

Beginning Journeys - Volume 6

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EDITORIAL

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In April this year I had the pleasure of being the Visiting Scholar for the Research Week held in the Faculty of Health & Sciences at Christchurch Polytechnic Institute of Technology. During the week I had the chance to talk to many nurses and midwives about their research. Our discussions ranged across current, completed and planned projects, methodological snags, and ideas and dreams for the future. In every discussion there was a clear commitment to doing the best possible research in terms of intent, method and ethics, to ensure the best outcome for everyone involved. We also talked about the process of maintaining research — not just how to get started on a project but how to sustain the momentum. With all the competing demands on our time and energy and head-space, what tips can we swap about keeping going with a project right through to the communication of our findings?

One of the challenges in reporting research is to find the right medium. Each project has a number of potential audiences — people with professional, academic, or personal interest in the subject. We have an obligation to share findings with as many groups as possible. In this way we honour the time and attention given to the research by participants, the gift of their stories or their willingness to complete a questionnaire, as well as our own efforts in carrying out the project. It might be relatively easy to identify an academic or professional journal suitable for reporting findings, but it could be more difficult to find ways to tell a general audience about the research. We can write pieces for support group newsletters, speak at meetings, create posters or leaflets, make recommendations, write submissions, talk on radio or provide information for community newspapers. There are often other reporting requirements, such as to Ethics Committees, organisational managers who facilitated access to people or records, and funding agencies. And above all, we should report back to the participants themselves.

During the year staff members have presented their research at national and international conferences. This journal is another means of disseminating ideas. One of its strengths, evident in each volume, is that it provides a forum not only for staff but also for students. This volume is no different. There are articles ranging from the exploration of practice issues, to the application of theories, to aspects of nursing education. As the sixth volume, it indicates a continuing commitment to publishing ideas, research and scholarship. Through writing, publishing, reading and discussing, we can all contribute to the knowledge of our professions and, in using knowledge wisely, make a difference to the health of all.

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REFLECTIVE PRACTICE - A LITERATURE REVIEW

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Introduction

"The essence of learning through reflection is for the practitioner to surface any contradiction between what she intends to achieve within any situation and the way she actually practises" (Johns, 1999, p. 241).

Although this statement may perhaps be viewed as ideal, the potential for the use of reflection within nursing practice is frequently being examined (Atkins & Murphy, 1993). Consequently, literature relating to this topic is increasing and is addressing many facets of reflective practice. The following literature review will include information relating to various definitions and uses of reflection and reflective practice, and types of reflective practice. Several authors' observations relating to processes involved in commencing and using reflective practice, and advantages and disadvantages of reflective practice, will also be outlined.

Definitions

Reflective practice may perhaps be described as a deliberate attempt to analyse and evaluate areas of nursing practice, through conscious examination of one's past or present actions (reflection). Reflection itself is a complex process in which feelings and cognition are closely linked (Burrows, 1995). There are a variety of definitions linked with the use of reflection and reflective practice in nursing. These two terms appear to be used interchangeably in the literature and may not always be clearly defined (Johns, 1998). As will become apparent, definitions of reflection often appear to outline what occurs in reflective practice.

Johns (1999, p. 241) defines reflective practice as generally being espoused as a "developmental process to empower practitioners to achieve and sustain effective practice". Boud, Keogh and Walker (1985, p. 7) view reflection as being an "active process of exploration and discovery which very often leads to unexpected outcomes. Glaze (1998) provides a range of definitions of reflection and its uses which includes simple problem solving approaches such as Schon's (1987) reflection on action and reflection in action. It also includes more critically conscious types of reflection based on critical science and self-awareness. Reflection may also be viewed as a political act, which may lead to change (Johns, 1998; Kemmis, 1985). However, Johns (1998, p. 2) criticizes the need to provide a definition for reflective practice as being a "legacy of rational thought".

The literature review also highlights definitions or descriptions that are more specific to the context in which they describe reflective practice. These are in relation, for example, to journalling, (Holly 1987; Street, 1995), reflective topical autobiography (Johnstone, 1999), reflective learning (Fitzgibbon, 1994), nursing education, (Davies, 1995), intuition (Benner & Tanner, 1987), and reflection in relation to transforming nursing practice (Glaze, 1998). Although not all nurses will define themselves as being in a state of chrysalis as Glaze avers, this metaphor may be appropriate when examining the links between transforming practice and reflection.

Potential effects

Literature generally appears to support the use and value of reflective practice within nursing. Fitzgibbon (1994) believes that critical reflection is now favoured and accepted as a dominant discourse within nursing. Burrows (1995) believes that as the use of reflection can address the artistic (as opposed to scientific) elements involved in the delivery of nursing care, it may be viewed as a key process in uniting practice and knowledge in nursing. This is supported by Schon (1983) who believes that much of professional knowledge and practice, particularly in law and medicine, has been based on technical rationality, that is the application of scientific theory and technique to problems of practice. He believes that the use of this model alone is limited, as it does not take into account demands of real-world practice. Schon asserts that if technical rationality is placed in the wider context of reflective inquiry it may be possible to develop a model which links real-world practice and scientific research.

Carkhuff (1996) and Shields (1994) discuss the part reflective learning in the workplace may play as a change agent relating to professional development and system integration. Although Fitzgibbon (1994) avers there is a scarcity of literature that describes how to practice reflection, she believes reflecting on experience can link practical nursing and research. This is supported by Benner and Tanner (1987) who outline the examination of skilled pattern recognition within nursing practice. Moon (1999) suggests that the work of Habermas, Barnett and Van Manen indicates reflection may have many roles. The ideal role is reflective inquiry which may critically evaluate both existing knowledge and practice.

Kemmis (1985), Greenwood (1998) and Johns (1998) believe that reflective practice may result in empowerment of nursing through changes at professional, social and political levels. Johns qualifies this however, by stating that in order to be a change agent, reflection needs to occur within a supportive environment. Smith (1993) is undecided as to the value of reflective practice, citing a study by Smith and Hatton, which found no conclusive results relating to the effectiveness of strategies to produce reflection.

Davies (1995) defines how reflective practice can be used by nursing students as a tool with which to order and make sense of an experience. However, Atkins and Murphy (1993) and Newton (1999) believe that other factors such as age, previous life and nursing experience will affect a student's ability to reflect effectively. This is reinforced by Burrows (1995) who found that experience, rather than knowledge, was ranked by nurses as the most important factor in decision making.

Methods of reflection

In addition to the above factors, personal choice may influence the types of reflection a nurse may choose to use. Literature indicates a variety of ways in which reflection can be practised. These include the use of diaries or journaling and this use has been discussed by Holly (1987), Shields (1994), Davies (1995), Street (1995), Marland and McSherry (1997), and Johns (1998). Holly describes diaries as less structured, more personal records of events, whereas journaling involves a reconstruction of various dimensions of experiences. This may lead to the development of new perspectives, which in turn may result in changes to practice (Davies). Reflection may also take place by the use of clinical debriefing (especially with student nurses). Davies cites Horsfall as defining clinical debriefing as a "process whereby group members (nursing students) discuss and work through ideas, feelings or concerns generated by individuals in the group" (p. 167). A combination of journaling and clinical debriefing may also be used (Davies).

Records in reflective diaries completed during student clinical placements may also be analysed by a preceptor using an assessment tool. Following this assessment of the student's reflection on action, the preceptor is able to plan specific learning activities relating to student needs. This may then enrich the student's reflection in action (Marland & McSherry, 1997).

Reflective topical autobiography is a research method which requires the use of journaling and reflection (Johnstone, 1999). Emancipatory action research may also lead to the development of reflective practice (Kemmis, 1985).

Processes associated with reflective practice

Although different types of reflective practice may be used, there may be commonalities when undertaking the processes associated with reflection. Boud, Keogh and Walker (1985) outline three points which may influence the passage through processes involved in reflective practice. These are: learners initially have total control of what they learn and how they reflect on their own experiences; reflection (as defined by Boud et al) is pursued with intent; and there is a close integration and interaction between feelings and cognition.

Atkins and Murphy (1993) have identified from literature three key stages in the reflective practice processes. These are an awareness of uncomfortable feelings and thoughts, critical analysis of the situation, and the development of a new perspective relating to the situation. However, other authors describe processes differently. For example Burrows (1995, p. 346) believes that the process of reflecting begins with "exploration and discovery to make sense of new information and leads on to a process of critical reflection, reframing problems and identifying probable consequences".

Kemmis's (1985) description of the processes differs from the above. He views the reflective process as dialectical, focusing inward on one's own thoughts and processes and focusing outward at the situation one is involved with. Shields (1994), drawing on the work of Boud et al, has developed a systematic view of the phases involved, namely preparatory, engagement and end phases. He believes that practitioners may be more likely to regard reflection as helpful if they can see it as having a systematic process.

Advantages and disadvantages

As with any advance in practice, there are factors that may be seen as positively or negatively affecting people's desire to change. The literature review has identified advantages in using reflective practice including reflection being an effective way to evaluate and change existing practice. Chinn and Jacobs (as cited by Burrows, 1995, p. 347) believe that it encourages a "holistic, individualised and flexible approach whereby all knowledge...is viewed as being useful for some purpose". This is reflected by Shields (1994) who believes that journal writing is an effective way of evaluating experience and promoting learning. Street (1995) affirms that advantages of journaling can include being able to identify and own one's own practice, pose the problems of practice and make new perspectives, and also to use journaling as a collaborative research process.

Thus reflection can lead to the development of more critical thinking and the evaluation of the status of knowledge and development of theory (Shields, 1994; Glaze, 1998; Johns, 1998; Moon, 1999). Street (1995), Glaze (1998) and Johns (1998) elaborate on the potential for critical reflective practice to challenge current ideologies and hegemonic practices within nursing and society, and thus perhaps be an empowering and emancipatory process for nurses.

Johnstone (1999) discusses the advantages of reflective topical autobiography and states that this can be an unobtrusive method of providing beginning researchers with a rich introductory experience into interpretive research. It also provides opportunities to develop research that is distinctively related to nursing, and may enable production of post-modern narratives.

When viewing reflective practice from another perspective, Shields (1994) and Davies (1995), state that reflective writing can enable both students and more experienced nurses to discharge their feelings by

writing about them. Davies discusses the value of the combined use of journaling and clinical debriefing as reflective practice tools for student nurses. Critical reflection and peer support may enable them to individually and/or collectively describe their feelings, identify, share and work through common experiences and problem solving. They may be able to identify reasons for action and specific learning needs. Davies believes that this will result in better analysis of problems (sic) from a client-centered focus.

This type of considered linking may be advantageous particularly to younger students who may, as previously discussed, not yet be able to draw on previous nursing or extensive life experience, and have not yet reached their full adult cognitive development (Atkins & Murphy, 1993). Reflection can also be effective in transforming practice of qualified nurses when expert nurses have confidence to challenge themselves and others in a non-threatening manner (Glaze, 1998).

During the review of literature several disadvantages relating to the use of reflective practice were highlighted. Barnett (as cited by Moon, 1999) posits that there is a danger of reflective practice becoming an ideology that is limited to practice at interpretive levels and not empowerment and emancipation levels. Johns (1998) questions whether organisations want empowered staff thereby reiterating this stance. He believes that nurses may have an internalised sense of powerlessness, which may be difficult to change, particularly in an unsupportive environment. Glaze (1998, p.153) also believes that challenging ideologies is difficult for the nursing profession which has "based much of its practice on ritual and routine in the past". Johns (1999) further elaborates on this view, stating that the success of reflection may depend on the relationship between the practitioner and the supervisor, and a nursing organisation committed towards collaborative ways of relating.

There are also other disadvantages mooted in the literature. The transformation process needed to develop reflection skills, extend knowledge bases and implement changes to practice can be challenging (Shields, 1994; Glaze, 1998). Nurses may have difficulty finding time to practise a form of reflective practice and may be unsure of how to commence (Street, 1995). This may be partly due to the paucity of available literature which outlines the practical processes involved in learning reflective practice (Fitzgibbon, 1994; Johns, 1998). Research has not yet shown any conclusive evidence into the effectiveness of reflection as a tool in developing critical thinking (Smith, 1993).

Conclusion

This review has provided definitions which range from those describing reflection (Burrows, 1995) to those providing examples of different degrees of complexities, (Glaze, 1998), to definitions of reflective practice in terms of the context in which it was placed.

The many uses of reflective practice in nursing have been discussed. These include its potential to transform practice through the use of critical thinking and evaluation of existing practice. It is also viewed as being able to address the artistic elements of nursing practice, which authors such as Burrows (1995) and Schon (1983) discuss as being omitted by the use of scientific models of practice. The potential use of reflective practice as a change agent leading to empowerment and emancipation has also been briefly discussed. Types of reflective practice include the use of diaries and journals, clinical debriefing and reflection aimed at developing research through the development of reflective topical autobiographies (Johnstone, 1999).

A summary of what Atkins and Murphy (1993) believe to be the key stages of reflective practice and other examples of authors' descriptions were also included. Overall the main points appear to be that the learner has direct involvement, the process is performed with intent and that it involves a close integration and interaction between cognition and feelings.

Many authors discuss advantages of using reflective practice within nursing. Those propounded include the opportunity to evaluate personal and collective experiences, to learn from this, and to change existing practice. Other authors, for example Johns (1998), see it as a potential opportunity to develop critical thinking in nursing, and thus challenge current ideologies and hegemonic practices. Johns also critiqued the reality of this occurring. Other advantages discussed included the opportunity for both nursing students and expert practitioners to discuss their feelings and actions in relation to nursing practice. Discussion also indicated some possible disadvantages to the use of and processes involved in the topic. In light of existing conditions, for example current nursing and social ideologies and non-supportive working environments, it may be difficult for nurses to change their practice. The time needed to practise reflective practice has been identified as a constraint, as has the feelings of discomfort self reflection may initially uncover.

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FAMILY NURSING IN THE NEW MILLENNIUM - APPLICATION OF A FAMILY ASSESSMENT MODEL

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Introduction

Increasingly nursing is recognising the significance of the family to the health and well being of individual family members (Wright & Leahey, 1994). Hartrick (1998) suggests family nursing in undergraduate nursing education will provide nurses with theoretical and practical skills to work effectively with families. This paper will demonstrate the assessment of one family using the Calgary Family Assessment Model (CFAM). This model will provide information on the structural, developmental and functional components of the family. The family's strengths and weaknesses are identified, and the role of a community resource in this family's life is described. This discussion will demonstrate the relationship these concepts have to health, nursing and primary health care. Critical social theory is described in relation to the family's health needs. All members of the family interviewed for this assignment agreed to participate and pseudonyms have been used to ensure confidentiality.

The Calgary Family Assessment Model

The CFAM is an integrated conceptual framework developed by Wright and Leahey for use when interviewing and making assessment of families. The CFAM consists of three major categories: structural, developmental and functional. Each category contains its own subcategories that may be relevant or appropriate depending on the family being assessed. This assessment focuses on the interaction among all of the individuals within a family.

Structural category

Structural assessment aims to identify who is in the family, relationships among family members and those outside the family, and the family's context (Wright & Leahey, 1994). The Simpson family is a single parent family consisting of Marg and her three year old daughter, Lisa. Both are New Zealand Europeans as are their relatives, although Marg thinks she has Irish and Scottish ancestry. Lisa's father has not lived with them for two years and lives two hours away, as do Marg's family. Lisa has weekly contact on the phone with her father and stays with him one weekend a month. Marg's parents divorced when she was thirteen. Her father has remarried and has three daughters from his second marriage. There is no rivalry between Marg and her stepsisters. Marg's mother and elderly grand-parents have weekly contact with the Simpsons and are readily available to them both. Support may be financial, emotional or help with childcare. Marg described the relationship with her grandparents as very special. Marg sets the family boundaries at present and feels confident they both have support through friends and family to discuss any problems that may arise.

Marg and Lisa belong to many subsystems within their own family. They both belong to an only child subsystem, a female subsystem and a parent child subsystem. There are larger systems this family has meaningful contact with. These include Marg's work, Lisa's daycare, New Zealand Income Support Service (NZISS), the local health centre and the gym. These subsystems all contribute in some way to the health and well being of this family (Wright & Leahey, 1994). As a single mother Marg incorporates the traditional gender roles of male and female. This involves child-rearing and nurturing as well as financial and disciplining roles.

The Simpsons moved to the city 16 months ago hoping to improve choices and opportunities for themselves. Marg is on the domestic purposes benefit and works 20 hours a week in a hotel. Lisa is in daycare 25 hours a week that is subsidised by NZISS. They live in a large rented house and have a large dog for security. With one income and increased living costs of the city, the Simpson's remain in a lower socioeconomic class. Marg hopes to attend university in the future, but accepts it will be a struggle to meet the rising costs of housing, education and travel for herself and Lisa as a single parent family. Marg and Lisa expressed no religious or spiritual beliefs.

Developmental category

The focus of this category is on the developmental life cycle stage of the family including the emotional process and changes within family roles (Wright & Leahey, 1994). The Simpsons are presently in stage three of the family life cycle, which focuses on families with young children (Santrock, 1997). However, this is relevant to a middle class North American family and assumes there are two parents. The CFAM does not clearly define a life cycle for a single parent family. The relevance of a North American model in the New Zealand context is debatable. This model fails to consider differing lifestyles, cultures, population and economics that may affect a family. This highlights a possible need for an updated model that can be adapted to any family situation.

There are six stages in this developmental framework. These include leaving home, marriage, families with young children, families with adolescents, entries and exits from family system and families in later life. Within each stage there are specific tasks the family undertakes. At stage three these are, making space for children, joining in household tasks and activities and involving extended family in parenting and grandparenting roles (Wright & Leahey, 1994).

Marg's life changed considerably after the birth of her daughter. She adjusted her life to meet the responsibilities and needs of parenthood. Lisa's father found the adjustment in lifestyle difficult, resulting in their separation. Marg continues to provide for Lisa through parenting, financial support and performing household tasks. Lisa's father pays weekly payments that are included in Marg's benefit. Both parents contribute to Lisa's development as a person. Extended family members provide emotional support and some financial support to Marg and Lisa. Marg feels she has a closer bond with her parents and grandparents now. She encourages Lisa's involvement with Lisa's father. This has involved a realignment of Marg's relationship with him to provide healthy role models for Lisa. Lisa spends more time with her mother, thus they have a stronger relationship than she does with her father who is under involved with Lisa at present. Marg hopes this will improve.

Functional category

Functional assessment focuses on interaction and communication among family members. Two main aspects are instrumental and expressive functioning. Instrumental functioning refers to the routine activities of daily living (Wright & Leahey, 1994). Much of this is attended to by Marg. As Lisa's main caregiver she is responsible for ensuring her own and her daughter's food, hygiene and sleep requirements are met. If Marg is working or unwell she ensures Lisa's instrumental needs are met by a friend or extended family member. She encourages Lisa's independence with her own self care such as brushing her teeth, to remove some of the pressures of being a solo parent.

Expressive functioning focuses on patterns of interaction among family members through various means of communication (Wright & Leahey, 1994). Marg stated she feels able to express her feelings with Lisa. This was helped by a parenting course and anger management where Marg learnt new ways of expressing her emotions. They showed Marg the impact of circular communication patterns and how they influence relationships. She now uses therapeutic communication skills such as time out and eye contact with Lisa. Use of nonverbal communication was evident throughout the interview. Lisa would watch her mother's body language and facial cues for approval. If Lisa wanted attention she used a combination of touch, speech and eye contact with Marg.

The Simpsons expressed effective problem solving techniques. Marg discusses any problems with a close friend. For further support or advice she approaches teachers at Lisa's daycare, her family, doctor or practice nurse. A possible cause is identified and a plan of action implemented. Marg and her friend later evaluate the situation and seek more help if necessary. Marg stated she finds this effective and this removes some of the pressure of being the main caregiver and a first time parent.

As a single parent Marg's role extends beyond being a mother. She appreciates the influence her role may have on Lisa and encourages the relationships with her father and extended family so she can experience a variety of social influences. Since their move to the city, Marg feels the parent child bond with Lisa has strengthened, This is expressed through showing affection, verbal and non verbal and praise for each other. This bond is likely to be stronger as they share a mother child bond and live together away from extended family.

Marg uses mostly traditional medicine and trusts the advice of her doctor and practice nurse. Having a community services card and free health visits for Lisa makes this the preferred option. Marg occasionally uses alternatives from a health shop, but finds this very expensive, thus her choice is limited.

Family strengths

Support systems

Supportive relationships and adequate social networks are beneficial to health and well being (Aiken & Holdom, 1997). This is highly relevant to the Simpsons who have a wide network of friends, extended family and social agencies. Friends and family provide emotional and sometimes financial support. Lisa's daycare encourages her educational development and gives Marg the opportunity to work. They also help Marg with parenting education and nutritional advice. The Simpsons medical centre attends to their physical needs and offers education and advice on health issues such as smoking. All of these support systems contribute to the health and well being of the Simpson family.

Communication

It was evident from the expressive functioning category of the CFAM that the Simpsons use a variety of communication skills. This is important due to the developmental age of Lisa who may express feelings and emotions in different ways to a grown child or adult (Santrock, 1997). Marg attended a parenting course that aided recognition of these differences and helped her develop her own communication skills to improve their relationship. These skills assisted Marg in completing an anger management course. Marg is now more able and confident in expressing her family's health needs and requirements to benefit them both.

Nutrition

Eating habits based on moderation and variety can help maintain and improve health (Ministry of Health, 1999). Marg values the importance of nutrition through her own reading, information from Lisa's daycare and the practice nurse. She ensures Lisa has protein and calcium to assist her growth and carbohydrates for fibre and energy. They eat regular servings of fresh fruit and vegetables. Marg is aware of the high incidence of osteoporosis and iron deficiency in women and has increased her intake of calcium and red meat to account for this. It is hoped healthy eating in childhood will help Lisa make healthy choices as an adult (Pike & Forster, 1995).

Weaknesses

Smoking

Marg has smoked for seven years. She finds it "comforting" and if "helps relieve stress." Studies have shown people in lower socioeconomic groups are more likely to smoke (Ministry of Health, 1999). Marg is aware of the financial and health consequences of smoking and hopes to give up in the near future through nicotine patches available at a reduced cost from the medical centre. Knowing the harmful effects of passive smoking on Lisa and her own health, Marg is determined to give up this unhealthy and expensive habit.

Financial

The Simpsons are in a lower socioeconomic class due to their reliance on Government assistance for living costs. Although Marg works part time she loses some of her accommodation supplement as a result and has to pay part of Lisa's daycare costs. Their move to the city has meant increased housing costs and the cost of education for Lisa is greater, making their choices limited. Although health visits are free for Lisa, they have no medical insurance and have to rely on the public health system, thus restricting their access to health care.

Community resource

Barnardo's Early Learning Centre is an important community resource for the Simpson family. Barnardo's works with New Zealand families and communities in the care, education and support of children. They provide family support, early childhood education and care, family counselling and parenting education. These services are funded through fees, the Ministry of Education, NZISS and public support from local bodies, trusts, business' and clubs (Barnardo's, 1995). Lisa attends the centre five days a week while Marg is at work. This is run by two registered teachers and two teaching assistants. This community resource contributes to the health and well being of the Simpsons by providing education that encourages a healthy lifestyle, incorporating physical, mental and social aspects of health.

Community resource in relation to health and nursing

The community or practice nurse is able to refer families to Barnardo's, or families can access these services themselves. Marg heard of them through a friend. The nurse may recognise a need for nutritional advice. Barnardo's provides pamphlets and nutritional advice to parents and educates children on healthy eating. Their service is less expensive than other childcare providers, which is considered by the nurse when making a referral. Families may not be aware of the services available, so education is an important part of the community nurse's role. Barnardo's foster a caring community that encourages child development and a supportive family environment. Parents are free to discuss any concerns with staff at the centre. Marg has found this helpful with assessment of Lisa's behaviour and health. Barnardo's have a holistic approach to health that incorporates emotional, physical and social aspects of the family's health and well being.

Primary health care

Primary health care is concerned with health promotion and prevention of illness. It focuses on the accessibility, affordability and acceptability of health care services in the community (Johnston & Brown, 1995). The community resource identified by the Simpsons is a good example of active health promotion and primary health care. Barnardo's is accessible to most families as they have centres throughout New Zealand and provide a wide range of services. Lisa's daycare is in the suburb they live in, making it convenient and accessible for them. Barnardo's accept children and families of varying ethnicity, race and social class and provide for children with special needs. Lisa learns to accept people of differing cultures. Barnardo's is affordable as there are often subsidies available to families and their fees are generally lower than other childcare providers. NZISS pays a majority of Lisa's fees making this affordable for them. Barnardo's is acceptable within the community as it has a family and community focus and provides quality care, education and support (Barnardo's, 1995). Barnardo's Early Learning Centre promotes health promotion activities such as sun safety, health education and nutrition, exercise, parenting, personal and road safety and social interaction among peers and families. This contributes to a supportive environment with access to information and life skills that help make healthy choices easier (World Health Organisation, 1986). The nurse's role in primary health care involves enlightening people about the choices and services available so they can be empowered to access and utilize support networks in their community. The Simpsons have found Barnardo's and their practice nurse a great help since their move to a new city.

Critical social theory

Critical social theory was developed in the 1920s by a number of philosophers, at the Frankfurt School in Germany (Boychuk Duchscher, 1999). Jurgen Habermas later joined the Frankfurt school. This theory provides a philosophical framework that aims to liberate individuals to see the conditions in society that constrain their participation in social interaction (Wilson-Thomas, 1995). Fay (1997) has identified the three practical elements of critical social theory, which are enlightenment, empowerment and emancipation. These elements are useful for nursing practice as a pragmatic approach is required. Fay (1997) suggests critical social theory can only be achieved when all three elements are completed.

Enlightenment involves encouraging individuals to recognise social conditions and constraints that can influence their social reality (Boychuk Duchscher, 1999). The Simpsons have utilised the information on nutrition, parenting and safety. This education has encouraged them to acknowledge the importance of physical, emotional and social factors on their health and well being. Accessing and analysing this information is the first step towards empowerment. Through critical examination of their reality the Simpsons can empower themselves to make lifestyle changes that influence their health outcomes. Marg recognised the need for enlightenment on parenting and communication. Now she has the information and support, she is able to make changes that benefit her family and can move towards emancipation. Emancipation is aimed at freedom from oppression that influences people's lives (Wilson-Thomas, 1995). Through the process of enlightenment and empowerment the Simpsons have the skills to enhance their individual autonomy and responsibility in relation to their health needs. They have actively made changes to improve their nutrition and communication, thus influencing their health and well being.

Conclusion

The increasing importance of family nursing incorporating the use of an assessment framework has been identified. The CFAM was used to describe the structural, developmental and functional components of the Simpson family, Marg and Lisa. These components acknowledged the extended family, subsystems and larger systems this family has contact with. Their lower socio economic status and struggles as a single parent family were described in relation to their developmental life cycle stage, although the CFAM does not clearly define an appropriate cycle for this family. The Simpsons used a variety of communication skills to interact with each another and these skills assist in the expression of feelings and problem solving within the family.

The Simpson's support systems, communication skills and nutrition were identified as strengths in relation to meeting their health needs. Smoking and finances were noted as possible weaknesses. Lisa's daycare was recognised as an important community resource for this family through its provision of support and education that fosters the concept of primary health care. The nurse's role is relevant in family assessment to identify the need for education, support and enlightenment on the effects of social influences on health. As identified with the Simpsons, critical social theory is an important tool for nurses in recognising, supporting and improving the health of families.

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Beginning Journeys - Volume 6

A COMPARISON OF TWO STUDIES - IDENTIFYING THE USEFULNESS OF PRESSURE SORE RISK ASSESSMENT SCALES

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Introduction

The use of an agreed upon method to help health professionals effectively manage pressure sores is considered important. Edwards (1994) explains that pressure sores not only risk the health status of patients but also result in unnecessary suffering and cost. This essay will compare two studies that look at the usefulness of pressure sore risk assessment scales and will attempt to assess their validity. It will go on to discuss the implications of the findings of the studies for nursing practice.

Background to the topic

Flanagan (1995) proposes that if pressure sores are to be prevented, an individual's at-risk status must be assessed to allow causative factors to be minimised by pre-emptive changes in management. Pressure sore (PS) risk assessment scales attempt to determine an individual's risk status by quantifying a range of the most commonly recognised factors affecting a patient at any time.

The ideal PS risk assessment tool demonstrates a good predictive value, has high sensitivity and specificity and is easy to use (Flanagan, 1995). Sensitivity is defined as "the correct prediction of those who develop a PS" and specificity as "the correct prediction of those who do not develop a PS" (Watkinson, 1997, p. 341). A predictive positive test (PVP) is defined as "predictive of those who might develop a sore" and a predictive negative test (PVN) as "those who will not develop a sore" (Maylor & Roberts, 1999, p. 630).

Research by Pang and Wong (1998) involved comparing the Norton, Braden and Waterlow scales with the aim of determining which of these pressure sore risk calculators is the most relevant for the rehabilitation setting. Braden and Bergstrom (1994) researched the predictive validity of the Braden Scale and the timing of assessment for optimal prediction of PS development.

Overview of the research methods

Pang and Wong's (1998) research was conducted in medical and orthopaedic wards in a rehabilitation hospital. There were 106 patients who successfully completed the trial period. Instruments included a demographic data collection form, and a skin assessment chart that was used to record the patient's skin condition each day. A checklist recorded any pressure-relieving measures. The three pressure sore risk calculators were used. Within 48 hours of admission an initial assessment included skin and PS risk measurements. The skin was observed daily until the first pressure sore was discovered or for a maximum of two weeks. Any positive preventative measures that were utilised were recorded in the 'Nursing Intervention Checklist'.

Braden and Bergstrom's (1994) research involved 102 subjects in a skilled nursing facility. Instruments included the Braden Scale, and a skin assessment tool, which identified the bony prominences and required the identification of any lesions at each site. An assessment was made on the first day of the study and then every 48 to 72 hours for a month.

Research findings

The incidence of pressure sores in each study was similar. In Pang and Wong's (1998) study 21 (20%) of the 106 subjects developed pressure sores. Four of the cases were Stage 2. All of the remainder were Stage 1. In Braden and Bergstrom's (1994) study, 28 (27%) of the 102 subjects developed pressure sores. This time 21 were Stage 2, with only seven being Stage 1.

In Pang and Wong's (1998) study, pressure sores developed from days two to thirteen. Braden and Bergstrom (1994) similarly described most pressure sores developing within two weeks. They also found that all those who were going to develop pressure sores did so within four weeks.

Braden and Bergstrom (1994) found that age, gender or race did not determine the presence of pressure sores nor the number of sores discovered. Pang and Wong (1998) did not comment on this. Pang and Wong (1998) noticed no relationship between the nursing interventions (as recorded in the Nursing Intervention Checklist) and the incidence of PS formation.

Pang and Wong (1998) described the relative qualities of the three tools. In decreasing order of specificity were the Braden Scale (62%), Norton (59%) and Waterlow (44%). In terms of sensitivity were Waterlow (95%), Braden (91%), followed by Norton (81%). The Braden Scale had the most satisfactory predictive values of both positive and negative tests. In the final analysis, the rate of correctly predicting sores was highest with the Braden Scale (68%). This compares with Norton (63%) and Waterlow (54%).

Braden and Bergstrom's (1994) research considered the timing of assessment. Data analysis included only the values recorded at admission (Time 1), 48 to 72 hours following admission (Time 2) and the observation preceding the first recorded PS. They calculated the sensitivity, specificity, PVP, and PVN for each of the above three points over a range of Braden scores. Sensitivity was higher just before the first recorded PS (79%) than at Time 1, but the same as at Time 2. Specificity, PVP and PVN were all highest at the observation point preceding the first recorded PS.

In Pang and Wong's (1998) study the assessors were asked how they found the scales to use. The assessors felt that the Norton Scale was easy to use, but found some terms too vague, hindering objective assessment. They found the Waterlow scale more time-consuming and noted that some items lacked clear definitions and therefore over-relied on the interpretation of the assessor. They found the Braden Scale had clear and simple explanations and no significant problems were noted with its use. Braden and Bergstrom (1994) did not comment on the ease of use of the Braden Scale.

Critical comment

With the move towards evidence-based practice in nursing, it is important to consider the strengths and weaknesses of the studies when assessing their clinical usefulness (Mulhall, 1998).

Pang and Wong (1998) conducted a pilot study using four subjects to establish reliability (Beanland, Schneider, LoBiondo-Wood & Haber, 1999). Braden and Bergstrom (1994) do not mention a pilot study. In Pang and Wong's (1998) study, subjects were recruited after voluntary consent was obtained. It was unclear whether the process of selection was random in any way and hence bias may have been introduced (Beanland et. al, 1999). In Braden and Bergstrom's (1994) study, subjects were recruited from computer generated, random numbers. The sample sizes were similar in both studies and seemed adequate for statistical purposes (Beanland et. al, 1999). However, Pang and Wong (1998) included a more even distribution of males and females. The findings may be generalised to populations similar to that used in the studies (Beanland et. al, 1999).

To reduce bias, the assessors in Pang and Wong's (1998) research used only one scale to assess each patient. The assessors did not compare scores during the study. In Braden and Bergstrom's (1994) study, reliability was maintained by one nurse determining the Braden score at each observation while another nurse assessed skin condition. Each nurse was blind to the other's findings. It is difficult to be sure of the true effectiveness of this "blind" technique in either of the studies (Beanland et. al, 1999).

Pang and Wong (1998) describe how inter-rater reliability of the Nursing Intervention Checklist and Skin Assessment Form was tested separately by two assessors. This produced a correlation coefficient of 1.0. The correlation coefficient was also close to 1.0 when comparing the rating scores of each pair of assessors using each of the three pressure sore risk scales. These coefficients of reliability are acceptable as Beanland et. al (1999) recommend coefficients of 0.70 or higher. In the study by Braden and Bergstrom (1994), acceptable inter-rater reliability of the Braden Scale was maintained for all levels of nursing personnel with coefficients ranging from 0.84 to 0.99. Inter-rater reliability of the research staff in using the skin assessment tool was checked monthly and was maintained at 0.95 to 1.0 throughout the study (Braden & Bergstrom, 1994). The reliability coefficients in this study surpass the recommended value of 0.70 or higher (Beanland et. al, 1999).

In summary, both studies by Pang and Wong (1998) and Braden and Bergstrom (1994) involved adequate sample sizes and included techniques to maintain reliability.

Implications for practice

It would appear that the Braden Scale has advantages in practice over the other scales studied. It would also seem appropriate to encourage consistency in its use over a wide number of clinical situations. Frequent reassessment appears to improve positive predictive outcomes. Waterlow (1996) explains that the advantages of a standard classification system are many. It will be clear what another nurse has written and a record of all sores can be kept and monitored, knowing that everyone is using the same assessment. She also explains how educating staff becomes more cost-effective when only one risk assessment scale is taught.

Edwards (1994) says that of the many scales reported in the literature, the three which have been scrutinised the most frequently are the Norton, Waterlow and Braden Scales. The Braden Scale is claimed to be the most reliable of those reported in the literature (Edwards, 1994; Flanagan, 1995). Pang and Wong (1998) found the Braden Scale to be the most reliable risk calculator, achieving a better balance between sensitivity and specificity as well as having good positive and negative predictive values. They also reported that assessors found the Braden Scale easy to use. In view of these findings they suggested that the Braden Scale is the most relevant and accurate scale. Braden and Bergstrom (1994) found that the Braden Scale is a good indicator of the need to implement individualised interventions aimed at preventing pressure sores. They also found that prediction was maximised with regular reassessment of risk.

Whichever scale is used, it is important that it is repeated regularly to continue its validity. Flanagan (1995) states that because a patient's general condition is not static, neither is risk status and she therefore advises regular reassessment to detect patients' changes in risk.

Conclusion

This essay has compared two studies looking at the usefulness of pressure sore risk assessment scales. The studies generally used appropriate research methods and their findings are supported by wider literature. They conclude that the Braden Scale is a reliable risk assessment tool and is generally superior to other scales reviewed. This has implications for nursing practice in that a reliable assessment tool can be effectively used to ensure safety and consistency of care. Educating nurses to use a single assessment scale increases cost-effectiveness. Whichever score is used, the importance of regular use cannot be overstated.

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Beginning Journeys - Volume 6

THE RELATIONSHIP BETWEEN GOOD HEALTH AND THE SOCIAL AND MEDICAL MODELS OF HEALTH

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Good health enables people to participate fully in society and provides the "means by which people can pursue their goals in life". (Seedhouse, 1993, as cited in National Advisory Committee on Health and Disability, 1998, p. 20).

Good health is not evenly shared by all New Zealanders. Social, cultural and economic factors cause substantial inequalities in health. (Woodward & Kawachi, 1998, p. 1).

Introduction

This article will explain the relevance of the social model of health to nursing, with reference to the two quotes above. The social model of health will be described and compared to the medical model of health with its relevance to nursing also being examined in consultation with nursing literature. The concept of 'good health' is also discussed in relation to nursing and in relation to the quotes above. Good health is said to be fundamental to how individuals participate in life because it offers them the chances to achieve their goals. However there are authors who suggest that good health is not something that all people have (Lazenbatt, Orr, Bradley, & McWhirter, 1999; Woodward & Kawachi, 1998). Beyond the physiological presence of illness, good health can be affected by social conditions including unemployment, socio-economic status, quality of housing and poverty. The social model of health offers the opportunity for nurses to care for their patients in a way that is occasionally at odds with the prevailing focus of Western medicine.

The Social Model of Health

The World Health Organization (WHO, 2000) defines health as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". This implies that health may be viewed as something greater than that espoused in the traditional view of health as understood by Western medical practitioners. This traditional view is known as the 'medical model of health' and differs in focus from the more holistic approach of the 'social model of health'.

The medical model of health views human beings as the sum of their parts. It relies on the use of medical facts derived from rigorous scientific testing and objective research as the basis for medical practice (Gillespie & Gerhardt, 1995). This model focuses on ill health, tends to classify illness in a reductionist manner, and has a high level of control over the patient (Oberski, Carter, Gray, & Ross, 1999) but is unable to explain why rates of illness and death vary between social groups (Germov, 1999).

The social model of health is based "firmly on a belief that, behind the surface manifestations of disease, lie 'real' causes relating to the way in which society is organised and structured" (Gillespie & Gerhardt, 1995, p. 82). The social model "maintains that health and illness cannot be fully understood or addressed without considering the social context in which they occur" (Germov, 1999, p. 318) but does not deny the existence of psychological or pathological factors involved in disease. A social approach to health care seeks to (re-) establish a patient's independence by having them involved in their care plan (Oberski et al., 1999).

A useful comparison of the different approaches used by the two models of health can be drawn when considering an illness such as coronary heart disease. Gillespie and Gerhardt (1995, p. 93) comment that the "biomedical interpretation [of] the disease would be causally identified by clinical pathology, and found within the malfunctioning of the body" while the social model of health would add extra lifestyle information to this. In addition, "the lifestyle itself can be addressed, through examination of, for example, the relationship between poverty and health, exposing factors underlying the aetiology and the choices that people make" (Gillespie & Gerhardt, 1995, p. 93).

Relevance of the Social Model to Nursing

The relevance of the social model of health to nursing is in its focus. Traditionally nurses have worked within the sphere of medicine which takes as its *raison d'être* a view of health and illness that is empirically based. A strong foundation in anatomy and physiology has seen the development of diagnostic, medical and surgical competence (Buxton, 1996) that has led to important gains in social and personal health. However, where the focus for doctors is fundamentally microscopic, nurses view the processes of disease and illness more macroscopically and take into account the presence of factors that may not be seen as directly related. Nursing interventions "take proper account of the fact that people who are frightened, worried about their children, unable to eat properly because of ill-fitting teeth or lack of an appropriate diet, cannot achieve health solely through an isolated clinical intervention" (Buxton, 1996, p. 28). Indeed, health is defined and redefined depending upon whose point of view is being considered.

The social model of health provides an outline to help proactively extend nursing care into preventive health care. In South Auckland, for example, "an enhanced school health service has been developed, which is addressing unmet health needs through a school health referral system" (Farrell, 1999, p. 2). This service, run by public health nurses in the area, is one of several initiatives designed to target those New Zealanders for whom "good health is not evenly shared" (Woodward & Kawachi, 1998, p. 1). Unfortunately, the service is also a response to the socio-economic inequality and poor health status experienced by a disproportionately high number of Maori in New Zealand society (National Advisory Committee on Health and Disability, 1998).

The social model of health encompasses social, cultural, and economic factors relevant to an individual's life and it allows a more holistic view of the individual and their state of health. A part of nursing involves interpretation and reflection on the whole 'being' of an individual in nursing care, that is, where the person has come from, how they are now, and where they will be going (back) to later. Kilday (1999, p. 21) asks how nurses can work "holistically when today's emphasis is on cost control and doing 'more' with 'less'". The answer is that nurses are in a position to investigate the health inequalities that exist for their patients in ways that doctors and health administrators cannot. In this respect the social model of health in combination with nursing practice functions as a bridge between two otherwise incompatible contexts - the subjective view of the patient and the empirical view of the doctor.

A Maori perspective of health, as presented by Durie (1998), has a lot in common with the social model. The whare tapa wha (a four-sided house) model represents four different yet inter-related dimensions: spiritual (wairua), thoughts and feelings (hinengaro), physical (tinana), and family (whanau). This perspective, according to Durie, is not unlike the holistic view of health nor dissimilar to the WHO definition of health but differs from both by being strongly focussed on a spiritual as well as the somatic base. To have this spiritual focus is to have an understanding of the relationship between the human context and the environment. Without this awareness an individual cannot be healthy.

The WHO (2000) definition of health has been credited as being the catalyst that has allowed holism to be accepted as part of general health care. While superficially the definition appears to be value-neutral, Wilson (1998) believes it encourages greater involvement of 'gate-keeping' health professionals in the physical, mental, emotional, and spiritual well-being of ordinary people. Furthermore, she argues: "If social problems are presented as having medical solutions there is less chance that the political and economic causes of ill health will be revealed or addressed" (Wilson, 1998, p. 20). This is a good point although her concern over the gate-keeping health professionals seems to assume that nurses and their patients are passive actors within the medical model of health. Perhaps the slow acceptance of related ideas - preventive health care, community nursing, alternative medicine, holism, and the social model of health - will result in small pockets of success in the wider community.

Good Health

Good health, according to Seedhouse (1993, cited in National Advisory Committee on Health and Disability, 1998, p. 20) enables people to participate fully in society and provides the "means by which people can pursue their goals in life". However, good health is a relative term, the exact meaning of which might differ between any two people. Certainly, the *amount* of health, good or otherwise, that an individual possesses is dependent upon various conditions being met.

Several authors have identified key areas that affect good health (Gillespie & Gerhardt, 1995; Lazenbatt, Orr, Bradley, & McWhirter, 1999; Woodward & Kawachi, 1998). The National Advisory Committee on Health and Disability (1998) has also listed determinants for good health that include good housing, adequate income, affordable food, and educational and social support within communities. In essence good health is concerned with social, cultural, and economic determinants and the inter-relationships between them.

As Durie (1998) points out in his discussion on Maori health, good health for many Maori depends upon the continued harmony between the individual and the wider environment. However this harmony breaks down when factors like good housing, employment, educational achievement, and adequate incomes are absent in the wider environment. The variations in health status between Maori and non-Maori therefore are greatly influenced by environmental factors that can be changed. As Woodward and Kawachi (1998, p.10) point out, "there is no doubt that the predominant causes of ill-health among Maori are, potentially, preventable".

Of the contributing factors to good health, income is seen as the most important determinant. The correlation between low income and poor health is consistently demonstrated (National Health Committee, 1998). Economic factors, including unemployment, are frequently cited as strong determinants of poor health (Lazenbatt et al., 1999; Page, 1999) and they are often associated with poverty and poor social conditions.

It has been said that "the decisions that individuals make about health care are clearly shaped by the environment in which they are conceived, raised and live their adult lives" (Woodward & Kawachi, 1998, p. 9). Low socio-economic status is one part of the social environment that impacts on health because it affects social behaviour. When social conditions are poor, knowledge of poor health practices (for example smoking or having a high fat intake) is often not enough in itself to change the conditions (National Health Committee, 1998). However, Page (1999, p. 753) believes that some success is possible but that "the message must be tailored to the individual, whose socio-economic circumstances should be taken into account at the assessment stage of the nursing process".

Conclusion

The social model of health encompasses a wide variety of issues that may not be apparent when a patient presents for medical or nursing care. One concern of nursing is how external factors have affected the patient up to the point of treatment. Another concern is how these factors will continue to influence the quality of life for the patient after the period of care has finished. The social model allows nurses to consider the impact of environmental factors present in the patient's life and how they affect the patient's good health. These factors include employment, income, quality of housing, education, cultural background, and their social network of friends and family. The social model of health focuses on obtaining qualitative information which is at times at odds with the focus of the medical model. Nonetheless, despite the differences in philosophy the two models have the individual as the focus of their attention and nursing benefits from having access to both schools of thought.

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MYTHS & REALITIES OF A TRANSFORMATIVE CURRICULUM

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The basis of this paper was written and presented in 1998 at the 9th International Critical and Feminist Perspectives in Nursing conference in Adelaide, Australia. Whilst we acknowledge nothing stays constant, much of what we discussed two years ago remains relevant in 2000.

Introduction

For many decades nursing curricula have been taught within the positivist paradigm, and this has not positioned nurses advantageously to address the rapidly changing face of health care which is occurring at a national and international level. Nursing graduates of the 21st century are required to be well equipped to understand and meet the burgeoning social, political and economic influences on health. Learning must therefore be facilitated within paradigms broader than the positivist, and inclusive of interpretive and critical paradigms. The critical paradigm has an explicit aim of challenging the status quo, and of generating change through emancipation and transformation. Within this paradigm, education has the potential to develop graduates who have an ability to generate change.

This paper will discuss some of the myths and realities inherent in the transformative education of a nursing graduate at Christchurch Polytechnic Institute of Technology (CPIT). The evolving and developing approaches to teaching and learning in this curriculum will become apparent. We wish to acknowledge that the issues we discuss arise from a broad range of student experiences, but that they are not reflective of the experiences of all students.

Christchurch Polytechnic Institute of Technology Nursing Curriculum

The transformative curriculum at CPIT was created from a desire to develop a nursing programme which would enable graduates to think critically, be reflective practitioners who are able to theorise their practice, provide competent and culturally safe care for all people and develop beginning skills in scholarship. Pivotal to this transformative curriculum are the 11 key educational and health concepts which include critical thinking and reflective practice, health assessment, holism, caring and communication, social model of health, tools of nursing and cultural safety (Nursing and Health Education, Christchurch Polytechnic, 1994). These concepts are threaded throughout the programme, provide a framework for the curriculum and are congruent with critical social theory, the underlying philosophy of this transformative curriculum. The key concepts enhance the emphasis of a curriculum that is focused on the process of learning, rather than the achievement of pre-determined outcomes. Predetermined outcomes have tended historically to reproduce some behaviours, knowledge and attitudes which are not congruent with emancipation and transformation.

The processes of learning focus on the skills, attitudes, thoughts and individuality of each learner and generates ongoing potential for learning. This focus on the processes of learning enables the learner to integrate many different kinds of knowledge and thinking. Inherent within this process is the concept of the 'transitional dynamic', in which the learner moves from external direction to the more androgogical position of greater self direction (French & Cross, 1992). However, whilst this movement is apparent for some students, not all adult learners are motivated towards self-direction or become engaged in problem solving. With a similar perspective Darbyshire (1993) strongly criticises the positive light in which intrinsic self motivation is held and argues that androgogy has very little to offer critical transformative nurse education. Harden (1996), in agreement, argues that the ideology androgogy has become, limits and constrains educators' abilities to develop a critical consciousness in nursing students. Both Darbyshire and Harden espouse a new critical pedagogy which they contend will provide far more radical, powerful and transformative possibilities for nursing education.

Wilson-Thomas (1995, p. 572) views critical social theory as a "form of science that seeks to liberate individuals from conscious and unconscious constraints that interfere with balanced participation in social interaction". Fay (1987) describes the practical application of critical social theory occurring with completion of the three components of enlightenment, empowerment and emancipation. No one component is sufficient in itself. Liberation requires a new understanding from the oppressed group, and a desire and a will for empowerment to reach the goals of emancipation. There are however, difficulties inherent in the transition from the theoretical to the practical.

Until quite recently, nursing curricula have been situated and constrained within medical and political hegemony which has not encouraged empowerment and emancipation for nurses (Clare, 1993). However, through this transformative curriculum it is anticipated that nurse practitioners will become empowered to think critically and develop a critical consciousness. The rapidly changing health context within New Zealand demands such practice, but how effective are educators at providing such graduates, and how effective is the practice world at utilising these graduates?

Some myths and realities

As the underlying philosophy of this curriculum is critical social theory we will use the three components, enlightenment, empowerment and emancipation as a framework for discussing some of the myths and realities of a transformative curriculum. Fay's (1987) argument that these three components of critical social theory are necessary for the practical intent to be achieved begs the question 'what is accomplished through the curriculum at CPIT?'

Enlightenment

Enlightenment can occur within positivist, interpretive and critical paradigms, and is not specific to the critical paradigm. Fay (1987) believes enlightenment may occur through the illumination and imparting of knowledge. However, enlightenment alone is insufficient for change to occur.

Valuing differing knowledge paradigms

Personal experiences and knowledge are valued as valid knowledge and used as a base for learning. It is important for students to identify their own beliefs, expectations and personal knowledge. However, personal biases should be challenged in order for safe nursing to occur. In year one sharing and challenging often occurs during tutorials (18 students) and small reflection groups (6 students). Sharing in small groups and being appropriately challenged can be a stressful process. However, it could lead to the valuing of knowledge outside the individual's comfort zone. Challenging therefore occurs within constraints of promoting confidence and encouraging dialogue.

The application of theory in different contexts involves interpretation and this requires a level of proficiency and adaptability which beginning students may not have. Initially students often want to be given 'the rules' and be shown 'the way'. They may find it frustrating to be presented with multiple ways. Hand-washing provides an example of different types of knowledge with technical knowledge identifying 'the way' of removing transient organisms with warm water and appropriate solution. Practical knowledge identifies 'the way' to wash hands in the context of automatic sensor taps, mixer taps, separate hot and cold taps, or a cold tap only, and with various solutions. Whilst valuing both technical and practical knowledge may help to prevent an apparent theory and practice gap, some students can have difficulty when exposed to multiple ways. Challenging learners thinking encourages us to value knowledge outside our comfort zones.

In year 3, during the maternal and infant component of the programme, students who have experienced pregnancy and childbirth have the opportunity to share their experiences with their colleagues. Many are delighted to be able to do so and provide rich and colourful learning for their peers. Students find personal anecdotes valuable learning in relation to family and community health and enjoy being able to link such personal knowledge with learned technical knowledge. Families and friends share experiences of pregnancy, birth and health episodes and this demonstrates to students that knowledge related to health is owned by people, not by the nursing and medical professions. Students are introduced to the concepts of enlightenment, empowerment and emancipation as they relate these concepts to family health. An example of such knowledge is the richness and complexity of the social construction of gender in relation to health.

Reflective practice

In year one professional practice courses there is a high commitment to journal writing and reflective practice. The aim is that students learn from their practice experiences and theorise their practice. Time is allocated within student clinical practice hours for this to occur. At this beginning level, journal writing is descriptive with beginning analysis. Facilitators of reflection sessions encourage students to relate practice experiences to theoretical concepts and knowledge. Feedback from students indicates that most of them find journal writing and reflection beneficial, although a few state it is "not for me". The relevance of journal writing and reflecting on experiences remains elusive for some. However, learning occurs within a range of comfort levels, confidence, openness and honesty.

Whilst learning from practice is considered critical, a level of competence is required for safety. Socialisation is important as students identify with professional nursing values and standards. Making the values and standards obvious and clear may be one way of reducing the hidden curriculum. Initially lecturers and practitioners decide which values and standards are met, whilst recognising that ultimately the students, as registered nurses, will decide how they will practice.

Students continue to journal and reflect in varying degrees throughout year three in a variety of clinical placements. Anecdotally it appears that students generally do not journal unless an unusual situation is experienced, or a lecturer suggests they do so. However, reflecting on their practice is perceived to be most relevant. Many of the registered nurses who work with the students in clinical placements have never journalled and therefore do not encourage this process. The differing educational and practice levels of registered nurses reflect one of the ongoing issues faced by nurse educators. Reflection occurs informally with the nurse educator visiting the student at the clinical placement.

Formal reflection occurs in tutorial groups when the students return to CPIT, where they are encouraged to use the political, social and economic framework of the Family and Community Health course. It is often in these sessions that the hidden curriculum is uncovered as students discuss nursing practice, which is at odds with their classroom learning. Power issues and differing nursing practices are often the focus of these reflection sessions. Socio-economic and political issues challenge many students as they are confronted by

living conditions and personal values and beliefs that are beyond their current experiences. Harden (1996) suggests that the concepts of critical theory provide a useful lens with which students can examine health care and structures. Students can readily identify and understand the impact of social, political and economic determinants of health. However, their ability to move beyond enlightenment to action remains questionable.

Empowerment

Fay (1987) believes empowerment is a practical force which can galvanize people into 'socially transformative action'.

External to internal direction

In year one, while there is a high level of external direction, students develop a commitment to their learning. Lectures, tutorials, simulated sessions and assessments are pre-determined which provides an appropriate level of direction for beginning students. Feedback from students suggests that the majority cope successfully with the level of structure in place, often acknowledging that there is less external direction than they have previously experienced. Some students however, do not desire this level of direction. Ensuring students gain critical foundation knowledge can act as a constraint to empowerment. This generates the question 'How relevant is a transformative curriculum at this stage of higher external direction?'

In year three there is a burgeoning level of internal direction commensurate with decreased external direction. Health promotion, primary health care, family and community health are explored within the political, social and economic perspectives. Much of the explorations involve personal aspects of the students' lives as they all belong to a family and live within a community. From day one of year three lecturers make explicit that the students are expected to be more independent in their learning. They are responsible for ensuring the learning environment is what they feel suits them best. Lecturers check in with the students on a weekly basis where any issues may be raised. Students are strongly encouraged to resolve issues and communicate openly.

The pivotal component of critiquing and challenging takes place both in lecture format and in small tutorial groups. In clinical placements there are also preset learning outcomes and students are expected to develop their personal learning outcomes for specific placements. An informal learning contract is provided for them to document these personal goals and they are encouraged to share and discuss these with clinical staff. The move to internal direction occurs in varying degrees.

Empowering students for what?

Is this curriculum endeavouring to empower students, the people they nurse, or both? Robinson and Hill (1995) suggest that to enable students to facilitate empowerment of the people they nurse, the student should first experience such empowerment through educational processes. Whilst one goal of the nursing degree is empowerment, this may be an elusive process. Constraints within nursing education still exist, and arise from educational and health institutions and facilities.

Emancipation

Emancipation involves liberation. The philosopher Horkheimer, a central figure in the Frankfurt School, asserted that critical theory was guided by an interest in the emancipation of people from class constraints and from domination in all its forms (Held, 1980). In more contemporary times, Harden (1996) believes emancipation in education not only requires teaching practices that are liberating, but also a commitment from the learners.

As year one progresses students grapple with the troughs of higher and lower work-loads, and with the realities of nursing. They develop varying levels of commitment. Feelings of oppression are not explicitly voiced although some students will admit to keeping their heads down and working steadily to keep meeting course requirements. Whilst year three students demonstrate a certain level of commitment, some may continue to express feelings of disempowerment. We hear students say "we know we're an oppressed group; you continually tell us so, but what can we do about it?" Perhaps we have been so busy deconstructing the nursing profession, in an effort to understand our oppression that we have forgotten to reconstruct it in the positive light we view the profession.

Nursing students often commence nursing within the 'traditional paradigm' expecting to be trained, rather than educated. In New Zealand many educators have moved beyond this traditional model, but do all students and clinicians understand the difference between education and training? Harden (1996) would argue that by raising students consciousness we are only doing half the job, and in fact we contribute to their feelings of powerlessness. It is important therefore that students have the opportunity to develop the skills to move beyond enlightenment to empowerment and emancipation.

Some final thoughts

A transformative curriculum is to do with change. It is a way for learners to "perceive critically the way they exist in the world, with which, and in which they find themselves; they come to see the world not as a static reality, but as a reality in process, in transformation" (Freire, 1996, p.64). A commitment for change is required from both the learner and the teacher. At this time we are unable to reach a conclusion as this

discussion is part of an ongoing experience for us, both at a personal and professional level. Many students, we believe, are enlightened, sometimes empowered, rarely if ever emancipated. We contend that it is unrealistic to expect that all students will be emancipated at the end of this three year undergraduate programme. Whilst enlightenment and empowerment are realities of this transformative curriculum, emancipation appears to be a myth.

The reality of nursing practice is that it continues to take place in the context of medical and political hegemony. The pervasive market ideology that currently drives health structures is the antithesis of the humanistic nature of nursing. The recent nursing taskforce identification of constraints to nursing practice can be seen as a step towards the enlightenment of the profession (Ministerial Taskforce on Nursing, 1998). However, it is yet to be seen whether the rhetoric emanating from the taskforce can be transformed into empowerment and beyond. There remain many challenges within nursing education, not the least of which is the empowerment of nurses and nursing practice.

This curriculum is an attempt to position nurses more advantageously to meet the rapidly changing health care needs of New Zealanders. The critical paradigm offers an opportunity for students to identify constraints and tensions which impact on their practice. This consciousness raising is consistent with the intent of the three components of critical theory, enlightenment, empowerment and emancipation.

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MEASURING NURSING OUTCOMES

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Escalating costs of health care are in part a result of the progress medicine has made in recent years, as well as the increasing availability of technology to sustain life and New Zealand's aging population. These increased costs have meant decisions have had to be made to rationalise increasingly scarce resources and this limits which health strategies and activities are to be undertaken (Antrobus, 1997; Barnett & Barnett, 1997; Crookes, 1992; Grew & Feek, 1996; Griffiths, 1995; Williams, 1997). One of the challenges facing health care providers is to provide evidence that the care provided makes a difference to those receiving it.

Recent trends in health care, led by government policy which is influenced by economists, have necessitated health care professionals demonstrate the effectiveness of the services that they provide. Effectiveness is measured in fiscal terms, such as cost-effectiveness, rather than clinical effectiveness as has historically been the case (Antrobus, 1997; Barnett & Barnett, 1997; Griffiths, 1995; Ray, 1999; Spitzer, 1998; Williams, 1997). Whilst all health related disciplines are experiencing difficulties with this concept, the generalist nature of nursing and its poorly recognised and articulated value within the domain of patient outcomes, presents a number of unique difficulties which will form the basis of discussion in this paper.

Prior to the change to a National Government in 1990, Barnett and Barnett (1997) identified the existence of a dual health system in New Zealand. This dual system had developed as a result of a contrasting allocation of funds. This resulted in inequalities in access, cost shifting and fragmentation of services. Barnett and Barnett describe modest restructuring in 1989 which emphasised increased accountability, result-orientated reporting and utilisation of market and administrative strategies in an unsuccessful attempt to contain growth.

With the change of government in 1990, in a stated attempt to increase efficiency and create a more equitable and accessible health care system, the roles of purchasing, providing and policy making were separated in a partially competitive managed market. Crown Health Enterprises (CHE's) were formed (Barnett & Barnett, 1997). Hornblow (2000, p. 133) states that "accompanying the advocacy for these laudable goals, were repeated and largely unsubstantiated accusations of gross inefficiency, poor targeting and provider capture" which eventually led to a "climate of mistrust between boards, management and professional staff". Ray (1999) expressed concern at the dominant theme of the time, describing it as one of avoiding negative outcomes within cost containment practices.

By November 2000 the recently elected Labour government, as part of its rejection of the commercial health model, plans to have in place democratically elected District Health Boards (DHB's) which will function as statutory corporations (Luke, 2000). Luke questions how these changes themselves will be measured, given that they have less than two years in place before the next general election. He poses that with the shift of focus to improvements in community and population health, it is likely to take far longer for any improvements to be achieved, and to be measurable as well as measured. Despite this apparent rejection of the commercial model, health spending will still require rationing and the boards will have a number of roles to juggle as they are lobbied by different health sector groups.

Providing evidence of the cost effectiveness of care given, and subsequent positive patient outcomes has become the primary means utilised by health care professionals to maintain and compete for health services (Ray, 1999). Ray (1999) raises questions as to who decides what forms of evidence are legitimate, what it is that constitutes a meaningful difference and what constitutes quality. She also argues that the ability of a profession to translate their research and contributions into the language of institutional analysis gives them a greater chance of being heard within this environment. She believes that nursing has been compromised as a result, both by our lack of demonstrated ability in this area and also because there is little data on the types of services nurses provide and their contribution to patient outcomes.

If it is recognised that nurses deliver 80% of direct patient care (Beardshaw & Robinson, 1990 in Antrobus, 1997) then they must contribute to patient outcomes. Bill English, former Minister of Health, asserted in his 1997 address to the New Zealand Nurses Organisation Conference that he believed nurses held the key to the nations health. He suggested that they were the most openminded and ready to change group within health, and that they had been undervalued and underutilised. The Ministerial Taskforce on Nursing document (1998) also acknowledges this, stating that nurses have a unique overview of client and community needs and that nursing's role in improved patient outcomes has been firmly established.

There is an absence of an accepted definition of nursing and identification of the unique contribution it is that nursing offers. This means that nursing is at risk of not being able to articulate the influence it has on positive patient outcomes. It is therefore in a weakened position and at risk of loss of professional recognition and economic compensation (Ellis & Hartley, 1995; Griffiths, 1995; Radsma, 1994; Taylor, 1997; Willis, 1994).

Benner and Wrubel (1989) identify that the 'intangible' elements of caring and clinical judgement inherent in nursing, are ignored. Benner (1984) attempts to describe the intangible elements of nurses' work by identifying seven domains of practice which incorporate both direct patient care and also illuminate professional caring, organisation and monitoring and team practices. However, the phenomenological approach utilised does not aid the production of the required measurable outcomes.

The Ministerial Taskforce on Nursing document (1998) asserts that not enough nursing research is done in New Zealand and that which is done is mainly qualitative in nature. Qualitative research, whilst valuable, is not sufficient or appropriate when measurable outcomes are required. The Taskforce document states that the focus on research from a qualitative perspective has been used because of the difficulties of quantifying peoples' experiences of health and illness but by implication suggests quantitative research as providing focus and direction for health initiatives. Some of the strategies to address this imbalance proposed by the Taskforce include establishing a nursing research centre. This would have a role in clarifying the relationship between nursing input and health outcomes as well as encouraging nurses to both produce and use research. It would also identify a visible site for other health professionals to access nursing research.

Whilst such a centre would be valuable, it must be asked whether the desired emphasis on quantitative research would not further compound the problem of articulating what nurses do. It may devalue nursing further by ascribing to this commercial model of health research. Awareness of the likelihood that findings may be used to justify decisions which may not be in nursing's best interests, or within the realm of what is considered by nursing to be in their patients interests, must also be taken into consideration. This may act to inhibit collaboration in such a venture.

In contrast to the Taskforce document, Hegyvary (1991, in Griffiths, 1995) argues that the failure of research to take into account patient condition changes which may have occurred irrespective of nursing intervention, interventions performed by other health professionals and other variables negates outcomes solely attributable to nursing input. Antrobus (1997) concurs stating that the complexity and nature of nursing practice makes measurement of outcomes within the current context next to impossible. She also believes that science only recognises the most visible part of nursing which only partly explains what nurses do.

Jacques (1993) focused on the question of what nurses do and observed that it was accepted by both nurses and non-nurses that caring differentiated nursing from other professions. The concept of caring has been identified by others as the core of nursing and inherent to effective nursing practice (Benner, 1984; Benner and Wrubel, 1989; Lawler, 1991; Radsma, 1994; Spitzer, 1998). The difficulty with the concept of caring is its ambiguity, invisibility, lack of definition, recognition and value. Added to this are behaviours from within nursing which increase nursing invisibility by minimising nursing work.

Benner and Wrubel (1989) state that because caring is associated with women's work, which is devalued and usually unpaid, it is rendered culturally invisible. They believe, however, that to care and feel cared for promotes health both at a personal and societal level. They also state that:

As long as the society overvalues technology's heroic promises of disimburdenment and freedom from pain and fails to recognise the care required to support such a technological self-understanding, those who provide care will feel the stress of being invisible and undervalued by the society. (p. 398).

The encroachment of technology into nursing practice is out of the scope of this paper. However, Willis (1994) notes a study by Brewer (1983) where patients communicated information via private microphones in the ceiling. These were monitored by a communication technician and information passed on to the nurse concerned. The technology failed because the social aspects were ignored and patients found it embarrassing.

Jacques (1993) identified that part of what nurses did whilst caring, was making connections between absolutely anything concerning their patients and anybody else. This was deemed to be necessary for a positive outcome for their patient. He stated:

The problem for nursing is that nursing tasks are most often not meaningful as isolated acts, they take on meaning only in relation to each other... 'expertise' is often based on a diffuse awareness of numerous facts and activities, mundane in themselves, but critical in their relationship to each other as they interact to form the patient's regimen of care... in much of nursing work, the visible outcome belongs to another party... connecting work ... when competently performed, it drops out of sight leaving no evidence that there was work to have been performed in the first place. (p. 6-7).

The connecting behaviours observed by Jacques (1993) included an observation that nurses were often doing more than one thing at a time including constantly scanning the environment, processing and selecting appropriate data and delivering this information to all others in the unit thereby assisting others in the performance of their duties. These behaviours were not necessarily related to the immediate work at hand but made possible the work of the Organisation. They also affected the quality of performance benefiting all workers and patients, yet went largely unnoticed and unrecognised even by the nurses

performing them.

Further to this concept is the term 'minifisms' coined by Lawler (1991). 'Minifisms' describes behaviours which minimise the significance or severity of problems, often to benefit the patient, by making situations acceptable. She identifies that this understating of problems dealt with would further render care invisible and result in it being poorly valued.

Similarly, McWilliam and Wong (1994) identify hidden nursing work in relation to patient discharge where the patient sees only direct care. Factors such as the nurse compensating for the characteristics of bureaucracy, coordinating the work of others, mending fragmented control and acting as the patients advocate are hidden. They note that these efforts took time and energy, caused frustration, a loss of professional autonomy and were often not recognised by the nurses or others involved in care.

In an attempt to measure nursing contributions to patient outcomes Lowe and Baker (1997) developed what they have called a "Nursing Report Card" to organise data so that nursing's contribution to patient outcomes could be measured. Integral to this design was the belief that care linked with outcomes could be measured. Despite the efforts of those involved they found that correlations between care and outcomes or quality could not be drawn as they did not reflect pure nursing care. They also encountered some difficulties with a lack of enthusiasm from staff who feared what the results would reflect and how the data would be used. They persisted with the design over four years however and assert that the information was useful in improving practice and staffing levels. The concept has been developed further by specialty areas to more accurately reflect their nursing practice. However the appropriateness of the data reflected must be questioned given that quality indicators used were reductionist and medically based with a focus on outcomes such as infection rates, medication errors, falls and skin ulcer prevalence.

Contributing to the lack of value ascribed to nursing practice is the dominance of the medical profession within the health arena which has culminated in the oppression of nursing and other health professions (Street, 1992; Willis, 1994). Kitson (1997) explores evidence-based medicine and clinical effectiveness initiatives from a nursing perspective. She states that these are undoubtedly medically-led initiatives and the framework on which they have been built is one that discriminates positively to the knowledge and outcomes which are valued by medicine.

Medicine's dominance has a significant effect on definitions of value but is compounded by the over-representation in senior administration and health care policy formation of medical personnel (Adamson, Kenny & Wilson-Barnett, 1995). The lack of nurses involved in managerial decision making in health care has been noted in The Ministerial Taskforce on Nursing document (1998) and the belief espoused has been that this has exacerbated fragmentation of services. The Taskforce argues for increased input at all levels of policy through the Ministry of Health and other agencies.

The importance of nursing involvement at this level cannot be underestimated as emphasised by Crooke (1992):

health care is inextricably linked to politics, as it not only has budget/cost implications, but also because the type and style of provision reflects, in many ways, the ideologies, motivations and vested interests of those who influence and decide health policy. (p.16).

Antrobus (1997) believes that the marginalisation of nursing is a gender issue. She states nursing's historical lack of influence at a political level and in health policy decision making affects patient outcomes. Increased involvement at this level would enable nurses not only to be involved in decisions regarding provision of care, health care strategies and priorities but would also provide opportunities to influence how these decisions were made and on what basis need and effectiveness were decided. Antrobus (1997, p.449) takes the stance that "current health policy is inappropriate in its attempt to impose a mechanistic, scientific and masculine culture on a service orientated to health and care".

In conclusion, it is clear that nurses must demonstrate the value of nursing and nursing's contribution to positive patient outcomes in order to survive in the competitive market place that now exists in health care. The difficulty for nurses remains, whether they should present this information in the clear scientific and economic terms that are required, when this is not the value ascribed by nurses to nursing. Nurses need to either produce outcomes that conform to the language of the day or they need to increase their political involvement and exert their influence at policy level, changing the values and measurements utilised. In other words, nurses need to either "play the game or change the reference point by which the game is being played" (Antrobus, 1997, p.452).

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EXEMPLAR: CRISIS

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Crisis: "A turning point after which the patient either improves or deteriorates"
(McFerron, 1994, p. 109).

Introduction

Crisis can develop after prolonged dis-equilibrium and an absence of balancing factors. This essay will outline crisis theory and apply this to one patient, 'Olivia', who is identified in a personal journal entry. Reflection on this journal entry has generated an understanding of a person in crisis. The journal entry is included with this essay.

" According to crisis theory, a person strives to maintain a constant state of emotional equilibrium. If a person is confronted with overwhelming threat and is unable to cope, crisis ensues " (Johnson, 1997, p. 790).

Crisis theory

Aguilera and Messick (1986) state that a stressful or traumatic event in a person's life may cause dis-equilibrium to some degree at a biological, psychological, or social level. According to Caplan (as cited in Aguilera & Messick, 1986) a person is compelled to maintain equilibrium and any continuance of dis-equilibrium leads to increased tension and discomfort precipitating the event of crisis. This is supported by Johnson (1997), who states that the activation of a crisis state is the result of a sequence of phases taking the person through increasing anxiety leading to intolerable levels. Hoff (1984) also argues that prolonged dis-equilibrium can cause overwhelming anxiety and emotional discomfort.

Crisis can occur because of maturational and situational events where the problem is unable to be resolved. This may cause a prolonged state of dis-equilibrium (Aguilera & Messick, 1986). These authors suggest that maturational events can include life changes, for example, puberty. Situational events include unexpected happenings such as the sudden loss of a partner.

The duration of a crisis can last approximately four to six weeks (Hoff, 1984; Aguilera & Messick, 1986; Johnson, 1997). Prolonged intolerable anxiety can cause a person to become either suicidal or homicidal and therefore at risk of harm to themselves or others (Aguilera & Messick, 1986). Hoff (1984) supports this position, stating that if a crisis is not resolved then emotional or mental illness can occur, resulting in excessive drinking, drug abuse, or disruptive behaviours.

The changes that occur in the four to six week duration of a crisis can lead to the possibility of psychological vulnerability, or opportunities for growth (Aguilera & Messick, 1986). Johnson (1997) agrees, suggesting that a person can either return to the pre-crisis state, develop more effective coping mechanisms, or enter a state of a decreased level of functioning. Aguilera and Messick (1986) state that crisis intervention is a necessary component for the psychological resolution of the problem and a return to homeostasis. The ultimate goal therefore is to return to a level of functioning greater than the pre-crisis state.

According to Aguilera and Messick (1986), whether a person enters a crisis state depends on a balance of factors. These factors include the perception of the event, situational supports and coping mechanisms. The perception of the event refers to the meaning of the event in relation to the effect on future outcomes and personal values. Aguilera and Messick (1986) believe perception can be either realistic or distorted. Within realistic perception the event and resulting stress is recognised making it more probable that problem solving techniques are successful in relieving the dis-equilibrium. Within distorted perception a connection is not made and the outcomes are perceived as overwhelming with the result of continuation of the emotional disturbance.

Situational supports can be people who are trusted, and who are available to provide emotional support and assistance resolving the problem (Aguilera & Messick, 1986). Aguilera and Messick (1986) suggest that throughout life people learn coping strategies to deal with 'life's ups and downs'. During a traumatic event the way a person copes, or deals with these ups and downs can determine whether a crisis will ensue. If coping mechanisms are adequate crisis can be avoided, however, if coping mechanisms are inadequate dis-equilibrium may continue potentiating a crisis.

Prolonged dis-equilibrium and crisis can be avoided if all balancing factors are present and adequate (Aguilera & Messick, 1986). However if just one balancing factor is absent then resolution of the problem may be hindered, dis-equilibrium may continue, and crisis could develop.

Application of crisis theory

Crisis theory has been applied to a situation described in my journal entry. This application identified two events in which a woman experienced dis-equilibrium that could potentially precipitate a crisis. This elderly woman experienced dementia. I will refer to her as 'Olivia'. For this person balancing factors were absent or ineffective, and any resolution of the problem was hindered by this and by her history of dementia.

The first situational event was the unexpected fracture of her hip, which required surgery. Through the application of the paradigm of balancing factors (Aguilera & Messick, 1986) it is revealed that Olivia's perception of the event was distorted. Therefore the traumatic event was not recognised. Dementia prevented Olivia from remembering what had happened and caused her distress as she was unable to remember where she was and why she was there. Olivia's situational supports were few as her family visited infrequently. This left the nursing staff to support her. Dementia prevented her from remembering when her family did visit as well as the reassurance given by nursing staff. Therefore, the supports available could be described as being absent to Olivia.

Olivia wanted to make sense of the situation, however her coping mechanisms were ineffective because her dementia prevented her from remembering that she had asked and received answers to her questions. Therefore, she appeared to be in a constant cycle of anxiety with the uncertainty of the situation. One minute she was aware of what was happening, and the next she was not.

The second situational event occurred during the process of urinary catheterisation. Whilst the procedure and rationale was explained to Olivia, her perception was distorted. This caused her to experience a fearful event. It must have appeared to her that her situational supports were absent as the people who would normally be her supports were the very people who were performing this terrifying event. Her way of coping was to scream and thrash and try to escape. Her coping mechanisms were ineffective as she did not succeed in escaping. The more she thrashed the more the nurses and myself restrained her. She had no power, only a sense of anxiety, fear, and powerlessness.

Exemplar

I was assisting a nurse who was going to catheterise an elderly woman who was recovering from surgery after repair to her fractured neck of femur. This woman was not my patient and I had no previous contact with her, but I had been told that she had chronic dementia. During the first moments spent with this woman I could tell that she had no idea that she had broken her hip as she continuously asked where she was and why she was there. She was always given an answer but just a few minutes later she was asking the same question again. I tried to focus her attention onto something else so I asked if she had any children. She told me that she had four and she named them for me. I asked the same question a little while later but this time she told me she only had three children. I immediately thought how hard it must be for her family to see their mother like that, then I remembered that I had actually never really seen anyone come to visit. Perhaps they find it too hard, or perhaps it is too inconvenient to come and visit.

The most traumatic part of my contact with her was during the catheterisation. The nurse explained everything so well but Olivia just did not understand and was reluctant to let it happen. There was certainly no consent given. As soon as we began she started to push us away and began to cry and plead with us to stop. She continuously asked us what we were doing. It was hard to watch this woman who was obviously distressed by the situation. For a moment I thought that the nurse was going to give up. I wish she had, but instead she asked me to get another nurse to help to restrain her. One came and forcibly held her bent knees apart while I was instructed to firmly hold the woman's arms across her chest. Now this woman was really crying and screaming "what are you doing? Oh please stop. How can you be so cruel"? She was fighting against us with all the strength that she had. The nurse finally managed to get the catheter inserted.

The look of relief quickly came across the woman's face as she realised that we had stopped restraining her. I was talking to this woman throughout the experience to try and take her mind off what was happening but she was just too distraught and fearful that all she could focus on was the whole horrific event taking place. When she looked at us she must have seen evil people. In her mind we were not kind nurses there to help her, we were the cause of all her distress. Every time she asked how we could be so cruel, I was certain that she was only directing that question to me. I hated the situation as I could see and hear her fear, lack of understanding and the emotional distress that we were inflicting on her. Her struggle with us and attempts to free herself and prevent the situation from continuing only left her more fearful and powerless. She was still weeping when we left the room, there was no way that any of us could have comforted her at that time. In my view we persisted with something that was obviously causing much emotional distress.

I felt as though the nurses were only acting because the medical staff had told them to. Had they questioned the necessity of it? Had they felt the same way as me? Did they not care about her feelings? I can only imagine because of the way that I was feeling, that this woman must have been experiencing something out of a horror movie. Imagine being forced against your will to have something put inside you while you were being restrained by the people you thought you could trust. I can only speculate that the other nurses were feeling uncomfortable too. I refuse to believe that they had no remorse about the fear and anxiety they had helped cause. They were probably under pressure to get the job done. Maybe they were actually torn between stopping the procedure and following the instructions of the medical staff.

What I learnt from this whole experience was that there were a variety of factors and influences dictating the situation and I was not prepared for it. I asked myself:

- Was it necessary to catheterise this woman?
- Did the client's wishes not count?
- Was she in a state of mind to be able to make that decision?
- What kind of view did the original decision maker have?
- What were the advantages/disadvantages?
- Were we working in the best interests of the client or making life easier for us?
- Was it OK to cause major distress if it was better in the long run?
- Why did someone not advocate against the procedure once it was obvious that it was causing her much turmoil?
- Did it matter anyway, she may not remember the event in the end?
- But what if the event was just too horrific that it would be something that she would always remember?
- Was her reaction a result of just not understanding, her dementia, or both, or was she even reliving a past horrific experience?

The point of the story is that we are taught to respect the rights and wishes of others but on certain occasions there are circumstances that cannot enable people's wishes to be respected. I have learnt that I am uncomfortable with forcing people against their will. I wish that I had questioned the situation and the necessity of it. I will take into the future the knowledge that I have the power to cause stress and fear in someone. This of course is something that I will not participate in. I have recognised that I possess this power therefore I can work against practising in this way. I know that in most cases things are done for the benefit of the client, but how can something be of benefit if it causes so much unnecessary distress and possible long-term damage?

Reflection

Reflecting on my journal entries, I can see that crisis can be either a short duration or long duration. More than one state of crisis can happen at a time with each individual event diverse in nature and severity. I can see how the connection between balancing factors and the situation can precipitate a crisis. For Olivia the uncertainty of her hospital stay was distressing. However it was not as severe as the situation in which she was forced to comply with something perceived as horrific, and performed by people who were supposed to be supportive. This resulted in a sense of invasion, persecution, fear, powerlessness and helplessness.

There was no crisis intervention offered to this woman and her emotional turmoil continued. Whilst the cause of the dis-equilibrium had ceased, all balancing factors were absent, including the availability of adequate, trustworthy supports. I believe it was the responsibility of all those involved in this event, including myself, to have intervened. In this way we could have prevented any further distress, and she would not have had to suffer the consequences of what I believe was a traumatic psychological experience. The lack of intervention could develop into a decreased level of functioning, or contribute to increased vulnerability to other life stresses for Olivia. I talked with this woman during the event but found that I was ill prepared for her response. My talking was not helping, it probably only made things worse. Here was this person talking calmly and smiling at this woman. Only, the smile belonged to the person restraining her and ignoring her pleas to stop. What kind of message was that giving?

At the time I felt as though I had no power or authority to speak my mind. It was as though I thought that the experienced nurses must know what they were doing. I felt very uneasy about the situation and realise now that I should have spoken up, even just to voice my feelings. I may then have had an opportunity to hear the nurses' reasons for continuing with the procedure.

Conclusion

Crisis can occur after prolonged overwhelming emotional stress which begins from either a traumatic maturational or situational event. However crisis does not necessarily develop as a result of a traumatic experience. Crisis may be due to a lack of balancing factors hindering the resolution of the problem which caused the prolonged dis-equilibrium. Crisis can be a turning point where either improvement or deterioration can occur. Intervention is important for the recovery of the person into a level of functioning equal to or greater than their pre-crisis state. Failure to intervene during the crisis can result in intolerable anxiety which may lead people into maladaptive behaviours harmful to self and others. Crisis can however result in growth from the experience.

In this essay crisis theory has been used to analyse two practice experiences. Olivia suffered from dementia and experienced two separate situational traumatic events within a close time frame. All three balancing factors were absent with the causes of dis-equilibrium being different with respect to their intensity and duration. There was no crisis intervention for this woman thereby leaving the real possibility of negative outcomes. The application of crisis theory enables a nurse to determine the risk of crisis and to provide intervention which may avoid deterioration and promote a more productive outcome.

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Beginning Journeys - Volume 6

EXEMPLAR: THE HELPING ROLE

THE APPLICATION OF BENNER'S THEORY TO NURSING PRACTICE

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Introduction

In this essay I will outline the 'helping role' of Benner's (1984) nursing theory, described in her book 'From novice to expert: Excellence and power in clinical nursing practice'. I will also use exemplars from my clinical journal entries to illustrate how the domain 'the helping role' applies to my practice.

Benner (1984) developed her theory to meet a gaping need to formally acknowledge what nurses do. The deeply engrained oral tradition of nursing has left us without a written history and robbed us of the opportunity to track our development and acknowledge the full extent of our role. Her theory attempts to explain the essential and often intangible perceptual aspects of nursing judgement which are so central to expert nursing practice as well as the obvious physical components of nursing. Benner explains that nurses need to keep a record of our nursing practice to assist the future growth and development of our nursing practice. She states "Not knowing who and what we are about now will seriously impede what we want to become" (Benner, 1984, p. 21).

Benner's theory has been developed from descriptive research and dialogue with nurses and from the five competency levels identified by Dreyfus and Dreyfus (1980, cited in Benner, 1984). Benner highlights that the examples she uses are real situations, not abstract ideals. They occur despite the flaws and problems with which nurses work every day.

Benner (1984) has taken the Dreyfus model of skill acquisition and applied it to nursing. The Dreyfus model identifies five developmental stages which are novice, advanced beginner, competent, proficient and expert.

Benner also identifies seven domains of nursing practice which are as follows:

1. The helping role
2. The teaching-coaching function
3. The diagnostic and patient monitoring function
4. Effective management of rapidly changing situations
5. Administering and monitoring of therapeutic interventions and regimes
6. Monitoring and ensuring quality of health care practices
7. Organizational and work-role competencies

Within each of these domains Benner (1984) identifies competencies. It is the purpose of this essay to focus on the first domain 'the helping role.' Benner identifies the following competencies as being facets of the helping role:

1. The healing relationship: creating a climate for and establishing a commitment to healing.
2. Providing comfort measures and preserving personhood in the face of pain and extreme breakdown.
3. Presencing: being with a patient.
4. Maximizing the patient's participation and control in his or her own recovery.
5. Interpreting kinds of pain and selecting appropriate strategies for pain management and control.
6. Providing comfort and communication through touch.
7. Providing emotional and informational support to patients' families.
8. Guiding a patient through emotional and developmental change: providing new options, closing off old ones: channeling, teaching, meditating.

I have chosen to discuss two competencies of the helping role: 'the healing relationship: creating a climate for and establishing a commitment to healing' and 'presencing: being with a patient'. The following exemplars are from a series of interactions with two clients, Mr O and subsequently Mr W. I believe that the first three exemplars demonstrate my development in the competency of 'the healing relationship: creating a climate for and establishing a commitment to healing'.

Exemplar 1

Today I found Mr O asleep at the newspaper reading. He awoke as I approached him and we began to talk. He appeared very melancholy and so I inquired after his mood. He began to disclose how unhappy he was with his living situation and especially the rigidity of the routine of the institution. This fills me with sadness for Mr O. He is so resistant to anything I suggest. He said the worst thing was cold toast in the morning, so I said I'd organize for him to have hot toast and a lie-in next Thursday but he declined. The more I try to make suggestions the more he closes down on me. I know I am doing something wrong but I just don't know how to help him. I find that at the end of the clinical day I am so worn out and disillusioned that the thought of coming back and trying to pierce the wall that Mr O has erected around himself is completely disheartening.

Exemplar 2

When we got to the hospital we had to go to X-ray. When we got to the right floor Mr O 'made a break for it', stepped quickly out of the elevator and walked off in the wrong direction, much to my dismay. I caught him up and tried to explain to him that we needed to go in the other direction but he was emphatic that he was right saying that this was the way that he always came. I attempted to explain again but Mr O began to raise his voice insisting that "NO! this is the way we go". I didn't want to agitate him further so I trailed pathetically behind as we walked in the wrong direction. Meanwhile his SOBOD was becoming more marked. I didn't know what to do. The two things that I knew were aggravating Mr O the most were firstly, my presence and secondly, me trying to direct him. I think that his motivation was an independence issue and he probably recognizes that he can't cope on his own any more but refuses to admit it. I think that my presence is forcing him to acknowledge this and his response is to express anger toward me and my handling of the situation. I know that I am not meeting Mr O's needs in a way that he can accept and I feel incompetent and stupid. I feel like I just want to give up. I can completely understand where Mr O is coming from but I just can't help feeling like that.

Reflection

This highlights my inability to commit to a healing relationship despite wanting to. This contrasts strongly with another client I was given much later in the semester. I had just been assigned a new client, Mr W and met him for the first time that day. He had a diagnosis of impaired cognition, comprehension and communication skills. On our initial meeting I had not hit off with an instant rapport. In the afternoon I took Mr W for a walk in the institution's grounds.

Exemplar 3

First I introduced myself, my purpose and when I would return to help Mr W. He returned with a completely blank dementia type stare. His pale blue eyes, unblinking, appeared to register nothing. I stepped forward and repeated myself slowly and clearly. Mr W gave a minute nod that indicated some degree of understanding. That afternoon I took Mr W for a walk. I really wanted to make a connection with him. I had got the impression early on that Mr W is largely ignored by the staff because he is so withdrawn. This strengthened my resolve. I really want to make a difference. Later that same day I took Mr W for a walk. Mr W had been a gardener. I asked him questions about his garden and the location of his home. I had been walking beside him, one hand on his shoulder, the other pushing his wheelchair. We had come to a sheltered bay in the garden with a seat and I pulled the wheelchair up and sat opposite my client. I watched Mr W's face and in fact his whole body alter position ever so slightly but the change was dramatic. We had stopped talking for just less than a minute and then it was as if a fog of indifference or incomprehension had lifted. I watched thoughts like clouds float across Mr W's face, the flicker of a smile followed by two large tears welling in his eyes. I felt the immediate urge to reassure Mr W that it was okay as he hurried to hide his tears. I placed my hand on his arm and caught his eye. We looked at each other for several long moments and then I asked him if he was having a bad memory. He mumbled "my wife". Mr W put his hands on his knees. I felt that he didn't want my pity, his body language was open but I didn't feel that he wanted me to take his hands. I sat in quiet reassurance and watched as Mr W explored his thoughts and memories, then as quickly as I had observed this moment of clarity appear, Mr W ceased to express himself through his body language. I wheeled him inside, made him comfortable and as I walked down to write my notes the impact of our interaction hit me. I had connected with Mr W, we had shared a moment.

Reflection

On reflection I can see the growth I have made in the area of commitment to the development of a healing relationship. When I was interacting with Mr O our rapport was unstable. I was doing all of the things that I

thought he needed in a very functional manner instead of listening to my instinct which told me all he wanted was to be left alone. My frustration and preoccupation with how the situation made me feel left me feeling like there was nothing I could do for Mr O and this had an even greater detrimental effect on our rapport. I feel that there has been a huge leap forward when I compare this with my interactions with Mr W who has a reputation for having people on as a way to avoid them. However I made a commitment to myself and to Mr W to try to reach him and connect. As our rapport grew this eventually happened. I listened to Mr W and with his limited communication skills used trial and error to develop a commitment to address his social isolation.

Presencing: Being with a patient

The following two exemplars are from interactions with two clients, Mr S and then Mr W. I believe that they demonstrate my development within this competency. I had been assigned a new client Mr S, for the next week and had only had a few moments interacting with him. I was due to leave clinical in about ten minutes and the R.N. had asked if I would assist her to weigh him.

Exemplar 4

As we approached Mr S was slumped in his wheelchair and when we got to him he was as purple as the polytech jazz school walls (very purple) and of course not breathing. When we got to him I said to the R.N. "He's blue" and then felt stupid for stating the obvious. But quick as you can blink, we were whisking him down to his room and we lifted him onto his bed. Mr S started to breath again, his eyes bulged in an almost unreal fashion as he drew in a huge gasp of air. I sat with him for about ten minutes and then decided to leave. If he was going to die I felt that I wanted to respect his privacy. I didn't want to watch the indignity of his passing. I didn't feel that it was my place. The people who should be there were people who knew him. A nurse was sitting with him holding his hand telling him it was okay to go. I felt that it was enough. I didn't want to stand gawking.

Reflection

This contrasts with the next exemplar where I feel that my presencing had developed. It highlights how comfortable I felt when attending to Mr W by just being with him. I planned a social activity that was extra to requirement, however I had the time and I wanted the opportunity to spend one-on-one time with Mr W in an environment that was outside of the institution. The activity was picnic afternoon tea in the Botanical gardens followed by a stroll in a wheelchair around the grounds.

Exemplar 5

I had to modify plans for the picnic as it was overcast today. I took a wheelchair anyway. Mr W still wanted to go, though in all honesty I think he'd forgotten all about it. We went on our merry way. I had a sinking feeling as I was driving to Mona Vale, our new destination, that it may be a disaster. This was short lived. Mr W is such a withdrawn man I feel lucky if he keeps his eyes open for ten minutes. I felt that in the past that I had been successful in making a connection with Mr W, however in retrospect they were never huge. Mr W would never give more than a word or two in reply, and he would never initiate conversation. In comparison to his normal communication, he chatted and the conversation came to a natural end. Mr W's new found eloquence stunned me. I felt as if taking him out of the institution had given him a chance to behave in a way that didn't involve the behavioral strategies he had developed to deal with the institution environment. Throughout the hour and a half we spent together Mr W opened up to me and disclosed stories about his past. We also spent large periods of time in silence. I felt comfortable and sensed that Mr W shared my ease with this silence. The highlight of the whole trip for me was when after a long period of silence I asked Mr W what he wanted to do and he replied "Anything you want, I just like the company of another person". It was confirmed to me at that point how much of an impact my effort and just being available for Mr W had had on him.

Reflection

I have reflected on these exemplars regarding the competency 'presencing: being with a patient' and identify there has been an attitudinal shift that has facilitated my development in this area. I feel that in the fourth exemplar I was more concerned with the maintenance of Mr S's dignity. I think that this was in part a reaction to the way he looked physically. I think I wanted to protect him from a superficial judgement by appearance. I failed to take into account his spiritual and emotional needs. Also I think that I did not fully comprehend the purpose of being there. I felt roleless because I was not physically doing anything. However Mr W highlighted to me just how much it meant. By just being with Mr W and not imposing myself and opinions I conveyed to Mr W he is valued. It gave him a chance to tell his stories. As I reflect I feel that presencing can be as therapeutic for the nurse as it is for the client. Being given the opportunity to see the real Mr W made me feel so special, it is like being given a gift.

Conclusion

In conclusion, I have been given the opportunity to reflect on my practice within the framework of Benner's theory (1984) and it has been a fantastic learning tool. I am able to track my learning by journaling and having a record of my experiences and feelings. By comparing my journals at different stages of development I create a forum for constructive autocriticism leading to growth and development and a measure of achievement. To reiterate, as Benner points out so much is lost when it is not recorded, and without knowledge of where we are now, how can we make provision to develop in the future. Benner's theory also verbalizes the intrinsic and perceptual aspects that would otherwise go unrecognized. Exploration of the helping role has explained for me why it is that I do something, such as provide comfort and communicate using touch. Before, in my practice, I would use touch but not comprehend the reason why and the impact on the client.

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Beginning Journeys - Volume 6

AN EXEMPLAR: REFLECTIVE LISTENING SKILLS

Mihoko Ford - Transition to degree nursing student

Introduction

Listening has, for a long time, been recognised as a very effective method for helping people who have problems or concerns. As a form of communication, "listening is a powerful message to a suffering person. It conveys respect, acceptance, and understanding of their difficulty" (Bolstad & Hamblett, 1997, p. 91). It is a technique that is used in many professions. For nurses, the ability to listen to a patient is an important professional skill. In our class we have learnt about different types of communication skills. In this essay, I will describe how a situation developed during my work as a phlebotomist, how I used one particular communication skill (reflective listening), and the outcomes. I will also discuss what I learnt from the situation.

Journal Entry - 23 March 2000

I work as a phlebotomist in a small hospital. When I met Mrs B for the first time, I introduced myself and explained that I needed to take blood samples from her. Mrs B was a patient who I suspected had received a brain injury. Since I am a phlebotomist, I have no right to access patients' information at all, so I did not know her real condition. She seemed to understand that I was going to take blood from her. However she refused the blood test in an angry manner. I have met many patients who refuse a blood test, so I was not surprised. However, in this case, I felt she refused vigorously, and I thought that I should stop trying to persuade her especially since a patient has a right to refuse a blood test. But it was not clear why she was so angry. I wanted to know the reason why and to understand her. I felt that it was a good opportunity to use the reflective listening skills, and I wanted to see how the conversation would develop.

Mrs B: "No! I don't want any blood test!" She stared hard at me.

MF: "So, Mrs B, you don't want to have your blood taken at all, do you?"

Mrs B: "No, I don't. Because a huge bruise has just disappeared, so I don't want another bruise. So you can't take blood from me." She turned up her nose at me.

The bruise had already disappeared and I was not able to see it at all.

MF: "You had a big bruise here, didn't you?" as I touched the spot.

Mrs B: "Yes, that's right. The other day, the other person stuck a needle in many times."

MF: "It sounds as if it was a really horrible experience. So, you don't like many punctures, do you?"

Mrs B: "Yes, you understand me very well." She smiled, and I smiled too.

Silence for a while.....

Mrs B: "You can take my blood because you understand my feelings." and gave me her arm. I was surprised because she changed her mind so quickly and so easily, and what was more, she mentioned that she knew I understood her. She was willing to have the test. I hesitated for a while.

Mrs B: "Are you good at this?"

MF: "Yes. I do only this all day."

Mrs B: "I know you are very good at...."

MF: "Then I will use the most gentle method to avoid bruising."

Mrs B smiled and said, "Oh, thank you!"

I took blood samples from her by putting a needle into her only once.

MF: "Are you all right, Mrs B?"

Mrs B: "Oh, you are so good! I did not feel it at all. I know you are very good at it."

I checked the bleeding had stopped and she did not have any bruising.

MF: "It looks all right, Mrs B. Thank you very much!"

Outcome

By using reflective listening skills, I felt that I had overcome an awkward and possibly embarrassing situation, and avoided any unnecessary conflict. The patient was very angry at the beginning, but she changed her mind from completely rejecting the idea of having a blood test to becoming cooperative. Moreover, as a result of using reflective listening skills, she felt that I understood her well.

Discussion

I used the reflective listening skills in the above case. It worked well, and I found it was a very powerful method of quickly establishing a rapport with the patient. The first reason it was successful was, as Bolstad and Hamblett (1997) show, it was an appropriate situation to use it. The patient had her own problems, and I was willing to listen to her. By using reflective listening, I (as a listener) was able to get a much clearer picture what the speaker really wanted to say, that is, she was angry at the previous bad experience of a blood test. I was able to understand and to accept her. She (as the speaker) spoke out more and felt that she was accepted and her concerns were being understood. I usually explain to patients who have some bruising, why a bruise occurs and that it is not as big a problem as some people might think. If I had done so in this case, her strong opposition might not have diminished, especially as she may have experienced a brain injury, and she might not react the same way as other patients might. I could have dismissed her fears and insisted that I take blood. However, I believe that it might have ended up as an unpleasant confrontation, possibly involving other staff in the ward.

A second reason why it was successful was because I did not expect the patient to settle down so quickly. I did not try to make an extra effort to persuade her. Bolstad and Hamblett (1997) point out that reflective listening does not require a lot of energy, and most of the failures occur when too much effort is made. I felt the skills are useful in situations when you have no idea how to reply to a person who has emotional problems, and it is, perhaps, not a good idea to ask the reason directly. For a non-native English speaker in a different culture, we are perhaps less aware, or are slower to recognise, some types of emotional signals. Reflective listening is a useful non-threatening way of dealing with a situation when you are not quite sure of the right social response.

Conclusion

I found that the skill of reflective listening is a very powerful method if used in an appropriate situation. It shows my understanding and acceptance of and to a speaker. I would like to use this communication skill again.

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Beginning Journeys - Volume 6

OUR ADVENTURE TO THE OTHER SIDE OF THE WORLD

Candice Verbeck and Angela Burkhardt - Bachelor of Nursing students, Sinclair School of Nursing, University of Missouri, USA

Our journey began on May 6, 2000 at St. Louis Lambert Airport. As other travellers were bustling about, we were bubbling over with enthusiasm about our learning opportunity on the other side of the world. Most of us did not have international travel experience and some had not even been on an airplane! After stops in Chicago and Los Angeles and a total twenty-seven hours of travel time, we finally made it to our destination, Christchurch, New Zealand on May 8. Although extremely fatigued, we were overwhelmed with excitement and eager to learn more about this amazing city.

On our first visit to the Christchurch Polytechnic Institute of Technology (CPIT), on May 9, we were very warmly welcomed by the Dean of the Faculty of Health & Sciences, Dr. Selwyn Maister. While enjoying morning tea, we exchanged introductions with some of the faculty and students from all levels of the nursing school. We learned about each of the nursing programs and curriculum, and talked with students one-on-one about the many similarities and differences between our two programs.

The nursing students were surprised to learn that prospective students at the Sinclair School of Nursing are required to fulfill particular general education classes prior to applying for entrance into the nursing school. Required classes include: Anatomy, Physiology, Biology, Microbiology, Psychology, History, Sociology, Statistics, English and a foreign language. These prerequisites are usually fulfilled in two years. After acceptance into the nursing program the final two years of the baccalaureate program are divided between nursing classes and clinical time in the hospital setting. We were surprised and envious at the great amount of clinical time nursing students had in the hospitals. Another aspect that particularly interested us was New Zealand's bicultural health care system and the need for nursing students to be knowledgeable about Maori culture. After meeting with the students we went to the Maori Culture Center on the campus and gained a brief insight into Maori culture and folklore. To supplement our knowledge we attended a traditional Maori ceremony at the national Marae. Some of our brave classmates volunteered to participate in a war dance, which was definitely a comical sight.

Other facets of our agenda included touring the Christchurch Hospital and the Medical School. Registered nurses working on their baccalaureate degree were kind enough to meet with us during their lab time. We broke up into small groups and compared the nursing environments in our two countries. We were surprised by two subjects that left a lasting impression. First was the approach to physical assessment, specifically the modification of the physical assessment in the nursing process to just address the chief complaint and that doctors were the only ones to perform the in-depth head-to-toe assessments. Secondly, we were informed that there were no lawsuits brought against nurses in New Zealand, hence there is reduced need to purchase malpractice insurance. Malpractice is a major concern that nurses in the United States face every day.

Other topics for discussion during our visit included important aspects of rural nursing, evolution and current status of New Zealand's established health care system and opportunities for advanced practice nursing in the rural setting. The New Zealand Cancer Society provided us with a delightful discussion regarding health promotion and disease prevention campaigns that they use in the community. The Cancer Society gave us generous amounts of educational materials that they utilize in their campaigns to share with fellow students in the United States. Although many of the posters have made their way to the walls of our apartments, many of the students are using the posters in class presentations and their Cap-stone projects.

To learn more about student life, two visiting students, Angela Burkhardt and Amanda Seymour, had the wonderful opportunity to billet with two nursing students from Christchurch Polytechnic Institute of Technology, Nikki Codyre and Kirsten Walker. The students took time out of their busy schedule to show Angela and Amanda around Christchurch and expose them to life in New Zealand. Angela and Amanda could not stop talking about what an awesome time they had with their friends from CPIT. Nikki and Kirsten came with the American students on a day tour of New Zealand's countryside, so everyone would have the opportunity to get to know them. We discovered many new things between the two cultures and ways of life. We all enjoyed being able to spend the day with them.

Please understand that this excursion was not all work and no play. After 27 hours of travel time, we deserved to have fun too! To further our knowledge of New Zealand's culture, we explored Christchurch's active nightlife. We also attended a rugby match of the "Canterbury Crusaders" versus "Canberra Brumbies". It was very exciting to see how many New Zealanders are passionate about rugby, to which we have only limited exposure in the United States.

On our last day in Christchurch, we went back to the School of Nursing at CPIT for one final visit with the faculty and students. We interacted with first year student nurses practicing their physical assessment skills. To end our stay in Christchurch, we received a wonderful farewell by the faculty and students of CPIT. It was

an emotional farewell for the students from Sinclair School of Nursing because we gained so much insight that we can apply to our future nursing practice. On a final note we look forward to CPIT nursing students coming to our school of nursing in the very near future.

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CULTURAL DIFFERENCES IN COMMUNITY NURSING - VISITING NURSING STUDENTS

Judy Yarwood - Lecturer, Christchurch Polytechnic Institute of Technology

Nursing students from New Zealand and North America came together recently when the School of Nursing at Christchurch Polytechnic Institute of Technology (CPIT) hosted a visit by 17 students from the Sinclair School of Nursing, University of Missouri, USA. This visit was not only the first step in establishing links between the two Schools of Nursing, but it also provided the visiting students with an opportunity to observe and study community health in a different culture from their own. The catalyst for this visit was Dr Linda Bullock who accompanied the students. Linda was delighted to return to CPIT as she was on staff in the School of Science while living in New Zealand in the 1990s.

The first morning of the visit was spent at the School of Nursing where the students and academic staff were welcomed by Faculty of Health & Sciences Dean, Dr Selwyn Maister and Head of School, Cathy Andrew. Nursing students joined with academic staff from CPIT to welcome the visitors and it was great to see how quickly rapport developed between the students. A lunchtime forum, where two CPIT final year students discussed their attendance at a recent nursing research conference, to which they had been sponsored, was a highlight for the visitors. The American students were delighted to hear of the students' involvement in and enthusiasm for research.

Although the American students were only in Christchurch for a week, their programme ensured that many aspects of the community were visited and considered. Visits covered a wide health spectrum from the Centre for Rural Health Nursing, to a centre of high acuity, Christchurch Hospital. Jean Godfrey from the New Zealand Cancer Society provided an overview of current health promotion programmes, and an evening visit to the Ng Hau E Wha national marae gave further insight to our cultural heritage. The student group visited two classrooms in action; one with undergraduate students, the other with registered nurse students all studying health assessment skills. These classroom visits were most successful as the American students were able to talk of their learning experiences with these skills, and the CPIT students heard how health assessment is very much a part of a nurse's daily practice in USA. Nursing lecturers at CPIT found these visits invaluable.

During the student's time in Christchurch they were undertaking a community assessment in the form of a Windshield survey. This enabled the students' to gather a composite of subjective data through personal observations of people, their lifestyles and the environment in which they live and work. Apart from fewer people, it appears Christchurch is not unlike Missouri, and they were pleased to see the ubiquitous yellow M offering some of their favourite food.

Discovering the social delights of Christchurch was an important part of this survey, and the trendy cafes and bars were very quickly discovered. An important Super 12 football match held in the city was also very well attended where the strength of parochial pride was no doubt clearly seen. Weekend activities included white water rafting and a trip on the Tranz Alpine express through the virtually (unfortunately) snow free Southern Alps. Two of the visiting students spent the weekend with CPIT student billets and learnt the delights of student flatting, and owning a rather old mini motor car.

Whilst the time disappeared all too quickly, this visit has been invaluable for all participants. Visiting and experiencing different communities and cultures broadens and promotes an understanding of the human condition, an essential dimension in community health nursing. This visit has been the first step in what both institutions hope will be a fruitful and ongoing relationship which provides reciprocal benefits. To this end, Missouri University have recently recognised CPIT's Family and Community course which will enable two Missouri students to visit and study at CPIT in Semester 1, 2001. It is hoped CPIT students will be able to return this very successful visit to Missouri in the not too distant future.

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THE BEGINNING OF A JOURNEY - A PERSONAL STORY

Linda Craig - Plunket additional care and support team

1999 saw me assessing my educational requirements for the new century. I looked at whether I would begin an undergraduate degree to update my nursing diploma awarded in 1970, or whether I would begin a direct entry postgraduate degree.

Eventually in November an enrolment package arrived at Plunket asking people who were interested in studying for a Certificate in Advanced Nursing, Child and Family Health to apply for the course which was to be offered by Otago Polytechnic and the Christchurch Medical School. This course is funded by the Clinical Training Agency for people working in the field. There began my journey. The first step was to pull together all the bookwork required for application and to have it all certified. The next step was to convince my employer that I qualified and was also capable of studying at this level. Six staff members applied, passed the first hurdle and on the last day for submission, added our applications for the next step in the process, approval by Otago Polytechnic. I received notification that I had been accepted on my last working day of the year. At this stage I had no idea where my journey would lead me.

The next stage of the journey began the day after my fiftieth birthday when I joined twenty-seven other nurses from many different workplaces, including hospital and community. We learnt over the next two days what to expect for the rest of the year. Two hours study most nights plus time at the weekends as well. Six assignments, family visits, alternative placements and portfolios to produce, study days and block weeks to attend. Photos for access to the hospital, library cards to collect, email addresses to obtain. Fifty was bringing challenges already and the big day was only yesterday.

There began one of the largest journeys of my life. A literature review and reflective practice assignment was the first to be submitted in March. Feeling completely out of my depth I sent my assignment for a formative assessment only to find out the tutor had gone on unexpected leave. Where was my assignment now? It never did return, but eventually I resubmitted it to another tutor hoping it wouldn't need much readjustment, as time for final submission was close. Amazingly the assignment with all its changes was in two days before the due date. One of the things I've learnt about myself is that I like to finish assignments ahead of time.

We now have three assignments submitted, three more to go and now only ten weeks till the end of the course. It has been interesting to explore where theory meets practice and how it ties together. One theory explained why I missed the boat with some clients and not others. On reflection this has led me to wonder more frequently what stage of development the client is at and to not move too quickly to something new. Whyte's text "Explorations in Family Nursing" (1997) opened the door for me, giving me a model for the family work I carry out in the Plunket Additional Care role. I found it difficult to put this book down once I had started reading it, the first time a text book has appealed to me in this way. I also enjoyed Hartrick and Lindsey (1995) who have assisted me to make sense of the theory and practice of family nursing. I have reflected, analysed and assessed my work practice, as well as compiling a portfolio of the effects of this study on my nursing practice.

I have learnt many new skills: how to use a computer; how to access the library and how infuriating this can be when I can't find the articles I need; and how to use email which was completely foreign to me at the beginning of the year. This has been a very difficult year. The first tutor had unplanned leave which left the class floundering. Then getting used to a new tutor with different expectations was challenging. I have alternatively felt in control then completely out of my depth, sometimes I think I have some knowledge, then none.

My workload over this year has been high. Along with my usual position of Plunket Additional Care and Support, working with families with high needs, I have also been a co-facilitator for Professional Supervision workshops in the South Island as Plunket introduces Peer Supervision to its staff.

The course has encouraged me to look at things from a different perspective. I look at things more globally now, am not afraid to voice my opinion, and have made submissions on various papers which last year I would have ignored.

In hindsight I would have been advised to wait a year before beginning this journey as I will not need to travel for the Supervision workshops, which will decrease my workload. One of the reasons I chose to start the journey was the opportunity to begin studying without the cost of the study fees and for that I'm very grateful to the CTA for their foresight to offer this opportunity to us.

This has certainly been a challenge for my fiftieth year, one that while not being exactly enjoyable has been challenging, invigorating, stimulating and thought provoking. Thank you to my family who have supported me through the beginning of this journey.

I wonder where the journey will take me in 2000.

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IMPROVING STUDENT LEARNING THROUGH ACTION RESEARCH - EXPERIENCES IN NURSING EDUCATION

Kaye Milligan & Jackie Walker - Lecturers, Christchurch Polytechnic Institute of Technology

Combined paper presented at the New Zealand Action Research Network conference, September 18th 2000, at Christchurch Polytechnic Institute of Technology.

Improving student learning is the aim of most educators in the tertiary sector today. We will be presenting research on two aspects of improving student learning through changes in teaching, in the Bachelor of Nursing at Christchurch Polytechnic Institute of Technology. Both projects were undertaken as a component of the Diploma of Tertiary Teaching and, as this coincided with implementation of a new curriculum, the research provided a mechanism for change.

This presentation will discuss the two projects, the process and results in the context of the action research cycle. We will be highlighting the trials, tribulations and achievements of undertaking this type of research as novice action researchers. The first project which was undertaken over 30 months, examined the use of physical assessment skills in the clinical setting by year one nursing students. The second project examined the effectiveness of specific classroom teaching strategies in a second year problem-based learning course over four months. During the presentation there will be an opportunity for discussion and critique of the projects to facilitate sharing experiences with this research method.

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FLEXIBILITY & INNOVATION IN TRANSITION (BRIDGING) PROGRAMMES

Mary Wade - Lecturer, Christchurch Polytechnic Institute of Technology

This is an abstract of a paper presented at the 9th National Nurse Education Conference held in Sydney, 28 June - 1 July 2000.

Abstract

The disestablishment of the enrolled nurse position, Healthcare restructuring, the acute registered nurse shortage and the proposed move to Competency Based Practicing Certificates has resulted in a drive to find cost-effective, flexible education to enable nurses to gain the education that they need.

Christchurch School of Nursing recognised the inadequacy of the traditional programmes for nurses already in the workforce and led New Zealand (and offshore) in offering the first flexi bridging programmes to ensure access barriers were removed. Enrolled nurses (EN's) and single registered nurses (RN's) such as psychopaedic, general and obstetric or psychiatric, have had the option of bridging to Comprehensive Registration and Degree, full-time, part-time, onsite or by the distance learning mode. There has also been the option of combining any of these choices so a student may have a combination of all four. RN's and Comprehensive Registered nurses also have the above choices to bridge to degree only.

This paper includes some of the pertinent findings from this writer's recent research, on the educational needs of registered nurses in the changing health environment and the 21st Century. The recent New Zealand Nursing Council policy change that disallows bridging programmes is discussed and challenged in terms of the acute nursing shortage. The question is asked as to 'whose interests are served' by this. It concludes with a brief discussion on whether the nursing profession would be better served by deregulation.

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HEALTH ASSESSMENT - A NECESSITY FOR NURSING PRACTICE 2000 & BEYOND

Deb Gillon, - Lecturer, Christchurch Polytechnic Institute of Technology

Whilst some nurses tell me that they haven't the time, and others say it is doctors work, I argue that nurses should be able to undertake a systematic patient history and complete physical examination. In fact they haven't got time not to! Changing healthcare environments and developing nursing roles mean that skills and knowledge in health assessment will be paramount for nurses to ensure they are adequately prepared to meet the challenges of nursing practice in the 21st century, and thus able to contribute to improved health outcomes for New Zealanders.

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25TH ANNIVERSARY CONFERENCE - A CELEBRATION OF NURSING RESEARCH

NURSING RESEARCH SECTION OF NZNO 24 - 25 MARCH 2000, WELLINGTON

Joanna Leppard, Tony Stephens - Bachelor of Nursing Students, Christchurch Polytechnic Institute of Technology

During March of this year we were lucky enough to be sponsored by the School of Nursing to attend the annual Nursing Research Conference, held in Wellington. This year's conference was the 25th anniversary conference and was celebrating 25 years of the Nursing Research Section (NRS) of the New Zealand Nurses' Organisation. The NRS aims to encourage nursing research, support nursing researchers, help disseminate and publish New Zealand nursing research and promote national and international links between nursing researchers (Nursing Research Section, 2000).

The Anniversary Conference provided an interesting mixture of history of the NRS, current research activities, and some possibilities for future nursing research in New Zealand. Just as important as hearing reports on current research projects, was the opportunity to network with nursing students, nurses, and nurse researchers from clinical and academic settings throughout New Zealand. Guest speakers from North America, Australia, Norway and South Africa provided international input.

Over the two days of the conference there were 39 presentations plus poster displays. With three presentations on at any one time it was sometimes difficult to decide which session to attend, as they all looked interesting. We will discuss four sessions which were of particular interest to us.

Keynote Address : Celebrating nursing research: A personal view.

Nancy Kinross.

This session provided a personal view of the development of nursing research in New Zealand by the founder of the NRS, Nancy Kinross. The slow move by nursing in New Zealand to undertake research during the 1960s and 1970s was discussed, along with the transition of nursing education from hospitals to tertiary education institutions. These trends gave further encouragement to the rise of nursing research. During this time Kinross worked for the Department of Health and was able to 'pull strings' to overcome resistance to formalising nursing research in New Zealand. By 1975 a nursing research group had been established. This group then developed the groundwork for further research by developing a code of ethics and by legitimising the qualitative research method used in some nursing research.

The beginners guide to journal clubs.

Katherine Leamy.

This session detailed a study on research utilisation by New Zealand nurses. Journal clubs were identified as a strategy for nurses to become aware of and to implement research findings in practice. Journal clubs for nurses are similar to book clubs - an article is selected, distributed and then discussed by a group of nurses. The main aims of a journal club are to inform, enlighten, initiate change and reflect on practice and research. Leamy found that a small group of nurses, preferably from the same work area, worked best. For a nurses' journal club to succeed there needs to be a leader/motivator and a commitment from the group to participate. Supportive management is also required, as new ideas may be trialed as a result of discussion on particular research. Interest may be maintained by having group members select articles they are interested in and choosing articles relevant to the work area and current issues occurring in the work area. Leamy also recommended holding journal club meetings away from the work environment and the distractions of work. Journal clubs work best if the meetings are social, fun and stimulating. Holding a meeting and discussion at a quiet cafe or before a pot luck dinner were two suggestions to help create a positive atmosphere.

Leamy found the biggest barrier to successful journal clubs was a lack of a specific time for meetings. A regular time and place away from work is required so work pressures do not intrude on a meeting and discussion. Journal clubs also require access to databases and journals, either physically through a library, or via the World Wide Web. Establishing a journal club is one way of helping nurses become aware of nursing research. Once aware of research nurses can then decide if they could trial research based techniques. This helps nurses keep up to date with new developments, develop new skills and improve practice through improved patient care or improved efficiency. Some hospitals in New Zealand, including Canterbury Health, are running nursing journal clubs.

Hazards of air travel.

Christine Cavanagh.

This seminar was a mixture of a personal story, reflection, research ideas and health education/promotion. The hazards of air travel was about the risk of developing deep vein thromboses (DVT) while flying on long distance aeroplane flights. This session also reinforced that nursing research does not have to be complicated.

DVTs are caused by blood stasis due to lack of circulation in the legs. Pressure on the back of the legs caused by sitting for long periods is a principle cause of DVTs in flight. People have developed DVTs after long bus, car and train trips. During the Second World War some people died after developing DVTs and pulmonary embolisms after sitting in bomb shelters for long periods. Some of the risk factors for DVTs identified by Cavanagh include immobility, cramped seating arrangements, dehydration, longer flights, taller and shorter people, people with poor circulation such as those suffering from diabetes and those with heart conditions. However, many DVTs occur in people with no history of circulation or blood problems.

Cavanagh also explained some simple preventive measures: feet and leg exercises while sitting; walking in the cabin once per hour; deep breathing; avoiding alcohol; and avoiding sleeping in uncomfortable positions. For people more at risk of DVTs they could consider wearing low compression TED stockings while on long flights. According to Cavanagh some pilots wear TED stockings while flying.

Knowledge about DVTs and preventive measures could be important to a nurse working at a health centre giving vaccinations for travellers for example. While giving the injections the nurse could also give a brief education session to the traveller or write a brief pamphlet about the risks and how to prevent DVTs.

Influences on nurses pain management practice within institutions.

Kerene Strochnetter.

Strochnetter believes that despite a lot of literature outlining effective interventions patients continue to suffer pain. Her research findings gave us all something to think about, and no doubt challenged us on our ability to manage our patient's pain. Strochnetter's research identified themes, which included:

- nurses who have legitimate endorsement for their practice prescribing analgesia after identifying a client need and obtaining a medical signature
- nurses are being constrained by a health care system which inadvertently delays pain relief, through high patient acuity and time constraints.
- non-accountability for pain management to continue at a professional and institutional level - who is held responsible for unrelieved pain?
- nurses cannot do their job within a health care system that devalues the expertise necessary to assess and implement effective pain management strategies.

Strochnetter believes that until nurses assume professional responsibility for patient comfort and can autonomously initiate strategies to manage pain, then improvement in pain management is unlikely.

Conclusion

We really appreciated the opportunity to attend this conference and found it to be of great value as we are just about to head out into fulltime practice. We recommend this conference to anyone with a passion for research or improving practice. The conference was both challenging and inspiring and was a very worthwhile experience. If people are interested in nursing research in New Zealand the NRS has developed a website.

The address is: <http://www.nursingresearch.co.nz>.

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25TH ANNI VERSARY CONFERENCE

A CELEBRATION OF NURSING RESEARCH WELLINGTON, 24-25 MARCH 2000

Rose Mitchell, Cynthia Stokes, Lynda Jeffs - Lecturers, Christchurch Polytechnic Institute of Technology

What impressed us about this excellent annual conference was the variety and calibre of presenters. This made it somewhat difficult choosing which sessions to attend. Our strategy was to focus firstly on sessions directly related to clinical practice and student focused presentations, then on areas of personal interest. The format for both days centred on a keynote address to commence, followed by a choice of three parallel presentations of 40 minutes each, which included time for questions and comments from the floor. Nan Kinross, keynote speaker on the first day, put the historical struggle of nursing research and postgraduate education and study in New Zealand into perspective. As one of a small group of senior nurses well known and respected in New Zealand circles, she outlined the development and ultimate acceptance of a culture of research in nursing in New Zealand.

Nan's humour and honest portrayal of developing a nursing curriculum within tertiary education was appreciated by those of us who have followed behind and have been involved in further development of the original ideology.

Deborah Spence, spoke about her work on nursing people from cultures other than one's own. The struggle and tension created within nursing and the wider community, by the introduction of Kawa Whakaruruhau into nursing and midwifery education was addressed. Her findings challenge nurses to continue working towards a deeper understanding of cultural difference and applying this increasingly to their everyday practice.

Lynda Jeffs followed Deborah's presentation and offered a framework for culturally safe nursing research. This included the main elements of cultural safety such as the nurse as researcher understanding her/his own culture, power and the management of these in the implementation of nursing research practice. The presentation generated much discussion.

O'Reilly, Arps, Gage, Heather and Matheson addressed issues surrounding student's first experience of the death of a client. One issue highlighted, was how dealing with death was part of the "silent" work of nursing and how ward and tutorial staff can help students by talking about the death of a client.

Bonnie Schroven and Jane Hewlett addressed the issue of improving communication and negotiation of personal learning objectives between student and staff nurse. This student based research highlighted strategies students (and their tutors) could use to ensure improved teaching and learning in the clinical area. Of particular note was the students awareness that they needed to take responsibility in achieving their individual learning goals for clinical experience.

We appreciated the many fascinating presentations and the chance the conference gave us all to meet fellow nurse researchers and network with national and international colleagues. The celebratory dinner offered the chance to talk with other nurse educators on a variety of topics, exchange ideas and make new contacts. It was also an opportunity to listen to stories from nurses, who although retired, are clearly actively involved and interested in nursing research and education. The Nursing Research Section is to be commended on such a professional and thought provoking conference.

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7TH TRIENNIAL INTERNATIONAL CONGRESS ON NURSING INFORMATICS - ONE STEP BEYOND

THE EVOLUTION OF TECHNOLOGY & NURSING 28 APRIL - 3 MAY 2000, AOTEA CENTRE, AUCKLAND, NZ

Elizabeth Hanley - Lecturer, Christchurch polytechnic institute of Technology

Over 400 delegates, from 28 different countries, attended this international congress. Twenty per cent of the attendees were from New Zealand and a further 20% from the Pacific Rim other than the Americas. The highlights of this conference were that it provided the opportunity to network with other like-minded nurses and it enabled me to put faces to those authors I had read many times.

Prior to the conference I attended two workshops on developing online courses. These were co-ordinated by Peter Murray (UK) and Ramona Nelson (USA) and focused on the practical and theoretical issues of online courses and online assessment and evaluation. The third workshop I attended was on nursing informatics education from an international perspective, co-ordinated by Kaija Saranto (Finland). This workshop described some of the projects developed to complement nursing informatics education in Finland — two in particular were a communication and information service for pregnant women and their support persons and, a multidisciplinary computer based careplan.

The keynote speakers were leaders in health informatics and spoke of their experiences and contributions to nursing informatics in the last century as well as visions for the future. Dr Ed Hammond (USA) presented the progress of patient records whereby hospitals today have some form of Hospital Information System but few are fully automated. With the shift to more community based care the advent of wireless technology and the increasing numbers of people having access to health information over the Internet mean changes in the ways data is collected, transmitted and stored. Because the current electronic health record is based on the paper record, the management of data has in many cases been overlooked. How relevant are a person's daily temperature recordings once they have been discharged. How does the record get "purged" of this redundant data? Ed left us with many questions to ponder on.

As a pioneer in nursing informatics Dr Kathryn Hannah (USA) spoke of her experiences and contributions to nursing informatics from her first book in 1976 through to her new book launched at the conference. She left us with many challenges and issues to consider with changing health enterprises.

Dr James Cimino (USA) described the development of a medical record that had many links or "infobuttons" built into it, as a means of integrating clinical systems and web-based information resources. The most useful so far have been links to drug information in Medline and Micromedex.

Paula Procter (UK) focused on nurse education and emphasised the need for education and practice to collaborate in defining what students should learn consciously and what can be learned subconsciously. For example, the link between information and communications technology where quality information sites, patient-led mail lists, computer assisted learning and video communications can be used. Students learn personal management of data through the development of database skills, security and protection of data. Dissemination could occur through discussion groups, electronic mail and video conferencing. These are ideas we are exploring with distance students.

The final keynote speaker was the innovative and challenging Dr Dave Warner (US) who proposed a medical communication matrix known as Strong Angel. Dave also described some of the biometric input and communication devices he has developed to assist the physically compromised.

The over 90 concurrent scientific sessions and eight panels covered a wide range of topics on education, informatics projects, and research. There were also 52 poster presentations to view, six scientific demonstrations and at lunchtime each day were peer discussion groups where there was an opportunity to talk with colleagues about topics such as informatics standards, monitoring, research and nursing concepts.

The two most memorable sessions I attended were the presentation of the Nightingale Project in Europe and the use of the Nightingale Tracker in community based experience for student nurses. The Nightingale project aims to co-ordinate nursing informatics education by developing a core curriculum and courseware materials for nursing informatics education within the European Community.

The Nightingale Tracker is a small handheld device, which is used for care planning at the point of care, using the Omaha System nursing language. Communication technology allows the student in a community placement to communicate with their lecturer for assistance, such as in care planning. At the end of the day the data can be downloaded on to a PC or transmitted to the lecturer.

The ideas I came away with were that we, at Christchurch Polytechnic, are in the forefront of undergraduate education in Nursing Informatics. Many countries were interested in what we are doing and wish to introduce

similar courses into their programmes. I have made some valuable contacts with whom to share resources and ideas for future development of Nursing Informatics courses. I appreciate the opportunity to attend this congress which can only benefit the quality of nursing informatics courses we provide.

The three books launched at the conference were:

Scholes, M., Tallberg, M., & Pluyter-Wenting, E.S.P. (2000). International nursing informatics: A history of the first forty years, 1960-2000. Wiltshire, UK: British Computer Society.

Appelton, M., Carr, R., & Hausman, J. (2000). NINZ: The first 10 years. Auckland, NZ: Nursing Informatics New Zealand, Inc.

Ball, M., & Hannah, K. (2000). Nursing informatics: Where caring and technology meet(3rd ed.). New York: Springer-Verlag.

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FACULTY OF NURSING - UNIVERSITY OF SYDNEY

9TH NATIONAL NURSE EDUCATION CONFERENCE 28 JUNE - 1 JULY 2000, SYDNEY

Mary Wade, Bernice Tracy, Esther Vallance, Robyn Brasell-Brian - Lecturers, Christchurch Polytechnic Institute of Technology

This conference opened with a keynote address from Professor Margaret McMillan entitled "Meeting the Challenges of Flexibility in Teaching and Learning". This topic set the scene for the whole conference. Margaret revisited nursing history and also posited that everything around us suggests that we 'flex-up' and move outside of the 'normal' structures and our comfort zones. She suggested that we are in a changing professional paradigm because of globalisation and the need to value and accommodate diversity. She identified the need to introduce the virtual classroom, flexi delivery and offsite education. To facilitate these changes the following were identified: technical support, academic time to write content (online and offline), and the need to set up infrastructures to support clinical and academic staff, and students, in particular overseas students to manage the changes. Margaret summarised her address by advocating nursing move away from imposing an old world view of caring and recognise the concepts of artful nursing. She also advocated the need to teach nurses to engage in different conversations to reduce horizontal violence. She stressed that only by a positive culture and collegiality can nursing hope to move into a new professional paradigm.

There were four plenary sessions:

- "The Story of Fable". A narrative analysis by Wendy Penney, Deakin University, Victoria.
- "Arousing the Senses of Learning". A role play by Karen Glaister and Allan Tulloch, Curtin University, Perth.
- "Nurse Meeting Another: Cultural Safety in Nurse Education" by Aroha Fitzpatrick, Rotorua.
- "The Dissonance Between Professional Development Aspirations and Health Service Needs" by Jan Andrews, Consultant, NSW.

The Story of Fable

The story of fable is the outcome of Wendy Penny's Master of Nursing Studies research. Fable is created by blending the stories of four new graduates. Her presentation began with a sharing of the research process which included her professional research journal. This highlighted Wendy's journey, in particular her difficulty making the transition from expert clinician to academic.

The main themes that arose in her research were:

- being a new graduate
- being a nurse
- shiftwork
- turning the corner
- becoming a nurse

Wendy pointed out that stories provoke reflections of our own experiences and this was evident when she shared the new graduates' stories. This was memorable because one felt drawn into this story by the richness of the narrative.

Arousing the Senses of Learning

This plenary began with a humorous pertinent role play of a student nurse in clinical. This was given as an example of Allan and Karen's move from a quantitative to a qualitative way of transmitting knowledge. They wanted to facilitate deep learning through sensory arousal which included interactive learning activities such as drama, games, role plays, videos and poster presentations. These were supported with website activities; tutorials, e-mail, connecting with other websites and an online bulletin board for immediate feedback.

Nurse Meeting Another: Cultural Safety in Nurse Education

This began with an overview of cultural safety in New Zealand from its beginning, through to the angst in the nineties to the current situation. Aroha presented the Nursing Council of New Zealand Cultural Safety Curriculum requirements for all Schools of Nursing as well as for lecturers. She explained that cultural safety

had several main prongs: Treaty of Waitangi; Maori Health Status; Colonisation; the Health Care System and all the 'ISMS' such as ageism and sexism. Aroha also pointed out that previously in New Zealand, nurses were taught to nurse "regardless" of culture but now nurses are taught to be "regardful" of gender, age, ethnicity and so on. The Australian audience appeared to find this presentation thought provoking.

Dissonance Between Professional Development Aspirations and Health Service Needs

Jan highlighted issues and concerns in the nursing profession in the provision of education for professional development. Her experience was that nurse consumers were bombarded with literature about getting ahead and upskilling. However, currently many flyers are 'binned' and inappropriate courses are chosen because of lack of guidance/mentorship. She challenged educators to support the practice setting by 'needs analyses' to ensure professional development is relevant and assists retention of staff. Her final challenge was to educators to keep networking and maintain professional contacts. She suggested the timing was right for turning rhetoric into action and that this had to arise from an education base. There were 76 concurrent sessions Of these 20 were presented by New Zealanders.

- Themes of the concurrent sessions, and poster presentations included:
- flexible interactive delivery and approaches
- innovative teaching methods and programmes
- new graduate programmes and outcomes
- preceptor programmes
- clinical practice
 - students' experiences
 - assessment
 - sessional tutors
 - exchanges
 - health expos
- post Graduate education
- migrant nurses needs
- transcultural nursing
- linking theory to practice
- online teaching
- webpages to support teaching

Conclusion

In summary, it was an excellent conference with many amazing flexi and innovative ideas presented. It provided opportunity for networking and collegiality in a personable environment. Overall, it was encouraging to realise our own School of Nursing is leading the way in areas such as Transition/Distance Education and Clinical Practice Education Exchanges.

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TREATY CONFERENCE 2000 6 - 8 JULY 2000, AUCKLAND

Lynda Jeffs & Helen Gibson - Lecturers, Christchurch Polytechnic Institute of Technology

This conference was collectively convened by: Programme on Racism; Pax Christi Aotearoa-New Zealand; Net work Waitangi Inc. Soc.; and Women's International League for Peace and Freedom, for the purpose of facilitating an environment for Pakeha/tauiwi communities coming together to affirm the Treaty of Waitangi. It was held at the Sacred Heart College, Glen Innes, in Tamaki Makaurau/Auckland, New Zealand. One of the conference's aims was to ensure and promote cultural safety and Irihapeti Ramsden, the architect of the theory and practice of cultural safety in nursing, had the role of facilitating this process. Both Lynda and Helen work in the area of cultural safety and presented a paper for comment and critique. There was a collection of very stimulating and relevant speakers present on issues of importance to nursing, education and New Zealand's race relations.

The conference started on Thursday with an address from Joseph Williams, Chief Judge, Maori Land court and Mitzi Naim, Conference of Churches Aotearoa/New Zealand. Judge Williams emphasised the importance of sustainable settlements as a necessary pre-requisite to reparation and the future development of our country. He underlined the importance of the settlements being germane and promoting the sustainability of each community recognising that some communities are over 1000 years old. These settlements will be difficult as the Waitangi Tribunal is now moribund, weighted down by the processes and claims. One of the difficulties he expressed was that the law itself was a barrier to change as its foundation was to support the status quo.

Moana Jackson, Ngati Kahungunu, Ngati Porou, Constitutional Lawyer, Founder and Director of Maori Legal Services set the scene on Friday for the rest of the conference. He offered an inspirational address on naming, labeling and the power vested in the namer and the labeler. He challenged the conference participants to question what a name meant, how it was constructed, who holds the power to name and the relevance of this to the Treaty of Waitangi and Constitutional Change. He began with a quote from Benito Mussolini who suggested that 'invention was more useful than the truth', and suggested that the truth of the Treaty was obscured by inventions, and the power to invent and redefine, was particularly allocated. He questioned the concept of accountability in relation to the Treaty and suggested we have lost sight of who should be accountable to whom. In a society besotted with labels and branding he suggested the Crown lawyers, as masters at re-labeling, have de-contextualised the Treaty from an instrument of colonial dispossession within a culture of colonisation to a framework for continued colonisation. He challenged the participants at the conference to identify their own identity, take it seriously, understand its boundaries and its power so Maori can take the power to name their own world and determine their own destiny. The following session offered by Winston Halapua, St John's Theological College, Auckland and Karen Way and Margaret Stuart, Network Waitangi, continued with the theme of the importance of identity. One interesting suggestion was that Pakeha might be more visible if there was a Ministry of Pakeha Affairs.

The rest of the day comprised presentations and strategy workshops in four different streams of concurrent sessions. The presentations included:

- "Kawanatanga - A Tauiwi Perspective" by Brenda Cambell for the National Collective of Independent Women's Refuge.
- "Learning To Be Good Neighbours" by Charmaine Poutney and Tanya Cumberland.
- "An Approach to Achieving Organisational Change" by Chris Oaks for the Manukau City Council.
- "Working for Change: Whanganui Journeys Since Pakaitore/Moutoa Garden" by some members of the Getting On, Moving On Network and Project Waitangi Manawatu.
- "Kaitiakanga and the Crown" by Moea Armstrong, Whangarei Network Waitangi.
- "Biculturalism and Multiculturalism: Are They Mutually Exclusive?" by Dr Love Chile, Unitec.
- "TUHA-NZ- Implementing a Tiriti Strategy in Health Promotion" by a representative from the Health Promotion Forum of New Zealand.
- "Values that Underlie Constitutions" by Anne Wells and Catriona Budge from Network Waitangi Wellington.
- "Identifying Institutional Racism: Researching a Tertiary Institution's Commitment to its Treaty of Waitangi Charter Provisions" by Cat McIsaac, from CIT.
- "Issues in Treaty Education" by Jennifer Margaret and Christine Herzog, Manukau Institute of Technology.
- "Addressing the Treaty of Waitangi in Teacher Education" by Ann Bondy, Pip Smith and Ally Bull from

the Wellington College of Education.

- "Urupare Rangapu" by Trevor Wilson and Megan Huffadine from Nelson/Marlborough Institute of Technology.
- "Insights from Organising Locally" by Katherine Peet from Network Waitangi.
- "Nga Whaea Atawhai o Tamaki Makaurau as Whanaunga Treaty Partners" by Mary Foy and Denis Horton from Sisters of Mercy, Auckland.
- "The Waiora Model" by Tania Thomas, from the NZ Council of Christian Social Services representative on Te Kaiawhina Ahumahi council.
- "Tino Rangatiranga in the Performing Arts" by Madeline McNamara and Parekotuku Moore from Magdalena Aotearoa/Tii Kouka.
- "A Critique of the Political Culture in Pakeha Heads" by Jim Holdom from CORSO, Waikato.
- "Exploring Pakeha Cultural Awareness" by Rose Black from the University of Waikato.
- "Looking Behind the Mirror: A Strategy for Preparing Students for Treaty Education" by Helen Gibson and Lynda Jeffs.
- "Teaching Cultural Safety in a Nursing Education Programme" by Fran Richardson from Massey University at Wellington.

The paper that we presented was an exploration and analysis of the connections between theory and practice. Our premise is that many people are unaware and have little understanding of the impact of their culture on their daily lives. We focused specifically on the importance that we place on those members of the dominant culture in Aotearoa/New Zealand (the greater number of our students) developing an awareness and understanding of the very specific nature of their culture, which we termed 'whiteness'. Our theory, developed out of our research and teaching experiences, holds that this process of bringing the invisibility of 'whiteness' to conscious understanding as a legitimate culture, will break down resistance and enhance the ability of students to engage in Treaty of Waitangi education.

The Saturday sessions started with a formal presentation from the Maori caucus to the conference participants on issues to be addressed in relation to the Treaty of Waitangi. Particular emphasis was made of the inappropriateness of non-Maori using Maori words as these can be a form of labeling and colonisation. This was followed by a panel of people who addressed the Treaty of Waitangi and the expression of culture in Aotearoa/New Zealand. Patricia Grace, a well recognised and admired New Zealand author, led this discussion and once again reinforced what was becoming an underlying theme of the conference. The belief that Pakeha New Zealanders work to identify their own culture and act to support people to whom they are different, as required and defined by those to whom they are different. Albert Wendt, an author and Professor of English at the University of Auckland discussed the implications of being one of the many Polynesian countries situated in this part of the world. He outlined some of the wonderful artists whose work he had examined and reaffirmed their special contributions to art and to this part of Polynesia. The final panelist was Paddy Austin, member of the Heart of the Nation strategy group who talked generally about the work they had been doing to develop a plan of support and resources for the different artists and forms of art in this country.

The last part of the morning session was devoted to the non-Maori communities and their relationships to the Treaty of Waitangi: Present and future perspectives. There were three speakers who developed small group discussions on many topics, including the role multi ethnic and multi cultural communities have in relation to the Treaty of Waitangi. The three speakers included Shanti Patel, representing the New Zealand Federation of Ethnic Councils, Dr Nagalingam Rasalingham, representing the Refugee Council of NZ and Karun Lakshman the Convenor for Human Rights/Race Relations and the New Zealand Federation of Ethnic Councils.

The afternoon was devoted to developing strategies for the implementation of the Treaty of Waitangi and recommendations for further action.

The conference offered a wonderful opportunity to network with others working in the same area. We gained many different ideas and an affirmation of both the intellectual and practical work we are engaged in. The material offered and the affirmations received made this a very energising experience. The participants came from a wide variety of different areas, some were fellow cultural safety educators but many more were workers in Treaty Education for both the Public, Private, Voluntary and Religious sectors. The conferences hope was that our living of our Treaty agreements give wellbeing to all people, hospitality to guests and care to our environment.

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COLLEGE OF NURSES AOTEAROA (NZ) CONFERENCE 2000

CHRISTCHURCH, 28-29 SEPTEMBER 2000

Tricia Baker - Bachelor of Nursing Student, Christchurch Polytechnic Institute of Technology

Two transition nurses, and two undergraduate students were sponsored to The College of Nurses Aotearoa (NZ) Conference, held 28 and 29 September, 2000. As a mature student, I found that nurses at the Conference were somewhat surprised when they'd ask "And what field are you in?" "I'm a Stage Five nursing student." "Oh really? Are nursing students included as Conference delegates? What a wonderful idea!" And so I hope this will become a tradition for all future conferences, as it offers a valuable interaction between students and Registered Nurses.

At a time when there appears to be some (legitimate) negativity regarding nursing such as: low staff/patient ratios; strikes; low pay; graduates moving overseas for better opportunities, it was exciting for me to attend the Conference and to be challenged by the directions nursing is going in. There was so much positivity! These nurses were excited about their careers! They were out in the workplace making changes! They were involved in research! They had dreams and visions! They were interacting with Government!

At the same time, nurses were challenged by Dr Jenny Carryer, the Executive Director of the College of Nursing:

- to shed their victims status - 90% of which nurses do to themselves.
- stop complaining and start critiquing because this is what leads to change
- do not accept mediocrity
- keep building on culturally safe practice
- trust and support each other in the political arena: debate in private and share convictions publicly.
- don't wait for someone to give us power, but assume power.

The Right Honorable Annette King talked about updating the Nurses' Act in 2001, further education regarding nurse prescribing to be commenced in 2002, and her previously announced introduction of second tier nursing. Considerable discussion from the conference delegates centered on the position of the registered nurse following the reintroduction of enrolled nurses. Their training as apprentices within the hospital and their lower salaries, may make them more attractive than the higher qualified, higher salaried registered nurse. Could there not be a change of name at least? Annette King was not convinced that RNs felt vulnerable.

The most difficult aspect of the Conference for me, was deciding which session to attend! How does one choose between:

- preceptorship or rural nursing
- health assessment or the tension between theory and practice
- team nursing or nurse prescribing
- lesbian experiences or "Don't just think it - do it"
- hospital restructuring or reflection
- experiences of a school nurse, and so on.

I was encouraged and fascinated by the research that is actually happening. The nurses at Conference really wanted to make a change. I appreciated the challenge to nurses given by Dr Linda Johnson, an Associate Director of Nursing Practice Research in Victoria, to not allow barriers like lack of time, lack of confidence, or the failure of research findings to make any difference, prevent us from undertaking relevant research. And most importantly, to publish research. Only 4.3% of nurses publish their research in international academic/professional journals! The whole point of research is to improve patient outcomes.

I especially enjoyed the informal interactions I had with nurses during break times. A nurse (who was also one of the guest speakers) had been exposed to interstitial cystitis herself, and had nursed patients with this devastating condition. In fact, she became so interested in IC that she had travelled to the USA and Europe studying IC. She is now passing this information onto health professionals and patients and is raising public awareness of the condition in magazines etc, and has established an IC clinic. This is an ordinary nurse with

an extraordinary vision.

Wow! We students can do this! We don't have to sit back and wait for someone else to do it. We are receiving a fine education which equips us to undertake research, to find a niche, and make a difference. In spite of obstacles, let's accept the challenge to take nursing forward into the 21st century.

I specially want to thank the organising committee for sponsoring me to the College of Nurses Aotearoa (NZ) Conference. I found it stimulating, and encouraging to be amongst nurses who are out there making a difference

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