1991)	This study
Procedure is time consuming	Data set small - for both questions sample of 22 small quantities of written data - total pages for Qu 5(7) 2, for Qu 15 9.
Materials may have been "prescreened or edited by others" (310).	This was not considered to be a disadvantage as the responses to specific questions were directly from the respondents.
Data may not have been "compiled systematically" (310).	This was not considered to be relevant to this study because of the nature of the data.
"Judgement is required to interpret the meaning of another's communication"(310). A risk of subjectivity by the researcher.	This applies to many other methodologies.
"Legal or ethical problems may be encountered regarding the use of information gathered for another purpose" (310).	This did not apply to this study.
Methods of analysis "that rely heavily on inductive approaches to categorising data are not well formulated and are highly individualistic" (Miles 1979 cited Waltz et al 1991, 310)	A potential disadvantage for any qualitative analysis.

Table 35 Disadvantages of content analysis

As tables 34 and 35 demonstrate, the advantages of this method of analysis for a study of this nature outweigh the disadvantages. The respondents would be providing data in response to a process that mimicked their everyday activity. The data would not be subjected to any third party alteration or amendment and was designed specifically for the purpose of this form of analysis. The data set was small in size and suitable for a cut and paste based process (Webb 1999).

Bringing together the responses to the candidates in a word processed format would make analysis of the data more straight forward and the sample size of 22, for both questions, was suitable to enable a "cut and paste" process to be used (Webb 1999, 323). Burnard (1994) describes a process, "sentence busting" (Burnard 1994, 35), that makes use of the facility in most word processing packages to cut and paste sections of text and the ability to sort lists alphabetically.

The use of such a methodology, for content analysis, had a number of advantages. The opportunity to review the documentation whilst maintaining the integrity of the original written record meant that changes of decisions in relation to particular elements could be easily facilitated. The need to input all data and divide the responses into their different elements also meant that decisions were beginning to be made in relation to context and meaning within the data. The use of cut and paste or card shuffling techniques requires the whole of the material to be reviewed again every time new concepts or ideas emerge from the data, though the use of the computer "find" command words could speedily be highlighted and considered as incidences of a particular concept or quality.

Table 36 demonstrates an example of preparation of data for content analysis by this method using data from the study. The qualities (A) were "sentence busted" (Burnard 1994, 35), into phrases and single words (B), rearranged to place the key word first (C) and then alphabetically sorted by the word processing package WordPerfect 9 for Windows (D) (table 36).

A	The qualities	The applicant should show insight into:- understanding the communication system of children, developmental needs of children, needs of family, own views of children, understanding of sick children
B	Sentence busted	understanding of communication system with children developmental needs of children needs of family own views of children understanding of sick children
C	Key word first	communication system with children understanding of children developmental needs of family needs of children own views of children understanding sick
D	Sorted	children developmental needs of children understanding sick children own views of communication system with children understanding of family needs of

Table 36 An example of “Sentence busting” (Burnard 1994, 35) and alphabetical sorting

PILOT STUDY

Oppenheim (1992, 50) states that in undertaking a pilot study “some issues will receive greater priority than others”. These should be the areas of the study which are considered to pose the most difficulties. For this study the priorities were considered to be:-

a) the clarity and focus of the question wording

b) the layout, appearance and ease of use of the completed document

Sample

Treece and Treece (1986) in their discussion of pilot studies indicate that for a population of 100 a pilot of 10 "should be a reasonable number" (Treece and Treece 1986, 383). The NMCCH Applicants Handbook (ENB 1995) listed 43 institutions which offered the child branch at Dip HE. Five of these were excluded from this study, three because they selected students for the child branch at the end of the Common Foundation Programme, one because it was awaiting validation of a new provision and South Bank University School of Paediatric Nursing and Child Health (Great Ormond Street) because of the specialist nature of the institution.

This study, therefore, had a potential population of 38. Four institutions were used for the pilot, a proportion of the whole number similar to that recommended by Treece and Treece (1986). Two of these institutions, from the south and west of England, were chosen because the researcher was personally known and both were known to have child branches which had been running for about five years. The other two pilot sites were chosen from other areas of

the country. Three of the four pilot questionnaires were returned completed. The fourth was returned with details of the institution's selection process but with no other data.

Results of the pilot

Fox and Venture (1983) state that question wording needs to be tested for clarity. A measure of the ease with which questions can be understood is whether the answers "tell us what we need to know" (Oppenheim 1992, 53). Poor questions which have not been understood by the respondents will not produce the appropriate data.

The pilot questionnaire had asked respondents "What are your criteria for selecting potential students for" with the four branches being listed separately and a separate heading for the academic and personal qualities. One of the three respondents had only completed the academic requirements and the responses from the other two had appeared cramped in the amount of space that was available. In the pilot study the respondents were asked to consider the "hypothetical" candidates and consider "how acceptable" they would be for the college's child branch. Answers given by the respondents indicated that they would wish to interview the candidate before deciding.

In the pilot study information on the qualifications that were considered acceptable had required the respondent to list the qualifications, along with the personal qualities that would be expected for each branch. The space that had been left for the collection of these data appeared to be very cramped when the questionnaires were returned. When responding in

relation to the hypothetical candidates the pilot respondents had been asked to indicate "How acceptable would this applicant be for your college's child branch?". Two of the three returned questionnaires indicated that they would determine acceptability at interview, therefore not providing the required data. Respondents in the pilot study did not appear to have had any difficulties in moving through the questionnaire appropriately.

THE MAIN STUDY

Changes for the main study (appendix 3)

Additional questions were included to ascertain the face to face method used for selection and the range of personnel involved in these processes as this had not been considered in the development of the pilot study. A number of different processes were set out and respondents were also given the option of providing the details of their processes if they did not meet those included in the questionnaire. Visual analogue scales were used to determine whether something never or always occurred. The inclusion of these questions also allowed for the collection of more data related to the involvement of practising clinical nurses in the selection procedures.

In the full study a grid of possible entry requirements was provided, based on information from the NMCCH (ENB 1995). This increased the accuracy of data that would be obtained, as respondents were required to identify qualifications against a set list rather than making assumptions that respondents had listed all their acceptable qualifications.

The pilot questionnaire had asked respondents "What are your criteria for selecting potential students for" with the four branches then being listed separately. The focus of this question for the main study was altered to ask "What personal qualities do you look for in candidates for your Dip HE (Nursing). The change to the use of the word candidate was intended to focus the respondents on the individual during the application process. The questionnaire still

provided spaces for each of the four branches.

The hypothetical candidates (appendix 3)

For the main study this question was rephrased to ask "How likely is it that you would want to interview this candidate for your college's child branch". The request for the respondents reasons for their ranking of the student was also reworded to “Please give reasons for your decision about the acceptability of this applicant for interview”. It was anticipated that this change in the focus of the question would encourage the respondents to provide data indicating why they had made such an initial assessment of the candidate in the “prescreening” phase of selection (Land 1993, 5).

Increasing response

Oppenheim (1992) suggests that writing to a named person increases that potential for response. Experience during the pilot stage had indicated that finding a named person was not always easy, this was also potentially more difficult due to ongoing mergers and consequent changes of role for those who work in the institutions. For the main study the questionnaires were sent to the Head of Recruitment and Selection as this was the title generally used by the ENB in their careers contact information. It was anticipated that this would be the most appropriate title to ensure that the questionnaire made its way to the appropriate department in the organisation.

Layout, appearance and ease of use of the completed document

Respondents in the pilot study did not appear to have had any difficulties in moving through the questionnaire appropriately. For the open questions about the quality of candidates the space available for the answers was increased, as the responses in the pilot study had appeared cramped. The instructions following filter questions were also highlighted by the use of a box, to ensure that they stood out more clearly from the other print on the page.

Prescott and Soeken (1989) in their review of nursing research texts state that pilot studies are "usually defined" as smaller versions of the main study looking at

> "a) feasibility of the planned study, b) adequacy of the instrumentation and c) problems in data collection strategies and proposed methods" (Prescott and Soeken 1989, 60).

The pilot study had indicated that the proposed study was feasible and the instrument chosen appeared to be adequate for the purpose. Such a small pilot study could not be expected to demonstrate whether there would be problems in obtaining a response from the institutions available to be included in the main study.

Oppenheim (1992) states that changes which are made as a result of pilot work should themselves be piloted. In a study with a limited total population such as this techniques have the potential to significantly reduce the final size of the study. The decision was made, therefore, that the changes would not be piloted and any opportunity for further refinement or development of the questionnaire was lost in order to retain the potential sample size.

A total of 34 questionnaires were sent to institutions approved to run the Dip HE child branch in England. The questionnaires were directed to Heads of Recruitment and /or Selection as given in the English National Board (ENB) Careers information for February 1995 (ENB 1995b). It was considered that this would provide the most appropriate access into the institutions, as these departments would probably be the most stable at such a time of change.

A month was allowed for the return of the questionnaires. At the end of this period a further package containing a reminder letter, a second copy of the questionnaire and a further return envelope was sent to the non-respondents with a new deadline for return of one month (ucl.ac.uk 2001). At the end of this period addresses and titles of the non- responding institutions were again checked with the latest edition of the ENB careers information (ENB 1996a) as this was considered to be the most up to date. A third mailing was undertaken to these institutions.

RESULTS

Response rate

A total of 25 questionnaires were returned, a response rate of 73.5%. A response of 75-85% to a postal questionnaire is considered to be "doing extremely well" (Treece and Treece 1986, 293). Not all respondents answered all questions. Results are presented in the order in which the questions were asked in the questionnaire.

Question 1

How long has your institution been running the child branch?

At the time of data collection, in September 1995, child branch students had been progressively admitted to Project 2000 programmes since September 1989 a period of 6 years. Respondents answered this question in a variety of ways, giving dates of intakes or number of years. Figure 1 (overleaf) clearly demonstrates the development of the Dip HE child branches in England in the period leading up to data collection. This pattern matched expectations based on the progressive roll out of the Project 2000 programmes across England, as money was released by the Department of Health.

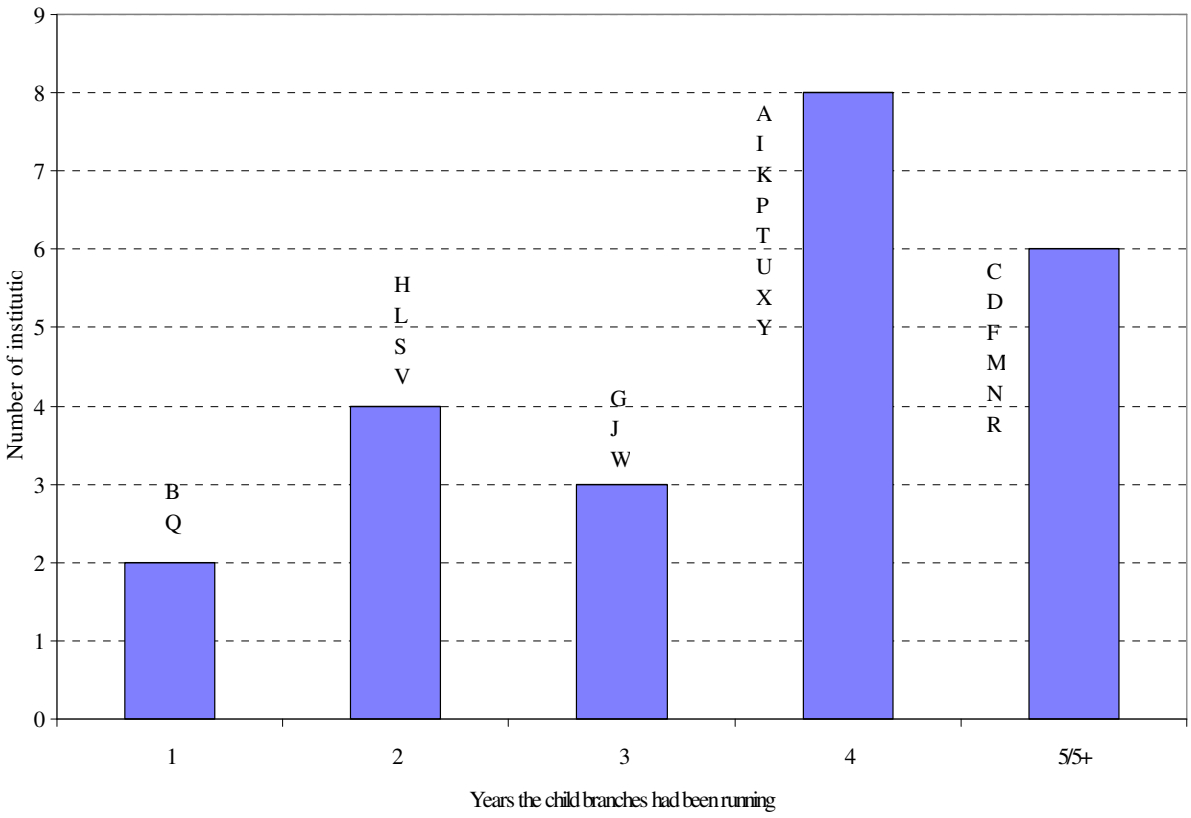


Figure 1 The number of years institutions had "run" the child branch (n=23)

Question 2

Which of the following branches do you offer?

The result demonstrated in figure 2 was as expected. When the Dip HE programmes were first receiving approval the ENB required institutions to offer at least three of the four branches (ENB 1993). Most institutions would already have been offering Adult and Mental Health nursing courses at pre-registration level, prior to Project 2000. The introduction of the opportunity to offer programmes leading to initial registration as a children's nurse was a new venture for all the institutions concerned.

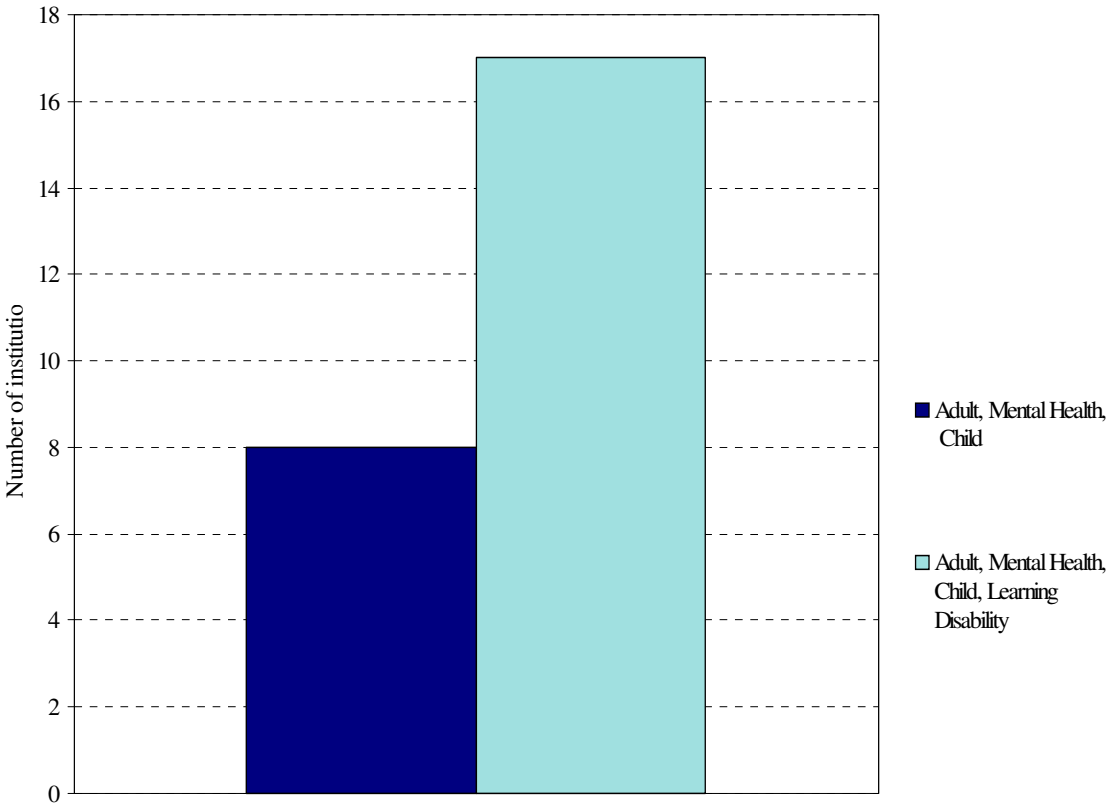


Figure 2 The branches offered by the different institutions

Question 3

How many groups do you admit each year and how many students are recruited for each?

a) How many groups are admitted each year?

As anticipated the number of groups of adult nursing students is larger than for the other three branches (figure 3). Figure 4 demonstrates that not only are there more adult groups but, as anticipated the adult branch has by far the largest number of students. Institutions offering Dip

HE (Nursing) programmes usually admit two cohorts per academic year, with one group commencing around September and the second usually in January or February. Some respondents offered the child branch once a year the others twice.

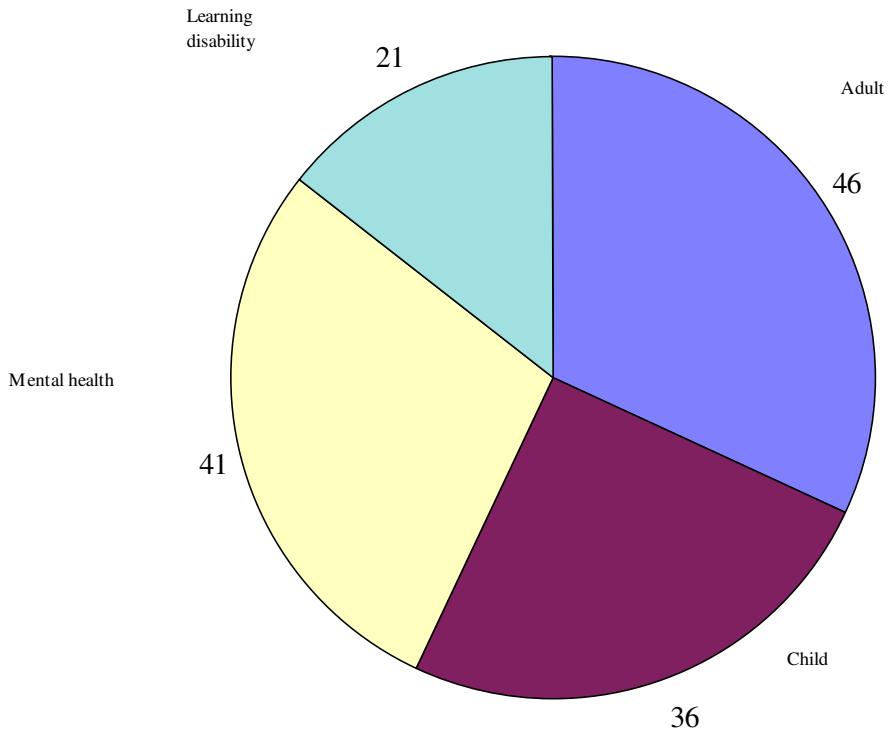


Figure 3 Total number of groups admitted each year (n=24)

b) How many students are admitted to each group?

Figure 4 indicates the total number of places offered to students in the 1994/5 admission cycle. Twenty one institutions gave full figures for applications for each of the branches that

they ran. Both figure 3 and 4 reflect anticipated results. It is also possible to look at the total numbers of students admitted to the branches across the sample (figure 5).

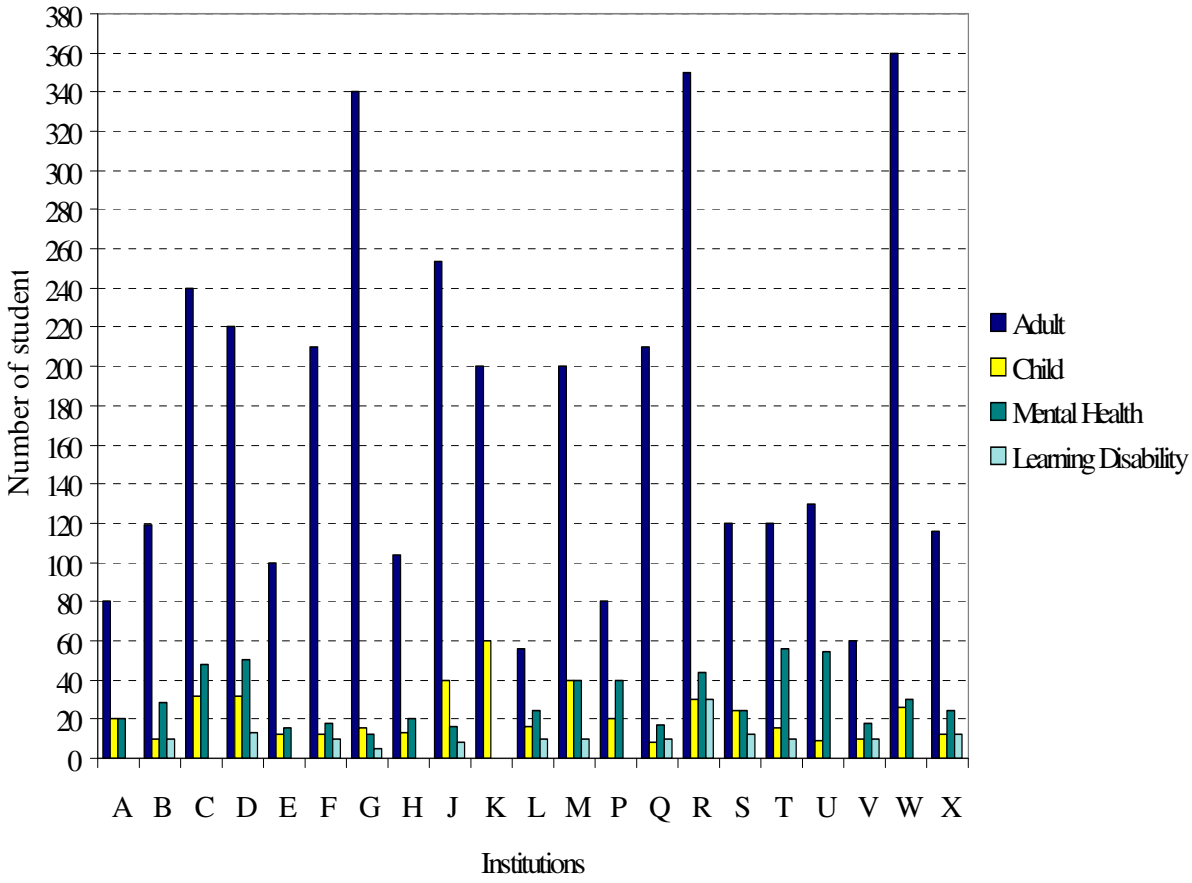


Figure 4 The total number of places offered to students in the 1994/5 admission cycle (n=21)

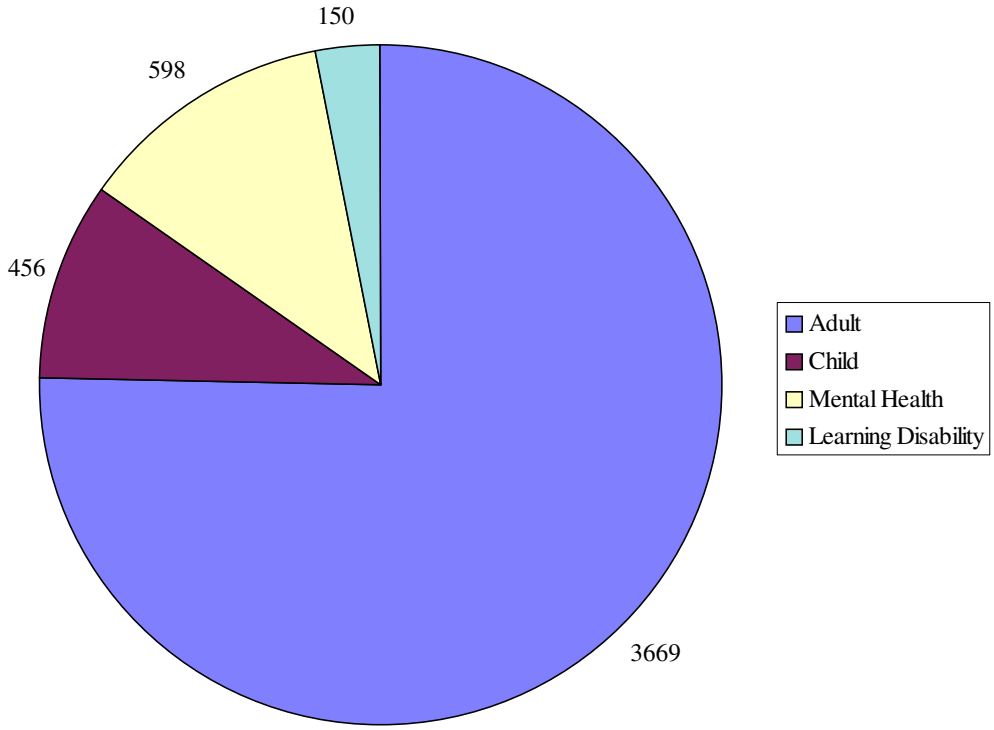


Figure 5 The total number of students admitted to the institutions in the sample (n=21)

Question 4

In total how many applications did you receive for each of the Dip HE branches in 1994?

Full data for adult, child and mental health applications were provided by seven institutions. Although the total number of child branch groups commencing each year was 10 less than for the adult Branch, the total number of students admitted to the child branch was far less (figure 5). The total number of applicants for each branch was compared with the available places demonstrating the percentage of applicants who were successful in obtaining a place in each

of the institutions (figure 6).

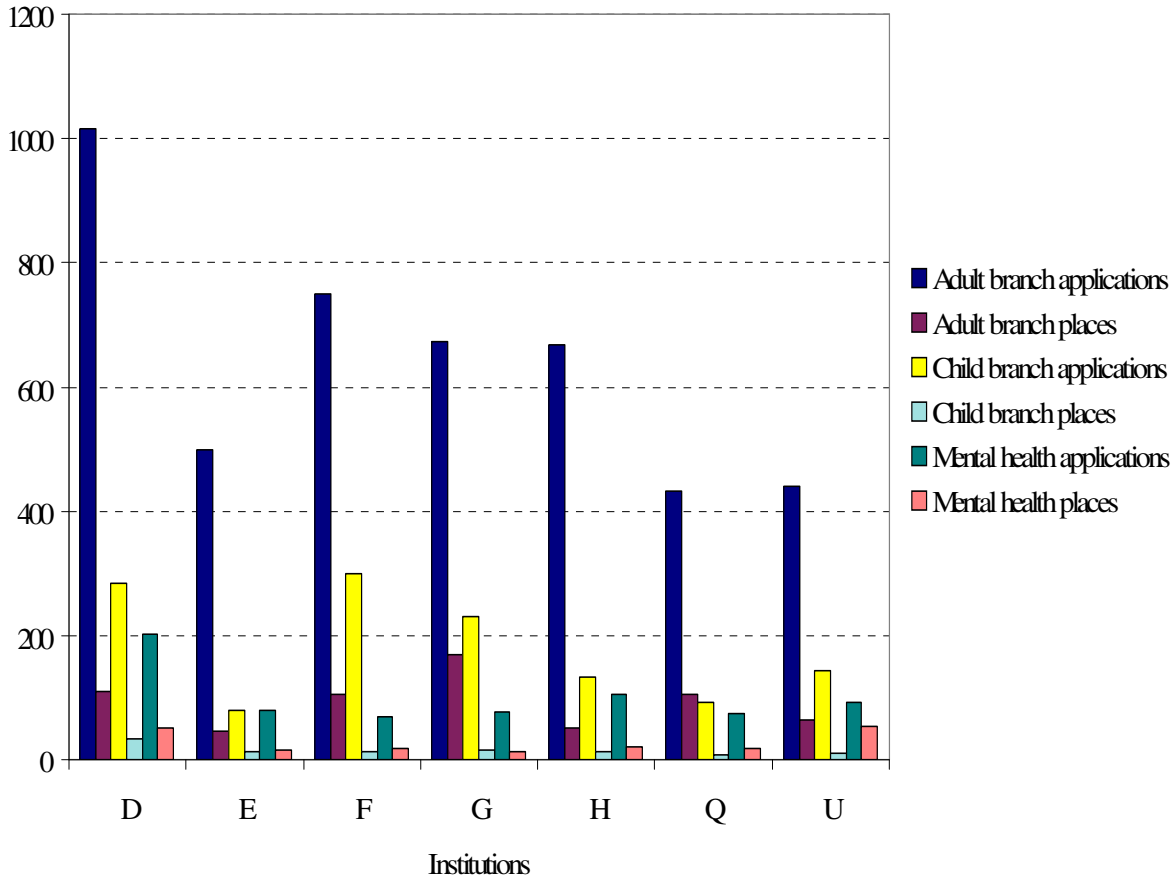


Figure 6 The number of applicants and the number receiving places (n=7)

It is also possible to represent these data from the seven institutions across the branches (figure 7) and demonstrate the mean reduction from applications to places across the branches and these seven institutions (table 37). The figure for the child branch matches that derived from NMAS and ENB data (table 16, 139). In interpreting these data it is important to remember that each candidate has the potential to apply to up to four institutions, though they

can only accept one place.

Adult branch	Child branch	Mental health branch
15%	9%	26%

Table 37 Mean percentage of applicants receiving places on their chosen branch

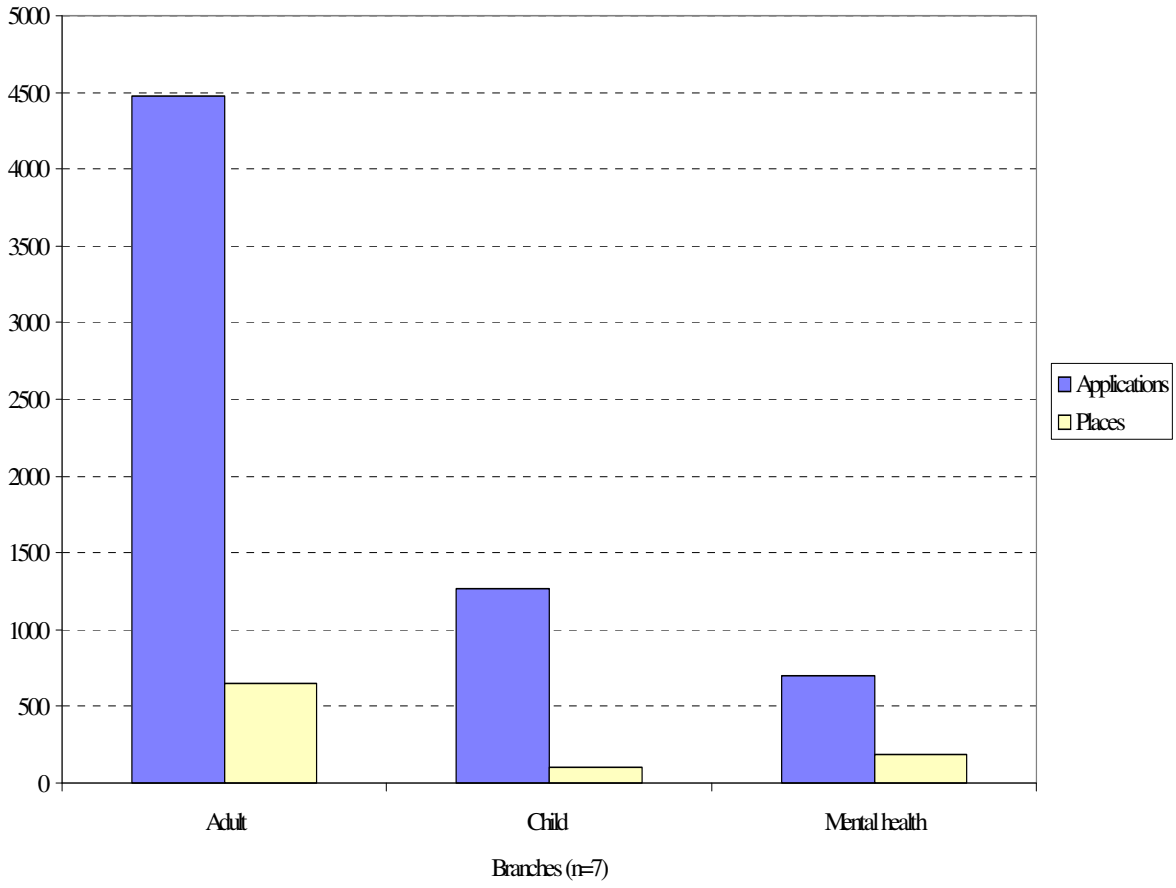


Figure 7 The reduction from applications to places across seven institutions providing data

Question 5

Who selects candidates for interview?

Analysis of responses to this question proved difficult. The variety of titles used by people

possibly holding similar jobs appeared to be peculiar to individual institutions. For example, a person may have been described as a branch teacher, a role which in another institution might be described as a tutor. Responses also included use of words such as tutors, without the added clarification of the number or qualifications of those involved in this stage of selection. The question had not specifically requested data on the number of people involved in the process or whether application forms were circulated around those involved in short listing or taken to a central meeting for discussion by a panel.

Analysis was undertaken to determine those involved in this process and the extent to which they worked alongside others (figure 8). There were a number of references to student services, personnel and Registry which were grouped together. One institution (O) which used a short listing panel added a comment indicating the difficulty of encouraging service involvement now that hospitals were NHS Trusts.

For two institutions (J, W) it was clear from the data that "Registry" had criteria to aid in the selection process, although the respondents did not clarify the role of registry in their particular institutions. It was not clear to what extent lecturers or clinical nurses were involved in the processes undertaken by "Registry". As figure 8 demonstrates five institutions (20.8%) used a short listing panel, in three institutions selection for interview was undertaken by course leaders and three other institutions involved service colleagues, at the point of selection for interview. From personal experience the findings related to the involvement of service personnel was not unexpected. Questions 10-14 which focussed on the "interview" process

were expected to demonstrate the involvement of service colleagues in this later stage of selection.

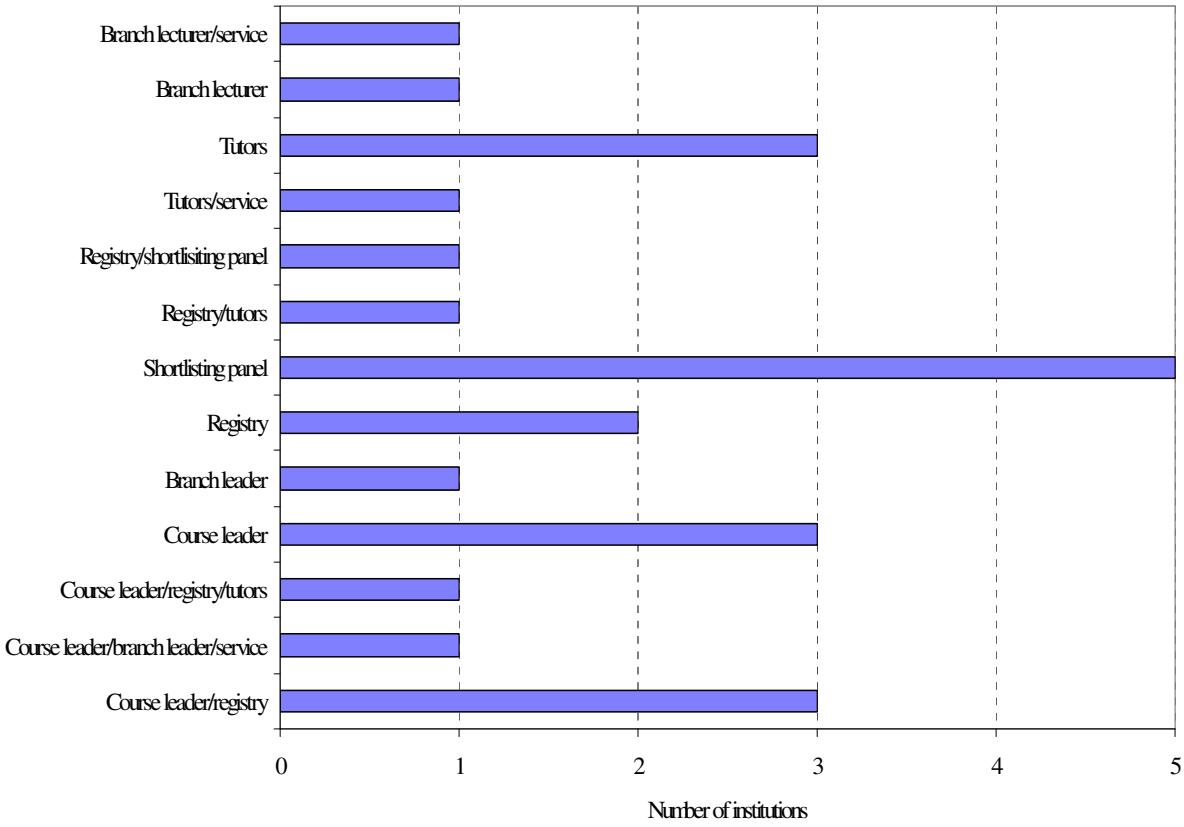


Figure 8 Those involved in selecting candidates for interview

Question 6

Qualifications accepted by the institutions for entry

Appendix 2 lists the minimum statutory qualifications and approved alternatives that were acceptable for entry to pre-registration programmes at the time of this study. Institutions are free to set their own requirements above the minimum and such requirements may also be set to take into account the specific entry requirements of the Higher Education Institutions with

overall responsibility for the programmes. Twenty four institutions responded to this question, with two providing data solely related to child branch students.

Data were analysed in two ways. First the qualification "the UKCC considers equivalent" ie the approved "alternatives" (ENB 1995, 10). Figures 9 and 10 demonstrate that a range of "alternative" (ENB 1995, 10) qualifications were seen as acceptable to the institutions to a varying extent. One institution claimed that the ENB did not allow a "mix and match of quals" *(sic)*, an inaccuracy as the UKCC, the statutory body that sets the standards allows candidates to combine combinations (ENB 1995).

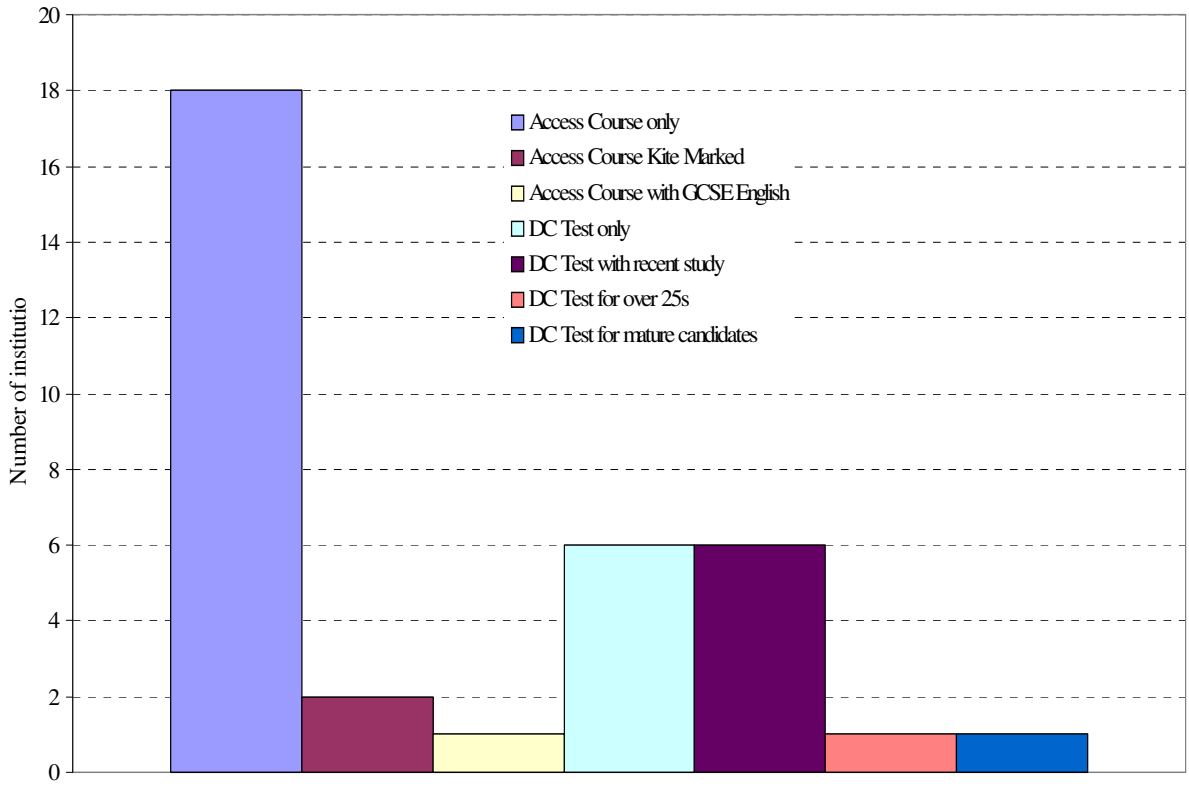


Figure 9 Alternative qualifications accepted by the institutions (n=24)

Two respondents had specifically added the word "Kitemarked" to their response in relation to the acceptability of access courses. It can also be seen that organisations accepting these qualifications tended to ask for additional evidence of academic suitability over and above the statutory minimum. Institution U indicated that they did not accept the UKCC DC test (see 140) or Access courses for entry to the child branch because of the number of applications.

Comparison of the acceptability of all the "alternative" qualifications (ENB 1995a, 10) (figure 10 overleaf) demonstrates that some institutions are more open to accepting these than others. Again institutions seemed keen to require slightly more than the minimum academic entry requirement. At the time of this study the BTEC was a well known and well accepted qualification for entry to pre-registration nursing programmes (appendix 2). The National Vocational Qualifications (NVQ) and the advanced General Vocational Qualification (aGNVQ) were newer and not as well known though the responses of institutions in relation to these newer qualifications could be interpreted as demonstrating increasing acceptance.

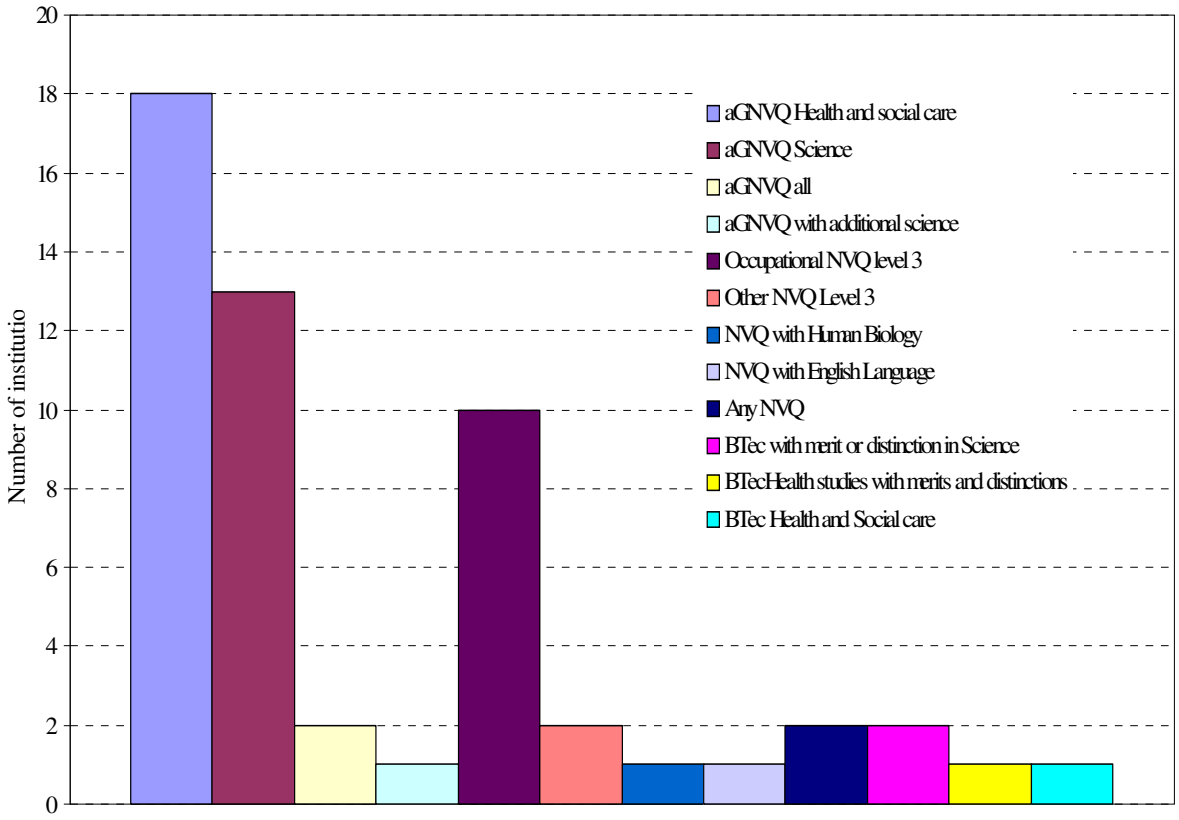


Figure 10 Alternative qualifications accepted the institutions (continued) (n=24)

Figure 11 demonstrates the acceptability of GCSEs and the specific requirements of some institutions that meant that they were asking for more than the minimum. Thirteen institutions accepted any five GCSEs. Amongst the other eleven there were a range of expectations, above the statutory minimum, with all requiring candidates to have English Language. Eight institutions specifically requested a science and four specified Mathematics. Some institutions indicated a preference for evidence of further study, with one specifically asking for A Levels and another indicating that they were advantageous. One organisation indicated that they also accepted degree students, although this information had not been directly sought in the

questionnaire.

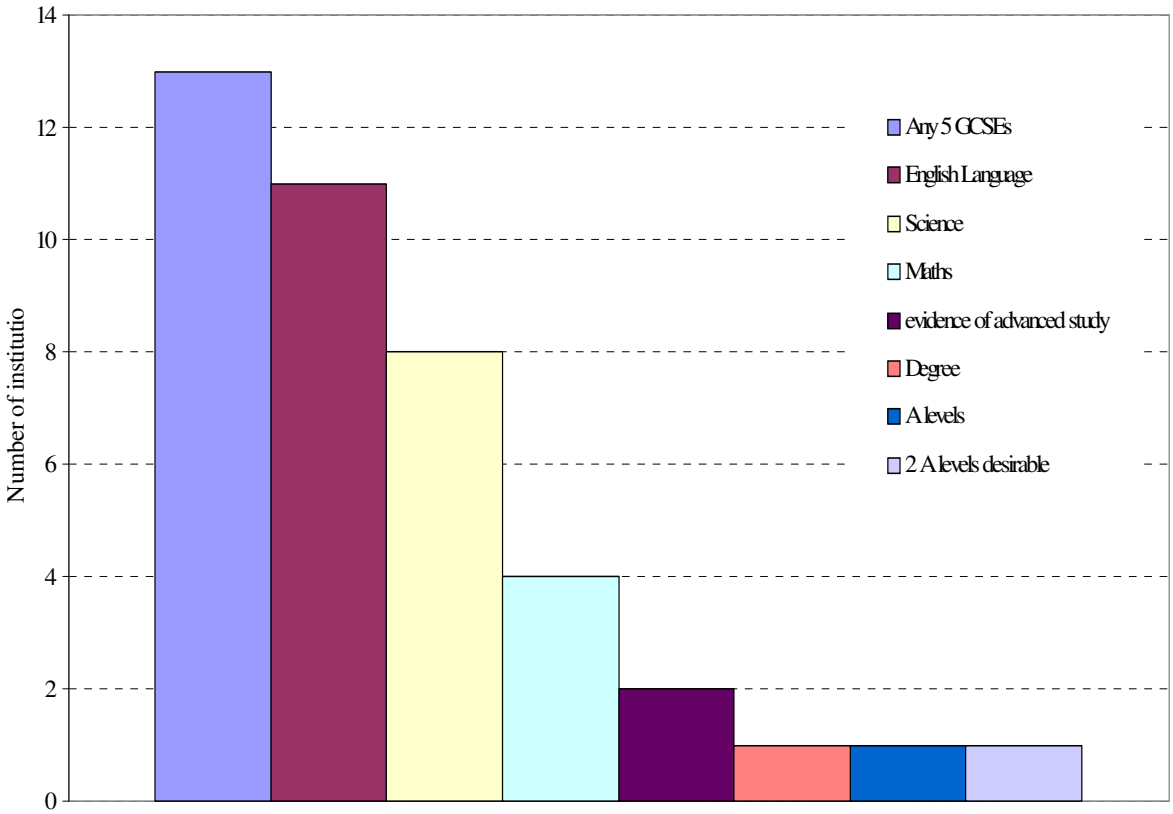


Figure 11 Institutions requirements for specific GCSEs and qualifications above the minimum (n=24)

Question 7

What personal qualities do you look for in candidates for your Dip HE (Nursing)?

One institution did not answer this open question, while two others selected students for their branches at the end of the Common Foundation Programme. These three institutions were not included in the data analysis leaving 22 responses. Three institutions stated plainly that they would look for "reason for choosing the branch" which it was assumed was used as a

mechanism to distinguish between candidates understanding of the different types of nursing. They did not elaborate on what this may mean in reality. Seven institutions indicated that they expected the same qualities for all branches that they offered. It was unclear whether the six institutions who responded with data related only to the child branch distinguished between branches. Analysis focused on qualities looked for in candidates for the adult and child branches, as all the institutions offered these two branches. Where respondents had not distinguished between these two branches data were used as though applying equally to both branches.

The qualities (A) (table 38) were "sentence busted" (Burnard 1994, 35) (see 208), into phrases and single words (B), rearranged to place the key word first (C) and then alphabetically sorted by the word processing package (D) (table 38).

A	The qualities	The applicant should show insight into:- understanding the communication system of children, developmental needs of children, needs of family, own views of children, understanding of sick children
B	Sentence busted	understanding of communication system with children developmental needs of children needs of family own views of children understanding of sick children
C	Key word first	communication system with children understanding of children developmental needs of family needs of children own views of children understanding sick
D	Sorted	children developmental needs of children understanding sick children own views of communication system with children understanding of family needs of

Table 38 “Sentence busting” (Burnard 1994, 35) and alphabetical sorting

In total five institutions demonstrated that they expected either clearly different criteria or additional criteria for candidates for the child branch (table 39).

	Adult branch	Child branch
J	Appearance and presentation, degree of confidence, humor, genuineness. Interaction with others, including degree of warmth and empathy. Verbal and non verbal communication. Degree of interest and initiative	Ability or potential to assess situations, including judgement, creativity and decision making. Ability to plan and carry out actions, including logical reasoning, tolerance, leadership and organizational ability.
O	Good communication skills, self awareness regarding own strengths and weaknesses, potential to change situations, awareness of the practical, academic demands of nursing, awareness of adult nursing , previous experience	The applicant should show insight into:- understanding the communication system of children, developmental needs of children, needs of family, own views of children, understanding of sick children
L	Motivated, ability to think critically, good communication skills, able to write good standard of English, Interest in the world in which they live, a desire to study at this university, courteous	**PLUS** for child branch Have some significant contact with children (nursery, brownies, beavers, classroom help) and insight into the problems of children/family/carers.
U	Articulate, sound argument and reason, assertive, questioning, sense of humor, good communication skills, knowledge what course involves in both theory and practice, understanding of role, some experience related to caring	**PLUS** for child branch as adult but can demonstrate the difference in the needs of children and adults, current issues related to children. Adaptability and needs of different age group.
I	Good communication and listening skills Charisma Sense of humor Awareness of strengths and weaknesses	Good communication and listening skills Recognition that children are not mini adults Patience Adaptability

Table 39 Institutions that distinguished between adult and child branch candidates

The qualities derived from this analysis were matched against the “inherent qualities of children’s nurses and qualities common to all nurses identified through the review of the

literature" (table 29, 175 repeated here for convenience - table 40).

Common to all nursing student candidates	Communication skills	Interpersonal skills	Self aware	Friendliness	Academic ability
	Caring attitude	Motivation	Warmth	Reliability	Confidence
	Psychomotor skills/physical dexterity	Observational skills	Athletic/ social/ other interests	Voluntary/ community work	Knowledge of/ experience of nursing
	Sociability		Initiative		
Common to children's nursing candidates	Understanding what nursing children involves	Awareness of others contributing to care	Caring skills	Ability to work with people of all ages.	Motivation/ Wanting to work with child and family
	adaptability		emotional stability		

Table 40 Inherent qualities of children's nurses and qualities common to all nurses

The full analysis is presented in appendix 4, table 41 presents one example of the process.

Quality identified from the literature	**Responses to question 7 considered to match the expectation of that quality**	**Institution requiring this quality**
Understanding what nursing children involves	understanding sick children own views of children developmental needs of children understanding of communication system with children needs of family	O O O O O

Table 41 Example of matching against qualities identified from the literature

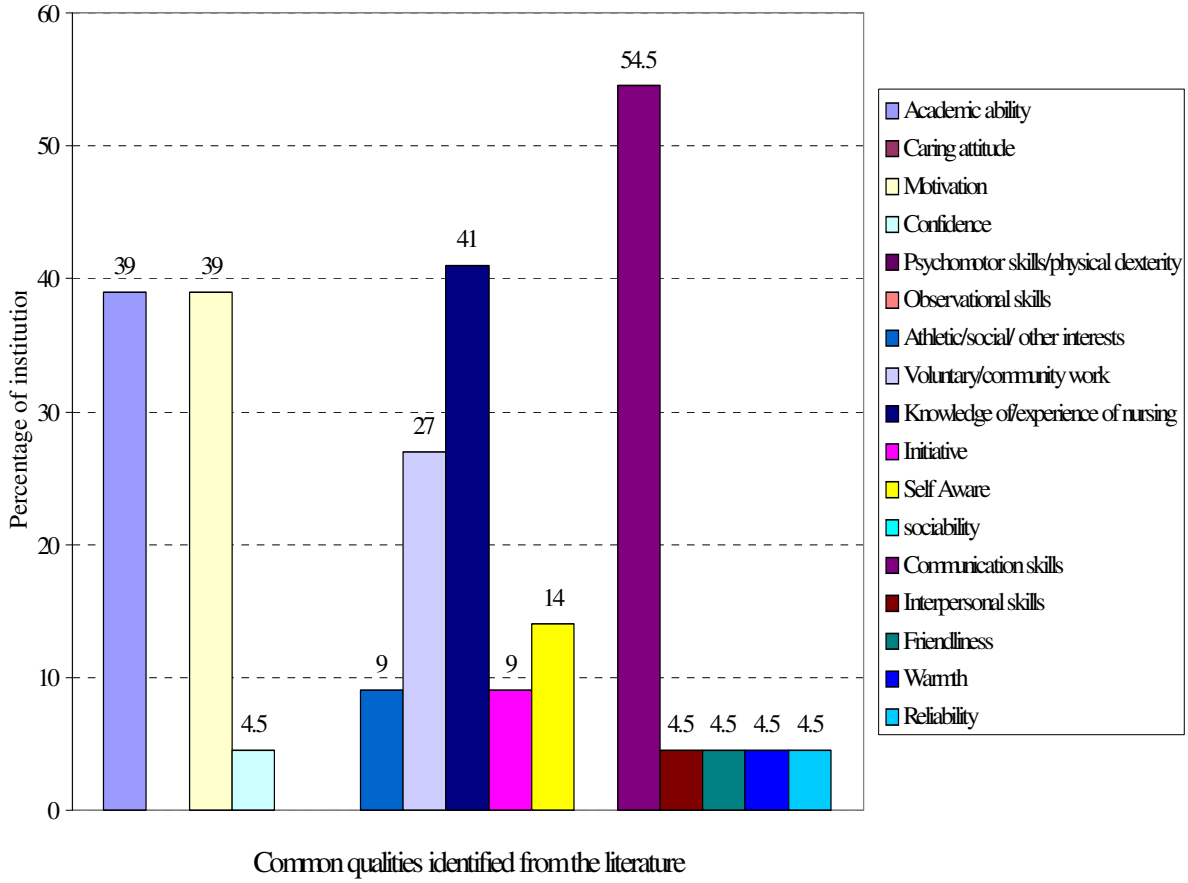


Figure 12 The percentage of institutions requiring the qualities considered common for all students identified from the literature (n=22)

Figure 12 demonstrates the percentage of institutions identifying qualities that matched those considered common to all nursing students. The responses were further matched against the qualities that had been identified in the literature as being specifically required by children's nursing students (figure 13). Full details are presented in Appendix 4.

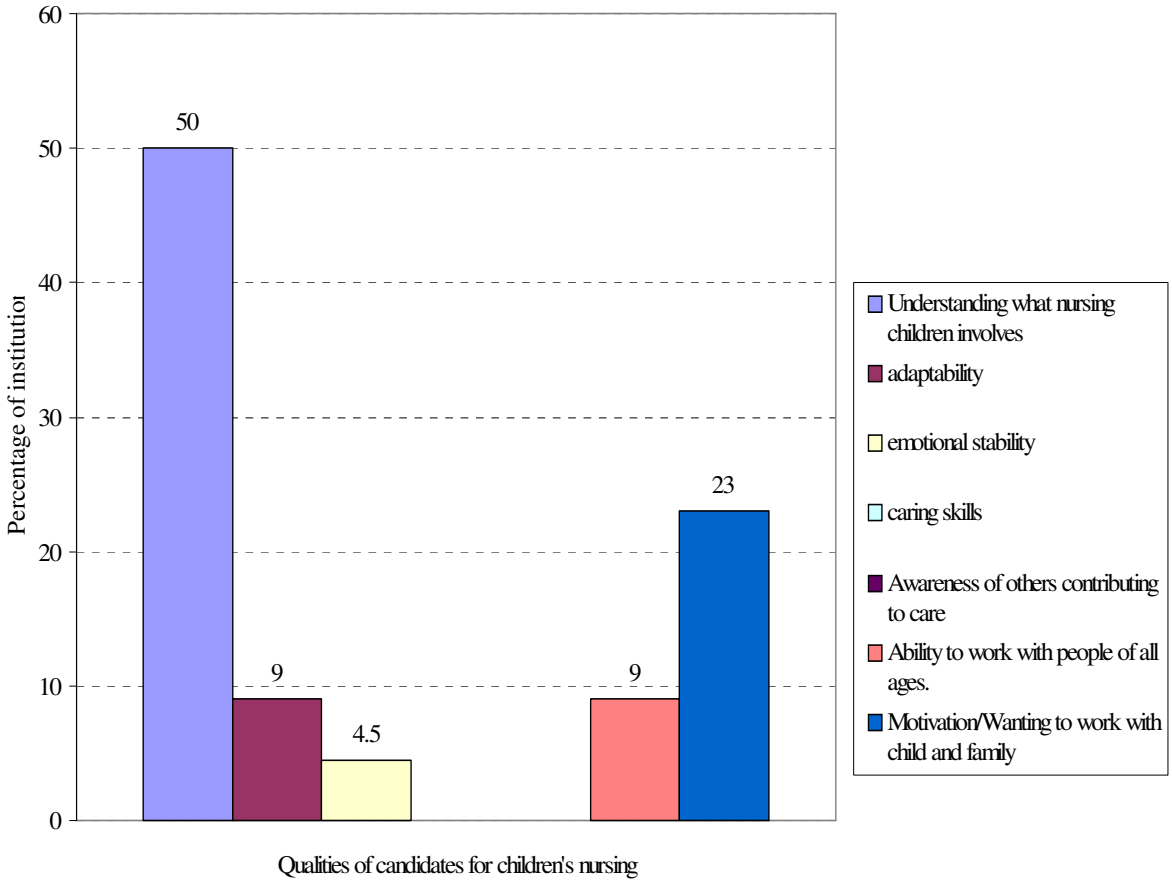
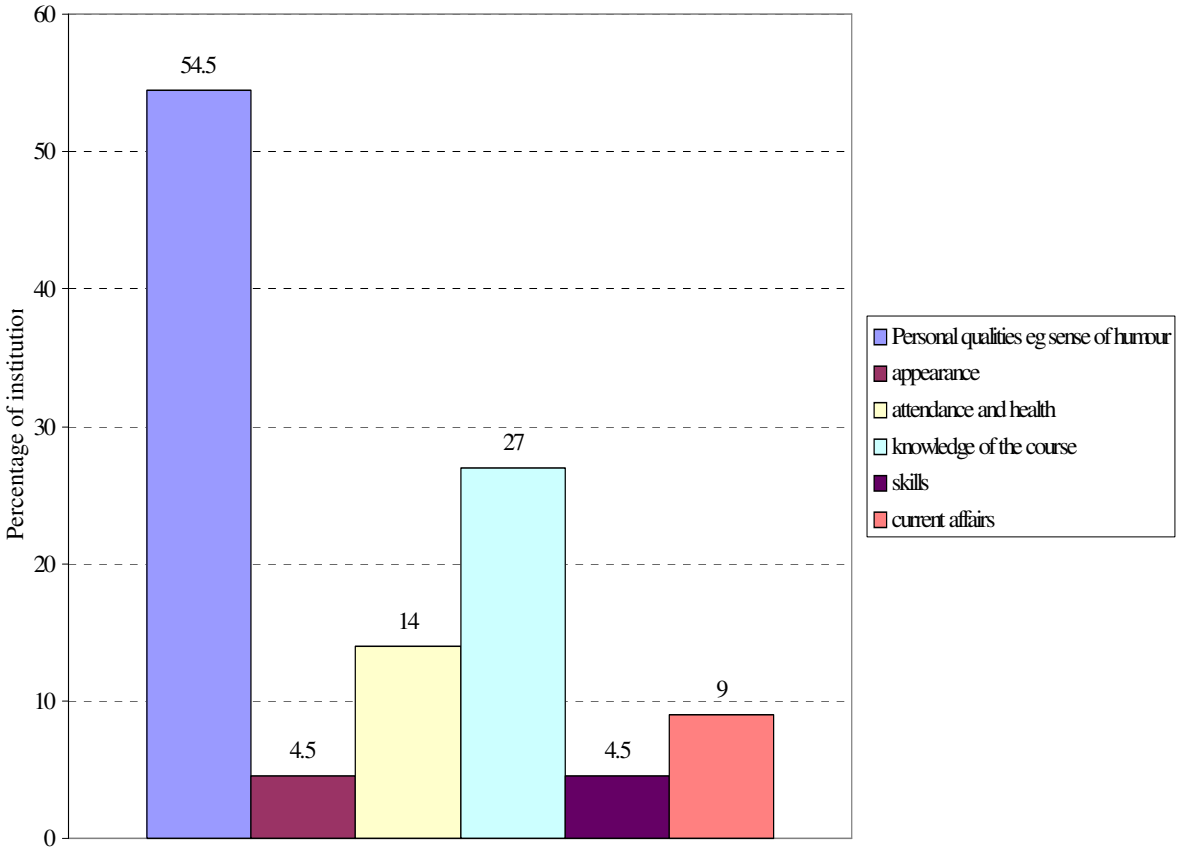


Figure 13 Responses matched against the qualities of candidates for children's nursing identified from the literature (n=22)

Figures 12 and 13 demonstrate a limited level of agreement with the proposed qualities of candidates for children's nursing. The highest percentage of institutions looked for interpersonal skills (54.4%), with academic ability (39%) being the next most important (figure 12). There was no reference to caring attitude, psychomotor or observational skills or sociability. In figure 13, 50% of institutions stated they would expect an understanding of what nursing children involved. None of the respondents referred to qualities that could be

seen as demonstrating caring skills or an awareness of others contributing to care.

A number of additional qualities looked for by institutions were evident during the process



of analysis (figure 14). A number of these - Personal qualities eg sense of humor 18%, tolerance (9%), patience (9%) were grouped together.

Figure 14 Additional qualities identified by the institutions

The appearance of a candidate required by 4.5% of institutions (one) would only have been

ascertained at the point of interview. Surprisingly in light of the recommendation in the Allitt Inquiry (HMSO 1994)

> "that for all those seeking entry to the nursing profession, in addition to routine references the most recent employer or place of study should be asked to provide at least a record of time taken off on grounds of sickness" (HMSO 1994, 128)

and the fact that the NMCCH application form requires this information only three (14%) institutions made any explicit reference to the candidate's health and attendance record.

The use of an open question had been successful in allowing respondents to use their own institutions' qualities in response to this question. The phrasing of this question had not been specific in asking respondents to indicate the qualities that they would look for on candidates' written application forms. Some of the criteria emerging from these data could possibly only be assessed or at least personally determined during a face to face encounter such as an interview.

Interpretation of the less explicit data from the sample had the potential to be influenced by the subjectivity of the researcher. Direct comparison with the findings of "The Nurse Selection Project" (Child et al 1988) was not undertaken as this would have added another layer of subjectivity in attempting to match with the data and the categories of analysis used in that study.

Question 8

Has your selection process for students changed since the implementation of Project 2000?

IF YES please describe your previous system

This open question had been asked in order to determine whether, as Child et al (1988) had predicted, the advent of Project 2000 had led to changes in the selection methods used by institutions. The responses received in relation to this question indicated that this question may have been badly worded. It had been hoped that this would give details of previous activity which would be followed by what was happening now in response to the following questions.

One institution did not respond to this question. Eight stated that they had not made any changes to their selection methods. Two respondents were not aware of the previous system though one knew that there had been some change. A further two respondents indicated that the change to a fixed application period now meant that they no longer processed candidates' applications on the principle of "first come first served" (D, N), they did not state whether the actual method of selection had changed.

Data which emerged from responses from the remaining 12 institutions (table 33) were divided between those who indicated what the previous system had been (5), those who indicated what the changes had been from the previous system (7). One of these respondents indicated that the process was currently in the process of changing since the merger of a number of smaller organisations (table 42).

	Institution	Process	Number
Previous system	B, E, Q, R, V	Interview only prior to P2000	5
Now	R	Now more specific and does not depend on the interview panel's personal decisions	1
	H	Inclusion of a science, non academic criteria more clearly specified, more structured group discussion	1
	I	group exercise discussion, written work, mathematics questions	1
	U	DC candidates - now look for more evidence of academic skill. Only usually now consider mature students with DC test	1
	M	No essay before Project 2000	1
	V	essay and numeracy test, group discussion, interview, guided tour	1
	O	students have to write an essay Academic criteria now include English lang and a science	1

Table 42 Changes to selection methods since the introduction of Dip HE (Nursing)

Responses in relation to this question appear to indicate that some institutions were trying different methods of managing the selection process and the events on the day of interview. The rationale for such change had not been sought.

Question 9

Do you use the same selection methods for each branch that you offer?

This question had been included to determine whether the institutions used different processes for the branches that had a higher ratio of applications to places. Twenty three five institutions

indicated that they used the same process for all the branches they offered. Two institutions presented ambiguous answers of "on the whole" (Y) and "no for the child branch" (C).

Institution C admitted students to the Common Foundation Programme (CFP). Those students who then wanted the child or mental health branches were reconsidered in relation to their performance and interviewed individually for their branch choice at the end of the CFP. The rationale for this process was linked to the need to meet the "limited" places available on these branches due to contract numbers .

This question was also designed as a filter question with instructions to direct respondents to the next relevant part of the questionnaire. The effectiveness of this device was variable as only two institutions had indicated that they used different methods for different branches but responses were made by eight institutions in the follow on from question 11.

Question 10

Please choose <u>THE ONE</u> selection process that most closely describes what your college uses for the Dip HE.

Filter questions were used to direct respondents to one of three options:-

> Candidates are interviewed on their own by a panel
> Candidates are assessed on their performance in a discussion group
> Candidates are assessed on their performance in a discussion group and have an individual interview.

Adding some of the data from questions 8 and 11 to the responses to this question

demonstrated a range of activities used as part of the selection processes (table 43).

As table 43 demonstrates an interview was the most popular method for selection of candidates with 11 of the 23 institutions using this approach. With 10 responses the interview and discussion group was the next most popular bringing together two different methods to determine the suitability of candidates.

Instit	Interview	Interview and discussion	Discussion group	Additional activity
B		X		English and maths test lunch with students
D		X		
E		X		Information, lunch visit to school
F	X			
G	X			
H		X		Course information
I		X		Health screening, written work, maths test
J			X	Information giving , medical
K			X	Information giving
L		X		
M	X			Essay
N	X			
O	X			
P	X			
Q		X		Essay
R	X			
S	X			
T	X			
U	X			
V		X		Numeracy test, information tour
W	X			
X		X		
Y		X		

Table 43 Methods used in the selection of candidates

Question 11

Please describe the process that you use.

Responses to this question should have been related to any different selection processes that were used if different methods were used for different branches or any process not within the options presented in the survey. Institution C described the process that was undertaken for students who wished to enter the child and mental health branches. These processes were undertaken at the end of the common foundation programme and took account of the student's performance up to that point in the programme.

Questions 12-15

Questions 12-15 all included visual analogue scales (VAS). At the point of data analysis it was clear that the instructions for completing these scales had not been sufficiently explicit. Some responses were in the form of a line through the scale (/), other respondents had used a X on the line, others had circled a point on the line whilst others had circled an anchor point word. As recommended by Waltz et al (1991) a set of rules was established for measuring responses (table 44). The negative point eg "never", or "Not likely" was taken as zero.

Mark	Measuring rule
/	at the point where the line bisects the scale
X	at the point where the centre of the cross bisects the scale
circle round a point on the scale	at the mid point of where the circle bisects the line
circle around an anchor word	either 0 or 10 depending on which anchor point was circled.

Table 44 Rules for measuring responses on visual analogue scales

Question 12

Candidates are interviewed on their own by a panel (appendix 3, 6)

Twelve institutions used this form of interview, six of whom always used a mixed panel of lecturers and clinical staff (figure 15). Institution F demonstrated a confusing picture, claiming to always use a panel of nursing lecturers, while at the same time indicating that they used a mixed panel. The response of institution O is also peculiar, in that they claim to use a panel that is both nearly never made up of all nursing lecturers and nearly never made up of a mix of lecturers and clinical staff. Two institutions clearly used only nursing lecturers with the remaining two having “mixed practice”.

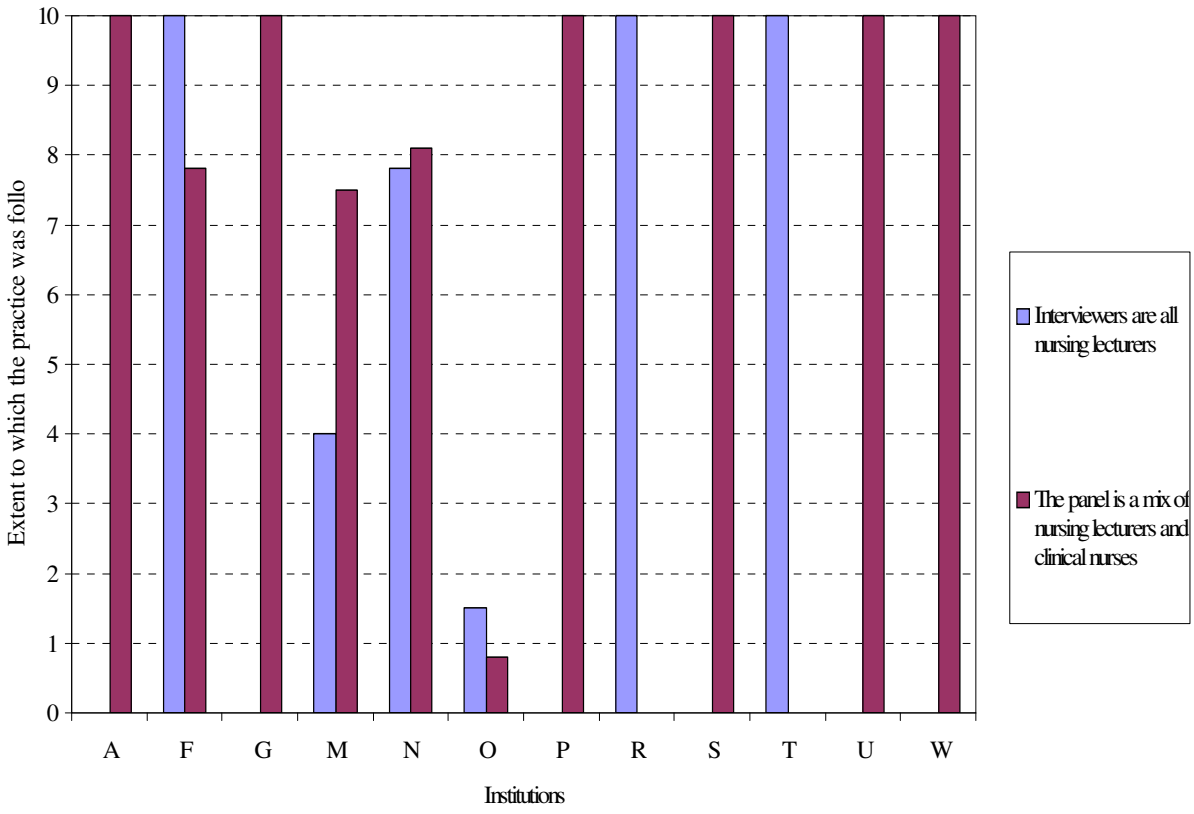


Figure 15 The make up of the interview panel

Nine of the twelve institutions always used nurses and/or nursing lecturers from the candidates' chosen branch to undertake the interviewing. Figure 16 demonstrates the extent to which the three remaining institutions were able to achieve this target. Institution T added the additional information that there was always a person with an appropriate qualification on the interviewing panel.

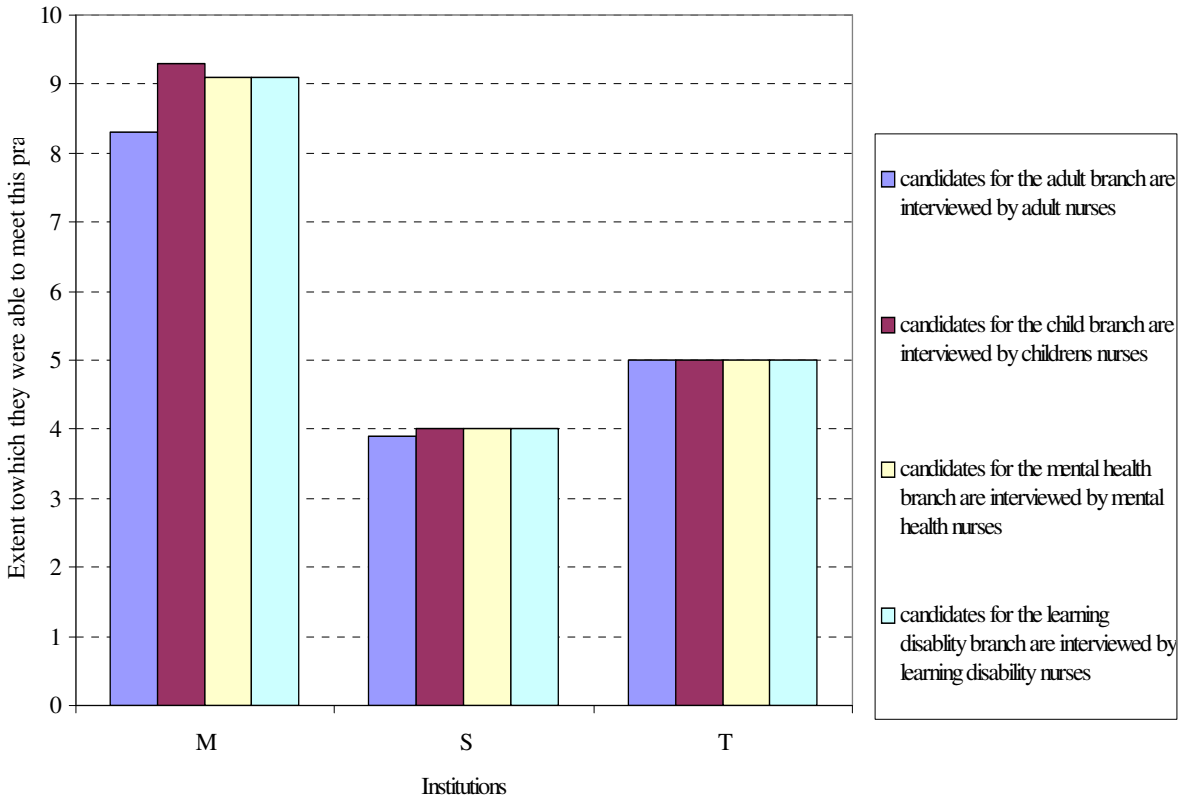


Figure 16 The extent to which candidates are interviewed by someone from the branch they wish to enter

Question 13

Candidates are assessed on their performance in a discussion group

Although two institutions indicated that they used this method, only one provided data in the format that was requested. The institutions were not requested to indicate the criteria that they used in assessing the candidates' performances in this method of selection.

Institution K who responded to this question grouped 12-15 students together with two interviewers. The discussion was described as lasting for 5 minutes per candidate, with the

groups having different topics, not chosen by the group leader. The candidates were (65mm) likely to be in group with others who wanted to do the same branch, usually being lead in discussion by nursing lecturers (68mm). No clinical staff were involved in this method of selection.

Institution K referred the researcher to Leach (1988), a report of the selection methods used by their institution. In this institution (K) a small group of eight candidates was given group activities to undertake. Leach (1988) indicates what would be expected of students wishing to train as mental health nurses, no data on the activities expected from potential children's nurses were provided.

Question 14

Candidates are assessed on their performance in a discussion group and have an individual interview

Table 45 demonstrates the responses to questions asked about this method of selection. Respondents were requested to give details of the size of the group, the number of interviewers and the time usually allowed for the discussion. Discussions lasted between 30 and 60 minutes with a median of 45 minutes.

Question	B	D	E	H	L	Q	V	X	Y
How many candidates in a discussion group	16	5	8	8	8	8	12	8	5
How many interviewers per group	4	3	3	2	1	1	3		2
*How long does the discussion last	30	60	45	40	60	60	45	40	60
Groups have the same topic for discussion	10	10	10	4.5	0	10	9	4.5	10
The group leader choses a topic for discussion	0	0	0	4.5	10		9	4	10
Candidates are in a group with others who want to do the same branch	0	0	7	10	9	10	9.5	8	10
The interviewers are ALL nursing lecturers	0	9	0	0	10	10	1	10	4
The interviewers are a mix of nursing lecturers and clinical nurses	10	5	10	10	0	0	9	6	8
*How long is the individual interview	10	15	10	10	30	15	20	20	30
How many interviewers are involved in the individual interview	2	2	2	2	2	2	2	2	2
The individual interview is done by nursing lecturers	NA	10	0	10	10	10	8	10	2
The individual interview is done by a mixture of nursing lecturers and clinical nurses	10	5	10	9	0	10	8.5	5.5	7.5
*How long does the discussion last	30	60	45	40	60	60	45	40	60
*How long is the individual interview	10	15	10	10	30	15	20	20	30

Table 45 Candidates undergo a group discussion and an individual interview.
* = time in minutes
other figures represent measurement on the visual analogue scale with 0 being the lowest ie never and 10 being always.

As table 45 demonstrates there were a wide range of practices within this method of selection. Four institutions B, E , H, V had involvement from clinical colleagues for either all the time or 90% (9cms), while other organisations appeared not to involve clinical colleagues at all in

the process of selection. The experience of the candidates' participants in the group discussion also varied. Four institutions always or nearly always had those wishing to enter the same branch in a discussion group together, while two of the nine institutions would appear to have mixed groups of candidates.

The content of the individual interview and the length of time it took varied between institutions (table 46). Institution Q did not provide any data in response to section of the question.

Instit	Interviewers	Time	Topic of individual interview
B	2	10	Concepts of nursing, strengths / weaknesses from the day
D	3	15	Reasons, special needs, criminal convictions (if any)
E	3	5-10	Aspects of application needing clarification, performance in group
H	2	10	Motivation for course, commitment to study/study skills, perceptions of nursing and experience, interests
L	2	20-40	Their work experience, education interests
V	2	20	Reasons for choosing child branch, experience with children or general contact with the public, employment school history, understanding of the role of the children' nurse, studying skills
X	2	20-30	Reasons for wanting child branch, recent experience with "caring" work especially children. Some strengths and weaknesses of candidate, some stresses involved in nursing (and studying)
Y	2	30	Strengths and weaknesses, interest in children, interest in nursing, stressful events, problem solving.

Table 46 Topics and timings for individual interviews

Four common themes emerge from this data. Institutions appear to use this time to check on candidates' reasons for their branch choice (5 institutions). Four institutions appeared interested in perceptions of nursing held by the candidates, with an equal number interested in the candidates' experience with caring. Three institutions claimed to pick up on the candidates' strengths and weaknesses. Data requested by the researcher had not required the respondents to indicate whether the same group of people were involved in the discussions and interviews on a regular basis, or whether this was a responsibility "shared" amongst a big group of staff.

Question 15 - The hypothetical candidates

How likely is it that you would want to interview this candidate for your college's child branch?

Respondents from two institutions did not complete this section of the questionnaire as it was their practice to choose students for the child branch at the end of the Common Foundation Programme. Two other institutions failed to complete a full set of responses for the candidates. A total of twenty one full sets of numerical data, were therefore available for analysis using Microsoft Excel 97.

Agreement between institutions

The six candidates had been developed to reflect two most acceptable candidates (2, 4), two moderately acceptable (1, 5) and two not acceptable (3, 6) (table 32, 197). As there were more than three sets of ordinal data and less than seven sets of scores, the data were suitable

for analysis using Kendall's Coefficient of Concordance (Hicks 1990). This statistical test demonstrates a relationship between three or more sets of rank (Cohen and Holliday 1996), demonstrating the level of agreement on a particular issue, in this case "how likely" the candidate would be chosen to come forward for interview.

Calculation of the data yielded a *s* of 3213 ($p < 0.01$). This demonstrated a strong agreement between the respondents as to the likelihood of the hypothetical candidates being chosen to come forward for interview as a group.

The Kendall Coefficient of Concordance uses ordinal data, resulting in a considerable loss of information from the original data set, with the result that the wide variation in scores attributed to individual candidates by different respondents was not demonstrated. For example candidate 6 was given raw scores of between 2.2 and 8.0 cm on the 10cm visual analogue scale on the seven occasions that she was ranked third. Calculations of the mean, median and standard deviation were undertaken on the 21 full sets of data to determine the range of scores given to individual candidates (table 47).

Candidate	Mean	Median	St. dev
1	6.13	6.5	2.73
2	7.19	7.5	1.71
3	2.32	2	1.69
4	7.06	7.7	2.54
5	6.81	8.1	3.04
6	5.19	5.9	2.45

Table 47 Mean, median and standard deviation scores for 21 institutions

If scores are closely clustered mean scores are a way of indicating a typical score (Clegg 1982). Comparison of the mean scores (table 47) indicated that candidate 2 with the highest mean of 7.19 could be seen as overall being most likely to be invited for interview. Candidate 3 with the lowest mean of 2 could, conversely, be seen as the least likely to be interviewed by the institutions. The rankings of both these candidates mirrored the opinion of the expert panel (table 32,197).

Mean scores may, however, be influenced by scores which are at either end of the range. The calculation of the median which indicates the midpoint of scores rather than the average gives a measure of central tendency. Comparison of median scores indicated that overall candidate 5 had the highest scores, with a median of 8.1 while candidate 3's scores with a median of 2 were again clearly the lowest (table 48).

On measures of mean and median candidates 1, 3, 4 and 6 were consistently ranked in the

order expected by the researcher and confirmed by the opinion of the expert panel. There was less agreement in relation to candidates 2 (most acceptable) and 5 moderately acceptable (table 48).

	Ranking by		
Candidate	**Researcher**	**Mean**	**Median**
1	Moderately acceptable (4)	4	4
2	Most acceptable (1)	1	3
3	Not acceptable (6)	6	6
4	Most acceptable (2)	2	2
5	Moderately acceptable (3)	3	1
6	Not acceptable (5)	5	5

Table 48 Ranking of candidates' scores against expectations

Scores for individual candidates

A *Z* score transformation of the raw scores for the candidates was undertaken (table 49). *Z* scores indicate where a score lies in relation to the mean score, either above or below (Clegg 1982; Cohen and Holliday 1996).

Instit	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**
B	1.2	0.2	-1.1	-1.2	-1.7	-1.5
C	-0.6	1.6	-0.4	1.1	0.9	0.6
D	0.4	-0.2	-0.4	-2.3	0	-1.2
E	0	0	0	-0.1	-0.5	-1

Instit	C1	C2	C3	C4	C5	C6
F	-0.2	-2.2	-0.2	0.3	-0.4	0.6
G	0	0.2	-0.5	0.1	0.4	-0.5
H	-1.5	0.9	-0.8	0.2	0.3	-1.2
I	0.9	-0.1	-1	0	0.8	-0.5
J	1.2	1	0.7	0.3	0.5	1
L	-1.8	1.1	-1.4	-2.8	0.8	1.6
M	0.6	-1.3	-0.8	0.3	0.1	-1.6
N	1.5	0.6	1.1	1.1	-2.2	1
O	0.9	0.7	0.2	0.7	0.8	0.5
P	0.9	1	2.5	0.1	-2.1	0.2
Q	-0.5	-1.6	-0.9	0.5	0.4	-1.4
S	-1.4	-0.1	1.6	0.2	-0.1	0.1
T	0.3	0.1	-0.1	-0.4	-0.1	0.2
V	-1.1	0	1.1	0.4	0.6	1.1
W	-0.9	-1.7	-1	0.7	0.8	0.3
X	0.2	0.4	0.5	0.6	0.7	0.7
Y	1.2	0.5	0.1	-1	-1.7	-0.5

Table 49 Z scores

Data from table 49 demonstrate a number of occasions where an institution's rating of a candidate was clearly different from that of the overall sample. For example institution L with a score of -2.8 for candidate 4 could be considered to have a lower opinion of the quality of the candidate. The same would seem to apply to Institution P who ranked candidate 3 2.5 points above that of other institutions.

Please give reasons for your decision about the acceptability of this applicant for

interview.

Respondents had not been required to compare individual candidates against each other on the basis that in practice candidates are judged on their own merits rather than being in direct competition with each other for places. It was anticipated that comparison of comments related to candidates would demonstrate common themes related to the acceptability of the candidates for interview. In other words candidates were criterion rated. The responses of all the institutions who had completed the visual analogue scales were considered, though four comments on individual candidates were missing. One institution had indicated that they did not consider the head teacher's report when considering who to invite for interview.

Data analysis

There were 23 sets of data for analysis and the same process that had been used for question 7 “What personal qualities to do you look for in candidates for your Dip HE (Nursing)?” was used for responses to this question. The full analysis is presented in appendix 4.

Rating the responses

To aid data analysis the manipulated variables in the applications were assigned a number and then decisions were made rating the comments as either negative, positive or unsure (appendix 5). The process was then repeated without reference to the initial assignment to ensure consistency. For example institution J’s reason for their rating of candidate 1 stated

> “Certainly appears to be keen to join caring profession. Not sure about her choice of CN. I would need to investigate this choice further”.

This became

- "caring profession, certainly appears to be keen to join caring profession" which was seen as a positive response
- Children's nursing. "Not sure about her choice of children's nursing I would need to investigate this choice further" which was seen as a negative response.

In the few circumstances where there was variation of assignment responses were reconsidered. For example "Doesn't say why she likes working with children" (candidate 2 institution n) could be matched against both "motivation/commitment eg reason for wishing to be a children's nurse" or "Motivation/wanting to work with children and families". With such comments the total context of the response was taken into account, looking at the overall statement and the VAS score that had been given to the candidate.

Some respondents made global responses to the candidates such as "Would appear a good candidate potentially" (candidate 2 institution G) or "Very good application. Excellent background for CB" (candidate 5 institution O). Some institutions stated "reference generally supportive". In both cases there was no reference to specific evidence that had led to this conclusion.

Analysed data from 23 institutions is presented in two ways

- responses to the individual candidates,
- responses to the manipulated variables across all six candidates .

As content analysis enables "the presence , frequency.... of the selected characteristics

(Markoff et al 1977, cited Waltz et al 1991, 299) to be determined, and all respondents had been asked the same questions (Pearson 1997) it was possible to present the findings in a numerical format. Microsoft Excel 97 was used to enable the presentation of results in chart form which also enabled a visualisation of the respondents opinions of the candidates.

Candidate 1 (C1) (figure 17)

(Anticipated moderately acceptable/ numeric ranking 4th)

Respondents reacted favourably to her work experience with statements such as "has found appropriate experience" (N). When responses related to her motivation towards children's nursing and her understanding of what children's nursing involved are combined 21% related uncertainty about her choice of child branch. Institution H's "Not clear why she want to undertake the child branch" being typical.

For C1 comments from respondents did not always appear to match the rating on the VAS. Institution J, the most generous scorer (median 8.4) rated this candidate's likelihood of being invited to interview at 9.3 on the VAS, but was seen as presenting a partly negative reason stating "certainly appears keen to join caring profession. Not sure about her choice of CN would need to investigate this choice further".

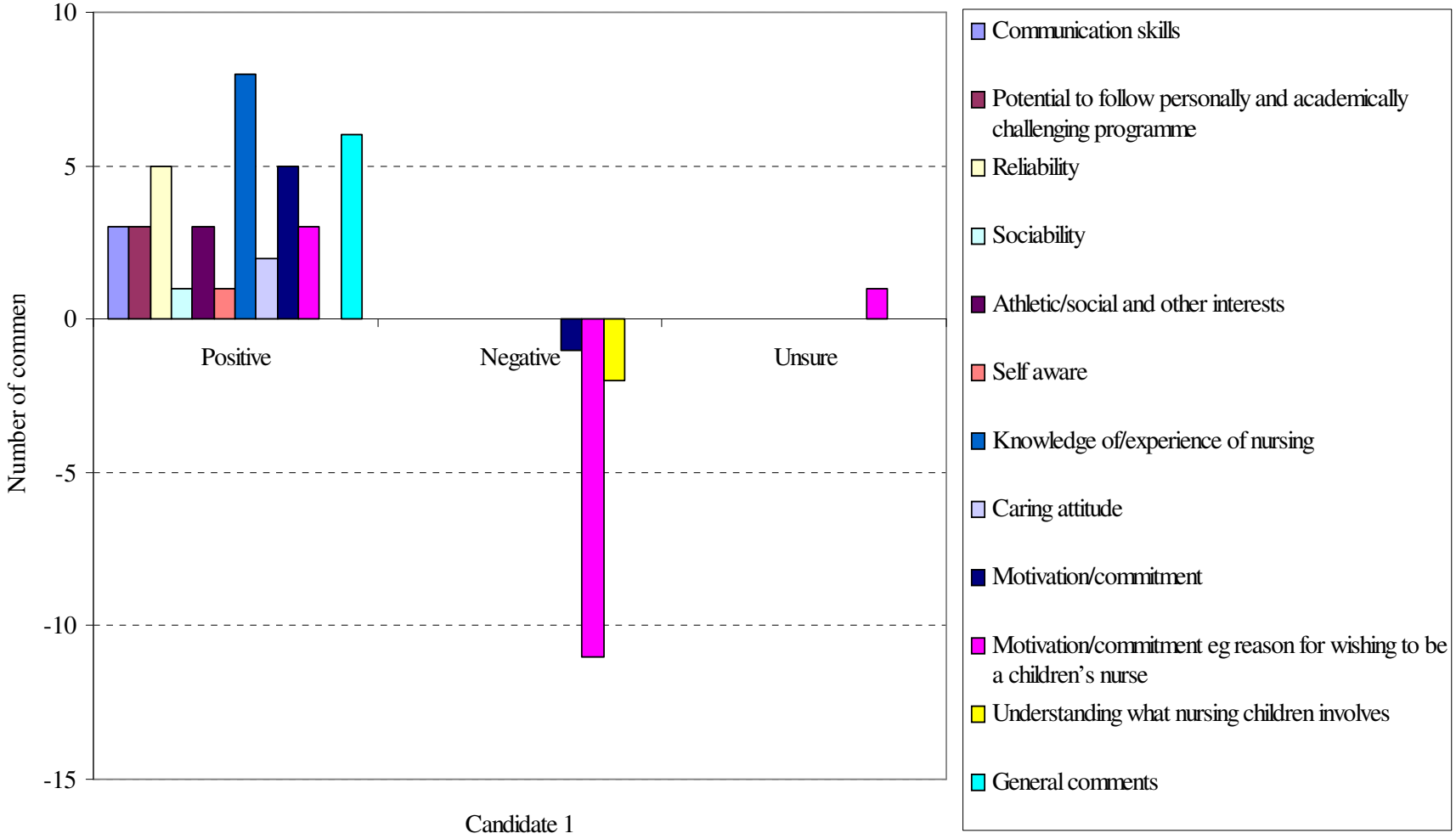


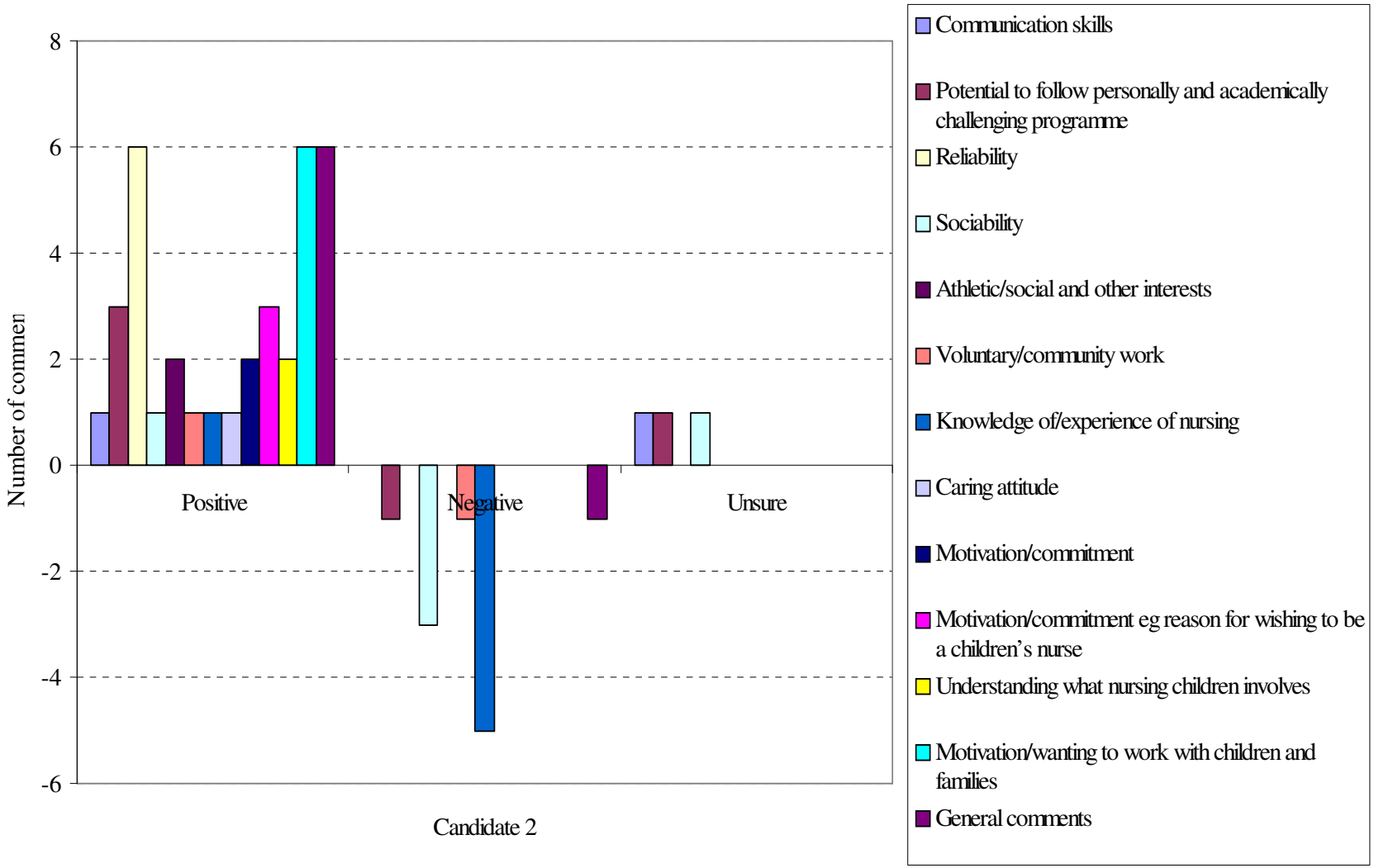
Figure 17 Responses to candidate 1

Candidate 2 (C2) (figure 18)

(anticipated most acceptable/ numeric ranking 1)

Thirty-five percent (35%) of comments responded positively to her motivation, understanding of nursing children and wanting to work with children. This was balanced against 12% negative comments on her lack of work experience and limited experience with children. There were also conflicting views of C2. Institution M stating "No experience of caring" while institution T stated "experience of caring".

C2's head teacher had made reference to ".. Is quiet in class, preferring to try and solve problems with her work herself before seeking assistance from the staff", which was seen by the researcher as a positive quality demonstrating suitability for the often less supportive learning environment of higher education. This raised concerns amongst some respondents over her suitability for children's nursing. Institution M (5) stated "personality - quiet, prefers to work alone - could have problems in nursing which relies on a team approach". Conversely others saw this as a positive reference demonstrating problem solving ability an ability to "concentrate and work alone" (P).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Candidate 2
Communication skills
Potential to follow personally and academically challenging programme
Reliability
Sociability
Athletic/social and other interests
Voluntary/community work
Knowledge of/experience of nursing
Caring attitude
Motivation/commitment
Motivation/commitment eg reason for wishing to be a children's nurse
Understanding what nursing children involves
Motivation/wanting to work with children and families
General comments

Figure 18 Responses to candidate 2

Candidate 3 (C3) (figure 19)

(Anticipated not acceptable/ numeric rank 6th)

C3 had been created as the least acceptable candidate, with his total lack of care experience, and wanting to join the medical profession. His median score of 2 on the VAS combined with the smallest st dev (1.69) of the six candidates demonstrated a close level of agreement about this candidate. Two respondents (J, M) stated that he needed career counselling about the most appropriate way to achieve his ambition. Overall, however, C3 was seen in a negative light, being "confused about career" (H) and with "no real substantive rationale for a career in nursing let alone the CB" *(sic)*(K).

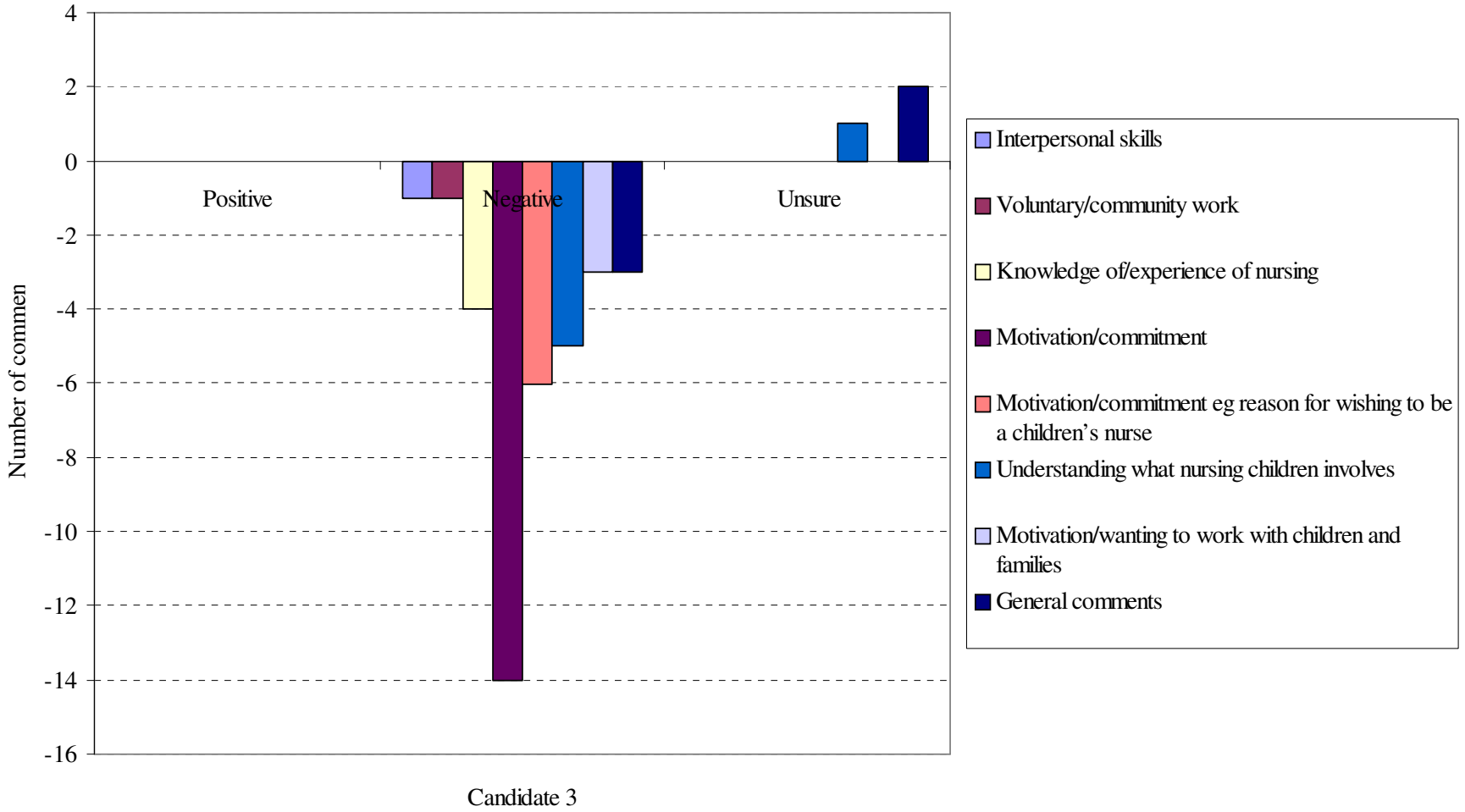


Figure 19 Responses to candidate 3

Candidate 4 (C4) (figure 20)

(Anticipated most acceptable/numeric ranking 2)

The element of C4's application that attracted the greatest number of positive comments (23%) was his motivation to be a children's nurse. Five respondents also commented on his understanding of children's nursing and his recognition of an "area where he will be able to specialise" (H) and his being "aware of deficit in paediatric the male role models" (X). Conversely two respondents (D, F) wondered whether he realised the "breadth of CN" (F) and that he would need to care for "all ages of children (babies)" (D).

Four respondents (B, E, I, Y) highlighted a concern about his motives for entering children's nursing. Institution Y stated "comment about adolescent boys needing a male nurse would need to be explored as it may be a cause for concern". Institution E expressed concern "about the circumstances of his decision. Would explore gently at interview".

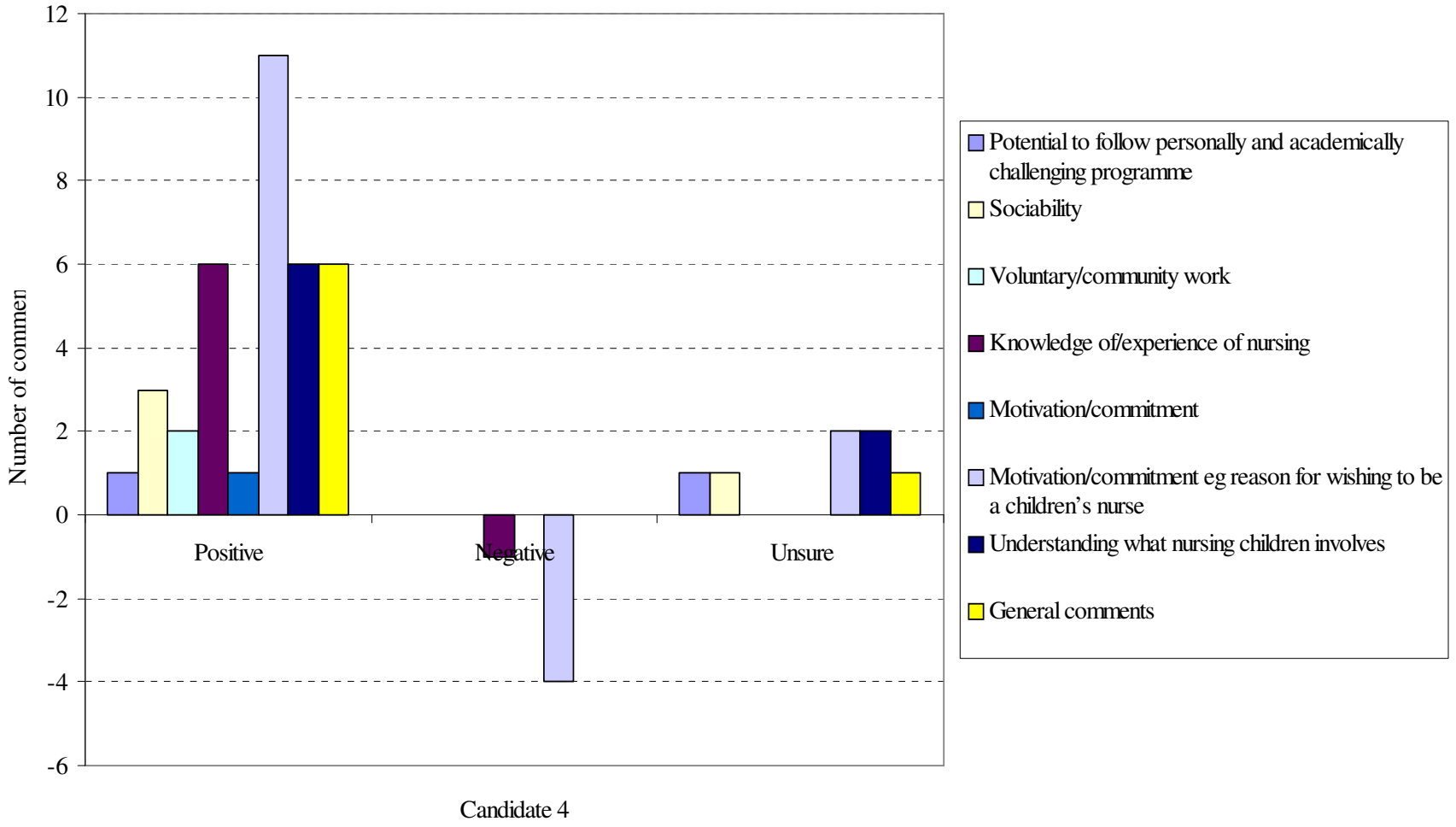


Figure 20 Responses to candidate 4

Candidate 5 (C5) (figure 21)

(Anticipated moderately acceptable/numeric ranking 3)

With 77% positive comments C5 came first in this measure of likelihood of being invited to interview. Respondents highlighted her knowledge and experience as a nursery nurse (17%) and her understanding of what nursing children involved (23%).

In an attempt to ensure a focus on the manipulated variables respondents had been requested to assume that their institutions' specific academic requirements had been met by all candidates. Four institutions expressed concern about C5's academic ability. For example "would not at present cope with academic demands of the programme", although this was seen as being balanced by her "strong motivation" (E). Institution K was alone in stating "could utilise painting abilities", a reference to one of her hobbies. Overall responses to this candidate present a mixed view of her as a person with positive elements to her application but also concern about her ability to achieve academically. A balance between choosing a suitable person to be a children's nurse against a student who would achieve a diploma of higher education.

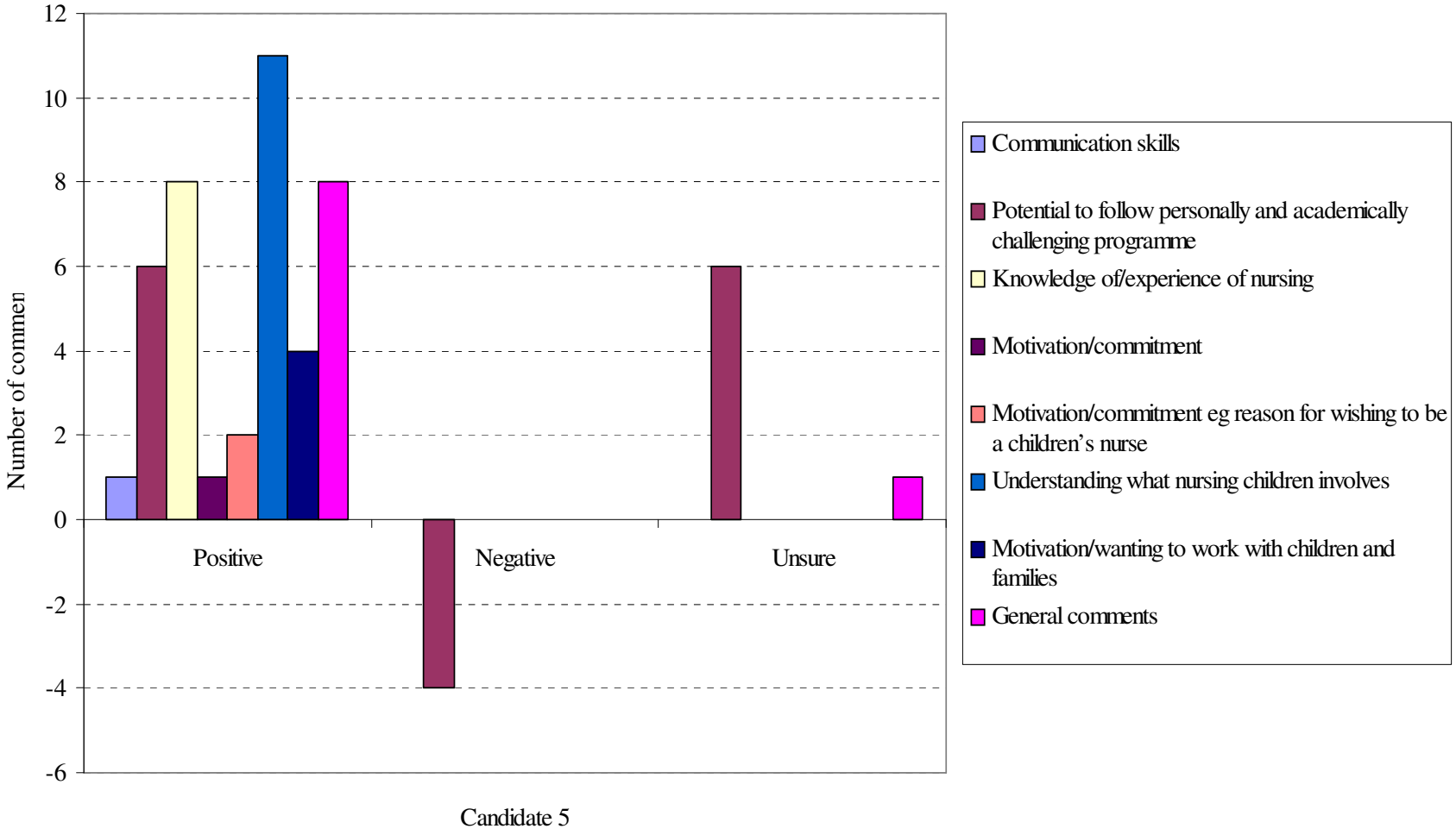


Figure 21 Responses to candidate 5

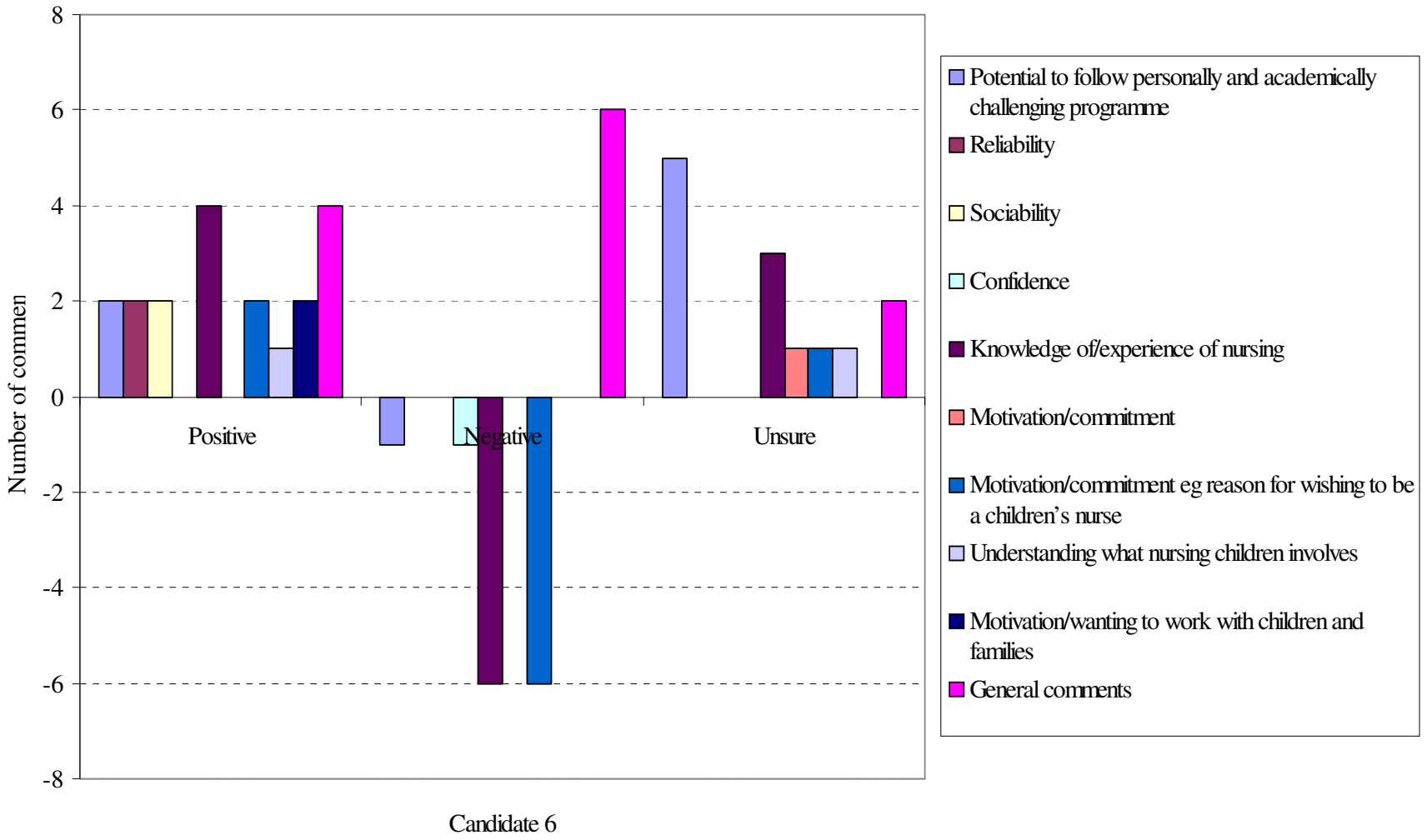
Candidate 6 (C6) (figure 22)

(Anticipated not acceptable/numeric ranking 5th)

With her percentage of positive comments (43%), putting her in fifth place, responses to this candidate matched the predictions of the researcher and the expert panel. With 27% of comments defined as "unsure" respondents appeared less able to make up their minds about her application, although both her mean (5.2) and median (5.9) scores supported her position of fifth out of the six candidates.

C6 was seen as a candidate with no "experience caring" (D) with "little specific indication as to why she wants to be a CN" (I). Five respondents picked up the headmaster's statement that " sometimes she seems to fail to express herself in writing". Institution P (5.9) writing that "if invited for interview I would ask her to bring some written work along". It is not clear whether this would be an expectation of all candidates applying to particular this institution or a practice that may be carried out with a small number of candidates.

Institution S's response captured the feeling of uncertainty about C6 stating "not sure about this. Would discuss with colleagues. Cannot gain a picture of this candidate".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Number of commen
Positive
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Unsure
Candidate 6
Potential to follow personally and academically challenging programme
Reliability
Sociability
Confidence
Knowledge of/experience of nursing
Motivation/commitment
Motivation/commitment eg reason for wishing to be a children's nurse
Understanding what nursing children involves
Motivation/wanting to work with children and families
General comments

Figure 22 Responses to candidate 6

Manipulated variables

A total of 25 inherent qualities of child branch students had been identified from the literature. Of these 20 had been manipulated in the development of the six hypothetical candidates (194-5). The comments of institutions had been "sentence busted" (Burnard 1994, 35) and assigned to the variables (appendix 5 and 207). Six qualities did not appear to have been noted by the respondents:- warmth, initiative, friendliness, caring skills, psychomotor skills/physical dexterity and an ability to work with people of all ages.

Analysis was undertaken to determine the percentage of respondents who had made reference to some particular quality. This was considered the most appropriate measure as the comments made by some respondents had included repeated responses to the same quality (table 50)

Commented variable	Percentage of institutions
Knowledge/experience of nursing	83
Motivation/commitment eg reason for wishing to be a children's nurse	83
Potential to follow personally and academically challenging programme	78
Understanding what nursing children involves	74
Motivation/commitment to nursing	74
Voluntary/community work	55
Motivation/ commitment to work with children and families	39
Sociability	35
Reliability	30
Communication skills	22
Athletic /social and other interests	22
Caring attitude	9
Interpersonal skills	4
Confidence	4
Self aware	4
Awareness of others contributing to care	4

Table 50 The commented variables

Knowledge/experience of nursing and motivation/commitment eg reason for wanting to be children's nurse, were on this measure equally important with academic ability coming a close second. Communication skills received comment from less than a quarter of respondents a quality that 54.4% of respondents had identified as important in response to question 7.

The variables were also analysed to determine the percentage of comments that related to each (table 51).

Quality	%
Motivation/commitment eg reason for wishing to be a children's nurse	52
Knowledge of/experience of nursing	46
Potential to follow personally and academically challenging programme	34
Understanding what nursing children involves	30
Motivation/commitment	25
Motivation/wanting to work with children and families	15
Reliability	13
Sociability	12
Communication skills	6
Athletic/social and other interests, Voluntary/community work	5 each
Caring attitude	3
Interpersonal skills, confidence,	1 each
Self aware, Awareness of others contributing to care	1 each

Table 51 The percentage of comments related to each variable

Other findings from the data

Institution T had indicated that they did not consider the references at the point of short listing for interview. Out of the remaining 22 institutions in this element of the study 11 (50%) made comments about the head teacher's reference. Some simply stated "good reference" (E) or "academic reference" (H), while others made comments on elements within the reference, for example, "her failure of expression in written work..." (U).

Institution L's responses were focussed on whether or not the candidate met the criteria, with very little additional expansion (table 52 overleaf). Such limited responses would provide very

little information should a rejected candidate wish to challenge a decision or get advice on how to improve their application.

C 1	1	Does not meet our criteria. No reason to believe that its CN she really wants
C 2	9	Meets our criteria for interview
C 3	0	Doesn't meet our criteria. Wants to be medic not nurse
C 4	0	Doesn't meet our criteria
C 5	9.5	Meets criteria
C 6	9.5	Meets criteria

Table 52 Responses from institution L

DISCUSSION

Introduction

This survey had been undertaken to explore the answers to two questions arising from the concept analyses of children's nursing and the special needs of children. The questions raised by these analyses were:-

> Do people who select child branch students look for the inherent qualities identified in the literature?
>
> Is there agreement amongst selectors on these qualities and the ways in which they may be evidenced?

A new methodology, that focussed on six child branch applications specifically developed and derived from analysis based on the definition of the special needs children when they need nursing. This methodology was intended to mirror the usual practices of those involved in selecting candidates for an interview shortlist. Respondents, to the postal questionnaire, had also provided data related to the length of time that they had run the child branch and the numbers of applications received and places available. The questionnaire had sought data in relation to the face to face methods used to select candidates following prescreening, the initial scrutiny of the application forms.

As discussed previously the implementation of the recommendations of Project 2000 (UKCC 1986) had re-established a direct route for entry to children's nursing, removing the requirement for an existing nursing registration. During the time when institutions had been required to select from previously trained nurses those putting themselves forward would have

done so based on their actual experience of caring for children during their initial training, or their experience as a general nurse employed in this field of practice. Selectors would have been able to make decisions informed by references from those who knew the quality of the nurse's practice with children and their families. With the reintroduction of a direct entry to children's nursing selectors were now choosing mainly from raw recruits a significant number of whom might be school leavers, with limited formal care experience. This is supported by figures for the child branch intake in 1998, for which NMAS figures show 81% would have been under the age of 25 (NMAS 2001).

Response to the survey

The survey was undertaken at a time of great change in nursing education in England. The roll out of Project 2000 which moved pre registration nursing education from certificate to diploma of higher education level was just about complete. As part of a process of rationalisation, colleges and schools of nursing were merging to create larger schools and a large number of these new organisations had linked with or were in the process of preparing to join institutions of higher education. A response rate of 73.5% at such a time of institutional and personnel change was therefore considered to be "doing extremely well" (Treece and Treece 1986, 293).

Section 1

Questions 1-6

Question 1 How long has your institution been running the child branch?

Responses to this question demonstrated the spread of experience across the sample and therefore the representativeness of the institutions. The results in this question were as anticipated due to the government's policy of funding the roll out of the Dip HE (Nursing) over an extended period, starting with an initial thirteen demonstration sites in 1989. The dilemma for all institutions when selecting students for any new pre-registration nursing course is the period of time that it takes for a course to complete and for the full evidence related to selection and educational processes to be available in relation to student achievement and wastage. This time delay has the potential to be greater dilemma for those institutions providing an entirely new course, such as a child branch, with no previous experience in selecting that particular type of student.

Question 2 Which of the following branches do you offer?

English National Board regulations (ENB 1993) in force for the introduction of the Dip HE (Nursing) programmes required institutions to offer 3 or 4 branch programmes, as a prerequisite for approval, therefore the results for this question were as anticipated. The rationale for the ENB's policy at that time is not available in the public domain. Later, in 1993, ENB policy changed in response to an anticipated reduction in the number of student places that would be commissioned by the Regional Health Authorities (RHA) (ENB 1993). The change in policy allowed greater flexibility for provider institutions, particularly if they

were in the position of losing a contract for one of their branch programmes.

Institutions responding in this particular survey were all offering either three or four of the branch programmes and would previously have offered pre-registration programmes leading to qualification as an RGN (Registered General Nurse) or RMN (Registered Mental Nurse), with a smaller number offering the RNMH (Registered Nurse Mental Handicap). Responses to this question again demonstrated the sample's representativeness in relation to the total possible population.

Question 3 a) How many groups do you admit each year and b) how many students are recruited for each?

Question 4 In total how many applications did you receive for each of the Dip HE branches in 1994?

These two questions had been developed to provide data to facilitate comparison between similar sized institutions, to look at the level of competition for places on the different branches and attempt to determine whether institutions with a high ratio of applicants to places were more "choosy" (Child et al 1988, 59) than others. As discussed previously (177) Harding had undertaken a small study looking at selection for the child branch. With a convenience sample of five respondents, her survey was undertaken in response to the fact that "the number of applications consistently exceeds the number of places available" (Harding 1999, 14).

Although only seven respondents provided full data related to the total numbers of applications the branches (question 4) the percentage reduction from applications to places across the sample to 9% mirrors the figures derived from the NMAS statistics (129). Harding (1999), in her much smaller study, reported that one institution filled all its places in accepting 36% of those who applied in 1997 but only 21% of those who applied in 1998 again a demonstration of the popularity of this branch.

Question 5 Who selects candidates for interview?

Results from this question demonstrated that it was rather simplistic in focussing solely on the personnel involved in this stage of selection and not capturing the real nature of this first part of the selection process. This first step is important as selectors need to attempt to bring forward the most suitable applicants, or they may be lost to the organisation for ever. Decisions, at this point in the selection of student nurses, are based on some form of scrutiny of a written application submitted on the standardised application form required by NMCCH/NMAS. Robertson and Smith (2001) in their review of personnel selection express surprise at the limited amount of research that has been undertaken on the impact of application forms in selection. As they state these are the first contact between a candidate and a possible future employer and mistakes at this point in the selection process have the potential to have a larger effect (Robertson and Smith 2001).

It is a straight forward matter for selectors to determine whether candidates have met the institutional requirements in relation to academic qualifications, as these can be easily checked

against a standard list. It is the consistent interpretation of the "soft biodata" (Drakely 1989, 440) in areas such as the supporting information that is more difficult to achieve, as is demonstrated later in the discussion of the six hypothetical candidates. A similar point was made by Child et al (1988), in their study related to selection of nursing students, when they recommended that there should be clarity in relation to the particular "precisely defined" qualities candidates were expected to display and the way in which they should be evidenced (Child et al 1988, 112-113).

The structure of this question did not capture any systems, put in place by institutions, to ensure consistency of decision making at this point in the selection process. Neither was there the opportunity to determine any processes that may have been in place to check what might be described as the inter rater reliability between different personnel, ensuring that the same decisions about candidates would be made by all those involved in this initial process of scrutiny.

Question 6 Qualifications accepted by the institutions for entry to nursing.

As discussed previously the UKCC (NMC since 2002), as the statutory body for nursing, sets the minimum academic entry requirements for pre-registration programmes (Appendix 2). At the time of this study these requirements were based on 5 GCSEs grade A-C or "equivalents" (ENB 1995, 10) and there were, as now, no specific set subjects for nursing programmes, leaving institutions free to set their own requirements for specific subjects and levels of achievement above the minimum if they wish. Institutions are also free to decide which of the

"equivalents" (ENB 1995, 10) they are willing to accept.

The results from this survey were a snapshot of 1995 requirements and there had been no attempt to determine from respondents whether their organisation had implemented changes since the move to diploma level education with the roll out of Project 2000, as this evidence was available from scrutiny of previous editions of the applicants handbook (139). Results from this question, as anticipated, mirrored details in the NMCCH's Applicants Handbook (ENB 1995) which showed a broad range of qualifications considered acceptable by the different institutions. One institution (U) had responded that, unlike for the adult and mental health branches, the UKCC DC test or Access courses were not accepted for entry to the child branch due to the number of applications, although no such information was found for any institution in the applicants' handbook.

The rationale underpinning decisions in relation to the academic expectations of the institutions were not explored, as finding the appropriate personnel to answer such questions would have been difficult using this methodology, particularly at a time of institutional change when previously rival organisations were sometimes being brought together and having to develop new systems and strategies. Personal experience in the statutory approval of programmes had also demonstrated the extent to which regulations of the Higher Education Institution in relation to requirements for admission to programmes at different levels may also impact on the requirements for nursing programmes. Programme based decisions about academic requirements could be based on previous experiences of students with or without

particular qualifications, an institutional policy to accept some of the newer qualifications or links with feeder organisations, such as colleges of further education who offer particular routes to achieving programme entry requirements.

While these trends would appear to demonstrate achievement of a wish to see a widening of the entry into nursing (UKCC 1999) there is the potential for this wider diversity of previous learning experience to impact on the need for student support, particularly in the early part of the programme. It is difficult to determine the effect that wider academic entry qualification has on student achievement and retention as figures reported by bodies such as the ENB, whose annual reports to the Department of Health, solely reported numbers of discontinuations of students with additional detail related to reason. Figures produced by the ENB, before its demise, demonstrate that discontinuation figures for the child branch have remained reasonably steady (table 53). Although these figures are comparable with those for the adult branch this should be a matter for some concern when percentages are translated into numbers of students not completing the child branch.

	Percentage	**Number of students**
1997/1998	16	238
1998/1999	18	310
1999/2000	15	302
2000/2001	17	369

Table 53 Discontinued students on the child branch (ENB 1998, 1999, 2000b, 2001)

Question 7 What personal qualities do you look for in candidates for your Dip HE (Nursing)?

Responses to this question were presented as "Qualities of candidates for children's nursing education: RCN International Paediatric Conference, Bournemouth, 1999

As discussed previously with the introduction of Project 2000 selectors were now in the position of choosing entrants to children's nursing from among the general public as there was no longer a need to be a qualified nurse to access such training. There had always been direct entry for the other three branches. The intention in asking the question "What personal qualities do you look for in candidates for your Dip HE Nursing?" and providing clear opportunity to respond in relation to the different branches offered by the institutions had been to see whether selectors differentiated between the branches in the qualities they would look for. This was also the first opportunity to compare findings from the survey and compare them with the theoretical qualities derived from the literature.

In their study of nurse selection, undertaken in 1986-6 Child et al (1988) had asked "What qualities are looked for in the applicant on the basis of information on the application form?" (Child et al 1988, 128). In their study, institutions did not appear to have any registration specific qualities in mind when scrutinising application forms. Responses in this survey, undertaken 10 years after the nurse selection project, appeared to indicate that almost one third of the institutions did not explicitly distinguish between candidates for the different branches of nursing, although this finding may be distorted by the fact that some institutions only responded in relation to the child branch.

It was not possible, however, to determine whether the selectors would expect their list of common qualities to be demonstrated in different ways by candidates for different branches. For example, it was not clear whether the selectors would expect candidates to have "knowledge/experience of" the specific branch of nursing they wished to enter, or whether an understanding of the difference between nursing and other health care professions *per se* would be sufficient. It may be that organisations set similar criteria for different groups of candidates but the level at which applicants for the more oversubscribed branches were considered to demonstrate their suitability would be more strictly applied.

The institutions which expected candidates to demonstrate an understanding of children and their families were those which had clearly distinguished between branches or provided data relating only to the child branch. The different responses which were grouped into this category demonstrated a range of expectations from "insight into the problems of children and families" to "have had some significant contact with children". These statements would appear to expect the student to have some knowledge of the group they wished to care for. Unlike one of the institutions in Harding's study that indicated an expectation of "6/12 full time/one year part-time experience with children" (Harding 1999, 16), none of the respondents gave any indication of any criteria against which they would measure knowledge or experience.

As a consequence of the methodology and the short phrases used by the respondents, it was not possible to determine whether personnel in the different institutions held a common

perception of what would demonstrate an understanding or knowledge of children and their families. Differences in what would constitute evidence of an understanding of children could have an impact on candidates' success at interview, their ability to complete the education process and their ability to gain employment.

This raises the question of what may be a realistic expectation of what is meant by understanding of children at the point of application. For example, it may be that some candidates have a restrictive view of nursing children. They may believe that nurses do things to and for the child, with little regard of the role of the family, while such beliefs may lead to rejection at interview, other candidates may be accepted become dissatisfied with the approach to children and their families and the institution's lack of "fit" with their personal beliefs, causing them to leave.

The fact that one third of respondents clearly indicated that they expected candidates to have some knowledge or experience of nursing was not unexpected. The ability of the candidates to achieve this requirement may, however, be influenced by a number of factors. For example there may be candidates who live miles from any available experience, while others may find that local experience has significantly reduced the willingness of hospitals and other institutions to allow voluntary or part time unqualified assistance, this was particularly noticeable post the Allitt Inquiry (HMSO 1994). Mature students and those who have limited financial support may also be required to spend any free time in other forms of employment, which may pay more, in order to support themselves and their studies. This may limit their

insight into the role they wish to be educated for and their ability to be convincing at interview.

There had been an expectation that communication skills would be mentioned by most institutions, particularly as this was one of the areas that referees are requested to comment on in the application process, "following consultation with the institutions" (ENB 1995, 117). Student nurses have to communicate with those for whom they are providing care and be able to pass theoretical and practical assessments which rely on a range of written and verbal communication skills. The importance of these skills to nursing had led the researcher to believe that such qualities would be considered essential by all those involved in selection of students for whichever branch. It was therefore considered surprising that almost half the sample made no reference to this quality.

Qualities such as a sense of humour, warmth, compassion, self awareness and understanding which had been identified from the literature were also referred to by a limited number of institutions. These qualities would not appear to distinguish any specific group of nurses and may be applicable across the whole spectrum of nursing and indeed any health care profession or work where there is contact with people. A number of the qualities of children's nurses identified through the review of the literature did not appear to be supported. These included an ability to work with people of all ages, observational and psychomotor skills.

Institutions looked for a range of personal qualities which the literature had not identified as

being inherent specifically in prospective children's nurses. The qualities of "honesty", "integrity", "politeness" and "sociable", however, would not appear to particularly distinguish prospective nurses for any branch as it could be argued that such qualities would be expected of anyone who had a job working with and for others.

The use of a different methodology such as a checklist of qualities and ways in which they may be evidenced on an application form may have enabled better exploration of the qualities looked for by selectors, such a method would however have forced people to respond to qualities which they in fact did not in reality take into account when scrutinising application forms.

Question 8 Has your selection process for students change since the implementation of Project 2000? If yes please describe your previous system

Child et al (1988) had predicted that the introduction of the recommendations of Project 2000 would lead to a "reassessment of selection criteria and methods" (Child et al 1988, 115). The data in this study would seem to imply that, in relation to the method of selection, this was starting to be the case with a move away from individual interviews to processes involving a range of other activities. The rationale for such changes had not been explored as due to organisational and personnel changes many of the people responsible for arrangements at the time of this survey may have left the institution or have no knowledge of systems which had been in place in organisations they had merged with.

Question 9 Do you use the same selection methods for each branch that you offer?

Responses to this question were as anticipated, with 23 of the 25 respondents clearly using the same method for selecting students irrespective of branch. Institution Y's comment of "on the whole" gave no indication of what might potentially be different. It was also unclear what was meant by "no for the child branch" (instit C). Findings in response to this question are similar to those of Child et al (1988), who recorded the fact that the majority of schools used the same selection processes "irrespective of the part of the register" (Child et al 1988, 61).

It is being argued within this study that, if as a profession nurses subscribe to the notion that there are specific bodies of knowledge required for effective practice in the four branch areas, there would be different initial characteristics of the neophytes entering the four educational programmes. If this view of difference was supported it might be argued that a range of different selection techniques would be effective in selecting those with the most appropriate characteristics to develop into registered practitioners. There is, however, the impact of equal opportunities policies to be considered as was demonstrated by personal experience of approving a child branch where the course team's proposal of using a different approach to selection, because of the number of applicants and their belief in the specialness of children's nursing, was rejected by both the ENB and the university as being inconsistent with equal opportunities policies.

Question 10 Please chose THE ONE selection process that most closely describes what your college uses for the Dip HE.

This was the filter question designed to direct respondents to one of three selection processes that might be used by their institution. As it could be assumed that those involved in selection choose a method they believe will be effective the purpose of this question was to determine the nature of the processes used rather than to test the respondents' opinions on the efficacy of their chosen method. There was no attempt to determine what characteristics or qualities the selectors would be actually looking for during their chosen selection activities.

Question 11 Please describe the process that you use.

This question had been intended to gather data from those institutions which used different selection methods for each of the branches or used a method that was different to the options presented in the survey. The data may not be representative of the whole sample due to the random way in which it was volunteered, however, it is in line with findings from other studies undertaken either prior or around the same time (eg Land 1993a, Hek 1994).

Herriot (1989) and others (eg HR-Guide 2003) in discussing competitive job interviews state that there are other purposes that can be achieved at the same time. These are particularly related to the "selling the organisation" (Herriot 1989, 435) and allowing the candidates to ask questions and find out how they would feel working for the organisation (Robertson and Smith 2001). From analysis of the random data presented by the sample in this study there is evidence that selling may be considered an important element of the time spent with

candidates. Selling can include the provision of course information, lunches with current students and tours of the institution. A range of similar activities specific to nurse selection had also been identified by Child et al (1988).

Although both Land (1993a) and Hek (1994) identified a range of activities related to nurse selection, only Land studied the impact on the recipients of such practices. She identified that in schools and colleges where a range of activities took place the candidates often thought there was too much time between different activities. In her study candidates appreciated that discussions and essay writing were being used to test communication skills, literacy and attitudes (Land 1993a). Respondents in Hek's study had been "asked to describe their selection/interview procedure" (Hek 1994, 27) which led to the identification of a number of activities undertaken by schools and colleges of nursing. All those who responded to her request indicated they used an interviews with almost half also using discussion groups and lesser percentages requiring applicants to write essays and/or undertake tests of numeracy.

Questions 12-14

The focus of this section of the study was on the methods used by institutions to select students and the personnel involved. Respondents had deliberately not been asked to give a rationale for their choice of selection method, as this would probably have not been their individual decision. There had been no attempt to determine institutions' effectiveness in selecting candidates who would complete the programme and become effective nurses.

Context

The mergers of schools and colleges of nursing and the move to programmes with a minimum of diploma level outcomes would have provided the opportunity for review of selection processes used for pre-registration students. The move to Project 2000 would also have the potential to create changes in processes. Previously there would probably have been selection days dedicated to entry for particular parts of the register. With the advent of diploma level Project 2000 programmes institutions may have taken the opportunity to move to a combined selection day, where students looking for access to all the different registers would be invited at the same time. The mergers with universities also had potential to impact on selection as no longer were the majority of institutions physically close to the NHS organisations that provided placements for students. There is anecdotal evidence that some in the NHS felt that now the universities were taking over the old schools of nursing, the selection of students and their education would be entirely their responsibility.

The Applicant Handbook (ENB 1995), current at the time of this study, stated that "the NMCCH is not aware of any institutions who offer places without first interviewing the applicant" (ENB 1995, 19), although the NMCCH does not define interview. Some students wishing to undertake degree level preparation for registration would, on the other hand, have found that they were offered places purely on the basis of their application form without any personal encounter with those who had selected them.

Methods of selection

As has been discussed in question 11 a number of organisations incorporated information giving and assessment of students' written and numeracy skills into their selection process. From the data provided in response to questions 12-14 two institutions used discussion combined with information giving as their method of selection. The others used either interviews or interview and discussion groups.

Data analysis of the interview element of selection demonstrated a missed opportunity to compare the nature of interviews between organisations who used only interview and those who combined it with discussion. Some variation in interview processes was however demonstrated when respondents used interviews combined with discussion.

Herriot (1989) cites Kinicki and Lockwood's (1985) "interview impression" (Herriot 1989, 434) describing a process within an interview situation where selectors are attracted by candidates displaying qualities similar to those they think they have (Porteous 1997). Those organisations who used interviews to look for motivation, experience, "strengths and weaknesses" (instit y) were apparently using the opportunity of being "face to face" (Herriot 1989, 435) with candidates to find out what they are "really like" (Herriot 1989, 435).

Five years after the data collection for this study a DoH commissioned project into Student attrition (DoH 2000) specifically looked at "Good practice in recruiting and retaining students" (DoH 2000, 9). Seventeen providers of pre-registration nursing education responded

to the survey, which collected data through telephone interview and "paper-based surveys" (DoH 2000, 9). As in 1995, the time of data collection for this study, 90% of respondents to the DoH commissioned survey used face to face interviews. These were seen as a "key component in assessing a candidate's suitability" (DoH 2000, 28). Selectors reasons for using interviews were recorded as being to look at communication and interpersonal skills, motivation and confidence. In listing areas of good practice the researchers highlighted, amongst others, the inclusion of "tests in basic written English" ensuring that candidates have the necessary communication skills and using the interview to allow candidates to "verbalise nursing issues in greater depth" (DoH 2000, 30).

A study of group techniques used by institutions to inform their decisions would be informative in determining whether candidates are judged against criteria, ie criterion based, or on their performance in comparison with the members of their selection group when they are involved in group discussion ie normative and how measures to maintain consistency were monitored session by session. Tuckman (1965, cited Burnard 1985) argues that groups have to pass through three stages of forming, storming and norming to reach the performing stage where they can work together (Burnard 1985) and Burnard (1985) proposes this may take considerable time, certainly longer than that allowed for in the selection process, used by the institutions in this study.

If it is appropriate to apply this theory of groups to such an event then selectors would be required to make decisions emerging from group performance which may create a range of

different behaviours. These behaviours may be those related to forming the group, a time of "testing the waters" and "discovering their role in the group" (Burnard 1985, 105) through to "pairing" (Burnard 1985, 109) where just two group members hold the discussion through to flight where

> "The group avoids serious issues by taking avoiding action: talking lightheartedly, intellectualising or changing the topic" (Burnard, 1985 p 109).

Application impression

During the interviews that Child et al (1988) observed, 55 candidates were accepted from the 66 interviewed, which could be interpreted as demonstrating the effectiveness of institutions' "prescreening techniques" (Land 1993, 5). The personal experience of the researcher and anecdotal evidence from others involved in selection for nursing would in the majority continue to support the value of actually seeing candidates to ascertain with the reality does in fact match the application impression.

Personnel involved in selection

Child et al (1988) reporting on data collected in 1985/6 indicated that a wide range of personnel from both institutions and practice were involved in selection. In the interviews, observed by the nurse selection research team, clinical representatives were always present and they were usually senior nurses at nursing officer or director of nursing service level.

Ten years later data from the twelve institutions who used interviews presented a changing

picture with only half always having service representation. Two had no representation from service while the remaining four presented a varied pattern of service involvement. The pattern of clinical colleagues involvement may in part be attributable to the time that the selection processes took, as for institutions that had a mix of interview and discussion service involvement was less with three institutions using only lecturers and a mixed pattern for service involvement in the remaining 6. Nurses with equivalent qualifications to those which the candidate wished to study were included in 75% of the interview panels.

Reasons why not all institutions were able to achieve the presence of clinical colleagues were not explored, though the make up of these panels might be seen as a logistical response to the potential pressures experienced by clinical staff in being able to devote time to student selection. For some organisations the changing structure of the schools of nursing may also have led to a feeling of geographical separation. No longer were clinical nurses involved in selecting students for their own organisation, rather they were contributing to a process that selected students who may undertake experience and gain eventual employment in an entirely different organisation. An alternative explanation, for the lack of involvement of clinical staff, may be that in the institutions where clinical staff were not involved they were simply not invited.

With the drift towards lecturer only selection of candidates there may be other effects to consider. The earlier studies of Child et al (1988) and Land (1993a) both reported a division of role between the lecturer and the clinical nurse. The lecturers role being to assess the

candidate from an academic perspective with the clinical nurse focussing on candidates' understanding of the practical aspects of nursing. Studies in the mid 1990s highlight concerns over the possible loss of nursing skills (Gilmore 1999), lack of contact with the caring situation and a lack of "up to date knowledge and clinical credibility" (UKCC 1999) amongst nursing lecturers . For such lecturers such lack of contact and knowledge may mean that when they do not have a clinical partner involved in the selection process they are required to make decisions based academic ability and outmoded ideas of the reality of nursing.

The UKCC Commission for Nursing and Midwifery Education (UKCC 1999) writing four years after the data collection for this study recommended that "recruitment and selection should be a joint responsibility between service providers and HEIs" (UKCC 1999, 23). This recommendation alongside the NHSE directive "That there should always be an NHS representative involved in and present during the selection process" (DoH 1999b, 10) would lend support to the anecdotal evidence that NHS staff were no longer actively involved in the initial selection of those who would in the majority eventually become their employees. This was also reflected in "Making a Difference" (DoH 1999) in which the Chief Nurse for England states that

> "The NHS must also be more engaged with selecting and supporting students, valuing them as the life blood of the NHS in the years ahead" (DoH 1999, 28).

This new guidance, however, does not state at which point representatives from the health service should be involved and personal experience of changes in nurse selection since the time of the publication of this policy from the Department of Health has shown a mix of practice. It would be interesting to monitor the extent to which the promises of involvement

in selection are maintained in the long term.

In common with all other higher education admission processes the introduction of a centralised admissions service, combined with moves from multiple smaller cohorts to two cohorts per year had imposed a new time frame on nursing admissions by the time of this study. Although the weight of literature that indicates that interviews are not considered to be effective methods of choosing staff the introduction of more complex selection methods may have the potential to significantly increase the staff workload and involvement in student selection which is in reality only one aspect of their role. More complex methods would probably have been seen as very time consuming in a higher education climate where large numbers of students are offered places to study for degrees on the basis of their paper qualifications alone.

One purpose in asking questions related to the processes used to select students had been to look for differences between branches and whether this related to the ratio of applicants to places. Institutions who responded to this study appeared to use the same interview process for every branch. Within their own organisations they were also consistent across branches in relation to the extent to which students would be selected by those from the branch they wished to enter.

The rationale for undertaking selection using representatives of the branch the candidate wished to enter would be worthy of more detailed study. In the current climate of being

required to “engage” (DoH 1999, 28) in student selection the argument has potential to be linked with choosing the appropriate people for future employment in a particular role, people with particular characteristics and skills to work within the health service. From this perspective selection for those who will eventually be employed in the health and caring professions is different to selecting students to undertake non-vocational education. They are chosen to undertake a specific preparation for a specific role.

Question 15 The Hypothetical candidates

How likely is it that you would want to interview this candidate for your college's child branch?

Responses to this question have been
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The six hypothetical candidates had been developed to test institutions' responses to candidates for children's nursing based on the qualities derived from the literature. Respondents had been asked firstly to grade their responses to the candidates through the use of a visual analogue scale (VAS) with anchor points of "Not likely" and "Very likely" and secondly to provide the reason for their decision. In designing the question it had been anticipated that respondents would cite similar details from the application form as the evidence on which they had based their decisions.

Although the methodology had been designed to mirror the normal practice of those involved in scrutinising the application forms in order to develop a shortlist for further selection processes, in reality selectors would probably make decisions to bring forward or reject candidates rather than grade them. As the methodology in this study required a reason for their decision respondents, may have taken more time than usual to make judgements against their own internal or institutional criteria. One respondent had simply stated whether or not candidates met their criteria.

Levels of acceptability - Scores received by the candidates

As a group the respondents agreed with the expert panel's anticipated levels of acceptability of the six candidates, though within in this overall agreement the calculation of the standard deviation demonstrated a wide range of opinions within the sample. Candidate 5, the nursery nurse who was also a mature candidate demonstrated the widest difference of opinion.

The theoretical qualities

The six candidates had been designed to test the qualities derived from the literature. By asking the respondents to react to each of the candidates as individuals rather than as a group to be compared against each other it was anticipated that they would be considered against the institutions usual criteria, that is be criterion rated. As the data demonstrate there was a wide range of responses with both positive and negative comments related to the manipulated theoretical variables. Discussion of the data also needs to take account of the possibility that responses represent a summary of the respondents reasons for their decision, rather than a detailed exploration of every quality of the candidates. This would reflect the personal experience of such processes, where due to pressure of time, only sufficient detail to justify a decision would be included on the selection feedback form, rather than a totally exhaustive report.

The equally most commonly commented on quality was "knowledge/experience of nursing" mentioned by 83% of the institutions. It is not possible to make a direct comparison with Child et al's (1988) study where this had appeared to be less important with 10% and 28%

looking for this quality on application forms and at interview respectively, as they looked at all applications rather than just those for the child branch. This survey methodology did not allow for exploration of why such a quality was so important for those selecting child branch students. It is possible that this is part of a response to the increasing competition for places on child branches, as both the literature review and responses to questions about applications and available places (3 and 4) have demonstrated. A similar explanation could be attributed to the other top findings of motivation (83%), potential to follow an academically challenging programme (78%) and understanding what nursing children involves (74%).

The use of this methodology, with similarly developed and manipulated qualities, for candidates wanting admission to the adult branch would be one way of determining whether those involved in selecting students for this branch had similar expectations to those involved in child branch selection. Such a study could also be designed to test both this conclusion and the rationale for such changes to determine whether they have in fact come about as a mechanism to manage demand for places or as a response to the national requirement to reduce attrition.

With the implementation of the recommendations of Project 2000 with its diploma level outcomes it may have been anticipated that candidates academic ability would have risen in importance. Child et al's (1988) study had found 75% of institutions interested in this element of an application, a very similar figure to this study. Any further comparison is not available as Child et al (1988) did not provide details of the academic entry requirements actually

required by their responding institutions. Despite the instruction to assume that the candidates had the institutional requirements for admission, candidate 5, the nursery nurse was perceived as being academically weak by a number of organisations.

Other findings from the data

As the scores given by respondents indicated there was a range of opinions related to the candidates and a number of examples of different conclusions drawn from the same evidence. This can be seen, for example, in candidate 2 whose head teacher had indicated that she tried to solve problems with her work in the class room before asking for help, a quality which had been seen as positive by the researcher. One institution explicitly agreed with this perception whilst another saw this as a deficit in a career that required team work. Candidate 4 was another candidate where diametrically opposite opinions were expressed. One institution responded to his application with an enthusiastic "has all the background I would hope for!" whilst several others questioned his motives in wishing to care for children. This concern was in some measure anticipated, in developing his application, given the discussion that had been ongoing in the nursing press in relation to the involvement of male nurses in caring for children (Glasper and Campbell 1994).

Sixteen of the 20 theoretical qualities of a candidate for children's nursing had received comment from the respondents. It had been anticipated that respondents might make comment in relation to the ways in which some of the candidates had set about finding the appropriate experience, undertaken study in preparation for their application or involved themselves in

activities at school, seeing these activities as an example of initiative. This particular word had not been used in any of the comments related to the candidates, neither had the analysis of the data assigned any of the comments against this quality. The ability to work with people of all ages was not commented either though one respondent did comment positively on the least acceptable candidate's application, candidate 3, stating that he would have worked with the general public.

The reason for the theoretical qualities not receiving obvious comment may be related to the survey methodology. The use of a checklist to require respondents to indicate whether they felt particular candidates displayed particular qualities may have led to different results. It may also be that selectors felt that particular qualities were shown by candidates, thereby meeting institutional requirements but not being worthy of comment because they had been demonstrated on the application form.

A national standard?

The methodology had been designed to test the extent to which there was agreement on the qualities of candidates applying for admission to the child branch and the type of evidence that selectors would wish to see on the application form. The results demonstrated a strong level of agreement between the institutions on the overall level of acceptability of the hypothetical candidates. The varying level of agreement, on the subjective elements of candidates' applications, may be indicative of an underlying standard for preregistration students of children's nursing, with less agreement on the evidence that demonstrates such

qualities. What is not so clear is whether such standards can be seen to be applied in the same way for all candidates at every institution they choose to apply to, as for example, some respondents thought the nursery nurse was a very good candidate, whilst others thought she would be totally unsuited.

As has been discussed previously respondents interpretation of the evidence in the application form was not always in agreement leading to both positive and negative comments on the same aspect of the application. This highlights two further issues in relation to the selection of candidates based on written evidence. Firstly the supporting information that candidates are required to submit is "soft biodata" (Drakeley 1989, 440). As such it allows candidates to express "aspirations", "motivation", "attitudes and expectations" (Drakeley 1989, 440). The intention in creating these elements of the selection process had been to combine the theoretical "inherent" qualities of candidates derived from the literature in a variety of ways which would mimic the normal selection process used for Dip HE Nursing students. As such the assessment of the applications would be affected by the biases of the survey sample, the researcher's opinions and the researcher's choice of the expert panel to ratify the rankings of the candidates.

One measure of the effectiveness of selection processes might be level of attrition from programmes. It may be tempting to attempt to match effective selection against attrition. Whilst this might be possible at the institutional level there are difficulties on a more national basis as the definitions of attrition used by different organisations were, until recently, not

always compatible. It was only in October 2002 that the DoH undertook a consultation exercise to propose a national standard for the measurement and recording of attrition. This move was brought about partly by changes in pre-registration that now enable students to step off programmes for a period of time and the fact that institutions have been facilitating students taking a period away from programmes. There is also a lack of data for those students who leave for personal reasons, or who fail to cite any reason at all. The National Audit Office report (National Audit Office 2001) provides a clear example of this dilemma for nursing where just under a quarter of nursing students left for "reasons not specified in the survey" or "Not known" (National Audit Office 2001, 27), making it difficult to find solutions to any underlying problems related to selection or student experience on the programme.

Conclusion

The sample of respondents to this survey were representative of the larger population of organisations offering the child branch. As anticipated from the literature review the child branch is a very popular choice for those wishing to enter the profession of nursing and demand for places exceeds availability. The institutions contributing to this survey used a range of selection processes to choose students for their programmes. Clinical colleagues, representatives of the eventual employers of children's nurses were involved to some extent. This finding matched personal experience and expectations of the situation at that time, a point where students were seen as being the responsibility of the universities and colleges.

The extent to which institutions distinguished between students for different branches

appeared limited. Expectations of how similar qualities may be displayed and assessed against criteria for admission to the different branches was not tested and might on further examination been shown to be more focussed. Neither was it possible to determine the extent to which the barrier to be crossed may have been set higher for students on oversubscribed branches.

The theoretical qualities derived from the literature were supported by the findings though there was a range of variation between institutions. The use of a different methodology such as checklists of qualities may have led to different findings in this section of the questionnaire. There was no strong evidence of an explicit national standard for students of children's nursing and evidence from this survey indicated that some students would have more likelihood of being invited to interview in some institutions whilst being rejected by others. This diversity can be seen as being good for the profession allowing a range of people with different skills and qualities to prepare for the register and then work with a similarly broad range of children and families.

It might be argued that a national standard would be appropriate in an attempt to reduce the attrition from programmes. The level of attrition for this branch of nursing is not dissimilar to that for other branches and the Department of Health, who funds these programmes is willing to accept that some attrition will occur. This is surely a better situation than letting all those who are accepted complete a programme no matter what their level of skill and achievement.

The survey had been undertaken to ask the questions:-

> Do people who select child branch students look for the inherent qualities identified in the literature?
> Is there agreement amongst selectors on these qualities and the ways in which they may be evidenced?

The conclusions that can be drawn from this survey are:-

That there is some support, amongst selectors, for the inherent qualities of the child branch student derived from the literature.

Those involved in selection do not always comment on the qualities demonstrated by candidates in their application forms or the evidence that may demonstrate the presence of these qualities.

LIMITATIONS AND RECOMMENDATIONS FOR FURTHER STUDY

Methodology

The chosen methodology of a postal questionnaire had achieved a response rate of 73.5%, which is just under the 75-85% Treece and Treece describe as "doing extremely well" (Treece and Treece 1986, 293). At a time of such massive structural change within nursing education institutions in England this can be seen as an excellent response which enabled data collection from a range of institutions across England.

van Teijlingen and Hundley (2002) emphasise the advantages of a pilot study as a way to test the appropriateness of "methods or instruments" (van Teijlingen and Hundley 2002, 33). In this study the total maximum population was 38 and of these four institutions were asked to participate in the pilot study. Whilst this fits the 10% sample size recommended by Treece and Treece (1986) in reality this is a very small sample. Changes were made and the decision made not to repeat the pilot study to maintain as large a sample as possible and ensure an increased validity for generalisation any findings.

A second pilot would possibly have enabled further development, in particular in relation to question 7 which looked for the personal qualities of candidates for the branches and the processes used on the selection day. Question 7 could have been further refined to focus on qualities that were important on the application forms enabling some comparison with the findings of Child et al (1988), though that study did not produce data related specifically to

any particular branch of nursing. Greater study of the processes used on selection days would have provided opportunity to record the perceived purpose of such a day and the qualities selectors were looking for when meeting candidates in face to face situations.

In an attempt to look for comparisons between the four branches the questionnaire had been directed to the heads of recruitment and selection. Some institutions had obviously passed the questionnaire directly to those involved with the child branch, limiting the data in relation to other branches that would have enabled a fuller comparison to have been undertaken. This also meant that tracking where responses to candidates originated from was not possible. The extent to which the findings are therefore based totally within the speciality of children's nursing could therefore be questioned. Division of the questionnaire into several specific parts, one for the administrators of the selection process and the others for those involved in decisions related to suitability for particular branches may have increased the opportunity to make comparisons across branches. The likelihood of all the possible respondents from each institution returning such a questionnaire is, however, questionable.

The new methodology devised to look at the six hypothetical candidates has not been used in any other studies. The development of the six candidates was based on the characteristics of children's nurses identified from the literature. The presumption throughout this early element of the study was that there would be some specific qualities that those involved in the selection of child branch candidates would agree on. There were varying levels of support for the identified qualities.

Any further study using the methodology employed in this section would need to consider two ways forward. The creation of a much larger collection of applicants who all displayed the characteristics to be tested in either an negative or positive way would enable more testing of the inherent qualities. The use of actual applications could also be considered. The extent to which ethical considerations would impede a study using actual applications was not explored on this occasion. The use of a different methodology such as the Delphi technique could also be explored enabling the bringing together of a much larger expert panel.

Analysis of qualitative data was undertaken through the process of sentence busting (Burnard 1994). This process mirrors other qualitative data analysis processes in requiring the text to be broken into small sections. Unlike other packages the use of the word processor "sort" function then allows the collection together of similar phrases. Sentence busting unlike other more technological methods does not facilitate easy referral to the context of the word or phrase. To look for context requires a manual search, as opposed to the easier process which is part of packages such as QRS NUD*IST . For the quantity of data created in this study this method was found to be efficient in relation to the time taken and the ability to use data already entered into a word processing package. Unlike programmes such as QRS NUD*IST there was no need to learn special searching techniques.

While this method of analysis enables easy searching and a chance to review the data as it is entered into the word processing package, interpretation of the findings remain subject to the potential bias of the researcher. The reliability and validity of results derived from this method

could be increased through the use of an expert panel to agree on the findings.

Further study, using a different methodology, could be undertaken to determine the rationale behind the different criteria that institutions use to judge candidates for nursing programmes, and whether these are built on instinct, experience or more systematic approaches to selection. There is also potential to explore the nature of the evidence that selectors deem to have met their institutions' criteria.

Within the usual three year cycle of pre-registration nursing programmes, there is a long period before the effect of decisions made at the point of selection can be reviewed. For some students who were selected at an early point in the selection system it may be up to four years before they eventually complete their programme. Selection decisions are made at a number of points, with pre-screening to create a shortlist, then some form of face to face selection process, followed by an educational programme based in both theory and practice. It is very difficult to determine which of these different elements can be directly linked to the end result of success, failure or wastage. Most studies to date (eg Kevern et al 1999) have looked at single issues such as previous educational achievement. This may become particularly important in relation to the new Fitness for Practice programmes (HMSO 2000), approved in 2000-2002 in which there is, for the first time, opportunity for candidates to be considered for Accreditation of Prior Learning and Accreditation of Prior Experiential Learning into pre-registration programmes.

The fact that in this study a number of organisations offered information related to activities they used as part of their selection processes demonstrates that institutions were trying to gather additional information about candidates alongside impressions gained through interview. The proportionate contribution that each element of such a day makes to decisions related to candidates would be worthy of study to try to determine whether such activities do in fact remove some of the subjectivity of interviews and provide a wider evidence base for the qualities of the candidates.

WORKING AS A CHILDREN'S NURSE

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INTRODUCTION

The definitions of children's nursing and the special needs of children were derived through the application of Rodgers evolutionary model of concept analysis (2000a), using data from a range of stakeholders, including government policy, statutory bodies, the profession, professional organisations and pressure groups representing children and their families (16). Rodgers states that the final stage in the evolutionary model of concept analysis is the generation of implications for further enquiry (Rodgers 2000a). The first implication related to the selection of child branch students has been explored. The next question arising from the definitions of children's nursing and the special needs of children is:-

> Do those who employ newly qualified children's nurses expect them to work in multi-disciplinary settings meeting the needs of children and their families through the delivery of planned care that utilises a range of scientific, technological, psychological, and educational skills?

LITERATURE REVIEW

There is a range of literature related to employment as a children's nurse, that describes the role in broad terms. The first area is NHS careers advice

Children's nursing as a career

The NHS is the majority employer of children's nurses at the point of registration and, as part of its overall strategy to ensure appropriate staffing of the NHS, it has a dedicated careers service providing information for anyone who wishes to enter a healthcare profession. In 1995, the point when this study began, the careers service described children's nursing as

> "Care in all senses of the word", working in "one of the fastest changing branches" being "Part of a team" "Developing relationships" and agreeing "with parents the role that they will be playing in caring for their child".
>
> Requiring nurses who "In addition to caring for children and anticipating their needs, children's nurses also need to know about how children play, and how to develop a relationship with children and their parents" (DoH 1995, 4)

In 1999 children's nursing was being still being described as

> "This branch involves everything from nursing a sick new-born to an adolescent road accident victim. The challenges are therefore very varied, with family care and support a key element" (DoH 1999c, 12).
>
> With a focus on "partnership with parents", understanding "how a healthy child develops" (DoH 1999c, 12).

A different sort of nursing to that of the adult, which was described as

> "In the 'adult branch', you will be learning how to care for people with chronic and acute physical illness - both in hospital and the community" (DoH 1999c, 8).
>
> "You will enjoy a unique overview of all the professionals' involvement, and have close and long contact with the patient (and the patient's family)" (DoH 1999c, 8).

The same theme of partnership and working with children and their families was still present in 2001, with the NHS Careers website describing children's nursing as being, amongst other things, about

> "Nursing a child is not just a question of caring for a miniature adult. You have to understand how a healthy child develops towards adulthood and know how to

minimise the impact of illness or hospital admission on the child. This involves working in partnership with the parents, or whoever looks after the child at home" (NHS Careers 2001a, 1)

Working in the NHS

The newly qualified children's nurse, at the start of their employment, would usually be placed the "D grade" salary band, a development of the original grading structure for nurses with clinical responsibilities, that was initially established in 1948, at the beginning of the National Health Service (NHS) (DHSS 1988, 1). In 1985 a Joint Working group, set up to review nursing and midwifery salaries (DHSS 1988), was charged with producing

> "a structure which:
> - produced appropriate relationships within nursing, midwifery and health visiting
> - allowed for flexible responses to varying circumstances and recognise the responsibilities carried by staff
> - was simple to administer and, as far as practicable allowed for sensible career progression.
> - allowed now and for the future for the very wide variety of tasks nurses, midwives and health visitors undertake" (DHSS 1988, 1).

Through a process of questionnaire based activities, interviews, discussions between staff and management, and analysis of 1300 jobs, covering England, Wales and Scotland a new clinical grading structure for nursing and midwifery salaries and responsibilities was agreed. Within this structure D grade was designated as the first employment point for first level nurses, ie registered rather than enrolled nurses. Table 54 outlines the first two first level (registered) nursing grades (D and E) and demonstrates the distinctions between the levels of responsibility of the posts at the different grades. As can be seen from this table an E grade nurse has greater responsibilities in relation to the regular management of the clinical

environment and the teaching of other staff. Individual NHS Trusts, working from these standardised guidelines, develop job descriptions for particular posts within their own service.

D Grade	E Grade
2.17 Applies to posts in which the post-holder is responsible for the assessment of care needs and the development of programmes of care, and/or the implementation and evaluation of these programmes. The post-holder is expected to carry out all relevant forms of care without direct supervision and may be required to demonstrate procedures to and supervise qualified and/or unqualified staff	2.18 1. Applies to posts in which the post-holder is responsible for the assessment of care needs and the development, implementation and evaluation of these programmes of care. and is expected to carry out all relevant forms of care and is designated to take charge regularly of a ward or equivalent sphere of nursing or midwifery in the absence of the person who has continuing responsibility. The post holder is expected to supervise junior staff and be able to teach qualified and unqualified staff, including basic and/or post basic students **or** 2 The post holder is required to take responsibility for as the prime care giver for one, or a defined group of patients/mothers, in the hospital setting. He/she works with minimal supervision in the assessment of all relevant care needs, the development, implementation and evaluation of programmes of care. The post holder is able to supervise and teach junior staff including basic and/or post basic students
The post holder is required to have i. first level registration or ii. second level registration plus a recognised post basic certificate, or to have an equivalent level of skill acquired through experience or iii. second level registration and to supervise the work of other staff	The post holder is required to have first level registration plus i) a further registerable qualification or ii) a recordable post-basic certificate/statement of competence, or an equivalent level of skill acquired through experience

Table 54 Clinical grading adapted from Annex to Executive Letter EL (88)P33 (DHSS 1988)

Job descriptions

Prospective employers state their requirements of their staff through job descriptions and these act as "a benchmark of what can be expected of the employee" (Business Link 2003). Job descriptions can be seen as an "idealised statement" (Miner 1992, 344) of the purpose of the job, defining "a person's role and accountability" (businessballs.com 2003), in this case the children's nurse. As such they should contain details of the "tasks, duties and behaviours required in a given job" (Miner 1992, 344) and should also include the "objective or purpose of each task" (Business Link 2003). Job descriptions may also include information in relation to

"the job title"
"work activities and procedures"
"physical environment"
"social environment"
and "conditions of employment" (Miner 1992, 347)

Within the NHS job descriptions are agreed within trusts and are, therefore, a collective statement of expectations of the role and the means and methods by which the employer expects the employee to carry it out. As with other job descriptions NHS employers often include a summary of the purpose of a particular role, that could be described as demonstrating their philosophy of care to the patient.

METHODOLOGY

A survey of English NHS Trusts, that employ newly qualified children's nurses at D Grade was undertaken to answer the question:-

> Do those who employ newly qualified children's nurses expect them to work in multi-disciplinary settings meeting the needs of children and their families through the delivery of planned care that utilises a range of scientific, technological, psychological, and educational skills?

The first sample of job descriptions were collected in 1998 and Binley's Directory of NHS Trusts (1998) , a resource that is updated three times a year and lists all NHS organisations, was used to gain details of trusts with a children's service. The second sample of job descriptions was collected in 2002 with the purpose of determining whether there had been any change in the expectations of the D grade, in this "fastest changing" branch (DoH 1995, 4). The second sample used the same trusts that had responded in 1998 with Binley's directory being used to check address detail. The use of the same trusts in each survey was deliberate, to enable direct comparison and details of changes, rather than introduce potential variables of different employers' views into the survey. There are no other studies of the role of the children's nurse using this approach based on the expectations of the employer rather than practitioners descriptions of practice.

Survey method

A letter requesting an application pack for "a position as a D grade Staff Nurse on your children's ward/s." was sent to personnel/human resource departments in English NHS trusts, chosen to provide a wide geographical spread. This request was not sent in response to any

advertisement but with the knowledge that such information is usually readily available within personnel and human resource departments. This request stated the purpose of the study and the proposed methodology as

> "looking at the expectations that NHS Trusts in England have of newly registered children's nurses. I propose to do this through a content analysis of job descriptions and person specifications."

This method of gaining data on the purpose of children's nurses, from the perspective of the employer, was considered the most appropriate for three reasons.

- The data for analysis would not be structured to fit any preconceived ideas.
- Job descriptions are agreed within trusts. A job description should therefore be a collective statement of expectation rather than an individual response in request to questions designed by the researcher.
- D grade posts, as the first post for the newly qualified children's nurses are more likely to contain elements of the role that are common across trusts, rather than the possibly specialist roles of the higher grade nurse.
- Human resource/personnel departments are potentially used to unsolicited requests for applications for posts. It was therefore anticipated that this request would elicit a response from a wide sample number of trusts. It was also anticipated that the time taken to collect the data would therefore be minimised.

In 1998 a total of 60 requests were mailed and then in 2002 requests were mailed to the trusts that had responded to the first request for data. A total of 25 trusts responded to this second request and were matched against responses from the first request to make the study sample (appendix 6).

Qualifications required to do the job and date of development of the job description

The information sent by the responding trusts included data related to the nursing qualifications required by the trust for the role of the D grade on a children's ward. This provided the opportunity to look at

- the range of qualifications considered to be acceptable
- the extent to which trusts appeared willing to employ people without a specific qualification in children's nursing
- changes in the range of acceptable nursing qualifications following the implementation of Project 2000 (UKCC 1986) which brought a new registration for children's nursing into being, (Part 15) from 1992 onwards.

The inclusion of the date of development of a majority of the job descriptions also provided opportunity to reflect on the frequency of potential change to the role of the D grade children's nurse within the responding trusts.

Content Analysis

The nature of this third question required demonstration of "the presence, frequency, intensity or nature of the selected characteristics" (Markoff et al 1977 cited by Waltz et al 1991, 299) required that "systematic, objective analysis" (Treece and Treece 1986, 348) of the data should be undertaken. Content analysis was again chosen as the methodology for analysis for the reasons discussed in the preceding study on the selection of child branch students (199).

As the following tables (55, 56) demonstrate mapping this methodology against the needs of

this study demonstrated that the methodology had the potential to support the processes required to test the hypotheses.

Advantages (Waltz et al 1991)	This study
The use of existing information available at low cost	Information available for the cost of postage and stationary
Study can be undertaken "without requiring subjects to do anything out of the ordinary" (309)	The response to requests for job descriptions is a routine part of personnel departments' activities
"Information produced for non scientific purposes can be made usable for scientific inference" (310)	This was not a consideration for this study. It would be a consideration eg in using records of patient care.
"Available data sources cover long time frames" allowing for the study of trends (310)	Not a consideration for this study as its focus was an analysis of the situation now.
Computerised approaches simplify categorising and coding procedures	The use of a) scanner technology to import the varied pages of data b) a word processing package to manipulate the data for use in a computerised programme were within the capabilities of the researcher
"Categorical schemes are generally developed after data are collected and thus do not constrain or bias the data" (310)	The collection of job descriptions in the format presented by the trusts also ensured that there was no constraint or bias to the data

Table 55 Advantages of content analysis

Disadvantages (Waltz et al 1991)	This study
Procedure is time consuming	The use of a computerised package would reduce the time taken for analysis. The initial period spent in learning to use the package would have some initial impact on the time. It would however also mean that care was taken with the processes required for setting up the analysis. Human fatigue and its potential impact on the consistency of the analysis in a time consuming procedure would also be reduced by the use of technology.
Materials may have been "prescreened or edited by others" (310).	This was not considered to be a disadvantage as the job descriptions would have been developed by the trusts. Analysis of the result of this development was the intended focus of the study.
Data may not have been "compiled systematically" (310).	This was not considered to be relevant to this study because of the nature of the data. This would have been a disadvantage of a study involving data collection in other forms eg interview by a number of different researchers.
"Judgement is required to interpret the meaning of another's communication"(310). A risk of subjectivity by the researcher.	This applies to many other methodologies.
"Legal or ethical problems may be encountered regarding the use of information gathered for another purpose" (310).	This did not apply to this study. The letter to respondents had clearly stated the purpose of the request.
Methods of analysis "that rely heavily on inductive approaches to categorising data are not well formulated and are highly individualistic" (Miles 1979 cited Waltz et al 1991, 310)	A potential disadvantage for any qualitative analysis.

Table 56 Disadvantages of content analysis

As can be seen from the above tables the use of a computerised approach to categorising and

coding is seen by Waltz et al (1991) as being applicable to content analysis and it would also ensure greater consistency of analysis between individual job descriptions and across both samples (1998 and 2002).

Content analysis requires the application of "explicit rules" (Waltz et al 1991, 300). Such rules can reduce the potential for variations in the method and process, a quality which is important in situations involving a number of researchers. The use of rules should also ensure consistency of analysis with the solo researcher. Content analysis can be used as an "inductive theory-building" or "deductive theory-testing technique" (Waltz et al 1991, 299). The researcher's previous experience within children's nursing education had the potential to distort the development of categories required for the use of a deductive technique. The suitability of content analysis for use through an inductive approach was therefore considered as an advantage of this methodology.

Waltz et al (1991) describe a series of steps which must be taken when undertaking content analysis. Table 57 (overleaf) demonstrates these steps and the processes which need to be considered in undertaking a content analysis of the D grade job descriptions.

Step (Waltz et al 1991)	Process	This study
"Define the unit of content to be examined" (301)	May be the whole universe (ie all the material available) (Waltz et al 1991)	The content would be the details of the job itself, with the extraneous links other employment issues removed
"Identify the characteristics or concepts to be measured" (302)	"what do I need to know about or learn from the content" (Waltz et al 1991, 302)	The employers' expectations of the role of the D grade staff nurse on a children's ward and how that matches the definition developed through concept analysis.
"Select the unit of analysis to be employed" (302)	The use of words, phrases, themes (Waltz et al 1991). These may be gained from an initial scan of the written sources	Collating the chosen elements of the job descriptions, for clarity would give an initial sense of the ways in which the data could be divided.
"Develop a sampling plan" (303)	Specific instructions eg in relation to the number of chapters from a book (Waltz et al 1991).	The content would be the details of the job itself, with the extraneous links other employment issues removed
"Develop a scheme for categorising the content" (304) (also Cavanagh 1997)	Some may be predetermined and others may emerge during the analysis (Moseley and Mead 1997)	The decision was made to match against the requirements for registration as a children's nurse (HMSO 1989) and the definition of children's nursing
"Develop explicit coding and storing instructions" (305)	In qualitative research these issues are important. Codes may need adjustment (Cavanagh 1997).	Matching against the requirements above would facilitate the development of coding instructions
"Pretest the categories and coding instructions" (305) (also Cavanagh 1997)	Though the use of a small sample of the content to be analysed (Waltz et al 1991).	Though the use of a small sample of the content to be analysed (Waltz et al 1991).

Step (Waltz et al 1991)	Process	This study
"Revise coding rules" (Cavanagh 1997, 8)		
"Train coders and establish an acceptable level of reliability" (306)	Training of other coders is not an issue for a solo researcher. Stability and reproducibility would be enhanced through the use of a computer.	Not an issue for a sole researcher
"Perform the analysis" (306)		Sample size was a total of 50 job descriptions (25 each from 1998 and 2002). They came in a variety of formats and for consistency require word processing. Leading to the decision to consider a computerised approach to analysis.

Table 57 Steps in content analysis matched against proposed study

Answering the question

> Do those who employ newly qualified children's nurses expect them to work in multi-disciplinary settings meeting the needs of children and their families through the delivery of planned care that utilises a range of scientific, technological, psychological, and educational skills?

required simple calculation of the frequency with which the different elements of the role of children's nursing occurred across the sample. This could possibly have been achieved through the use of "sentence busting" (Burnard 1994, 35), however the data set for this study was significantly larger than in the study on the selection of child branch students, being in the order of 120 sides of A4 paper in a range of styles and formats. "Sentence busting" could have been undertaken through the use of the find command in the word processing package. This would have meant that single words or common phrases could have been retrieved, however the capacity to search for a group of similar words such as family, parent, relative would have meant several repetitions of the search for just one element of the job description. Referral back to the context of such finds would also be extremely time consuming.

The use of computer packages to aid the analysis of such qualitative data has been discussed since the 1980s (Buston 1997). Although researchers express concerns about the impact of computers on the nature of research and the separation that they create from the data it is generally agreed that such packages have the capability "to ease the researcher's work load, save time and generally enhance the power of qualitative analysis" (Buston 1997, 1.2).

Buston (1997) presents one of the few detailed descriptions of using a computer package in undertaking a research project. The rationale for his team's choice of NUD*IST was based

on the fact that it is "easily available, could be learned quickly, others recommended it" and its "basic ability to index and later retrieve categorical interview segments" (Buston 1997, 3.2). In undertaking the analysis Buston describes the "superb organisational skills and facilities for automation" of NUD*IST as "making mundane tasks easier to get through" (Buston 1997, 10.5) an opinion supported by Morison and Moir (1998) in undertaking a study of families "living with a young person who wets the bed" (Morison and Moir 1998, 107). Woods and Roberts (2000) note the importance of determining text units when using NUD*IST, a process which allows the division of data into a range of different sized sections for analysis. Although this might be an initial dilemma for the novice user the fact that the original documents are contained within the computer allows for easily restarting the whole project again.

Computer packages are able to repeatedly undertake such new searches without fatigue and with consistency (Moseley et al 1997) and it is possible to rework the searches very quickly to recheck findings (Pateman 1998). NUD*IST has the ability to search for a number words at any one time, meaning that it would be possible to search consistently for phrases such as family, friend, relative. This consistency was an important quality as there was a need to undertake the same searches in the two sets of job descriptions (1998 and 2002). Although some (eg Pateman 1998) describe the process of transcribing the data into NUD*IST as very time consuming this was not seen as a disadvantage in this study. The nature of the data required transcribing into a consistent word processed format for clarity, particularly in light of some of the poor quality copies of job descriptions, and this gave the opportunity to look

for other themes in the data that may not have been considered in developing a sampling framework. Pateman (1998) also describes the fact with the data in the computer it may be possible to gather almost unmanageable amounts of data. This was not a disadvantage in this study as the sample size was clearly defined at the beginning of the study. Weighing the advantages against the disadvantages of this "easily available" package (Buston 1997, 3.2) against possible disadvantages lead to the decision to use NUD*IST as the framework for analysis of the job descriptions.

Formatting the Data Files

Documents which are to be analysed through the use of QRS NUD*IST (N4) (QRS N4) require formatting and the inclusion of appropriate instructions, in a specific word processing format. In preparing the data the job descriptions were either computer scanned or typed into a word processing package, WordPerfect 9 for Windows. Following the instructions in the QRS N4 user guide (QRS 1997) tabulations, indentations, numbers and brackets were removed. Hard returns, made using the enter key in word processing, were removed from the raw data through the use of the find and replace facility and references within the job descriptions to bodies such as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting were found using the same process and replaced with UKCC, to ensure consistency throughout the documents. Other extraneous information in relation to Trust No Smoking policies, details of the processes for reviewing the requirements of the post and statements on Equal Opportunities not directly related to the function of the role were also removed.

The use of QRS N4 also requires the identification of headers and sub-headers. These are references to the sections within the data, and are indicated through the use of asterisks (*) and hard returns, made using the enter key. Text units are required for searching with QRS N4 and should be short enough for the search facility to be able to identify the elements of the text as instructed. The principles of "sentence busting" (Burnard 1994, 36) were applied to the data to ensure that phrases or words of significance were separated into text units each incorporating a particular concept or requirement of the role. As QRS N4 is able to handle large numbers of documents a separate file was created for each job description, to enable easy referral to specific trusts and allow the incorporation of sub-headers which were present in the job descriptions.

Comparison of job descriptions with statutory instrument

Content analysis was undertaken to determine the extent to which the expectations in relation to fitness for practice as stated by statute matched fitness for purpose as determined by the employer and stated in the job descriptions. The statutory instrument was divided into sections and edited to make phrases and words which could be searched through the use of QRS N4 (eg table 58). Phrases and words were highlighted in bold type.

Statutory instrument (HMSO 1989, 5)	Edited for searches with QRS N4
"a) the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability or ageing for the individual, her or his friends, family and community"	the identification of the **social and health implications** of pregnancy and child bearing **physical and mental handicap, disease, disability** or ageing for the **individual, her or his friends, family** and community
"b) the recognition of common factors which contribute to, and those which adversely affect, physical, mental and social well-being of patients and clients and take appropriate action"	the recognition of common factors which contribute to, and those which adversely affect, **physical, mental and social well-being of patients and clients** and take appropriate action

Table 58 Example of "Identification of the characteristics or concepts to be measured" (Waltz et al 1991, 302) (full list appendix 7)

QRS N4 facilitates the use of pattern searches, enabling the researcher to search for a number of different words or phrases with the same or similar meaning at the same time. This meant that it was possible to match words and phrases from statute with equivalent words or phrases as expressed in job descriptions. For example, from scrutiny of the job descriptions it became apparent that the word assign was used in the same context as the word delegate (table 59).

Words and phrases used in the search of job descriptions against statute			
assess/assessment/ identify/ identification	assign/assignment/ delegate/delegation	care/care plan/treatment	child
communicate/ communication	competence/compe tent/competency	culture/cultural/ customs/ethnic	development
disability	disease/illness/ill health	ethics/ethical	evaluate/ evaluation
family/parent/ relatives	friend	handicap	health promotion/ health education/ prevention/promotion

Words and phrases used in the search of job descriptions against statute			
implement/implementation/deliver	individualised/ process/holistic/ model	legislation/legal	literature/journals
multi/medical/ professional	need	patient	physical
psychological	relationship	research/trends/ developments/ trials	social
spiritual/religious/ religion	supervise/ supervision	teach	team
therapeutic	well being		

Table 59 Words and phrases used in the search of job descriptions against statute

A total of 34 searches in QRS N4 were carried out on the job descriptions and reports created. The reports retain the reference to the text sections and sub headers within the original documents (eg table 60).

```
Text search for '[assess|assessment|identify|identification]'

'assess' or 'assessment' or 'identify' or 'identification'

Searching document JOBA....

Searching document JOBAA.WPD...
The post holder is responsible for the ASSESSment of care needs and the
development                                                    75
1 text unit out of 81, = 1.2%

Searching document JOBB.WPD...
Provide ASSESSment, implementation and evaluation of programmes of care
for                                                            7
1 text unit out of 32, = 3.1%
```

Table 60 Example of a search for the word assess

Using the "browse" and "jump to source" facility available in QRS N4 (QRS 1997, 6) it is also possible to link findings directly with job description and this process was undertaken to ensure that each finding of the word was appropriate. For example within the search for "individualised/process/holistic/model" there were occasions when the word model was related to being a role model, rather than expecting the nurse to use a nursing model. When this editing of the reports was completed the number of occurrences of particular words and phrases were entered into Excel 97 to enable display in chart format.

The purpose of a children's nurse

Many of the job descriptions also contained a separate section outlining the purpose of the role of the D grade staff nurse. These sections were processed and imported into QRS N4 using the processes previously described and thirteen searches were undertaken (table 61).Words chosen for searching were derived from statute, generic expectations of the role of the D grade in relation to professional conduct (code) and clinical grading, for example supervise. The child and family were also included.

accountable	child	code	communicate
family	health	legal	multi disciplinary
policies	research	supervise	supervision
training			

Table 61 Searches for the purpose of the children's nurse

Supervising others or being supervised by others

The expectation that the D grade will supervise others is included in both statute (HMSO 1989) and clinical grading criteria (DHSS 1988). There is also a requirement, from the statutory body, that those nurses working outside their field of registration will be supervised by those with the appropriate registration, in this situation - children's nurses (UKCC 1994, NMC 2002b).

PILOT STUDY

As discussed in relation to the study on the selection of children's nursing students (194) it is usual practice to undertake a pilot study as part of the process of determining which elements of the study may pose difficulties. For this particular study there were considered to be no problems with the method chosen to collect the data. The focus of pilot activity was therefore based on gaining proficiency with the computerised approach to content analysis.

A number of practice searches were undertaken to

- enable the development of understanding of the possibilities of QRS N4
- determine the most suitable ways in which to store and handle the data developed during the search processes
- determine the phrases and strings of words that would form the basis of the full study.

RESULTS

Sample

The trusts included in the study represented a geographical spread of English NHS trusts, with responses from areas such as the Southwest, London, the Midlands, the North East and the North West England (Appendix 6). There were four children's hospitals in the sample.

Qualifications for the post

Twenty four trusts provided information identifying qualifications considered appropriate for the D grade posts on their children's wards in the 1998 job descriptions (figure 23) while only 19 of the 2002 job descriptions included similar information (figure 24). In the second sample the remaining 6 trusts appeared to have generic descriptions for all posts at D grade with the trusts using the term registered nurse, rather than referring to particular parts of the nursing register, a change in the four years since 1998. In 1998 trusts had made reference to 10 different combinations of qualification reducing to 8 in the 2002 sample.

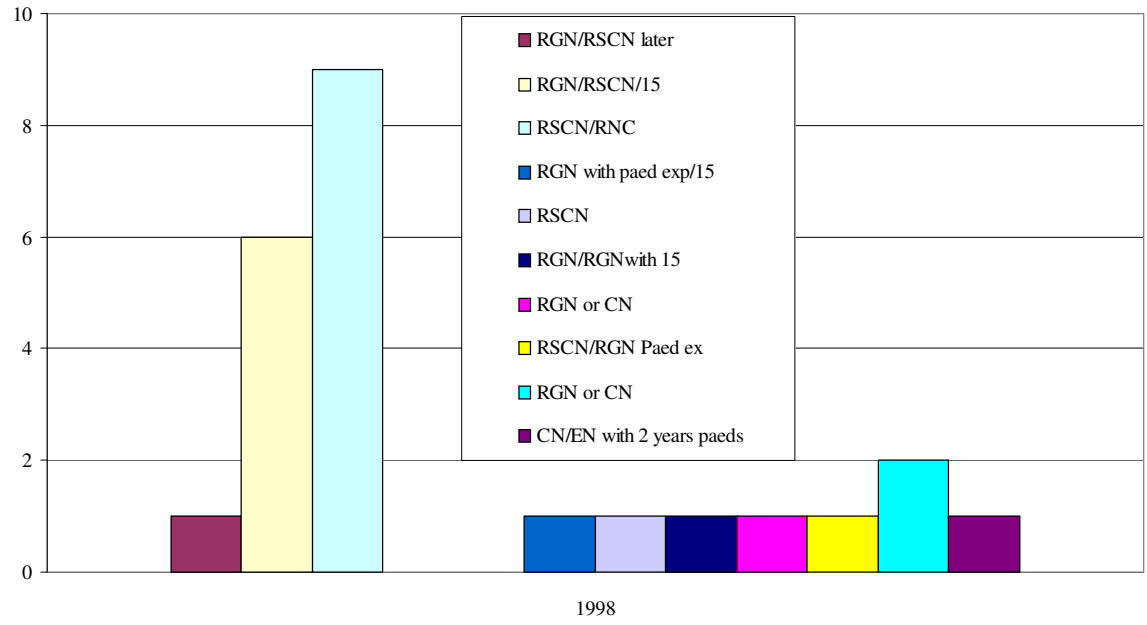

Figure 23 Qualifications suitable for employment as a D grade on a children's ward, 1998

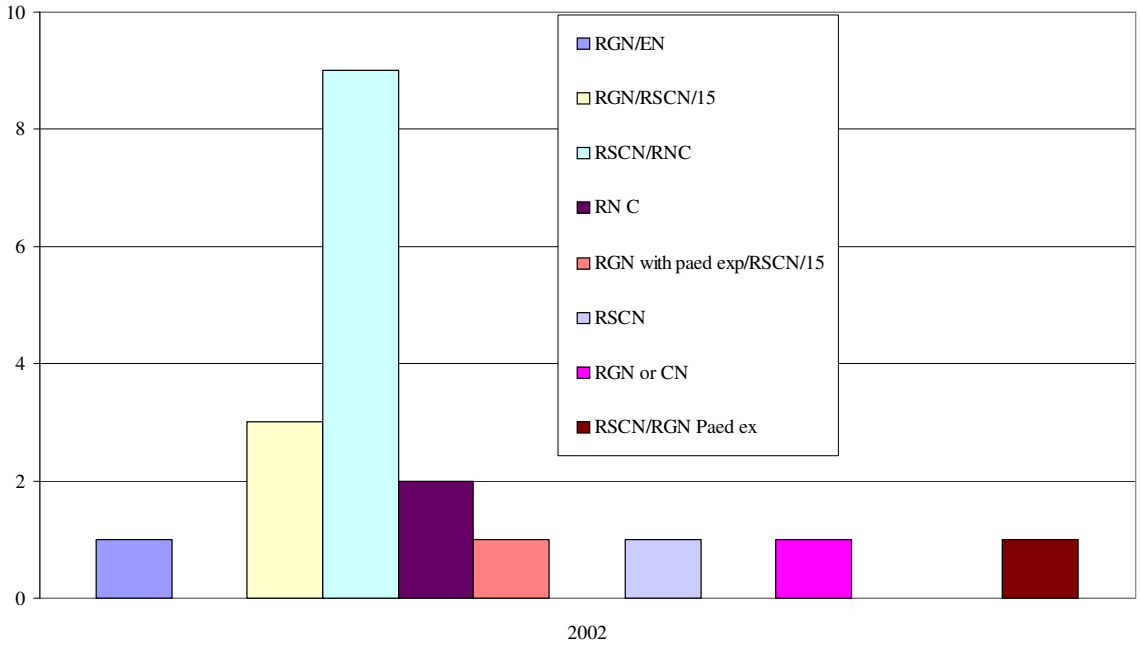

Figure 24 Qualifications suitable for employment as a D grade on a children's ward, 2002

As can be seen from the legend in figure 23 in 1998 fourteen of the trusts (56%) were apparently willing to employ nurses without a children's nursing qualification, including Registered General Nurse (RGN) or Enrolled Nurse qualifications (EN). Ten trusts (40%) specified only a children's nursing qualification (CN, RSCN). Four trusts qualified the requirement for the non children's nurse with either the expectation that they would take the qualification in the future or that they had a period of paediatric experience. One of the children's hospitals was apparently willing to consider employing D grade staff nurses without a children's nursing qualification with no stated requirement to undertake a children's nursing programme in the future.

Comparison of the results for 1998 (figure 23) with those for 2002 (figure 24) shows a reduction to 8 possible combinations of qualifications now considered acceptable with one trust in the 2002 sample appeared to be looking for only an RGN/EN (Registered General Nurse/Enrolled Nurse), while in total 7 trusts (28%) appeared willing to consider a nurse with an RGN qualification, alongside children's nurses from either Part 8 (RSCN) or Part 15 (Child Branch) of the professional register. In 2002 one of the children's hospitals still appeared willing to accept nurses with the RGN qualification. From the data available in the 2002 sample it was clear that four trusts had changed their registration requirements by removing any reference to RGNs.

Date of development

In the 1998 sample four of the job descriptions had no information related to the date of

development of the job description. The others were dated between 1993 and 1998

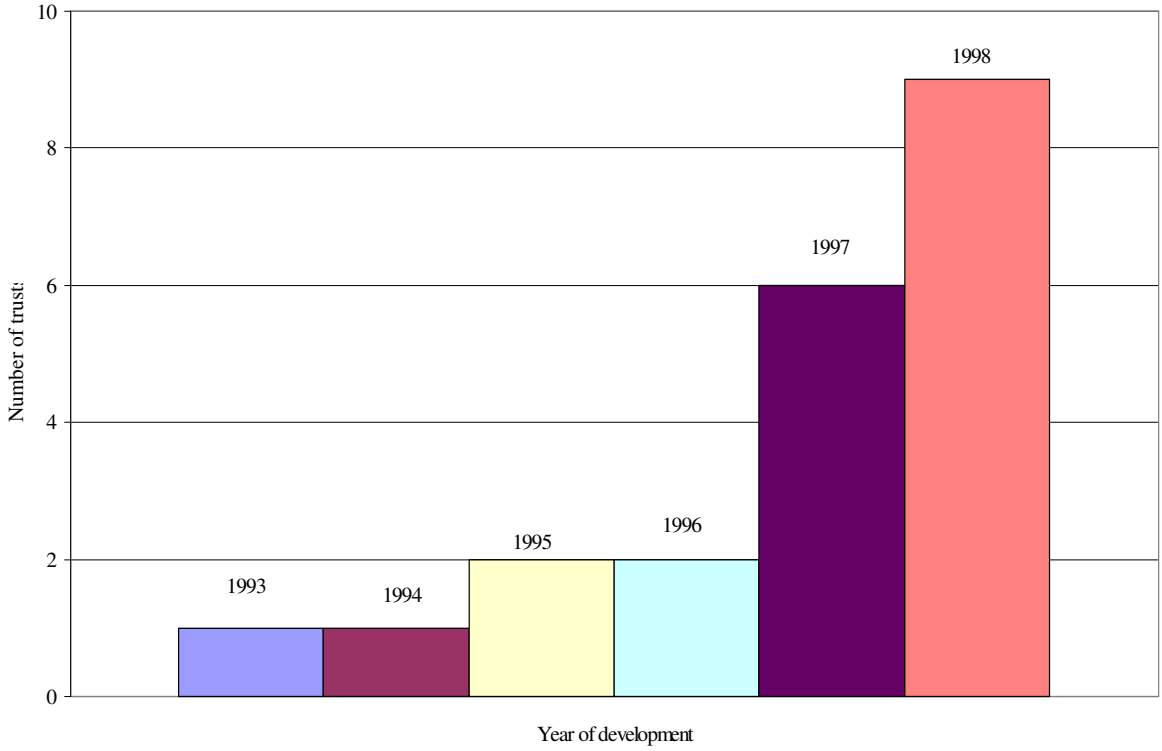

Figure 25 Date of development of the 1998 job descriptions

As figure 26 (below) demonstrates a number of trusts had new dates for development on their job descriptions. In total 11 had changed the details of the job description, five trusts had made no change and one job description, in this second sample, was now 7 years old. Seven of the job descriptions had been changed to "generic" trust wide statements of the role of the D grade, with a focus on the role rather than the person who would be in receipt of nursing care.

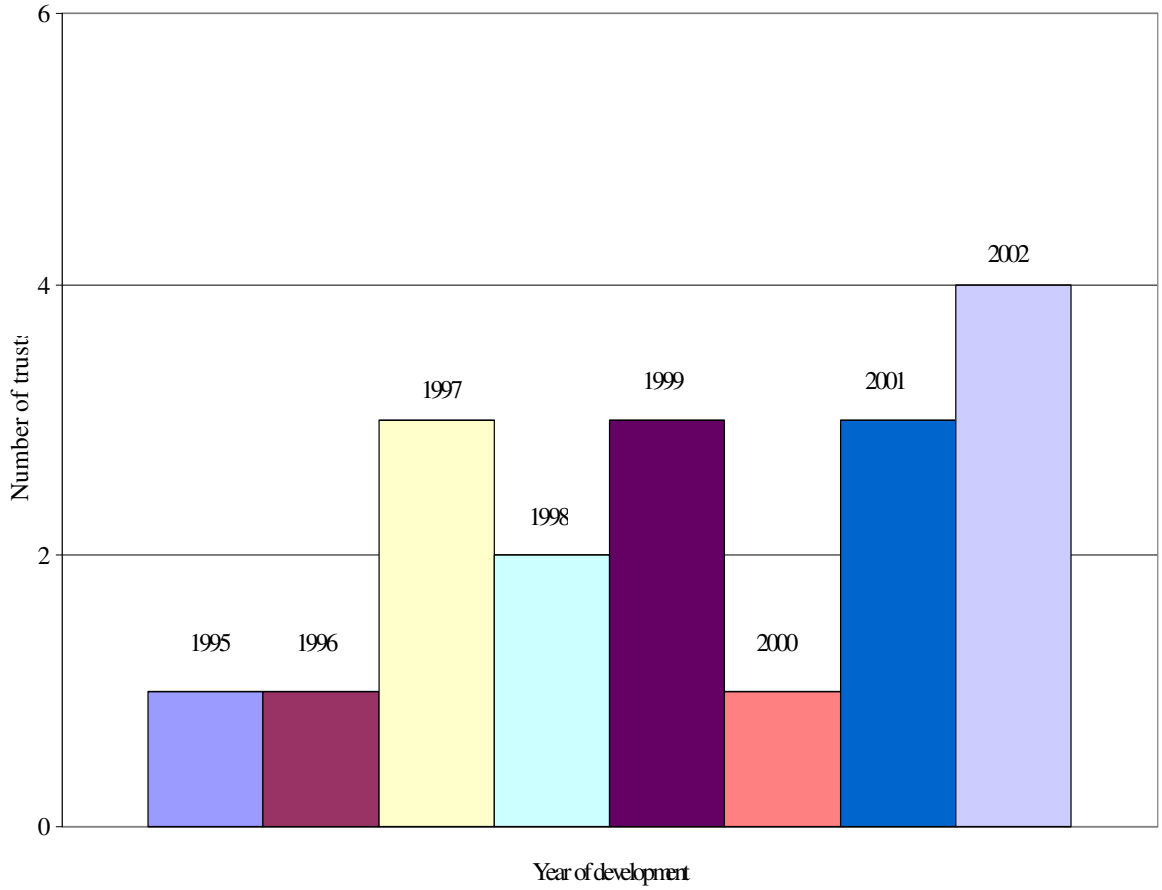

Figure 26 Date of development of the 2002 job descriptions

Comparison of the job descriptions against statute

As described in the methodology QRS N4 was used to search the job descriptions in both samples. A total of 34 searches were undertaken using phrases and words from statute combined with matching words that were used for similar functions within the job descriptions eg assess/assessment/identify/identification (table 56, 320). The data were entered into Excel 97 and are presented in four charts for clarity (1998 figures 27, 28), (2002 figures 29, 30).

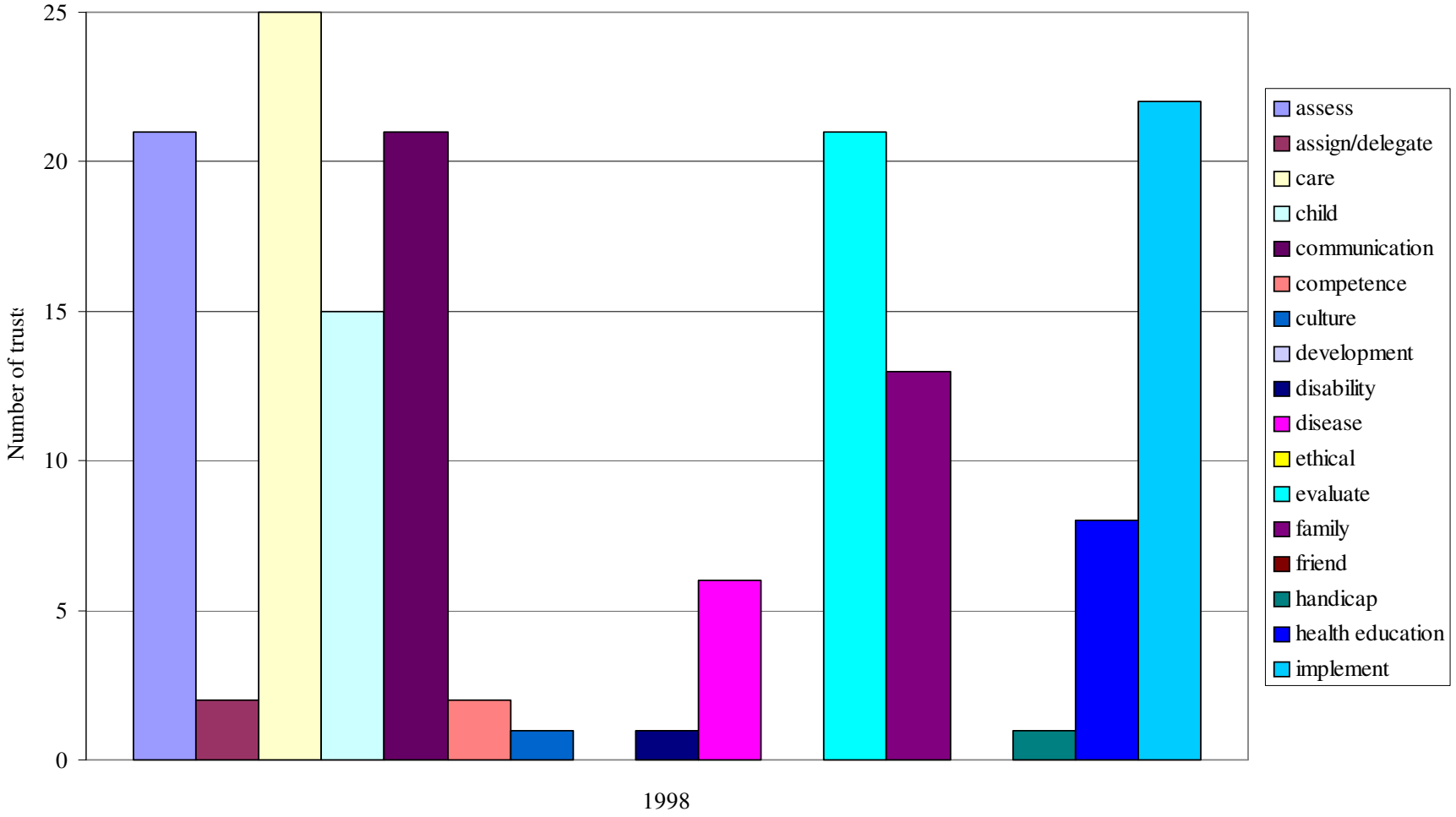

Figure 27 Searches against statute 1998

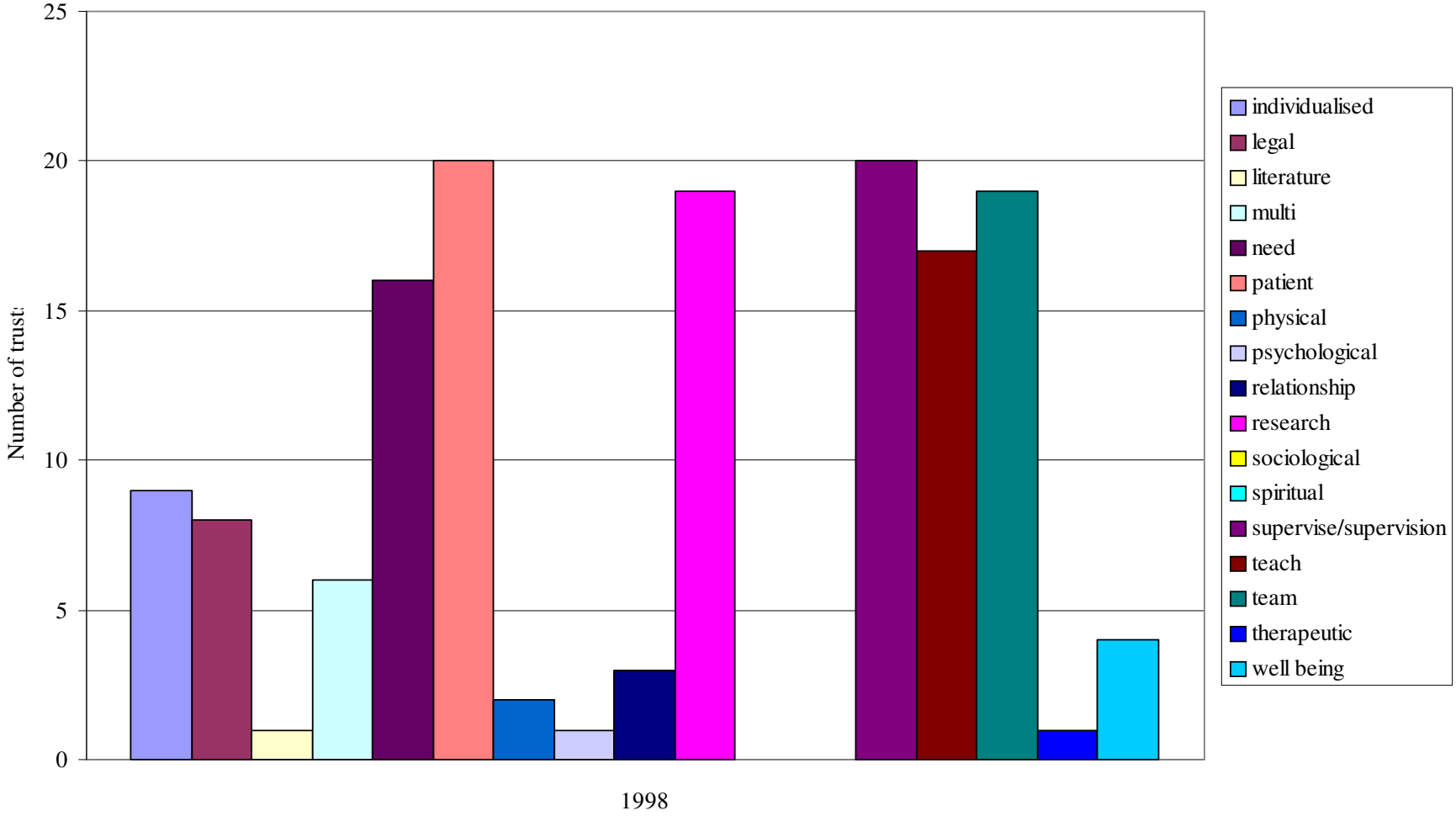

Figure 28 Searches against statute 1998 (continued)

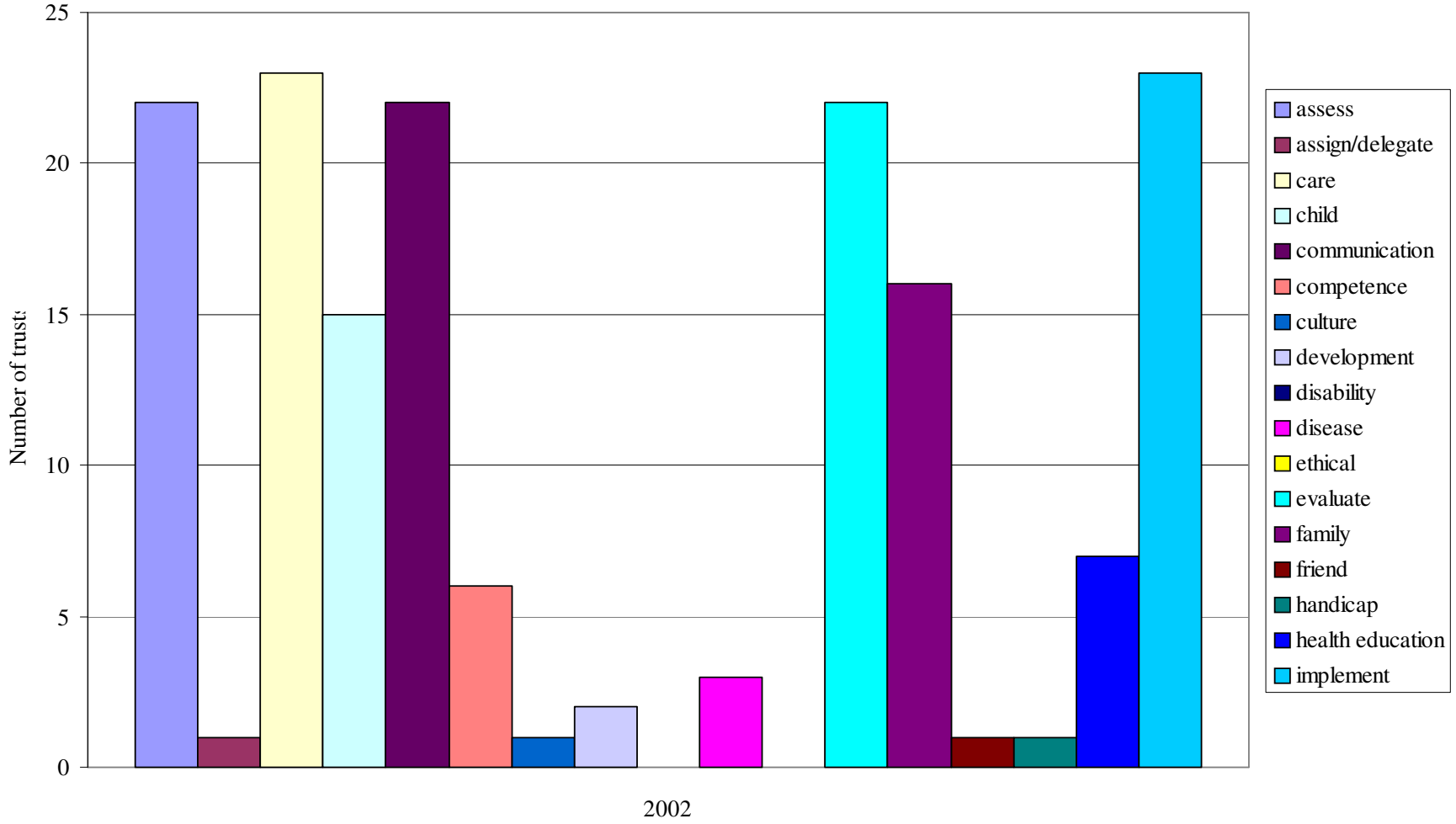

Figure 29 Searches against statute 2002

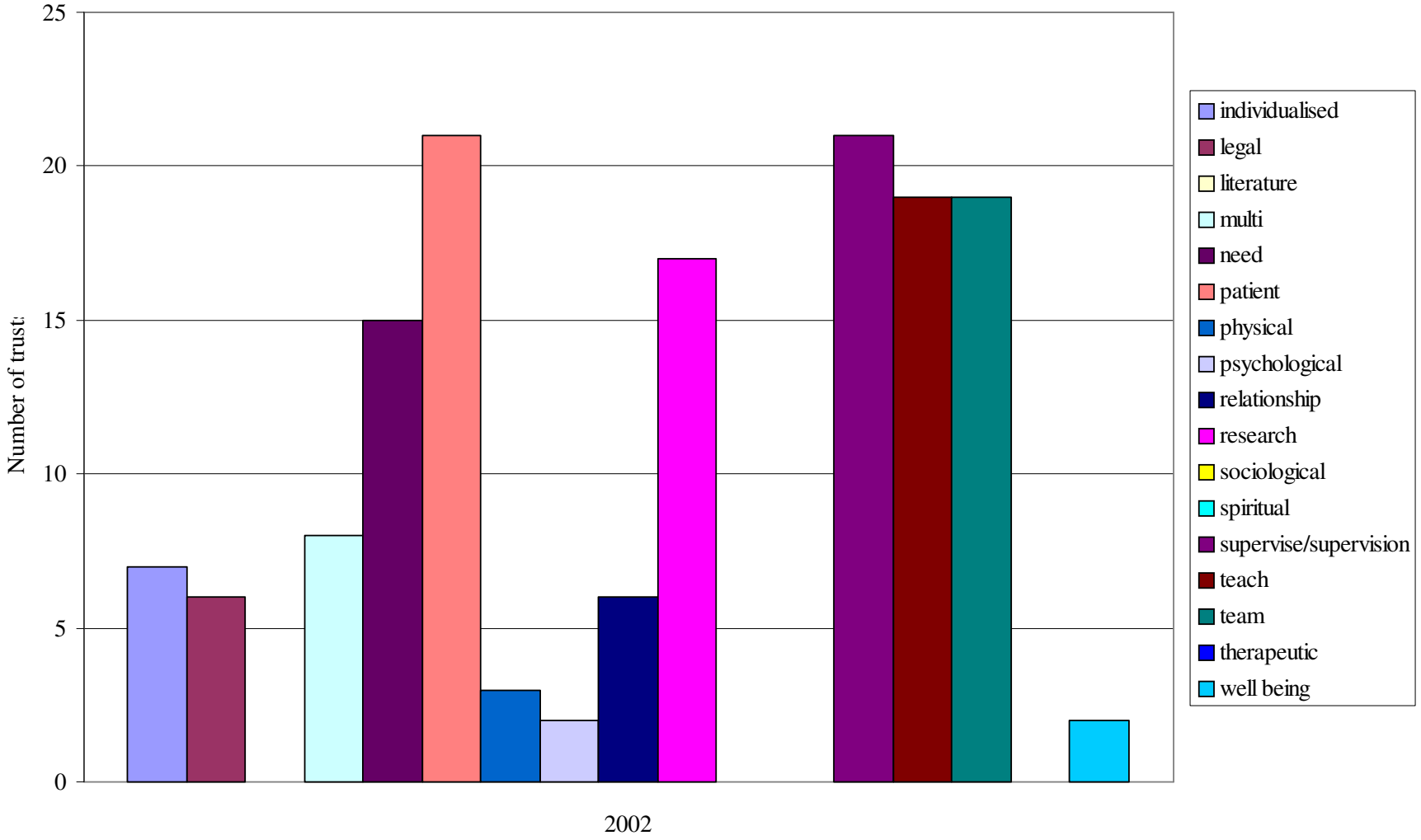

Figure 30 Searches against statute 2002 (continued)

Use of this method of analysis demonstrates limited differences in the job descriptions between the two samples with a comparable number of findings in relation to elements of the statutory instrument. Areas of standard practice such as the stages of the nursing process (assess, plan, implement and evaluate) were present in the job descriptions but despite the use of a number of different terms, such as assess or identify, not all elements were explicit in all job descriptions. Both samples had the same number of references to the child as the focus of care, however, this was only evident in 15 job descriptions, 60% of the sample. Three more trusts made reference to the family in 2002 than in 1998, however this was only in 16 trusts (64%), with the others either referring to relatives or failing to make reference to any family members.

There were some differences between the samples. For example, in 2002 there were increased references to "competence", rising from 2 in 1998 to 6 in 2002. A similar change was recorded in references to "relationships", again rising from 2 in 1998 to 6 in 2002. Reference to "friend" was an addition in the 2002 sample, being mentioned on one occasion. A similar number of trusts made reference to health education/promotion in both samples (8 in 1998 and 7 in 2002), which, in view of the strong health focus of both nursing education and government policy at the time this finding, might be described as disappointing.

The number of references to forms of communication remained similar, though again not present in all job descriptions. Two fewer job descriptions made reference to research in 2002, than in 1998, down from 19 references to 17. The expectations of trusts in relation to research

and its role varied from:- "ensure practice is research based" (D17), to "participate in nursing research" (D2), to "Initiate and undertake approved clinical nursing research" (D20) and "To participate in any research undertaken in the unit" (D23). Despite the number of direct references to research in both samples there were no references to ethics or ethical practices in either sample. In the present climate of increased emphasis on the multi-disciplinary working the fact that this was explicit in only 8 (32%) of the 2002 sample could be described as disappointing.

Searches also included terms related to the needs of children. One trust in 1998 and 2 in 2002 made reference to the psychological needs of the child and there were no references to the sociological needs of children. The same job description in both samples was the only one to make direct reference to the child's culture or ethnicity (D22).

Additional searches

Knowledge of the role of the D grade and observation of some phrases noted during the preparation of job descriptions for use in QRS N4 meant that a number of additional searches were undertaken on the job descriptions (figure 31). All the trusts made some form of reference to the requirement that employees should ensure they followed trust policies and procedures, which might be described as a catchall to cover any elements of the role of the D grade nurse not explicitly stated in the job description.

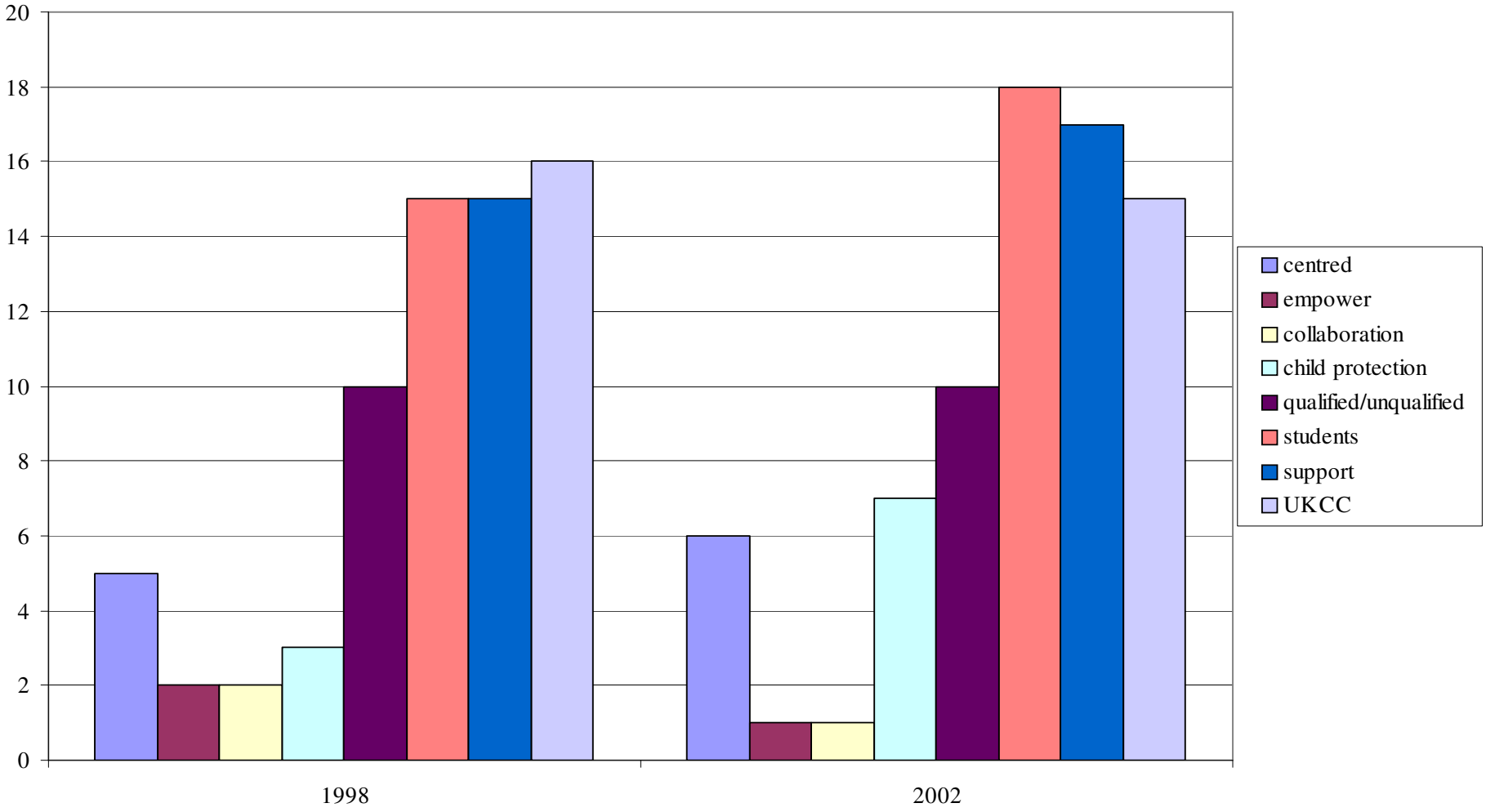
20
18
16
14
12
10
8
6
4
2
0
1998
2002
centred
empower
collaboration
child protection
qualified/unqualified
students
support
UKCC

Figure 31 Additional searches of job descriptions 1998 and 2002

Job descriptions were also searched for references to meeting the requirements of the UKCC Code of Professional Conduct (UKCC 1992). Although this is not an explicit element of statute in relation to education for registration adherence to the code is implicit within the requirement to understand legislation "relevant to the practice of nursing" (HMSO 1989, 5) In 1998 16 trusts made either explicit or implicit reference to the need for staff nurses to work according to the code of conduct. This figure was consistent in the 2002 sample with 15 trusts making reference to the code. Three trusts had obviously updated their job descriptions to reflect the changes in legislation that occurred in April 2002, as they now referred to the Nursing and Midwifery Council Code of Conduct (NMC 2002).

Responsibilities in relation to child protection were only present in 3 of the 1998 and 7 of the 2002 job descriptions, although as previously stated the blanket requirement for staff to follow hospital policies could be seen as ensuring all staff were aware of their obligations in this area of practice. The D grade nurse, in both samples had responsibilities in relation to support, guidance and teaching in relation to students, qualified and unqualified staff.

The purpose of the children's nurse

Twenty two of the job descriptions, in both samples, had a specific section related to the function of the post. These were prepared for analysis using QRS N4 and eleven searches were performed using words derived from the expectations of the role in relation to clinical grading and words related to the child and family (figure 32).

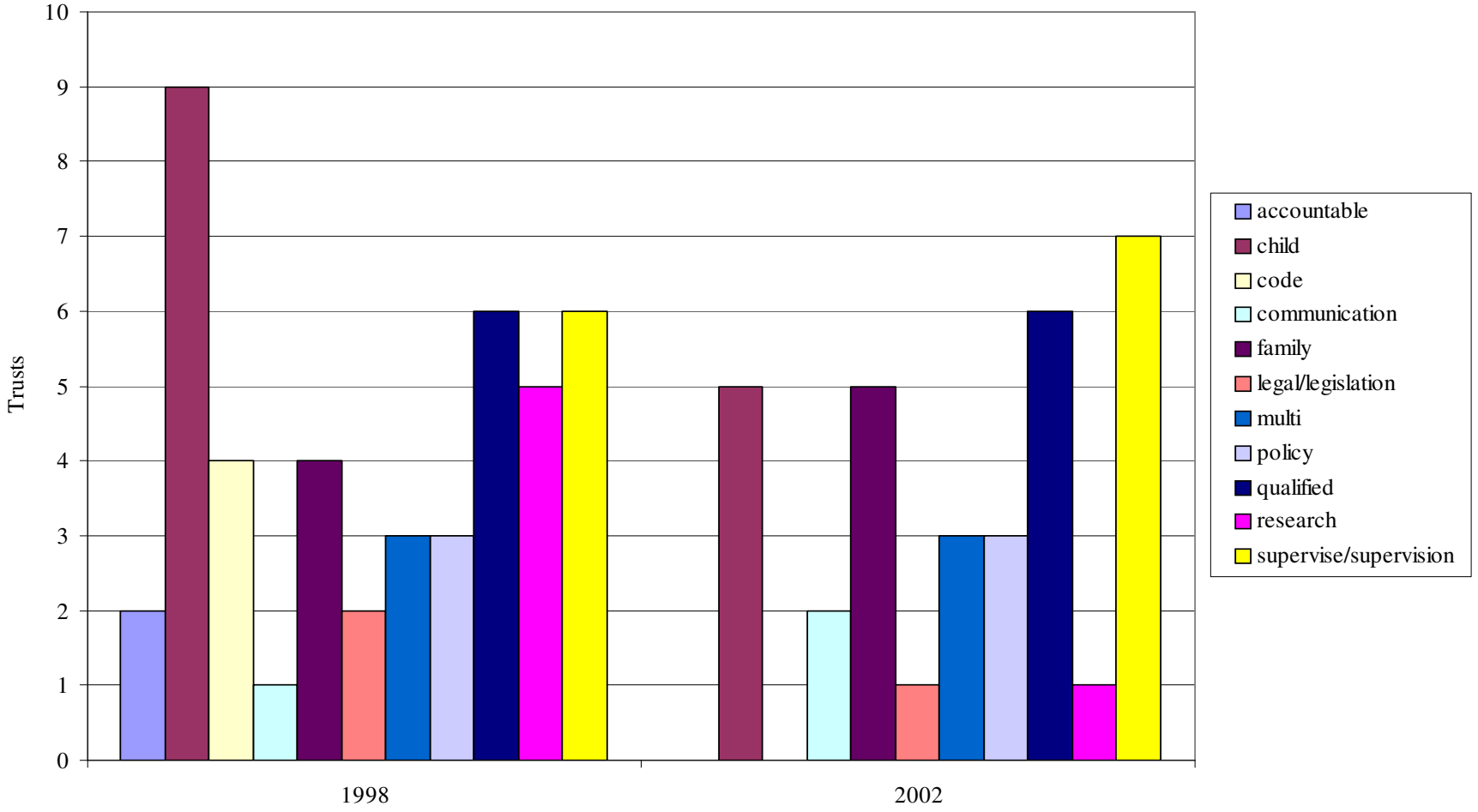
10
9
8
7
6
5
4
3
2
1
0
Trusts
1998
2002
accountable
child
code
communication
family
legal/legislation
multi
policy
qualified
research
supervise/supervision

Figure 32 Searches of the purpose of the role

As figure 32 demonstrates there were a number of changes between the two samples. In 2002 there were no references to accountability or the Code of Professional Practice in this section of the job descriptions. References to the child reduced from 9 to 5 and references to research reduced from 5 to 1 in the 2002 sample.

Supervising others or being supervised in the role

QRS N4 has the facility to enable the researcher to link results of searches to the original document this enables checking, analysis and interpretation of findings against the original context. Within the job descriptions three different aspects of the concept of supervision had became evident. Further analysis was therefore undertaken in three areas (figure 33 overleaf) focussing on:-

a) The expectations of the trusts in relation to the acceptable nursing registration for the post against the UKCC/NMC requirement that a nurse who is working in an area outside their area of registration should be supervised by a nurse with the appropriate registration (UKCC 1994; NMC 2002b). In this particular study this applies to those without a children's nursing qualification:- RGNs and EN (Enrolled nurses)

and

b) The expectation within the clinical grading structures that a D grade nurse

> "is expected to carry out all relevant forms of care without direct supervision and may be required to demonstrate procedures to and supervise qualified and/or unqualified staff" (DHSS 1988).

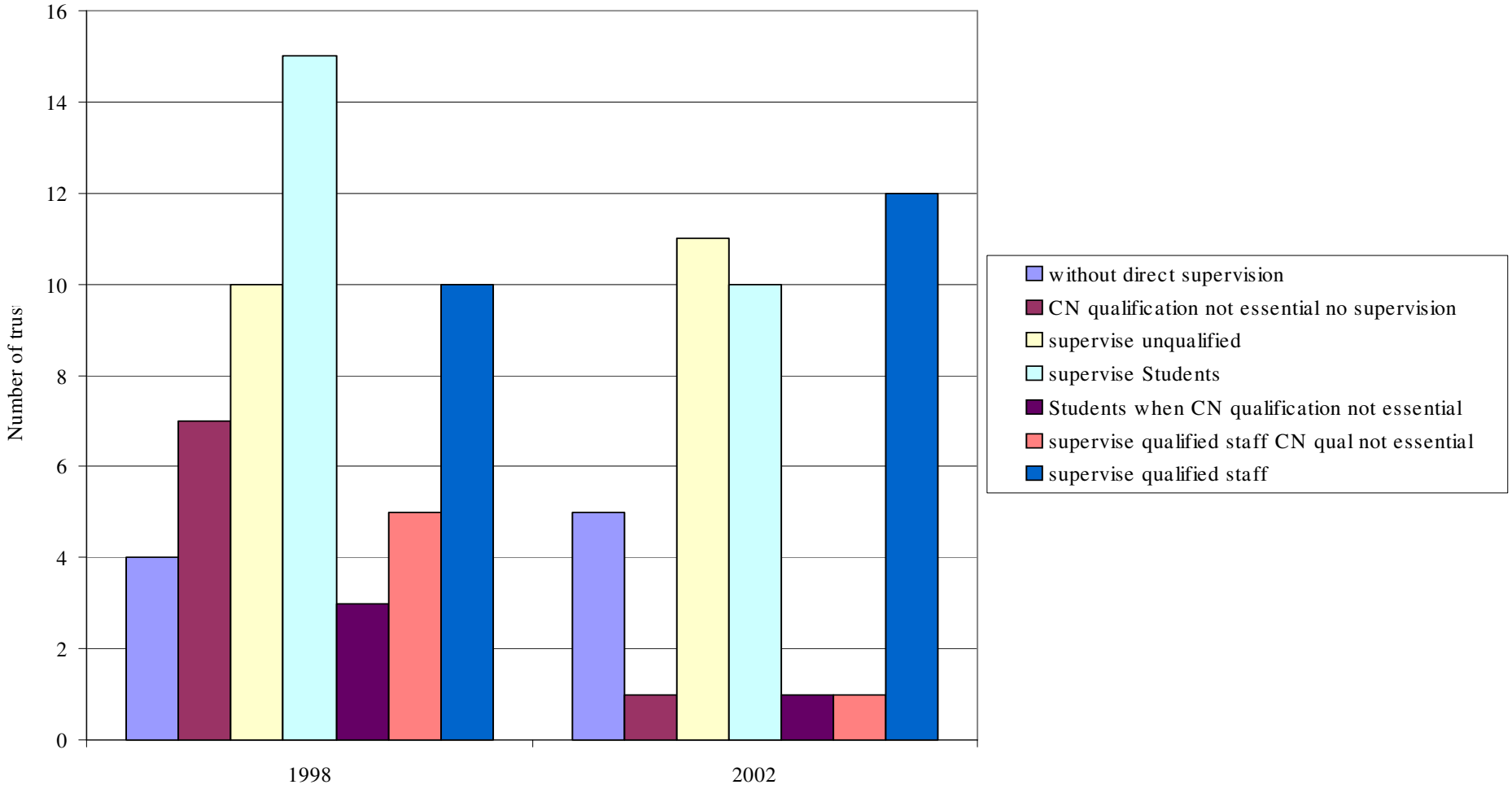

Figure 33 Supervising others or being supervised in the role

As figure 33 demonstrates the number of trusts who expect the non children's nurse to work without the supervision expected by the statutory body (UKCC/NMC) has reduced in line with the number of trusts apparently willing to employ non children's nurses. There is also a reduction in the number of trusts who expect the D grade to supervise students on placement in the clinical area. Slightly more trusts appear to expect the newly qualified D grade nurse to have responsibility for supervising other qualified staff. The job descriptions did not usually make explicit the nature of the "qualification" that these staff might hold.

DISCUSSION

The question

> Do those who employ newly qualified children's nurses expect them to work in multi-disciplinary settings meeting the needs of children and their families through the delivery of planned care that utilises a range of scientific, technological, psychological, and educational skills?

had been developed following the use of Rodgers evolutionary model of concept analysis (Rodgers 2000a) to define children's nursing and the special needs of children. This definition had taken account of a range of stakeholders including government policy, statutory bodies, the profession, professional organisations and pressure groups.

This survey of D grade job descriptions, for posts on children's wards in the NHS trusts in England focussed on the expectations of a different stakeholder, the employers, the NHS trusts.

The sample

The survey methodology had generated a sample of job descriptions from 25 English NHS trusts, from both 1998 and 2002. As appendix 6 demonstrates this sample can be described as being geographically representative of a range of trusts from across England, and included four specialist children's hospitals. Many of the trusts sent full recruitment packs with glossy folders full of information intended to sell their particular organisation to new employees and such data, combined with the job descriptions matched the requirements for transforming into

the raw data for the proposed computerised method of content analysis.

Qualifications for the post

The majority of job descriptions, in both 1998 and 2002 included details in relation to the nursing qualifications considered suitable for employment on the trusts' children's wards. Although analysis of data of this nature had not been initially considered as part of the process of asking the question, the presence of such data provided additional insight into the beliefs of the NHS trusts in relation to the suitability of employing nurses from the children's or non-children's parts of the nursing register. In 1998 around half of the trusts (56%) were apparently willing to consider employing nurses without a children's qualification at the level of a D grade staff nurse, reducing to 28% in 2002.

As previously demonstrated, through the use of Rodgers evolutionary model of concept analysis (Rodgers 2000a) both British government policy and the structure of the United Kingdom nursing register have consistently supported the education and employment of children's nurses to care for children in hospital, since the introduction of registration in 1919. Support for such a policy had been reiterated in England in 1991 with the Department of Health publication, "Welfare of children and young people in hospital" (DoH 1991), which stated that

> "It is accepted that the general nursing needs of children can best be met by grouping them in a discrete children's department with an experienced RSCN in charge **supported by other nurses qualified in the care of children.**" (DoH 1991, 33).

The issue of whether trusts actually employed non-children's nurses was not tested in this study, however there is evidence in statistics, issued by the DoH in 2001, that the employment of non-children's nurses in children's services is not unusual in the NHS in England. Although the DoH statistics relate to all children's nurses, rather than just D grade posts, they record a total of 16,683 nurses working in paediatric services, of whom only 9604 are described as Registered Sick Children's Nurses (DoH 2001a), meaning that at the time of publication a total of 42% (7079) of those employed to provide nursing care for children and their families were not children's nurses.

The conclusions that can be drawn from both the DoH statistics (DoH 2001a) and the findings from the analysis of this element of the job descriptions in this study reflect a similar situation to that described in previous surveys undertaken in England during the 1990s. For example the Audit Commission in its survey of 31 wards in 7 hospitals, published in 1993 found that wards were frequently staffed with only one RSCN (HMSO 1993) and that 50% of the wards in the survey "occasionally had none at all" (HMSO 1993, 20), thereby "failing to meet the DoH standard" of a least two children's nurses on any shift (HMSO 1993, 20). The findings of the Audit Commission were echoed in a wider survey, undertaken in England at about the same time, by the English National Board (ENB 1992). The ENB survey, attracting data from 174 organisations, identified that in 85.6% of units some nursing care was being provided by non RSCNs (ENB 1992). The Royal College of Nursing's written evidence to the select committee on children's health, in the 1995-6 session of parliament, also raised concerns about the staffing of children's areas pointing out to the members that the government had a

policy that

> "has still not been implemented. The Audit Commission has pointed out that the major reasons for this failure are the lack of management focus on and lack of insight into the specific health care needs of children" (HMSO 1996, 17).

There may be a number of reasons why some trusts advertise for and then possibly employ non-children's nurses. For some the policy of employing non-children's nurses may be historically related to the structures underpinning clinical grading of posts. Prior to Project 2000 the only route to qualification as a children's nurse had been through a second registration following a further programme of education. The personal experience of the researcher, in teaching such programmes, was that a number of quite senior staff from children's wards would be seconded by their employers in order to gain the RSCN qualification and thereby meet government guidelines. Others would previously have held staff nurse posts and when they had gained an additional registration would not have been considered appropriate for employment as a D grade, being most likely to be offered posts at the level of E or higher. The numbers of D grades in a trust may, therefore, by default be filled with Enrolled Nurses or Registered General Nurses, some of whom had been employed prior to the implementation of clinical grading and the publication of the recommendations of the DoH in relation to staffing (DoH 1991).

Secondly there may be a perception amongst those involved in employing nursing staff, that the qualifications of Registered General Nurse and Registered Children's nurse are in fact interchangeable. In a 1983 survey on the career prospects for children's nurses Hutt had concluded that at that time managers really did not see the need for RSCNs or even the

difference between the skills offered by those with different registrations (Hutt 1983). Certainly two later Royal College of Nursing (RCN) surveys (RCN 1999, 2001) present evidence of the extent to which trusts move both adult and children's nurses to cover staff shortages. In the 2001 survey almost a quarter of the respondents moved adult nurses to children's wards and almost 17% of trusts moved children's nurses to adult wards as frequently as weekly (RCN 2001). Unfortunately the RCN survey fails to clarify whether the children's nurses who were moved to adult wards were those with a dual qualification ie those with adult and children's nursing qualifications. It is also unclear whether the term adult nurse is being by the trusts and the RCN to refer to those nurses on Part 1 of the professional register, the Registered General Nurse, or those on Part 12 of the register, the Adult nurse from the Project 2000 programmes. It may be that some children's hospitals have this view of interchangeability as amongst the small sample of children's hospitals some were willing to consider people without a children's nursing qualification, this despite the fact that they would have been linked directly with a school of nursing offering children's nursing programmes.

A third reason for the findings in this study may be linked to the qualifications of those involved in drawing up the job descriptions. Although this study did not seek data in relation to who was involved in setting the registration requirements for posts on the children's wards, the fact that in 1998 over half of the trusts were still willing to consider employing a non-children's nurse may be a reflection of trusts' sometimes limited commitment to including children's nurses at levels above that of ward manager, in places where they could influence

employment practices. This conclusion is given some support by evidence from the Royal College of Nursing (RCN) surveys both of which highlighted the fact that across the United Kingdom less than 40% of trusts (32.5% in 2000) had a children's nurse in a senior position above ward level (RCN 2001). The impact of this on trusts' employment practices could be an area for further study, particularly in light of the recommendation, of the public inquiry into children's heart surgery at the Bristol Royal Infirmary, that there was a need for an urgent review of the current DoH policy in relation to the numbers of children's nurses who should staff the ward at any time (The Stationery Office 2001).

A further rationale for the findings in relation to the potential employment of non-children's nurses may be related to the number of children's nurses available to fill such posts. Although during the 1990s there was an increasing availability of newly qualified children's nurses suitable for employment as a D grade, with the numbers rising from 819 in 1992 (ENB 1997a) to 1561 in 2001 (ENB 2002). A survey of the children's nursing workforce (Elston and Thornes 2002), undertaken for the Royal College of Nursing and the Royal College of Paediatrics and Child Health, forecasts a projected shortfall in the numbers children's nurses of 1613 in the year 2004/05. Should this prediction be accurate then there is potential for an increase in the number of trusts who are willing to employ non-children's nurses simply to enable them to have sufficient staff to cover the workload requirements. This shortage has the potential to continue despite NHS campaigns to recruit qualified nurses from overseas, as can be seen from the statistics published by the NMC. In a year of "record overseas activity" (NMC 2002a, 11) there were only 59 nurses from overseas admitted to the children's parts of

the register, 0.4% of the total number of overseas applicants, a direct consequence of the fact that other countries do not follow the same pattern of nurse preparation as the UK.

Whether such employment practices have an impact on the quality of care is difficult to determine. Bodies such as the Commission for Health Improvement (CHI), who at the time of this study, have a statutory function to "scrutinise local clinical governance arrangements to support and promote high quality care" (CHI 2003a) and a further role in monitoring the implementation of the National Service Frameworks (CHI 2003b) have not yet produced any reports related to specifically to children's nursing.

Date of development (figures 25 and 26, 318-319)

Analysis of the date of development of the job descriptions had shown a pattern of change across the sample, although there was one job description that in 2002 was seven years out of date. As already discussed changes had occurred in relation to the acceptable nursing qualifications suitable for the post while for some trusts the motivating factor appeared to be processes related to trust restructuring and mergers.

This methodology did not allow for any further conclusions to be drawn in relation to any links between the date of development and changes to the employers' expectations of the D grade children's nurse. Such processes will, however, soon be under a great deal of scrutiny. As this present study is concluded a massive process of change is starting to role out across the whole of the NHS, with the implementation of the first new pay structure since clinical

grading, known as Agenda for Change. In the trusts that will go forward first, the early implementer sites, concern is already being expressed that "Out of date job descriptions have caused difficulties" (RCN 2003, 3) with organisations being encouraged to "start checking and updating job descriptions now" (RCN 2003, 3). The potential for such changes to impact on the future role and expectations in relation to children's nursing are discussed in the final chapter of this study - The Future.

Comparison with statute (HMSO 1989)

The focus in this study was on the "work activities and procedures" (Miner 1992, 347) of a D grade staff nurse, a post which is a first destination appointment for the newly qualified children's nurse. The decision to use learning outcomes from the statutory instrument underpinning the Project 2000 programmes (HMSO 1989) had been based on the requirement that before employment students will have completed an educational programme that ensures they achieve fitness for practice and thereby eligibility for registration (Appendix 7). As figures 27-30 (338-341) demonstrate there were some changes between the two samples, and there were differences across both samples in the extent to which some elements of statute and practice were made explicit.

Nursing process

The nursing process, as an approach to nursing care, is not specific to children's nursing, rather it an approach to the assessment of care needs that has been used in British nursing since the late 1970s. As stated in the results the various stages of the nursing process

(assessment, planning, implementing and evaluating) were present in the job descriptions, though not all were explicit in stating all four elements of the process. Due to the fact that trusts expected staff to follow the laid down policies and procedures this finding probably has limited significance, as the processes for assessing, delivering and recording any care would most likely be set out on a trust wide basis. If this is the case then such processes could rightly be seen as part of the role of every nurse.

Children and parents

Although children and parents are not explicit in the statutory instrument, there is a requirement that the learning outcomes are applied to "the area of practice of the branch Programme" (HMSO 1989, 5). As all these posts are for staff nurses on children's wards in NHS trusts, it seems rather impersonal to refer to the recipient of care in such an environment as a patient, which was the term used by 40% of the responding trusts, in both samples. Just over half of the job descriptions made reference to parents or the family in the 1998 sample (52%) rising to 64% in the 2002 sample which is an interesting change particularly in light of the finding that seven trusts had moved to generic descriptions of the role of the D grade, and who if referring to anyone other than the patient used the term relative.

The importance of the family is congruent with this thesis' expansion of the concept of children's special needs, from that originally defined by Price in 1994. In developing her definition of the special needs of children Price had stated that they were

> "those which are different from others undergoing a similar experience as they are specifically related to the individual child's stage of development" (Price 1994, 230).

In demonstrating how different people would be involved in the meeting of a child's needs when they were in hospital Price (1994) had also shown how as the child matured the balance of responsibility could change, a concept that was further expanded, earlier in this study, in the review of nursing care required by a baby with bronchiolitis and a child with diabetes (tables 25, 167; 26, 169), in which it was evident that the provision of care could move between the nurse, the parents and an older child. Allowing parents to become involved in care was one of the positive qualities of nurses identified by parents in Darbyshire's study of resident parents (1994) and Price warns that success in involving parents "is dependent on more than a statement in the ward's philosophy" (Price1997, 84).

The statutory bodies in their requirements for programmes leading to registration as a children's nurse emphasise a central "philosophy of working in partnership with children and families" (ENB 2000a, 3). This integration of parents into a caring partnership was reinforced by the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary. The authors of the report stated that parents

> "Overwhelmingly, ... emphasised the need for parents with a child in hospital to be involved in their child's care and for parents' expertise, as the people who know the child best and who care for the child, to be fully acknowledged and appropriately engaged. " (The Stationery Office 2001, 285).

It may be argued, by those responsible for developing job descriptions, that just because parents and family are not specifically mentioned does not mean they are excluded from the caring relationship. Conversely, whilst it may be practice in some trusts to use a generic trust

wide job description for all nurses at the same level, such a practice would appear to miss some of the flavour of NHS policy. For example in the 1991 policy document "Welfare of Children and Young People in Hospital" (DoH 1991), there are over two pages devoted to families and their importance to the child in hospital with strong phrases stating that

> "The care provided by a hospital has to centre firmly on the recognition of the **child as a member of a family** - a family whose support during the hospital stay is essential to the child's well being" (*sic)* (DoH 1991, 16).

The findings in relation to the employers' expectations of the children's nurse in relation to the parents are also congruent with the development and manipulation of the variable of "Motivation/wanting to work with children and families" in the applications of the six hypothetical candidates in the study of selection of students for the child branch.

Competence

The increased number of references to competence, from 2 to 6 in 2002, reflect the change in vocabulary that started to occur during the later part of the 1990s. The move towards formal structures for training all levels of staff and the consequent links with occupational standards and the National Vocational Qualification (NVQ) framework with the expectation of competence at a range of levels was increasing. The later discussion of the changes in nursing education that followed the evaluation of Project 2000 will expand this theme.

Health education, health promotion

One of the main planks of the present government's policy in relation to health was set out in "Our Healthier Nation", a follow on from the previous governments "The Health of the

Nation". This policy led to the setting up of the "Healthy school initiative" in 1998 (DoH 2003b), an initiative that is seen by the government as being a important element in contributing to the overall future health of the nation (DoH 2003b). In light of such a strong push towards education for health the limited number of trusts that made reference to health education or promotion in both samples of the job descriptions could be described as disappointing (8 in 1998 and 7 in 2002).

Some might argue that during the acute and often quite short hospital stays experienced by most children entering hospital there is limited time for such practices. This finding could alternatively be seen as a demonstration of a failure of acute trusts to make more explicit the need to think of prevention and its potential reduction in hospital admissions as part of an ongoing process of managing the workload of the organisation. A different methodology looking at how children's nurses actually practice and what they do with children and their families may have presented different results and highlighted a range of areas in which health advice and guidance are part of the every day routine.

Research and ethics

A large number of trusts mentioned research in the role of the D grade (19 in 1998 and 17 in 2002). As noted in the results there were a range of expectations in relation to the nurse and research varying from "ensure practice is research based" to "Initiate and undertake approved clinical nursing research". Although the sample of job descriptions did not enable comparison with other branches such as adult, mental health or learning disabilities it is unlikely that this

is just an expectation related to activity on children's wards. In view of this finding the lack of any explicit reference to ethics or ethical practice can be described as concerning particularly in light of the professional expectations placed on health care professionals.

Practising ethically is an expectation of the Code of Professional Conduct (UKCC 1992, NMC 2002) although just under half of the trusts were explicit that D grade nurses should work within their code of conduct. The code, which had been published and issued to all registered nurses since 1992, requires registered practitioners to "act always in such a manner as to promote and safeguard the interests and well being of patients and clients" (UKCC 1992, 2). In further guidance on the Code of Professional Conduct, published in 1996, the UKCC particularly refers to the involvement that registered nurses may have in research and a range of specific criteria that should be met, including ethical approval (UKCC 1996). This expectation is carried forward in the new code of conduct, published in 2002 by the Nursing and Midwifery Council (NMC) the successor body to the UKCC, which states

> "You must work with other members of the team to promote health care environments that are conducive to safe, therapeutic and ethical practice" (NMC 2002, 9).

British textbooks on children's nursing (eg Carter and Dearmun 1995; McQuaid et al 1996) have whole chapters outlining ethical principles and the ways in which they may impact on the care of children. In an era when research is also part of medical development and treatment and may be part of the activity in areas where children and their families receive medical and nursing care it is essential that all those who may be involved are aware of issues

such as acting in the best interests of the child and their family, responsibility for giving consent and telling the truth (Charles-Edwards 1995).

The UKCC, in referring to contracts of employment, supports the findings of this analysis highlighting that contracts of employment "do not always cover concerns about the ethics of research" (UKCC 1996, 35). A concern that was also picked up by the Bristol Inquiry into the experiences of children undergoing heart surgery (The Stationery Office 2001) which made many references to ethics and practising ethically seeing this as an important area of knowledge for health service managers who would face "clinical and ethical issues" in their "career in health service management" (HMSO 2001, 328). It could be argued that such knowledge is even more important for those staff who have to deliver care that should reflect both local and national policies and their code of conduct and that it may be expected to be incorporated into the job descriptions against which they are held to account. In a health service subject to changes that are occurring at a great pace (UKCC 1999) the lack of references to ethics, in the role of the children's nurse, fails to reflect the need for nurses to use such knowledge and understanding in the roles that they undertake with children and their families.

Use of a different methodology or data sample may have enabled a clearer demonstration of the employing trusts attitudes towards ethical practice. It may be that the trust policies referred to as a requirement for employees have clear statements in relation to the role of ethics in practice in each particular trust. The extent to which employees know, understand and

incorporate changes and developments in trust policy into their everyday practice would be worthy of further study.

Multi-disciplinary working

A constant theme throughout the education of future health care workers, of what ever grade, is the requirement to work as part of a multi-disciplinary team and this was also an element in the definition of children's nursing. Again although this is an element of practice that is not specific to children's nursing there were limited explicit statements within the job descriptions. A study of the links that children's nurses make while they are caring for children might be more suitable to determine the full extent of multi-disciplinary activity that is on going on the ward, and the areas of practice where is more or less frequent.

The needs of children

The definition of children's nursing, derived from the concept analysis based on government policy, writing by the profession, the statutory body, professional organisations and pressure groups, was based on the concept of a child being a person with special needs. The definition of these special needs had linked them inextricably to the individual child's stage of development. Findings explicitly related to children's needs were extremely limited in both samples of job descriptions. Again a different methodology focussed on individual nurses, their practice and their rationales for their actions may have produced different results, with practitioners being able to demonstrate which needs they were meeting with particular actions.

Spiritual, cultural and ethnic needs

As can be seen from appendix 6 the responding trust covered all the regions of England. In what is now such a multi-cultural society it is concerning that only two trusts made explicit reference to people's spiritual, cultural and ethnic needs. No matter what the age of the person requiring health care spiritual and cultural needs and ethnicity have the potential to affect all aspects of care from matters such as ensuring an appropriate diet to rituals and beliefs around illness and death. Again it may be the case that those trusts that were not explicit in this requirement do in fact have a good understanding of the needs of the different cultural and ethnic groups who make use of their services but to leave this as a potentially implicit part of the role gives no sense of the philosophy of care adopted by the employer.

Additional searches

The results of the additional searches again showed a range of occurrences across both samples (figure 31, 344). By 2002 seven trusts were making explicit reference to the nurses' need to know about child protection, a function which for other trusts may again be covered by the catch all requirement to follow trust policy. In light of the current concerns in relation to child protection and the publication of the Green Paper "Every child matters" (DoH 2003c) which followed the report into the death of Victoria Climbie a future repeat of this section of the study may uncover very different findings.

In both samples 40% of trusts expected the D grade to have a role in relation to both qualified and unqualified staff, an expectation that is clearly linked to the clinical grading expectations

of D grades which require them to supervise others (DHSS 1988). In view of the number of trusts in both samples who could potentially have employed a non-children's nurse in the D grade post the expectation that they could be involved with students and their learning and assessment goes directly against the standards for clinical learning set in place by the ENB (ENB 1997), which have been subsequently adopted by the NMC.

Amongst some of the trusts in which there was the potential for non-children's nurses to be employed, there was a lack of an explicit requirement for them to work under the supervision of a qualified children's nurse. This appears to go against the expectation expressed by the UKCC (UKCC 1994) and its successor body, the NMC (NMC 2002b), that nurses working outside of their field of registration should be supervised by an appropriately qualified nurse. Although this method of data collection did not enable further exploration of this finding it may be that such trusts set out such requirements in other areas of policy. If the job descriptions developed by the trusts are truly linked to the "tasks, duties and behaviours required in a given job" (Miner 1992, 344) then could be interpreted as condoning registered practitioners working outside the guidance of their statutory body, particularly as the requirement to work in line with the requirements of the UKCC/NMC code of professional conduct was not present in all the job descriptions.

The purpose of the children's nurse

Twenty-two of the job descriptions in both samples had a specific section stating the purpose

of the role. In keeping with the findings in relation to reference to the child in the body of the job description less than half the sample (9 in 1998 and 5 in 2002) made reference to the child in this section, the lower number of references in 2002 being linked to the increased number of generic, trust wide descriptions of the D grade post, in which the delivery of the role rather than the person who is the focus of nursing seemed to be more strongly stated. Also in keeping with the changes in the main body of the job description there was a slight increase in the number of references to the family in the 2002 sample.

The finding that 16% of trusts included communication in the purpose of the role in 1998 while there were no references to this element of the role in 2002 raises the question of the extent to which this is seen as important enough to be specified by employers. Child et al (1988) in their study of the selection of students and NMCCH (ENB 1995) in their directions to referees highlight the importance of communication skills. This skill had also been one of the manipulated variables in the development of the hypothetical candidates in an early part of this study and 50% of selectors had indicated that they would look for this in prospective candidates for the child branch.

Conclusions in relation to job descriptions

This study had been undertaken to ask the question:-

> Do those who employ newly qualified children's nurses expect them to work in multi-disciplinary settings meeting the needs of children and their families through the delivery of planned care that utilises a range of scientific, technological, psychological, and educational skills?

Using this methodology it was possible to demonstrate that there were a range of expectations of the newly qualified children's nurse that were linked to the definition of children's nursing and the special needs of children. The expectations, linked to the two definitions were not, however, always explicitly demonstrated by individual trusts' expectations of the D grade on their children's wards, as expressed by individual job descriptions. Across the sample there were some changes in the expressed expectations of the role of the nurse, the largest being the greater inclusion of parents in the 2002 sample. There are, however, what may be described as a range of other authorities or influences that direct the work of any registered nurse and in it may be in these areas that the full extent of the role of the children's nurse becomes clearer.

Other authorities

Where trusts refer specifically to the needs of patients and meeting their nursing needs they are implicitly relying on the knowledge of all staff to know what such needs are and how they should be met. However, as the English DoH document, "A Health Service of all the talents: Developing the NHS Workforce" (DoH 2000c) acknowledged there is a clear responsibility laid on trusts to ensure staff are up to date and able to deliver the services provided, as

> "At employer level it is the responsibility of each NHS Trust or other local employer to develop workforce plans for their organisation and be held to account for their delivery." (DoH 2000c, 7).

Nurses, like an increasing number of other health care practitioners have a second authority with a call on the quality of care that they give, their statutory body with its Code of

Professional Conduct (UKCC 1992, NMC 2002). At the time of the data collection for the first sample of job descriptions the UKCC code published in 1992 was in place. By 2002 when the second 25 job descriptions were collected the NMC had succeeded the UKCC and issued an updated code that brought together requirements from a number of other publications (The Scope of Professional Practice; Guidelines for Professional Practice and The Code of Professional Conduct). Failure to comply with the requirements of the code can lead to a nurse, midwife or health visitor being removed from the register and thereby losing their license to practice.

This may be the crux of the matter. The job description will set out the broad requirements of the role and the range of activity expected to be undertaken by the D grade on the children's ward and their purpose in providing care. The measure of the extent to which they do that, however, is also set against the requirements of the Code of Professional Conduct and it is this that requires that nurses should meet the needs of children and their families.

A course of preparation should enable the achievement of registration which is a symbol of fitness for practice. Fitness for practice means that the practitioner is able to gain employment and also ready to assume the responsibilities imposed by the code as the guide for students of nursing and midwifery (NMC) states

> "Registering with the NMC demonstrates that you have met the standards expected of registered nurses and midwives. It also demonstrates that you are professionally accountable at all times for your acts and omissions.
>
> Professional accountability involves weighing up the interests of patients, using your professional judgement and skills to make a decision and enabling you to account for

the decision you make." (NMC 2002c, 3).

The obligation of accountability could therefore be described as practising and being accountable for delivering care that "is safe and competent" (NMC 2002, 3). In the case of children the accumulated evidence is that hospitalisation has the potential to harm children unless their needs are taken into account. Therefore, the purpose of the children's nurse at any level is to meet the needs of children and although this purpose may not always be explicit in the job descriptions it is an overriding requirement.

LIMITATIONS OF THE STUDY

Data collection

The collection of the data met the expectations of the researcher producing a sample size of 25 job descriptions from a wide geographical area for the study (Appendix 6). The intention had been to use a scanner to convert the documents into a word processed format which could then be entered into the QRS N4. The quality of presentation of some of the job descriptions, which had been poorly photocopied or set out in indistinct type face meant that there was a need to physically retype a significant number which made this section of the process more time consuming than had been anticipated. The process of checking the successfully scanned documents or word processing those which would not scan did however enable the researcher to gain some initial thoughts of words, phrases or concepts that could be included in the content analysis.

The use of this method of data collection did not allow exploration of the "feelings" of the trusts. Questionnaires or interviews with those responsible for employing children's nurses may have had the potential to uncover the child centred nature of services in a way that was not possible using a paper based approach. It could also be argued however, that the initial perception that potential employees have of an organisation would be gained through looking at descriptions of the trust and the expectations of the role, and that therefore this method of data collection was not subject to respondents trying to please the researcher with child centred responses.

Although in both 1998 and 2002 a number of the trusts appeared willing to employ non-children's nurses in their children's wards this method did not provide any opportunity to determine the actual numbers of non-children's nurses employed. It may be the case that in reality posts are more frequently filled by children's nurses than not.

QRS N4 NUD*IST

The speed with which the computer package was able to scan documents and create reports which could themselves be "saved" in a word processing package met expectations. The ability to undertake further searches, modify the phrases and words for searching, without fatigue (Moseley, Mead and Murphy 1997) also meet expectations. The ability to combine a number of words with the same or similar meaning (eg research/trends/developments/trials) with confidence that all occurrences would be recorded was also an advantage of this methodology. As stated previously, the ability to repeat the searches with the same degree of accuracy was also seen as an advantage.

The same content analysis processes could have been applied to the analysis of other methods of data collection such as transcripts from interviews, a methodology that could have enabled more exploration of issues such as the registration of nurses that were actually employed, the expectations of the D grade staff nurse and the particular qualities that made them good at their job. Any such qualities could then have been analysed to determine which may be inherent and therefore existing at the point of selection and which could be developed through a process of professional education.

Further activity

This study focussed on job descriptions for D grade posts with English NHS acute trusts. Repetition of this study using job descriptions from Welsh, Scottish and Northern Irish trusts would enable an interesting comparison, particularly since devolution has centred responsibility for health within the devolved executives.

A number of other areas for further study have been identified throughout the discussion of the findings they are:-

- The level of comparative seniority of the highest grade children's nurses in a trust and the role they play in determining job descriptions and suitable registrations for employment on the children's wards.
- The processes for ensuring that changes in trust policy or legal requirements, for example, in relation to child protection are incorporated into practice.

CHILDREN'S NURSING - THE FUTURE

INTRODUCTION

One of the philosophies of Rodgers' model of concept analysis is the belief that concepts may and do change over time (Rodgers 2000a). The definition of children's nursing in 2000 (87-88) had taken account of one of the largest changes ever to impact on pre-registration nursing education, the implementation of Project 2000. In 1992, just as the first Project 2000 nurses were beginning to enter into employment, the Chief Nursing Officer for England was beginning to ask questions about "the effectiveness" of the changes (Snell 1992, 19). This and similar concerns expressed during the time that the analysis and studies, reported on in this thesis were underway, led to a number of reviews of nursing education.

During the late 1990s a number of reports were commissioned and written reviewing and making recommendations about the future pattern of nursing education in the UK. Against a background of continuing health policy development, the proposals for and restructuring of, nursing's statutory bodies and the publication of "The Report of the Public Inquiry Into Children's Heart Surgery At the Bristol Royal Infirmary 1984-1995" (The Stationery Office 2001), new proposals for nursing education were discussed, set out and implemented.

Although these changes are relatively new they form the basis for any development and change in the concept and definition of children's nursing in the future.

CONCEPT ANALYSIS

In keeping with earlier stages of this thesis, Rodgers' evolutionary model of concept analysis (Rodgers 2000a) will be applied to the changes and developments that have occurred in pre registration nursing education since the implementation of Project 2000, published reports and developments in government policy in relation to the NHS and specifically children, in an attempt to determine whether the concept of children's nursing may be changed. In undertaking a further concept analysis the same processes as described previously (8) will be followed.

"Identify the concept of interest associated expressions (including surrogate terms)" (Rodgers 2000a, 85)

In using Rodgers' evolutionary model the first step is to clarify the concept and any terms that may be used as an alternative. For the reasons outlined earlier (14) the concept remains children's nursing and includes the same range of surrogate terms ie children's nurse, paediatric nurse, Registered Sick Children's Nurse (RSCN), child branch nurse and Registered Nurse Child, as they all remain in current use. The range of surrogate terms also includes the formal registration titles used by the registering body, now the Nursing and Midwifery Council (NMC):- Part 8: Nurses trained in the nursing of sick children or Part 15: First level nurses trained in children's nursing.

"Identify and select an appropriate realm (setting and sample) for data collection" (Rodgers 2000a, 85).

<u>Setting</u>

The use of Rodgers' evolutionary model requires the researcher to determine the "time

period" and the "disciplines or types of literature" (Rodgers 2000a, 87). To understand the changes that occurred in relation to pre-registration nursing education as a children's nurse this time band will include the later part of the 1990s, when the evaluative studies into Project 2000 were commissioned. The recommendations from these stakeholder reports and studies led to changes in the structure of pre-registration nursing education in the UK. These changes required the introduction of a new statutory instrument which came into force on 1st September 2000 (The Stationery Office 2000a). These new programmes have become known as either "Fitness for Practice" (FFP), taking their name from the title of the report from the UKCC (UKCC 1999), or "Making a Difference" (MAD) from the title of the English Health Service Circular (DoH 1999a) that set the process of change in motion. In England, the changes to pre-registration nursing programmes started in 2000 and were almost all completed by January 2002.

Disciplines

The previous analyses and definitions of children's nursing (87-88) had incorporated data from a range of stakeholders, covering the period up to 2000 (table 2,16-17). In applying Rodgers' model to this further time band a similar range of stakeholders and accompanying literature can be included in the sample alongside evidence from the studies reported earlier in this thesis. As table 62 demonstrates there is a need to take account of the significant statutory change, created by the closure of the ENB and the change from the UKCC to the Nursing and Midwifery Council (NMC), that occurred on 1st April 2002.

As previously, this further analysis will not be exhaustive, rather the data will be sampled using the experience of the researcher as a participant in some of these changes and include "landmark or classic sources" (Rodgers 2000a, 90). The literature and data sources will be focussed on four major stakeholders (table 62).

Stakeholder	Type of literature / data source
The Government, through the Department of Health	• Government commissioned reports • Policy documents • Standards for the delivery of health services eg National Service Framework for Children, Young People and Maternity Services (DoH 2003a) • Acts of Parliament and Statutory Instruments related to nursing regulatory bodies and training. • Health Service Circulars requiring implementation of government policy
The statutory body responsible for setting standards for registration, United Kingdom Central Council (UKCC) (1983-2002) and the Nursing and Midwifery Council (NMC) 2002- ongoing	• Activity related to changes to education and training of nurses for registration eg Fitness for Practice (UKCC 1999) • Guidelines for the content of education programmes leading to registration (UKCC 2001a)
English National Board (ENB), the statutory body responsible for approving and monitoring nursing education programmes (1983-2002)	• Policy • Guidelines and requirements • Curriculum guidelines
Professional associations such as the Royal College of Nursing (RCN)	• RCN Policy documents • Surveys

Table 62 Stakeholders and the potential range of literature available to be sampled 1996-2003

Findings

In 1992, just as the first qualified nurses were starting to emerge from Project 2000

programmes, the Chief Nursing Officer for England was quoted as “asking questions about the effectiveness of Project 2000" (Snell 1992, 19). Within two years the Universities of Warwick and Liverpool had been commissioned by the DoH in England to undertake a national study “to examine the ‘fitness for purpose’ of the Project 2000 nursing education reforms” (Carlisle et al 1999, 1256). Data collection commenced in 1994, two years after the first Project 2000 qualifiers would have entered the employment market. Indeed ENB figures of those eligible for registration through the traditional and Project 2000 routes between 1993 and 1996 demonstrate the small potential sample such a study could have (table 63), with 23% of adult nurse and 38% of children’s nurses, in England being on the new Project 2000 parts of the register.

“Adult nurses”	Eligible to register	“Children’s Nurses”	Eligible to register
Part 1 RGN	47949	Part 8 RSCN	3272
Part 12 Adult nurse	14923	Part 15 Child Branch	1910
% = Project 2000	23		36

Table 63 Adult and children’s nurses eligible for registration - during the study

The report’s conclusions, like many others related to Project 2000, are broad based and lack any particular focus on specific branches; however, the findings from this early study raised concerns about the new preparation for nurses. Balanced against this is the fact, acknowledged by the research team, that the managers and health service representatives who were included in the various samples for this early study had limited experience of the product of Project 2000 programmes, only needing to have had experience of one cohort to be included in the

sample (Carlisle et al, 1999). The researchers concluded that Project 2000 had "realised its goal" but that the "profession now has to decide if it wants to move the goal posts" (University of Warwick University of Liverpool 1996, 136). This study highlighted concerns over the clinical skills of those entering employment who had been through the Project 2000 programmes, in comparison to those from the "traditional" routes to registration. Although, at the of this study the respondents would have had limited experience of these new nurses, this theme of a deficiency in the clinical skills of Project 2000 nurses emerged again, in later reports and policy developments. For example, the DoH's publication "Making A Difference" stated that

> "Evidence suggests that in recent years students completing training have not been equipped at the point of qualification with the full range of clinical skills they need." (DoH 1999, 14)

and the UKCC Education Commission Report, "Fitness for Practice" recorded a comment that

> "People tell me that newly qualified-staff don't have all the necessary skills on registration" UKCC 1999 (43).

One contextual change that the Warwick and Liverpool team do not appear to have taken account of, specifically in relation to newly qualified children's nurses, was the beginning of the move to an initial route to registration and employment. With the advent of Project 2000 employers were having to come to terms with employing newly qualified children's nurses who had no prior experience of practice and ward management as a qualified nurse, unlike RGN undertaking a second route to registration and whose knowledge and skills should have been developed and enhanced through the completion of the RSCN programme.

This early review of Project 2000 also has to be considered in the context of other changes taking place in the NHS at the time. The Warwick and Liverpool study had collected data between 1994 and 1996, a period when the health service was going through a process of considerable upheaval due to the implementation of clinical grading for nursing. This was a period when 20% of districts were "engaged in skill mix restructuring in direct conflict with the agreed ground rules" (Gavin 1995, 382), a process that diluted the skill mix and reduced the numbers of higher paid staff (Gavin 1995). As managers in this study noted at the same time there were a range of nursing role developments which also changed expectations of the lower grades of staff, leading managers to reflect that "we may have to rethink what we are expecting" (Carlisle et al 1999, 1261). The variations between D grade job descriptions, found in the survey reported in the previous section of this thesis, may be a reflection of this uncertainty (339-349), affecting the development of nursing roles and the changing expectations of newly qualified nurses, whichever part of the register they entered.

In 1997 the UKCC commissioned a "Report of the analysis of the literature evaluating pre-registration nursing and midwifery education in the United Kingdom" (Gilmore 1999). The Chief Executive/Registrar for the UKCC stated the purpose of this analysis as being "to collect as much evidence as is available in order to air the concerns that have exercised the minds of many" (Gilmore 1999, preface) and assist the work of the UKCC Joint Education Committee in their statutory role of focussing on standards for fitness for practice. Gilmore's uncritical analysis of the evaluative studies was organised into six chapters (table 64).

Chapter	Topics covered
Introduction	Background The literature review The report
Learning in the clinical environment	Practice placement availability Supernumerary status Placement culture Mentors
Curriculum issues	Common Foundation Programme Teaching and learning methods Curriculum content issues
Assessment issues	College based assessment Assessment of student's practical competence
Teaching and supporting students on clinical placement	The role of nurse/midwife teacher in the clinical setting Lecturer practitioners
Some factors affecting the outcomes of pre-registration nursing and midwifery education	Entry level and academic performance Learning disability nursing Midwifery education Knowledgeable doers

Table 64 Chapters of Gilmore's review of evaluative studies of Project 2000

As can be seen from table 64 Gilmore's analysis was able to bring together a wide range of evaluative studies, including a number of projects commissioned on behalf of the four health departments by the four national boards. Although, for example, out of 50 research reports commissioned by the ENB between 1992 and 2002, of the13 particularly related to Project 2000 only one had pre-registration children's nursing as its main focus. Cash et al's study of "The preparation of Sick Children's Nurses to work in the Community (P2000 evaluation)" (Cash et al 1994), focussed on one particular element of children's nursing preparation, with the remainder making limited referrals to the child branch. In reporting her findings Gilmore

noted, that "Very little research has been undertaken to assess the effectiveness of pre-registration education in preparing nurses and midwives for practice" (Gilmore 1999, Ch 6.1), although Gilmore does not clarify whether she is using this term in relation to meeting the standard for registration, or the needs of the employer, in other words fitness for purpose. Gilmore's report summarised findings, many of which related to the practical processes of bringing in a new pre-registration education programme, but offered no specific recommendations in relation to changes that should be considered.

In 1998 the UKCC, whose statutory responsibility was "to set standards for pre-registration education" (UKCC 1999, 6), set up "Fitness for Practice: The Commission for Nursing and Midwifery Education" (UKCC 1999). Interestingly, in an environment where new healthcare roles were developing, the commission did not present a definition of nursing, believing that it "would be too restrictive for the profession" (UKCC 1999, 15). They did, however, note that

> "there seems to be general agreement that Henderson's (1961) definition of nursing has not been bettered:
>
> > "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him regain independence as soon as possible." (UKCC 1999, 15).

In light of the fact that "fields of health care and higher education have continued to change in response to government review and reforms"(UKCC 1999, 6) the UKCC felt that it needed "to provide an authoritative stance on pre-registration education"(UKCC 1999, 6) and

> "To prepare a way forward for pre-registration nursing and midwifery education that enables fitness for practice based on health care need, with particular regard to:
> - the contemporary and anticipated needs of health care
> - an outcomes-based competency approach to fitness for practice
> - sound assessment of practice and its integration with theory
> - the nature of and standards for the teaching of nursing and midwifery
> - positioning in relation to possible inter-professional approaches where appropriate."(UKCC 1999, 6).

The UKCC aims matched those of the DoH who at the same time was setting out its "vision for the future of nursing in the NHS" in England (DoH 1999, 6) stating that

> "The Government has shared with the Commission its plans to improve nurse education and training. The Government's priorities are to:
> - provide more flexible career pathways into and within nursing and midwifery education;
> - increase the level of practical skills within the training p r o g r a m m e ;
> - deliver a nurse training system that is more responsive to the needs of the NHS.
>
> We will work in partnership with the regulatory bodies, the universities and other key organisations to achieve these three goals and to strengthen practice-based teaching." (DoH 1999, 24)

and that

> "we propose to agree outcomes for the end of each of the three years of the education programme in England to ensure that there is a greater consistency in the knowledge and skills that students have at the end of each year of the educational programme." (DoH 1999, 29).

With 12 months to complete their work the UKCC commission undertook a range of visits and received evidence and comment from 259 organisations and 61 individuals, and hosted a series of 24 seminars across the four countries of the UK. "Fitness for practice" (UKCC 1999) was another broad based report containing only five references to children. Of these one related to child care for students, two related to child health and its role in the midwifery

curriculum, one related to the shortage of clinical placements in children's settings and the fifth referred to the child branch as one of the four branches.

The UKCC commission looked at the broad issues of both changing health needs and types of care, the need for more flexible approaches to entry and exit from the programmes and the need to refocus programme outcomes on "outcomes based competency principles" (UKCC 1999, 4), mirroring the DoH ambition, but not as can be seen from the analysis of the job descriptions, reported previously, the realities of employment as a nurse in the NHS. For the commission an outcomes approach was seen as a way of increasing the "student centred" and facilitative focus of education (UKCC 1999, 35), and strengthening the focus on application in practice that was also valid in educational institutions. The commission also pointed to the need to re-establish the partnership between education and the health service, as the

> "gap between education and service has widened since nursing and midwifery education has moved into HEIs and this is a cause for great concern" (UKCC 1999, 40).

In particular they noted that "Responsibility for the recruitment and selection of students lies primarily with HEIs" (UKCC 1999, 22), a finding that seems at odds with the picture presented by the study on selecting child branch students, earlier in this thesis (figure 15, 244). The commission did, however, note different practices between the four countries as "In Scotland, for instance, there is a requirement for service providers to be involved in student interviewing" (UKCC 1999, 22).

With a list of 33 recommendations the UKCC set out what it considered should be the pattern,

the structure, for future pre-registration nursing education. There was now to be a one year foundation programme followed by a two year branch programme with recommendations related to the structures and partnerships that should encompass the delivery of nursing education. In relation to the actual content of programmes the UKCC remained constrained by the European Nursing Directives, for those "nurses responsible for general care" from 1977 (Quinn 1978a, 8) and the later amendments of 1989 (European Nursing Directive 1989), which are specific in the range and focus of theoretical and clinical learning required for registration.

The new nursing programmes

In September 1999, bringing together the government document Making a Difference (DoH 1999) and the UKCC's Fitness for Practice (UKCC 1999), the DoH stated "the value and importance of developing outcomes within a competency framework" (DoH 1999a, 4). In an attempt to stimulate discussion a Health Service Circular (HSC) presented a number of outcomes that could be achieved by the end of the foundation programme, "examples based upon the role of a senior health care assistant within the NHS ..... linked to occupational standards" (DoH 1999a, 4).

New requirements for pre-registration nursing education were developed and for the first time there were statutory requirements set out for entry to the branch at the end of the first year, with competencies for entry to the register to be achieved at the end of the programme (Appendix 8). The UKCC did not wish to include details of expected content for programmes,

rather the overall requirements of the programme were expressed, as previously (HMSO 1983; HMSO 1989) in broad terms as

> "The Common Foundation Programme and the Branch Programme in respect of a course of preparation provided under rule 14B shall be designed to prepare the student to assume the responsibilities and accountability that registration confers, and to prepare the nursing student to apply knowledge and skills to meet the nursing needs of individuals and of groups in health and in sickness in the area of practice of the Branch Programme, and shall, respectively, include enabling the student to achieve the outcomes and competencies set out in the Schedule attached hereto." (The Stationery Office 2000a, 3).

The main difference between this new statute and the requirements for Project 2000 is the reference to the outcomes and competencies, instead of "learning outcomes" (HMSO 1989, 5) as comparison of the new competencies for registration with the learning outcomes from 1989 demonstrates. There are three additions, one of which, key skills, was a new educational concept (table 65) and two making reference to developments in health care practice in the UK, with the remainder being able to be matched against each other, as shown in the examples in table 65 (full list appendix 9). These competencies remain based on the requirements from the EU directive (Quinn 1978a; European Nursing Directive 1989). The required statutory instrument which made these new programmes legal was signed by the Secretary of State for Health on 29th August 2000, coming into force 2 days later. Students entering employment from these new competency based programmes would however, as demonstrated in the earlier study of job descriptions, be taking up roles described in a variety of ways, with a wide range of expectations, that they may still not be fully able to fulfil.

Project 2000 (HMSO 1989, 5)	Fitness for practice (The Stationery Office 2000a, 5-6)
the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability or ageing for the individual, her or his friends, family and community	Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.
the recognition of common factors which contribute to, and those which adversely affect, physical, mental and social well-being of patients and clients and take appropriate action	Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.
the use of relevant literature and research to inform the practice of nursing	Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe nursing practice.
	Demonstrate key skills.
	Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice.
	Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk management strategies.

Table 65 Comparison of 1989 statute with 2000 statute (full list appendix 9)

Although the UKCC had not wished to define nursing or prescribe specific programme content the ENB in its guidance for approved institutions set out its expectations for the different branch programmes. Comparison of these requirements (ENB 2000a) with those of Project 2000 published in 1994 (ENB 1994a) demonstrates a range of similar expectations and

a similar role for the children's nurse as the extracts in table 66 show, with continuing links to family centred care and an understanding of the biological, psychological and social sciences.

Project 2000 (ENB 1994a, 18)	**Fitness for Practice (ENB 2000a, 1)**
Central to the nursing care of the child is the provision of holistic family-centred care. This care not only relates to the health status of the child but also her or her stage of development and family and cultural background informed by an in-depth understanding of the psycho-social biological sciences. All aspects of development should be a predominant theme threading through the branch programme.	The central philosophy of children's nursing is based" upon the principle of family-centred care and the belief that children should be cared for by people they know and, wherever possible, within their home environment. This belief requires children's nurses to understand the complex relationships between personal, socio-economic and cultural influences upon child health and child rearing practice. As such, the holistic assessment, on which nursing care is planned, implemented and evaluated should be informed by relevant biological, social and psychological sciences whilst recognising the moral, personal, scientific and aesthetic domains of nursing knowledge

Table 66 Comparison of Project 2000 and Fitness for practice child branch philosophies

In 1999, while the UKCC evaluation of Project 2000 was ongoing, the DoH in England issued a Health Service Circular (HSC) (DoH 1999a), setting out the expectations for Education Consortia, the commissioners of health care education, in relation to taking forward any changes recommended for nursing and midwifery pre-registration education. Following a selection process the DoH choose sixteen lead partnerships, of Education Consortia, partner HEIs and NHS trusts to take forward the new pre-registration nursing programmes, known

as Fitness for Practice (FFP), with a deadline of September 2000 for their implementation. Those who would be moving to implementing the changes later on were also required to take forward a number of actions. These, like for the lead partnership sites, included developing part time programmes, the introduction of cadet schemes, earlier and longer practice placement, improved links between lecturers and clinical staff and action to ensure that "the NHS and education providers are jointly involved" in the recruitment and selection of students (DoH 1999a, 10). As with the UKCC commission before them, the DoH had focussed on the processes underlying selection, rather than the qualities that successful candidates might be expected to display, apparently ignoring their own previously commissioned research (Child et al 1988) and the findings of previously published research based on the studies reported earlier in this thesis (Price 1999, 2000, 2002; Price and Hicks 2000).

Working with requirements developed but not formally published by the UKCC, and with published ENB guidelines (ENB 2000), the educational institutions and their service partners went forward for approval by the ENB.

Changes to the statutory bodies

In 1997 as part of a commitment issued in the White Paper, "The New NHS" (DoH 1997), the four health departments of the UK commissioned JM Consulting to undertake a review of the statutory arrangements for nursing, midwifery and health visiting with a view to looking at ways to "strengthen the existing systems of professional self-regulation" (DoH 1999a, 5). Amongst the 45 recommendations, many of which related to the size of the proposed new

council, elections to council and processes within council, there were three directly related to pre-registration education, in particular "The council should define standards in terms of the outcomes of courses of nursing and midwifery education" (JM Consulting 1998, 5), a theme picked up by the UKCC in "Fitness for Practice" (UKCC 1999), a year later. JM Consulting's report started the process towards change for the UKCC and the four National Boards.

By 2001 the DoH had produced its plans for the new statutory arrangements for nursing, midwifery and health visiting, at the same time as putting forward its plans for the statutory regulation of twelve other professions allied to medicine. Movement towards the new arrangements had to be agreed between all four countries and take into account the devolved powers of Wales and Scotland in relation to health. The new statutory instrument enabling the formation of the Nursing and Midwifery Council (NMC) was passed just before Christmas 2001, coming into force on 1st April 2002 (The Stationery Office 2002).

Government monitoring, reports and standards

With the closure of the ENB there was a need for new arrangements for the statutory approval and monitoring of programmes in England. The NMC, as part of a process to reduce the duplication of quality assurance processes, is required by statute to work collaboratively with "key stakeholders" (NMC 2003a), something they have done particularly with the DoH in England (NMC 2003a), which contracted with the Quality Assurance Agency (QAA) to undertake reviews of all government funded health care education (DoH 2003d). This collaboration required the development of benchmarks and processes which would meet the

requirements of both the funding and statutory stakeholders. There was also a shift in focus from being purely on the HEI providing the education, to include the partnership with the NHS.

Through a consultative process involving representatives of higher education and nursing practice and the statutory bodies a range of benchmarks for nursing programmes were developed and then tested in prototype reviews undertaken in 2001-2002 as part of the developmental processes of the DoH QAA contract.

These benchmarks published in 2001 which contain expressions of the expectations for the four branch programmes. Children's nursing is described as meeting

> "The developing needs of children from infancy to adolescence, in relation to physical and mental health and special needs, form the heart of children's nursing. Children's nursing is practised within a philosophy of child-focussed and family-centred care in which, whenever possible, the child, parents and carers are equal partners. This partnership enhances self esteem, enables children to reach their full potential and encourages the development of autonomy in care and decision making.
>
> Ill children present with complex multi-dimensional problems, some being life limiting or life threatening, and many which persist through childhood into adult life. These problems impact upon the child's development, choices and family life. This requires children's nurses to work collaboratively with other professionals in health and social care to promote health, minimise illness and protect vulnerable children.
>
> Children's nurses practise within the child's own home, hospital, school, community and voluntary settings. The wide spectrum of health problems, care settings and opportunities for health promotion require nurses to demonstrate confidence and competence in child specific nursing. This involves the coordination of care and the use of refined interpersonal and communication skills with both children and adult carers, underpinned by knowledge of child development.
>
> Children's nurses need to be politically aware, applying knowledge of health and social policy, law and ethics in order to champion the rights of children both as a

group and as individuals receiving care." (QAA 2001, 7).

It could therefore be assumed that this description of children's nursing not only meets the requirements of the statutory body and the profession but also expresses the requirements of the body that funds nursing education and directs the action of the NHS, the Department of Health. This QAA description of children's nursing, is congruent with the definitions of both children's nursing (87-88)and the special needs of children proposed earlier in this thesis (114).

The NHS Plan put forward proposals for "radical reform .... in NHS education to reshape care around the patient" (DoH 2000b, 85). In 2002 the DoH provided funding for four English universities to "develop multi-professional education, where health professionals share skills and knowledge on core subjects" (DoH 2004, 1). Under the direction of a steering group the new programmes, including medicine, nursing and at least two other health care professions will work to develop new ways of learning and common practice skills.

At about the same time as the UKCC were reporting on the evaluation of Project 2000 and the DoH was setting out the way forward for nursing one of the most extensive inquiries into children's health services began. "The Report of the Public Inquiry Into Children's Heart Surgery At the Bristol Royal Infirmary 1984-1995" (The Stationery Office 2001), which became known as The Kennedy Report, after its chairman, cost millions of pounds and made 198 recommendations. Amongst many findings the inquiry made a number of references to the national shortage of children's nurses during the two decades covered by the Inquiry and

the fact that the trust in question had therefore employed nurses who were not trained for the role,

> "Two particular problems were evident throughout the 1980s and the 1990s. First, there were insufficient numbers of paediatrically trained staff (nurses and doctors) to provide a fully paediatric service. Secondly, there was a national shortage of Registered Sick Children's Nurses (RSCN) during the late 1980s and early 1990s." (The Stationery Office 2001, 60).
> "The difficulty throughout the period of our Terms of Reference (and until today) was that shortages in trained nurses meant that employers routinely required nurses to undertake responsibilities for which they had not been fully trained." (The Stationery Office 2001, 194). (The Stationery Office 2001, 231).

Once more there was reference to the fact that government policy was still not being implemented and strong support for the employment of children's nurses to care for children, with the recommendation that

> "The standards should be reviewed as a matter of urgency to take account of changing patterns in the provision of acute healthcare services" (The Stationery Office 2001, 459)

The findings from the two surveys of D grade staff nurse posts (figures 23, 24; 335 and 336) (Price 2002) would appear to imply that the situation in relation to the possible employment of non children's nurses, almost 10 years after the period covered by the Kennedy Report (The Stationery Office 2001), had not changed.

The National Service Framework (NSF) (DoH 2003a) published in April 2003 set out the standard for hospital services for children and young people, in England. With frequent references to both The NHS Plan and the Bristol Inquiry, The Kennedy Report (The Stationery Office 2001), the NSF sets out a standard intended to

> "deliver hospital services that meet the needs of children, young people and their

> parents, and provide effective and safe care, through appropriately trained and skilled staff working in suitable, child-friendly, and safe environments" (DoH 2003a, 8).

There are no references to the numbers of children's nurses that should be in place at any one time, rather the government has moved to the use of the term "appropriately trained and skilled staff" (DoH 2003a, 8), which along with the lack of specific measurable targets can be seen as giving "some cause for concern" (Casey 2003, 3). Again as in 1991 (DoH 1991) the document also contains recommendations, such as

> "Children visiting or staying in hospital have a basic need for play and recreation that should be met routinely in all hospital departments providing a service to children" (DoH 2003a, 14).

There are very few absolute requirements, distinguished by the expression "must", occurring only in areas where there is current legislation (Casey 2003). For example in the area of child protection where hospital chief executives

> "must introduce systems to ensure that no child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child" (DoH 2003a, 19).

Despite possible concerns about how measurable and enforceable the standards will turn out to be the NSF, possibly for the first time, sets out a clear rationale for a specific framework for children's services. Using a range of statements, mirroring the evidence from the analyses undertaken in this thesis, the DoH states that

"Children are different from adults, so they need distinct and tailored services:

- Children's physiology differs from that of adults and changes as they grow and develop.
- Children suffer from a different range of diseases and disorders to those commonly seen in adults. This includes a higher proportion of rare and often complex congenital and inherited disorders.

- Children's mental capacity and level of understanding, for example about their bodies, illness and death, may differ from that of most adults, and changes as they develop.
- Children's legal status, for example, in respect of consent to treatment, differs from that of adults, and changes, in the eyes of the courts, at certain key points in chronological age, and with developmental and emotional factors.
- Children are more vulnerable than most adults, and have a greater need for safeguarding their welfare.
- Children using health services are usually accompanied by a parent or other responsible adult. This person may have distinct legal rights in respect of the child, for instance over consent to treatment. They will also have their own needs, for example, for explanation and reassurance.
- Children are strongly affected by the context in which they live. Usually the most important element of this context is the family; followed by friends, school, neighbourhood and community.
- Children will become adults; and there is a growing understanding of the effects of childhood experiences, including illness, on their adult life." (DoH 2003a, 10).

The NSF, in terms which almost accuse trusts of failing to meet the needs of children in the past, states that "services neglect to see children as a 'whole person' with basic developmental, physical, mental and social needs that are very different from those of an adult" (DoH 2003a, 11). The NSF also advocates that "all staff" working with children should have "appropriate training" which, for example includes "child development, parents as partners in care" (DoH 2003a, 26).

Changes to the branches?

In one of its last major acts before its closure, the UKCC set up Post-Commission Development Group to take up the task of reviewing the four branches of nursing (UKCC 2001). In its report this group reviewed developments in nursing and health care since 1986, when the work on Project 2000 had begun and looked at the agenda for increasing the inter-professional nature of health care education and practice. The group put forward six proposals

for the structure of pre-registration nursing education and in four of the six proposals proposed retaining the child branch, in some form or other.

Each proposed branch structure was considered in relation to responsiveness to patient need, inter-professional opportunities, feasibility, regulatory and resource implications. Issues such as parity with European nursing preparation and the consequent mobility of British nurses, increased student experience in community settings reflecting the drive to more community based provision of health care and opportunities for shared learning with other professions were also considered. The group also discussed the possible impact on recruitment to the branches, particularly in models of preparation that did not include mental health, learning disability or children's routes to initial registration. The Post-Commission Development Group's proposals also made reference for the impact of devolution of responsibility for health care to the four countries health departments and the consequent potential impact of country based policy on the future preparation of nurses. In particular they cited moves in Scotland towards a more social care approach to the care of those with learning disability, rather than the current health service approach.

The report made no attempt to define the differences between the branches of nursing except for commenting that the current branch structure had two age focussed branches, adult and child and two problems based branches, mental health and learning disability. Interestingly, within those proposals without a child, mental health or learning disability branch, the group expressed concern about the development of sufficient specialists for these other areas of

practice (UKCC 2001) apparently implying that a generalist nursing education would in fact be adult focussed, with consequent huge implications for staffing other three current areas of nursing practice. Being unable to take forward any further work on these proposals, due to changes in the structure of the statutory bodies, the NMC as the successor to the UKCC, were recommended to take forward any further work with the caution that

> "Whichever option the NMC adopts, in conjunction with the government health departments in the four countries, will require tough decisions to be made and will be viewed as a major change." (UKCC 2001, 59)

The publication of the work undertaken by UKCC Post-Commission Development Group (UKCC 2001) had caused concern in some quarters that generalist pre-registration nursing education might be recommended as the way forward for British nursing. The RCN Children's Leadership and Management Forum undertook a survey, amongst their members, to determine what impact such a move might have. Their report which looks at findings from a survey of 70 nurses in management positions, in children's nursing, highlights the concerns of this group in relation to the question "Would a newly qualified generalist nurse be able to fulfil the same competencies as a newly qualified children's trained nurse?" (RCN 2003a, 12). Although currently there is nothing that would indicate the requirements of a generalist course, 97% of the respondents detailed 315 specific competencies that they felt would be lacking in the generalist nurse, the main areas are illustrated in figure 34.

The RCN report does not provide details of the way in which the data analysis was performed or the different responses collated; however, figure 34 (400) demonstrates the "main areas" in which managers' concerns were expressed. The largest response was in relation to the non-

children's nurses' competence in working with families and implementing family centred care. They also expressed concerns in relation to a generalist nurse's ability to observe and assess children, the application of clinical skills and the way in which they would care for children's "psychological, social and physical needs" (RCN 2003a, 12). The RCN's question and presentation of the data in this negative format, describing what would be missing from the generalist nurse rather than describing the skills the managers believed that children's nurses would actually have, missed an opportunity to discover the competencies that managers might expect of newly qualified children's nurses. Such additional data, from an alternative source, would have presented an additional opportunity to compare the findings from the survey of D grade job descriptions, presented earlier in this thesis, with a study employing a different methodology.

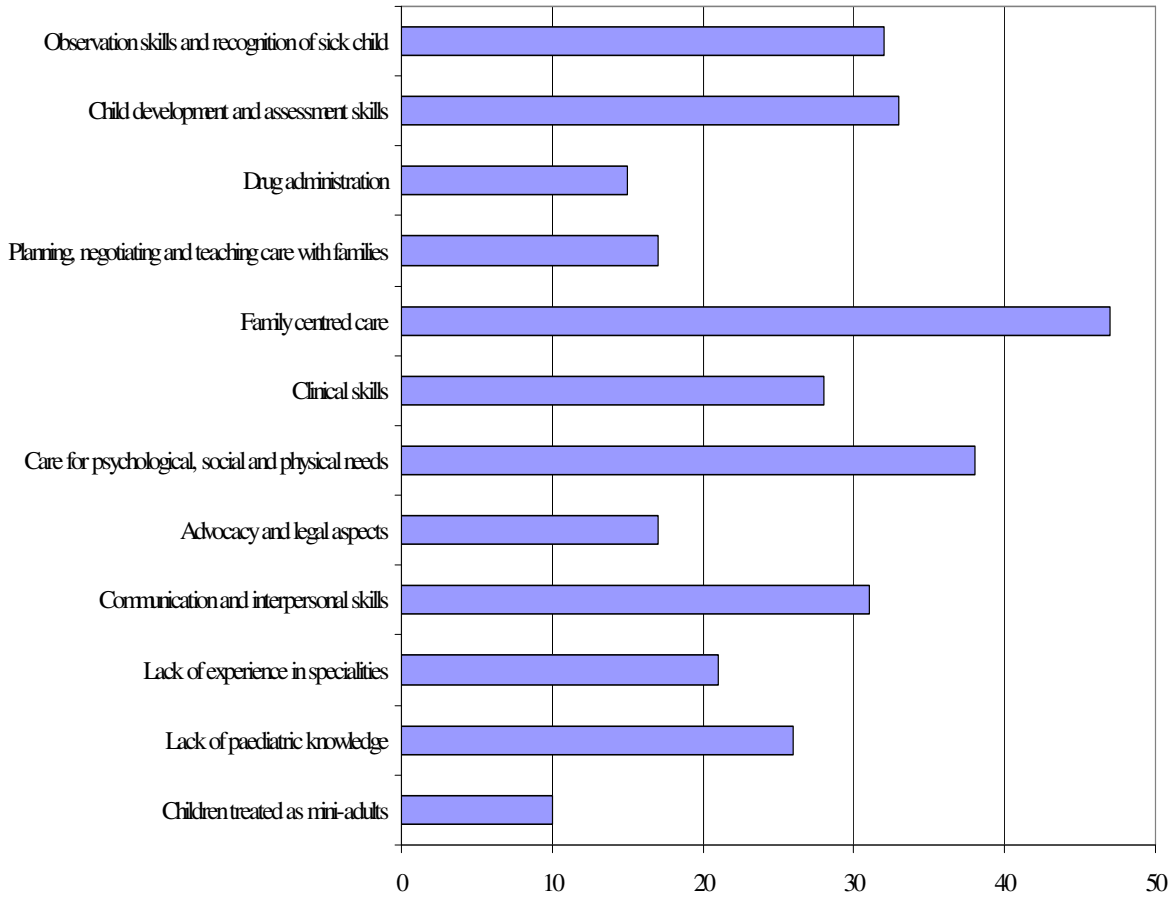

Figure 34 Competencies that a generalist nurse would not have compared with a children's nurse (RCN 2003a)

The concept of children's nursing 2003 at the beginning of the 21st century

"Collect data relevant to identify: a) the attributes of the concept: and b) the contextual base of the concept, including interdisciplinary, sociocultural and temporal (antecedents and consequential occurrences) variations." (Rodgers 2000a, 85).

As stated previously, within the use of the evolutionary model of concept analysis these questions are:-

Antecedent	What happens before children's nursing occurs?
Consequences	What is happening when children's nursing occurs?
	What happens after..... or as a result of children's nursing?
Sociocultural/temporal	Are the expectations of children's nursing different in different situations and with different people?

Having reviewed the literature relating to children's nursing from the later part of the 1990s through to publications concurrent with the period at the end of this thesis the same questions will be asked of the data as were in the previous applications of the evolutionary model of concept analysis.

<u>What happens before children's nursing occurs?</u>

As in the previous analyses and definitions (72, 87-88) there is a threat to children's developmental potential, which may be caused by a either a short or long term problem and may last into adult life (QAA 2001, 7) and that requires interventions specifically focussed on the individual child's needs (114) (Price 1994). Although such problems may generally be expected to be physical, there are over one million children in the UK described as having a

mental health disorder (DoH 2003e). Due to improvements in medicine and technology an increasing number "of disabled children with complex health needs are now surviving into adulthood." (DoH 2003a, 3). Some of these children may develop both learning and physical disabilities and need frequent access to medical, nursing and social care services which may be provided both at home or in a hospital setting. Although there is an increasing emphasis placed on the partnership between children, their parents and the health care professionals (QAA 2001; DoH 2003a), children will require nursing when their needs exceed the abilities of their carers. As previously (87-88), children and their parents access children's nursing in a range of settings in hospital as well as in the community, in an increasingly co-ordinated multi-disciplinary framework (DoH 2003a).

What is happening when children's nursing occurs?

Children's nursing requires the use of a range of skills, based on specific areas of knowledge (eg table 25 (168) and 26 (170)). The needs of both children and their families will be assessed (DoH 2003a) and their care planned, implemented and evaluated (The Stationery Office 2000a), using child focussed knowledge that is "informed by relevant biological, social and psychological sciences" (DoH 2003a; ENB 2000a, 1) (eg tables 25 (168) and 26 (170)). Children's nursing will take account of the child's level of development (RCN 2003a), and their "physical, psychological, social and spiritual needs" (The Stationery Office 2000a, 5-6) (114). Children's nursing requires the use of "appropriate communication and interpersonal skills" (The Stationery Office 2000a, 5-6), educational strategies (UKCC 2001a) and working in partnership with other health care professionals (QAA 2001) (see also tables 25 (168) and

26 (170)), with whom in the future they have undertaken elements of common training (DoH 2004). With the increase in both mental health problems and long term problems in childhood children's nurses will also need knowledge and skills relevant to these areas of care (UKCC 2001). For children with long term problems children's nursing will be part of a process that ensures they and their families are able to transfer effectively to adult health services (DoH 2003a).

What happens after..... or as a result of children's nursing?

As stated previously (eg 80) the threat to the child's health and growth and development is mitigated or removed, by children's nursing, as part of a package of care. Through effective partnerships families and children, who are old enough to take part in their care, learn how to manage their health problems and live lives that enable them to reach their full potential (QAA 2001). Children and their families with longer term health problems will gain independence (The Stationery Office 2000a) and feel confident in providing care and knowing when they need to seek professional assistance.

Are the expectations of children's nursing different in different situations and with different people?

The expectations at the beginning of the 21st century are currently similar to those in the 1990's. The DoH expects that children accessing health services will be cared for by "appropriately trained and skilled staff" (DoH 2003a, 8) because children are different and require the application of different knowledge and skills; however the DoH has not made it

mandatory for trusts to employ children's nurses. Evidence from the previously reported survey of D grade job descriptions where there was some evidence that the employment of non-children's nurses was still possible (335-336) (Price 2002) may mean that some managers continue to see no difference between general and children's nurses. The RCN survey of the children's nursing workforce (Elston and Thornes 2002), highlighting the potential shortfall in the numbers of children's nurses, may force some employers into employing non-children's nurses simply to staff their services. Without a clear mandate from the DoH, there will be no force behind any recommendation.

Children's nursing at the beginning of the 21st century

From the review of the literature facilitated by the use of Rodgers' evolutionary model of concept analysis children's nursing at this point in the 21st century, it is clear that what makes children's nursing different, to other branches of nursing, is its development and use of a child focussed body of knowledge combined with the appropriate skills to apply that knowledge appropriately. In the current pattern of UK pre-registration education the same statement can be made for each of the other three groups.

At the beginning of the 21st century children's nursing continues to reflect the values of the late 20th century with an increased emphasis on the child's independence and can, therefore, be defined as

> The delivery of nursing care following an assessment of the child and their family and based on their special needs. Children's nursing occurs in a range of settings as part of

a multi-disciplinary package of care and where possible involves the child and parents in the planning and delivery of that care. Children's nursing utilises a range of child focussed technological, psychological and educational knowledge and skills to ensure that children's needs are met, that they gain independence and they are able to achieve their potential.

CONCLUSIONS

Introduction

The structure of the nursing register in the UK is based on the assumption that different groups of people require nurses with distinctive knowledge and skills to care for them. Such assumptions in relation to children's nursing have existed in the UK, as has been demonstrated by the literature reviewed in this thesis, since the founding of Great Ormond Street Hospital for Sick Children in the 1850s (27) and the setting up of the nursing register in 1919 (38). The rationale for the development and maintenance of this field of nursing practice, used by both children's nurses and government policy alike (eg DoH 2003a), is that children have special needs which are different to those of other groups and therefore require special nurses.

Children's nursing and children's special needs

The use of Rodgers evolutionary model of concept analysis (Rodgers 1994; 2000a) has demonstrated the evolution of children's nursing and established a definition of children's nursing at the beginning of the 21st century. This definition focusses on the expectations of the stakeholders, in the form of the government and the statutory body, possibly the first time this has been undertaken from the perspective of stakeholders concerned with health service policy development and implementation and regulation. The development of children's nursing has to take account of these stakeholders as they are both the statutory body responsible for setting and maintaining standards, since 1919, (NMC 2003b) and since the beginning of the NHS in 1948 the funder of education and the developer of policy for the delivery of that service. As

new policies, such as the National Service Framework continue to emerge (DoH 2003a), knowledge about children increases changes and children's nursing roles develop this definition should change. Without this initial definition, however, there can be no common starting point, no basis for debate, discussion and agreement on what is and what is not an example of children's nursing and no common understanding from which to evaluate children's nursing's "strengths and limitations" (Rodgers 2000a, 80) and "promote understanding in our colleagues about the phenomena being discussed" (Walker and Avant 1995, 380).

This thesis in developing a definition of children's special needs establishes the proper focus of children's nursing. It will enable children's nurses to be more precise in articulating what these needs are and their real difference compared to those of other groups. That children's nursing is different is in line with bio-pyscho-social knowledge and published statements from the stakeholders. In the National Service Framework (DoH 2003a) the DoH in England has published the first clear statement of their belief in the difference of children. By implication the NMC, through acceptance of the QAA/DoH benchmarks for the different branches of nursing (2001) has set the standard that children's nursing education and practice must meet, both at the point of registration and during practice. The establishment of such standards has to inform the continuing development of knowledge and skills for this specific role.

Implications

Defining concepts such as these leads to the "identification of directions for further enquiry"

(Rodgers 2000a, 98). The number of child branch applications has continually exceeded the number of available places (table 16, 138) Despite this large pool of applicants attrition from child branch diploma programmes averaged almost 17% between 1999 and 2001, a higher figure than any of the other three branches (adult 16%, mental health 16%, learning disability 15%) (ENB 1999; 2000b; 2001). Although the reasons for this level of attrition from the child branch have not been the subject of specific study, the reasons for student attrition from nursing programmes have generally been identified. Common factors such as academic difficulty, wrong career choice, course based problems (eg Glossop 2002), financial difficulties and workload (Robinson et al 2004) have been cited by students leaving their programmes before completion.

This study has demonstrated a different approach and a need to move the discussion from process and why students leave to whether selectors can develop better ways of identifying the inherent qualities of those who would become successful students. Only one paper, identified in a search of the British Nursing Index (February 2004), focussed on the possibility of using a range of existing personality tests. These researchers concluded that was possible to identify "positive aspects of personality" but that "associations are not sufficiently strong to recommend screening for candidates .. at entry" (Deary et al 2003, 81).

Rather than losing students it would be more cost effective to focus on the process of identifying suitable candidates for selection at the earliest opportunity, from their application forms. The inherent qualities which were the focus of the survey, reported in this thesis, (Price

1999, 2000, 2002; Price and Hicks 2000) should be tested further. These qualities could be used as a framework for the analysis of a larger number of candidates' applications. Using actual applications forms from those students who are successfully completing their programme would enable identification of the nature of the evidence for a core of qualities that were present on application and may be better indicators for success.

The processes and structures that underpin the job descriptions of employees in the NHS are, at the time of this study, undergoing potentially massive change with the introduction of a new pay structure known as Agenda for Change. There is a wide range of activity related to the development of competencies for different levels of staff. Such activity includes bodies such as the Royal College of Nursing, and representatives of trusts working with local representatives. Alongside this there are a number of competency frameworks in the process of development, that will inform practice and determine the levels of remuneration. The definitions of children's nursing and the special needs of children may be able to contribute to this debate, a debate that should enable the development of a better and an agreed understanding of what is required of children's nurses both in terms of fitness for practice and fitness for purpose

LIST OF APPENDICES

Appendix 1

Comparison of Project 2000 statutory instrument (HMSO 1989) and ENB content requirements for Adult and Child Branch (ENB 1994a)

Statutory instrument (HMSO 1989, 5)	**Child branch indicative content (ENB 1994a, 19)**	**Adult branch, indicative content (ENB 1994a, 13**
(a) the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability or ageing for the individual, her or his friends, family and community	the study of genetics, genetic counselling and research; possible effects of ill health, disability on the child and family unit and of short and longer term hospital admission;	informatics as it relates to the care of adults in institutional and non-institutional settings and the identification of “at risk” individuals
(b) the recognition of common factors which contribute to, and those which adversely affect, physical, mental and social well-being of patients and clients and take appropriate action	knowledge of the psycho-social biological development of the child from birth to adolescence within the context of the family unit; knowledge of factors which contribute to and detract from the child achieving his/her full potential;	assessment and care planning in relation to the bio-psycho-social **needs of a diverse range of individual and client groups in different health care settings and during all phases of the health illness continuum including the dying patient**
(c) the use of relevant literature and research to inform the practice of nursing	practical application, interpretation and critique of nursing and other disciplines research relating to children	practical application, interpretation and critique of nursing and other disciplines research relating to the care of adults
(d) the appreciation of the influence of social, political and cultural factors in relation to health care	resourcing, budgeting and contracting in relation to health care provision and distribution; the nurse’s contribution to local and national policy making and to the organisation as a learning organisation;	resourcing, budgeting and contracting in relation to health care provision and distribution; the nurse’s contribution to local and national policy making and to the organisation as a learning organisation;

Indicative content for Adult and Child branches compared with the statutory instrument differences highlighted in **bold**

Statutory instrument (HMSO 1989, 5)	**Child branch indicative content (ENB 1994a, 19)**	**Adult branch, indicative content (ENB 1994a, 13**
(e) an understanding of the requirements of legislation relevant to the practice of nursing	legislation relating to children and child care, child protection and abuse;	ethical, legal, political, cultural and environmental issues specifically relevant to Adult Nursing ergonomics, safe use and management of technical equipment and aids
(f) the use of appropriate communication skills to enable the development of helpful, caring relationships with patients and clients and their families and friends, and to initiate and conduct therapeutic relationships with patients and clients	interpretation of concepts of communication, counselling and interpersonal relationships, advocacy and negotiation essential to the better understanding of the process of nursing children	interpretation of concepts of communication, counselling and interpersonal relationships, advocacy and negotiation essential to a better understanding of the process of nursing children
(g) the identification of health related learning needs of patients and clients, families and friends and to participate in health promotion	health promotion, and prevention of ill health as they related to the healthy, episodically acute and longer term ill **child** across the age range and the meeting of health care targets	health promotion, and prevention of ill health as they related to the healthy, episodically acute and longer term ill **individual** across the age range and the meeting of health care targets
(h) an understanding of the ethics of health care and of the nursing profession and the responsibilities which these impose on the nurse's professional practice	moral, ethical, cultural and political considerations relating to the care of children and the family unit	ethical, legal, political, cultural and environmental issues specifically relevant to Adult Nursing

Indicative content for Adult and Child branches compared with the statutory instrument differences highlighted in **bold**

Statutory instrument (HMSO 1989, 5)	**Child branch indicative content (ENB 1994a, 19)**	**Adult branch, indicative content (ENB 1994a, 13**
(i) the identification of the needs of patients and clients to enable them to progress from varying degrees of dependence to maximum independence, or to a peaceful death	knowledge of the psycho-social biological development of the child from birth to adolescence within the context of the family unit; knowledge of factors which contribute to and detract from the child achieving his/her full potential; adaption of essential (core) nursing skills **required to promote the child's** maximum health potential and independence; complex nursing skills required in the care of the highly dependent, traumatised children and technological procedures unique to children's nursing;	assessment and care planning in relation to the bio-psycho-social **needs of a diverse range of individual and client groups in different health care settings and during all phases of the health illness continuum including the dying patient** adaption of essential (core) nursing skills **associated with activities of daily living required to promote the individual patients** maximum health potential and independence; complex nursing skills required in the management **of medical and surgical emergencies and accidents and specialised** technological procedures **unique to adult nursing;**

Indicative content for Adult and Child branches compared with the statutory instrument differences highlighted in **bold**

Statutory instrument (HMSO 1989, 5)	**Child branch indicative content (ENB 1994a, 19)**	**Adult branch, indicative content (ENB 1994a, 13**
(j) the identification of physical, psychological, social and spiritual needs of the patient or client; an awareness of the values and concepts of individualised care; the ability to devise a plan of care, contribute to its implementation and evaluation; and the demonstration of the application of the principles of a problem-solving approach to the practice of nursing	assessment, planning, delivery and evaluation of care of children across the age range, in different health care settings and during all phases of the health illness continuum; application of theories of nursing to the care of the child and family unit;	evaluation of effectiveness of nursing interventions relating to individual patients and within the wider context of quality assurance. Evaluation of the relevance and potential of models of nursing in the provision of care
(k) the ability to function effectively in a team and participate in a multi-professional approach to the care of patients and clients	multi-disciplinary team functioning and emerging differing role boundaries including the role of carers;	multi-disciplinary team functioning and emerging differing role boundaries including the role of carers **and the notion of substitution.**
(l) the use of the appropriate channel of referral for matters not within her sphere of competence	teaching, supervising, assessing and mentorship skills	teaching, supervising, assessing and mentorship skills
(m) the assignment of appropriate duties to others and the supervision, teaching and monitoring of assigned duties	teaching, supervising, assessing and mentorship skills; the organisation, management and leadership of the multi-disciplinary caring team;	teaching, supervising, assessing and mentorship skills; the organisation, management and leadership of the multi-disciplinary caring team;

Indicative content for Adult and Child branches compared with the statutory instrument differences highlighted in **bold**

Appendix 2

Statutory minimum entry requirements for pre-registration nursing education

"**A minimum of five subjects at**

- General Certificate of Secondary Education (GCSE) in England, Wales, or Northern Ireland grade A, B or C; or
- Ordinary level grade A, B or C in the General Certificate of Education (GCE) of England, Wales or Northern Ireland; or
- Grade 1 in the Certificate of Secondary Education (CSE); or
- Ordinary or Standard Grade, grade 1, 2, or 3 in the Scottish Certificate of Education (SCE); or
- Ordinary Grade (bands A, B, or C) in the SCE ; or
- 'Passes' in the examination for the Northern Ireland Grammar School Senior Certificate of Education

Or

- other qualifications the UKCC considers equivalent to those above, or
- a specified 'pass' in the standard UKCC DC Educational Test; or
- the following approved vocational qualifications awarded by the National Council for Vocational Qualifications (NCVQ) or the Scottish Vocational Education Council (SCOTVEC):
  - National Vocational Qualification (NVQ) Level 3
  - General National Vocational Qualification (GNVQ) Advanced
  - Scottish Vocational Qualification (SVQ) Level 3
  - General Scottish Vocational Qualification (GSVQ) Level 3"

Alternative UK Educational Qualifications for Nursing and Midwifery Applicants

Not all alternatives are listed - only those which relate to the data in the responses to the questionnaire

- "a *degree* from a university in the United Kingdom
- a *degree* awarded by the Council for National Academic Award (CNAA)
- a *Higher National Certificate* or *Higher National Diploma* awarded by the Business and Technical Education Council (BTEC)
- a former *Higher National Certificate* or *Higher National Diploma* (HNC/HND)
- a *National Certificate* or *National Diploma* awarded by the Business Education Council (BEC)"

cont'd

Access to Higher Education Courses

"The approved courses that satisfy the entry requirement for pre-registration nursing programmes are all 'kitemarked' Access to Higher Education Courses. The 'kitemark' gives recognition to Access courses which meet the criteria established by the Council for National Academic Awards (CNAA) and the Committee of Vice Chancellors and Principals (CVCP).

The courses are now monitored by the Higher Education Quality Council (HEQC) and meet the entry requirements for Higher Education at diploma or degree level."

(ENB 1995, 10, 11, 13)

Appendix 3

Questionnaire

The selection of Nursing students

The following questionnaire relates only to candidates applying for the 3 year Diploma in Higher Education (Nursing) (P2000) and is part of a larger study looking at student nurses' attitudes to different groups of patients.

The first part of the questionnaire looks at the selection students. The last section focuses on candidates who have chosen the Child branch.

Any information that you provide will be strictly confidential. No college of nursing will be identified within the written report of the study.

PLEASE FOLLOW THE DIRECTIONS CAREFULLY AS YOU DO NOT HAVE TO ANSWER ALL THE QUESTIONS

Thank you for taking the time to complete this questionnaire

Sue Price

PLEASE RETURN TO
Sue Price
Admissions Tutor
Department of Nursing
The University of Birmingham
Birmingham
B15 2TT

BY SEPTEMBER 10TH 1995

1. **How long has your College been running the Dip HE Child branch?**

2. **Which of the following branches do you offer?**

Adult [ ] Child [ ]
Mental Health [ ] Learning disability [ ]

3. **How many groups for each branch do you admit each year and how many students are recruited for each?**

Branch	Groups per year	No of students
Adult		
Child		
Learning disability		
Mental Health		

4. **In total how many applications did you receive for each of the Dip HE branches in 1994?**

Adult branch Learning disabilities
Child branch Mental health

5. **Who selects candidates for interview?**

6. **The table on the next page lists the qualifications which are suitable for entry into preregistration nursing education.**

Please indicate which of these are accepted by your institution for the branches that you run.

AD = Adult branch CB = Child branch
MH = Mental Health LD = Learning disabilities

The column entitled DETAILS is for information related to other acceptable subjects, or any specific grades that you might require.

Qualification	Criteria	Details	AD	CB	MH	LD
GCSE	Any 5					
GCSE Specific subjects	English Language					
	Science					
	Maths					
	Other eg subjects or A Levels					
GNVQ advanced	Health and Social care					
	Science					
	Other					
NVQ level 3	Occupational					
	Other					
BTec						
ACCESS COURSE	On its own					
	combined with					
DC Test	On its own					
	combined with					

7. What personal qualities do you look for in candidates for your Dip HE (Nursing)

ADULT BRANCH

Personal qualities

CHILD BRANCH

Personal qualities

MENTAL HEALTH BRANCH

Personal qualities

LEARNING DISABILITIES BRANCH

Personal qualities

8. Has your selection process for students changed since the implementation of Project 2000?

YES [ ] NO [ ]

IF YES please describe your previous system

SECTION 2

THE SELECTION PROCESS

9. Do you use the same selection method for each branch that you offer?

YES [ ] NO [ ]

If YES GO TO QUESTION 10 Page 5

If NO GO TO QUESTION 11 Page 5

10. Please choose <u>THE ONE</u> selection process that most closely describes what your college uses for the Dip HE.

A) CANDIDATES ARE INTERVIEWED ON THEIR OWN BY A PANEL

Please go to question 12 page 6

B) CANDIDATES ARE ASSESSED ON THEIR PERFORMANCE IN A DISCUSSION GROUP

Please go to question 13 page 7

C) CANDIDATES ARE ASSESSED ON THEIR PERFORMANCE IN A DISCUSSION GROUP AND HAVE AN INDIVIDUAL INTERVIEW

Please go to question 14 page 8

11. Please describe the process that you use

PLEASE GO TO QUESTION 15 PAGE 10

12. CANDIDATES ARE INTERVIEWED ON THEIR OWN BY A PANEL

a) The interviewers are ALL nursing lecturers

Never Always

b) the panel is a mix of nursing lecturers and clinical nurses

Never Always

c) candidates for the adult branch are interviewed by adult nurses

Never Always

d) candidates for the child branch are interviewed by children's nurses

Never Always

e) candidates for the mental health branch are interviewed by mental health nurses

Never Always

f) candidates for the learning disabilities branch are interviewed by learning disability nurses

Never Always

PLEASE GO TO QUESTION 15 PAGE 10

13. CANDIDATES ARE ASSESSED ON THEIR PERFORMANCE IN A DISCUSSION GROUP

a) How many candidates are usually in a discussion group?

0-4 [ ] 5-7 [ ] 8-10 [ ] OTHER

b) How many interviewers are involved in the discussion?

c) How long does the discussion usually last?

d) Groups have the same topic for discussion

Never Always

e) The group leader chooses a topic for discussion

Never Always

f) Candidates are in a group with others who want to do the same branch programme

Never Always

g) The interviewers are ALL nursing lecturers

Never Always

h) The interviewers are a mixture of nursing lecturers and clinical nurses

Never Always

PLEASE GO TO QUESTION 15 PAGE 10

14. CANDIDATES TAKE ASSESSED ON THEIR PERFORMANCE IN A DISCUSSION GROUP AND HAVE AN INDIVIDUAL INTERVIEW

a) How many candidates are usually in a discussion group?

0-4 [ ] 5-7 [ ] 8-10 [ ] OTHER

b) How many interviewers are involved in the discussion?

c) How long does the discussion last?

d) Groups have the same topic for discussion

Never Always

e) The group leader chooses a topic for discussion

Never Always

f) Candidates are in a group with others who want to do the same branch programme

Never Always

g) The interviewers are ALL nursing lecturers

Never Always

CONTINUED OVERLEAF

h) The interviewers are a mixture of nursing lecturers and clinical nurses

Never Always

i) How long is the individual interview?

j) How many interviewers are involved in the individual interview?

k) What might the individual interview discuss?

l) The individual interview is done by nursing lecturers

Never Always

m) The individual interview is done by a mixture of nursing lecturers and clinical nurses

Never Always

PLEASE GO TO QUESTION 15 PAGE 10

THE APPLICATION FORM

15. Please read the following "personal details" and references for prospective CHILD BRANCH students.

For each student
a) indicate how likely you might be to consider them for interview for your college's Child branch.

and

b) give reasons for your decision.

PLEASE ASSUME THAT ALL THE CANDIDATES HAVE ACHIEVED YOUR ENTRY REQUIREMENTS.

CANDIDATE 1 FEMALE Second year of 6th Form	Previous employment - Part time Woolworths
I want to be part of a caring profession and gain a knowledge and understanding of health and sickness. In the last two years I have had experience shadowing a midwife and a district nurse. I have also had a week's experience on a geriatric ward at my local hospital. I would like to be a children's nurse I have held various positions of responsibility at school. In the fifth year I was a prefect and at present I am a member of the school council. In my spare time I am involved with a variety of school sports teams and I have almost completed my Duke of Edinburgh's silver award. I would describe myself as friendly, caring and outgoing	..... is a hard working student. She is a great asset in the classroom as she willingly engages in classroom discussions. She should do well in her forthcoming examinations. ..... is well liked and respected by both peers and staff. She has always indicated an interest in a career in nursing. Her caring attitude, instilling confidence in those who deal with her, combined with her academic ability make her ideal for a career in nursing. Written by the Headmaster
How likely is it that you would want to interview this candidate for your college's child branch? Not Likely ——— Very likely	Please give reasons for your decision about the acceptability of this applicant for interview

CANDIDATE 2 FEMALE Second year of 6th Form	Previous employment NONE
I have chosen to do nursing because I would like a career that combines the skill and knowledge to care for the sick and the ability to communicate with and listen to those who are in pain. I am particularly interested in the nursing care of the child as I like working with children. I spent a week's work experience working in a nursery which I thoroughly enjoyed. I am in my second year as a school prefect. I am also a member of the school orchestra and I have taken part in organising fund raising for the orchestra's trip to France during the Easter holiday. In my spare time I like reading novels and I like going to the theatre.	..... is caring and considerate, well aware of the demands made by a career in the medical profession. She has a strong sense of responsibility which she demonstrates in her role as a prefect and a member of the school orchestra. ..... is quiet in class, preferring to try and solve problems with her work by herself before seeking assistance from the staff. All in all I have no hesitation in recommending her to you. She has the qualities to make an admirable member of the nursing profession. Written by HEADMASTER
How likely is it that you would want to interview this candidate for your college's child branch? Not Likely ——— Very likely	Please give reasons for your decision about the acceptability of this applicant for interview

CANDIDATE 3 MALE 6th FORM	Previous employment Part time MacDonalds
I have always wanted to enter the medical profession. When I have completed my course I would like to go on to be a hospital manager. I have been captain of the school football team for almost two years and I also represent the school in athletics. My part time job at MacDonalds has helped me to develop patience with members of the general public. I am hoping that I might be able to arrange some work experience in my local hospital during the next school holiday. I would particularly like to be a children's nurse.	.....entered the 6th form with 6 GCSEs grade C or above. His decision to apply for nurse training has only been made in the last few months. .... has always been involved in out of school activities and takes the responsibilities that these activities require very seriously. The school is hoping that they can help .... secure appropriate work experience during the forthcoming holiday Written by Headmaster
How likely is it that you would want to interview this candidate for your college's child branch? Not Likely ——— Very likely	Please give reasons for your decision about the acceptability of this applicant for interview.

CANDIDATE 4 MALE 2nd year of 6th form	Previous employment
Since spending time in hospital 4 years ago I have decided that I would like to become a children's nurse. I believe that it is important for there to be male nurses, particularly for adolescent boys. I have been able to get some work experience in my local hospital and I have worked in a number of departments such as XRay and pathology as well as on a surgical ward shadowing a nurse. I am a member of the school's "enterprise" group as well as helping with the library and contributing to the school magazine. In my spare time I like to go the cinema or to the theatre.	..... is a quiet boy, who is hardworking and should have reasonable success in his 6th form examinations. ..... has always shown a mature sense of responsibility as evidenced by his involvement in school activities. ..... is unshakable in his determination to become a children's nurse. The visits to various hospital departments were organised by ..... He has used his work experience effectively and has a thorough understanding of the commitment he would be making. Reports from his hospital placements describe .... as being very interested in all aspects of hospital work. .....'s teachers describe him as a "pleasure to teach" Written by Headmaster
How likely is it that you would want to interview this candidate for your college's child branch? Not Likely ——— Very likely	Please give reasons for your decision about the acceptability of this applicant for interview

CANDIDATE 5 MATURE FEMALE 25	Previous employment employed as Nursery Nurse
Since leaving school with 2 O levels at the age of 16 I have always wanted to be a nurse. When I was 18 I went back to college part time and passed my nursery nursing course. I have worked as a nursery nurse in a local hospital, partly involved in preparing children for surgery, through the use of play. Now I want to go on and qualify as a children's nurse, specialising in Intensive care nursing or oncology. In my spare time I am involved with running a brownie pack and I am also a Sunday school teacher when my off duty allows. My hobbies include painting and photography. I am planning to take a GCSE in human biology before starting my training.	..... has worked at ..... hospital since qualifying as a nursery nurse. She is hardworking and very caring. She is able to use her skills particularly well in preparing children for surgery. ..... has attended a number of study days related to aspects of her work. ..... would make a good children's nurse. I support her application for Project 2000. Written by present employer Nurse manager
How likely is it that you would want to interview this candidate for your college's child branch? Not Likely ——— Very likely	Please give reasons for your decision about the acceptability of this applicant for interview.

CANDIDATE 6 FEMALE 2nd year of 6th form	Previous employment
I am very involved in school activities. I am captain of the hockey team and tennis team and represent the county in both these sports. I am a member of the school council, as well as having been a prefect for the past year. I am also involved in the show that the 6th form is putting on in the Summer Term. I am hoping to have some work experience in the Easter holiday, possibly working with handicapped children, taking part in a local sports scheme. I have also done some work with junior school children helping them to read. I have always wanted to be a nurse and would like to be a children's nurse.	.... is very involved with all aspects of school life. Her involvement with any such activities usually guarantees success. ..... is also an enthusiastic student and is often quite vocal in classroom discussion. She should gain reasonable results in her examinations, though sometimes she seems to fail to express herself in writing. .....'s plans are well in hand for organising her work experience. Written by Headmaster
How likely is it that you would want to interview this candidate for your college's child branch? Not Likely ——— Very likely	Please give reasons for your decision about the acceptability of this applicant for interview

THANK YOU FOR TAKING TIME TO FILL IN THIS QUESTIONNAIRE
Could you please provide the following details

YOUR
Name

Title

Qualifications

How long have you been in your present post in candidate selection?

Appendix 4

Analysis of the responses to question 7 "What personal qualities do you look for in candidates for your Dip HE (Nursing)?"

Raw data

b	Knowledge of caring and some idea of type of nursing involved. Preferably work experience
d	Motivation, communication, reasons for choosing branch, awareness (health issues)
e	Evidence of motivation and interest, some communication skills, some evidence of reliability, some evidence of caring about others.
f	academic reference indicates potential for further study the application form is well structured, fluent, clearly concisely written and presented legibly without spelling or grammatical errors no evidence of any potential health problem clearly indicates why they have chosen nursing and the specific branch indicates some knowledge of the structure and content of current nursing courses substantiates their motivation to the specific branch, initiative dependability, commitment, self reliance confidence involvement in social activities/sports activities contact with people in a caring situation
g	Communication skills, individual maturity, self and social awareness, interest and motivation in nursing, sense of humour, proven ability to study, experience working with the public, patience, tolerance and even tempered, good health and attendance, social and solitary hobbies
h	Candidates are expected to show clear rationale for the branch they have selected and insight into nursing and health care
i	Recognition that children are not mini adults, patience, adaptability, good communication and listening skills
j	Ability or potential to assess situations, including judgement, creativity and decision making. Ability to plan and carry out actions, including logical reasoning, tolerance, leadership and organisational skills
k	Ability to communicate awareness of child/family issues, insight and self awareness
l	Motivated, ability to think critically, good communication skills, able to write satisfactory level of English, Interest in the world they live in, a desire to study at this university, courteous. Have had some significant contact with children (nursery, brownies, classroom helper - anything really) and insight into the problems of children/families/carers

m	Honesty, integrity, commitment to study and care of selected group of patients
n	Motivation to study and commitment to children
o	The applicant should show insight into: understanding of communication system with children, developmental needs of children, needs of family, own views of children, understanding sick children
p	evidence of motivation/interest in paed nursing, social insight into childhood/family life, insight into self, social awareness, current affairs awareness, work experience, good attendance record at school, ability to communicate, general appearance, stability (psychological/personal)
r	Insight into profession, insight into course, commitment, valid experience
s	Effective communication skills, commitment and motivation, insight into nursing, sense of humour
t	Previous experience with infants/children (babysitting etc), insight into course demands, kindness/empathy on application form
u	Articulate, have sound argument and reason, assertive, questioning, sense of humour, good communication skills, knowledge what course involves in both theory and practice, understanding of role, some experience related to caring if possible. can demonstrate the difference in needs of children and adults, current issues related to children, adaptability to needs of different age group
v	motivation, understanding of role, academic ability communication skills
w	realistic approach to training, ability to work as part of a team, evidence of coping mechanisms, flexible approach, able to show initiative, evidence of self motivation and constructive enthusiasm, ambition, previous experience in health care, undertaken voluntary activities, interpersonal skills, communication skills, the ability to study effectively, knowledge about nursing
x	Understands that children are persons in their own right not just sweet little givers of love, Balanced views on current issues about health service
y	Friendliness, professionalism, warmth, sense of humour, creativity, dynamic, articulate, empathy, affinity with children understanding of children

Sentence busted

B	Knowledge of caring some idea of type of nursing involved work experience preferably
d	Motivation communication reasons for choosing branch awareness (health issues)
e	motivation and interest evidence of some communication skills some evidence of reliability some evidence of caring about others
f	academic reference indicates potential for further study the application form is well structured, fluent, clearly concisely written and presented legibly without spelling or grammatical errors health problem no evidence of any potential branch clearly indicates why they have chosen nursing and the specific knowledge of the structure and content of current nursing courses indicates some branch substantiates their motivation to the specific initiative dependability commitment self reliance confidence social activities/sports activities involvement in caring situation contact with people in a caring situation
g	Communication skills individual maturity self and social awareness interest and motivation in nursing sense of humour proven ability to study experience working with the public patience, tolerance and even tempered good health and attendance social and solitary hobbies

h	clear rationale for the branch they have selected insight into nursing and health care
i	Recognition that children are not mini adults patience adaptability good communication and listening skills
j	Ability or potential to assess situations judgement creativity decision making Ability to plan and carry out actions logical reasoning tolerance leadership and organisational skills
k	Ability to communicate awareness of child/family issues insight and self awareness
l	Motivated ability to think critically good communication skills able to write satisfactory level of English Interest in the world they live in a desire to study at this university courteous Have had some significant contact with children (nursery, brownies, classroom helper - anything really) insight into the problems of children/families/carers
m	Honesty integrity commitment to study and care of selected group of patients
n	Motivation to study commitment to children
o	understanding of communication system with children developmental needs of children needs of family own views of children understanding sick children

p	evidence of motivation/interest in paed nursing social insight into childhood/family life insight into self social awareness current affairs awareness work experience good attendance record at school ability to communicate general appearance stability (psychological/personal)
r	Insight into profession, insight into course commitment, valid experience
s	Effective communication skills commitment and motivation insight into nursing sense of humour
t	Previous experience with infants/children (babysitting etc) insight into course demands kindness/empathy on application form
u	Articulate have sound argument and reason assertive questioning sense of humour good communication skills knowledge what course involves in both theory and practice understanding of role some experience related to caring if possible. demonstrate the difference in needs of children and adults current issues related to children adaptability to needs of different age group
v	motivation understanding of role academic ability communication skills

w	realistic approach to training team ability to work as part of a coping mechanisms evidence of flexible approach initiative able to show motivation evidence of self and constructive enthusiasm ambition health care previous experience in voluntary activities undertaken interpersonal skills communication skills, study effectively the ability to nursing knowledge about
x	Understands that children are persons in their own right not just sweet little givers of love Balanced views on current issues about health service
y	Friendliness professionalism warmth sense of humour creativity dynamic articulate empathy affinity with children understanding of children

sorted by word processor and divided into qualities

able to write satisfactory level of English

academic ability
academic reference indicates potential for further study

adaptability

age group adaptability to needs of different

ambition

appearance general

argument and reason have sound

articulate
Articulate

assertive

assess situations Ability or potential to

attendance record at school good
attendance good health and

branch reasons for choosing
branch substantiates their motivation to the specific
branch clearly indicates why they have chosen nursing and the specific

caring about others some evidence of
caring Knowledge of
caring situation

child/family issues awareness of
childhood/family life social insight into
children current issues related to
children and adults demonstrate the difference in needs of
children Understands that are persons in their own right not just sweet little givers of love
children developmental needs of
children commitment to
children own views of
children/families/carers insight into the problems of

children Have had some significant contact with(nursery, brownies etc)
children affinity with
children understanding sick
children understanding of

commitment
commitment
commitment to study
commitment to care of selected group of patients
commitment and motivation

communicate ability to
communicate Ability to
communication skills good
communication skills,
communication skills
communication and listening skills good
communication skills some
communication skills effective
communication skills good
communication
communication system with children understanding of
Communication skills

confidence

contact with people in a caring situation

coping mechanisms evidence of

course involves in both theory and practice knowledge what
course demands insight into
course insight into

courteous

creativity
creativity

current affairs awareness

decision making

dependability

dynamic
empathy

experience some related to caring if possible.
experience valid
experience with infants/children (babysitting etc)Previous
experience working with public

family needs of

flexible approach

Friendliness

health problem no evidence of any potential

health care previous experience in

health service Balanced views on current issues about

health issues awareness

hobbies social and solitary

Honesty

humour sense of
humour sense of
humour sense of
humour sense of

initiative able to show
initiative

insight and self awareness

integrity

interest and motivation in nursing

Interest in the world they live in

interpersonal skills

judgement

kindness/empathy on application form

knowledge of the structure and content of current nursing courses indicates some

leadership

logical reasoning

maturity individual

Motivated
motivation/interest in paed nursing evidence of
motivation and interest evidence of
motivation evidence of self and constructive enthusiasm
motivation
Motivation

nursing and health care insight into
nursing knowledge about
nursing insight into

organisational skills

patience
patience

plan and carry out actions Ability to

profession Insight into

professionalism

questioning

rationale for the branch they have selected

Recognition that children are not mini adults

reliability some evidence of

role understanding of

self reliance

self and social awareness
self insight into
social activities/sports activities involvement in

social awareness

some idea of type of nursing involved

stability (psychological/personal)

study effectively the ability to

study at this university a desire to

study proven ability to
study Motivation to

team ability to work as part of a

tempered even

the application form is well structured, fluent, clearly concisely written and presented legibly without spelling or grammatical errors

think critically ability to

tolerance
tolerance

training realistic approach to

understanding of role

voluntary activities undertaken

warmth

work experience
work experience preferably

Qualities looked for by institutions compared with the inherent qualities derived from the literature

Quality Identified from the literature	**Responses to Qu7 considered to match the expectation of that quality**	**Institution requiring this quality**
Academic ability	academic reference indicates potential for further study proven ability to study ability to think critically articulate have sound argument and reason questioning logical reasoning academic ability the ability to study effectively	f g l u u j v w
Caring attitude		
Motivation	interest and motivation in nursing commitment to study commitment and motivation motivated motivation commitment commitment evidence of self motivation and constructive enthusiasm	g m s l v f r w
Confidence	confidence	f
Psychomotor skills/physical dexterity		
Observational skills		
Athletic/ social/ other interests	social and solitary hobbies involvement in social activities/sports activities	g f

Quality Identified from the literature	Responses to Qu7 considered to match the expectation of that quality	Institution requiring this quality
Voluntary/ community work	work experience work experience preferably experience working with public previous experience with infants/children (babysitting etc) have had some significant contact with children (nursery, brownies etc) undertaken voluntary activities	p b g t l w
Knowledge of/ experience of nursing	some experience related to caring if possible knowledge of caring some evidence of caring about others insight into nursing and health care insight into nursing awareness health issues balanced views on current issues about health service contact with people in a caring situation valid experience previous experience in health care knowledge about nursing	u b e h s d x f r w w
Initiative	initiative able to show initiative	f w

Quality Identified from the literature	Responses to Qu7 considered to match the expectation of that quality	Institution requiring this quality
Understanding what nursing children involves	awareness of child/family issues social insight into childhood/family life demonstrate the difference in needs of children and adults commitment to children understanding sick children own views of children developmental needs of children understands that children are persons in their own right not just sweet little givers of love insight into the problems of children/families/carers current issues related to children understanding of communication system with children needs of family recognition that children are not mini adults some idea of type of nursing involved understanding of role understanding of role understanding of children	k p u n o o o x l u o o i b v u y
adaptability	adaptability flexible approach	i w
emotional stability	stability (psychological/personal)	p
caring skills		
Awareness of others contributing to care		
Ability to work with people of all ages.	adaptability to needs of different age group affinity with children	u y

Quality Identified from the literature	Responses to Qu7 considered to match the expectation of that quality	Institution requiring this quality
Motivation **Wanting to work with child and family**	reasons for choosing branch commitment to care of selected group of patients rationale for the branch they have selected evidence of motivation and interest evidence of motivation/interest in paed nursing motivation clearly indicates why they have chosen nursing and the specific branch substantiates their motivation to the specific branch	d m h f p d f f
Self Aware	insight and self awareness insight into self self and social awareness	k p g
sociability		
Communication skills	the application form is well structured, fluent, clearly concisely written and presented legibly without spelling or grammatical errors communication skills ability to communicate ability to communicate communication some communication skills good communication skills good communication and listening skills good communication skills communication skills able to write satisfactory level of English effective communication skills communication skills articulate	f f k p d e l i u g l s w y
Interpersonal skills	interpersonal skills	w
Friendliness	friendliness	y
Warmth	warmth	y
reliability	some evidence of reliability	e

Additional	Qu7 Responses	Instit
Personal qualities	ambition	w
	sense of humour	g
	sense of humour	s
	sense of humour	u
	sense of humour	y
	honesty	m
	tolerance	g
	tolerance	j
	courteous	l
	patience	g
	patience	i
	integrity	m
	assertive	u
	kindness/empathy on application form	t
	leadership	j
	individual maturity	g
	judgement	j
	even tempered	g
	social awareness	p
	ability to work as part of a team	w
	evidence of coping mechanisms	w
	dependability	f
	self reliance	f
	professionalism	y
	dynamic	y
	creativity	y
	empathy	y
appearance	general appearance	p
attendance and health	no evidence of any potential health problem	f
	good attendance record at school	p
	good health and attendance	g

Additional	Qu7 Responses	Instit
the course	knowledge what course involves in both theory and practice	u t
	insight into course demands	n
	motivation to study	l
	a desire to study at this university	f
	indicates some knowledge of the structure and content of current nursing courses	w
	realistic approach to training	
skills	ability or potential to assess situations	j
	creativity	j
	decision making	j
	organisational skills	j
	ability to plan and carry out actions	j
Current affairs	interest in the world they live in	l
	current affairs awareness	p

Appendix 5

Analysis of the responses to question 15:-"Please give reasons for your decision about the acceptability of this applicant for interview"

Institution - B Mean 4.1 Median 2.9 Stdev 3.6

C 1	9.3	D of E, Offices at school, Caring experience, ?why she wants be a CN at interview
C 2	7.5	?Why sick children at interview ?why no previous job
C 3	0.5	Wrong reasons Manager/No experience yet
C 4	4.2	?Why in hospital, why males should look after boys
C 5	1.6	Needs to prove her academic ability
C 6	1.5	reapply next year after work experience

Institution - C Mean 5.6 Median 8.4 Stdev 3.5

C 1	4.3	I would have her to the 3 year course, but would want to see her after her sampling of sick children's as she has no experience with children she may want adult to go into midwifery
C 2	9.8	I would take her to the 3yr programme but would want to see her again after her CB sampler. She has experience of well children but sick children may give her a problem. Also I would want to see her development in the team on the ward
C 3	1.7	This boy may develop when he leaves school. Would take him into the 3yr programme, but would definitely want to see his clinical teacher after CB sampler and also his clinical mentor that he is committed and able to deal with sick children. No mention of care! But may be immature or "coasting"!
C 4	10	Has all the background I would hope for!! Has experience and maturity commented on. Looks good but would review again after child sampler as he may go into mental health if he is committed to adolescence - unfortunately this happens locally. We would talk about his goals after 18 months
C 5	10	This lady will probably be good - has all the right credentials. From her background she will be relieved to finish the CFP
C 6	7	Would have her onto the 3yr programme. I would need to see her again after child sampling as her experience is only with well children. She does not really know her mind I would say and may chose any branch from this background. I like involvement and enthusiasm

Institution - D Mean 5.8 Median 4.5 Stdev 2.9

C 1	7.2	Would need sickness/attendance record

C 2	6.8	?Quiet ?Sickness/attendance record
C 3	1.7	No experience caring/voluntary work. ? Work with children
C 4	1.4	? CNs nurse all ages of children (babies)
C 5	7	Would need academic ref
C 6	2.2	?academic ability, No experience caring / reasons

Institution - E Mean 4.7 Median 5.7 Stdev 2.1

C 1	6	Good reference "Long held ambition to nurse" Some experience with nurses/midwives indicating interest and motivation. Good prospective academic base Endearing personal qualities Probably weakness - no link demonstrated with children -would explore at interview and look out for in group situation
C 2	7.2	Generally supportive reference. Demonstrated interest in nursing. Participates at school in a range of activities. Seems to have reasonable personal qualities eg sense of responsibility
C 3	2.4	Seems unclear about what he wants to do. Has he made any real effort to get information available? Might interview - he has some strengths but might suggest try again when he has "dipped his toe in the water"
C 4	6.9	Good reference, good commitment, good motivation. Bit worried about the circumstances of his decision would gently explore at interview
C 5	5.4	Good background. Weak academically probably but strong motivation. Probably got good organisational skill. Interest in children. Supportive reference
C 6	2.7	Good in some respect (personal strengths etc) but why nursing

Institution - F Mean 5.2 Median 5.7 Stdev 2.2

C 1	5.4	Reference fine No orientation to child health evident Commitment/rationale for paeds not well elucidated
C 2	3.5	Doesn't reflect contemporary orientation of nursing to health. Romanticised view, but acknowledge minimal paed experience, although one week only. ?Other child health experience> Slight concern re academic reference and solitary problem solving
C 3	2	Reservations re: medical orientation, "shopping around" career wise. under commitment to work experience "might" "hoping" poor rationale for choice of paeds

C 4	8	Evident commitment to chosen career. Taken opportunity to explore hospital environments. Clear commitment to paediatrics. Wonder if breadth of CN is realised as interest stems from a specific personal experience
C 5	5.9	Clear commitment to children. Seems to have potential. Concerns re academic journey ahead and what is involved. ?insight into difference between play specialist and paed nurse role
C 6	7	Generally appears fine. Slight concern re "over confidence" (would explore at interview) Unclear focus on nursing and rationale for choice of career, although demonstrates clear commitment to children

Institution - G Mean 5.5 Median 6.7 Stdev 2.6

C 1	5.9	Would offer an interview but appears uncertain about which branch to pursue
C 2	7.5	Would appear a good C potentially
C 3	1.5	Does not display insight gained through thorough research into nursing
C 4	7.5	Worthy of an interview
C 5	8.3	nr
C 6	4	No elaboration on nursing

Institution - H Mean 5.3 Median 5.0 Stdev 3.6

C 1	1.7	Not clear why she wants to undertake the child branch. Wants to be part of caring profession. Not convincing it has to be nursing
C 2	8.7	Would interview and then would need to ascertain feelings about sick children
C 3	1	Seems confused about career and what being a CN might lead to. Needs to give more rationale about choice of career and branch entry
C 4	7.7	Recognises area where he will be able to specialise. Some work experience. Academic reference
C 5	8.1	Determined, understand through previous employment pressures of being children's nurse
C 6	2.2	No experience as yet academically may be weak

Institution - I Mean 5.5 Median 7.1 Stdev 3.2

C 1	8.5	Indicates that she would have some degree of insight into nursing, though gives little indication of why CN. Previous work experience may help in terms of communication skills. Reference from headmaster outlines willingness in discussions and a long standing interest in nursing
C 2	7.1	Able to give an overall summery. Though she has some experience working with children this is minimal. No other work experience. Headmaster indicates that she knows when to seek help and that she copes well with responsibility
C 3	0.7	Indicate initially desire to enter medical profession, unsure as to commitment to CN in particular, but also to nursing as a whole. ?age
C 4	7.1	Has had some experience of "hospital" work. Would be interested to follow through needs of adolescent boys. reference highlights motivation to become a CN. Presumably adolescent himself when hospitalised
C 5	9.5	Demonstrates some determination in terms of gaining academic qualifications. has experience of both well and ill children. Could utilise painting abilities. Reference a little brief. Able to give some indication as to future prospects. Maturity may well be an asset
C 6	4.2	Gives little specific indication as to why she wants to be a CN but does plan to have some work experience. ?Consider LD nursing. Some concern from reference eg difficulty with expression in writing and also aspect re classroom discussion

Institution - J Mean 7.0 Median 8.4 Stdev 2.1

C 1	9.3	Certainly appears to be keen to join caring profession. Not sure about her choice of CN. I would need to investigate this choice further
C 2	8.8	Generally speaking the information provided demonstrates an individual with the potential to do well on the course. I would need evidence that the CB was the right choice
C 3	3.6	I would suggest this young man receives some career counselling and advice before his application is decided upon
C 4	7.9	He has made some very positive moves to help him in his decision making. Well supported by headmaster

C 5	8.8	Assuming the Nursery Nurse qualification is a BTec Dip, she would be invited to a selection day because she demonstrates 1) an ability to cope academically and 2) a commitment to work with children 3) has "professional" support and backing to follow a CN career 4) has a well thought through idea of what her career will entail
C 6	8	To date had demonstrated sufficient evidence of her ability to cope with the course and that CN is the right career choice.

Institution - K did not enter full set of scores Mean 7.3 Median 9 Stdev 2.98

C 1	9.0	Has indicated a preference which at this stage may need consolidation by an interview/selection process
C 2		
C 3	2.6	No real substantive rationale for a career in nursing let alone the CB
C 4	9.3	Based on actual experience which has been explored in a more work lead capacity subsequently and therefore has clearly considered what he wishes to do
C 5	9.5	Experience in a related field would be a useful rationale for this proposed career change of direction. May need academic support but nursery nurse would be a BTec and therefore qualification as suitable entry
C 6	6.0	Probably would invite for selection day but not sure whether the decision is well thought out

Institution - L Mean 6.3 Median 5.0 Stdev 4.9

C 1	1	Does not meet our criteria. No reason to believe that its CN she <u>really</u> wants
C 2	9	Meets our criteria for interview
C 3	0	Doesn't meet our criteria. Wants to be medic not nurse
C 4	0	Doesn't meet our criteria
C 5	9.5	Meets criteria
C 6	9.5	Meets criteria

Institution - M Mean 4.9 Median 6.2 Stdev 3.2

C 1	7.7	Although not clear about rationale for application for CN, she has had some experience of caring through part time work, has mixed with the public and gained insight into work ethic. D of E award and Reference support application

C 2	5	No experience of caring or experience of work with children - only one week with well children. Personality - quiet, prefers to work alone - could have problems in nursing which relies on team approach
C 3	1	?Needs career counselling re how to enter management training scheme, appears to have qualities required. No rationale for nursing no experience in caring
C 4	8	Rationale for application shows insight into the needs of sick children. Has gained experience in a variety of settings achieving good reports on progress made
C 5	7.3	Has knowledge and experience of the care of children in a normal environment and in hospital. Professional reference good. Would need to show evidence of further study - attainment in Human biology ?may need Eng lang
C 6	1.2	No involvement with the public other than in sports teams- contact with children minimal. No experience of caring. Rational for application unclear ?supported by reference. No indication about the type of work experience being planned

Institution - N Mean 5.9 Median 8.1 Stdev 3.9

C 1	10	Has found appropriate caring experience. Provide relevant information. Appears to "get on" socially and is a contributor in class. Positive ref.
C 2	8.2	Demonstrated interest in children but a little restricted. Doesn't say why she likes working with children. Positive reference
C 3	4.2	Perhaps has potential but application does not seem to have a very realistic idea about nursing
C 4	10	Has sought the right "types" of experience. Motivation very apparent. Supportive reference. Would need to explore academic ability
C 5	0	Would not at present cope with academic demands of the programme. I would like to meet with this C and discuss how she might prepare herself for a future application after a period of further study
C 6	8	Motivated but not very clear about why nursing. I would be worried about the Headmasters statement about academic skills. seems to be a good team worker

Institution - O Mean 7.1 Median 8.5 Stdev 2.5

C 1	8.5	Although placements do not clearly reflect the applicants interest in CN overall the application appears satisfactory
C 2	8.4	Application satisfactory. Shows special interest in children
C 3	2.7	Application unconvincing. Little evidence of special interest in children
C 4	8.9	Application overall satisfactory. Impressed by his endeavour to gain work experience in a hospital. Would prefer more experience with children specifically
C 5	9.5	Very good application Excellent background for CB
C 6	6.8	Satisfactory application. Overall shows willingness to gain more experience with children

Institution - P Mean 6.9 Median 7.1 Stdev 3.1

C 1	8.5	Motivated -work experience, trust worthy position of responsibility. Hard working and perseverance -D of E award. Caring, friendly attitude. self aware.
C 2	8.9	Motivated - work experience in a nursery. Ability to organise self and probably others. Socially interested/responsible caring and considerate. Ability to concentrate and work alone.
C 3	6.7	This C appears interested in medicine, hospital management and nursing. As he is unsure what he really wants to do he needs to explore these areas through work experience. I would possibly offer him an interview as he has experience with people and can work in team
C 4	7.5	Well motivated. determined. Participates in group activities. Appears socially aware. Self aware. The concept of "male nurse" and "adolescent boys" would be explored at interview
C 5	0.5	At present this C would not fulfil our criteria for interview. I would advise her to reapply after taking her GCSEs
C 6	5.9	Appears motivated towards CN. If invited for an interview I would ask her to bring some written work along

Institution - Q Mean 5.6 Median 4.6 Stdev 3.3

C 1	4.6	Commitment to nursing clear, but commitment to children's nursing not particularly obvious
C 2	4.5	One week's experience of child care only
C 3	0.9	Commitment to nursing not obvious

C 4	8.6	
C 5	8.5	Appears well motivated to care of children. Good experience.
C 6	1.7	Good intentions but little evidence

Institution - S Mean 5.3 Median 6.3 Stdev 2.0

C 1	2	Doubtful of insight into nursing related to children
C 2	7	Although maybe quiet communication ability could be assessed at interview
C 3	5.1	Has future in sight. Interview may enable insight into nursing to be gained. May be more suited for a different role in caring
C 4	7.7	Appears to have commitment and aptitude
C 5	6.8	Insight into nursing should be evident. Academic commitment would be queried at interview
C 6	5.7	Not sure about this. Would discuss with colleagues. Cannot gain picture of this C

Institution - T Mean 5.8 Median 6.5 Stdev 1.9

C 1	6.7	Previous experience of caring, specific interest in CN (Needs to have only applied for CN)
C 2	7.4	Insight into course applied for. Experience of caring
C 3	2.2	Limited insight into demands of course. No evidence of previous experience
C 4	6.3	Despite initial thoughts might have wrong motives. Would probably be interviewed to clarify statements
C 5	6.8	Experience with children. Evidence of recent study
C 6	5.9	Assume 6th form means doing A levels some experience which needs more clarification

Institution - U did not enter a full set of scores Mean 3.6 Median 3.3 stdev 1.03

C 1	3.3	This C may be interviewed depending on the number of applications and if she was a local girl she may have limited opportunity of children's experience due to availability
C 2	5.1	Appears to have made an effort to be involved with children but in a nursery. This would have given her the opportunity to communicate and mix well with the children. Her quietness may be due to authority

C 3	3.1	Would depend on other applicants. Can be a manager in the NHS without doing nursing
C 4		
C 5	4.1	Should be given the opportunity of an interview demonstrates involvement and understanding of children
C 6	2.4	Appears to have tried to gain experience with children. Her failure of expression in written work could be explored at interview. Students usually present written work and profile. May not have yet reached potential

Institution - V Mean 6.3 Median 7.8 Stdev 2.5

C 1	2.8	Does not show particular interest in CN
C 2	7.2	Work experience, responsibility shown
C 3	4.2	No demonstration of experience or motivation towards children
C 4	8.3	Shows reasons for wanting to be a children's nurse with some understanding of role and motivation
C 5	9	Experience, knowledge of role, academic ability would need to be explored at interview
C 6	8.3	Some experience with children. Also has taken responsibility

Institution - W Mean 6.1 Median 5.2 Stdev 3.3

C 1	3.6	Awareness that involves health and illness- some health care experience although not with children - responsibility - prefect etc - caring/hardworking academically able - however does not indicate why CN this would require exploration if interviewed
C 2	4.3	Some awareness of what nursing involves though focus on illness.- likes children enjoyed nursery ?any further experience required exploration. - responsible and able to organise self , problem solving ability
C 3	0.8	Not sure this C has considered or really tried to find out about nursing.- No indication of previous involvement with children or why he wants to be a nurse
C 4	9	Gives reason for choosing CN. Had experience of being a child in hospital ? increased insight into what involved. Commitment - motivation organising placements. Works well in group/team scenarios
C 5	9.5	Experience with children both ill and well, motivation -nursery nursing to GCSE etc, future plans, skills in communicating and caring for children

C 6	6.1	Experience and plans to gain further experience, lacks health care experience, ?insight into what nursing involves, works as part of a team/group responsible

Institution - X Mean 6.4 Median 7.5 Stdev 2.2

C 1	6.5	No reason given for her wanting to do CN. Useful experience on school council
C 2	7.8	Sounds articulate - enjoyed nursery work and well children
C 3	3.3	Sees himself as a manager in the "medical profession" (Lay term for nursing). No reason given for CN
C 4	8.7	Aware of deficit in paediatrics the male role models
C 5	9.4	coherent goal setting demonstrated re academic progression and specialism in CN for later
C 6	7.2	Would have to give feedback on work with handicapped children at interview

Institution - Y Mean 5.9 Median 4.3 Stdev 2.7

C 1	9.2	Demonstrates commitment, good personality traits, academic ability, has work experience in hospital, responsible positions
C 2	6.3	Commitment through work experience. Interests and hobbies, Interest in children. No suggestion of academic ability. Concern over comment re quiet in class but would still interview
C 3	2.6	Less likely to interview as seems less prepared for the reality of nursing. Also suggestion that he has to develop patience with the public. Concern also re desire to be a hospital manager, does he really want to be a nurse?
C 4	4.6	Interest apparent in information. Comment about being quiet would have to be explored at interview. Also comment about adolescent boys needing a male nurse would need to be explored as it <u>may</u> be a cause for concern.
C5	1.7	Her motivation and experience are excellent. I would like to interview her. If she could demonstrate adequate academic ability I would suggest D test and obtain reference in relation to her GCSE work
C 6	4	Unsure from information available about her academic ability. If she had suitable GCSEs I would interview her as she is very interested in children and is a very active and organised person. Concern over her writing ability would have to be allayed.

Candidate 1

D of E, Offices at school, Caring experience, ?why she wants be a CN at interview

I would have her to the 3 year course, but would want to see her after her sampling of sick children's' as she has no experience with children she may want adult to go into midwifery

Would need sickness/attendance record

Good reference "Long held ambition to nurse" Some experience with nurses/midwives indicating interest and motivation. Good prospective academic base Endearing personal qualities Probably weakness - no link demonstrated with children -would explore at interview and look out for in group situation

Reference fine No orientation to child health evident Commitment/rationale for paeds not well elucidated

Would offer an interview but appears uncertain about which branch to pursue

Not clear why she wants to undertake the child branch. Wants to be part of caring profession. Not convincing it has to be nursing

Indicates that she would have some degree of insight into nursing, though gives little indication of why CN. Previous work experience may help in terms of communication skills. Reference from headmaster outlines willingness in discussions and a long standing interest in nursing

Certainly appears to be keen to join caring profession. Not sure about her choice of CN. I would need to investigate this choice further

Has indicated a preference which at this stage may need consolidation by an interview/selection process

Does not meet our criteria. No reason to believe that its CN she <u>really</u> wants

Although not clear about rationale for application for CN, she has had some experience of caring through part time work, has mixed with the public and gained insight into work ethic. D of E award and Reference support application

Has found appropriate caring experience. Provide relevant information. Appears to "get on" socially and is a contributor in class. Positive ref.

Although placements do not clearly reflect the applicants interest in CN overall the application appears satisfactory

Motivated -work experience, trust worthy position of responsibility. Hard working and perseverance -D of E award. Caring, friendly attitude. self aware

Doubtful of insight into nursing related to children

Previous experience of caring, specific interest in CN (Needs to have only applied for CN)

This C may be interviewed depending on the number of applications and if she was a local girl she may have limited opportunity of children's experience due to availability

Does not show particular interest in CN

Awareness that involves health and illness- some health care experience although not with children - responsibility - prefect etc - caring/hardworking academically able - however does not indicate why CN this would require exploration if interviewed

No reason given for her wanting to do CN. Useful experience on school council

Demonstrates commitment, good personality traits, academic ability, has work experience in hospital, responsible positions

Candidate 2

?Why sick children at interview ?why no previous job

I would take her to the 3yr programme but would want to see her again after her CB sampler. She has experience of well children but sick children may give her a problem. Also I would want to see her development in the team on the ward

?Quiet ?Sickness/attendance record

Generally supportive reference. Demonstrated interest in nursing. Participates at school in a range of activities. Seems to have reasonable personal qualities eg sense of responsibility

Doesn't reflect contemporary orientation of nursing to health. Romanticised view, but acknowledge minimal paed experience, although one week only. ?Other child health experience> Slight concern re academic reference and solitary problem solving

Would appear a good C potentially

Would interview and then would need to ascertain feelings about sick children

Able to give an overall summery. Though she has some experience working with children this is minimal. No other work experience. Headmaster indicates that she knows when to seek help and that she copes well with responsibility

Generally speaking the information provided demonstrates an individual with the potential to do well on the course. I would need evidence that the CB was the right choice

Meets our criteria for interview

No experience of caring or experience of work with children - only one week with well children. Personality - quiet, prefers to work alone - could have problems in nursing which relies on team approach

Demonstrated interest in children but a little restricted. Doesn't say why she likes working with children. Positive reference

Application satisfactory. Shows special interest in children

Motivated - work experience in a nursery. Ability to organise self and probably others. Socially interested/responsible caring and considerate. Ability to concentrate and work alone.

One week's experience of child care only

Although maybe quiet communication ability could be assessed at interview

Insight into course applied for. Experience of caring

Appears to have made an effort to be involved with children but in a nursery. This would have given her the opportunity to communicate and mix well with the children. Her quietness may be due to authority

Work experience, responsibility shown

Some awareness of what nursing involves though focus on illness.- likes children enjoyed nursery ?any further experience required exploration. - responsible and able to organise self , problem solving ability

Sounds articulate - enjoyed nursery work and well children

Commitment through work experience. Interests and hobbies, Interest in children. No suggestion of academic ability. Concern over comment re quiet in class but would still interview

Candidate 3

Wrong reasons Manager/No experience yet

This boy may develop when he leaves school. Would take him into the 3yr programme, but would definitely want to see his clinical teacher after CB sampler and also his clinical mentor that he is committed and able to deal with sick children. No mention of care! But may be immature or "coasting"!

No experience caring/voluntary work. ? Work with children

Seems unclear about what he wants to do. Has he made any real effort to get information available? Might interview - he has some strengths but might suggest try again when he has "dipped his toe in the water"

Reservations re: medical orientation, "shopping around" career wise. under commitment to work experience "might" "hoping" poor rationale for choice of paeds

Does not display insight gained through thorough research into nursing

Seems confused about career and what being a CN might lead to. Needs to give more rationale about choice of career and branch entry

Indicate initially desire to enter medical profession, unsure as to commitment to CN in particular, but also to nursing as a whole. ?age

I would suggest this young man receives some career counselling and advice before his application is decided upon

No real substantive rationale for a career in nursing let alone the CB

Doesn't meet our criteria. Wants to be medic not nurse

?Needs career counselling re how to enter management training scheme, appears to have qualities required. No rationale for nursing no experience in caring

Perhaps has potential but application does not seem to have a very realistic idea about nursing

Application unconvincing. Little evidence of special interest in children

This C appears interested in medicine, hospital management and nursing. As he is unsure what he really wants to do he needs to explore these areas through work experience. I would possibly offer him an interview as he has experience with people and can work in team

Commitment to nursing not obvious

Has future in sight. Interview may enable insight into nursing to be gained. May be more suited for a different role in caring

Limited insight into demands of course. No evidence of previous experience

Would depend on other applicants. Can be a manager in the NHS without doing nursing

No demonstration of experience or motivation towards children

Not sure this C has considered or really tried to find out about nursing.- No indication of previous involvement with children or why he wants to be a nurse

Sees himself as a manager in the "medical profession" (Lay term for nursing). No reason given for CN

Less likely to interview as seems less prepared for the reality of nursing. Also suggestion that he has to develop patience with the public. Concern also re desire to be a hospital manager, does her really want to be a nurse?

Candidate 4

?Why in hospital, why males should look after boys

Has all the background I would hope for!! Has experience and maturity commented on. Looks good but would review again after child sampler as he may go into mental health if he is committed to adolescence - unfortunately this happens locally. We would talk about his goals after 18 months

? CNs nurse all ages of children (babies)

Good reference, good commitment, good motivation. Bit worried about the circumstances of his decision would gently explore at interview

Evident commitment to chosen career. Taken opportunity to explore hospital environments. Clear commitment to paediatrics. Wonder if breadth of CN is realised as interest stems from a specific personal experience

Worthy of an interview

Recognises area where he will be able to specialise. Some work experience. Academic reference

Has had some experience of "hospital" work. Would be interested to follow through needs of adolescent boys. reference highlights motivation to become a CN. Presumably adolescent himself when hospitalised

He has made some very positive moves to help him in his decision making. Well supported by headmaster

Based on actual experience which has been explored in a more work lead capacity subsequently and therefore has clearly considered what he wishes to do

Doesn't meet our criteria

Rationale for application shows insight into the needs of sick children. Has gained experience in a variety of settings achieving good reports on progress made

Has sought the right "types" of experience. Motivation very apparent. Supportive reference. Would need to explore academic ability

Application overall satisfactory. Impressed by his endeavour to gain work experience in a hospital. Would prefer more experience with children specifically

Well motivated. determined. Participates in group activities. Appears socially aware. Self aware. The concept of "male nurse" and "adolescent boys" would be explored at interview

Appears to have commitment and aptitude

Despite initial thoughts might have wrong motives. Would probably be interviewed to clarify statements

Shows reasons for wanting to be a children's nurse with some understanding of role and motivation

Gives reason for choosing CN. Had experience of being a child in hospital ? increased insight into what involved. Commitment - motivation organising placements. Works well in group/team scenarios

Aware of deficit in paediatrics the male role models

Interest apparent in information. Comment about being quiet would have to be explored at interview. Also comment about adolescent boys needing a male nurse would need to be explored as it may be a cause for concern.

Candidate 5

Needs to prove her academic ability

This lady will probably be good - has all the right credentials. From her background she will be relieved to finish the CFP

Would need academic ref

Good background. Weak academically probably but strong motivation. Probably got good organisational skill. Interest in children. Supportive reference

Clear commitment to children. Seems to have potential. Concerns re academic journey ahead and what is involved. ?insight into difference between play specialist and paed nurse role

Determined, understand through previous employment pressures of being children's' nurse

Demonstrates some determination in terms of gaining academic qualifications. has experience of both well and ill children. Could utilise painting abilities. Reference a little brief. Able to give some indication as to future prospects. Maturity may well be an asset

Assuming the Nursery Nurse qualification is a BTec Dip, she would be invited to a selection day because she demonstrates 1) an ability to cope academically and 2) a commitment to work with children 3) has "professional" support and backing to follow a CN career 4) has a well thought through idea of what her career will entail

Experience in a related field would be a useful rationale for this proposed career change of direction. May need academic support but nursery nurse would be a BTec and therefore qualification as suitable entry

Meets criteria

Has knowledge and experience of the care of children in a normal environment and in hospital. Professional reference good. Would need to show evidence of further study - attainment in Human biology ?may need Eng lang

Would not at present cope with academic demands of the programme. I would like to meet with this C and discuss how she might prepare herself for a future application after a period of further study

Very good application Excellent background for CB

At present this C would not fulfil our criteria for interview. I would advise her to reapply after taking her GCSEs

Appears well motivated to care of children. Good experience.

Insight into nursing should be evident. Academic commitment would be queried at interview

Experience with children. Evidence of recent study
Should be given the opportunity of an interview demonstrates involvement and understanding of children

Experience, knowledge of role, academic ability would need to be explored at interview

Experience with children both ill and well, motivation -nursery nursing to GCSE etc, future plans, skills in communicating and caring for children

coherent goal setting demonstrated re academic progression and specialism in CN for later

Her motivation and experience are excellent. I would like to interview her. If she could demonstrate adequate academic ability I would suggest D test and obtain reference in relation to her GCSE work

Candidate 6

reapply next year after work experience

Would have her onto the 3yr programme. I would need to see her again after child sampling as her experience is only with well children. She does not really know her mind I would say and may chose any branch from this background. I like involvement and enthusiasm

?academic ability, No experience caring / reasons

Good in some respect (personal strengths etc) but why nursing

Generally appears fine. Slight concern re "over confidence" (would explore at interview) Unclear focus on nursing and rationale for choice of career, although demonstrates clear commitment to children

No elaboration on nursing

No experience as yet academically may be weak

Gives little specific indication as to why she wants to be a CN but does plan to have some work experience. ?Consider LD nursing. Some concern from reference eg difficulty with expression in writing and also aspect re classroom discussion

To date had demonstrated sufficient evidence of her ability to cope with the course and that CN is the right career choice.

Probably would invite for selection day but not sure whether the decision is well thought out

Meets criteria

No involvement with the public other than in sports teams- contact with children minimal. No experience of caring. Rational for application unclear ?supported by reference. No indication about the type of work experience being planned

Motivated but not very clear about why nursing. I would be worried about the Headmasters statement about academic skills. seems to be a good team worker

Satisfactory application. Overall shows willingness to gain more experience with children

Appears motivated towards CN. If invited for an interview I would ask her to bring some written work along

Good intentions but little evidence

Not sure about this. Would discuss with colleagues. Cannot gain picture of this C

Assume 6th form means doing A levels some experience which needs more clarification

Appears to have tried to gain experience with children. Her failure of expression in written work could be explored at interview. Students usually present written work and profile. May not have yet reached potential

Some experience with children. Also has taken responsibility

Experience and plans to gain further experience, lacks health care experience, ?insight into what nursing involves, works as part of a team/group responsible

Would have to give feedback on work with handicapped children at interview

Unsure from information available about her academic ability. If she had suitable GCSEs I would interview her as she is very interested in children and is a very active and organised person. Concern over her writing ability would have to be allayed.

No	QUALITIES COMMON TO ALL STUDENT CANDIDATES
1	Communication skills
2	Initiative
3	Potential to follow personally and academically challenging programme
4	Reliability
5	Sociability
6	Athletic/social and other interests
7	Interpersonal skills
8	Warmth
9	Friendliness
10	Confidence
11	Observational skills
12	Self aware
13	Voluntary/community work
14	Knowledge of/experience of nursing
15	Caring attitude
16	Motivation/commitment
17	Psychomotor skills/ physical dexterity

QUALITIES SPECIFIC TO CHILD BRANCH STUDENTS	
18	Motivation/commitment eg reason for wishing to be a children's nurse
19	Understanding what nursing children involves
20	Awareness of others contributing to care
21	Caring skills
22	Ability to work with people of all ages
23	Adaptability
24	Emotional stability
25	Motivation/wanting to work with children and families

Candidate 1 sentence busting and sorting by word processor

Quality	Var	+/-
academic ability, −	3	+
academic base Good prospective	3	+
academically able -	3	+
care experience some health care experience although not with children -	14	+
caring she has had some experience of caring through part time work,	14	+
caring profession Wants to be part of caring profession. Not convincing it has to be nursing	16	-
caring Previous experience of caring,	14	+
caring/hardworking	15	+
caring Has found appropriate caring experience.	14	+
caring profession Certainly appears to be keen to join caring profession.	16	+
Caring, friendly attitude	15	+
Caring experience	14	+
child branch Would offer an interview but appears uncertain about which branch to pursue	18	+/-
child branch Not clear why she wants to undertake the child branch	18	-
child health No orientation to evident	18	-
children Doubtful of insight into nursing related to children	19	-
children Probably weakness - no link demonstrated with children -would explore at interview and look out for in group situation	18	-
Children's nursing however does not indicate why Children's nursing this would require exploration if interviewed	18	-
Children's nursing Although placements do not clearly reflect the applicants interest in children's nursing application appears satisfactory overall	18	+
Children's nursing No reason to believe that its Children's nursing she really wants	18	-

Quality	Var	+/-
Children's nursing Although not clear about rationale for application for Children's nursing	18	-
Children's nursing Not sure about her choice of Children's nursing. I would need to investigate this choice further	18	-
Children's nursing specific interest in Children's nursing (Needs to have only applied for Children's nursing	18	+
Children's nursing Does not show particular interest in	18	-
Children's nursing Commitment/rationale for paeds not well elucidated	18	-
Children's nursing No reason given for her wanting to do Children's nursing.	18	-
Children's nursing indicates that she would have some degree of insight into nursing, though gives little indication of why Children's nursing.	19	-
Children's nurse why she wants be a Children's nurse at interview	18	-
class contributor in.	1	+
commitment Demonstrates commitment,	16	+
communication skills Previous work experience may help in terms of	1	+
D of E award and	6	+
D of E award - Hard working and perseverance	6	+
D of E	6	+
discussions Reference from headmaster outlines willingness in	1	+
Good reference "Long held ambition to nurse"	16	+
health and illness Awareness that involves health and illness-	14	+
Motivated -work experience,	14	+
motivation. Some experience with nurses/midwives indicating interest and motivation.	16	+
nursing a long standing interest in (Reference from headmaster)	16	+
Offices at school	4	+
personal qualities Endearing		+

Quality	Var	+/-
personality good personality traits,		+
preference Has indicated a preference which at this stage may need consolidation by an interview/selection process	18	+
Provide relevant information.	G	+
reference Positive.	G	+
Reference fine	G	+
Reference support application	G	+
responsibility trust worthy position of responsibility.	4	+
responsibility - prefect etc -	4	+
responsible positions	4	+
school council Useful experience on school council	4	+
self aware	12	+
socially Appears to "get on"	5	+
work experience has work experience in hospital,	14	+
I would have her to the 3 year course, but would want to see her after her sampling of sick children's as she has no experience with children she may want adult to go into midwifery		+
Would need sickness/attendance record	No other comment	
Does not meet our criteria.		
work ethic has mixed with the public and gained insight into work ethic.	New category	
This C may be interviewed depending on the number of applications and if she was a local girl she may have limited opportunity of Children's nursing experience due to availability	Local circumstances	

Candidate 2 Sentence busting and sorting by word processor

Quality	Var	+/-
Ability to organise self and probably others.	4	+
Ability to concentrate and work alone.	3	+
academic reference Slight concern re academic reference and solitary problem solving	3	+/-
academic No suggestion of academic ability.	3	-
caring and considerate.	15	+
caring Experience of caring	14	+
child health Other child health experience	14	-
child care One week's experience of child care only	14	-
children likes children enjoyed nursery	25	+
children Shows special interest in children application satisfactory	25	+
children Why sick children at interview	18	+
children Demonstrated interest in children but a little restricted.	25	+
children. Doesn't say why she likes working with children.	25	-
children. Interest in	25	+
children. No experience of caring or experience of work with children - only one week with well children.	14	-
Commitment through work experience.	16	+
communication Although maybe quiet communication ability could be assessed at interview	1	+/-
enjoyed nursery work and well children	25	+
experience working with children Though she has some this is minimal. No other work experience.	14	-
experience any further experience required exploration. -	14	-
Headmaster indicates that she knows when to seek help	3	+
Interests and hobbies,	6	+

Quality	Var	+/-
Motivated - work experience in a nursery.	18	+
nursing Some awareness of what nursing involves though focus on illness.-	19	+
nursing Demonstrated interest in nursing.	16	+
Personality - quiet, prefers to work alone - could have problems in nursing which relies on team approach	5	-
problem solving ability	3	+
quiet Concern over comment re quiet in class but would still interview	5	+/-
Quiet	5	-
quietness Her quietness may be due to authority	5	-
reference Positive reference	G	+
reference. Generally supportive reference.	G	+
responsibility and that she copes well with responsibility	4	+
responsibility shown	4	+
responsibility Seems to have reasonable personal qualities eg sense of responsibility	4	+
responsible	4	+
responsible and able to organise self ,	4	+
school Participates at school in a range of activities.	6	+
sick children Would interview and then would need to ascertain feelings about sick children	18	+
Socially interested	5	+
Sounds articulate -	1	+
job why no previous job	13	-
Work experience,	13	+
Would appear a good C potentially	only com ment	+

Quality	Var	+/-
Appears to have made an effort to be involved with children but in a nursery. This would have given her the opportunity to communicate and mix well with the children.		✢
I would take her to the 3yr programme but would want to see her again after her CB sampler. She has experience of well children but sick children may give her a problem. Also I would want to see her development in the team on the ward		✢
Insight into course applied for.	19	✢
Generally speaking the information provided demonstrates an individual with the potential to do well on the course. I would need evidence that the CB was the right choice		✢
Doesn't reflect contemporary orientation of nursing to health. Romanticised view, but acknowledge minimal paed experience, although one week only. ?	Low score	-
Able to give an overall summery.	General statement	
Meets our criteria for interview	Only comment	
Sickness/attendance record	Information required	

Candidate 3 Sentence busting and sorting by word processor

Quality	Var	+/-
Application unconvincing.	G	-
career counselling ?Needs career counselling re how to enter management training scheme, appears to have qualities required.	16	-
career counselling I would suggest this young man receives some career counselling and advice before his application is decided upon	16	-
caring May be more suited for a different role in caring	16	-
caring no experience in caring	14	-
children Little evidence of special interest in children	25	-
children No demonstration of experience or motivation towards children	25	-
children Not sure this C has considered or really tried to find out about nursing.- No indication of previous involvement with children or why he wants to be a nurse	18	-
children? Work with children	25	-
children's nursing poor rationale for choice of paeds	18	-
Children's nursing Seems confused about career and what being a CN might lead to.	19	-
Children's nursing No reason given for CN	18	-
Children's nursing No real substantive rationale for a career in nursing let alone the CB	18	-
Children's nursing unsure as to commitment to CN in particular, but also to nursing as a whole. ?age	18	-
criteria Doesn't meet our criteria.	G	-
experience No evidence of previous experience	14	-
experience under commitment to work experience "might" "hoping"	14	-
experience No experience caring/voluntary work.	13	-
experience No experience yet	14	-
information Has he made any real effort to get information available?	G	-

Quality	Var	+/-
insight Limited insight into demands of course.	19	-
interview Might interview - he has some strengths but might suggest try again when he has "dipped his toe in the water"		+/-
manager Concern also re desire to be a hospital manager, does he really want to be a nurse?	16	-
manager Would depend on other applicants. Can be a manager in the NHS without doing nursing	16	-
medic Wants to be medic not nurse	16	-
medical profession Sees himself as a manager in the "medical profession" (Lay term for nursing).	16	-
medical Indicate initially desire to enter medical profession,	16	-
medical Reservations re: medical orientation, "shopping around" career wise.	16	-
medicine This C appears interested in medicine, hospital management and nursing. As he is unsure what he really wants to do he needs to explore these areas through work experience. I would possibly offer him an interview as he has experience with people and can work in team	16	-
nursing Commitment to nursing not obvious	16	-
nursing Does not display insight gained through thorough research into nursing	19	-
nursing Perhaps has potential but application does not seem to have a very realistic idea about nursing	19	-
nursing Has future in sight. Interview may enable insight into nursing to be gained.	19	+/-
nursing No rationale for nursing	16	-
nursing Less likely to interview as seems less prepared for the reality of nursing.	19	-
patience Also suggestion that he has to develop patience with the public.	7	-
rationale Needs to give more rationale about choice of career and branch entry	18	-
reasons Wrong reasons Manager	16	-

Quality	Var	+/-
unclear Seems unclear about what he wants to do.	16	-
This boy may develop when he leaves school. Would take him into the 3yr programme, but would definitely want to see his clinical teacher after CB sampler and also his clinical mentor that he is committed and able to deal with sick children. No mention of care! But may be immature or "coasting"!	G	+/-

Candidate 4 Sentence busting and sorting by word processor

Quality	Var	+/-
Academic Would need to explore academic ability	3	+/-
Academic reference	3	+
Application overall satisfactory.		+
boys why males should look after boys	18	-
Boys Would be interested to follow through needs of adolescent boys.	18	-
Boys Also comment about adolescent boys needing a male nurse would need to be explored as it may be a cause for concern.	18	-
Boys The concept of "male nurse" and "adolescent boys" would be explored at interview	18	-
Children Would prefer more experience with children specifically	14	-
Children's nurse Shows reasons for wanting to be a children's nurse with some understanding of role and	19	+
Children's nursing Clear commitment to paediatrics.	18	+
Children's nurses Wonder if breadth of CN is realised as interest stems from a specific personal experience	19	+/-
Children's nursing Gives reason for choosing CN.	18	+
Children's Ns nurse all ages of children (babies)	19	+/-
circumstances Bit worried about the circumstances of his decision would gently explore at interview	18	+/-
Considered and therefore has clearly considered what he wishes to do	19	+
commitment good commitment,	18	+
commitment Evident commitment to chosen career.	18	+
Commitment - motivation organising placements.	16	+
Commitment Appears to have commitment and aptitude	18	+
Criteria Doesn't meet our criteria	only comment	

Quality	Var	+/-
Experience Impressed by his endeavour to gain work experience in a hospital.	13	+
Experience Has gained experience in a variety of settings achieving good reports on progress made	13	+
Experience Based on actual experience which has been explored in a more work lead capacity subsequently	14	+
Experience Some work experience.	14	+
Experience Has sought the right "types" of experience.	14	+
Group team Works well in group/team scenarios	5	+
Headmaster Well supported by headmaster	G	+
hospital Taken opportunity to explore hospital environments.	14	+
Hospital Had experience of being a child in hospital ? increased insight into what involved.	19	+
Hospital Has had some experience of "hospital" work.	14	+
hospital ?Why in hospital,	General	+
Hospitalised Presumably adolescent himself when hospitalised	General	+/-
Interest apparent in information.	18	+
Motivated Well motivated. determined.	18	+
motivation good motivation.	18	+
motivation	18	+
Motivation very apparent.	18	+
Motivation reference highlights motivation to become a CN.	18	+
Motives Despite initial thoughts might have wrong motives. Would probably be interviewed to clarify statements	18	+/-
Participates in group activities.	5	+
Positive He has made some very positive moves to help him in his decision making.	14	+
Quiet Comment about being quiet would have to be explored at interview.	5	+/-

Quality	Var	+/-
Rationale for application shows insight into the needs of sick children.	19	+
reference Good reference,	G	+
Reference Supportive reference.	G	+
Role model Aware of deficit in paediatrics the male role models	19	+
Socially Appears socially aware. Self aware.	5	+
Specialise Recognises area where he will be able to specialise.	19	+
Worthy of an interview	G	+
Has all the background I would hope for!! Has experience and maturity commented on. Looks good but would review again after child sampler as he may go into mental health if he is committed to adolescence - unfortunately this happens locally. We would talk about his goals after 18 months	G	+

Candidate 5 sentence busting and sorting by word processor

Quality	Var	+/-
academic an ability to cope academically	3	+
academic ability would need to be explored at interview	3	+/-
academic Needs to prove her academic ability	3	-
academic coherent goal setting demonstrated re academic progression and	3	+
Academic Would need academic ref	3	+/-
Academic commitment would be queried at interview	3	+/-
Academic Demonstrates some determination in terms of gaining academic qualifications.	3	+
Academic Would not at present cope with academic demands of the programme. I would like to meet with this C and discuss how she might prepare herself for a future application after a period of further study	3	-
Academic Would need to show evidence of further study - attainment in Human biology ?may need Eng lang	3	+/-
Academic Evidence of recent study	3	+
Academic Concerns re academic journey ahead and what is involved.	3	+/-
Academic May need academic support but nursery nurse would be a BTec and therefore qualification as suitable entry	3	+
Academically Weak academically probably	3	-
Application Very good application	G	+
Assuming the Nursery Nurse qualification is a BTec Dip, she would be invited to a selection day	3	+
Background Good background.	14	+
Background Excellent background for CB	14	+
children commitment to work with children	25	+
Children Clear commitment to children.	25	+
Children Interest in children.	25	+

Quality	Var	+/-
Children's nursing, understand through previous employment pressures of being children's nurse	19	+
communicating skills in communicating and caring for children	1	+
Credentials This lady will probably be good - has all the right credentials. From her background she will be relieved to finish the CFP	19	+
Criteria At present this C would not fulfil our criteria for interview. I would advise her to reapply after taking her GCSEs	3	-
Criteria Meets criteria	G	+
Determined	16	+
Experience has experience of both well and ill children.	14	+
Experience in a related field would be a useful rationale for this proposed career change of direction.	14	+
Experience with children.	14	+
Experience Has knowledge and experience of the care of children in a normal environment and in hospital.	19	+
Experience,	14	+
Experience Good experience.	14	+
Experience with children both ill and well,	14	+
future plans,	19	+
future has a well thought through idea of what her career will entail	19	+
future specialism in CN for later	19	+
Future Able to give some indication as to future prospects.	19	+
insight into difference between play specialist and paed nurse role	19	+
Insight into nursing should be evident.	19	+
Interview Should be given the opportunity of an interview demonstrates involvement and understanding of children	19	+
Maturity may well be an asset	G	+
Motivated Appears well motivated to care of children.	25	+

Quality	Var	+/-
motivation -nursery nursing to GCSE etc,	18	+
Motivation but strong motivation.	18	+
Organisational Probably got good organisational skill.	New	+
Painting Could utilise painting abilities.	G	+
Potential Seems to have potential.	G	+
professional has "professional" support and backing to follow a CN career	G	+
Professional reference good.	G	+
Reference a little brief.	G	+/-
Reference Supportive reference	G	+
Role knowledge of role,	19	+
Her motivation and experience are excellent. I would like to interview her. If she could demonstrate adequate academic ability I would suggest D test and obtain reference in relation to her GCSE work	3	+/-

Candidate 6 Sentence busting and sorting by word processor

	Var	+/-
academic ability,	3	+
Academic Her failure of expression in written work could be explored at interview. Students usually present written work and profile. May not have yet reached potential	3	+/-
Academic Assume 6th form means doing A levels	3	+
Academic If invited for an interview I would ask her to bring some written work along	3	+/-
Academic I would be worried about the Headmasters statement about academic skills.	3	+/-
Academic Unsure from information available about her academic ability. If she had suitable GCSEs I would interview her as she is Concern over her writing ability would have to be allayed.	3	+/-
Academic Some concern from reference eg difficulty with expression in writing and also aspect re classroom discussion	3	+/-
academically may be weak	3	-
Application Satisfactory application.	G	+
Caring No experience of caring.	14	-
Children although demonstrates clear commitment to children	25	+
children very interested in children	25	+
Children No involvement with the public other than in sports teams-contact with children minimal.	14	+
Children's nursing Appears motivated towards CN.	18	+
Children's nursing Gives little specific indication as to why she wants to be a CN	18	-
Children's nursing To date had demonstrated sufficient evidence of her ability to cope with the course and that CN is the right career choice.	18	+
Criteria Meets criteria	G	+
Evidence Good intentions but little evidence	16	+/-

	Var	+/-
experience some experience which needs more clarification	14	+/-
experience but does plan to have some work experience.	14	+/-
Experience Some experience with children.	14	+
Experience No experience as yet	14	-
Experience No experience caring	14	-
Experience and plans to gain further experience, lacks health care experience,	14	-
Experience No indication about the type of work experience being planned	14	-
Experience Would have to give feedback on work with handicapped children at interview	14	+/-
Experience reapply next year after work experience	14	-
Experience Appears to have tried to gain experience with children.	14	+
Experience Overall shows willingness to gain more experience with children	14	+
Fine Generally appears fine.	G	+
insight into what nursing involves,	19	+
Invite Probably would invite for selection day but not sure whether the decision is well thought out	18	+/-
Learning Disability ?Consider LD nursing.	19	+/-
Motivated but not very clear about why nursing.	18	-
Nursing No elaboration on nursing	18	-
Nursing Good in some respect (personal strengths etc) but why nursing	18	-
organised a very active and organised person.	New category	
Over confidence Slight concern re "over confidence" (would explore at interview)	10	-
Rationale for application unclear	18	-
Rationale Unclear focus on nursing and rationale for choice of career,	18	-

	Var	+/-
reasons		+/-
Reference ?supported by reference.	G	+/-
Responsibility Also has taken responsibility	4	+
responsible	4	+
Team worker seems to be a good team worker	5	+
Team works as part of a team/group	5	+
Would have her onto the 3yr programme. I would need to see her again after child sampling as her experience is only with well children. She does not really know her mind I would say and may chose any branch from this background. I like involvement and enthusiasm	G	+
Not sure about this. Would discuss with colleagues. Cannot gain picture of this C	G	+/-

Appendix 6

NHS Trusts responding to request for an application form for a D grade staff nurse on the children's ward

Responding NHS trusts (no relationship with alphabetical designation)

Burton Hospitals	*Great Ormond Street Hospital
* Royal Liverpool Children's	The Royal Wolverhampton Hospitals
South Downs	Stoke Mandeville
Treliske	Walsall
Sandwell	Scarborough and NE Yorkshire Healthcare
Blackpool Victoria Hospital	Milton Keynes
Royal United Hospital, Bath	St Helens & Knowsley Hospitals
Alexandra Healthcare, Redditch	St Richards, Chichester
Airedale	*The United Bristol Healthcare
Walsgrave Hospital, Coventry	St Peters Hospital, Ashford
Gloucestershire Royal	St Mary's, London
*Birmingham Children's Hospital	Goodhope, Sutton Coldfield
University College London Hospitals	

* children's hospitals

Appendix 7

Statutory instrument for Project 2000 (HMSO 1989) showing phrases used for searches of job descriptions

Statutory instrument (HMSO 1989, 5)	Edited for searches in QRS N4
the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability or ageing for the individual, her or his friends, family and community	the identification of the **social and health implications** of pregnancy and child bearing **physical and mental handicap, disease, disability** or ageing for the **individual, her or his friends, family** and community
the recognition of common factors which contribute to, and those which adversely affect, physical, mental and social well-being of patients and clients and take appropriate action	the recognition of common factors which contribute to, and those which adversely affect, **physical, mental and social well-being of patients and clients** and take appropriate action
the use of relevant literature and research to inform the practice of nursing	the use of **relevant literature and research** to inform the practice of nursing
the appreciation of the influence of social, political and cultural factors in relation to health care	the appreciation of the influence of **social, political and cultural factors** in relation to health care
an understanding of the requirements of legislation relevant to the practice of nursing	an understanding of the **requirements of legislation** relevant to the practice of nursing
the use of appropriate communication skills to enable the development of helpful, caring relationships with patients and clients and their families and friends, and to initiate and conduct therapeutic relationships with patients and clients	the use of appropriate **communication skills** to enable the **development of helpful, caring relationships with patients and clients and their families and friends,** and to **initiate and conduct therapeutic relationships with patients** and clients
the identification of health related learning needs of patients and clients, families and friends and to participate in health promotion	the identification of **health related learning needs** of patients and clients, families and friends and to participate in **health promotion**
an understanding of the ethics of health care and of the nursing profession and the responsibilities which these impose on the nurse's professional practice	an understanding of the **ethics** of health care and of the nursing profession and the responsibilities which these impose on the nurse's professional practice

Statutory instrument (HMSO 1989, 5)	Edited for searches in QRS N4
the identification of the needs of patients and clients to enable them to progress from varying degrees of dependence to maximum independence, or to a peaceful death	the **identification of the needs of patients** and clients to enable them to progress from varying degrees of dependence to maximum independence, or to a peaceful death
the identification of physical, psychological, social and spiritual needs of the patient or client; an awareness of the values and concepts of individualised care; the ability to devise a plan of care, contribute to its implementation and evaluation; and the demonstration of the application of the principles of a problem-solving approach to the practice of nursing	the **identification of physical, psychological, social and spiritual needs of the patient** or client; an awareness of the values and concepts of **individualised care**; the ability to **devise a plan of care, contribute to its implementation and evaluation**; and the demonstration of the application of the principles of a **problem-solving** approach to the practice of nursing
the ability to function effectively in a team and participate in a multi-professional approach to the care of patients and clients	the ability to **function effectively in a team** and participate in a **multi-professional approach** to the care of patients and clients
the use of the appropriate channel of referral for matters not within her sphere of competence	the use of the appropriate channel of **referral for matters not within her sphere of competence**
the assignment of appropriate duties to others and the supervision, teaching and monitoring of assigned duties	the **assignment of appropriate duties** to others and the **supervision, teaching and monitoring of assigned duties**

"Identification of the characteristics or concepts to be measured" (Waltz et al 1991, 302)

Appendix 8

Statutory outcomes for entry to the branch and entry to the register

Fitness for Practice Programmes (The Stationery Office 2000)

"SCHEDULE

Rules 2(4)(b) and 3(2)

Outcomes to be achieved within a Common Foundation Programme

Discuss in an informed manner the implications of professional regulation for nursing practice.

Demonstrate an awareness of the UKCC's Code of professional conduct.

Demonstrate an awareness of, and apply ethical principles to, nursing practice.

Demonstrate an awareness of legislation relevant to nursing practice.

Demonstrate the importance of promoting equity in patient and client care by contributing to nursing care in a fair and anti-discriminatory way.

Discuss methods of, barriers to and the boundaries of effective communication and interpersonal relationships.

Demonstrate sensitivity when interacting with and providing information to patients and clients.

Contribute to enhancing the health and social well being of patients and clients by understanding how, under the supervision of a registered practitioner, to contribute to the assessment of health needs; identify opportunities for health promotion; identify networks of health and social care service.

Contribute to the development and documentation of nursing assessments by participating in comprehensive and systematic nursing assessment of the physical, psychological, social and spiritual needs of patients and clients.

Contribute to the planning of nursing care, involving patients and clients and, where possible, their carers, demonstrating an understanding of helping patients and clients to make informed decisions.

Contribute to the implementation of a programme of nursing care, designed and supervised by registered practitioners.

Demonstrate evidence of a developing knowledge base which underpins safe nursing practice.

Demonstrate a range of essential nursing skills, under the supervision of a registered nurse, to meet individuals needs, which include: maintaining dignity, privacy and confidentiality; effective communication and observational skills, including listening and taking physiological measurements; safety and health, including moving and handling and infection control;

essential first aid and emergency procedures; administration of medicines; emotional, physical and personal care, including meeting the need for comfort, nutrition and personal hygiene.

Contribute to the evaluation of the appropriateness of nursing care delivered.

Recognise situations in which agreed plans of nursing care no longer appear appropriate and refer these to an appropriate accountable practitioner.

Contribute to the identification of actual and potential risks to patients, clients and their carers, to oneself and to others and participate in measures to promote and ensure health and safety.

Demonstrate an understanding of the role of others by participating in inter-professional working practice.

Demonstrate literacy, numeracy and computer skills needed to record, enter, store, retrieve and organise data essential for care delivery.

Demonstrate responsibility for one's own learning through the development of a portfolio of practice and recognise when further learning is required.

Acknowledge the importance of seeking supervision to develop safe nursing practice.

{ref} Rules 2(4)(b) and 3(2)

Competencies to be achieved for entry to Parts 12-15 of the register

Manage oneself, one's practice, and that of others, in accordance with the UKCC's Code of professional conduct, recognising one's own abilities and limitations.

Practise in accordance with an ethical and legal framework which ensures the primacy of patient and client interest and well-being and respects confidentiality.

Practise in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups.

Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills.

Create and utilise opportunities to promote the health and well-being of patients, clients and groups.

Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.

Formulate and document a plan of nursing care, where possible in partnership with patients, clients, their carers and family and friends, within a framework of informed consent.

Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe nursing practice.

Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences.

Evaluate and document the outcomes of nursing and other interventions.

Demonstrate sound clinical judgement across a range of differing professional and care delivery contexts.

Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk management strategies.

Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team.

Delegate duties to others, as appropriate, ensuring that they are supervised and monitored.

Demonstrate key skills.

Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice.

Enhance the professional development and safe practice of others through peer support, leadership, supervision and teaching."

(HMSO 2000, 5-6)

Appendix 9

Comparison of the statutory outcomes for Project 2000 programmes and the Fitness for Practice Programmes

Project 2000 (HMSO 1989, 5)	**Fitness for practice (HMSO 2000, 5-6)**
the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability or ageing for the individual, her or his friends, family and community	Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.
the recognition of common factors which contribute to, and those which adversely affect, physical, mental and social well-being of patients and clients and take appropriate action	Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.
the use of relevant literature and research to inform the practice of nursing	Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe nursing practice.
the appreciation of the influence of social, political and cultural factors in relation to health care	Practise in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups. Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences.
an understanding of the requirements of legislation relevant to the practice of nursing	Manage oneself, one's practice, and that of others, in accordance with the UKCC's Code of professional conduct, recognising one's own abilities and limitations. Practise in accordance with an ethical and legal framework which ensures the primacy of patient and client interest and well-being and respects confidentiality.
the use of appropriate communication skills to enable the development of helpful, caring relationships with patients and clients and their families and friends, and to initiate and conduct therapeutic relationships with patients and clients	Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills.
the identification of health related learning needs of patients and clients, families and friends and to participate in health promotion	Create and utilise opportunities to promote the health and well-being of patients, clients and groups.

Project 2000 (HMSO 1989, 5)	**Fitness for practice (HMSO 2000, 5-6)**
an understanding of the ethics of health care and of the nursing profession and the responsibilities which these impose on the nurse's professional practice	Practise in accordance with an ethical and legal framework which ensures the primacy of patient and client interest and well-being and respects confidentiality.
the identification of the needs of patients and clients to enable them to progress from varying degrees of dependence to maximum independence, or to a peaceful death	Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.
the identification of physical, psychological, social and spiritual needs of the patient or client; an awareness of the values and concepts of individualised care; the ability to devise a plan of care, contribute to its implementation and evaluation; and the demonstration of the application of the principles of a problem-solving approach to the practice of nursing	Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities. Formulate and document a plan of nursing care, where possible in partnership with patients, clients, their carers and family and friends, within a framework of informed consent. Evaluate and document the outcomes of nursing and other interventions. Demonstrate sound clinical judgement across a range of differing professional and care delivery contexts.
the ability to function effectively in a team and participate in a multi-professional approach to the care of patients and clients	Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team.
the use of the appropriate channel of referral for matters not within her sphere of competence	Manage oneself, one's practice, and that of others, in accordance with the UKCC's Code of professional conduct, recognising one's own abilities and limitations.

Project 2000 (HMSO 1989, 5)	**Fitness for practice (HMSO 2000, 5-6)**
the assignment of appropriate duties to others and the supervision, teaching and monitoring of assigned duties	Enhance the professional development and safe practice of others through peer support, leadership, supervision and teaching. Delegate duties to others, as appropriate, ensuring that they are supervised and monitored.
	Demonstrate key skills.
	Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice.
	Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk management strategies.

Comparison of the statutory outcomes for Project 2000 programmes and the Fitness for Practice Programmes

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