

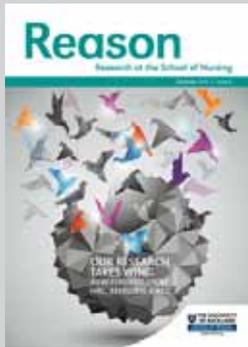
# Reason

Research at the School of Nursing

December 2013 | Issue 6



**OUR RESEARCH  
TAKES WING**  
*NEW FUNDING FROM HRC,  
MARSDEN & THE EU*



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# WELCOME

European Union (EU), HRC & the Marsden Fund: major funders are supporting new SoN research



Research Director  
Professor Merrynn Gott

**K**ia ora tatou katoa. The illustration on the cover aptly represents our perspective as we approach 2014. We're flying high with funding for several innovative research projects. For instance, new senior lecturer, Dr Clare Gardiner, is a named

investigator on a \$3 million European Union-funded study exploring the assessment of complex health interventions. I am leading a \$1.1 million HRC project that seeks to optimise palliative and end of life care for the oldest old, and Dr Katey Thom has just been awarded a prestigious \$300,000 Marsden Fund grant. (More on Katey in the article below.) The success rate for Marsden funding is only nine percent, and the University has had it's best year ever in terms of grants awarded.

In these pages you'll find out more about these projects as well as about ones already underway. Dr Terryann Clarke reports on the third wave of the

**"We're flying high with new funding for several innovative projects."**

national health and wellbeing survey of secondary school students. Interesting findings include an identified decline in alcohol, tobacco and illicit drug use

since the 2007 survey, something at odds with media portrayals of young people in New Zealand.

Dr Kate Prebble writes about the ongoing Nurses Education and Research Foundation (NERF)-funded Nursing Oral History Project. Her article explores the experiences of student nurses on the wards in the 1950s.

An update on Dr Kathy Peri's Canterbury earthquake research addresses the stereotyped reporting of the news media around older people. Kathy also offers her own firsthand account of her experiences at Princess Margaret Hospital when the second earthquake hit.

The postgraduate research section includes reports on the research undertaken by our PhD and master's students. Finally, we end with a listing of our publications for the year. In it you'll see the scope and breadth of our scholarship.

As ever, we welcome hearing from you.

Mauri ora

## MARSDEN FUND WINNER

**D**r Katey Thom has been awarded \$300,000 to investigate what 'therapeutic' means in the context of problem-solving courts in New Zealand. "The courts' aim is to promote healthy behaviours and ultimately reduce recidivism," says Katey, but what exactly therapeutic means in this context remains unclear."

Applications to the Marsden Fund are highly competitive. This year the fund distributed \$59 million to 109 research teams around the country. Katey is one of The University of Auckland's 35 Marsden recipients. This total represents \$17.8 million in grants, amounting to thirty per cent of the funds awarded this year.



Dr Katey Thom

## Hearing VOICES

*New pilot project to assess palliative care experiences in New Zealand*

The Palliative and End of Life Research Group is adapting a key UK tool for use in NZ. The group is rolling out the Views of Informal Carers (VOICES) questionnaire in a pilot project that will investigate family and whānau experiences of, and preferences for, end of life care. “The lack of available information about what people want is limiting the development of palliative care services in New Zealand,” says Merryn Gott, the project’s principal investigator.

A second objective will be to uncover differences in palliative care experiences according to demographic, cultural and diagnostic factors. “VOICES has the potential to identify inequities in access to services, such as for Māori and Pacific people,” says Merryn.

VOICES has been used extensively in the UK to survey the experiences of bereaved family members of people who have died with a life-limiting illness indicating palliative care need. The UK Department of Health has granted the New Zealand team the right to use VOICES and to make minor changes to ensure a fit with the NZ context.

Working in collaboration with the Auckland District Health Board, the research team is interviewing the bereaved family and whānau of up to 30 people who have died recently in Auckland City Hospital. They are conducting in person interviews to trial the VOICES questionnaire and to obtain feedback on how it might be further adapted for a large-scale project.

Palliative and End of Life Research Group members Clare Gardiner, Jackie Robinson, Stella Black, Tess Moeke-Maxwell, Lisa Williams and Gabriella Trussardi are also involved in the VOICES study.

## YOUTH ‘12 OVERVIEW NATIONAL REPORT

NZ youth show improvements in school life, health-compromising behaviours, risky driving, violence and sexual coercion/abuse

Youth ‘12 Overview, the report from the third national health and wellbeing survey of secondary school students indicates NZ youth have demonstrated some significant improvements in their health and wellbeing over the past 11 years. The first two surveys were undertaken in 2001 and 2007. All three have been carried out by the University of Auckland Adolescent Health Research Group (AHRG).

According to Dr Terryann Clark, a senior lecturer in the School of Nursing and AHRG’s principal investigator, gains have occurred in aspects of school life, health-compromising behaviours, risky driving behaviours, violence experienced from others, and sexual coercion/abuse. For example, more students report feeling adults at school care about them and that their substance use (cigarettes, marijuana and binge drinking) is down, as is their drink driving.

Terryann notes that these findings are at odds with typical media portrayals of youth. “Young people have reported a decline in alcohol, tobacco and illicit drug use in the Youth ‘12 survey, whereas many a media story, particularly in relation to youth drinking, suggests the opposite.”

Yet not all the news was positive. Students reported little or no change in some areas: inconsistent condom and contraception use, being bullied, being overweight or obese, not feeling they spend enough time with at least one parent and significant depressive symptoms. Areas that have significantly worsened over time are related to socio-economic factors, included parents worrying about having enough money for food, access to a family doctor and participation in paid, ability to get part-time employment.

Differences among students surfaced when results were factored by deprivation levels. Compared to the 2007 survey,





**The Auckland Adolescent Health Research Group.  
PI Dr Terryann Clark is 3rd from right.**

more students were either obese or overweight. The figure ranged from more than a third to over 60 per cent in areas of high deprivation. Students experiencing high deprivation were more likely to attempt or think about suicide, smoke cigarettes, and have unprotected sex. They were also less

**“Differences among students surfaced when results were factored by deprivation levels.”**

likely to have a job or see enough of their parents.

Eighty-five hundred students from 91 schools took part in the survey. The full list of topics covered included culture and ethnicity, home and families, school,

health and access to health care, nutrition, exercise and activities, emotional wellbeing, substance use and gambling, gender identity, sexuality and sexual health, motor vehicle risk behaviours and violence, and community and contribution.

The Adolescent Health Research Group welcomes inquiries from NZ-based and international researchers interested in using the data from the survey for secondary analysis. The Group is also interested in hearing from those who would like to utilise the data for publications or Masters/PhD projects. Information about how to access data is



available on our website. The study was funded by Ministries of Youth Development, Social Development, Health, Education and Justice, the Department of Labour, the Families Commission and the Health Promotion Agency.

A copy of the Youth '12 Overview, and the Youth '12 Prevalence Tables report may be downloaded from the AHRG website: [www.youthresearch.auckland.ac.nz](http://www.youthresearch.auckland.ac.nz)

## RESEARCH NEWS

# REPORT FINDS NEW ZEALAND HAS **UNIQUE** SYSTEM FOR PROTECTING RIGHTS



**T**he New Zealand Law Foundation commissioned the Centre for Mental Health Research to report on the role of District Inspectors (DIs). DIs are appointed by the Minister of Health to ensure that the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) are carried out correctly.

DIs, who are lawyers, provide a safeguard for people who may be dissatisfied with the way they are being treated under the Mental Health Act, recognising that those subject to compulsory psychiatric treatment have lost significant rights to freedom.

Currently there are 34 DIs and 1 Senior Advisory DI in New Zealand.

“Research suggests the DI role is unique to New Zealand,” says Dr Katey Thom, principal investigator. “We found that overseas jurisdictions have different safeguards in place that do not statutorily require lawyers to undertake such a watchdog role.”

DIs visit hospitals, community health centres and people’s homes to assist those being assessed and treated under the Mental Health Act by providing them with information and support to ensure their rights are upheld.

Recommendations listed in the report included 1) investigating how DIs can be

supported to respond to patients in the community and vulnerable people who reside in residential facilities, particularly older adults; 2) supporting new DIs with a formalised ‘buddy system’ with continued and regular contact by experienced DIs and 3) improving information about the role of DIs for service users.

Dr Kate Prebble, Stella Black and Associate Professor Kate Diesfeld from AUT (Auckland University of Technology) were the other members of the research team.

## *GROUND BREAKING CONFERENCE* JOINS MENTAL HEALTH & ADDICTIONS NURSES

Close to Home: 1st Australasian Mental Health and Addictions Nursing Conference convened in June



**M**ental health and addictions nurses from New Zealand, Australia, the US and the UK met for three days to discuss issues such as homelessness, trauma and abuse that form the core of much of their work. Convened by Te Ao Maramatanga New Zealand College of Mental Health Nurses and DANA (Drug & Alcohol Nurses of Australia), it was the first conference in New Zealand geared to both disciplines.

The School of Nursing staff played a major role in hosting the conference. Dr Kate Prebble served as co-convenor and Dr Helen Hamer and Debra Lampshire were plenary session speakers. Tony O’Brien chaired the abstract selection committee and presented a paper. Jane Barrington and Michele Yeoman also presented papers.

Kate explained that involving service users in all aspects of the conference was a top priority. “One of the aims of the conference was to highlight the importance of clinician-service user partnerships in practice, education

and research. Service users not only contributed to the programme but also served on the organising committee and the abstract selection committee.”

The Close to Home theme reflected the aspirations of mental and addiction nurses to provide services as close to home as possible. As the conference’s mission statement asserted, service users will dictate how and where they receive treatment, nurses will respond to the needs of diverse populations and foster hope, resilience and creativity. Home is often a place of healing but it can also be the source of mental health and addiction problems.

Tish Siasoi,  
Kaiwhakahaere for  
Te Ao Maramatanga,  
the New Zealand  
College of Mental  
Health Nurses and  
conference co-  
convenor Kate Prebble





Victoria Radley, LiLACS interviewer for Opotiki (left) and Tess Moeke-Maxwell, field research team leader

## ACC TEAMS WITH THE SCHOOL OF NURSING AND WAIKATO DHB

*A first for New Zealand: New randomised controlled trial (RCT) to test whether WDHB's START programme can help ACC clients in need of intensive rehabilitation.*

START stands for Supported Transfer & Accelerated Rehabilitation Team. It is a trial programme for transitional care involving: health care assistants under the guidance of registered nurses (RN), occupational therapists, physiotherapists and geriatricians. START aims to reduce or eliminate hospitalisation for older patients in inpatient care or attending the Emergency Department (ED). The START model was replicated in Canterbury following the 2011 earthquake as it aims to increase the capacity of hospitals by facilitating earlier discharge home.

The RCT will gauge whether intensive rehabilitation in client homes provided by START will achieve therapeutic benefits. The trial will measure whether in-home rehab will decrease length of hospital stays, decrease re-admissions and time spent in hospital in the year following discharge, maximise clients' independence and health related quality of life as well as reduce ACC costs.

Eligible ACC clients who agree to take part will be randomised into either an intervention or control group. The control group and clients who do not agree to take part will receive usual care. The intervention group will receive up to six weeks intensive rehabilitation under START. A total of 472 clients will be recruited from Waikato DHB emergency departments, medical and surgical wards and post-acute (NAR - Non-Acute In-patient Rehabilitation) care.

School of Nursing researchers Dr John Parsons and Prof Matthew Parsons are the PIs. The rest of the team includes Christine Smith (study manager), A/Prof Tim Kenealy (Primary Care), A/Prof Paul Rouse (Economics), Rochelle Parsons (Researcher) and Avinesh Pillai (Bio-Statistician).

## \$1.1 Million HRC Grant

# Exploring the end of life: What care do people need?

The Health Research Council of New Zealand has awarded Te Pakeketanga: Living and Dying in Advanced Age full funding for three years.

Families in five North Island east coast communities will share their experiences about the end-of-life care of their now-deceased older family members. The purpose of the project is to build up community-based models of palliative and end of life care. As NZ, in line with the rest of the OECD, is experiencing a rapidly aging population, the results will have national implications.

Already the field research team of Dr Tess Moeke-Maxwell (Ngai Tai ki Tamaki and Ngati Pukeko) Stella Black (Tuhoe) and Dr Lisa Williams have conducted a dozen interviews. The goal is to talk to the families and whānau of up to sixty Māori and non-Māori older people who were enrolled in the Life and Living in Advanced Age: A cohort Study in New Zealand (LiLACS) study. LiLACS NZ is a longitudinal project begun in 2009 that is investigating successful ageing

for people over age 85. Although linked to LiLACS, NZ Te Pakeketanga is a separate and independent project.

"We're asking them about the services that were available to support their family member," says PI Professor Merryn Gott. "We're working collaboratively with the participant's whānau or family, using input from the whole family wherever possible."

The research will also address important issues related to Māori end-of-life caregiving. "There's a myth about large Māori families being around to look after their older people," says Tess, "but that's often not the case any more. And people move around a lot, so we're discovering what's happening with older people and their families, and how whānau are responding to their needs, given there are other pressures on them too."

## 1ST SPECIALIST STROKE NURSING COURSE

Capitalising on Dr Julia Slark's research expertise, the SoN will be up-skilling registered nurses with NZ's first specialist stroke nursing course in 2014. It will take place over six days in the first semester and will be open to any registered nurse with an interest in stroke. "We're responding to increasing demand," she says. "The need for specialist knowledge is really growing. Partly because of New Zealand's ageing population, partly because stroke as a nursing specialty is new to New Zealand."

Julia joined the School this year as a senior lecturer. She completed her PhD in secondary stroke prevention and has brought with her from the UK 12 years' experience as a clinical nurse specialist in stroke.

Before moving to NZ, she steered London's largest hyper-acute stroke unit, at Imperial College Healthcare NHS Trust in London, through the implementation of the London Stroke Model. The Model ensures that everyone in London with a suspected stroke is taken to a Hyper Acute Stroke Unit (HASU) within 30 minutes, where they are treated by specialist stroke staff with advanced intervention and treatment. In 2012 the London Imperial HASU was voted by the Royal College of Physicians as the UK's best out of 150 units.

Julia was also just named as one of six finalists for the *Nursing Times* (UK) 2013 Nurse of the Year Award.



**ABOVE:** An image from the resource kit's short video. Auckland LGB community member Rob Calder played the part of Chris, an older gay man admitted to residential care. Nursing student Charlotte Young acted as his caregiver. The Rule Foundation funded the project.

## Growing nurse leaders in the Waikato

by Matthew Parsons

The Nursing Honours programme has been available at The University of Auckland for over a decade. The programme has allowed students to 'fast-track' to doctoral studies.

However, invariably those individuals who achieve high grades in academic studies also succeed in their clinical area, and there is an opportunity to consider both the clinical and academic tracks.

Waikato DHB and the University of Auckland have established an exciting venture whereby nurses may undertake the Honours programme to develop their potential as nurse leaders. The criteria for inclusion includes a minimum B+ grade in their Bachelor of Nursing programme, active support from their clinical leader and employment with the Waikato DHB. Students, guided by Waikato DHB general managers as well as the executive team, will choose an Honours topic most akin to their clinical area.

Graduating from the Honours programme is intended to open additional pathways for successful nurses. It may lead to enrolment in a Master's or PhD programme that may include additional coursework around prescribing to support applications for nurse practitioner status.



## KIT FOCUSES ON RIGHTS FOR RAINBOW OLDER PEOPLE

The rights of Lesbian, Gay and Bisexual (LGB) residents in Aged Residential Care (ARC) facilities is the focus of a new resource kit designed by the School of Nursing to educate ARC staff about homophobia.

The resource kit, aimed at cultural safety for LGB residents, includes a short video, workbooks for facilitators and participants, a brochure with guidelines, certificate of training completion and an evaluation form.

The kit was created in collaboration with a working group drawn from the aged care sector and the Auckland

LGB community. It was developed in response to the recognition that New Zealand, like many countries, has an aging

society that includes an older LGB populace.

“Our research shows that staff working in residential aged care facilities may be unaware of their own prejudices or the unique needs of lesbian and gay residents and their families,” says Michal Boyd, the project’s leader and a senior lecturer in the School.

The resource kit approaches the topic from a human rights, as well as from a quality of care, perspective. Workbook discussion questions emphasise that regardless of ARC staff members’ personal views, all residents have the same rights.

While developed for staff in ARCs, the resource kit is intended to have a life beyond this particular audience. The video was designed to stand alone and is available to interested groups.



Photo: Yvonne Shearer for gayexpress.co.nz

**LEFT:** Project team members at the resource kit’s launch in August. The project pulled together researchers from the University of Auckland Schools of Nursing, Education and Psychology, Massey University and The Media Design School as well as experts in the Aged Residential Care sector and members of the Auckland LGB community.

## New project links NZ to European Union by Clare Gardiner

INTEGRATE-HTA is a new three-year project funded by the European Union for € 3 million.

Using palliative care as a case study, this project aims to develop concepts and methods that enable a patient-centred, comprehensive assessment of complex health technologies. The research is being led by the University of Bremen (Germany) and has input from four other countries in Europe, in addition to the University of Auckland. My role as a co-investigator is to work on the palliative care case study.

Health Technology Assessment (HTA) is a multidisciplinary field of policy analysis. It studies the medical, social, ethical and economic implications of development, diffusion and use of health technology. Complex health

technologies, such as palliative care delivery, are imperative for matching the rise in chronic diseases in ageing populations. HTA is currently sub-optimally equipped for the assessment of complex technologies, despite considerable achievements in recent years.

INTEGRATE-HTA aims to adapt and develop concepts and methods for HTA to enable an integrated assessment of issues of complex technologies. This will include assessment of effectiveness- / economic, social, cultural, and ethical issues of complex technologies; assessment of patient preferences and patient-specific moderators of treatment; assessment of context, setting, and implementation; integration of all issues in a



comprehensive patient-centred assessment; closing of existing methodological gaps in the assessment of complex technologies.

Insights from the palliative care case study will provide a comprehensive understanding of the implications of palliative care interventions.

For more information: <http://www.integrate-hta.eu/>

# GROUNDED THEORY

## DIGGING DEEPER INTO THE DATA

*Dr Karen Hoare and student researchers Eve Decker, Kim Ward and Catherine Lambe explain Grounded theory's fascinations, frustrations and why researchers should give it a go, no matter the scale of their project.*

**K**aren: *Grounded Theory differs to other forms of qualitative data analysis by taking the reader one step further in presenting the findings. This further step is achieved by a process of abstraction which is (very superficially) defined as 'deep thought'.*

*The theory that is constructed from the categories produced out of the data and 'deep thought' must be truly grounded in participants' voices. By writing a storyline narrative about the phenomenon under examination, the analyst then has the ability to ensure that all components of the story are underpinned with data.*

*Kim has had her breakthrough with a core category in her PhD research by identifying a recurring comment in participants' stories from her Masters project. She will now, for her PhD, theoretically sample participants who demonstrate the same experience, to support her developing theory and thus gain greater insight.*

*A Grounded Theory should have what the originator, Glaser, described as 'grab and fit' i.e. when the theory is presented to a reader and they have had the opportunity to read the story, they have that 'aha – I see' moment.*

*Finding a Basic Social Process (BSP) within the data is a delight. This BSP can happen in a small summer student project, such as Eve's Catalysing Conversations – a sexual*

*health promotion leaflet for 15 – 18 year olds and a larger Master's project such as Catherine's theory of Maintaining the Balance: The Role of the School Nurse in Managing Skin Infections.*

*I was delighted to find the BSP of Reciprocal role modelling in my PhD data - where new graduate nurses in general practice acted as knowledge brokers to experienced practice nurses who in turn role modelled communication and clinical skills to the new graduates.*

*Grounded Theory is great – give it a go!*

**Q. With all the methodologies out there, why pick Grounded Theory?**

**Kim:** Grounded Theory gives you a way to look at the mundane or everyday – the hidden moments where people's lives really happen – and explain not only what happens for them but how to solve a research problem. An attraction is that the data used are the participants' own words: their stories. So the outcome is grounded in their world, their lives and their experiences.

Grounded Theory lets you conduct research in such a fluid, creative and dynamic way. It's almost magical the way the moments of insight and clarity happen; they leap out of the data at you. Yet it's not a wishy-washy process.

For example, Grounded Theory is trustworthy because you always examine what you are thinking by recording the research process and the decisions made along the way. Such recording (memoing) acts as a check

and balance by allowing others to interrogate your theory development to ensure it remains grounded in the participants' words and not the researchers imposed ideas.

**Eve:** Using a reverse-engineered hypothesis allows you to approach a field of research without an initial hypothesis. I believe this is the most beneficial aspect of Grounded Theory. The researcher is required to acknowledge their existing knowledge and assumptions regarding the field they are researching and approach the data with an open mind.

**Catherine:** My motivation for undertaking the study was my feeling that we didn't have the full picture of what was going on with skin infections in young people in NZ. So I had a clear idea of what I wanted to research, but no idea what methodology to use.

Initially, I did A LOT of reading on various methodologies, eventually narrowing it down. The things which attracted me to Grounded Theory were its usefulness in social justice research and in challenging prior assumptions.

The concept of staying close to the data appealed to me as well, as I had confidence interviews with school nurses would yield great data.

**Q. What were some of the challenges you faced when using Grounded Theory?**

**Eve:** As an undergraduate student, tackling a qualitative project felt like a stretch. Then, adding to that the fact I would need to understand and apply a new research method was definitely a few steps outside of my comfort zone.



“It’s almost magical the way the moments of insight and clarity happen; they leap out of the data at you.”

– PhD student Kim Ward

Fortunately, I was able to access literature aimed at providing researchers with an initial understanding of Grounded Theory, and Karen was able to point me in the right direction, discussing the harder concepts with me.

**Catherine:** Becoming familiar with the various terminology and viewpoints around GT was challenging. Writing the methodology chapter was essential in clarifying these issues for me.

Once I started the research, everything went really well, and I found the interviews and analysis really enjoyable. Memo writing was also a pleasure, as it was a great way to take a break from academic writing and just write down ideas and thoughts throughout the project.

**Kim:** Developing an understanding of ‘doing’ Grounded Theory takes time, though the beauty of it is that the ‘doing’ of the research process is the teacher.

One of my biggest challenges was grappling with the philosophical underpinnings of the Grounded Theory paradigm (an on-going process). Whether you consider Grounded Theory a methodology or simply a methods package is determined by how you understand and assimilate the philosophy behind this type of research into your thought processes.

**Q. What advice do you have for other researchers at your same level who want to undertake a Grounded Theory project?**

**Kim:** Talk to others currently doing what you want to do and assess what is involved. It will be more than you think.

Secondly, (and especially if you are planning this as a PhD) plan to complete a foundation philosophy paper; you will need this knowledge to understand what you are doing. Though note that your philosophical understanding and insight would be incremental throughout the spectrum from summer project to PhD. Thirdly, embrace the uncertainty - clarity will arrive! And finally, just have a go and let the Grounded Theory process be your teacher.

**Eve:** As an undergraduate (or postgraduate) student don’t be afraid to tackle a Grounded Theory approach towards your research. Approaching a field you are passionate about asking, “What are the major problems facing the participants? How are they trying to solve it?” can open your eyes to a whole new variety of concepts you might not have previously unearthed.

It also provides results and discussion relevant to your participants’ reality whilst contributing original thought to the academic world.

**Catherine:** Choose a topic you feel passionate about. You will be putting a lot of time into this, after all. You will learn many new skills, but try to make use of skills you already possess as well – I used interviews, which I also use often in my role as a school nurse.

I think this made getting quality data easier, and made the whole process of data generation more relaxed. I tried to do at least some work each week.

So even if you are waiting for feedback or ethics approval, do something...read, draft the next chapter, write memos or re-edit previous work. It helps to always feel like you are moving forward.

# STUDENT NURSES ON THE WARDS IN THE 1950S:

## *'Oh nurse, your potties do look nice!'*

Why did young women choose to start nursing? What were their work and living conditions? What was their education experience? How did they socialise?

*The aim is to interview 60 women and men who started nursing in the 1950s-1960s.*

*The recordings will be added to the Alexander Turnbull Library's large nursing oral history collection and will form the basis of an oral history website. Interviews and photographs will be available for nurses, researchers and the public for many years to come.*

Dr Kate Prebble reports on the ongoing Nurses Education and Research Foundation (NERF)-funded Nursing Oral History Project. Professor Linda Bryder from the Faculty of Arts Department of History is the principal investigator. School of Nursing Honorary Associate Professor Margaret Horsburgh and independent researcher and historian Debbie Dunsford are also members of the research team.

**O**ur interviewees talked about hard work, discipline and hierarchy on the wards. Junior nurses, or probationers, were expected to clean the wards, make beds and hand out meals. Beryl Hughes explained that cleaning duties included sweeping the ward with tea leaves before breakfast, and being in charge of the sluice room, cleaning the pans and potties. She related the story of how one day the sub-matron, Miss Smallbones, came into the sluice room and said, 'Oh nurse, your potties do look nice!'

Bed making was important. Grace Benson explained how essential it was to get it right; 'In fact, we used to go back at nights, Audrey and I, to make more beds, to get them perfect and make them in three minutes....' Margaret Faulkner commented that when she came into contact with nurses who trained around the world, what struck her was 'everyone made a bed a different way'. Pat Oettli told the story of when she was a tutor at Green Lane Hospital and had to train a class for Parents' Day, 'Rona McAleer (the head tutor) said, "You have trained these girls to make beds the Waikato way" ... [she] told me off,' she said.

In a world of limited resources and no disposable equipment, managing the ward utensils was important. Jill

Cameron explained that 'No one left a ward at end of shift until all the work finished. All equipment had to be counted at end of each shift'. She recalled one nurse who was 'absolutely manic about counting the teaspoons'. Another interviewee recalled having a

stack of spare teaspoons, since they were not allowed to leave until all had been accounted for.

All our interviewees commented on the hierarchy of the ward, but didn't seem to mind it. Rae Brooker explained that 'after breakfast the ward had to be very tidy and hushed as doctors came for their rounds'. Doctors, she said, 'were like gods who came into the hospital'.

Annette Smale also explained the strict requirements, with beds inspected by the sister before medical staff arrived. She found the sisters scary and gave the example of one sister who would yell down the length of ward.

Diana Masters mentioned a particularly scary ward sister - 'She terrified me' - but also noted occasional acts of kindness by ward sisters. On one occasion Sister Burton noticed that she was feeling unwell, put her to bed in the doctor's room and gave her a cup of tea. 'I will never, never forget it'.

Most interviewees mentioned that clinical teaching consisted primarily of role modelling and learning by doing, 'on the job'. Kamiria Gosman recalled that 'Most of the learning came just before you did these things or while you were doing them'. The individual ward sisters had a big influence on the learning environment. Gosman reflected,



Margaret Faulkner, Christchurch Hospital



Preliminary School, Pat Oettli, 23 April 1951

'It depended on the charge nurses where you were'. Masters noted that ward sisters did a lot of teaching but there was no correlation between the classroom learning and ward learning.

The interviewees invariably commented that they were given huge responsibilities, especially on night shift. Smale described a particularly frightening night shift at the end of her first year, when she had to manage multiple responsibilities, including caring for a man in a diabetic

coma. She reflected that, 'Many things were beyond our experience or our knowledge'. Brooker related how as a senior student nurse, 'a third striper', she had been placed in charge of a gynaecological ward by herself at night, calling it a 'quite extraordinary responsibility'.

Trainee nurses were not expected to engage therapeutically with their patients. Oettli told a story of how, when she was working in a women's medical

ward with six patients in one room, 'one of them was crying all the time'. It was only after six weeks that she found out that the woman had had a heart attack; apparently her husband had got such a shock that he had died of a heart attack himself! Oettli explained 'I didn't know she had just lost her husband ... if I had known I wouldn't have known what to say ... [We] really nursed in ignorance'.

Nevertheless the interviewees also recalled that as junior nurses, as Mary Wentworth said, 'patients often talked to you ... [we] sometimes learned things they hadn't told the senior nurses'.

Rosemary Ellyett pointed out that patients sometimes stayed for a long period, providing the chance to get to know them. She recalled that patients often talked to nurses about personal issues at night. When Diana Grant-Mackie eventually acquired her own employment files, she was happy to see that every report said that she was 'kind to the patients'. She was pleased as this is what she felt was important in nursing.

Looking back on their trainee years, most nurses reflected positively on their experience, even on the strict hierarchy. As Diana Masters commented, 'you knew exactly where you were, what you could do and what you couldn't do ..... maybe [that] wasn't such a bad idea'.



Annette Smale, Final Year class, Dunedin Hospital, 1961

# the Canterbury Earthquakes



Gabriella Trussardi and Kathy Peri

## Older people: How the media portrayed them

*In the aftermath of the Canterbury earthquakes, the New Zealand media used negative and stereotypical language to describe the experiences of older adults.*

Principal investigator Dr Kathy Peri, summer student Richard Chen, and research assistant Gabriella Trussardi studied newspaper and TV current event reports to examine how media framing may contribute to perceptions of older adults. Their content analysis revealed that the media generally used negative emotive language to describe older adults, calling them vulnerable, frail, fragile, frightened, helpless, alone, and suffering. The only positive word used was stoic.

Only 3.6 per cent of newspaper stories published any direct quotes from older people. Most commonly, newspaper stories featured discussion about 'older people' as a homogenous category, in generalized terms.

A reporter for the *Christchurch Star* wrote, "I couldn't help wondering how many elderly and infirm people might be trapped in their homes or suffering from heart attacks, strokes or stress with no way of getting help." Such language reduces older adults to 'other': lacking full agency, helpless without outside assistance. In contrast, 94.5 per cent of television stories interviewed older adults; however these were inevitably

selected for their role as victims of the earthquakes. Current affairs programme *Close Up* offered an exception in its story about four older adults who drove to Christchurch to shovel liquefaction. The volunteer coordinator said, "they're real sweeties".

"This infantilizing 'elderspeak' is a form of benevolent ageism," said Kathy. "Such language frames intelligent, independent and confident adults as more akin to children."

In contrast to media reports, research on older adults tells a different tale. "Adults aged over 65 are not a homogenous group," said Gabriella. "Age alone is a poor indicator of the effects of disaster: community-dwelling adults have vastly different needs and responses to adults in a residential care facility."

A number of older adults struggled with financial, housing, and health issues that impacted both their physical and emotional wellbeing. However, negative quality of life outcomes following disaster are linked to existing health conditions and socioeconomic status, not to age.

While media do not create the stereotype of old age as tragedy, they provide imagery and language that contribute to it.

"We see an opportunity for media in New Zealand to be mindful of the ways they select and frame stories that contribute to a devaluing of older adults," said Kathy. "Instead, they could position the active participation of older adults in society as normal and unexceptional."



Christchurch street scene after the 2nd earthquake, photo by Jonathon Wilson

Behind the scenes:

## Nursing during the 'quakes

“We started to see people collapsing outside. And we were going, ‘Oh gosh what is this? We’re okay looking after our old people, we’re okay looking after our staff and we’re okay to do the residential care. But what is this coming?’ Of course people thought, ‘Here’s a hospital’, so all the casualties around our area were coming to Princess Margaret unannounced.

Our hospital, which was not an A&E department whatsoever, suddenly became one with very serious trauma victims. And so we just built this triage trauma centre down in the day hospital and used house surgeons and our senior nursing staff to run it.

We had very, very unwell and injured people turning up, and the ambulances were bringing them as well. Christchurch Hospital was quite damaged, and at first you couldn't get through – what would have normally been a 10 minute trip took up to three hours, because of the liquefaction and cracks in the road.

It was a very long day and night because the mother ship – what we called Christchurch Hospital – was very damaged. Two floors of Christchurch Hospital had their patients evacuated out to Hagley Park.

They had to go somewhere, and because we had a couple of dusty, empty wards they came to us. So not only did we have a full triage and emergency department happening we had to task ourselves with setting up two wards from scratch.

At about two o'clock in the morning, this cattle truck arrived, and it was the first of the patients from Christchurch Hospital.

Kathy Peri was Director of Nursing of Older Person’s Health Services at Princess Margaret Hospital in Christchurch during the 2010-2011 earthquakes. Her story about events at Princes Margaret just after the second earthquake reveals the immediacy of the events, even though more than two years have passed.

As it turned up at the front door, I said, ‘Oh gosh how are we going get these patients out of here, we haven’t got a ramp...?’

We went around to the back where they loaded all the supplies, and there was about a two foot gap between the truck and the loading dock. That meant there was no way we could get the beds off. But these wonderful maintenance engineers, in less than a minute, constructed a ramp out of milk crates. Unbelievable.

They were mostly older people in those beds on the cattle truck, and so they came off; they had staff with them, who took them up to the wards. The truck did three or four times before the transfers was completed. By the time that was over we were knackered.

I had some senior nurses who couldn't go home, and a couple of others on our Vulnerable Person’s response team who also couldn't go home. I took them to my house, which was just over the river from Princess Margaret Hospital.

I got them into bed, and I said, ‘I'm leaving the front door open just in case something happens.’ You’ve got to remember that all this time we’re having very, very severe aftershocks.

We had no toilets; we had no showers in fact, none of us showered for a week. The following day after the earthquake we started working with the Aged Residential Care facilities, so for the next week we were out and about in our cars, sometimes up till midnight, evacuating older people into Princess Margaret, or out onto planes and buses to other places around New Zealand.”

# NEW TO THE SCHOOL

*Researchers bring strengths in palliative care research, Kaupapa Māori, critical theory and addiction research*



**Clare Gardiner**

**C**lare joins the School of Nursing as a senior lecturer from the University of Sheffield in the UK. She has been involved in palliative and end of life care research for six years, and has a particular interest in developing and evaluating models of palliative care for people with underserved needs,

including older people and those with non-cancer diagnoses. Her research has been supported by grants from Health Charities, the UK Department of Health and UK Universities. She has published more than 30 peer reviewed research papers, as well as book chapters and reports. She supervises Master's and PhD students. She earned her PhD from the University of Sheffield.



**Tess Moeke-Maxwell**

**T**ess has led Kaupapa Māori and Māori-centred qualitative research projects for ten years. Her current interest is with Māori whānau palliative care and end of life experiences, although she previously undertook research in mental health. In 2009 Tess won a Health Research Council post-doctoral award to undertake an ethnographic study on Māori experiences of dying, death and

bereavement from a whānau perspective. Prior to this Tess worked for Te Rau Matatini, the national Māori workforce development agency as a senior researcher. She provided contract research to DHBs, NGOs and the Mental Health Commission. Tess is currently a co-applicant and project lead researcher on Te Pākeketanga, the HRC funded LiLACs NZ End of Life Carers Sub-Study.



**Gabriella Trussardi**

**G**abriella's PhD is from AUT University in critical theory. She has an extensive teaching background, with a strong focus on feminist and participatory methodologies.

She is particularly interested in how people construct meaning through creating and telling narratives. Her eclectic

background includes "several interesting careers;" she has spent many years in costume for film, theatre and television. She is the Te Pākeketanga project manager and a research assistant, working with Dr Kathy Peri to investigate the impact of the Canterbury earthquakes on older people.



**Claire Meehan**

**C**laire's role with the Centre for Mental Health Research is to engage with the Problem Solving Courts (PSC), especially the drugs court. She is also looking at young people's online safety, particularly issues such as grooming and sexting. She holds a BSc (hons) in Criminology and Criminal Justice, a PGCE (qualified teacher), and MSSc in Criminology from the

University of Ulster and Queen's University Belfast, in Northern Ireland. In 2011, she moved to London to take up a full time lectureship in Criminology and Sociology. She was awarded her PhD in early February 2013, 10 days before moving to NZ.



Reena Patel

## Early warning: Nurses' response to patients in crisis

Reena Patel's PhD research investigates the 'concern' criterion and its role as a safety strategy for nurses when patients deteriorate.

Early warning scoring tools include ratings of vital signs such as patients' temperature, pulse rate, blood pressure, respiratory rate, level of consciousness, and oxygen requirements. If the total score is outside the expected parameters, then an emergency call to the response team would be warranted.

In addition, these tools typically include an indicator known as the 'concern' criterion. This indicator legitimates staff calling the emergency response team if they have a concern despite the patient's objective criteria being within normal parameters.

To date little is known about what constitutes this criterion or how nurses use and respond to it. Thus, this study is exploring nurses' activity when they are concerned about a patient's condition despite vital signs being within the normal parameters.

The first phase of this study involves a retrospective audit of databases collected by the Patient at Risk (PAR) team at a New Zealand Hospital. The purpose of the audit is to identify common indicators for nurse concern with patient deterioration.

This audit involves retrospective data collection. Information from the audit will then refine the line of enquiry for the second phase of the study.

The second phase will involve focus group discussions to explore and identify nursing actions prior to contacting the PAR team when concerned about a patient.

Expected outcomes for this study will include providing critical information about nurses' reactions and suggestions for new pathways to improve responses to unexpected patient deterioration.

**P**atient deterioration occurs when a person's health condition changes and becomes worse. It is unexpected and the person may demonstrate physiological changes that could lead to harm caused by a life threatening emergency.

Safety strategies such as a rapid response system are designed to detect and treat deteriorating patients. These typically include an early warning scoring tool to detect patient deterioration and the deployment of emergency response teams.

## Medication safety: User-applied labelling of syringes

A report on Dayle Pearman's Master of Nursing thesis

by Andrew Jull

**P**reparing medications for injectable administration is complex, and the process of intravenous (IV) administration of medications is associated with error. New Zealand has no national guidelines on medication administration. Therefore, local policy guides practice.

Local policies vary and can lack specific detail for parts of the administration process: user-applied labelling of syringes is one example. Inadequate user-applied labelling of medications has been identified as one contributor. For her thesis, Dayle Pearman focused

on the syringe labelling in an intensive care unit for her thesis.

Dayle wanted to explore intensive care nurses' attitudes, knowledge and behaviours towards medication safety with respect to user-applied syringe-labelling and to evaluate the effect of an improvement initiative on increased adherence to local guidelines. She used two methods.

First, she used an online survey to explore nurses' syringe labelling behaviours, knowledge of best practice, and barriers to labelling syringes.

Second, she used pre- and post-intervention clinical audit to evaluate the effect of the improvement strategy. Both pre- and post-intervention audits were conducted over several weeks to ensure that different staff were audited rather than the same staff in different ICU bedspaces.

Dayle found that there was difference in the way nurses said they practiced in

the online survey when this was compared to their measured practice in the baseline clinical audit. Despite more than 80% agreeing that medication labels decreased errors in the survey, half the syringes audited at baseline were not labelled.

However, following a simple education initiative, the unlabelled syringes fell to 12% ( $P < 0.001$ ). Dayle noted though that despite non-compliant syringe identification methods being reduced, the overall standard of information on the labels remained similar.

Although the majority of nursing staff surveyed were aware of the guidelines they should be following in medication administration, they did not always follow them.

It is this human factor that makes overcoming medication error so difficult, and improvement strategies that focus on human behaviours will truly make the nurse the final barrier to medication error.

## DOES ALTERNATIVE EDUCATION REALLY PROVIDE ALTERNATIVES FOR AT-RISK YOUTH?

*Jodi Smith's Master of Nursing project on Alternative Education (AE) is informed by her work as a nurse in AE as well as her research with the Faculty of Medical and Health Sciences' Adolescent Health Research Group. At present Jodi is a school nurse working in South Auckland. Dr Kate Prebble and Dr Theresa Fleming were her supervisors.*



**Kate Prebble and Jodi Smith**

**A**lternative Education (AE) is meant to help students alienated from mainstream NZ education. It is targeted to at-risk youth ages 13-16 who meet certain criteria, such as having been out of school for two terms or more, having multiple suspensions from different schools, or having a history of dropping out of mainstream or correspondence schools.

Because of her experience working with AE, Jodi had seen firsthand its benefits for students. But did AE truly make a lasting difference? To find out, she interviewed 13 former AE students (between 18-26 years old) to gauge their perspective on the influence, if any, AE had on their wellbeing and life course. Her results captured their views on 1) their disenfranchisement from mainstream education, 2) how AE helped them reconnect to learning 3) their transition out of AE and 4) the ongoing impact of AE after they left it.

"What the findings show is that AE provides a place of belonging," Jodi says. "Participants experienced unity with other students and found a sense of family or whānau."

Tutors made a tremendous difference in students' lives, and students credit their commitment with prompting them to succeed. "Tutors cared about them, which was categorised as 'the love factor'. They gave them second chances and pushed them to achieve," says Jodi. "Tutors became a gateway to health care. Participants with close relationships to tutors could ask for help with their health needs."

All 13 interviewees stated that if it wasn't for AE, their lives would have continued on 'the downward slide'. AE taught them about respecting others, gave them confidence and the ability to persevere.

Transitioning out of AE provided difficult, however. Since alternative education in New Zealand only extends to age 16, students must exit it before their high school education is complete. Only 4 of the 13 participants described a successful transition into another course.

As a result of her study, Jodi developed recommendations that centred on increasing funding and support for AE. "Young people in AE shouldn't be further disadvantaged by having less access to academic opportunities than those in mainstream schools," she says.

"They want to learn, but when they leave mainstream schools, they lose out on such things as group sports, computers and reading teachers." Tutors could also use more support. "Tutors are amazing. They are what make AE work. They need to be supported and acknowledged."

Jodi suggests extending the age of entitlement for AE so that it aligns with international practice. "The Education Act (1989) states that all young people in NZ should have the right to a free education up to the age of 19 years. But in New Zealand, it's only funded for students until their 16th birthday. Worldwide, AE provision allows for students to remain in AE until they have completed their high school qualification."

The service AE provides could be improved through increased collaboration with other education, social and health services who work in partnership with the tutors and students, Jodi says.

She suggests that health care professionals develop strong, trusting relationships with tutors and students in order to provide a comprehensive and holistic health service.





**Barry Keane**

**T**he world's ageing population means the need for palliative care is rapidly expanding. In New Zealand, this translates into an anticipated 50% increase by 2026, with a corresponding need for a 23% increase in the specialist palliative care workforce. One strategy to increase the capacity for palliative care is to 'spread the load' by involving the wider health care workforce often referred to as the general/ specialist model. In his master's thesis, Barry Keane explored how general practice teams and palliative care specialist services work together, including the barriers to and benefits of their cooperation.

Using focus groups, Barry interviewed 35 general practice and specialist palliative care team members from two District Health Boards to discover how they collaborate to provide palliative care. Overall, he found that they showed considerable commitment to working in partnership. "The quality of their relationship is strongly influenced by their ability to maintain trust and respect," Barry says. However as critical as these informal ties were, Barry found that only limited formal systems were in place to support their practice..

As well as 'quality of the relationship,' Barry reported on two other significant themes in his research: 'sense of identity' and 'rules of engagement'.

### **Sense of identity**

"Although both GPTs (General Practice Teams) and SPCTs (Specialist Palliative Care Teams) were committed to working in partnership, their ability to work together was influenced both positively and negatively by their understanding of their own roles as generalists or specialists," he said.

GPT participants emphasised their in-depth knowledge of their patients and the continuity of care they provided for family and whānau as well as for the individual patient:

*As a GP you can make a huge difference because you have got the years of knowing that patient and they really value what we think and how we behave and the whole experience – I think we have a big input in it. You know it is a very special time isn't it? [GP focus group participant]*

## HOW DO GENERAL PRACTICE TEAMS AND SPECIALIST PALLIATIVE CARE TEAMS WORK TOGETHER?

Since 2000, Barry Keane has undertaken a number of leadership roles in palliative care and cancer nursing. He currently works as Nurse Director for the MidCentral Health Regional Cancer Treatment Service and the Central Cancer Network, based in Palmerston North. Professor Merryn Gott was his supervisor for his Master's project.

On the other hand, SPCT participants identified themselves as specialists who became involved in a complementary arrangement when the patient's needs were beyond the skill set of the GPT or generalist. Their view on the exact parameters of their roles varied, ranging from regarding themselves as advisors, to sometimes providing what could be considered generalist care, as well as specialist care.

### **Rules of engagement**

A history of territorialism and the separate ways their disciplines developed influenced how GPTs and SPCTs engaged with each other. As a result, many aspects of their partnership remained ill-defined and challenging. "The advent of hospice had, in the past, resulted in a number of turf issues between hospices and GPT," Barry noted. Yet now, there was more of a focus on building partnerships with general practice teams by nurturing relationships and building trust. "One medical specialist described the relationship currently as respectful, adding that it was 'a long time since we had a don't stand on my turf sort of thing'. However that history still informed the way their relationship was played out in practice."

### **Implications for practice**

Barry asserts that the working relationships between GPTs and SPCTs, like with other generalist specialist collaborations, needs to be underpinned by a national framework that offers formal systems for referral and collaborative care.

He also advocates strengthening advanced practice nurse roles in specialist palliative care. "The role has significant potential to facilitate the patient and family through their palliative care journey," he says, "as well as strengthen the working partnership between specialists and generalists though 'brokering' good communication and mutual understanding."

## The link between Māori and heightened suffering from intrathecal morphine induced (ITMI) pruritus

*Jennifer Boudreau, who has more than 30 years of experience as a nurse, set up the post-operative pain service at Whakatane Hospital, which earned praise for its proactive management of patients' post-operative pain. Currently she works at Tauranga Hospital.*

“Recently, my 15-year old nephew, who is of Māori descent, was scheduled for the second and most complex surgery in a series of operations required for the correction of congenital malformation of his right foot. His only parent, my sister, was extremely anxious prior to the surgery knowing that her son, who suffers with Asperger’s syndrome, experiences intense morphine induced pruritus post-operatively. During his previous admission my sister had to spend countless hours with him, trying to calm him in the prevention of self-harm as he relentlessly tried to soothe his itching skin.”

*(Adapted from Jennifer Boudreau’s Master’s thesis: Prevalence and Management of Intrathecal Morphine Induced Pruritus in the New Zealand Maori Population.)*



**Jen Boudreau**

While on rounds with Whakatane Hospital’s post-operative pain service, Jen Boudreau noticed Māori patients were suffering from intrathecal morphine induced (ITMI) pruritus more frequently than NZ European patients. Spurred to action by her nephew’s experience, Jen focused her Master’s research on the topic, investigating whether ethnicity, age or gender influenced the incidence of ITMI pruritus. A second aim of her research was to explore how health care professionals manage such pruritus. Dr Gigi Lim and Francesca Storr were her supervisors.

Pruritus is one of the most common adverse effects of intrathecal morphine, with a reported incidence of 30-100%. Jen found this to be true in her own research, with a 31% rate of incidence amongst the 96 surgical patient records she reviewed that fit her study’s inclusion criteria. She looked at patients who had either caesarean sections or orthopaedic surgery (total hip and knee replacements).

### **Māori suffer more, receive less treatment**

Jen’s results indicated that NZ Māori have a significantly increased incidence of ITMI pruritus compared to NZ Europeans. Doses of morphine between 201 mcgs and 300 mcgs produced no adverse effects in either population however, pruritus was experienced above 301 mcgs in both groups. Nineteen (47.5%) of the 40 New Zealand Māori and 11 (19.6%) of the 56 New Zealand Europeans experienced ITMI pruritus. Further exploration of her data revealed that at lower doses compared to NZ European, more than half the NZ Māori scored their pruritus as moderate to severe. More importantly the results showed that NZ Maori were less likely to receive treatment for pruritus than NZ European.

For the second phase of the study, Jen surveyed 30 nurses and midwives about their knowledge, observations and management of ITMI pruritus. Results from the survey found that both groups acknowledged that ITMI pruritus did occur, however management of pruritus was not considered a priority for post-op nursing management. Post-operative hypotension was a priority for the majority of nurses, while midwives considered improving

the mother/baby bonding experience and reducing the amount of opiate which the baby received from the lactating mother as more important.

### **Implications for practice**

Among her recommendations, Jen advocates education for patients and health care professionals. Registered nurses and midwives need further education to ensure they are aware that Māori may be more susceptible to ITMI pruritus. “Increasing our knowledge and awareness of the potential adverse effects of drugs on certain ethnic population may lead to improved overall management,” says Jen. “Nurses and

midwives can’t control the amount of intrathecal morphine patients receive, however, they can be more vigilant in their assessment and management of these patients with the knowledge that certain doses may affect patients differently.”

## 2013 Publication List

Over the past year researchers within the School of Nursing have been busy writing up. We have included a selection of our newest publications below. Please remember to check out our website for staff member's profiles listing all their projects and publications. You can find us online at [www.fmhs.auckland.ac.nz/son/research](http://www.fmhs.auckland.ac.nz/son/research).

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**S**ON PhD students, like those everywhere, face the challenges of completing their research with grit, grace, determination and not a little bit of humour. These photos reflect what we found when we went wandering around their cubicles.



So, a thought crossed your mind? Must have been a long and lonely journey.

—Anonymous

