Published by the NZ Nurses Organisation

Vol 10 No 1
October 2019

Kai Tiaki Nursing Research

CONTENTS

Kai Tiaki
Nursing Research
Published by the NZ Nurses Organisation
Vol 10 No 1 October 2019
ISSN: 1179-772X

EDITORIALS

RESEARCH PAPERS

LITERATURE REVIEW

RESEARCH BRIEFS

METHODOLOGY

Kai Tiaki Nursing Research

Kai Tiaki Nursing Research is an internationally, double-blinded, peer-reviewed nursing research journal, published by the New Zealand Nurses Organisation. It contains research manuscripts from New Zealand-based nurse researchers (or other researchers where the research can be shown to have relevance to nursing in New Zealand).

Papers in all areas of nursing are welcome. Authors should present original work, or new and original analysis of existing work. Letters to the editor are also published. All articles and manuscripts will be subjected to the same rigorous review process.

EDITOR-IN-CHIEF
Patricia McClunie-Trust, RN, PhD
Patricia.McClunie-Trust@wintec.ac.nz

PRODUCTION EDITOR
Kathy Stodart
kasstonz@yahoo.co.nz

JOURNAL ADMINISTRATOR
Philippa Ireland
Ph 03-378-0591
PO Box 4102, Christchurch 8011
philippai@nzno.org.nz

PUBLISHER
New Zealand Nurses' Organisation,
PO Box 2128, Wellington 6140.
www.nzno.org.nz

SUBSCRIPTIONS
Ph 0800-28-38-48 or
email library@nzno.org.nz

ADVERTISING
Queries to: Evelyn Nelson, Ph 027-447-6114,
evelyn@bright.co.nz

ISSN
1179-772X

PRINTER
Bright Communications, Wellington

SUBMITTING MANUSCRIPTS
Manuscripts should be 3000-5000 words long (excluding abstract, tables and references). All manuscripts should be submitted electronically as Word files. Enquiries to: Kai Tiaki Nursing Research, C/o NZNO Library, New Zealand Nurses' Organisation, PO Box 2128, Wellington 6140. Ph: 0800-283848. Email: kaitiakiresearch@nzno.org.nz **For submission guidelines, go to www.nzno.org.nz/ktnr**

GUEST EDITORIAL: **Zoë Tipa**

The significance of kaupapa Māori research methodology

Zoë Tipa (Kāi Tahu and Ngāti Kahungunu), RN, MPhil, BHSc(nurs), PGCert(primary health care nursing) *is a principal academic staff member at Te Kura Mō Ngā Mahi Tiaki I Te Hapori, the Centre for Health and Social Practice, Waikato Institute of Technology, Hamilton. She is a PhD candidate at the Auckland University of Technology.*

Kaupapa Māori research methodology situates Māori belief systems, protocols and worldviews above other research philosophies (Hiha, 2016). It emerged in the 1990s in the nation-wide movement to revitalise Māori culture and was supported by an increasing commitment to enhancing the partnership between Māori and the Crown (Powick, 2003). Many Māori were frustrated with their involvement in research conducted by Pākehā, and the methodologies used were often inappropriate or unacceptable for Māori research participants (Powick, 2003; Walker, Eketone & Gibbs, 2006). Kaupapa Māori research challenged the dominant cultural approaches to conducting research with Māori, and reinforced the need to protect and legitimise mātauranga Māori (Māori knowledge) within research processes (Cram, 2001; Smith, 2012). Attempts to define kaupapa Māori research have been fraught, as doing so requires compartmentalisation into structures that are not informed by Māori worldviews, therefore contradicting the emancipatory intent of the methodology (Smith, 2012; Walker et al, 2006).

Improving Māori health outcomes

An important premise of kaupapa Māori research methodology is that the intention of the research must lie in improving Māori health outcomes (Smith, 1999). Cram (2006) discussed the important role of kaupapa Māori researchers – firstly in terms of reaffirming Māori identity and self-belief, and secondly, in relation to critiquing non-Māori (and colonial) constructs of Māori realities. Pihama, Smith, Taki and Lee (2004) describe kaupapa Māori research approaches as supporting the transition required for Māori tikanga and reo to be viewed as the "norm", rather than the "other". They acknowledge this is a challenge within many "mainstream" institutions, however suggest there are increasing opportunities to embed kaupapa Māori approaches in a variety of research contexts to promote tino rangatiratanga (self-determination).

Te Ara Tika: Guidelines for Māori research ethics (Hudson, Milne, Reynolds, Russell & Smith, 2010) differentiate between kaupapa Māori research, Māori-centred research and mainstream research. Kaupapa Māori indicates an approach that is underpinned by te ao Māori (the Māori world). It is guided by tikanga (protocols) that can be linked to historical pūrākau (Māori creation narratives) and requires Māori design, delivery and participation in the research process. Māori-centred research involves the establishment and maintenance of partnerships with Māori communities. It calls for Māori involvement in roles to allow for adequate and credible representation of Māori perspectives as the research progresses. The minimum requirements in mainstream research relate to upholding the rights and protecting the interests of Māori, as well as considering the relationship of the research with Māori goals and aspirations.

Zoë Tipa

Given the differences between these three approaches to research in Aotearoa, it is important that research projects correctly identify the methodology and do not assume that any research involving Māori is "kaupapa Māori" methodology by default. Kaupapa Māori research requires Māori input into the design and development of the research to be evident throughout the research process. It is not enough to consider Māori "perspectives", as this indicates an overlay of Māori worldviews against dominant cultural norms (Ramsden, 2002), and would sit more accurately within a Māori-centred research design. Kaupapa Māori research requires authentic involvement and consultation with Māori stakeholders throughout the research process – including the development of the research question, the aims and the proposed outcomes.

The link between kaupapa Māori research and the intention of cultural safety is worth exploring. Ramsden (2002) defined cultural safety as a *"mechanism which allows the consumer to say whether or not our service is safe for them to approach and use"* (p.181). Kaupapa Māori research provides a vehicle to ensure that research experiences for Māori are culturally safe. This is not about referring to a checklist of cultural norms or processes, but rather ensuring that all stages of the research are informed and placed within Māori contexts and worldviews. Kaupapa Māori research is about reinforcing and validating Māori identity and worldviews (Cram, 2006). Despite this, there continues to be a tension between externally-generated ideas that "otherise" Māori and the lived reality of being Māori (Smith, 2012). In establishing research environments where Māori worldviews are privileged, researchers can challenge the dominant cultural discourse, create opportunities for meaningful involvement and increase the reliability of outcomes.

Kaupapa Māori research is about reinforcing and validating Māori identity and worldviews.

Shifting power to the minority culture

Central to the establishment of cultural safety is the concept of power. Cultural safety requires a power shift from the dominant culture to the minority culture. This shift is facilitated by creating opportunities for feedback and change within practice and systems. Likewise, kaupapa Māori research is fundamentally about reclaiming tino rangatiratanga for Māori; this is considered within a broader context of social justice, with a primary aim of addressing oppression

(Smith, 2012). Understanding the intent of kaupapa Māori research in nursing can be supported by making the connection with the concept of cultural safety and recognising the impact of cultural dominance in a research environment.

Kaupapa Māori research is driven by Māori needs, conducted by Māori and negotiated by Māori communities. It favours collective ownership of the research process over individual ownership. It positions the research as part of te ao Māori, rather than this being a token consideration. The connection with cultural safety allows for increased understanding of the rationale of kaupapa Māori methodology throughout the nursing profession. Kaupapa Māori research is not about following a specific formula, but creating research environments that optimise the responsiveness to Māori. Nurses can support kaupapa Māori research by raising the understanding and awareness of this methodology, which will help challenge the power of the dominant culture in the way research is conducted and enhance the credibility of research outcomes.

References

Cram, F. (2001). *A civilising mission?: Perceptions and Representations of the Native Schools System*. Auckland, New Zealand: Auckland University Press.

Cram, F. (2006). Talking ourselves up. *AlterNative: An International Journal of Indigenous Peoples, 2*(1), 28-43.

Hiha, A. (2016). Kaupapa Māori Methodology: Trusting the Methodology Through Thick and Thin. *The Australian Journal of Indigenous Education, 45*(2), 129-138. https://doi.org/10.1017/jie.2015.30

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika. Guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Health Research Council. Retrieved from http://www.hrc.govt.nz/sites/default/files/Te%20Ara%20Tika%20FINAL%202010.pdf

Jones, A. (2012). Dangerous liaisons: Pākehā, kaupapa Māori, and educational research. *New Zealand Journal of Educational Studies, 47*(2), 100–112.

Pihama, L., Smith, K., Taki, M., & Lee, J. (2004). *A literature review on kaupapa Māori and Māori education pedagogy*. Prepared for ITP New Zealand by The International Research Institute for Māori and Indigenous Education (IRI). Wellington, New Zealand.

Powick, K. (2003). *Nga Take matatika mo te rangahau. Māori research ethics: a literature review of the ethical issues and implications for Kaupapa Māori research involving Māori, for researchers, supervisors and ethics committees*. Hamilton, New Zealand: Wilf Malcom Institute of Educational Research.

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* (doctoral dissertation, Victoria University of Wellington).

Smith, L. (2012). Towards developing indigenous methodologies: Kaupapa Māori research. In L. Tuhiwai Smith (Ed.), *Decolonizing methodologies: Research and indigenous peoples* (pp. 297-314). Retrieved from https://ebookcentral.proquest.com.

Walker, S., Eketone, A., & Gibbs, A. (2006). An exploration of kaupapa Māori research, its principles, processes and applications. *International Journal of Social Research Methodology, 9*(4), 331-344.

FROM THE EDITOR: **Patricia McClunie-Trust**

Guiding and fostering nursing research

The inaugural edition of the annual journal *Kai Tiaki Nursing Research* was published in 2010. The naming of the journal was significant because the words "kai tiaki" are derived from kaitiakitanga. The meaning of "tiaki" is *"to guard, preserve, foster, protect and shelter"* (Te Ara, 2007). Since 2010, *Kai Tiaki Nursing Research* has generated a body of knowledge and evidence for nursing practice that reflects the interests and concerns of nurses from differing perspectives across the breadth of nursing in Aotearoa New Zealand. The journal also serves as a medium to foster nurses as both emerging and experienced researchers, especially in publishing research that is relevant to our local context.

While the research published in *Kai Tiaki Nursing Research* represents a comprehensive body of knowledge for nursing, there are some gaps in its representation of voices and interests across the profession. Three key themes in this edition attempt to address those gaps, including representation of the work of Māori nurse researchers, research on health disparities, and support for emerging researchers.

The guest editorial by Tipa explores the significance of kaupapa Māori research methodology in challenging dominant cultural approaches to conducting research with Māori, and the importance of legitimising Māori knowledge in nursing research. We encourage Māori nurse researchers to publish their research and become a stronger voice in future editions of this journal. Research on the contribution nursing could make to reducing inequalities in health outcomes and avoidable hospital admissions is also a focus of this edition, particularly in relation to disparities between Māori and Pākehā.

Patricia McClunie-Trust

Nursing workforce

Contemporary approaches to developing the nursing workforce need to look beyond models that have served past health-service needs. The World Health Organization (WHO, 2016, p. 12) advocates investment in transformative education, streamlining education pathways for people wishing to change careers from other disciplines to the health professions, enabling direct entry of graduates from other professional fields. Jamieson and Harding present a case study reporting on the establishment of the first graduate-entry nursing programme in New Zealand. The research captured the views of key stakeholders on the complexities and success of the programme, which is now in its seventh year.

Increasing the number of Māori and Pacific nurses is another contemporary issue for the nursing workforce in Aotearoa New Zealand. One strategy to reduce health disparities between Māori and Pakeha involves "localisation" (Callister, Badkar & Didham, 2011) – increasing the number of Māori health workers and using Māori knowledge to improve health outcomes. Chittick, Manhire and Roberts examined the experiences of Māori graduate nurses to

understand factors that help Māori students succeed in a bachelor of nursing programme. The research noted that providers of tertiary education and clinical learning environments could do more to create teaching and learning environments that are culturally appropriate for Māori. Registered nurses also need to develop more cultural competence in working with Māori nursing students in clinical practice.

Reducing health disparities

The New Zealand Health Strategy (Ministry of Health, 2016) proposes a health workforce for the future focused on community-based services. These services would deliver people-centred care which encompassed social determinants of health, health promotion, disease prevention and management of long-term conditions. Nurses have an obligation to find ways to engage all cohorts of our population with health services, particularly people with long-term conditions. The Tāne Takitu Ake programme combines cultural, physical and clinical interventions to build cultural competency, increase health literacy and provide tools to improve well-being. Ryan's research on this health programme, specifically designed for Māori men, showed how the health-service environment is integral to providing a culturally safe, relational space for self-growth and for tāne to learn about their health and well-being.

Research on the contribution nursing could make in reducing inequalities in health outcomes and avoidable hospital admissions is also a focus of this edition . . .

Taylor, Budge, Hansen, Mar and Fai evaluated the relationship between care planning and support for health goals for a sample of Māori and non-Māori clients with long-term conditions. The study found that people with documented care plans were more active in managing their health and reported better interactions with health professionals. More Māori than non-Māori reported having a written care plan, and support for health goals in the absence of a written care plan. The findings of this study suggest that providing written care plans and support for health goals appears to benefit people with long-term conditions, but there are challenges in embedding care planning into routine primary care.

Immunisations are effective in preventing communicable diseases, but a proportion of children in Aotearoa New Zealand have either missed or delayed vaccinations. Wyllie-Schmidt, Tipa and McClunie-Trust conducted an integrative review of the international research on factors affecting timely immunisation of children. The findings of this review suggest that child poverty is a significant barrier to timely immunisations. Health literacy, level of formal education, income, and accessibility of health services for families are important contributing factors that nurses need to consider in providing immunisations.

Quality care

The health-service contexts nurses work in affect their ability to provide safe, appropriate and professional care. Research by Westrate, Cummings, Boamponsem and Towers investigated factors influencing compliance with disability and health service standards for aged residential care facilities. They were interested in how much the outcomes of individual certification audits have changed over time and what factors possibly influenced this change. The research concluded that the 2016 level of compliance with the standards had significantly increased from previous audits.

The literature review by Donaldson explores the emerging need for emergency departments in New Zealand to establish specialist roles for forensic clinical nurses. The findings of the review suggest nurses potentially lack the specialist education in forensic nursing needed to manage the medico-legal requirements of some situations presenting to emergency departments. These situations include documenting the handling of evidence for victims of violence or unexplained death.

Research briefs

The research briefs in this issue provide limited reports on research that has implications for the nursing workforce. Wraight reports on research using a clinical communication assessment framework (CCAF) to assess the English-language proficiency of internationally qualified nurses with English as an additional language. This pilot study found the CCAF assessment tool allowed easy identification of the specific clinical English-language training needs of IQNs, to ensure their success in the clinical environment, beyond the minimal requirements for registration.

Ledesma-Libre's research explored factors influencing nurses' decision to work in mental health services for older people (MHSOP), including their perceptions of the service. This research suggests that nurses attached importance to the idea of being able to use all of their skills to provide the most comforting and therapeutic environment for their patients. Despite challenges experienced in the work setting, MHSOP nurses are generally motivated to continue working in this specialty.

Methodology focus

Supporting emerging researchers to undertake and publish research is a significant responsibility for the nursing profession. Experienced researchers are encouraged to publish methodological reviews and critiques in this journal that relate their "know how" and practice expertise to guide our emerging researchers. In this issue, two experienced researchers share their experiences of using particular methodological approaches. Crawford reflects on her use of focused ethnography to study nurse-parent emotional interaction, while Lesa shares her experience of designing a research case study to examine how nursing students experience simulation as an environment for learning.

References

Callister, P., Badkar, J., & Didham, R. (2011). Globalisation, localisation and implications of a transforming nursing workforce in New Zealand: opportunities and challenges. *Nursing Inquiry, 18*(3), 205-215. https://doi.org/10.1111/j.1440-1800.2011.00528.x

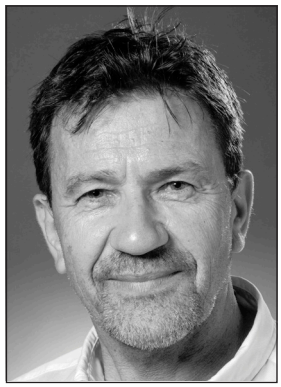
Ministry of Health. (2016). *New Zealand Health Strategy: Future direction*. Wellington, New Zealand: Author.

Te Ara. (2007). *Kaitiakitanga – guardianship and conservation*. Retrieved from https://teara.govt.nz/en/kaitiakitanga-guardianship-and-conservation/page-4

World Health Organization (WHO). (2016). *Global strategy on human resources for health: workforce 2030*. Geneva: WHO Press. http://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf?sequence=1

THE PERSPECTIVES OF KEY STAKEHOLDERS REGARDING NEW ZEALAND'S FIRST GRADUATE-ENTRY NURSING PROGRAMME

Isabel Jamieson



Thomas Harding

About the authors: *Isabel Jamieson, RN, BN, MNurs(Melb), PhD, CertAT, is a principal lecturer – nursing, at Ara Institute of Canterbury, and a senior lecturer in nursing at the University of Canterbury, Christchurch, New Zealand.*
Her correspondence address is Isabel.jamieson@ara.ac.nz

Thomas Harding, RN, PhD, is a senior lecturer in the School of Health Sciences, at the University of Canterbury, Christchurch, New Zealand.

ABSTRACT

Aim: The aim of this study was to understand the circumstances surrounding the establishment of New Zealand's first graduate-entry registered nursing programme.
Background: Since the late 1990s, the single point of entry to registered nurse (RN) education, as stipulated by the regulator, the Nursing Council of New Zealand, has been via a three-year degree programme. In 2014, Christchurch Polytechnic Institute of Technology (CPIT), (now known as the Ara Institute of Canterbury [Ara]), and the University of Canterbury (UC), in Christchurch, New Zealand, offered the country's first graduate-entry programme.
Methods: A qualitative, descriptive, case-study approach was used. Purposive sampling was used to select key stakeholders involved in the establishment of the graduate-entry programme.
Findings: The establishment of this programme was complex and challenging, given that no prototype existed in New Zealand. Stakeholders envisioned such a programme as enhancing and growing the profession, due to the numbers and diversity of the graduates. Many foresaw this programme as having the potential to support accelerated practice for graduates seeking promotion.
Conclusion: The complexity of developing a programme across two academic institutions and the health service, is evident in the opposing reactions of university and polytechnic staff to the proposal. However, historical collaboration between Ara and the health service appears to have resulted in a high level of trust across the organisations, hence the readiness of health providers to embrace this change.

This article was accepted for publication in May, 2019.

KEYWORDS

Case study, nursing education, graduate entry.

BACKGROUND: The history of nursing education in New Zealand

The professional standing of nursing in New Zealand was recognised with the passing of the Nurses Registration Act 1901 (Tennant, 1993). The passing of this act also marked the beginning of formal education for nurses, who were to be trained in hospital-based programmes via an apprenticeship system (Jamieson, 2012; Papps, 2002). Schools of nursing were affiliated with public hospitals, where work-based training was undertaken. Students graduated with a hospital-based certificate and became registered nurses (RNs) upon passing the Nursing Council of New Zealand's state exam. The medical profession oversaw nursing education by developing, administrating and marking the state exam (French, 2001). The benefits of this were threefold: 1) student nurses were exposed to "hands-on" nursing work, 2) employers were guaranteed a steady supply of inexpensive labour, and 3) newly-registered nurses were considered work-ready. However, because the theory taught to students in class did not always match up with the practical work they were doing in clinical placements, the links between theory and practice were not always evident (Ministry of Health, 1998).

From World War II on, health-care delivery changed (Gage & Horn-

blow, 2007). The health-care industry became one of New Zealand's largest employers and improvements in medicine, assisted by new technologies, created new medical specialties and sub-specialties. The changing environment of health care also demanded the delivery of more advanced nursing care (Jamieson, 2012). Following the publication of *The Carpenter Report* (Carpenter, 1971), the transfer began of nursing education from its traditional hospital-based environment, under the control of medicine, to tertiary-based institutions led by nurses (Jamieson, 2012). The first polytechnic courses for New Zealand nurses opened in 1973 in Christchurch and Wellington, followed by Nelson in 1974 and Auckland in 1975 (Department of Education, 1978). After a three-year programme of study, students gained a diploma of nursing and New Zealand registration. By 1989, the transfer of nursing education to the tertiary sector was completed. From 1990, polytechnics were able to offer their own undergraduate degree programmes (Jamieson, 2012). This resulted in the development of undergraduate degree programmes for nurses that offered students the opportunity to clearly link nursing theory to nursing practice, to develop critical thinking skills and to underpin their practice with research-based evidence (Ministry of Health, 1998). By the late 1990s, the single point of entry to RN education, as stipulated by the regulator, the Nursing Council of New Zealand, was via a three-year degree programme. Moving undergraduate nursing education to the tertiary education sector opened up postgraduate education opportunities for nurses at several universities and, eventually, at polytechnics across the country (Jamieson, 2012; Gage & Hornblow, 2007).

However, the move to tertiary education has not been without its critics. O'Luanaigh (as cited by O'Connor, 2005) questioned the suitability of nursing education being delivered via *"a trades-school type environment"* (p10). Likewise, Cottingham (2005) saw no evidence connecting academic writing skills and clinical nursing skills. He went on to say that tertiary institutions were failing to prepare nurses for the real world of clinical practice (p25). Laiho and Ruoholinna (2013) noted that nursing in Western countries had historically been viewed as a non-academic pursuit. The findings of these studies suggest the presence of an anti-academic discourse, underpinned by a view that nursing education should place more emphasis on practice-oriented experiences than on academic activities.

Graduate-entry programmes

While graduate-entry programmes are a relatively new concept in Australasia, they have been offered in the United States (US) since the 1970s, often as a means of managing nursing shortages (American Association of Colleges of Nursing, 2013; Cangelosi & Whitt, 2005). Cangelosi and Whitt noted that graduates from these programmes were considered by employers to be mature, clinically strong and fast learners. More recently, graduate-entry programmes have been established in the United Kingdom (UK). These programmes were established following Project 2000, which heralded nursing education's move from the National Health Service (NHS) apprenticeship model to higher education institutions (Stacey et al, 2014). McKenna and Vanderheide (2012) noted that graduate-entry programmes were a recent phenomenon in Australia, and had been established as a response to *"the aging nursing workforce, and subsequent demands on health care systems"* (p50).

New Zealand's first graduate-entry programme

In 2014, a new educational pathway to RN registration was offered by the Christchurch Polytechnic Institute of Technology (CPIT) (now known as the Ara Institute of Canterbury [Ara]) and the University of Canterbury (UC) (*Kai Tiaki Nursing New Zealand*, 2016). The first version of the pathway was a two-and-a-half year programme, comprising a masters of health science (240 points) awarded from UC and a bachelor of nursing awarded from CPIT. By 2016, the masters component had evolved to a masters of health science professional practice (nursing) (180 points), meaning that the combined programme could be completed in two years. To enrol, students are required to hold an undergraduate degree with a minimum grade average of B.

The first cohort, in 2014, numbered 16; subsequent intakes have had an average of 25 students. The academic backgrounds of the students range through theology, zoology, pharmacology, environmental biology and human biosciences (Jamieson, Dixon, Papps, Norris & Short, 2017). The programme appears to be attracting mature students, as well as being of interest to men (Harding, Jamieson, Withington, Hudson & Dixon, 2017).

This programme is unique for several reasons. Firstly, it was the first New Zealand graduate-entry nursing programme. Secondly, it allows students to graduate with two degrees in two years – a masters of health sciences professional practice (nursing) and a bachelor of nursing. Thirdly, the programme is offered across two education institutions, requiring staff to work together for a common good. O'Toole and Meier (2017) suggest that the way organisations react to such a project will differ across and within institutions, given the intricacies of workplaces, coupled with a potentially problematic array of views among individual staff members.

Hult (2011) notes that stakeholders who need to collaborate across workplaces play the role of *"boundary spanners"*, crossing workplace boundaries for the greater good.

METHOD

Design

A qualitative, descriptive, case-study approach was used for this study. Lambert and Lambert (2012, p255) note that a qualitative, descriptive, case study is *"a comprehensive summarization, in everyday terms, of specific events experienced by individuals".* This method is often used to study a modern phenomenon within its real-life context, because it facilitates the exploration of a single "unit" or "case" (Yin, 2009). The intent of this case study was to *"catch the complexity of a single case"* (Stake, 1995, p. xi) by understanding the circumstances surrounding the establishment of the graduate-entry programme.

Sample

Purposive sampling was used to select *"information rich cases"* considered by the researchers to be participants who would most benefit the study (Burns & Grove, 2009; Polit & Beck, 2012). Nine key stakeholders (KS) were selected due to the leadership positions they held during the establishment phase of the programme from January 2009 to December 2013. They were:

- A head of department/director of nursing (academic: polytechnic/university) (KS1).
- An executive director of nursing (clinical) (KS2).
- A director of nursing (clinical) (KS3).
- The first programme coordinator (KS4).
- A pro-vice chancellor (academic: university) (KS5).
- A dean (academic: university) (KS6).

- A head of department (academic: university) (KS7).
- The Kawa Whakaruruhau (Māori) Advisory Committee chairperson (polytechnic) (KS8).
- The New Zealand Nursing Council chief executive officer (CEO) (KS9).

Ethical considerations

Ethics approval was granted by the CPIT Human Ethics Committee (reference number 1758). All participants recruited into the study agreed to be interviewed at a time and place convenient for them. It was highlighted on the information sheet, and consent form, that participants might be identifiable, due to the use of their work titles, in any dissemination of the project's results. All agreed to be interviewed. A copy of the transcript of their interview was provided to each participant for approval and amendment. They were able to withdraw up until the time of completed data analysis – no one chose to do so.

Data collection

Individual, audiotaped, semi-structured interviews were conducted to collect the data. The participants were asked to reflect on their contribution to the establishment of the graduate-entry pathway. The interview schedule covered *"conversation starters"* relating to the broad topics of motivation, reaction, managing the unknown and future direction (see Table 1, below). The audiotapes were transcribed by a professional transcriber, who signed a confidentiality form.

Table 1. Interview schedule

Motivation
• When did you become involved in the development of this pathway? • What was your role in the development of this pathway? • Why did you decide to become involved and support the development and inception of the pathway?
Reaction
• What was your initial reaction to the proposal? Did this change at all during the development process? • If you spoke about this with colleagues or others whom you perceived as stakeholders, how did they react?
Managing the unknown
• What obstacles did you anticipate? Did they arise in reality? • What unexpected obstacles arose? • Conversely, did you receive unexpected support for the proposal? • On reflection, are there aspects of the developmental work you would now approach differently?
Future directions
• Do you think such a pathway to nursing registration has implications for the future of nursing?

Data analysis

The data analysis was informed by Braun and Clarke's (2006) method of thematic analysis. Both researchers commenced the initial data analysis independently, which required repeated reading of the transcripts and initial coding of data to three themes. The next level of analysis involved the researchers meeting to share and review their independent findings and their fittingness, before arriving at a consensus.

FINDINGS AND DISCUSSION

Three themes, and related subthemes, emerged from the findings:

1. Motivation
- a) Broadening and building upon previous learning
- b) Diversifying nursing
- c) Evidenced-based practitioners

2. Health sector response
- a) Resistance vs acceptance
- b) Leveraging collaborations

3. Future directions: Potential for accelerated practice

Motivation

Broadening and building upon previous learning

KS1's key motivation for developing this unique pathway to nursing in New Zealand was her observation of the frustration of graduates enrolled in undergraduate nursing programmes. While graduate students might be expected to flourish as they studied for another undergraduate degree, this did not appear to be the case:

> *"we just couldn't credit it or RPL [recognition of prior learning] previous degree work. Why did they need so many hours when they've clearly got a graduate-level grade that can absorb information, critique information much faster? But we're still making them sit in class with school leavers and go through the same content-driven processes and progression of their critical thinking skills and all that, rather than actually accepting these are adult learners who have degrees, who are critical thinkers, and can be pushed a lot further. So that was quite a big driver for me and that was over quite a number of years, and I just kept puzzling on what can we do that would be better".*

This participant had spent many years mulling over how to offer a graduate programme, given the regulations of the times, when the serendipitous opportunity arose to work with a university wanting to expand its education programmes in the health arena:

> *"So having this opportunity to work with a university meant that they could award the master's, we could award the undergrad, and it wasn't double-dipping in terms of academic credit". (KS1)*

Consultation followed with key stakeholders from education, the health service and the regulator, who agreed in principle that such a programme would be possible. The positive reaction from the other stakeholders was a motivating factor – they also foresaw that such a programme would allow graduates to build on their previous formal learning experiences:

> *"[it] will suit a number of people, because . . . if it's something like nursing they want to do, it's actually a pathway for those people [with a degree] to build on what they've already got". (KS2)*

Likewise, KS3's personal experience of a friend's daughter having been enrolled in such a programme in Australia meant KS3 had observed that students of graduate-entry programmes were highly likely to be motivated students, who would build on their expertise:

> *"I thought, well why not. And I suppose I was a bit sceptical about who would be attracted, which I shouldn't have been, because Bobbie [pseudonym used] was a typical – probably mimics exactly who is part of the programme now, highly motivated. So yeah, I thought it was a good idea". (KS3)*

At the time of the interviews, several participants noted they had received unsolicited feedback from clinicians in the health service that students and graduates from the graduate-entry programme were well-received in clinical practice. This was a tribute to their maturity and confidence (KS2, KS3, KS8). Such comments supported the predictions noted by others that such a programme would suit both graduates and health providers.

> *"What I'm hearing about the students that are coming through is because they've got life experience, they've got degrees from a variety of things. It seems to provide a good platform for them . . . and certainly there's been lots of comments around the standard. The master's students that come in, they're there for consolidation of learning the clinical side, the art of nursing . . . people comment about the standard that they bring and the enthusiasm, critical thinking skills. They want to know why they want to go and do this, they want to go and do that. They're not just thinking about, oh, I've got to complete this. They seem to have a broader breadth of confidence and knowledge." (KS3)*

Diversifying nursing

Other participants saw such a programme as enhancing and growing the profession, due to the diversity of the graduates and the emphasis on theory at postgraduate level:

> *"If you look at the bachelors of nursing around the country, and you look at postgrad nursing . . . the emphasis is on a clinical master's . . . and yes, nursing's all about the application to practice . . . but the pendulum's swung so far, then some of the things that excite me about nursing, which are the theoretical ideas behind nursing, or theory development, or research . . . had dropped off because they were doing the clinical master's". (KS4)*

In addition, KS4 felt that graduates would be able to *"meld their graduate degree with their nursing knowledge",* offering them a range of employment options.

Likewise, KS7's view was that *"we've brought different people into nursing . . . with skill sets [they] will be able to exploit within nursing that will grow the profession further than what it would normally".*

Evidenced-based practitioners

Unlike others interviewed, KS5 was motivated to support the programme because *"I do think having master's-level students provides the opportunity for a stronger research base coming through"* which would, over time, strengthen the profession. KS5 believed the profession would benefit from graduates who had the ability to undertake *"critical reflection, the inquiry-based reflecting on research more deeply and how it might influence practice. I think they are really important for any profession, and seeing how that might help influence and advance nursing and positive ways for our communities, I think, was probably one of the underpinning factors around, this is a really good thing to do. And it's an exciting pathway for nursing".*

Health service response

Resistance vs acceptance

Initial reactions to the proposal were mixed, which presented challenges for the developers of the programme. The participants in this study who were from the university sector described university staff, in general, as conservative and thus more likely to be slower to embrace change. This helped explain why the proposed programme was met with considerable resistance from the university sector. Health service providers, however, welcomed the proposal.

A participant from the university sector (KS7) said there were *"a range of views . . . university staff were concerned about [academic] standards",* while KS6 noted: *"There was a lot of resistance from [university] staff – I think their perception was that this would lower the value of the master of health sciences, because it had a strong practical component" . . . "I would have to say it was probably the most polarising qualification or proposal that I've ever been involved in.*

KS7 also noted that university staff struggled with the applied nature of the programme; however, there was some support of the concept: *" . . . the thing I really liked about it is the fact that it was aimed at postgraduates who've come from different sorts of places moving into a larger clinical space, but they will have – and we've got parts of that within the course – community focus or understanding as well. So it didn't sit so uncomfortably, philosophically."*

In terms of health providers, KS2 said: *" . . . in fact we had very little resistance [from the health industry], once you explained it to people. And whether that was because we had the culture really well and truly – the partnership culture, the collaborative culture between Ara and us was already well established, so therefore there was a high degree of trust from within practice".*

Participants KS5, KS6 and KS7 also commented that discussions about this programme were occurring at a time of transition for university staff, due to a change in some key leadership positions. This contrasted with a stable staff culture in the polytechnic. From the health industry perspective, once nursing directors knew this programme included the same number of clinical hours as the undergraduate programme and that graduates would be treated like other new graduates, any initial concerns were easily mitigated. Furthermore, *"we got nothing but positive feedback right from the word go"* (KS2) about the abilities students were demonstrating in their clinical placements. Some participants did anticipate there might be a resurgence of anti-academic discourse from the health service; however, this was not apparent:

> *"It's been really positive feedback from the nurses, who have obviously worked alongside some of these students who have come in, and they don't seem too fussed about it. There's not that sense of, 'Oh, they've got a master's and we haven't' – they seem very embracing of it". (KS3)*

The ability of nurses – both academics and clinicians – to work to-

gether was commented on by KS8, who had faith that any concerns would be worked out: *"Oh I just wondered how two different – you've got a polytech and you've got a university – how that would gel together . . . But being nurses, I think they worked it out anyway. Cos, just able to work across the board".*

Leveraging collaborations

Although some academic staff had expressed considerable concerns about the proposed degree, the university stakeholders interviewed for this project noted they were able to build on the successful history of collaboration between the polytechnic education provider and health-service providers to develop this *"ground-breaking"* (KS7) programme. Several participants (KS1, KS2, KS5 and KS7) said it was a unique opportunity for three institutions to work together for the good of nursing education, and, ultimately, patients. However, it was vital that those in key roles were well informed about education policy and regulations. It was also apparent to the key stakeholders that they needed a high level of trust among themselves.

All participants considered the involvement of the nursing regulator, the Nursing Council, to be important. The Nursing Council chief executive commented:

> *"I didn't feel wary at all, because I think the regulation's pretty clear-cut – the standards are the standards" . . . "Does the education pathway meet the standards and produce work-ready, safe-to-practice graduates" . . . "As long as it meets the standards, then that's the only thing that's our business." (KS9).*

In addition, the polytechnic was considered *"a very experienced provider and have a very good reputation with the council. They have been doing what they do well for a long time. So that obviously did give some confidence [to the Nursing Council]". (KS9).*

Given the New Zealand context, the involvement of the polytechnic's Kawa Whakaruruhau Committee[1] and the university's cultural advisory group was an important aspect of the consultation process for both education and health-service providers. However, little concern was evident. KS9 said she wondered how:

> *" . . we work together with the [university's] Māori departments" . . .* however *" . . . [our previous Kawa Whakaruruhau chairperson], she's Ngāi Tahu[2] and that worked quite well. She knew the people over there at the university and it was more those intricacies of iwi and, yeah, how we would work together with the iwi – and it's been no problem. It has not been a problem; it's been fine. From a Māori nursing perspective, it's offered opportunities that there weren't before".*

Future directions: Potential for accelerated practice

Participants generally agreed that the point of difference for this nursing programme was its potential to accelerate career trajectories, and to strengthen nurses' contribution to nursing research. KS2's view was that:

> *" . . . if they want to get into audit research, education, management, they've got the start of their postgraduate pathways already there . . . it's actually then a better building block to build on, otherwise you'd be doing six years and only come out with two bachelors . . . "*

Nursing participant KS5 suggested that:

> *"It's probably one of the reasons I really supported it, because I do think having master's-level students provides the opportunity for a stronger research base coming through. What's the difference between a master's and an undergraduate student? It is around the critical reflection, the inquiry-based reflecting on research more deeply and how it might influence practice. I think they are really important for any profession, and seeing how that might help influence and advance nursing and positive ways for our communities". (KS5)*

DISCUSSION

The purpose of this case study was to document the establishment of New Zealand's first graduate-entry nursing pathway programme. It is clear that its establishment was a complex undertaking, given that no programme of its type existed in New Zealand, so there was no template to follow; given how unique it was to offer a programme across different education providers; and given the need to get both academic staff and clinical staff "on board" with the concept.

Several factors motivated the stakeholders to support the establishment of this programme. These factors included their observations of how demotivated graduate students felt when enrolled in undergraduate nursing degree programmes, and the potential they saw for a programme designed for graduates to "turn this tide". These views echo the observations of Cangelosi and Whitt (2005), who noted that nurses in graduate-entry programmes were highly motivated learners. At the time the participants were being interviewed, many of these stakeholders were receiving unsolicited feedback from clinical staff on the students' placements, suggesting that the programme's graduate-entry students were indeed different – they were mature, confident and focused.

Evidence of the complexity of developing a programme across two academic institutions and the health sector was shown by the differing reactions of staff to the proposal. This perhaps reflects the phenomena of "organisational context" noted by O'Toole and Meier (2017), where employees' behaviour is driven by workplace opportunities and constraints. In this study, the differing contexts inside organisations were manifested by university staff, who were experienced at delivering master's-level education, and were wary about an applied degree that might impact negatively on the institution's academic standards. In contrast, polytechnic staff felt the "time was right" to step up to teaching beyond bachelor-degree level, as they were academically ready to do so.

At the same time, health-service staff were very used to working collaboratively with polytechnic staff. This historical collaboration appears to have resulted in a high level of trust across the organisations, hence the readiness of health providers to embrace this change. Zaheer, McEvily, and Perrone (1998) noted that organisations with high levels of trust among employees reap advantages in the marketplace. It is also apparent that the key stakeholders interviewed for this study were acting as "boundary spanners" (Hult, 2001; Mull & Jordan, 2014), who were able to network with, and link

1. "Kawa whakaruruhau" is a Māori term which means cultural safety (Nursing Council, 2011, Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice. http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses)

2. Ngāi Tahu, or people of Tahu, are a Māori tribe form the South Island of New Zealand. (https://ngaitahu.iwi.nz/ngai-tahu/who-we-are/)

staff across institutions, so that different perspectives, skills sets and knowledge could be interlinked.

It was also noticeable that the intent of the key stakeholders, as boundary spanners, was the common good, rather than just a move to increase student numbers. Health providers were not asking for more students, while the academic institutions were not filling any shortfall in student enrolments. No comments on such motivators were offered by any participants. Rather, the emphasis was on how to best serve the needs of mature students with degrees, who wished to become nurses and who could add to the diversity of the profession. The prediction that such programmes would contribute to the diversity of the nursing profession has been a noted feature of similar Australian programmes (McKenna, Brooks & Vanderdeide, 2017).

The apparent lack of anti-academic discourse between nurse educators and practitioners is noteworthy. It is over four decades since New Zealand nursing education moved to the tertiary sector. For many years, an anti-academic discourse, as described by Laiho and Ruoholinna (2013), was evident among New Zealand nurses. While findings from this small study are not generalisable, it does appear that nursing's clinical and education sectors, in this setting at least, are now well-aligned and respectful of each other.

A longitudinal study is being conducted to track the nursing careers of the graduates of this programme, which may go some way to answer questions from stakeholders about the potential for this programme to accelerate the graduates' careers.

LIMITATIONS

A strength of this study is the breadth of experience of the key stakeholders who agreed to be interviewed. A further strength is that this is the only study which has recorded the establishment of New Zealand's first graduate-entry programme for students who wish to become registered nurses. A limitation of the study is that only key stakeholders, as defined by the researchers, were asked to be included. Therefore the views of staff involved in establishing the programme and putting it into operation have not been captured.

CONCLUSION

The intent of this case study was to document the establishment of New Zealand's first graduate-entry nursing programme. It has achieved this aim by capturing the views of the key stakeholders. At the time this programme was established, it was innovative because for the first time in New Zealand it allowed graduate students to study to become registered nurses via a fast-track master's level programme. Although setting up the programme was a complex undertaking, the well-established links between education and practice contributed to the successful implantation of this innovative programme. This may prove to be a watershed moment for nursing education in New Zealand. Since its inception, another similar programme has been offered and several more are being developed. This would suggest its establishment was timely and met students' needs. The programme is about to enter its seventh year. Student demand is high and informal feedback from the health service is that these graduates are highly valued.

REFERENCES

American Association of Colleges of Nursing. (2013). *Accelerated programs: The fast track to careers in nursing*. Retrieved from www.aacn.nche.edu/publications/issue-bulletin-accelerated-programs

Tennant, M. (1993). Neill, Elizabeth Grace, *Dictionary of New Zealand Biography*. https://teara.govt.nz/en/biographies/2n5/neill-elizabeth-grace

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Burns, N., & Grove, S. K. (2009). *The practice of nursing research: Appraisal, synthesis and generation of evidence* (6th ed). St Louis, MO: Saunders Elsevier.

Cangelosi, P. R., & Whitt, K. J. (2005). Accelerated nursing programs: What do we know? *Nursing Education Perspectives, 26*(2), 113-116.

Carpenter, H. M. (1971). *An improved system of nursing education for New Zealand*. Wellington, New Zealand: Department of Health.

Cottingham, C. (2005). Essay wha? Is there any point whatsoever in nursing students writing essays? Do they really serve their supposed purpose of developing critical thinking skills and ascertaining how students are processing information? A former educator has his doubts. *Kai Tiaki Nursing New Zealand, 11*(8), 25.

Department of Education. (1978). *The evaluation of nursing courses in technical institutes: Interim report*. Wellington, New Zealand: Author.

French, P. (2001). Nursing registration: A time to celebrate? *Kai Tiaki Nursing New Zealand, 7*(8), 17-19.

Gage, J., & Hornblow, A. (2007). Development of the New Zealand nursing workforce: Historical themes and current challenges. *Nursing Inquiry, 14*(4), 330-334.

Harding, T., Jamieson, I., Withington, J., Hudson, D., & Dixon, A. (2017). Attracting men to nursing: Is graduate entry an answer? *Nurse Education in Practice, 28*, 257-263. doi:10.1016/j.nepr.2017.07.003

Hult, G. T. M. (2011). *Boundary-Spanning Marketing Organization – A Theory and Insights from 31 Organization Theories*. New York, NY: Springer.

Jamieson, I. M. (2012). *What are the views of Generation Y New Zealand Registered Nurses towards nursing, work and career?* (Doctoral dissertation). Retrieved from http://ir.canterbury.ac.nz/bitstream/handle/10092/6499/FINAL22Feb2012.pdf;jsessionid=C5DC5C5A77106AE4F102979FF0D5CAEC?sequence

Jamieson, I., Dixon, A., Papps, E., Norris, K., & Short, K. (2017, September). *Demographic characteristics of Masters Pathway nursing students*. Paper presented at the Australasian Nurse Educators Conference. Christchurch, New Zealand.

Kai Tiaki Nursing New Zealand. (2016). News and events: Intensified masters' programmes launch. *Kai Tiaki Nursing New Zealand, 22*(1), 8.

Laiho, A., & Ruoholinna, T. (2013). The relationship between practitioners and academics – anti-academic discourse voiced by Finnish nurses. *Journal of Vocational Education and Training, 65*(3), 333-350. doi:10.1080/13636820.2013.819561

Lambert, V. A., & Lambert, C. E. (2012). Qualitative Descriptive Research: An Acceptable Design. *Pacific Rim International Journal of Nursing Research, 16*(4), 255-256.

McKenna, L., Brooks, I., & Vanderheide, R. (2017). Graduate entry nurses' initial perspectives on nursing: Content analysis of open-ended survey questions. *Nurse Education Today, 49*, 22-26. https://doi.org/10.1016/j.nedt.2016.11.004

McKenna, L., & Vanderheide, R. (2012). Graduate entry to practice in nursing:

exploring demographic characteristics of commencing students. *Australian Journal of Advanced Nursing (Online), 29*(3), 49-55.

Ministry of Health. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington, New Zealand: Author.

Mull, C. D., & Jordan, J. W. (2014). Boundary spanning. *Reclaiming Children and Youth Journal, 23*(3), 56-59.

Nursing Council of New Zealand. (2016). *State final examinations*. Retrieved from www.nursingcouncil.org.nz/Education/State-final-examinations

O'Connor, T. (2005). Something is rotten in the state of education. *Kai Tiaki Nursing New Zealand, 11*(5), 10.

O'Toole, L. J., & Meier, K. J. (2017). Comparative public management: A framework for analysis. In Meier, K. J., Rutherford, A., & Avellaneda, C. N. (Eds.), *Comparative Public Management: Why National, Environmental and Organizational Context Matters* (e-book, pp. 1-48). Washington DC: Georgetown University Press.

Papps, E. (Ed.) (2002). *Nursing in New Zealand: Critical issue perspectives*. Auckland, New Zealand: Pearson Education.

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams and Wilkins.

Stacey, G., McGarry, J., Aubeeluck, A., Bull, H., Simpson, C., Sheppard, F., & Thompson, S. (2014). An integrated educational model for graduate entry nursing curriculum design. *Nurse Education Today, 34*(1), 145-149. doi:10.1016/j.nedt.2012.08.014

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage Publications.

Yin, K. K. (2009). *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publications.

Zaheer, A., McEvily, B., & Perrone, V. (1998). Does trust matter? Exploring the effects of interorganizational and interpersonal trust on performance. *Organization Science, 9*(2), 141-159.

SUPPORTING SUCCESS FOR MĀORI UNDERGRADUATE NURSING STUDENTS IN AOTEAROA/ NEW ZEALAND

Hannah Chittick **Kathy Manhire**

About the authors: *Hannah Chittick, RN, MHSc, is programme leader for the bachelor of nursing at the Universal College of Learning (UCOL) Wairarapa, Masterton, New Zealand. Her correspondence address is chittickhannah@gmail.com*

Kathy Manhire, RN, RM, MMidwifery, IBCLC, is a principal academic staff member and co-ordinator of the bachelor of nursing programme at Eastern Institute of Technology (EIT), Te Aho a Māui, Hawke's Bay, New Zealand.

Jennifer Roberts RN, MN, EdD (candidate), is a nursing policy advisor at the Nursing Council of New Zealand.

Jennifer Roberts

ABSTRACT

Aims: The aim of this study was to understand what factors help Māori succeed in bachelor of nursing education in Aotearoa/New Zealand, by examining the experiences of Māori graduate nurses.
Background: Increasing the number of Māori in the health workforce has been identified as one of several key methods for improving Māori health outcomes. Previous research has identified several barriers that can affect Māori success in tertiary education. Knowledge of these barriers is important, to implement and maintain strategies to help Māori undergraduate nursing students succeed.
Method: A qualitative descriptive study explored the perceptions of seven Māori bachelor of nursing graduates, through semi-structured face-to-face interviews in May/June 2017. Data were analysed using thematic methods to identify common themes.
Results: Five themes were identified: Striving to be a nurse; whānau, financial and institutional support; importance of relationships; cultural nurture and connectedness in the learning environment; and developing resistance in the face of racism and unconscious bias.
Conclusion: Key findings from the data and previous literature indicated that both tertiary education providers and clinical learning environments need to create teaching and learning environments that are more culturally appropriate for Māori. A commitment to providing these environments is required. More professional development to develop cultural competence among registered nurses in the current nursing workforce is also needed.

This article was accepted for publication in August, 2019.

KEYWORDS

Health workforce, qualitative, culturally appropriate, Māori, nursing education.

INTRODUCTION

Aotearoa/New Zealand will face a nursing shortage within the next 10 to 15 years. The Nursing Council of New Zealand (Nursing Council) and the Ministry of Health (MOH) have stressed the need to produce more registered nurses (RNs) to meet future demand (MOH, 2016; Nursing Council, 2016). The proportion of non-Māori RNs in the nursing workforce far exceeds that of Māori RNs (Curtis, Wikaire, Stokes, & Reid, 2012a), who currently comprise approximately 7 percent of the nursing workforce, similar to the proportion of nurses of Filipino (8.6 percent) and Indian (7.4 percent) ethnicity (MOH, 2016; Nursing Council, 2017). International research also indicates that indigenous (and usually minority) ethnic groups are widely underrepresented in the health workforce (Loftin, Newman, Dumas, Gilden & Bond, 2012). Nuku (2015) states that Māori student enrolment numbers are disproportionately low, compared to non-Māori students, and that the number of Māori RNs in the nursing workforce needs to at least double to gain parity with the Māori proportion of the population, which is approximately 15 percent. Wilson, McKinney and Rapata-Hanning (2011) state that increasing the number of Māori RNs in the nursing workforce would have a positive effect on reducing the health disparities the Māori population experiences.

Potential and actual barriers to success for Māori nursing students must be understood to increase Māori enrolment numbers, retention and successful completion rates in bachelor of nursing education (Curtis et al, 2015; Foxall, 2013). Researchers have explored several barriers to success for Māori in tertiary education, and more specifically, nursing education. These included enrolment barriers, personal barriers, and cultural isolation, both in tertiary education providers and clinical learning environments (Southwick & Polaschek,

2014; Wilson et al, 2011). Māori nursing students have often said they faced racial discrimination and a lack of cultural awareness from both fellow students and staff in tertiary education. Some felt unwelcome in the classroom and that their cultural identity was not recognised or valued (Wikaire et al, 2017; Wilson et al, 2011). These experiences have also been reported by Māori new graduates in the workforce. Foxall (2013) found that Māori new graduates experienced racism towards both themselves and patients, which resulted in them feeling disempowered and uncomfortable with their cultural identity in the clinical work environment.

The aim of improving parity between the number of Māori RNs and the Māori population will not be successful unless tertiary education providers and clinical learning environments identify and implement successful strategies to improve enrolment, retention and successful completion of undergraduate nursing qualifications (Clendon, 2010; Nuku, 2015).

DESIGN AND METHODOLOGY

This research used a qualitative descriptive design. Sandelowski (2010) describes this design as providing an in-depth description of the participants' perceptions or experiences, in as close a manner as possible to the original words used by the participants. Seven participants were recruited into the study by posting information on the research on tertiary education providers' Facebook pages. All participants identified as Māori and had graduated within the last five years. Data were collected via face-to-face, semi-structured interviews, on a one-to-one basis. The duration of the interviews, which took place over a two-month period, ranged from 45 to 90 minutes. All interviews were audio-recorded using a digital recording device and transcribed. Transcriptions were sent to the participants to check.

ETHICAL CONSIDERATIONS

Ethical approval was obtained through the Eastern Institute of Technology's (EIT) research ethics and approvals committee. The researcher identifies as Pākehā and therefore cultural supervision was important to ensure the research process remained culturally safe for the participants. Cultural supervision was provided by a research professor from the EIT research and innovation centre. This supervision provided the researcher with support in undertaking research with Māori participants, including tikanga in regard to recruitment, interviewing techniques and interpretation of the data from a Māori world view. The researcher was also a lecturer in a bachelor of nursing programme, so some participants were known to the researcher. Participants were previous graduates of the BN programme, so their vulnerability was limited. Participants were advised at the recruitment stage of the study, and throughout that they could leave the study at any time with no repercussion.

DATA ANALYSIS

Thematic analysis was used to find patterns and themes in the data (Braun & Clarke, 2006). The transcripts were read repeatedly, and audio recordings listened to, to draw out initial thoughts and ideas. Then codes were generated to help identify patterns in the data which could be grouped or coded. These groups or codes helped to identify important themes that related to the overall aim of the research (Braun & Clarke, 2006; Schneider & Whitehead, 2013). Finally, themes were reviewed thoroughly to ensure they were concise and accurate.

Research rigour

Rigour was ascertained by sharing the transcriptions, findings and discussion with the participants before the research was developed further and disseminated. Although the sample size was small, common responses from participants supported the reliability of the findings. Research supervisors were involved throughout the process, including review of the transcriptions, to ensure credibility of the data.

Due to the small sample size, the transferability of the findings is uncertain. However, the common themes that emerged from the data analysis, and the similarity with findings in previous literature support the usefulness of this study. The researcher's personal interest was a motivating factor for undertaking this study. Therefore, personal bias must be acknowledged and recognised as a potential limitation.

FINDINGS AND DISCUSSION

The five themes that emerged are portrayed in Figure 1 (below).

Striving to be a nurse

The desire to become a nurse was evident among all the participants. Reasons for this career choice varied, including having past exposure to nurses as role models, and a desire to improve the quality of life for themselves and their whānau. One participant spoke of how she had been supported by nurses at the time of her mother's death:

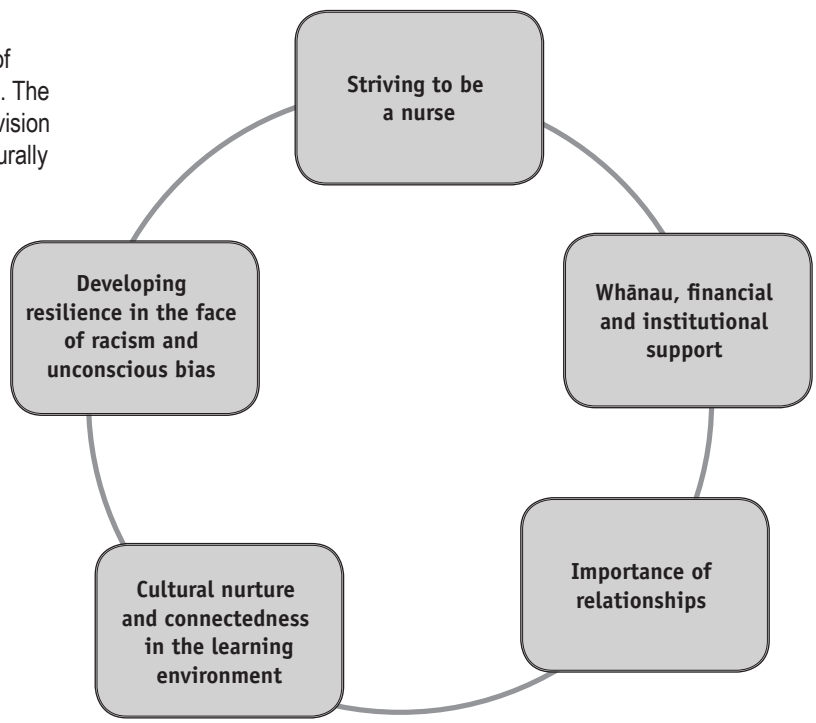


Figure 1. Factors that support success for Māori undergraduate nursing students in Aotearoa/New Zealand

"I had always thought about nursing and nurses 'cause . . . when my mother died, I would look at nurses if I went to hospital . . . and saw them up on this pedestal, that they were helping people, and they were caring, almost like a substitute mother role." (Participant 5 – P5)

Another motivation for some of the participants to enter nursing education was that they wanted and deserved better for themselves and their whānau:

"I didn't want my kids to have the same upbringing that I did. We basically lived in poverty and we had nothing, we were definitely from a low socio-economic family. We didn't have any role models in our family. So, when I had my first baby, I just didn't want him to be brought up that way. Because I was stacking shelves for a few years, and I just knew that I didn't want to do it [anymore]. And then my brother got unwell, and he said, 'You have to do what you want to do.' " (P6)

A desire to increase the visibility of Māori in the health workforce, and to be a role model for other Māori, was a significant driver for many participants:

"From a Māori perspective, because of all the negativity and the lack of brown faces. Absolutely – that was my number one drive . . . was that it can be done. Don't be turned away because of all the negativity. Its achievable! You just need to put your heart and soul into it really." (P3).

Various levels of adversity were experienced by participants during their studies, and one participant spoke specifically about how this adversity pushed her to carry on:

"It can be done. Regardless of whatever obstacles that came up . . . I lost my nephew in the first week of year one to suicide. I wanted to stop . . . I wanted to just focus on my family, on my sister who was just going through hell; his younger brother who was just closed off to everyone. He didn't want to talk to anybody. My young son who was his best friend . . . you know? There were all these things that were just telling me, 'Just stop; do it next year'. But I . . . there was just something that was in there that was saying, 'No, you can do this!', you know? Life happens! And you just have to carry on. I just felt like I needed to prove that you can do it. To anyone . . . regardless of what happens." (P3)

A range of factors motivated participants to want to become a nurse. There was a strong desire to be a positive role model to whānau. Becoming a nurse demonstrated success by making whānau members proud of their achievements, and the professional role they would hold in their communities as RNs. Participants recognised the importance of education and this strongly motivated them to enter the nursing profession. Wilson et al (2011) found that Māori often enter nursing education motivated by the opportunity to further their education and make a difference to Māori health. There was a strong sense of wanting better for their whānau and a desire for their children to have a different life than theirs. These beliefs have also been described as motivational in previous literature (Curtis et al, 2012a; Williams, 2011).

This study found that having the resilience to overcome obstacles was an important factor in achieving success. Individuals with resilience commonly share attributes – such as connectedness to family, friends and their social environments – that enable them to cope in difficult times (McAllister & McKinnon, 2009). The Ministry of Education (MOE) (2013) said that resilience enabled students to persevere through their studies, despite barriers they faced. Evidence suggests that in an educational context, resilience can be learned and improved. For learners to improve their resilience, learning environments need to be learner-centred, positive, demonstrate high expectations of learners, and support their social needs (McAllister & McKinnon, 2009). In this research, age and maturity were discussed as important factors that build resilience. While these are not factors that tertiary institutions can adjust, they need to be considered by institutions.

Whānau, financial and institutional support

Participants found there were various levels and types of support that helped them succeed. Many of the participants who had young families found their family responsibilities could present barriers to completion of their qualification. However, where whānau members provided essential support, this enabled the participants to continue their studies:

"My children and I bought a whare together . . . when I sat them down, I said, 'This is what's happening; this is what is going to happen and, financially, we're going to have to support each other', because I've always brought the money in, and it was good because they stepped up and they took over the finances of paying our mortgage; they realised there was times at night that I was tired; they cooked and cleaned, there were times I didn't go to bed for 36 hours . . . but you've got to get your whānau on board." (P7)

Scholarship opportunities were identified by the participants but they were often not clear about how to access this financial support:

"There are scholarships, but we are not told how to apply . . . so it's like . . . [in] 500 words please explain how you doing this course is going to help towards Māori health. Well, you don't know what you don't know. So, if someone could help with the scholarships and explain how to apply for them, that might help a little bit as well." (P5)

For a variety of reasons, participants felt that institutional support for Māori needed to be brought *to* Māori. These reasons included: being unaware of what support was available, feeling embarrassed, or not being clear how Māori support roles worked:

"I think perhaps what might have helped, maybe if the Māori liaison approached us individually and just told us what she was available for, what she could help with . . . I know she came to us as a class, and that was sort of like an introduction and the end, sort of thing. Perhaps she could have just touched base with a lot of Māori a bit more. I think that would have opened doorways . . . for people to approach her." (P3)

These findings show that the kind of support dedicated to Māori needed to be made clear to students, and to be more targeted and individualised for Māori to use it to its potential.

This research showed that whānau support was instrumental to Māori nursing students' success. Whānau support included financial assistance, help with childcare, providing encouragement and emotional support. Wilson et al (2011) and Williams (2011) found that to retain more Māori students in nursing/tertiary education, whānau need to be involved throughout students' education. One participant in this research noted that for Māori to be successful, whānau need to be "on board".

Williams (2011) also found that Māori students' responsibilities to

whānau may have an impact on their ability to successfully continue their education. Expectations on some Māori students to continue to provide childcare to children and grandchildren, to generate income, and to look after whānau presented difficulties that these students needed to navigate throughout their education (Williams, 2011; Wilson et al, 2011).

The importance of relationships

Positive and negative aspects of relationships either helped or hindered the participants' experiences and success. They spoke about strong relationships they developed with lecturers over the course of the programme. One participant said lecturers building trust with their students was essential to their success, but that for Māori students, building that trust was not easy:

> *"Gaining Māori students' confidence. Just to earn their [Māori students'] trust and then they're willing to talk. Because if we don't talk, we sink. We do. We need to be able to trust the person. If we've got someone we can confide in, and we can get support from, we can go really far, but I think we lack the trust aspect." (P4)*

Participants felt that being mentored by Māori nurses would provide another level of support, motivation and encouragement for students. This would encourage more Māori to undertake undergraduate nursing education, and would help Māori students understand the realities and complexities of being an RN. Although the strategy of involving Māori mentors in nursing education has been suggested earlier in the literature (Curtis et al, 2012a; Wilson et al, 2011), this study found no evidence of that mentorship in the nursing programme the participants had undertaken.

Several participants spoke of how they valued the support they received from some lecturers, in the form of moral support, helping to source financial assistance, or academic support. However, for Māori students to have open discussions with lecturers about their progress or any help they might need, trust needed to be developed between the lecturer and student. Bishop, Berryman, Cavanagh and Teddy (2009) found Māori had much better educational outcomes if they had positive relationships with their educators. Wilson et al (2011) identified institutional strategies including cultural support, which could include pōwhiri, Māori support groups, Māori mentorship and inclusion of whānau throughout students' time in education. The importance of these supportive strategies was also identified by the participants in this study.

Relationships with preceptors on clinical placements were also discussed in this study. Some participants said they had worked alongside RNs who had made racist comments or displayed racist behaviour. This increased the students' awareness of the power relationship that existed between students and RNs. Awareness and identification of potential power relationships is a key principle of culturally safe nursing practice (Nursing Council, 2011). Students are recipients of the RNs' practice, therefore are entitled to culturally safe practice, just as patients and whānau members are. The actions and attitudes of some RNs, as described by the participants, demonstrated a lack of culturally safe nursing practice.

Cultural nurture and connectedness in the learning environment

Participants commented on the importance for Māori students of feeling culturally nurtured in the classroom. Some participants spoke of feeling marginalised, being only one of a few Māori in the classroom, and sometimes, the only Māori student.

> *"It did help to see another Māori face in the room . . . you kind of feel like, 'Oh, I'm not just biting off more than what I can chew here.' " (P1)*

Most of the participants also found the lack of Māori lecturers on the programme was a downside of nursing education at their institution.

Protection of culture in the learning environment was seen as important for success. Some participants described a need to feel culturally cherished, or to feel free to speak up as Māori in the classroom.

> *"The cultural nurture is what I really, really needed at that time, but I just didn't feel safe and see, it's easy [now] because I'm immersed in it . . . but now I'm looking back on it, I should have just put up my hand – but I just couldn't at the time because I always had someone [Pākehā student] with me." (P5)*

Some of the participants acknowledged tikanga teaching practices that were used during their education, such as noho marae (staying on a marae), but felt these could have been delivered in a more culturally appropriate way:

> *"I know we had a noho marae day, but if we'd had the opportunity to go into the marae itself . . . and if I was given links into the iwi here . . . even the whole class, given the opportunity to make those links . . . so that if I thought that if they [Māori support staff] were not available and I wanted to go to that marae . . . just to get more nurture, I think I would have benefitted from that as well." (P5)*

Some participants raised pronunciation of te reo Māori as an issue in the classroom. Mispronunciation of common Māori words was seen as a negative experience:

> *"I sort of thought that people shouldn't be teaching like the Treaty of Waitangi and saying all these Māori words if they can't pronounce it properly. If you can't pronounce it and if you don't know enough about it . . . because someone would ask a question . . . and they'd read over what the slide just said. You know, like they didn't know it properly." (P6)*

There were also mixed opinions about the delivery of Te Tiriti o Waitangi education in the classroom. One view was that a shared delivery of Te Tiriti o Waitangi content from both Māori and non-Māori lecturers would be beneficial to their learning:

> *"I think if you both did it [Te Tiriti o Waitangi] together so that you were with a Māori lecturer, because sometimes it is seen as Māori bashing . . . "Oh, yeah . . . here we go! God! Another one!" And this sounds terrible but if you're presenting it together . . . to give it a little bit of credibility. Because if we come through and it is just Māori, people are just going to switch off. But with the two of you doing it together, it gives it . . . it makes it valid. But also, people are going to listen." (P5)*

The participants believed that if there were more Māori staff and students in their institutions, then students would feel more confident to speak up, particularly on issues relating to Māori health or te ao Māori (the Māori world-view). Wilson et al (2011) said having more Māori nursing role models both in and outside teaching faculty would uphold students' cultural identity in the learning environment. Some

tertiary institutions have recognised that they need to provide a more welcoming environment for Māori students and are working towards identifying and responding to those students' needs. However, this is happening slowly. As institutions implement the strategies suggested by the participants in this study, nursing programmes will become more culturally responsive and more Māori may be motivated to enrol. Such changes could also aid the recruitment of Māori lecturers. The low ratio of Māori nursing lecturers to non-Māori lecturers may be due to the lower proportion of Māori RNs (Ngā Manukura o Āpōpō, 2014).

Cultural connectedness, both inside and outside the learning environment, increased participants' self-confidence. This confidence could manifest as both feeling proud of being Māori, and not feeling ashamed, or feeling they had to defend their ethnicity and culture. Māori participants who felt a close connection with te ao Māori felt more confident in the classroom, particularly about topics directly relating to Māori and/or Māori health. This connectedness gave them the confidence to ask questions, or challenge lecturers and/or students if they felt that the discussions taking place about Māori were inaccurate. This confidence made individuals feel they had something to contribute in the classroom and confirmed their belief that they could succeed in the programme. These findings support a study by Stuart and Jose (2014), which looked at the well-being of Māori youth and the relationship between well-being and whanaungatanga. Their study found that if young Māori had a strong cultural connection, they were more likely to have an overall sense of well-being over longer periods of time.

Culturally appropriate delivery of tikanga in the learning environment, such as the experience of noho marae, classroom discussion of Te Tiriti o Waitangi, and correct pronunciation of te reo Māori, had a positive effect on the participants in this study. Studies by Wilson et al (2011) and Curtis et al (2012b) echo this, saying that Māori student success is strongly related to culturally safe and supportive learning environments. Participants said that learning experiences such as noho marae needed to be delivered in an authentic manner. If they just occurred in the usual classroom environment, it made the participants feel as though this experience was not considered important, which decreased their confidence in themselves and their tikanga. Ensuring that experiences such as noho marae are held on proper marae, including a pōwhiri, sharing of kai, the inclusion of appropriate Māori guest speakers, and possibly an overnight stay, make the experience more authentic, and give non-Māori students a positive experience and view of the Māori world.

Another recommendation from this study is that nursing lecturers should be encouraged to improve their pronunciation of te reo Māori. Participants found that mispronunciation of te reo Māori in the classroom had a negative effect on their learning. The Tertiary Education Union (TEU) has developed a policy to help TEPs introduce use of te reo Māori in their classrooms. As Te Tiriti o Waitangi makes clear, te reo Māori is a taonga, and needs to be protected and valued, both in society and in learning environments (TEU, 2014).

This study found that classroom education and discussion on Te Tiriti o Waitangi was not done well. Participants found that content was often brief and did not address all areas of Te Tiriti needed to gain a full understanding of its importance and its relationship to the health of all New Zealanders. Participants felt that some lecturers, particularly if they were non-Māori, did not have the knowledge to adequately educate students on important aspects of te Tiriti. They believed that delivery of this content should be done by both Māori and non-Māori lecturers, to gain knowledge from both perspectives.

Developing resistance in the face of racism

The participants described various experiences of racism during their nursing education. However, they also said that while these experiences were negative, they had developed resilience and resistance to combat the racism and discrimination, which they felt helped them succeed both during their education, and later in the nursing workforce. Participants described being involved in conversations with non-Māori students who had explicitly voiced their opinions about Māori in a negative manner;

> *"It was heavily talked about . . . the Māori faces on [the programme]. 'Oh! One, two, three . . . Oh! You all made it! Yeah! Yay!' It was . . . that . . . we made it into the quota. It did make it feel like I didn't make it in on my own merits." (P3)*

This belief about Māori privilege was not just expressed within a tertiary institution. The same participant was involved in a discussion with an RN, while on clinical placement at her local district health board (DHB), who had similar views about Māori nurse employment outcomes:

> *"In the DHB, there's a lot of entrenched old-school opinions about Māori health . . . and one [nurse] did say, 'I bet all the Māori student nurses are going to get a job because they are Māori'. And I was like, 'Oh my god', so I just tried to shrink a little bit more, just not to get bullied." (P5)*

One participant explained how, in the clinical environment, she felt she needed to *"stay humble"* and not be seen to celebrate any achievements.

> *"I am a Māori nurse, and yes, I did get the NETP . . . so you know I tried . . . but, you can't even celebrate . . . I did a little bit, but you've just got to stay really, really humble in case people try to say well, you are [privileged]." (P5)*

Participants described situations where they demonstrated an ability to resist racist comments or biased views. Participants showed they had the confidence to teach others about te ao Māori and tikanga. P5 also described herself as a mentor for students in the clinical environment, demonstrating and role-modelling correct tikanga and pronunciation of te reo Māori, and resisting institutional racism:

> *"I try and help them [students] when it comes to culture, I take them under my wing . . . 'Come on, this is how we do it'. I know there's the three p's . . . but there is so much more . . . that is just the start! But I stand up now, and help people say people's names [correctly]." (P5)*

The participants described strategies they employed as students that kept them safe on clinical placements. Some have taken these strategies with them into the workforce as new graduates, as they believed they faced the same judgmental attitudes there that they had faced as students. As the graduates developed a sense of confidence as RNs, they began to feel safe and more able to have a voice in the face of racism and unconscious bias.

This study has shown that racism exists in nursing education and practice. These instances of racism reported by the participants, both

in the classroom, and in clinical practice, from both student peers and RNs, are concerning. The participants described how racist comments had a negative impact on their learning and confidence in the classroom. Discriminatory comments from non-Māori students and non-Māori RNs made students feel as though they did not deserve a place in nursing education or in the nursing workforce. It is important for all students, both Māori and non-Māori, to feel as though they are succeeding on their own merit, in their education or in their employment (Chauvel & Rean, 2012). Racism was also evident in a study by Wikaire et al (2017), which examined first-year Māori and Pacific students in a range of health degree programmes. Southwick and Polaschek (2014) say that although cultural safety has been taught in the nursing profession in Aotearoa/New Zealand since the 1990s, the focus remains on the cultural safety of patients and clients, when it should be widened to include interactions between nurses, to tackle institutional racism.

While some studies have explored factors that predict or support success for Māori in tertiary education, there is limited literature on how Māori define what makes them succeed (Chauvel & Rean, 2012). In this study, participants revealed what success meant to them: achieving goals, regardless of how long it took, or the obstacles faced along the way. The role of nursing lecturers was vitally important in helping students overcome these obstacles, such as by providing encouragement, showing belief in their ability, or helping them source financial assistance to continue their studies. It demonstrates that lecturing staff have a vital role to play in retaining Māori tertiary students through to completion of their qualifications (Curtis et al, 2012b; Sopoaga & van der Meer, 2012).

LIMITATIONS

This study reflects the views of a small sample of graduates from one tertiary education provider, therefore it is uncertain whether its findings would be replicated in other tertiary education providers across Aotearoa/New Zealand. While data saturation was achieved, the limited sample size may not provide generalisability of these findings.

CONCLUSION

This study has provided insights into the varied barriers and challenges that Māori face in nursing education in Aotearoa/New Zealand. While changes have been made in tertiary education and clinical learning environments to improve enrolment, retention and completion for Māori, large gaps in parity remain. The provision of more culturally appropriate learning environments, and an effort to increase the capability of RNs in cultural safety and competence is recommended. Further research examining perspectives across a range of providers could highlight further factors that could support Māori success in nursing education.

RECOMMENDATIONS

This study highlights several changes or improvements that tertiary education providers and clinical learning environments could implement to increase Māori enrolment in bachelor of nursing programmes, their retention in their studies and their successful completion of the course. Ensuring that teaching and learning environments are more culturally appropriate will have some positive effects on both enrolment numbers and retention rates over the course of the nursing programme.

These recommendations include:

- Increasing numbers of Māori lecturers on nursing programmes.
- Ensuring meaningful inclusion of tikanga practices in the curriculum, such as karakia, waiata, pōwhiri and noho marae.
- Providing accurate, comprehensive and culturally safe te Tiriti o Waitangi content throughout the programme. Nursing lecturers must have regular and high-quality professional development in this area.
- Improving nursing lecturers' pronunciation of te reo Māori.
- Providing cultural competence education, in the form of regular professional development, for RNs – clinical learning workplaces must ensure that students' learning environments are culturally appropriate and safe.

ACKNOWLEDGEMENT

The authors would like to acknowledge Dr David Tipene-Leach for his cultural supervision throughout the process of conducting this research and writing this article. Ngā mihi nui, David.

REFERENCES

Bishop, R., Berryman, M., Cavanagh, T., & Teddy, L. (2009). Te Kotahitanga: Addressing educational disparities facing Māori students in New Zealand. *Teaching and Teacher Education, 25*(5), 734-742. https://doi.org/10.1016/j.tate.2009.01.009

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Chauvel, F., & Rean, J. (2012). *Doing better for Māori in tertiary settings: Review of the literature.* Wellington, New Zealand: Tertiary Education Commission.

Clendon, J. (2010). Continuing health inequalities must be addressed. *Kai Tiaki Nursing New Zealand, 16*(11), 24-25.

Curtis, E., Wikaire, E., Stokes, K., & Reid, P. (2012a). Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes. *International Journal for Equity in Health, 11*(1), 13-16. doi:10.1186/1475-9276-11-13

Curtis, E., Townsend, S., & Airini. (2012b). Improving indigenous and ethnic minority student success in foundation health study. *Teaching in Higher Education, 17*(5), 589-602. https://doi.org/10.1080/13562517.2012.658559

Curtis, E., Wikaire, E., Jiang, Y., McMillan, L., Loto, R., & Reid, P. (2015). Quantitative analysis of a Māori and Pacific admission process on first-year health study. *BMC Medical Education, 15*(1), 196. https://doi.org/10.1186/s12909-015-0470-7

Foxall, D. (2013). Barriers in education of indigenous nursing students: A literature review. *Nursing Praxis New Zealand, 29*(3), 33-40.

Loftin, C., Newman, S. D., Dumas, B. P., Gilden, G., & Bond, M. L. (2012). Perceived barriers to success for minority nursing students: An integrative review. *ISRN nursing, ID 806543*. http://dx.doi.org/10.5402/2012/806543

McAllister, M., & McKinnon, J. (2009). The importance of teaching and learning resilience in the health disciplines: A critical review of the literature. *Nurse Education Today, 29*(4), 371-379. https://doi.org/10.1016/j.nedt.2008.10.011

Ministry of Education. (2013). *Ka Hikitia: Accelerating success 2013–2017.*

Wellington, New Zealand: Author.

Ministry of Health. (2016a). *Health of the health workforce 2015*. Wellington, New Zealand: Author.

Ngā Manukura o Āpōpō. (2014). *The performance of New Zealand schools of nursing: Responsiveness to Māori nursing students – Scorecard 2014.* Whangarei, New Zealand: Northland District Health Board.

Nuku, K. (2015). Building the Māori nursing workforce. *Kai Tiaki Nursing New Zealand, 21*(1), 31.

Nursing Council of New Zealand. (2011). *Guidelines for cultural safety, the Treaty of Waitangi and Māori health in nursing education and practice*. Wellington, New Zealand: Author.

Nursing Council of New Zealand. (2016). *The 2005/06 and 2012/13 nursing cohorts report: 2016 edition*. Wellington, New Zealand: Author.

Nursing Council of New Zealand. (2017). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2016¬2017*. Wellington, New Zealand: Author. https://www.nursingcouncil.org.nz/Public/Publications/Workforce_Statistics/NCNZ/publications-section/Workforce_statistics.aspx?hkey=3f3f39c4-c909-4d1d-b87f-e6270b531145

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33*(1), 77-84. https://doi.org/10.1002/nur.20362

Schneider, Z., & Whitehead, D. (2013). *Nursing and midwifery research: Methods and appraisal for evidence-based practice* (4th ed). Sydney, Australia: Elsevier Health Sciences.

Sopoaga, F., & van der Meer, J. (2012). Investigating factors that influence success of Pacific students in first-year health sciences at university in New Zealand. *New Zealand Medical Journal, 125*(1352), 28-38.

Southwick, M., & Polaschek, N. (2014). Reconstructing marginality: A new model of cultural diversity in nursing. *Journal of Nursing Education, 53*(5), 249-255. doi:10.3928/01484834-20140415-01

Stuart, J., & Jose, P. E. (2014). The protective influence of family connectedness, ethnic identity, and ethnic engagement for New Zealand Māori adolescents. *Developmental Psychology, 50*(6), 1817-1826. http://dx.doi.org/10.1037/a0036386

Tertiary Education Union. (2014). *Te reo rangatira*. Retrieved from http://teu.ac.nz/2014/12/te-reo-rangatira/

Wikaire, E., Curtis, E., Cormack, D., Jiang, Y., McMillan, L., Loto, R., & Reid, P. (2017). Predictors of academic success for Māori, Pacific and non-Māori non-Pacific students in health professional education: a quantitative analysis. *Advances in Health Sciences Education, 22*(2), 299-326. https://doi.org/10.1007/s10459-017-9763-4

Williams, T. (2011). "It's about empowering the whānau": Māori adult students succeeding at university. *Waikato Journal of Education, 16*(3), 57-68. https://doi.org/10.15663/wje.v16i3.35

Wilson, D., McKinney, C., & Rapata-Hanning, M. (2011). Retention of indigenous nursing students in New Zealand: A cross-sectional survey. *Contemporary Nurse, 38*(1-2), 59-75. https://doi.org/10.5172/conu.2011.38.1-2.59

Timothy Ryan

About the author: *Timothy Ryan, RN, MN, is a long-term conditions nurse at Korowai Aroha Health Centre, Rotorua, New Zealand. His correspondence address is: Tim@korowai.org.nz*

This article was accepted for publication in August, 2019.

EXPLORING THE EXPERIENCES OF MĀORI MEN IN A CULTURALLY ENRICHED WELL-BEING PROGRAMME

ABSTRACT

Aim: The aim of this research was to explore the experiences of participants in a health education programme designed specifically for Māori males, Tāne Takitu Ake (men standing together), delivered by community health workers and a nurse.

Background: For primary health care nurses, engaging with some of the most at-risk men to make positive, achievable lifestyle changes poses a great challenge, even after repeated education interventions using a traditional Western health-centre consultation room and educational approaches.

Methodology: A qualitative descriptive methodology was used, with thematic analysis of data from a focus group cohort. The research was conducted in multiple environments, including outdoor activities and classroom-like environments for teaching sessions. All participants were Māori males aged 38 to 55 years, and all but one were unemployed. All had been referred to the programme via social and/or health services. Data were gathered from a focus group during a 10-week kaupapa Māori programme involving cultural and clinical educational sessions. The programme consisted of two to three sessions per week where the participants met with a variety of clinical and community facilitators.

Findings: The findings showed the men participating in this programme benefited in terms of health literacy and behaviour modification, and formed genuine relationships while supporting each other. Working in non-traditional health environments provided excellent opportunities for engagement. The key theme in the findings was that the learning environment created self-growth and self-identity. Most participants demonstrated a better understanding of their health and well-being.

Conclusion: This research showed how using non-traditional environments which connect the men with Māori culture is integral for Māori men's health education. Integrating cultural protocol with health education can support positive nursing interventions while providing a safe place for Māori men to engage.

KEYWORDS

Māori men, kaupapa Māori programme, cultural environment, health education, primary care.

INTRODUCTION

Primary health care nursing involves building long-term relationships, providing health messages and reassurance and using evidence-based practice (Muller, Ward, Winefield, Tsourtos & Lawn, 2009). Building rapport is integral to helping patients improve their health and well-being (Wilson, Kendall, & Brooks, 2006). One of the challenges in primary health care nursing is getting at-risk people to engage with the health service, so nurses can deliver health education to improve their health literacy and well-being. This can be even more of a challenge with Māori men, who may not be comfortable in a traditional Western-style health-care centre environment (Balls-Berry, et al, 2015; Ministry of Health, 2015b).

BACKGROUND

Primary health care aims to promote health through the provision of culturally safe and socially acceptable services that are affordable and accessible for the populations they serve (McElmurry, 1999). Disease prevention and health education are important aims of primary care – to achieve these aims, we need to adapt the way we deliver services to suit all service users, in particular high-risk patients (Coulter & Rozansky, 2004). However, the literature shows that Māori men are less willing to engage with existing health services or health education (Johnson, Huggard, & Goodyear-Smith, 2008; Ministry of Health, 2013). Māori men feature high in the health statistics for late presentations, early deaths and risky behaviours. When Māori men do engage with health services, it is often for a specific reason, and very rarely for health education (Came, McCreanor, Doole, & Simpson, 2017; Ministry of Health, 2013/14). Lack of motivation and feeling culturally unsafe can be behind the reluctance of some ethnicities to engage with health services (Ratima et al, 1999; Schommer et al, 2002; Rigby et al, 2011; Warbrick, Wilson, & Boulton, 2016).

Evidence suggests that early, appropriate and timely interventions, produce good health outcomes. However, engaging men generally and proactively in primary health can be challenging for health

professionals. As a result, men's health continues to be generally poorer than women's, and for Māori men even worse than for non-Māori (Ministry of Health, 2015a; Ministry of Health, 2015b). Data shows the leading causes of mortality for both Māori and non-Māori men are cardiovascular disease, diabetes, suicide and lung cancer (Ministry of Health, 2013/14, 2015a). Engaging with those most at risk can be a challenge for primary health professionals, and those most at risk are often living with long-term conditions. Long-term conditions are defined as diabetes, cancer, cardiovascular diseases, respiratory diseases, mental illness, chronic pain and chronic kidney disease (Ministry of Health, 2016). Poorer health outcomes for Māori tāne (men) with long-term conditions can be attributed to the social determinants of health, such as income, social supports, skills, education and literacy, and access to health services (Marmot, 2005). The prevalence of long-term conditions such as diabetes is increasing substantially (Ministry of Health, 2016), which puts pressure on the health services whose job is to clinically manage these patients.

The health and well-being of New Zealand Māori has historically been, and continues to be, unequal to that of Pākehā (New Zealander of European descent). Although the life expectancy for both Māori and non-Māori has increased in the last 10 years, mortality remains higher and life expectancy lower for Māori than for other ethnicities (Ministry of Health, 2015b). Some New Zealanders have lower health status than others, which can be connected to their socio-economic status, ethnic identity and gender (Arroll, Goodyear-Smith, & Lloyd, 2002; Ministry of Health, 2015b; Sporle, Davis, & Pearce, 2002; Westbrooke, Baxter, & Hogan, 2001). Therefore, it is important to deliver services that incorporate the values of, and are appropriate to, these sections of the community.

Environments for health education such as marae, churches, the outdoors or other community settings which are familiar to a targeted group, have been shown to work well because they allow these people to feel comfortable, which promotes positive engagement (Signal & Ratima, 2015). Traditional European settings can lack the values-based atmosphere that Māori patients feel more comfortable in (Simmons & Voyle, 2003). Research has shown that using male-friendly environments increases the engagement of men with their health professionals (Balls-Berry et al, 2015; Jordon, 2015).

In summary, the literature shows there is a discrepancy in primary health outcomes for Māori, and for Māori males. Engagement can be improved by using appropriate environments. This study explores the experiences of a group of men over a 10-week period while they participated in an innovative health and well-being programme designed for Māori men, namely Tāne Takitu Ake.

RESEARCH APPROACH/METHODS

This qualitative research study explored the experiences of nine Māori males participating in the Tāne Takitu Ake health and well-being programme. Data was collected using a focus group approach (Cresswell, 2014; Moule & Goodman, 2009). This method was selected because it encourages participants to voice their experiences using their own words, allowing the interview to focus on the participant's personal experiences and world-view (Stewart & Shamdasani, 2015). The focus group was held in a closed board room. The nine participants were seated around a table with a single moderator. Over the course of the programme, the group had formed a close relationship, resulting in a familiarity with each other which allowed genuine discussion to occur. A topic guide, consisting of four questions, was used by the moderator to encourage frank and open conversation. The focus group discussion was audio-recorded and then transcribed verbatim. Following the group interview, lunch was provided as a koha for their participation. The transcript was given to the moderator and one of the participants – both of them Māori – for comment and feedback on its accuracy. Thematic analysis was used to identify patterns in the participants' conversations. Braun and Clarke (2006) define thematic analysis as *"a method for identifying, analysing and reporting patterns (themes) within the data"* (p79).

TĀNE TAKITU AKE (MEN STANDING TOGETHER)

The Tāne Takitu Ake programme is based at Korowai Aroha Health Centre, in Rotorua, and has been running since 2013. It takes in four cohorts a year, and so far 288 tāne have gone through the programme. Participants are predominantly Māori but have included Pākehā and Pacific Island men. Tāne Takitu Ake combines cultural, physical and clinical interventions to provide a balanced programme focused on building cultural competency, increasing health literacy and providing tools to improve well-being. Health literacy, as defined in this programme, is the ability to understand long-term conditions – specifically cardiovascular disease, diabetes, mental health and cancer – and how to seek information on managing these conditions. Tāne Takitu Ake uses a kaupapa (plan or purpose) Māori approach, as described by Kapuaahiwalani-Fitzsimmons (2015). The kaupapa Māori approach means operating with a Māori world view, using protocol and procedures recognised by Māori. In doing so, the programme aims to educate men on lifestyle changes to improve their health, and to equip them with tools to restore ownership of and direction in their lives. Tāne Takitu Ake targets men who are either at risk of developing a long-term condition or who already have one, or who are struggling with social issues. The target group are tāne in the Rotorua region, aged 25 to 65 years, who were referred to the programme by a mix of non-government community organisations, hospital and general practice. The programme has three stages: tāne whakapiripiri (joining together), tāne te waiora (health and well-being) and tāne tokorangi (standing tall). The Tāne Takitu Ake programme relies on a strong commitment from and collaboration between community services in the Rotorua region such as Queen Elizabeth Health (a holistic wellness centre), Te Utuhina Manaakitanga (a kaupapa Māori drug and alcohol counselling service), the Heart Foundation, the Cancer Society and others. The programme combines Māori cultural values and beliefs with clinical interventions.

It is important that the relationship between participants and facilitators is established early – this is in keeping with the kaupapa of the programme. Whakawhanaungatanga (developing relationships) is accomplished in the first two weeks of the programme – this is the tāne whakapiripiri stage. In this stage, the men are exposed to the wider concept of wairua (spirituality) through kōrero (story-telling) in the context of whakapapa (genealogy). In the next stage of six weeks, tāne te waiora, the men are given tools to help them maintain their physical and mental well-being. This includes a strong emphasis on hinengaro (psychological health) through the sense of being Māori, using traditional Māori settings and Māori paewhiriwhiri (specialised community health workers). The final two weeks, tāne tokorangi, focus on sustaining newly-formed lifestyle behaviours.

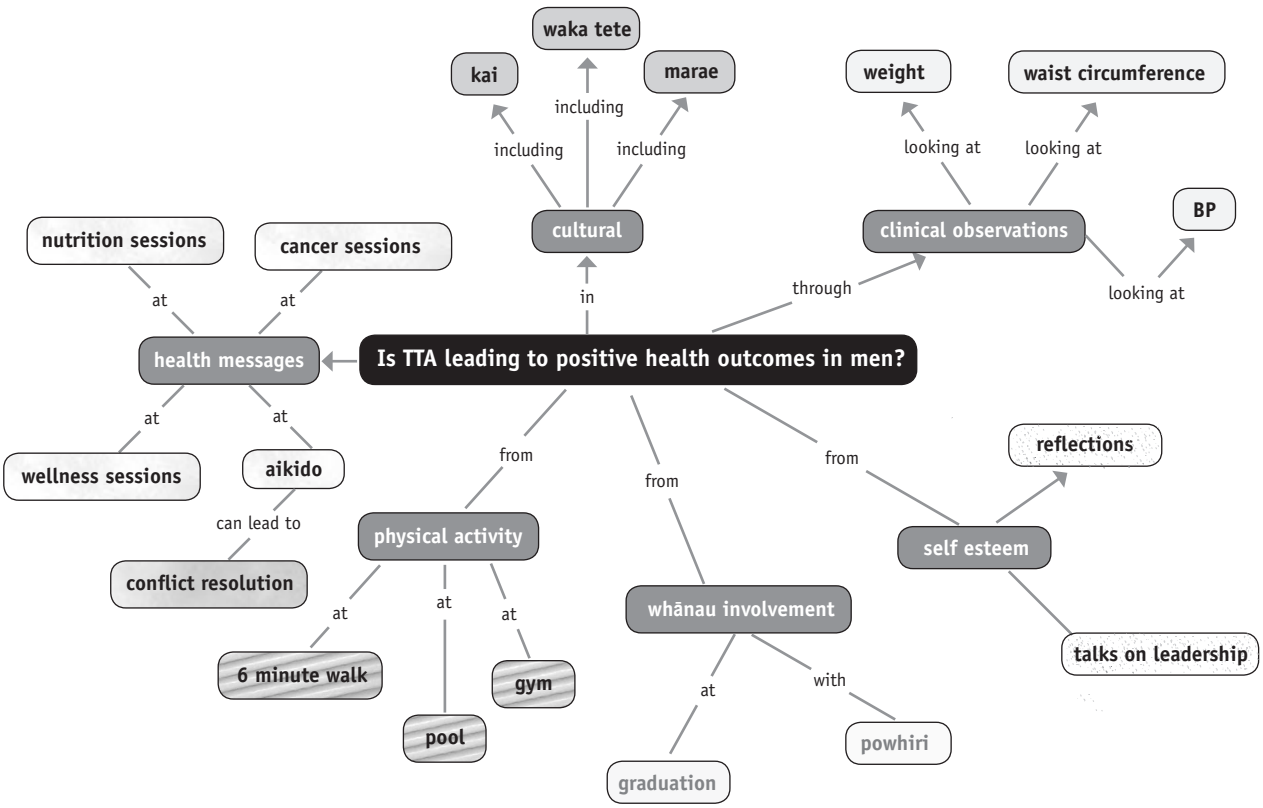


Figure 1. Concept map

During all stages, the men are free to interact, speak and contribute to discussions, while at the same time internalising their thoughts and behaviour. The connection to the environment through activities such as walking in the ngahere (forest) while gathering kai from the whenua (land), or on a waka in a lake, encourages a spiritual relationship to the land, of kaitiakitanga (guardianship). Each session or activity begins and closes with a karakia (prayer).

When research involves Māori, special considerations are required (Hudson, Milne, Reynolds, Russell, & Smith, 2010). The ethics application included consultation with the kaumātua of the marae that was used on the programme, the ethics consultant from Lakes District Health Board and a supporting letter from the senior management team at Korowai Aroha Health Centre. Finally, ethical approval for this study was granted by the University of Auckland human participants ethics committee.

RESULTS

Key words were identified in the text of the transcript which were relevant to tāne from a cultural, values and educational perspective. This involved examining the text for patterns and repeated ideas, which were coded using a cut and paste method (Stewart & Shamdasani, 2015). The codes were then grouped to form categories by focusing on areas that had repetitive concepts (Creswell, 2014). The categories were then further refined into two sub-themes and then a key theme. The sub-themes were "environment" and "self-identity", from which the key theme emerged: *"The learning environment creates self-growth and self-identity."* A concept map (see Figure 1, above) helped categorise the narratives into groups that guided the themes.

Code words from the narrative were identified and grouped into categories. These categories were refined further into two categories – external (those activities that attributed to learning new behaviours, such as waka tete), and internal (those narratives related to their self-concept) (see Figure 2, next page). Once this process was completed, the researcher then applied both tacit and academic knowledge about what was relevant to men's health and well-being to generate the sub-themes and key theme.

Of interest were the thoughts of the moderator and a focus group participant. Each was asked to read the narrative transcript and comment on what they identified as important to the group. Their comments are supported by the participants' narrative and are summarised in four points:

1) A supportive environment that is non-judgmental, honest, sharing, co-operative and bonding.

> *"The environment which the course offers is an environment which everyone should have access to." (PK)*

Focus group participant MD describes paddling a waka tete (a Māori fishing canoe with a carved figurehead and vertical stern piece) and how the waka activity affected him:

> *"It was all new to me and the waka was amazing. The outcome wasn't the one we would have liked [tipped out], it happened, and we dealt with it, and if anything, it brought us closer*

together, which was what it was supposed to do, I think. That's what the waka was all about." (MD)

2) Self-realisation, with an awareness of one's responsibility to one's self and one's whānau.

"It is like a whānau, whānau forever, no-one can change that." (PD)

". . . I probably would have killed myself if I wasn't on this course . . . you are in a world of darkness by yourself." (PK)

3) An increase in health literacy and looking after oneself holistically.

"Going into the bush looking for food instead of going down to the takeaways . . . the nearest thing I got to cooking anything was just a boil-up in the kitchen." (MD)

4) An embrace of the kaupapa Māori well-being philosophy.

". . . being amongst a Māori environment in a Māori focus with Māori tāne, that's been a real game changer for me." (KP)

These four points support the concepts of "environment" and "self-identity" which emerged from the focus group discussions. The focus group narrative also made it clear how significant group dynamics were in changing behaviour, encouraging personal growth and establishing identity. Comments from the tāne using words such as "comradeship", "fellowship", "bonding" and "safe", illustrated the relationship they felt with each other. Another example of the strong connection in the group was the number of times the word "brother" was used – this word was mentioned 12 times in the narrative. This bond they had formed may have made a significant contribution to the behaviour changes the participants made.

"Coming from a background of gang members and drug users and just horrible people until I came to this programme and

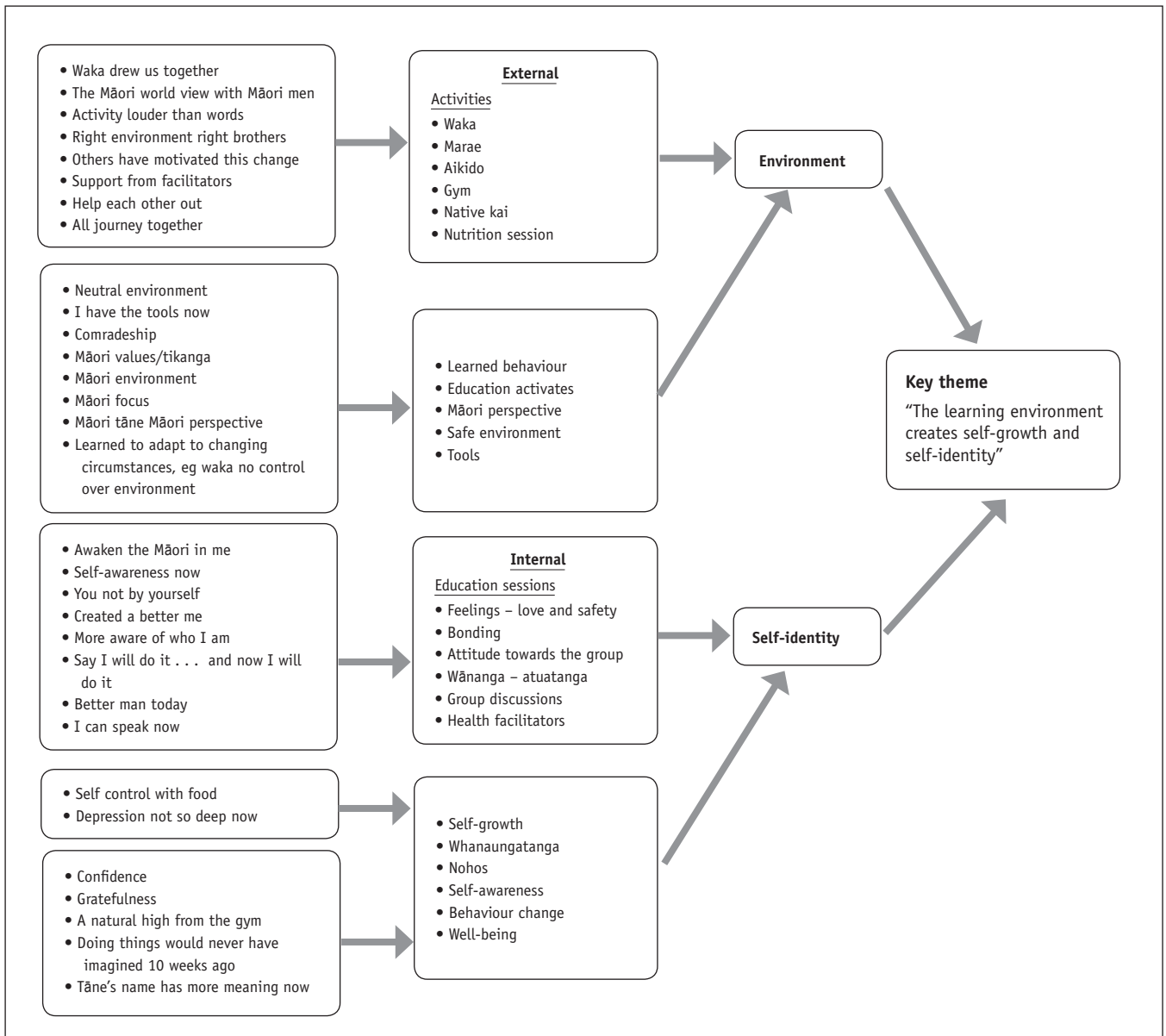


Figure 2. Development of sub and key themes

realised that I am not the only one out there struggling, so this environment for me has brought me to a group of like-minded men that come from different backgrounds in life, but we all struggle together." (KP)

The link between the sub-themes and the key theme, *"The learning environment creates self-growth and identity",* was the relationships the participants had formed in their group. The particular environment the course offered acted as a catalyst for self-acceptance and for breaking down barriers to learning new skills. The data showed them applying healthy lifestyle skills:

"The environment which the course offers is an environment which everyone should have access to." (PK)

"Aikido taught me to defuse a situation, defuse your environment. You know if you are in a negative environment or confronting environment to defuse it and just let it go by you, don't react." (ES)

"Big effects on just what I have learned here, the cooking was a big impression on the missus anyway." (ES)

"We know how to make a frittata." (MD)

"When we first started the process, Te Whare Tapa Whā [the four pillars] I have used that a lot to help." (MD)

This study has shown that using a kaupapa Māori approach, and environments outside of health centres, makes adopting healthy behaviours possible. Other benefits included increased health literacy, understanding of self-identity/ko wai ahāu (who am I), and the rediscovery of culture. The combination of the group dynamic and the physical environment allowed the men to have positive experiences of well-being. For this cohort of patients, this could be an alternative to engaging with the nurse in a traditional health-care centre. It offers an alternative health-education environment which promotes a therapeutic relationship with their nurse. While the educational methods that are the focus of this research would not suit all males, it is likely there will be a portion of the population for whom this culturally focused learning style is beneficial.

"It's changed me a lot. I was a couch-sitter prior to this course, but now I get up and catch buses to the Aquatics, come to the gym, go to courses, which is great, and I have learned a lot from it." (PD)

DISCUSSION

Providing an alternative environment to traditional primary health care centres, in which Māori tāne can engage positively with their primary care nurse, is an opportunity to improve their health and well-being. Men are at particular risk of poor health literacy (Davey, Holden, & Smith, 2015). The Health Quality & Safety Commission (2017) defines health literacy as the degree to which individuals can obtain, process and understand health information and services they need to make appropriate health decisions. Improving health literacy can reduce a person's dependence on health resources while having a positive impact on their health, potentially freeing up valuable health funds (Ministry of Health, 2015a; Walsh, Shuker, & Merry, 2015). Targeting long-term condition patients and those at high risk of poor health will give the greatest return on investment (Eckermann, Dawber, Yeatman, Quinsey, & Morris, 2014). The Tāne Takitu Ake programme offers the men the opportunity to learn about health literacy and well-being through a kaupapa Māori lens while incorporating Western health practices (Simon, Flett, & Babbage, 2014). Māori health expert Mason Durie's Te Whare Tapa Whā model (1985) is used to explain to the men how well-being is a whare (house) supported by four pillars – taha wairua (spiritual health), taha hinengaro (mental health), taha tinana (physical health) and taha whānau (family health). Using this model, and other cultural activities they can relate to, produced a familiarity that seemed to make the men feel safe. For example, the tāne in this study seemed to relate well to a discussion linking well-being and goal setting, while paddling a waka tete. They talked about who you needed on your waka to help you attain personal well-being goals. Delivering clinical information in an environment that speaks to them, improves the relevance and adherence of the health education message.

The programme uses both cultural and clinical interventions to introduce the men to health and well-being. The nurse works collaboratively with specialised community health-care workers (paewhiriwhiri). When such collaboration is used to deliver health interventions, patients have shown increased participation in health education (Warbrick et al, 2016). The purposely-structured environment used in the programme helps the participants to think about the relevance of what they are learning to their health and well-being (Hemming, Levine, & Gallo, 2017; Ratima et al, 1999). The clinical component of Tāne Takitu Ake programme helps ensure the safety of the participants, while allowing closer monitoring of, and education about, their medical conditions. This study highlights the benefits of developing a health programme focused on Māori men's health education needs – looking at what will relate to them that will help them learn healthy behaviours while improving their therapeutic relationship with the nurse. The challenges facing the future resourcing of primary health care – workforce shortages, increasing health burdens, funding concerns, inequality issues and political changes – may require a paradigm shift in how we deliver health services. Nurses have a role, when working with Māori men, to improve engagement, particularly with those most at risk of not engaging well with primary health, those with high health needs and those at potential risk of mortality.

Prevention is always better than cure, so while the health sector needs to service the unwell, an important aim of primary health care is the prevention of illness. Because it is located in the community, primary health care is in a unique position to engage with people to provide health education and improve well-being. This can be taken a step further by providing communities, particularly Māori tāne, with opportunities to take part in an alternative style of programme for well-being education and disease prevention.

The environment of a traditional primary health care centre can play a part in missed opportunities for health professionals to engage with at-risk patients (Balls-Berry et al, 2015). Some of the barriers to engagement are cost, transport, unfavourable past experience with health services or fear of hearing bad news. Health professionals face a challenge to turn these missed opportunities into proactive engagement in health literacy and well-being education (Schumacher et al, 2013). Finding environments in which Māori men feel comfortable about seeking information on healthy behaviours may reduce these missed opportunities. The Tāne Takitu Ake programme has provided opportunities for patient and nurse to engage outside traditional health settings (Balls-Berry et al, 2015). In doing so, it

enables the participants to feel safe and not whakama (embarrassed) about health education.

Primary health care services have an obligation to find ways to reach all cohorts of the population. The health statistics of Māori men require interventions to make a more equitable system (Ministry of Health, 2015). The health education programme Tāne Takitu Ake creates an environment that allows men to discuss and share in a unique way with their nurse, and often starts them on their well-being journey. The literature review looked at the reasons why men do not fully engage with health services, and showed there was an alarming disparity between Māori and non-Māori in engaging with general practice (Jansen, Bacal, & Buetow, 2011). This research found that when health interventions were tailored specifically for Māori tāne, they were better able to relate to what they had learnt about their health and well-being.

Engaging with Māori in primary care requires an environment that enables relationships to be formed (Pitama et al, 2011). From this research, it is evident that Māori tāne need to feel comfortable and safe, with opportunities for conversation. When tāne begin to talk freely, they will often reveal the issues that are behind their clinical symptoms, which can flow into positive clinical interventions. Environments such as marae, waka, hikoi, gathering native kai in the bush, all help discussion to flow (Jordon, 2015). These environments also have deep cultural significance, which is a point of difference this programme has in promoting free discourse on relevant health issues between the tāne and nurses. Perhaps the most important environment is the structured group (Moore, 2015) where bonding, fellowship and whanaungatanga help create a strong relationship between the men. Their identity is confirmed or reshaped by their engagement in the group. This strengthens their self-esteem and allows open discussion with health professionals on relevant health issues.

Nurses are equipped to be agents of change and can respond to cultural demands in the workplace (Durie, 1985; Muller et al, 2009; Rigby et al, 2011). The therapeutic nursing relationship can be put to use with groups of Māori tāne in a way which helps them understand themselves and their values (Nahon & Lander, 2013). A nurse's ability to innovate is an advantageous skill when engaging with those most at risk. This is not necessarily about coming up with an original idea, but more about how to put innovation into practice.

RECOMMENDATIONS

This study proposes the following recommendations for nurses working in primary health care with Maori tāne:

- Ensure primary care nursing staff are aware of the barriers some Māori tāne may encounter when engaging with primary health care services.
- Ensure health-care centres have a cultural focus that is welcoming to Māori tāne, and a culturally safe learning environment.
- Provide environments in primary health care that are friendly to Maori tāne, using male health-care workers.
- Target high-risk Māori tāne through health education programmes that use kaupapa Māori group participation, collaborating with community health services and nurses.
- Advocate for the use of environments outside traditional health-care centres to strengthen Māori tāne engagement with nurses delivering clinical education.

LIMITATIONS

This study has several limitations. The sample size of nine men was small, with data collected from one focus-group interview. While initial results showed the participants had learnt new skills in a relatively short period of time, measuring and gauging the sustainability of these skills would require further research, to increase our understanding of the long-term gains of the programme. The researcher is Pākehā and therefore limited in a deeper appreciation of Māori world-views. The world-views of Māori and Pākehā involve different assumptions, due to different experiences and cultural histories. The researcher has not been exposed to the same elements of cultural connection that most Māori experience, for example using te reo, or experiencing Māori kaitiakitanga for the land.

CONCLUSION

Primary health care services have an obligation to find ways to reach all cohorts of the population. The health statistics for Māori tāne require interventions to make a more equitable health system. For men, the environment in which services are delivered can influence their level of engagement with primary health care. The kaupapa Māori approach to holistic well-being, through culture, and through spiritual, whānau, mental and physical elements of health, is essential to understanding health and well-being of Māori tāne. When this approach is combined with nursing interventions and collaboration with community health workers, it can produce positive engagement and outcomes.

Engaging with patients in primary care can be both challenging and rewarding. It is challenging, because primary care requires health professionals to engage holistically with patients to help them make effective choices to help themselves. It is rewarding in the sense that we, as health professionals, are privileged when patients invite us to help them with their health and well-being journey. Using innovative approaches to deliver health messages to at-risk groups supports positive health outcomes. This research has shown how the therapeutic relationship can be enriched by working in a culturally-focused health-care environment. An example is using the waka tete as a learning tool for well-being via a tangible learning experience. Combining cultural responsiveness with positive engaging environments is about using nursing innovation and expanding the role of the nurse.

ACKNOWLEDGEMENTS

I would like to acknowledge the supportive staff at Korowai Aroha Health Centre, especially the management team.

To those participants who took part in the study, I acknowledge your time and honesty in supporting this exploration of how we can improve engagement in primary health education.

To my colleagues Tracy Ormsby, Stormy Hohepa, Aaron Randel, Kevin Pahina and Richard Rautjoki – without your knowledge, insight and commitment, none of the outcomes from this programme would have been achievable.

I would also like to acknowledge the other services and individuals who gave their time and expertise to help deliver quality sessions for the well-being of the participants.

Finally, I acknowledge the financial support of the McCutchan Trust Scholarship that enabled this study to be undertaken.

REFERENCES

Arroll, B., Goodyear-Smith, F., & Lloyd, T. (2002). Depression in patients in an Auckland general practice. *New Zealand Medical Journal, 115*(1152), 176-179.

Balls-Berry, J., Watson, C., Kadimpati, S., Crockett, A., Mohamed, E., Brown, I., & Davis, O. (2015). Black men's perceptions and knowledge of diabetes: A church-affiliated barbershop focus group study. *Journal of Racial and Ethnic Health Disparities, 2*(4), 465-472. https://doi.org/10.1007/s40615-015-0094-y

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Came, H. A., McCreanor, T., Doole, C., & Simpson, T. (2017). Realising the rhetoric: Refreshing public health providers' efforts to honour Te Tiriti o Waitangi in New Zealand. *Ethnicity and Health, 22*(2), 105-108. https://doi.org/10.1080/13557858.2016.1196651

Coulter, A., & Rozansky, D. (2004). Full Engagement In Health: Needs To Begin In Primary Care. *BMJ: British Medical Journal, 329*(7476), 1197-1198.

Creswell, J. W. (2014). *Research design: qualitative, quantitative, and mixed methods approaches* (4th ed). Thousand Oaks, CA: Sage.

Davey, J., Holden, C. A., & Smith, B. J. (2015). The correlates of chronic disease-related health literacy and its components among men: a systematic review. *BMC Public Health, 15*, 589. https://doi.org/10.1186/s12889-015-1900-5

Durie, M. (1985). A Māori perspective of health. *Social Science & Medicine, 20*(5), 483-486.

Eckermann, S., Dawber, J., Yeatman, H., Quinsey, K., & Morris, D. (2014). Evaluating return on investment in a school based health promotion and prevention program: The investment multiplier for the Stephanie Alexander Kitchen Garden National Program. *Social Science & Medicine, 114,* 103-112. https://doi.org/10.1016/j.socscimed.2014.05.056

Health Quality & Safety Commission. (2017). *Health literacy*. Retrieved from http://www.hqsc. govt.nz/our-programmes/consumer-engagement/work-streams/health-literacy/

Hemming, P., Levine, R. B., & Gallo, J. J. (2017). "Conversational Advice": A mixed-methods analysis of medical residents' experiences co-managing primary care patients with behavioral health providers. *Patient Education and Counselling, 101*(1), 85-89. https://doi.org/10.1016/j.pec.2017.07.014

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika guidelines for Māori research ethics: a framework for researchers and ethics committee members*. Retrieved from http://www.hrc.govt.nz/sites/default/files/Te%20Ara%20Tika%20FINAL%202010.pdf

Jansen, P., Bacal, K., & Buetow, S. (2011). A comparison of Māori and non-Māori experiences of general practice. *The New Zealand Medical Journal (online), 124*(1330), 24-9.

Johnson, L., Huggard, P., & Goodyear-Smith, F. (2008). Men's health and the health of the nation. *The New Zealand Medical Journal, 121*(1287), 69-76.

Jordon, M. (2015). *Nature and therapy: understanding counselling and psychotherapy in outdoor spaces*. East Sussex, United Kingdom: Routledge.

Kapuaahiwalani-Fitzsimmons, M. (2015). *Critical success factors in Kaupapa Māori AOD residential treatment: Māori youth perspectives* (unpublished master's dissertation). Dunedin, New Zealand: University of Otago.

Marmot, M. (2005). Social determinants of health inequalities. *Lancet, 365*(9464), 1099–1104.

McElmurry, J. B. (1999). Primary Health Care. *Annual Review of Nursing Research, 17*(1), 241-268.

Ministry of Health. (2013). *Primary care data and stats*. Retrieved from https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/primary-care-data-and-stats

Ministry of Health. (2013/14). *Annual update of key results 2013/14 New Zealand health survey: Respiratory disease*. Retrieved from http://www.health.govt.nz/our-work/populations/Māori-health/tatau-kahukura-Māori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/respiratory-disease

Ministry of Health. (2015a). *Health literacy review: A guide*. Retrieved from http://www.health.govt.nz/publication/health-literacy-review-guide

Ministry of Health. (2015b). *Tatau Kahukura: Māori health chart book*. Retrieved from http://www.health.govt.nz/publication/tatau-kahukura-Māori-health-chart-book-2015-3rd-edition

Ministry of Health. (2016). *New Zealand Health Strategy 2016*. Retrieved from https://www.health.govt.nz/publication/new-zealand-health-strategy-2016

Ministry of Health. (2015/16). *Mental Health and Addiction: Service Use 2015/16*. Retrieved from https://www.health.govt.nz/publication/mental-health-and-addiction-service-use-2015-16

Moore, J. (2015). *Men's sheds and intergenerational mentoring in New Zealand* (unpublished master's thesis). Auckland, New Zealand: University of Auckland.

Moule, P., & Goodman, M. (2009). *Nursing research: an introduction*. Los Angeles, CA: SAGE 2009.

Muller, R., Ward, P. R., Winefield, T., Tsourtos, G., & Lawn, S. (2009). The importance of resilience to primary care practitioners: An interactive psychosocial model. *Australasian Medical Journal, 1*(1), 1-15.

Nahon, D., & Lander, N. R. (2013). Working with Men in Groups from an Integrity Model Perspective. *Journal of Men's Studies, 21*(2), 162-177. https://doi.org/10.3149%2Fjms.2102.162

Pitama, S., Wells, J. E., Faatoese, A., Tikao-Mason, K., Robertson, P., Huria, T., . . . Cameron, V. A. (2011). A Kaupapa Māori approach to a community cohort study of heart disease in New Zealand. *Australian & New Zealand Journal of Public Health, 35*(3), 249-255. http://dx.doi.org/10.1111/j.1753-6405.2011.00702.x

Ratima, M. M., Slater, T., D'Souza, J. W., Pearce, N. E., Te Karu, H., Gemmell, T., & Fox, C., (1999). Long-term benefits for Māori of an asthma self-management program in a Māori community which takes a partnership approach. *Australian and New Zealand Journal of Public Health, 23*(6), 601-605.

Rigby, W., Duffy, E., Manners, J., Latham, H., Lyons, L., Crawford, L., & Eldridge, R. (2011). 'Closing the gap': Cultural safety in indigenous health education. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 37*(1), 21-30. https://doi.org/10.5172/conu.2011.37.1.021

Schommer, J. C., Byers, S. R., Pape, L. L., Cable, G. L., Worley, M. M., & Sherrin, T. (2002). Interdisciplinary medication education in a church environment. *American Journal of Health-System Pharmacy, 59*(5), 423.

Schumacher, J. R., Hall, A. G., Davis, T. C., Arnold, C. L., Bennett, R. D., Wolf, M. S., & Carden, D. L. (2013). Potentially preventable use of emergency services: the role of low health literacy. *Medical Care, 51*(8), 654-658. doi:10.1097/MLR.0b013e3182992c5a

Signal, L., & Ratima, M. M. (2015). *Promoting health in Aotearoa New Zealand*. Dunedin, New Zealand: Otago University Press.

Simon, T. B., Flett, A. R., & Babbage, R. D. (2014). Culturally adapted cognitive behaviour therapy for Māori with major depression. *The Cognitive Behaviour Therapist, 7*(20), 1-16. https://doi.org/10.1017/S1754470X14000233

Simmons, D., & Voyle, J. A. (2003). Reaching hard-to-reach, high-risk populations: piloting a health promotion and diabetes disease prevention programme on an urban marae in New Zealand. *Health Promotion International, 18*(1), 41-50.

Sporle, A., Davis, P., & Pearce, N. (2002). Social class mortality differences in Māori and non-Māori men aged 15-64 during the last two decades. *New Zealand Medical Journal, 115*(1150), 127-131.

Stewart. D. W., & Shamdasani. P. N. (2015). *Focus groups: Theory and practice* (3rd ed). Thousand Oaks, CA: Sage.

Walsh, C., Shuker, C., & Merry, A. (2015). Health literacy: from the patient to the professional to the system. *The New Zealand Medical Journal, 128*(1423), 10-16.

Warbrick, I., Wilson, D., & Boulton, A. (2016). Provider, father, and bro. Sedentary Māori men and their thoughts on physical activity. *International Journal for Equity in Health, 15*(1), 22. https://doi.org/10.1186/s12939-016-0313-0

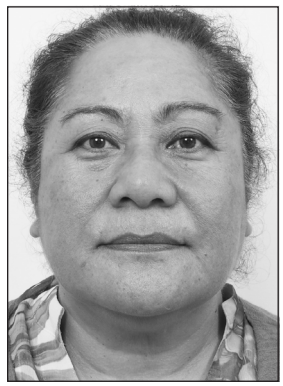
Westbrooke, I., Baxter, J., & Hogan, J. (2001). Are Māori under-served for cardiac interventions? *The New Zealand Medical Journal, 114*(1143), 484.

Wilson, P. M., Kendall, S., & Brooks, F. (2006). Nurses' responses to expert patients: The rhetoric and reality of self-management in long-term conditions: A grounded theory study. *International Journal of Nursing Studies, 43*(7), 803-818. https://doi.org/10.1016/j.ijnurstu.2005.10.011

WRITTEN CARE PLANS AND SUPPORT FOR HEALTH GOALS: IMPORTANT COMPONENTS OF LONG-TERM CONDITIONS CARE

Melanie Taylor **Claire Budge**

Chiquita Hansen **Materoa Mar**



Folole Fai

About the authors: *Melanie Taylor, RN, MN, is a project support nurse, long-term conditions, at MidCentral District Health Board (DHB), Palmerston North, New Zealand.*
Her correspondence address is: Melanie.Taylor@midcentraldhb.govt.nz

Claire Budge, PhD, is a research associate at MidCentral DHB, Palmerston North.

Chiquita Hansen, RN, MPhilNsg, is chief executive at THINK Hauora (formerly the Central Primary Health Organisation), Palmerston North, New Zealand.

Materoa Mar, RN, is upoko whakarae/chief executive at Te Tihi o Ruahine Whānau Ora Alliance, and director of Māori health at THINK Hauora, Palmerston North.

Folole Fai, RN, MN, is a senior registered nurse at MidCentral DHB, Palmerston North.

ABSTRACT

Aims: The first aim of this study was to measure the extent of care planning and support for health goals within a sample of Māori/non-Māori people with long-term conditions (LTCs). The second aim was to compare those with and without care plans, and those with and without support for health goals, with respect to health and experiences with general practice.

Background: Collaborative care planning, resulting in a written care plan, and providing support for patient-identified goals are important aspects of LTC management. In the MidCentral District Health Board region, primary care practitioners have had help to achieve this through the introduction of comprehensive assessment and care-planning tools.

Methods: 569 people with at least one LTC, who had recently enrolled in a local EnhancedCare+ programme or were receiving care from an LTC community clinical nurse, were recruited into the region's "Talking about Health" study, designed to explore LTC care from patient and provider perspectives. Consenting participants chose to complete a paper (by post) or electronic (email link) questionnaire, which included measures of health, healthy behaviours, experiences with doctors and nurses in general practice, patient activation, care planning/goal support and demographics.

Results: People with written care plans were more active self-managers, reported better interactions with primary-care doctors and nurses, and perceived receiving more support from the general practice team than those without. Results were similar for people receiving support for their health goals, but differences in mental and physical health were also evident. More Māori than non-Māori reported having a written care plan, and support for health goals in the absence of a written care plan. A slightly broader range of benefits was evident for non-Māori than Māori, but the different sample sizes need to be taken into account when drawing conclusions.

Conclusions: Written care plans and practitioner support for health goals appear to benefit people with LTCs. Support for health goals is important as, even without a written care plan, it was associated with better health and more positive ratings of practitioner interactions. Challenges for the region are to involve more people/whānau in collaborative care planning and to address system-wide barriers to embedding care-planning practices into routine care.

This article was accepted for publication in August, 2019.

KEY WORDS

Care plans, practitioner support for health goals, long term conditions, general practice, primary care, Māori.

INTRODUCTION

For many years, health practitioners and services have been challenged to redesign the way they provide effective management of long-term conditions (LTCs), with self-management a priority. Like many countries, Aotearoa New Zealand has focused on self-management, with services directed to provide care that is person-centred. This means people take a lead role in their own care planning and feel supported to work in partnership with health professionals to set goals and make action plans (MOH, 2016). Self-management includes *"the daily activities in which individuals engage, along with their family, community and health professionals, to manage a chronic illness"* (Schulman-Green, Jaser, Park, & Whittemore, 2016, p1469). One of the most effective ways of helping people to self-manage their LTCs is to personalise and plan care with them, taking heed of each individual's unique situation, abilities and aspirations. For Māori, this partnership should explore including the whānau (family), with whānau taking an active role in identifying their goals and steps towards hauora (well-being).

Literature review

Care planning is described by Burt et al (2012) as a collaborative process, where the patient and practitioner discuss diagnosis and treatment of the condition and formulate management goals together. Ideally, it should include support for self-management and behaviour change (Coulter et al, 2015). A care plan is a *written* document, recording the outcome of the care-planning process, that can serve as an extension of the medical record and as a guide to action that stimulates forward thinking and focuses on goals. It can also have a contractual purpose, such as advanced care planning during end-of-life care (Burt et al, 2014). While care-planning policy promotes capturing all of a patient's needs using a holistic approach, in practice, care plans have often been implemented using a condition-specific approach, eg to better manage a person's diabetes, rather than having a broader LTC focus (Burt et al, 2014; Lenzen, Daniels, van Bokhoven, van der Weijden, & Beurskens, 2017).

It is likely that care planning often takes place without a physical document being provided to the individual. The General Practice Patient Survey in the United Kingdom (UK) found 84 percent of patients with LTCs participated in care-planning discussions, while only 12 percent reported having a written care plan (Burt et al, 2012). Another UK study found that none of the 23 elderly patients with multiple LTCs reported explicit care-planning discussions or having a written care plan (Newbould et al, 2012). In several Australian states, care planning has been integrated into an automated, web-based collaborative, coordinated, care-management system. It was then found that patients were four times more likely than the national average to have their care plan followed up by regular review. In addition, general practitioners were more likely to follow evidence-based guidelines for those having regular reviews (90 percent compliance) than when working with patients with irregular or no care-planning reviews (50 percent compliance) (Precedence Healthcare, 2012). A recent study found that 63.7 percent of an Australian LTC sample indicated their health professional developed a plan of care with them *"to a large or great extent"* (Saunders, Carter, & Brown 2019). However, as noted earlier, developing a plan of care is qualitatively different to having a completed, written care plan.

Little information about the prevalence or outcomes of care planning for Māori or other ethnicities in Aotearoa New Zealand was found, but in a patient experience survey pilot conducted in a number of primary health organisations, only 30 percent of LTC respondents indicated they had a care plan and that it was followed up (HQSC, 2017). These figures relate to care-planning discussions and may or may not have resulted in an actual written plan.

The low uptake of care planning has been attributed to a variety of issues. The complexity of care-planning processes, the administrative burden it imposes and the potential lack of integration between care providers are all problematic (Harris & Zwar, 2007). Provider attitude can also contribute, with one study showing that practice nurses were sceptical about people's ability to set their own goals and action plans (Kennedy et al, 2014). A conversation analysis of action-planning and goal-setting talk between practice nurses and patients found the care-planning process was often dominated by the health practitioner, with the patient normally playing a passive role and not invited to share their ideas (Lenzen et al, 2018). Thille, Ward and Russell (2014) found that commonly the practitioner framed the discussion by identifying the patients' problems and proposing solutions in accordance with available services, rather than encouraging people to identify their own goals for improved health and well-being.

A Cochrane review of the benefits of care planning for people with LTCs (Coulter et al, 2015) found that the positive impact of care planning was greater when more stages of the process were completed, when contact with the health service was regular and when the person's own health professional participated. Benefits of care planning have been identified as: lower use of health services, with a 22 percent reduction in risk of being hospitalised for diabetes (Caughey et al, 2016); improved patient access to allied health services (Wickramasinghe et al, 2013); and encouragement of practitioners to follow clinical guidelines (Caughey et al, 2016; Wickramasinghe et al, 2013).

Unfortunately, even when care is planned, it may be different to what patients want or need (Kuluski et al, 2013). This is particularly problematic for those who are elderly or have co-morbidities, as they are likely to have multidimensional needs that focus on overall well-being and functioning (Francis, Carryer, & Wilkinson, 2018; Vermunt, Harmsen, Westert, Rikkert, & Faber, 2017).

The need to embed both personal goal setting and care planning into a package of care was driven by the pioneers of early self-management work. Bodenheimer et al (2002) proposed that people changed their behaviours if they had confidence in their ability to do so, and Lorig and Holman (2003) found changes in self-efficacy to be associated with changes in health behaviour and health status. Goal setting is often used as a tool to promote behaviour change (Lenzen et al, 2018), requiring patients and practitioners to mutually agree on patients' health-related goals with the aim of increasing motivation, confidence and understanding.

Confidence comes from prior and repeated success with small, realistic and person-specific goals. Patient-led problem-solving and goal setting, and efforts to enhance patient activation (ie the patient's level of active engagement both in managing their own health and engaging with health services) have been associated with improvement in outcomes for some patients (Holman & Lorig, 2004; Hibbard, Stockard, Mahoney, & Tussler, 2004). Research has shown that patients who are informed about their options have a greater desire to be involved in decision-making than those who are uninformed (Stacey et al, 2011). To use a person-centred model,

where the person's agenda or goals are prioritised, takes a shift in practice, as traditional more directive models do not provide the motivation for change. Instead the approach should be a team-based, person-centred one, enabling people with LTCs to find their own solutions and the motivation to take responsibility for their own health (Funnell, 2000).

Research context

For the last decade, the Central Primary Health Organisation (PHO) (now known as THINK Hauora) and the MidCentral District Health Board (DHB) have been engaged in redesigning primary care services to make planned, systematic and proactive care, as advocated in the Chronic Care Model (Wagner, 1998), part of everyday LTC care. The redesign was aligned with the Ministry of Health's "better, sooner, more convenient" policy (MOH, 2011) and included the introduction of a primary health care, LTC-focused, comprehensive health assessment tool (CHA) and patient care plan – with the assessment informing the content of the care plan. The assessment aimed to understand the individual's experience of living with their LTCs, and to identify the determinants of health affecting their well-being. These assessment and planning tools became an integral part of the locally-funded EnhancedCare+ programme. To improve equity, practitioners were urged to prioritise entry for those who would benefit most from this LTC programme, including Māori and Pacific people. Practitioners were expected to partner with patients, to share decision-making and identify health goals and possible interventions in accordance with best practice and patient preference. Regular care-plan reviews and updates were also required.

Despite best intentions, design of the electronic tools was hampered by problems. Some practitioners thought the care plan was too complex to be useful, while others were frustrated with the protracted redesign process. Consequently, resistance to practice change became commonplace and this, combined with the increasing demands placed on general practice, resulted in varying degrees of implementation. The quality and frequency of assessment and care-plan review differed across practitioners and health services. However, care planning, based on good assessment and using the nursing process, continued to be encouraged to support best practice.

AIMS

The overall aim of this paper was to explore care planning and practitioner support for health goals within a sample of people with LTCs in general practice. Specifically, this meant:

1) Identifying the extent to which written care plans are developed and reviewed, and to compare those participants with and without care plans with respect to self-reported health and ratings of their general practice interactions.

2) Identifying the extent to which health goals are checked on or supported, and to compare those participants with and without support for health goals with respect to self-reported health and ratings of general practice interactions.

3) Looking at the no care-plan group, to compare those with and without support for health goals with respect to self-reported health and ratings of general practice interactions.

Results are presented separately for Māori and non-Māori participants.

METHOD

The "Talking about Health" study gained approval from the Health & Disability Ethics Committee (HDEC) (ref. 16/NTA/32). Data were analysed using SPSS Statistics 20. No imputation of missing data was done. Means were calculated and chi-square and independent t-tests were performed to draw comparisons between groups.

Participants

Invitation letters were sent to all people aged 18 and over in the DHB region with a documented comprehensive health assessment during the previous three (Māori/Pacific) or two (other ethnicities) years (N=2730). The extended time period for Māori and Pacific people was implemented to encourage better representation. Interested individuals returned consent forms, and questionnaires were then sent out. An online option via SurveyMonkey was also provided.

Materials

The questionnaire for the Talking about Health study covered a wide range of topics related to health and self-management. The topics relating to the analyses in this study included general physical and mental health, healthy behaviours, patient activation, general practice experiences, care planning and support for health goals and demographics.

General health: The physical (GPH) and mental health (GMH) scales of the short form of the Patient-Reported Outcomes Measurement Information System (PROMIS; Hays, 2009) global health questionnaire were used. Each scale consists of four items, some rescaled and reverse-coded according to the scale instructions, with good internal consistency (GPH α=.81; GMH α=.86). Good validity was evidenced by correlations between PROMIS and the EQ-5D, a widely-used health-related quality-of-life measure (GPH r=.82; GMH r=.61). An additional question, seeking an overall rating, *"How much does having one or more long-term conditions affect your quality of life?"* was added, using a scale ranging from 0 ("no effect") to 10 ("very large effect").

Healthy behaviours: Use of a set of health-enhancing behaviours considered to be important to all people with LTCs was measured by asking respondents to indicate how many days each week, on average, they were carried out. A healthy behaviours scale was created by combining responses to questions about eating a balanced diet, eating fatty and sugary foods (reverse coded), doing gentle exercise, taking medication as advised and planning nice things to look forward to. Responses were averaged, allowing for one missing response, to produce a score ranging from 0-6.

Patient activation: Participants' knowledge, skill, and confidence to manage their health were assessed using the Patient Activation Measure (PAM) (Hibbard et al, 2004). Respondents were asked to indicate how much they agreed with 13 statements, using a four-point scale ranging from "disagree strongly" to "agree strongly", scored as 1 to 4, or "not applicable". Scores were calculated using a spreadsheet provided by Insignia Health LLC, which generates scores ranging from 0 to 100. Most scores fall between 39 and 95 (Greene & Hibbard, 2012). The PAM has been shown to have good internal consistency, with alphas of .81 (Prey et al, 2016) and .78 (Magnezi, Glasser, Shalev, Sheiber, & Reuveni, 2014) reported. Good construct and criterion validity were initially reported (Hibbard et al, 2004) and scores have been associated with changes in patient outcomes (Greene, Hibbard, Sacks, Overton, & Parrotta, 2015).

General practice experiences (GPE): General practice experiences were assessed in relation to doctors and nurses separately, using nine questions from the New Zealand version of the General Practice Assessment Questionnaire (Zwier, 2013). Minor wording changes were made and five additional questions developed by the study team. The item stem was: *"When you see the doctor/nurse at your practice, how good are they at . . ."* and items covered various aspects of the consultation, including listening, spending enough time, being patient and knowing you as an individual. Response options ranged from "excellent" (6) to "very poor" (1). Two of the 14 questions (relating to involvement of family/whānau/fanau in decision-making and practitioners learning about social support needs) were considered to be not applicable by a number of respondents and the total general practitioner (GPE:GP) and nurse (GPE:N) scales were calculated allowing two missing responses to accommodate this, thus retaining as many cases as possible for analysis. An additional question asking for an overall rating of *"How good is the care and support you get for managing your long-term conditions from the doctors and nurses at your general practice?"* was added, measured on a 0 ("not at all good") to 10 ("extremely good") scale.

Care planning and support for health goals: Participants were asked to indicate if they had a written care plan (yes/no/unsure); and if so, whether they were involved in its development (yes/no); if it was used on a daily basis for self-management (yes/no); and whether it was reviewed with a health professional (yes/no); and if so, how often (tick box). Care planning was defined as *"an agreement between you and your doctors and nurses to help you manage your health day-to-day. It is usually a written document you can carry with you to appointments and use at home. It can include information about your medicines, an eating or exercise plan, or goals you want to work towards, like returning to work or taking your medicines correctly. It will usually include steps towards managing your condition better".* They were also asked if a health professional checked on how they were getting on with their health goals and if they were supported in achieving them. Response options were "yes"/"no"/"I have no goals".

Demographics: Ethnicity was measured as in the New Zealand Health Survey (MOH, 2014) and participants were allowed to select more than one option. Anyone identifying as Māori, or Māori and one or more other ethnicities was counted as Māori for this study. Age was measured starting at 18-24 then increasing in 10-year increments ending at 85+ years, and sex as male or female. Income adequacy was measured by asking whether their total household income was enough to meet everyday needs, with response options of "not enough", "just enough", "enough" and "more than enough". Options for highest educational qualification were "no school qualifications", "school qualifications", "post school/polytech/trade qualification" and "university qualification". A list of common long-term conditions was provided and participants were asked to indicate which they had. A space for additional conditions was provided.

RESULTS

In this study, we explored both the activity and benefits of written care planning and practitioner support for health goals. Questionnaires were returned by 569 people (20.8 percent response rate). Participants were predominantly New Zealand or other European (82 percent), 15 percent were Māori and less than 1 percent Pacific. Just over half of the sample was female (56 percent) and the majority (62

Table 1. Mean scores and t-test results for care plan (CP) and no care plan (NCP) groups for Māori and non-Māori

	Māori					Non-Māori				
	Means			Confidence intervals		Means			Confidence intervals	
	CP	NCP	t	Upper	Lower	CP	NCP	t	Upper	Lower
Physical health	41.81	41.79	0.01	-4.12	4.15	43.81	42.17	1.66	-0.30	3.57
Mental health	45.45	44.04	0.76	-2.30	5.12	47.10	46.46	0.63	-1.33	2.60
Effect on QoL	6.05	6.14	-0.12	-1.55	1.37	5.74	5.74	0.01	-0.64	0.64
PAM	70.27	62.36	1.96	-0.13	15.95	67.13	62.21	2.61[2]	1.22	8.61
GPE:GP	5.24	4.37	3.12[2]	0.32	1.43	4.97	4.61	3.00[2]	0.12	0.59
GPE:PN	5.53	4.38	5.26[3]	0.71	1.58	5.02	4.70	2.83[2]	0.10	0.54
GPT support	9.11	7.53	4.08[3]	0.80	2.36	8.54	7.77	3.85[3]	0.38	1.18
Healthy behaviours	4.87	4.74	0.57	-0.31	0.56	5.52	5.30	1.81[1]	-0.02	0.44

[1]p<.05 [2]p<.01 [3]p<.001

CP= those with a care plan QoL= quality of life NCP= those without a care plan PAM= Patient Activation Measure
GPE:GP= general practice experiences – doctors GPE:N= general practice experiences – nurses GPT= general practice team

Table 2. Mean scores and t-test results for support for health goals (SHG) and no support for health goals (NSHG) Māori and non-Māori groups

	Māori					Non-Māori				
	Means			Confidence intervals		Means			Confidence intervals	
	HGS	NHGS	t	Upper	Lower	HGS	NHGS	t	Upper	Lower
Physical health	42.53	40.91	0.93	-1.84	5.08	44.10	41.00	4.17[3]	1.64	4.55
Mental health	46.20	42.25	2.56[1]	0.87	7.03	47.46	45.68	2.35[1]	0.29	3.26
Effect on QoL	5.93	6.35	-0.68	-1.65	0.81	5.45	5.97	-2.12[1]	-1.00	0.04
PAM	66.22	61.72	1.29	-2.45	11.44	65.52	60.56	3.45[2]	2.13	7.80
GPE:GP	5.01	4.03	4.35[3]	0.53	1.43	4.97	4.35	6.99[3]	0.44	0.79
GPE:PN	5.10	4.07	4.42[3]	0.57	1.50	5.03	4.47	6.72[3]	0.40	0.73
GPT support	8.57	7.09	3.15[2]	0.54	2.42	8.55	7.23	7.22[3]	0.96	1.67
Healthy behaviours	4.71	4.85	-0.57	-0.61	0.34	5.47	5.23	2.74[2]	0.07	0.41

[1]p<.05 [2]p<.01 [3]p<.001

HGS= those with support for health goals QoL= quality of life NHGS= those without support for health goals PAM= Patient Activation Measure
GPE:GP= general practice experiences – doctors GPE:N= general practice experiences – nurses GPT= general practice team

percent) were aged between 65 and 84 years.

Written care plans

Of the 104 (18.7 percent) respondents who indicated they had a written care plan, 23.2 percent were Māori and 18.0 percent non-Māori. Another 365 (65.8 percent) did not have a written care plan and 86 (15.5 percent) were unsure. Of those with care plans, 89 percent said they had contributed to the care plan and 71.4 percent used it for day-to-day health management. The majority (83.5 percent) indicated that a health practitioner reviewed their care plan with them; frequency of review ranged from more often than quarterly (9.2 percent) to less than annually (9.2 percent). While the modal response was quarterly (37.9 percent), 27.9 percent said it was every 12 months or less. Most people with a care plan (81 percent) also said that a practitioner provided support in reaching their health goals.

As it was likely that people with written care plans would be aware that they had them, those who indicated they were unsure were combined with those who indicated they did not have one. Demographic characteristics and scores on key study variables were then compared for these two groups: care plan (CP) and no care plan (NCP). Chi square analyses found no significant differences in the CP/NCP distribution according to sex, age, ethnicity, income adequacy or education. Also, no difference in mean number of LTCs was found between the two groups (CP *M*=3.4; NCP *M*=3.3) Independent t-tests were used to compare the care plan and no care plan groups within Māori (CP n=19; NCP n=63) and non-Māori (CP n=85; NCP n=388) separately (see Table 1). On average, Māori participants with a written care plan reported better interactions with doctors and nurses in primary care, as well as perceiving themselves to get more support from the general practice team than those without. The same was true for non-Māori, but in addition those with a care plan were more active self-managers and also indicated they engaged in healthy behaviours more frequently than those without. However in interpreting these findings, it is important to consider the smaller number of Māori participants and to look at the mean scores as well as the statistical test results. The difference in mean PAM scores is considerable for Māori, as well as for non-Māori.

Practitioner support for health goals

Practitioner support for health goals was also explored and, interestingly, 147 (28.5 percent of respondents) said they had no health goals – 24.7 percent of Māori and 29.2 percent of non-Māori. Half the sample said that a health professional regularly checked how they were getting on with their health goals and slightly more (51 percent) indicated they received support from a health professional to reach their goals. Responses to these two questions were combined to make a group who had a health professional checking on goals and/or providing support for them reaching their goals (identified as health goal support – HGS), and another group who indicated they had neither form of support (no health goal support – NHGS). No differences were found between the HGS (71.8 percent) and NHGS (28.2 percent) group membership with respect to ethnicity, age, educational level or income adequacy. However, men were more likely than women to say they received support from a health practitioner (χ^2 (1, *N*= 369) = 5.00, *p=.03*).

Additional mean comparisons between the groups, for Māori (HGS n=45; NHGS n=37) and non-Māori (HGS n=244; NHGS n=243), are

Table 3. Mean scores and t-test results for health and general practice interaction comparisons between support and no support for health goals groups within Māori and non-Māori participants with no care plans

	Māori					Non-Māori				
	Means			Confidence intervals		Means			Confidence intervals	
	HGS	NHGS	t	Upper	Lower	HGS	NHGS	t	Upper	Lower
Physical health	43.06	40.91	1.10	-1.83	9.65	43.75	40.83	3.52[3]	1.29	4.54
Mental health	46.83	42.25	2.59[1]	1.03	8.11	47.45	45.61	2.13[1]	0.14	3.55
Effect on QoL	5.85	6.35	-0.73	-1.90	0.89	5.51	5.93	-1.51	-0.97	0.13
PAM	63.25	61.72	0.38	-6.58	9.65	64.59	60.19	2.79[2]	1.30	7.50
GPE:GP	4.85	4.03	2.95[2]	0.26	1.37	4.93	4.34	6.04[3]	0.40	0.78
GPE:PN	4.79	4.07	2.59[1]	0.16	1.28	4.98	4.45	5.64[3]	0.34	0.71
GPT support	8.15	7.10	1.88	-0.07	2.19	8.47	7.15	6.53[3]	0.92	1.72
Healthy behaviours	4.60	4.85	-0.83	-0.84	0.35	5.40	5.23	1.74	-0.02	0.37

[1]p<.05 [2]p<.01 [3]p<.001

HGS= those with support for health goals QoL= quality of life NHGS= those without support for health goals PAM= Patient Activation Measure
GPE:GP= general practice experiences – doctors GPE:N= general practice experiences – nurses GPT= general practice team

displayed in Table 2 (previous page).

Māori who reported that a practitioner supported them in reaching their health goals were found to have better mental health, report more positive general practice experiences with both doctors and nurses and provided higher ratings of support received from the GPT than those without support for health goals. Looking at the means, there appeared to be a notable difference with respect to effect on quality of life and PAM scores for Māori as well. The non-Māori results indicated that the health goal support group was better off with respect to all the comparisons than the group without support.

A closer look at the no care plan group

The group who indicated they either had no written care plan or were unsure about it, were divided into two groups as before – those with a practitioner checking on or supporting them in reaching their health goals (HGS) and those without (NHGS). The latter group included those people who said they had no health goals. The two groups were compared on the same measures and the results, for Māori (HGS n=26; NHGS n=37) and non-Māori (HGS n=177; NHGS n=211) separately as before, appear in Table 3 (above).

These results suggest that even in the absence of formalised care planning, support for health goals is important. Māori participants who indicated they did receive health goal support reported better mental health and more positive general practice experiences than those without. For non-Māori, health goal support was associated with better physical and mental health, a higher level of activation and more positive general practice experiences and support from the general practice team.

DISCUSSION

The focus in this study was on exploring the extent to which written care plans are developed with people with LTCs and then given to them to assist with self-management. The emphasis was on *written* care plans, as care-planning discussions, even if documented in patient notes, may benefit practitioners in following up on treatment but are unlikely to help patients manage their conditions at home – something they need to do on a daily basis.

In this study, the number of participants with a written care plan was disappointing, only 18.7 percent reporting they had one, with a further 15.5 percent being unsure. This proportion is, however, comparable to that found by Burt et al (2012) in the United Kingdom. While slightly more Māori reported having a care plan (23.2 percent), there is room for considerable improvement in light of the DHB region's goal of improving equity and providing better LTC care, and improving this number would be a good goal to work towards. The development of a care plan was a compulsory requirement of the EnhancedCare+ programme and at the time, good leadership promoted the principles of effective patient engagement, self-management and self-management support. It is likely that the inability to provide electronic tools that practitioners liked and would use affected the uptake; however, other reasons may have contributed, such as a lack of time within the consultation. It is also possible that not all practitioners consider care planning to be part of their role, and some may assume it is being carried out by another member of the multidisciplinary team. Other likely contributing factors could be the many demands placed on general practice and a reluctance to change from familiar service-delivery models – primarily

those focused on acute care delivery. The finding that there was no difference in the number of LTCs experienced by those with and without a care plan is interesting and warrants further investigation. It may be that certain practitioners routinely engage in care planning, while others do not, and that the patient's complexity level does not alter standard practices. Blakeman et al (2006) note that practitioners may not be prepared to invest energy into care planning if they don't consider the evidence warrants it.

A large proportion of people with care plans reported contributing to the care plan, which is a key feature of the goal-setting and review process (Cramm & Nieboer, 2015; Funnell, 2000; Sidani & Fox, 2014). Regular review with the individual/whānau accommodates changing needs and enables important support to be provided (Morgan et al, 2016). However, a small group of participants (11 percent) reported having no involvement in care planning, which may indicate a lack of collaboration between the individual and practitioner in deciding on health goals and how to achieve them. Likewise, a small group said that they didn't participate in a care-plan review (16.5 percent). While 71 percent of people with care plans reported using it to help manage their health day to day, close to a third did not. We have to ask why not. Perhaps the care plans were not understood, written simply enough, realistic or individualised enough to be meaningful. Alternatively, the link to management at home may not have been made, particularly if the person did not feel appropriately involved and listened to in care-planning conversations.

The importance of collaborative goal setting and practitioner support for achieving goals was promoted within care-planning education. It was assumed that at least this could be integrated into practice, even if more extensive care planning was not. Unfortunately, it appears that only half of the group was supported in this way, and we were surprised by the finding that almost a third said they had no health goals at all. While the rate was slightly lower for Māori, perhaps indicating that more conversations were held, health literacy might be a contributing factor (as "health goals" were not explicitly defined in the questionnaire), or people may have forgotten that a conversation took place. Likewise, people may have resisted practitioner suggestions for behaviour change and consequently no goals were set. Weariness could also be a factor, particularly with co-morbidity, as *"patients have to force themselves to accomplish previously effortless physical tasks that become harder and harder as time passes"* (Francis et al, 2018, p4). More likely, practitioners chose not to meet the programme requirements, found that conversations on care planning or goal setting were difficult, or were not invested in providing self-management support (Cramm & Nieboer, 2015).

A second focus was on the benefits of having written care plans and/or support for health goals and these were apparent when comparisons of mean scores were made. Those with care plans rated their general practice experiences and support more highly, and non-Māori had higher activation and engaged in healthier behaviours, then those without. Having support for health goals showed a similar pattern of means, with better mental health for both ethnicities also being included.

A potentially important finding was that for the group without a written care plan, having practitioner support for health goals was still of benefit. Better mental health was identified for Māori and non-Māori, as well as higher ratings of general practice experiences. Additional differences were found for the larger non-Māori group. Further exploration of this would be beneficial, especially as there appears to be a dearth of literature on the benefits of practitioners providing support for patient-centred health goals.

The small number of Māori included in the study must be acknowledged, as the magnitude of the means show similar effects for both Māori and non-Māori in general. It is also important to acknowledge the more complex experience and definition of health for Māori with "self-management" encompassing support from whānau in its broadest meaning. Involving whānau in consultations, planning and support for goal setting, and ensuring they are prioritised for LTC care, is essential to support Māori – both with behaviour change activities and with their overall ability to manage LTCs on a daily basis. Cram, Smith and Johnstone (2003) identified the importance for Māori of receiving understandable – including visual – information, and receiving support and follow-up when accessing health services and making behavioural changes. These are clearly integral to the care-planning process. Pitama, Huria and Lacey (2014) describe an indigenous health framework which, based on a revised Meihana Model and the hui process, supports practitioners working with Māori people and their whānau to improve health outcomes.

The identified poor uptake of care planning may be indicative of a bigger issue. Practitioners want people to take responsibility for their own health; however, it appears that they themselves may be unwilling to undergo the level of practice change necessary for this to occur. Self-management does not magically happen, but requires concerted effort by practitioners and practice teams to help people develop the knowledge and skills required, and gain the confidence to act on them.

Limitations

The low response rate is a major limitation of this study, as the sample cannot be considered representative of the study population. This is particularly true for the Māori subsample, and consequently it is more important to look at the magnitude of the mean differences as they may provide a better sense of the effect size than the significance of the t-test results. For example, with respect to the patient activation findings, a 5-point difference in scores is considered to be of clinical significance (Fowles, Terry, Xi, Hibbard, Bloom, & Harvey, 2009) and this was found in the current study for both ethnicities. The sample is only taken from the MidCentral DHB region, which limits its broader generalisability. While "care plans" were described simply, we did not define "health goals" and this may have had some impact on participants' responses. The study was self-report, and data is therefore prone to the same biases as any other self-report research. However, it is difficult to collect this type of information in other ways, given that our interest was in people's perceptions of their own health and self-management and the general practice-based care they receive for their LTCs.

CONCLUSIONS

The identified benefits for patients who have a written care plan, or who receive support in achieving health goals, endorse the widespread need for these tools to be used in practice. Improved health and well-being, quality of life, experiences with general practice, and self-management ability are potentially life changing, and support the New Zealand Health Strategy's vision *"to enable people to live well, stay well and get well"* (MOH, 2016). Coulter, Locock, Zieband and Calabrese (2014) urge that patient experience

data such as this be used to enhance care provision rather than just being collected for research; hence it is very important that these findings benefit clinical practice. Tips for effective care planning and goal setting in clinical practice have been appended. These are based on literature, the first author's years of experience working in this field and from talking to patients and practitioners in primary care.

Based on our study, improvements suggested to the PHO included those that would increase the number of people having access to these tools and level of support and to prioritise Māori in order to improve health inequalities. Unfortunately, its realisation relies on the interplay of many complex factors including: having tools that practitioners like and have been educated to use; practitioners having dedicated time to be able to do this work and provide follow-up; and changing the consultation talk so that people can set their own goals, rather than those of the practitioner. In our view, it is only then that we will see more success in embedding written care plans and goal setting into every-day practice.

Acknowledgement: The authors would like to acknowledge the anonymous reviewers for their helpful comments.

REFERENCES

Bodenheimer, T., Lorig, K., Holman, H., & Grumbach, K. (2002). Patient self-management of chronic disease in primary care. *JAMA, 288*(19), 2469-2475. doi:10.1001/jama.288.19.2469

Blakeman, T., Macdonald, W., Bower, P., Gately, C., & Chew-Graham C. (2006). A qualitative study of GPs' attitudes to self-management of chronic disease. *British Journal of General Practice, 56*(527), 407–14.

Burt, J., Rick, J., Blakeman, T., Protheroe, J., Roland, M., & Bower, P. (2014). Care plans and care planning in long term conditions: a conceptual model. *Primary Health Care Research & Development, 15*(4), 342-354. doi:10.1017/S1463423613000327

Burt, J., Roland, M., Paddison, C., Reeves, D., Campbell, J., Abel, G., & Bower, P. (2012). Prevalence and benefits of care plans and care planning for people with long-term conditions in England. *Journal of Health Services Research & Policy, 17*(Suppl 1), 64-71. doi:10.1258/jhsrp.2011.010172

Caughey, G. E., Vitry, A. L., Ramsay, E. N., Gilbert, A. L., Shakib, S., Ryan, P., Esterman, A., McDermott, R. A., & Roughead, E. E. (2016). Effect of a general practitioner management plan on health outcomes and hospitalisations in older patients with diabetes. *Internal Medicine Journal, 46*(12), 1430-1436. doi:10.1111/imj.13286

Coulter, A., Entwistle, V. A., Eccles, A., Ryan, S., Shepperd, S., & Perera, R. (2015). Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews, 3*(3), CD010523. doi:10.1002/14651858.CD010523

Coulter, A,. Locock, L., Ziebland, S., & Calabrese, J. (2014). Collecting data on patient experience is not enough: they must be used to improve care. *British Medical Journal, 348*, g2225. doi:10.1136/bmj.g2225

Cram, F., Smith, L., & Johnstone, W. (2003). Mapping the themes of Māori talk about health. *New Zealand Medical Journal, 116*(1170). http://www.nzma.org.nz/journal/116-1170/357/

Cramm, J. M., & Nieboer, A. P. (2015). Chronically ill patients' self-management abilities to maintain overall well-being: what is needed to take the next step in the primary care setting? *BMC Family Practice, 16,* 123. doi:10.1186/s12875-015-0340-8

Fowles, J. B., Terry, P., Xi, M., Hibbard, J., Bloom, C. T., & Harvey, L. (2009). Measuring self-management of patients' and employees' health: further validation of the Patient Activation Measure (PAM) based on its relation to employee characteristics. *Patient Education and Counseling, 77,* 116-129.

Francis, H., Carryer, J., & Wilkinson, J. (2018). Patient expertise: Contested territory in the realm of long-term condition care. *Chronic Illness, 15*(3), 197-209. https://doi.org/10.1177/1742395318757853

Funnell, M. M. (2000). Helping patients take charge of their chronic illnesses. *Family Practice Management, 7*(3), 47-51.

Greene, J., & Hibbard, J. H. (2012). Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. *Journal of General Internal Medicine, 27*(5), 520–526. doi:10.1007/s11606-011-1931-2

Greene, J., Hibbard, J., Sacks, R., Overton, V., & Parrotta, C. D. (2015). When patient activation levels change, health outcomes and costs change, too. *Health Affairs, 34*(3), 431-437. doi:10.1377/hlthaff.2014.0452

Harris, M. F., & Zwar, N. A. (2007). Care of patients with chronic disease: the challenge for general practice. *Medical Journal of Australia, 187*(2,) 104-107. doi:10.5694/j.1326-5377.2007.tb01152.x

Hays, R. D., Bjorner, J. B., Revicki, D. A., Spritzer, K. L., & Cella, D. (2009). Development of physical and mental health summary scores from the patient-reported outcomes measurement information system (PROMIS) global items. *Quality of Life Research, 18*(7), 873-880. doi:10.1007/s11136-009-9496-9

Health Quality & Safety Commission (HQSC). (2017). *Primary care patient experience survey: Results from the first year of pilots.* Wellington: Author. https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Primary_care_experience_survey_report_Dec_2017_final.pdf

Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. (2004). Development of the Patient Activation Measure (PAM): Conceptualizing and measuring activation in patients and consumers. *Health Services Research, 39*(4pt1), 1005-1026. https://doi.org/10.1111/j.1475-6773.2004.00269.x

Holman. H., & Lorig, K. (2004). Patient self-management: a key to effectiveness and efficiency in care of chronic disease. *Public Health Reports, 119*(3), 239-243. doi:10.1016/j.phr.2004.04.002

Kennedy, A., Rogers, A., Bowen, R., Lee, V., Blakeman, T., Gardner, C., . . . Chew-Graham, C. (2014). Implementing, embedding and integrating self-management support tools for people with long-term conditions in primary care nursing: a qualitative study. *International Journal of Nursing Studies, 51*(8), 1103-1113. doi:10.1016/j.ijnurstu.2013.11.008

Kuluski, K., Gill, A., Naganathan, G., Upshur, R., Jaakkimainen, R. L., & Wodchis, W. P. (2013). A qualitative descriptive study on the alignment of care goals between older persons with multi-morbidities, their family physicians and informal caregivers. *BMC Family Practice, 14,* 133. http://www.biomedcentral.com/1471-2296/14/133

Lenzen, S. A., Daniëls, R., van Bokhoven, M. A., van der Weijden, T., & Beurskens, A. (2017). Disentangling self-management goal setting and action planning: A scoping review. *PLoS ONE, 12*(11), e0188822. https://doi.org/10.1371/journal.pone.0188822

Lenzen, S. A., Stommel, W., Daniëls, R., van Bokhoven, M. A., van der Weijden, T., & Beurskens, A. (2018). Ascribing patients a passive role: Conversation analysis of practice nurses' and patients' goal setting and action planning talk. *Research in Nursing & Health, 41*(4), 389-397. https://doi.org/10.1002/nur.21883

Lorig, K. R., & Holman, H. (2003). Self-management education: History, definition, outcomes, and mechanisms. *Annals of Behavioral Medicine, 26*(1), 1-7. https://doi.org/10.1207/S15324796ABM2601_01

Magnezi, R., Glasser, S., Shalev, H., Sheiber, A., & Reuveni, H. (2014). Patient activation, depression and quality of life. *Patient Education and Counseling, 94,* 432-437. https://doi.org/10.1016/j.pec.2013.10.015

Ministry of Health (MOH). (2011). *Better, Sooner, More Convenient Health Care in the Community*. Wellington: Author.

Ministry of Health (MOH). (2014). *New Zealand Health Survey*. Retrieved from https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey

Ministry of Health (MOH). (2016). *Self-management Support for People with Long-term Conditions* (2nd ed). Wellington: Author.

Morgan, H. M., Entwistle, V. A., Cribb, A., Christmas, S., Owens, J., Skea, Z. C., & Watt, I. S. (2016). We need to talk about purpose: a critical interpretive

synthesis of health and social care professionals' approaches to self-management support for people with long-term conditions. *Health Expectations, 20*(2), 243-259. https://doi.org/10.1111/hex.12453

Newbould, J., Burt, J., Bower, P., Blakeman, T., Kennedy, A., Rogers, A., & Roland, M. (2012). Experiences of care planning in England: interviews with patients with long term conditions. *BMC Family Practice, 13*, 71. https://doi.org/10.1186/1471-2296-13-71

Pitama, S., Huria, T., & Lacey, C. (2014). Improving Māori health through clinical assessment: Waikare o te Waka o Meihana. *New Zealand Medical Journal, 127*(1393), 117-129.

Precedence Healthcare. (2012). *Digital Regions Initiative cdmNet Australia. Final Report July 2009 – September 2012*. Australian Government, Department of Broadband, Communications and the Digital Economy. Retrieved from http://precedencehealthcare.com/site/wp-content/uploads/DRI-Final-Report-20121212.pdf.

Prey, J. E., Qian, M., Restaino, S., Hibbard, J., Bakken, S., Schnall, R., . . . Creber, R. (2016). Reliability and validity of the patient activation measure in hospitalized patients. *Patient Education and Counseling, 99*(12), 2026-2033. https://doi.org/10.1016/j.pec.2016.06.029

Saunders, C., Carter, D., & Brown, J. J. (2019). Primary care experience of older Australians with chronic illness. *Australian Journal of Primary Health, 25*(1), 13-18. https://doi.org/10.1071/PY18098

Schulman-Green, D., Jaser, S. S., Park, C., & Whittemore, R. (2016). A meta-synthesis of factors affecting self-management of chronic illness. *Journal of Advanced Nursing, 72*(7), 1469-1489. https://doi.org/10.1111/jan.12902

Sidani, S., & Fox, M. (2014). Patient-centred care: clarification of its specific elements to facilitate interprofessional care. *Journal of Interprofessional Care, 28*(2), 134-41. https://doi.org/10.3109/13561820.2013.862519

Stacey, D., Bennett, C. L., Barry, M. J., Col, N. F., Eden, K. B., Holmes-Rovner, M., . . . Thomson, R. (2011). Decision aids for people facing health treatment or screening decisions. *Cochrane Database Systematic Reviews, 10*, CD001431. https://doi.org/10.1002/14651858.CD001431.pub3

Thille, P., Ward, N., & Russell, G. (2014). Self-management support in primary care: Enactments, disruptions, and conversational consequences. *Social Science & Medicine, 108*, 97-105. http://dx.doi.org/10.1016/j.socscimed.2014.02.041

Vermunt, N. P. C. A., Harmsen, M., Westert, G. P., Rikkert, M. G. M. O., & Faber, M. J. (2017). Collaborative goal setting with elderly patients with chronic disease or multimorbidity: a systematic review. *BMC Geriatrics, 17,* 167. https://doi.org/10.1186/s12877-017-0534-0

Wagner, E. H. (1998). Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice, 1*(1), 2-4.

Wickramasinghe, L. K., Schattner, P., Hibbert, M. E., Enticott, J. C., Georgeff, M. P., & Russell, G. M. (2013). Impact on diabetes management of General Practice Management Plans, Team Care Arrangements and reviews. *Medical Journal of Australia, 199*(4), 261-265.

Zwier, G. (2013). A standardized and validated patient survey in primary care: Introducing the New Zealand General Practice Assessment Questionnaire (NZGPAQ). *New Zealand Medical Journal, 126*(1372), 47-54.

APPENDIX: Care plans – common problems and goal-setting tips for practitioners

Common problems	Recommended practice
The practitioner identifies problems or conditions and wants to use these as a basis for goal-setting.	• Rather than starting with problems, ask the person to discuss their health aspirations and then what challenges they have. These may or may not be health-related and make a good start for goal-setting. • Understand that improved health may not be a priority for some people. Investigate what their priority is and link it to their health. • Working with the person's rather than the practitioner's goals is integral to success. • People may resist if they think you are telling them what to do. Let them decide on the concerns and the actions they would like to take. • At every point of interaction, ask about who, if anyone, they would like to involve.
The practitioner takes the lead throughout the discussion.	• It is good for a practitioner to start the conversation, but to allow space for the person to think and respond. • Practitioners need to move away from thinking about people as service recipients, as they usually go along with this role division which does not encourage collaboration. • People *are* able to engage in conversations about their health and well-being. They are the experts in living with their long-term conditions, as they do it every day. • Ideally, people should do most of the talking and practitioners most of the listening.
The person feels unsupported.	• Encourage people to bring their family/whānau to these meetings to provide support, a second pair of ears, and to ensure cultural needs are met. • Encourage people to get support from others and from organisations.
Health goals are not documented.	• Document the person's goals in the clinical record or as part of their care plan, so that all practitioners involved can provide encouragement and support. • Include a section within the written care plan that allows the person or whānau to make notes and put down ideas to discuss at the next contact. • Ensure that they take a copy home. Some may elect not to have them, but as part of routine practice they should be encouraged to take it and use it.

continues over page

cont. APPENDIX: Care plans – common problems and goal-setting tips for practitioners	
Common problems	**Recommended practice**
The person's health literacy requirements are not met.	• Assume that people are not familiar with care-planning or goal-setting terms and explain the terms simply. • Consider developing information material which can be given out prior to the care-planning and/or goal-setting consultation. This would better aid people's understanding and give them a chance to think about what they would like to say prior to the appointment.
An individual condition approach, rather than a broader, holistic, multi-morbidity LTC approach is taken.	• First and foremost, focus on what matters to the person and whānau. • Sometimes practitioners focus on one condition, such as diabetes, at the expense of the others. This can happen when it is the area of greatest concern for them or is their specialty area of practice. Instead, have a broader focus, by thinking about how the person lives with their LTCs as a set. Consider context, determinants of health, other co-morbidities, the person's preferences and cultural and health literacy requirements to produce a care plan that best meets their needs. • Access other health professionals (when needed) to contribute to the plan.
The care plan is not meeting the person's needs.	• Consider brainstorming needs at the start of the discussion and ask the person to prioritise their most important concerns. • Discuss whether they are ready, willing and able to do the work required to meet the goals set. Use the importance confidence ruler to see if achievement of goals is likely and realistic. • If the goal appears unrealistic, consider reducing it or breaking it into several more manageable steps. • Once an achievable and realistic goal has been discussed, make sure it is specific, measurable and timely (SMART goal).
The care plan is not reviewed regularly.	• Regular review and updating of the plan/goals is part of good self-management support. • The person's social context may change, and different factors may become a priority. For example managing a fall, the death of a loved one, or dealing with new problematic symptoms. • Consider use of phonecalls or email contact instead of face-to-face review if time or finances are a major constraint.
The practitioner is unsure of the process or lacks confidence to have care-planning or goal-setting conversations.	• Seek additional training or education opportunities. • Identify a mentor or discuss as part of professional supervision. • Sit in with another practitioner while a care plan is developed.
Practitioner/practice team is unable to provide self-management support within the current care-delivery model.	• Identify this as a problem and discuss at next team meeting; 'protected time' is essential. • Identify other services that can do this better and refer people if appropriate. • Start small, and build activities using a quality improvement approach. • Invite people to be responsible for contacting the service, rather than vice versa. • Consider more active use of the patient portal.

FACTORS AFFECTING ACCESS TO IMMUNISATION OF UNDER-FIVE-YEAR-OLDS

Cilla Wyllie-Schmidt

Zoë Tipa

About the authors: *Cilla Wyllie-Schmidt, RN, MProfPrac, is the clinical nurse coordinator for the hospital opportunistic immunisation service, Waikato District Health Board, Hamilton, New Zealand. Her correspondence address is: Cilla.Wyllie-Schmidt@waikatodhb.health.nz*

Zoë Tipa, RN, MPhil, PhD candidate AUT, is a principal lecturer at the Centre for Health and Social Practice, Waikato Institute of Technology, Hamilton, New Zealand.

Patricia McClunie-Trust, RN, PhD, is a principal lecturer, at the Centre for Health and Social Practice, Waikato Institute of Technology, Hamilton.

Patricia McClunie-Trust

This article was accepted for publication in September, 2019.

ABSTRACT

Aim: The research reported in this article explored factors affecting access to immunisation of under-five-year-olds. In particular, it aimed to illuminate potential obstacles for whānau[1] that might have an impact on timely immunisation of tamariki[2].

Background: Immunisations are effective in preventing communicable diseases. The 2017 New Zealand national immunisation schedule offers free protection to children under 18 years of age against 13 vaccine-preventable diseases. A proportion of New Zealand children under five years old have either had missed or delayed vaccinations.

Methodology: An integrative review approach was used to aggregate and examine the findings of published international research on factors affecting timely immunisation of tamariki. An inductive thematic analysis, drawing on techniques from constructivist grounded theory, guided analysis of data.

Findings: "How people live", "how people understand", and "how people access health services" were key themes identified in the examined research. Challenges families experience internationally seem consistent with those potentially encountered by whānau in New Zealand. Child poverty is an intrinsic barrier to immunisations for tamariki. The level of education of whānau directly affects health literacy. There may also be links between formal education, income, and accessibility of health services.

Conclusions: Health-service providers need to consider how to facilitate timely immunisations for all tamariki. Helping whānau recognise and overcome the obstacles they face may improve access. Promoting community engagement may also create more equitable access to immunisation services.

KEYWORDS

Immunisation, communicable disease, prevention, children, tamariki.

INTRODUCTION

A timely immunisation programme is a vital public health intervention to prevent communicable diseases among tamariki (children). In line with World Health Organization (WHO) recommendations, New Zealand has an endorsed national immunisation schedule that offers free, well-timed protection from serious vaccine-preventable diseases to all tamariki in New Zealand (MOH, 2017a). Despite this, many tamariki are reported as under-vaccinated, an issue of concern to nurses working in primary care and child health-care services (MOH, 2018b). The purpose of this integrative review was to explore published international research to understand more about what influences whānau in accessing timely immunisations for tamariki in Aotearoa New Zealand.

BACKGROUND

Immunisation is one of the most effective interventions to prevent disease worldwide (Plotkin et al, 2012). The New Zealand national immunisation schedule offers free protection to children under 18 years of age against 13 harmful vaccine-preventable diseases: Diphtheria, pertussis, tetanus, rotavirus, haemophilus influenza type b (Hib), polio, hepatitis B, pneumococcal disease, measles, mumps, rubella, varicella and human papilloma virus (MOH, 2017a). The inclusion of the specific vaccines on the schedule and the stipulated

1. The Māori word whānau is used in this article to refer to caregivers, parents and families
2. Tamariki is the Māori name for children.

timing of immunisation events is consistent with WHO recommendations (2013, 2017a, 2017b) .

The recommended timings of immunisation events, according to the 2017 national immunisation schedule for children, are at age: six weeks; three, five and 15 months; then at four and 11 years of age.

The purpose of a schedule is to ensure tamariki are fully protected against vaccine-preventable diseases at an early age when they are most at risk of severe disease. Delayed or missed vaccinations (Grant et al, 2016; Mueller et al, 2012; Turner et al, 2017) make tamariki susceptible to disease, and the potential impact of that disease on both tamariki and whānau (Corbett, 2013). The Institute of Environmental Science and Research (ESR, 2017) reported on the following vaccine-preventable disease cases in children under five years of age in 2016: invasive pneumococcal disease (46 cases), measles (29 cases, half of which were in children less than one year of age), pertussis (177 cases), rubella (one case). There was one case each of diphtheria, tetanus and haemophilus influenza b.

Immunisation coverage is measured as a percentage of the eligible population that have received the immunisations by a particular age. As an indicator of timeliness, Aotearoa New Zealand has an immunisation target of 95 percent for all tamariki turning eight months of age to have completed their first three immunisation events (MOH, 2017a). At the end of 2017, the immunisation coverage for infants receiving the first three immunisation events on time by eight months of age was 92.2 percent (MOH, 2018a). The coverage rate can be affected by those that opt off the national immunisation register, and by whānau who delay or decline immunisations. Immunisation coverage in Aotearoa New Zealand is consistently reported as lower among some populations and in some geographical areas (Gilbert & Wrigley, 2009; Grant et al, 2010; Kiedrzynski, Bissielo, Suryaprakash, & Bandaranayke, 2015; Pal, Goodyear-Smith, & Exeter, 2014). According to the MOH (2018a), at the end of 2017, immunisation coverage for people who identify as New Zealand European was 93.2 percent, compared to coverage for Māori at 88.7 percent and Pacific people at 94 percent. In New Zealand, primary-care health providers have the major responsibility to deliver national immunisation schedule vaccines. As Wilson (2009, p9) noted, *"the majority of under-immunisation in New Zealand does not arise from opposition to vaccination and those in greatest need of immunisation are missing out"*. Unfortunately, there are many whānau and tamariki in Aotearoa New Zealand who do not have equitable access to primary health care.

METHODS

A qualitative integrative review approach was used to synthesise published research and other literature on factors affecting access to immunisation of under-five-year-olds. The integrative review method enables researchers to synthesise research from a variety of methodological approaches (Whittemore & Knafl, 2005). The research question was: *"What are the factors affecting access for whānau who seek to immunise their under-five-year-olds?"*

Stages of the integrative review

There are five stages to the integrative review process, including problem identification, location of the studies, evaluation of the studies, collection of data, and finally, data analysis and presentation (Evans, 2007). The first stage, problem identification, ensured the focus of the review was defined. In the second stage, a large number of citations for published research were reviewed to identify a relatively small number of relevant articles. Databases searched for this review included Pubmed/MEDLINE, Mednar, DOAJ, Ebscohost, ProQuest, ScienceDirect and Gale. Key search terms (shown above in Table 1) were used in various combinations and collectively as phrases.

The third stage involves evaluation of the studies. Selected articles were screened using a CASP (critical appraisal skills programme) qualitative review evaluative tool (CASP, 2017). The aim of the critical appraisal at this stage was to ensure only rigorous studies were

Table 1. Key search terms

Immunis/zation	Under-5-year-olds	Whānau	Factors
immunize* (immunise)	children	parents	challenges
vaccine*	infant	caregivers	barriers
	babies	family	obstacles

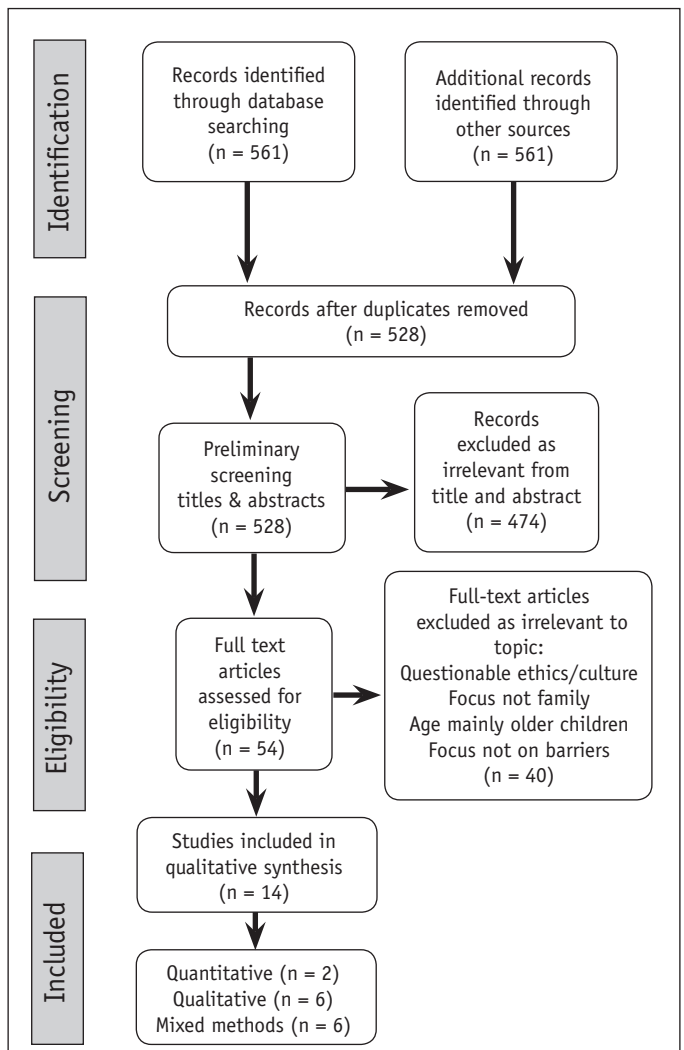


Figure 1. PRISMA diagram showing selection process

Table 2. Summary of studies selected for review

Study	Sample	Methods	Purpose	Conclusion
1. Legesse and Dechesa (2015) Ethiopia	Mothers and caregivers of children agd 12-23 months (*n*=591).	Qualitative cross-sectional study, focus group discussion and in-depth interview.	To assess complete immunisation coverage and associated factors.	Maternal health care utilisation and knowledge of mother are the main factors associated with complete immunisation coverage.
2. Riggs et al. (2012) Australia	Mothers (*n*=87)	Mixed methods study design informed by the socioecological model of health and a cultural competence approach, focus groups and interviews.	To explore experiences of using maternal child health (MCH) services from the perspective of families from refugee backgrounds and service providers.	Although parents had good initial access to and experience of using MCH services, significant barriers remain.
3. Pearce et al. (2015) Australia	Mothers/caregivers of children aged 3-19 months (n=5107).	Quantitative cross-sectional analysis of secondary data.	To examine the barriers to childhood immunisation experienced by parents in Australia.	The majority of incompletely immunised infants did not have a mother who disagreed with immunisation. Barriers to immunisation are heterogeneous, suggesting a need for tailored interventions.
4. Niederhauser and Markowitz (2007) USA	Parents, guardians, foster parents of children aged 24-59 months (*n*=64).	Qualitative single category, focus group design study.	To explore barriers to immunisations for parents whose children are not fully immunised by age two.	Five core themes emerged as barriers to childhood immunisations – parental, transportation, financial, child and organisation.
5. Willis et al. (2016) USA	Parents/caregivers of children median age 6 years (*n*=565).	Mixed methods community-based participatory research approach using surveys, and focus group discussions.	To reduce disparities in childhood immunisations.	Multi-layered interventions contributed to the elimination of immunisation disparities in children. A culturally tailored approach is effective.
6. Barbirye et al. (2011) Uganda	Mothers (*n*=58) and fathers (*n*=15) of children aged less than 5 years.	Qualitative focus group discussions and key informant interviews.	To examine influences on immunisation behaviour using the attitude/social influence/self-efficacy model.	Immunisation programmes should position themselves to address social contexts.
7. Jackson et al. (2017) United Kingdom	Family members (*n*=174).	Qualitative cross-sectional interview study informed by social ecological model.	To investigate views of travellers on barriers and facilitators to immunisation uptake and explore ideas for improving uptake, examining why responses vary across and within communities.	Common accounts of barriers and facilitators were identified, similar to those documented in the general population.
8. Tickner, Leman and Woodcock (2009) England	Parents of children aged 2-5 years (*n*=21).	Qualitative semi-structured interviews.	To explore parents' views about pre-school immunisation and to identify possible reasons for low uptake.	Parents reported uncertainties, anxieties and time constraints.
9. Adorador et al. (2011) USA	Mothers of children aged 2 months to 18 years (mean=6 years) (*n*=108).	Qualitative descriptive survey.	Identify low-income Latino mothers' perceived barriers to immunisation.	Latino mothers' perception of immunisations and knowledge of up-to-date status influenced their children's immunisation status.

CONTINUES ON NEXT PAGE

cont Table 2. Summary of studies selected for review

Study	Sample	Methods	Purpose	Conclusion
10. Odutola et al. (2015) Gambia	Mothers of children aged 12-59 months (*n*=1448).	Mixed methods cross-sectional survey.	To study the timeliness of routine vaccinations among children aged 12-59 months attending infant welfare clinics in semi-urban areas of The Gambia, a country with high vaccine coverage.	Despite high vaccination coverage reported in The Gambia, a significant proportion of children's vaccines were delayed for reasons related to health services as well as the profile of the mothers.
11. Semali (2010) Tanzania	Parents of children <5 years of age (*n*=3471).	Quantitative descriptive statistics.	To determine the trend in disparities in completion of immunisation using Tanzania demographic and health surveys.	Equity that existed in 1990 was more pronounced in 1996 and regressed to inequity in 2005, with significant disparity associated with changing context and reforms.
12. Garcia et al. (2014) Colombia	Parents of children <5 years of age (70% had incomplete immunisation schedules) (*n*=4802).	Mixed methods survey.	To understand immunisation attitudes and knowledge, perceived service quality, and barriers to childhood immunisation to tailor communication strategies.	A better understanding of immunisation barriers was gained to be able to tailor communication strategies to increase demand for immunisation services.
13. Opwora et al. (2011) Kenya	Family of children aged 0-60 months (*n*=397).	Mixed method descriptive cross-sectional interviews.	To investigate the barriers to accessing health-care services.	Caregivers' actions were thought to influence children's progression to illness or health, while health-care delivery system posed recurrent barriers to access.
14. Cockroft et al. (2014) Nigeria	Mothers and caregivers of children (*n*=5257).	Mixed methods cross-sectional survey.	To examine coverage of measles vaccination and reasons for not vaccinating children.	Measles vaccination remains suboptimal. Efforts to counter negative perceptions about vaccination and to ensure vaccinations are provided free may help increase vaccination rates.

included in the review. The fourth stage, data collection, involved accurate and complete documentation of all relevant findings from the identified studies (Evans, 2007). The fifth stage was data analysis and presentation of findings from the review. An inductive thematic approach to data analysis was informed by constructionist grounded theory research methodology (Guest, MacQueen, & Namey, 2012).

FINDINGS

Three key themes emerged as obstacles for immunisation – "how people live", "how people understand", and "how people access health services". This section uses the terms "children" and "families" consistently with the way they are used in the reviewed research.

How people live

The main elements of the theme "how people live" included lack of support, financial struggles, number of children in family, transient or moving since birth, lack of time and work commitments. Lack of support was identified in many studies [1, 2, 3, 4, 5, 6] as low social contact, or lack of help from the father or other family and the wider community, which were barriers to getting children immunised. One study [6] found mothers felt *"stigmatized and bullied by other women"* for not having *"presentable clothing"* to attend appointments. Low income was identified as a significant barrier in half of the studies [1, 3, 6, 9, 10, 13, 14]. For example, participants in study 6 spoke of having to choose between food and other provisions and paying for transport to get their children immunised.

Birth order and location of birth were factors that also affected access to immunisations – immunisations decreased with each successive birth in some families. The location of birth was important, with more children being immunised when born in a birth facility than those born at home [2, 10, 14], and fewer children being immunised the more moves a family had made since the birth of a child [2, 3, 4, 7, 9]. Work commitments were another significant barrier to getting children immunised. This included: being unable to miss work due to the resulting loss of income or work; what employers would think of their absence; and lack of time because of working. Half the studies reported competing commitments – such as caring for other family members and increased responsibilities at home – as barriers to

getting children immunised [2, 4, 7, 8, 9, 12, 14].

How people understand

Parents' or caregivers' level of knowledge affected their engagement with many aspects of the immunisation process and was a significant barrier for many parents. Health literacy, or the ability to understand information provided by health-care providers (this included immunisation support people, nurses and doctors) was important when parents or caregivers were making decisions about whether to vaccinate. Having less education affected parents' or caregivers' knowledge of vaccine-preventable diseases and the importance of vaccines [1, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14]. Often, low literacy equated with low health literacy. Health literacy was identified as an issue in four studies [4, 5, 7, 14], and in particular when *"medical jargon"* was used by health-care providers.

Knowledge of vaccine-preventable diseases and immunisation schedules (number of doses, what diseases they protected for, why they were needed) was reported as absent or incorrect among participants in eight studies [1, 2, 4, 5, 8, 9, 10, 14]. One study [2] also reported lack of knowledge about what immunisation services were available as a barrier. Being connected to, and having a *"good experience"* with health-care providers was important in facilitating immunisation [1, 2, 5, 7, 8, 9, 12, 13], while lack of trust in the health-care provider was identified as a barrier [6]. Three studies [5, 6, 7] reported participants feeling judged by health-care providers, including *"feeling discriminated"* against *"and marginalized"* [7].

Who was responsible for the decision to vaccinate varied across the studies. Four studies found this decision was the mother's responsibility [5, 7, 8, 10], while three others identified fathers as the decision-maker [6, 7, 14]. Two reported a joint or collective decision [6, 14] and some reported that older-generation family members were responsible [6, 7]. The person responsible for making the decision could be a barrier to immunisation as sometimes decisions were made not to vaccinate. One study reported that parents were not always in agreement about whether to immunise [6]. An intergenerational decision-making process was sometimes a barrier, where parents or caregivers may have wanted to vaccinate, but older family members did not support or agree with immunisation. Religious beliefs were also cited as a barrier to immunising children [4]. Lack of information from health- care providers was identified in two studies [8, 12].

How people access health services

The main issues found in the studies relating to how people accessed health services were the presence and location of the health services and the quality of service provided. Eleven studies reported attendance at a health service was challenged by lack of transport, location or distance [1, 2, 3, 4, 5, 6, 9, 10, 12, 13, 14]. Transport barriers ranged from: having no transport, requiring walking long distances, to having to use public transport, which could be unreliable and/or required multiple changes to get to the health service. Parking difficulties when using private transport were also identified as a barrier. Distance from the service, in terms of the amount of time required to travel there and back, ranged from minutes to hours. The number of transport service changes needed to arrive at the health service ranged from one to multiple changes (actual number not stated). Some families reported not being able to afford two cars, with the family member at work taking the car during the day.

Health-service barriers included: appointment times not being convenient; long waiting times for appointments; not having a vaccination card; or the health-care provider and/or the vaccines not available. Work commitments (necessity to work) were also identified as a barrier. The suitability of appointment times was cited in four studies as a barrier [4, 5, 7, 12]. The length of time, including waiting time, to be seen, was important in six studies [1, 4, 10, 12, 13, 14]. One study [4] mentioned being required to be checked by a doctor before being vaccinated, which contributed to the time required for the whole event. It was not always a cultural norm for participants to have appointments [7], and two studies [2, 10] noted participants forgetting appointments or having difficulty making appointments. Not having a "vaccination card", or the equivalent, was a barrier in four studies [1, 10, 12, 13]. Finally, many studies cited lack of a health-care provider and/or vaccines as a barrier [1, 6, 8, 10, 12, 13, 14]. In several cases, caregivers had travelled to the facility only to learn there was no vaccine available. In one instance, the appointment time for vaccination was limited to a specific day and time [8].

DISCUSSION

The themes identified in this review are congruent with the literature on access to whānau health services in New Zealand (MOH, 2013; Tipa, Wilson, Neville, & Adams, 2015; Turner et al, 2017). The New Zealand Health Strategy (MOH, 2016) and Māori Health Strategy (MOH, 2017b) seek to improve whānau engagement through *"embedding the improvement of Māori health across organisations"* (MOH, 2018b, para. 2). However, there are many challenges for whānau, especially those living in high-deprivation areas and those with low income or low educational levels, all of which have an impact on the lives of tamariki.

Cultural safety

How people live, their lifestyle, sociodemographic factors and socioeconomic status, and whether there are adequate support systems (from family, whānau and the wider community) all influence whether tamariki are immunised. Factors that influence the health and well-being of tamariki are interconnected – each factor affects the others. Socioeconomic inequalities were prevalent in the data from the reviewed overseas studies, and such inequalities have also been identified in New Zealand studies (Baker et al, 2012; Petousis-Harris et al, 2005; Turner et al, 2017).

The New Zealand Health Strategy acknowledges there are many factors that influence health and wellness over the course of a person's life which influence whether they receive equitable care (MOH, 2016). These factors, many of which were also identified in the reviewed studies, include: home environments, work commitments, transport issues, lack of social support, educational level and financial strain. "Wai ora", a concept in the Māori Health Strategy/He Korowai Oranga, captures the notion that the environments people live in have a significant impact on their health and well-being (MOH). The impact of wai ora on health was unmistakably evident in the findings of this review.

Lack of support is a factor undermining the ability to access immunisation for children. Support is considered necessary to facilitate access to health services (Babirye et al, 2011; Legesse & Dechasa, 2015; Niederhauser & Markowitz, 2007; Pearce et al, 2015; Riggs et al, 2012; Willis et al, 2016). The New Zealand Health Strategy theme "one team/kotahi te tīma" includes an emphasis

on strengthening whānau and communities as carers. However, competing interests, such as government targets, can affect health services' ability to collaborate with whānau (Turner et al, 2017).

For whānau to feel connected and willing to engage with health services, they need to have positive relationships with health providers. Whānau who have trust and confidence in providers are more likely to engage with health services (Petousis-Harris et al, 2005). Conversely, where health services display discriminatory attitudes towards whānau, negative associations are the result (Babirye et al, 2011; & Jackson et al, 2017; Willis et al, 2016). Discrimination or racism is associated with inequality in health-service provision (Reid, Cormack & Crowe, 2014). The judgmental attitude of a health provider can directly affect whānau engagement.

Child poverty as a barrier to immunisation

Poverty as a barrier to accessing health services was identified in the majority of the studies reviewed. In the Aotearoa New Zealand context, tamariki living in social deprivation are less likely to be fully immunised and are therefore more vulnerable to vaccine-preventable diseases. Poverty is not simply about having less, it is also about not having enough of the basic provisions for living a full life (Boston, 2014). Tamariki living in poverty experience greater disparities in health outcomes and have reduced opportunities to be protected from disease (Adorador et al, 2011; Babirye et al, 2011; Cockroft et al, 2014; Legesse & Dechasa, 2015; Odutola et al, 2015; Opwora et al, 2011; Pearce et al, 2015). Such disparity often results in negative health outcomes, exacerbated by a greater incidence of illness and increased hospitalisations (Boston, 2014). Nearly a third (27 percent) of tamariki living in Aotearoa New Zealand have been identified as living in poverty (Boston; Simpson et al, 2016). Boston suggests that half of these tamariki are of Māori or Pacific ethnicity.

Many whānau report transportation issues are a barrier to getting children immunised (Turner et al, 2017). Simpson et al (2016) reported that almost a quarter (21.5 percent) of tamariki (0-14 years old) had unmet needs for primary-care services. This study also reported that Māori and Pacific children were more than three times more likely to experience transport problems to get to primary-health services than non-Māori. Providing immunisation services "closer to home" can help to address the widely reported barriers of time and transport. For some whānau, taking time away from other family responsibilities, such as caring for older family members, was a significant barrier to taking a child for immunisations (Adorador et al, 2011; Cockcroft et al, 2014; Garcia et al, 2014; Jackson et al, 2017; Riggs et al, 2012; Tickner et al, 2009). Taking time off work may not be feasible, due to the impact of lost income and unwillingness of employers to allow absence from work to attend appointments. Transiency, often linked to poverty, creates a further challenge for health-care providers to connect with whānau, as location and contact details may change frequently (Turner et al, 2017). Temporary or transient living situations also make it difficult for continuity of relationships with health-care providers (Niederhauser & Markowitz, 2007).

Whānau-centred engagement

Whānau is a vital influencing factor in tamariki receiving immunisations on time. Education levels have an impact on health literacy, and on the awareness of the importance of timely immunisations and the understanding of how immunisations prevent disease (Simpson et al, 2016). Inability to understand health information due to the language used was also identified as a barrier, not only in relation to immunisations but also in regard to other aspects of health care. The direct result was a lack of a connection with health providers. This lack of connection can lead to loss of engagement with health-care providers if whānau do not understand or feel understood. Health-care providers can strive to work with whānau in a *"culturally responsive"* manner (Doutrich, Dekker, Spuck, & Hoeksel, 2014). Providing information that is both meaningful to whānau, and in line with their beliefs, is important, and the importance of connectedness and collaboration with whānau should not be undervalued. The attitude and approach of all health-care providers (including non-clinical staff) is a significant factor in encouraging whānau to engage with health services. Having an awareness of who influences the decision-making within whānau is also important. Establishing trust with all those involved in decision-making about immunisation enables whānau to feel sufficiently informed and have a sense of security about the process of engaging with health services.

LIMITATIONS

Research conducted in other countries may have limited application to the Aotearoa New Zealand context, owing to differences in the delivery of health services and other contextual factors. However, this review provided background information for future research. While research in Aotearoa New Zealand has explored a health-service perspective on barriers to immunising, consideration could be given to looking at the perspectives of whānau from specific population groups in New Zealand which have higher levels of delayed immunisation.

CONCLUSION

Timely immunisations play a significant role in reduction of disease, illness and hospitalisation. Equitable access for all tamariki is instrumental in achieving immunisation coverage targets (WHO, 2017a). Improving access to immunisations, increasing coverage and improving community protection are all positive drivers for everyone living in Aotearoa New Zealand. However, work needs to be done to address disparities in health outcomes for Māori tamariki. Health-care providers have an ethical obligation to facilitate timely immunisations, as tamariki are dependent and therefore not able to actively access care (Davies et al, 2010). Implementing strategies to overcome barriers, such as providing support to whānau and understanding the challenges or obstacles they face in attempting to immunise tamariki may improve access. To take action now is to improve outcomes for future generations. Providing positive, supportive, engaging immunisation services should lead to wider community engagement and a reduction in health disparities.

RECOMMENDATIONS

Health-service delivery models need to be more accommodating and efficient, making the best use of time for both whānau and health-care providers.

- ▶ Nurses and other health-care providers could contemplate offering flexible, joint or combined services to whānau to save time and resources, such as travel costs.
- ▶ Nurses and other health-care providers need to work more closely

with wider community agencies to identify which whānau need help to get tamariki immunised on time.

▶ Collaborative strategies are needed to improve whānau engagement with health services through more culturally focused and flexible services, ensuring the rights of whānau are respected.

▶ Nurses and other health-care providers in all acute-care facilities and emergency clinics should be encouraged to provide opportunistic immunisations to appropriate tamariki to improve immunisation uptake.

REFERENCES

Adorador, A., McNulty, R., Hart, D., & Fitzpatrick, J. J. (2011). Perceived barriers to immunizations as identified by Latino mothers. *American Academy of Nurse Practitioners, 23*(9), 501-508. https://doi.org/10.1111/j.1745-7599.2011.00632.x

Babirye, J., Rutebemberwa, E., Kiguli, J., Wamani, H., Nuwaha, F., & Engebretsen, I. MS. (2011). More support for mothers: A qualitative study on factors affecting immunisation behaviour in Kampala, Uganda. *BMC Public Health, 11*(1), 723-733. https://doi.org/10.1186/1471-2458-11-723

Baker, M. G, Barnard, L. T., Kvalsvig, A., Verrall, A., Zhang, J., Keall, M.,... Howden-Chapman, P. (2012). Increasing incidence of serious infectious diseases and inequalities in New Zealand: A national epidemiological study. *The Lancet, 379*(9821), 1112-1119. https://doi.org/10.1016/S0140-6736(11)61780-7

Boston, J. (2014). Child poverty in New Zealand: Why it matters and how it can be reduced. *Educational Philosophy and Theory, 46*(9), 962-988. https://doi.org/10.1080/00131857.2014.931002

Cockcroft, A., Usman, M. U., Nyamucherera, O. F., Emori, H., Duke, B., Umar, N. A., & Anderson, N. (2014). Why children are not vaccinated against measles: A cross-sectional study in two Nigerian states. *Archives of Public Health, 72*(1), 48-58. https://doi.org/10.1186/2049-3258-72-48

Corbett, T. (2013). *Recommendations to enhance general practice to improve access of tamariki to immunisations.* GlaxoSmithKline Vaccines. Retrieved from http://www.immune.org.nz/sites/default/files/resources/Written%20Resources/Corbett%2C%20improving%20Maori%20access%20to%20imms%2C%202013%20pdf.pdf

Critical Appraisal Skills Programme (CASP). (2017). *CASP qualitative research checklist*. Retrieved from https://casp-uk.net/casp-tools-checklists/

Davies, E., Crothers, C., & Hanna, K. (2010). Preventing childhood poverty: Barriers and solutions. *New Zealand Journal of Psychology, 39*(2), 20-31. Retrieved from https://www.psychology.org.nz/wp-content/uploads/NZJP-Vol392-2010-3-Davies.pdf

Doutrich, D., Dekker, L., Spuck, J., & Hoeksel, R. (2014). Identity, ethics and cultural safety: Strategies for change. *Whitireia Nursing and Health Journal, 21*, 15-21.

Environmental Science and Research [ESR]. (2017). *Science for communities*. Retrieved from https://www.esr.cri.nz/assets/Uploads/ESR-Profile-Publication-web-version.pdf

Evans, D. (2007). Overview of methods. In C. Webb & B. Roe (Eds.), *Reviewing research evidence for nursing practice* (pp. 137-148). Oxford, United Kingdom: Blackwell Publishing.

Garcia, D. A., Velandia-Gonzalez, M., Trumbo, S. P., Pedreira, M. C., Bravo-Alcantara, P., & Danovaro-Holliday, M. C. (2014). Understanding the main barriers to immunization in Colombia to better tailor communication strategies. *BMC Public Health, 14*(1), 2148-2173. https://doi.org/10.1186/1471-2458-14-669

Gilbert, R., & Wrigley, K. (2009). Opportunistic immunisation of paediatric inpatients at Rotorua Hospital: Audit and discussion. *New Zealand Medical Journal, 122*(1298), 25-30. Retrieved from http://www.nzma.org.nz/__data/assets/pdf_file/0007/17791/Vol-122-No-1298-03-July-2009.pdf

Grant, C. C., Chen, M., Bandara, D. K., Marks, E. J., Gilchrist, C. A., Lewycka, S., . . . Morton, S. M. B. (2016). Antenatal immunisation intentions of expectant parents: Relationship to immunisation timeliness during infancy. *Vaccine, 34,* 1379-1388. doi:10.1016/j.vaccine.2016.01.048

Grant, C. C., Turner, N. M., York, D. G., Goodyear-Smith, F., & Petousis-Harris, H. A. (2010). Factors associated with immunisation coverage and timeliness in New Zealand. *British Journal of General Practice, 60*(572), 113-120. https://doi.org/10.3399/bjgp10X483535

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Thousand Oaks, CA: SAGE.

Jackson, C., Bedford, H., Cheater, F. M., Condon, L., Emslie, C., Ireland, L., . . . Dyson, L. (2017). Needles, jabs and jags: A qualitative exploration of barriers and facilitators to child and adult immunisation uptake among Gypsies, Travellers and Roma. *BMC Public Health, 17*(1), 254-271. https://doi.org/10.1186/s12889-017-4178-y

Kiedrzynski, T., Bissielo, A., Suryaprakash, M., & Bandaranayke, D. (2015). Whooping cough – where are we now? A review. *New Zealand Medical Journal, 128*(1416), 21-27.

Legesse, E., & Dechasa, W. (2015). An assessment of child immunization coverage and its determinants in Sinana District, Southeast Ethiopia. *BMC Pediatrics, 15*(1), 31-45. doi:10.1186/s12887-015-0345-4

Ministry of Health (MOH). (2013). *Audience research: Delayers of infant immunisation*. Wellington, New Zealand: Litmus.

Ministry of Health (MOH). (2016). *New Zealand Health Strategy: Future direction*. Wellington, New Zealand: Author.

Ministry of Health (MOH). (2017a). *Immunisation handbook*. Wellington, New Zealand: Author.

Ministry of Health (MOH). (2017b). *He korowai oranga/Māori health strategy*. Retrieved from https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

Ministry of Health (MOH). (2018a). *National and DHB immunisation data*. Retrieved from https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data

Ministry of Health (MOH). (2018b). *Māori health*. Retrieved from https://www.health.govt.nz/our-work/populations/maori-health

Mueller, S., Exeter, D. J., Petousis-Harris, H., Turner, N., O'Sullivan, D., & Buck, C. D. (2012). Measuring disparities in immunisation coverage among children in New Zealand. *Health & Place, 18,* 1217-1223. http://dx.doi.org/10.1016/j.healthplace.2012.08.003

Niederhauser, V., & Markowitz, M. (2007). Barriers to immunizations: Multiethnic parents of under- and unimmunized children speak. *Journal of the American Academy of Nurse Practitioners, 19*(1), 15-23. doi:10.1111/j.1745-7599.2006.00185.x

Odutola, A., Afolabi, M. O., Ogundare, E. O., Yamu Ndow, L.-J., Worwui, A., Okebe, J., & Ota, M.O. (2015). Risk factors for delay in age-appropriate vaccinations among Gambian children. *BMC Health Services Research, 15*(1), 1-9. doi:10.1186/s12913-015-1015-9

Opwora, A. S., Laving, A. MR., Nyabola, L. O., & Olenja, J. M. (2011). Who is to blame? Perspectives of caregivers on barriers to accessing healthcare for the under-fives in Butere District, Western Kenya. *BMC Public Health, 11*(1), 272-281. doi:10.1186/1471-2458-11-272

Pal, M., Goodyear-Smith, F., & Exeter, D. (2014). Factors contributing to high immunisation coverage among New Zealand Asians. *Journal of Primary Health, 6*(4), 304-311.

Pearce, A., Marshall, H., Bedford, H., & Lynch, J. (2015). Barriers to childhood immunisations: Findings from the longitudinal study of Australian children. *Vaccine, 33*(29), 3377-3383. doi:10.1016/j.vaccine.2015.04.089

Petousis-Harris, H., Goodyear-Smith, F., Turner, N., & Soe, B. (2005). Family practice nurse views on barriers to immunizing children. *Vaccine, 23*(21), 2725-2730. doi:10.1016/j.vaccine.2004.11.038

Plotkin, S., Orenstein, W., & Offit, P. (2012). *Vaccines* (6th ed). Retrieved from Elsevier.

Reid, J., Cormack, D., & Crowe, M. (2016). The significance of relational continuity of care for Māori patient engagement with predominantly non-Māori doctors: Findings from a qualitative study. *Australian and New Zealand Journal of Public Health, 40*(2), 120-125. doi:10.1111/1753-6405.12447

Riggs, E., Davis, E., Gibbs, L., Block, K., Szwarc, J., Casey, S., . . . Waters, E. (2012). Accessing maternal and child health services in Melbourne, Australia: Reflections from refugee families and service providers. *BMC Health Services Research, 12*(1), 117-132. doi:10.1186/1472-6963-12-117

Semali, I. A. (2010). Trends in immunization completion and disparities in the context of health reforms: The case study of Tanzania. *BMC Health Services Research, 10*(1), 299-307. doi:10.1186/1472-6963-10-299

Simpson, J., Duncanson, M., Oben, G., Wicken, A., & Gallagher, S. (2016). *Child poverty monitor: Technical report*. Dunedin, New Zealand: New Zealand Child and Youth Epidemiology Service, University of Otago. Retrieved from https://ourarchive.otago.ac.nz/bitstream/handle/10523/7006/2016%20CPM.pdf

Tickner, S., Leman, P. J., & Woodcock, A. (2009). Parents' views about pre-school immunization: An interview study in southern England. *Child: Care, Health and Development, 36*(2), 190-197. doi:10.1111/j.1365-2214.2009.01020.x

Tipa, Z., Wilson, D., Neville, S., & Adams, J. (2015). Cultural responsiveness and the family partnership model. *Nursing Praxis in New Zealand, 31*(2), 35-49.

Turner, N. M., Charania, N. A., Chong, A., Stewart, J., & Taylor, L. (2017). The challenges and opportunities of translating best practice immunisation strategies among low performing general practices to reduce the equity gaps in childhood immunisation coverage in New Zealand. *BMC Nursing, 16*, 1-9. doi:10.1186/s12912-017-0226-2

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing, 52*(5), 546-553. https://doi.org/10.1111/j.1365-2648.2005.03621.x

Willis, E., Sabnis, S., Hamilton, C., Xiong, F., Coleman, K., Dellinger, M., . . . Simpson, P. (2016). Improving immunization rates through community-based participatory research: Community health improvement for Milwaukee's children program. *Progress in Community Health Partnerships, 10*(1), 19-30. doi:10.1353/cpr.2016.0009

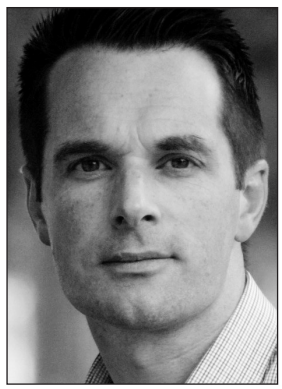
Wilson, E. (2009). Immunisation in hospital: An opportunity repeatedly missed. *New Zealand Medical Journal, 122*(1298), 8-10.

World Health Organization (WHO). (2013). *Global vaccine action plan 2011-2020*. Retrieved from http://www.who.int/immunization/global_vaccine_action_plan/GVAP_doc_2011_2020/en/

World Health Organization (WHO). (2017a). *Assessment report of the global vaccine action plan*. Geneva, Switzerland: Strategic Advisory Group of Experts on Immunisation (SAGE).

World Health Organization (WHO). (2017b). *Engagement of private/nongovernmental health providers in immunization service delivery: Considerations for national immunization programmes*. Geneva, Switzerland: Author.

Jan Weststrate **Cathy Cummings**



Louis Boamponsem **Andy Towers**

About the authors: *Jan Weststrate, RN, PhD, is director of Care-Metric (health service quality improvement advisers), Raumati, New Zealand. His correspondence address is Jan@Care-Metric.com*

Louis Boamponsem, PhD, is a quality assurance officer for the Laura Fergusson Trust (rehabilitation and support services), Canterbury & West Coast, New Zealand.

Cathy Cummings, RN, DBA, is director and specialist advisor for the DAA Group (health certification and accreditation), Wellington.

Andy Towers, PhD, MA, is a senior lecturer in the School of Health Sciences, Massey University, Palmerston North, New Zealand.

WHAT FACTORS INFLUENCE COMPLIANCE WITH HEALTH AND DISABILITY SERVICE STANDARDS FOR AGED RESIDENTIAL CARE IN NEW ZEALAND?

ABSTRACT

Aims: To identify compliance with the New Zealand Government's health and disability services standards (HDSS) in aged residential care (ARC) facilities in 2016, compared with previous years' outcomes, and its relationship with the surge of complaints in the public domain.

Methods: The 2016 audit reports of 185 ARC facilities were compared with their previous audit reports. The level of attainment of the different service groups was quantified (5: continuous improvement – 1: unattained).

Results: Audit reports of 185 facilities were included for analysis. Overall, the compliance with the standards improved from an average of 3.59 (± 0.80) to 3.76 (± 0.71). All service groups improved significantly over time, except for organisation and management. Number of beds and audit agency had no significant influence on the outcomes.

Conclusions: Compliance with the HDSS of the ARC facilities audited in 2016 significantly increased from their previous audit. There appears to be a discrepancy between the outcome of this study and the perception of the public; however this study could not draw conclusions whether this discrepancy is directly related to an increase in poor performance. The question emerges whether the current standards reflect sufficiently the provision of good quality of care.

This article was accepted for publication in August, 2019.

KEYWORDS

Quality, audit, compliance, improvement, aged care, certification, assessment, standards.

INTRODUCTION

New Zealand is experiencing a rising demand for aged residential care (ARC) facilities to accommodate a growing number of frail elderly. In 2011, approximately 31,000 New Zealanders were in ARC facilities: 5.1 percent of all people aged 65 and over, and 11.6 percent of all people aged over 80 (Productivity Commission, n.d.). In 2016, 14 percent of New Zealand's population were aged 65 years and older. This will increase to 22 percent by 2034 (Davidson, Elkin, & Carey, 2016). New Zealand is one of the bigger spenders on health care, as a proportion of total government funding, among Organisation for Economic Co-operation and Development (OECD) countries (OECD, 2017). With a projected need for up to 20,000 additional ARC beds within the next decade (Grant Thornton, 2010), an increasing older population will clearly affect the provision of aged care in New Zealand.

At November 7, 2013, there were 663 accredited aged-care providers in New Zealand, the majority (68 percent) of which were

privately owned, with a declining number operating on a not-for-profit basis (Grant Thornton, 2010; Ministry of Health 2013). The decision to invest in new long-term care facilities will therefore depend very much on profitability and return on investment. There is doubt such a market-driven care environment can appropriately serve frail elderly without the latter being the servant of the former (Woods, Phibbs, & Severinsen, 2017). In a market-driven environment, care providers must ensure that meeting an increasing ARC demand will not be at the expense of the quality of care. Residents in ARC facilities are some of the most vulnerable in our society, so effective assessment and assurance of care quality and safety is paramount (Controller and Auditor-General, 2009). It is therefore imperative for stakeholders to be regularly informed about the trend of certification audit outcomes, which are proxy indicators of quality of care for ARC residents.

This study investigates how much the outcomes of individual certification audits have changed over time and what factors possibly influenced this change.

Assessment of health and disability services standards (HDSS)

The New Zealand Health and Disability Services (Safety) Act 2001 requires that care provided by ARC facilities meets the health and disability services standards (HDSS). ARC providers must be certified by the Ministry of Health (the ministry) and, to remain certified, they must be audited regularly to make sure they meet the specified criteria set out in the HDSS. Much of this auditing is carried out by Ministry of Health-approved independent organisations called designated auditing agencies (DAAs). The ministry uses these audits as a basis for deciding whether an ARC facility can continue to operate, and for how long (New Zealand & Office of the Auditor-General, 2009) (Ministry of Health, 2013).

In addition to DAA auditing, local district health boards (DHBs) have a role in monitoring the quality of care ARC facilities provide. Most ARC facilities have a contract with their local DHB, which is required by law to monitor that facility's service delivery and performance (Controller and Auditor-General, 2009). DAA audit reports are used by DHBs to ensure contracted ARC facilities are complying with the aged-related residential care services (ARRCS) funding contract (Productivity Commission, n.d.). ARC operators are then required to report to their DHB on how they are addressing issues found at audit, and such improvements are verified at the next audit (Ministry of Health, 2015).

Meeting the HDSS

A 2009 government audit found that since its introduction in October 2002, certification of ARC facilities had not provided adequate assurance that rest homes met the criteria in the HDSS (Controller and Auditor General, 2012). There was evidence that the rate of improvement had slowed, and some ARC facilities consistently received poor ratings for the same or closely related criteria. In addition, ARC facilities throughout the sector were often given poor ratings for some particular HDSS – eg the medicine management standard (New Zealand & Office of the Auditor-General, 2009).

Following these findings, the ministry strengthened its certification and monitoring processes. It integrated DHB and DAA assessments, increased audit frequency when "high" risks were identified, introduced unannounced auditing, reintroduced third-party accreditation of independent auditing agencies and shifted the focus of audits from process-driven to outcome-driven (Office of the Controller and Auditor General, 2012).

Neville, Wright-St Clair, Healee and Davey (2016) concluded that the changes to the audit process were beneficial to quality of care and improved outcomes for residents, resulting in an increased number of ARC facilities being awarded a four-year certification. However, in response to repeated complaints from consumers, a 2017 inquiry (New Zealand Labour Party, Green Party of Aotearoa New Zealand, & Grey Power, 2017) into the state of ARC found that significant problems first outlined in a 2010 inquiry (New Zealand Labour Party, Green Party of Aotearoa New Zealand, & Grey Power, 2010) still remained. These included inconsistent care, poor housing stock, a lack of focus on client health outcomes, and chronic workforce underfunding. However, these problems were not universal across the sector, with some ARC providers performing better than others.

A key issue for the New Zealand aged care sector is that there is no single report identifying the degree of improvement in the sector overall, and whether such improvement reflects specific characteristics of the ARC itself (eg regional variation, facility size) or specific aspects of the care provided (eg certain audit criteria). Such a report would significantly change our currently muddled understanding of ARC care improvement in New Zealand and the driving factors for such improvement. This study aims to explore these issues and will attempt to answer the following research questions:

1) To what extent have ARC facilities improved certification audit outcomes in 2016, compared to their previous certification audit results?
2) Which factors (size, audit agency and region) influenced audit outcomes?
3) Which criteria of the HDSS are ARC facilities repeatedly failing to meet?

METHODS

This study represents a secondary analysis of existing certification audit data gathered by DAA agencies in ARC facilities in 2016. This data is made freely available by the Ministry of Health. Specifically, we utilised all the qualified full audit reports from the ministry's website of the facilities audited in 2016. Facilities that received other types of audits (surveillance audits, provisional audits, partial provisional audits) were excluded. For the selected facilities, we compared their 2016 results with the results of their previous certification audit. When no previous certification audit results were available, or no data were collected other than the 2016 audit results, only the 2016 results were used.

ARC providers are audited against the HDSS set out in the Health and Disability Services Act 2001 to gain certification. These standards are categorised into six service groups:

- consumer rights;
- organisational management;
- continuum of service delivery;
- safe and appropriate practice;
- restraint minimisation and safe practice; and
- infection prevention and control.

Each service group has several standards with associated criteria.

Table 1. The five levels of attainment		
Abbreviation	**Full wording**	**Achievement of standard or criteria**
CI	Continued improvement	Achievement beyond full attainment.
FA	Fully attained	Full attainment and meets requirements.
PA	Partial attainment	Partial attainment and improvement required.
UA	Unattained	Not met.
NA	Not applicable	Standard or criterion not audited as does not apply.

The standards focus on the outcomes that residents experience when services are of good quality. Overall, there are 50 standards and 101 criteria within the HDSS that can be used for audits (Ministry of Health, 2015).

Each ARC is ranked on how well they achieve each standard or criteria, and the level of risk based on non-achievement. Table 1 (above) shows the abbreviation, the level of attainment and the current interpretation of the attainment level. Where the attainment level is partial or unattained, a risk analysis is performed at criterion level. The risk may be determined as "negligible", "low", "moderate", "high" or "critical".

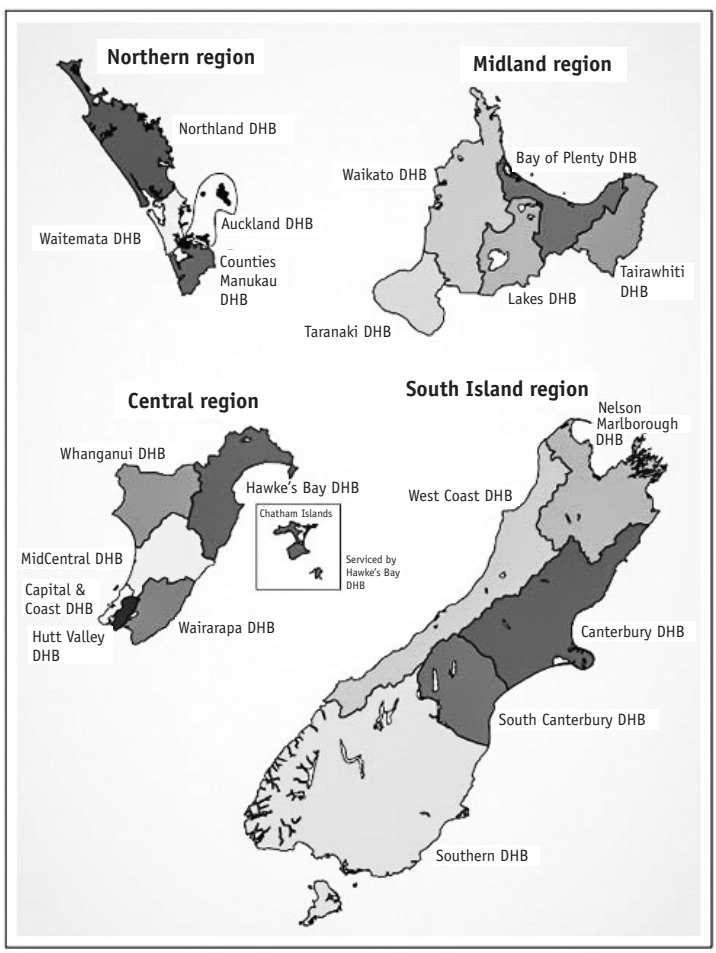


Figure 1. The 20 district health boards in New Zealand grouped into four regions. **(Controller and Auditor-General, n.d.)**

Measures

Improvement: A numerical value (and colour) was assigned to the attainment levels for each service group: Continuous improvement (blue) 5; fully attained (green) 4; partially attained, low risk (yellow) 3; partially attained, high risk (orange) 2; unattained (red) 1. The maximum value for each audit report is therefore 30.

As well as facilities' demographic data (name, DHB, number of beds, for profit/not for profit), the following data were collected from the audit reports:

- The date of the first day of the audit.
- The DAA agency that performed the audit.
- The region the ARC facility was located in. (The 20 DHBs in New Zealand are grouped into four regions – see Figure 1, below left.)
- The certification period the facility was given, based on the audit.
- The level of attainment for each of the six service groups.
- The number of standards and criteria that were reported on for each of the attainment levels.
- Descriptions of criteria that were either rewarded with a continuous improvement (CI) rating, or criteria that required corrective actions (CARs) from the facility. (A description of these criteria only became publicly available for certification audits carried out after August 2013.)

The following analyses were carried out:

- Audit outcomes (blue, green, yellow, orange and red) were compared at facility level, for each of the six service groups, between the 2016 audit results and the results of the previous audit, only for those facilities for which the two sets of data were available.
- Relationship between the size of the facility (number of beds) and audit outcomes.
- The change in reported numbers of CARs and CIs between the 2016 audit outcomes and the previous audit. The data were subjected to statistical analysis using IBM SPSS (Version 21). T-test, chi-square and one-way analysis of variance (ANOVA) were used to determine the statistical difference between groups. Where appropriate, a least significant difference (LSD) post-hoc test was applied following the ANOVA test. The level of statistical significance was set at 5 percent.

RESULTS

We analysed the 2016 certification audit reports for 185 ARC facilities in New Zealand. There was a previous certification audit report available for 152 of these facilities. Of those 152 facilities, 45 had a detailed previous audit report (this includes naming the specific criteria that required corrective action and/or received a CI rating); 107 did not, because before August 2013, only an abstract of the audit report was made public, not the complete report.

For the remaining 33 facilities (185 minus 152), no previous audit report was available. This was because, in previous years, no certification audits were performed for these facilities other than provisional and surveillance audits.

Table 2. The five standard criteria most often listed as CARs (corrective actions required) in 2016

Standard criteria	Description of criteria	N (CARS)	% of total CARs
1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation to comply with legislation, protocols and guidelines.	50	8.0
1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is provided within time frames that safely meet the needs of the consumer.	48	7.7
1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessment needs and desired outcomes.	45	7.2
1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	35	5.6
1.2.3.6	Quality improvement data are collected, analysed and evaluated and communicated to service providers and, where appropriate, consumers.	32	5.1

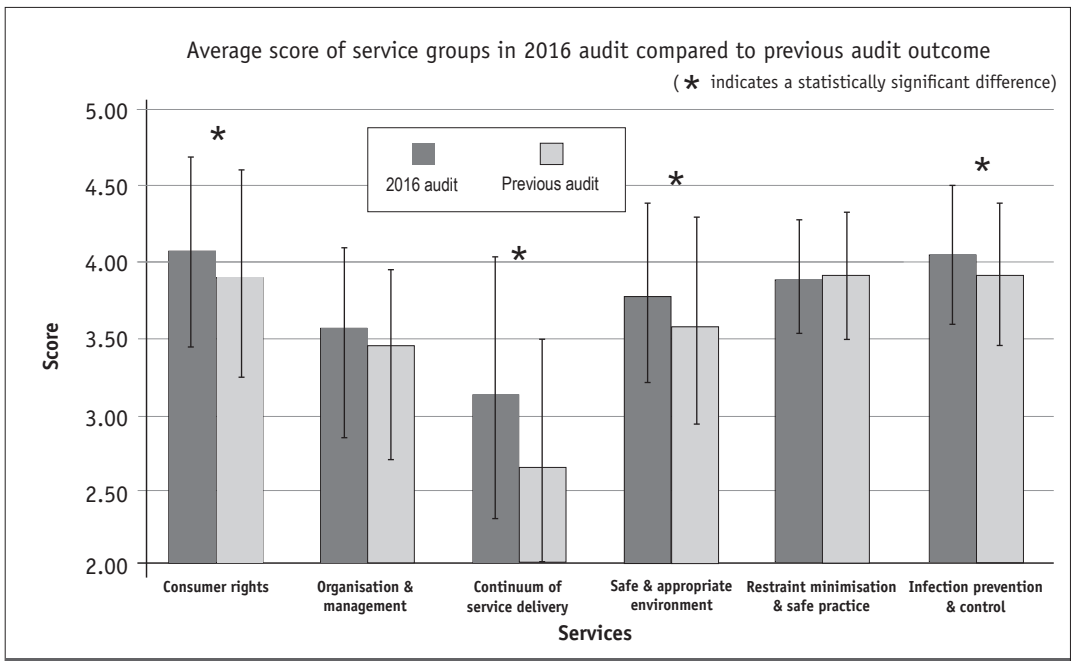


Figure 2. Average service group score in 2016 and previous average score

All the CARs and CI ratings of the 230 (185+45) detailed audit reports were also analysed. In total, we evaluated 1158 criteria (CI: 242 (20.9%); CAR: 916 (79.1%). In 2016, there were 855 (73.8%) criteria evaluated and for the previous years 303 (26.2%). In 2016, 627 CARs were recorded. Table 2 (above) lists the five criteria of the HDSS, with their frequency, that were most often listed as CARs. These five criteria made up one third of all the CARs reported in 2016.

Figure 2 (above) shows the outcomes per service group. Overall, facilities in all regions had significantly better outcomes in 2016, compared to their previous audit outcome, suggesting improvement in compliance with the standards – mean 2016: 3.76 (+-0.71) vs mean previous: 3.59 (+- 0.80; *p=.000*). The service levels that contributed the most to this improvement were: consumer rights, continuum of service delivery, safe and appropriate environment and infection prevention and control.

Table 3 (next page) shows the overall average service level outcome for the 152 facilities per region (see Figure 1). For the year 2016, the data showed a significant difference (*p<.05*) in outcomes related to which of the four regions the facility was located in [F(3,908)=3.212, *p=.022*]. Post-hoc comparisons using the Games-Howell test showed the mean score for the South Island region (M=3.7093, SD=0.79) was significantly lower than the other regions. There was no significant difference between the mean scores of the four regions in the previous audit results.

Table 3 also shows there was a significant positive increase in service group scores for the facilities in the Northern region [conditions t(239)=4.897, *p=.000*] and the facilities in the South Island [conditions t(257)=3.473, *p=.001*], comparing the 2016 service level scores with the previous year audit scores using the paired T-Test. These results suggest that in 2016, the facilities in the Northern and Southern regions had a higher compliance with the standards than in the results of their previous audit.

Table 4 (next page) shows the average service level outcome per bed size. Facility bed size was divided into four categories (0-49

Table 3. Average 2016 audit score per region, compared with previous audit score

Region	N (facilities)	N (service levels)	2016 audit Mean	SD	Std-error	Previous audit Mean	SD	Std-error	Sig (2-tailed)
Northern	40	240	3.8833	0.6229	0.04021	3.5708	0.86975	0.05614	*p=0.000*
Midland	29	174	3.7184	0.67662	0.05129	3.6092	0.81682	0.06192	*p=0.135*
Central	40	240	3.7333	0.70543	0.04554	3.6708	0.73466	0.04742	*p=0.274*
South Island	43	258	3.7093	0.78705	0.049	3.5271	0.78485	0.04886	*p=0.001*

Table 4. Average 2016 audit score per service level for each bed-size category, compared with previous audit score

Bed size	N (facilities)	2016 audit Mean	SD	Std-error	Previous audit Mean	SD	Std-error	Sig
0-49	420	3.6833	0.70268	0.03429	3.5976	0.79826	0.03895	*p=0.048*
50-99	372	3.7769	0.6936	0.03596	3.5833	0.80164	0.04156	*p=0.000*
100-149	96	4	0.71082	0.07255	3.6667	0.8165	0.08333	*p=0.000*
150+	24	4	0.72232	0.14744	3.3333	0.8165	0.16667	*p=0.005*

beds, 50-99 beds, 100-149 beds, more than 150 beds). For the 2016 audits, there was a significant difference in scores between the four different bed sizes [F(3,908)=6.441, *p=0.000*]. Post-hoc comparisons using the LSD test showed the mean score of facilities with 0-49 beds was significantly lower than for facilities with 150-199 beds (*p=0.031*) and those with 100-149 beds (p=0.000). Also, facilities with 50-99 beds had a significant different average service level score than those with 100-149 beds (*p=0.005*). In the previous audit results, there was no significant difference between the mean scores of the four bed sizes.

Investigating the difference in the average service level scores between the two audits at bed-size level, using a paired sample T-test, showed that for all four bed-size groups there was a significant difference between the two audits (*p<0.05*). These results suggest that regardless of the bed size, compliance with the standards improved over time.

Five DAAs conducted the 185 certification audits used for this study. The proportions of the audits carried out by the five DAAs were, in decreasing order: 59 percent, 29 percent, 8 percent, 7 percent and 1 percent. There was no statistically significant difference (*p=0.791*) between outcomes of audits conducted by the different agencies. This suggests there is no significant variation in the quality of the audits provided by the different audit agencies.

To identify what contributed to the improvement in compliance, the number of CIs and CARs were analysed. This data only became available in audits done after July 2013 (43 facilities). Table 5 displays the average number of CI and CARs for the facilities. All 43 facilities had CARs in their audit report and 21 facilities (48.8 percent) had one or more CIs listed. For both ratings, a significant difference was noted between the 2016 audit outcomes and the previous audit. The CARs reduced from an average of 6.44 per facility to 4.28.

DISCUSSION

This research investigated the extent to which ARC facilities' compliance with HDSS changed for the better in their 2016 certification audit, compared with their previous audit. This could bring clarity to discussion on this topic, where different sources produce reports with contradictory conclusions (New Zealand Labour Party, et al, 2017; Neville et al, 2016). The main outcome of this investigation is that the overall compliance with the HDSS improved significantly (from 3.59 to 3.76). In a more detailed look, four of the six audited service groups improved by a statistically significant amount, and two (organisational and management and restraint minimisation) did not. Overall, this is good news for the sector, as it has been under considerable pressure in recent years over the quality of care and services it provides to residents (Wilson, 2014; Woods et al., 2017). Specifically, this indicates an impressive improvement in practice and in attention to audit requirements by the registered nurses and health-care assistants who work at the aged-care coalface.

Table 5. Number of CARs and CI ratings handed out to a subset of facilities (N=43) in 2016, compared with their previous audit

Service level	N	2016 avg	SD	Previous avg	SD	Sig
Continuous improvement	21	2.19	1.44	0.76	1.61	*0.01*
Corrective action request	29	4.28	4.42	6.44	5.62	*0.04*

The audit outcomes for ARC facilities in the Northern DHB region and in the South Island improved significantly. One of the reasons rest-home facilities in the Northern region improved could be due to participation in the *First Do No Harm* programme (First Do No Harm, 2012). Regular get-togethers focussing on learning how to improve quality of care and how to reduce the incidence

of pressure injuries and falls may have contributed to an increase in compliance. Also, the fact that some DHBs use gerontology nurse specialists and nurse practitioners to work with ARC facilities to improve the quality of care may have contributed (Neville et al., 2016).

This overall improved compliance with the standards is supported by an increase in the number of CI ratings and a reduction in the number of CARs facilities were given. CI ratings are important to ARC facilities as they influence the number of certification years facilities are given (Neville et al., 2016). Audits are compulsory, expensive and financed by the rest homes themselves. So, in an already financially tight market, a decrease in audit costs can make a significant difference, especially for ARC facilities with a small number of beds. The bed size of the facilities had no significant influence on their audit results.

The reliability of our results is also supported by the fact that we could not detect a significant difference in the average compliance score of ARC facilities when different DAA agencies carried out the audit. Although there is not necessarily a causal link between audit company and outcome, it supports the observation that the different DAAs carry out the audits in a similar way. Audit quality was one of the concerns noted in the 2009 Controller and Auditor-General report (2009). In the follow-up report, the office of the Controller and Auditor-General mentioned that there were *"indications that the quality of the auditing process for rest homes has improved during the last two years" (*Office of the Controller and Auditor General, 2012, p35).

Interestingly, although this study shows increased compliance with the standards by ARC facilities, this has not led to the public experiencing an overall increased positive experience of the quality of care. An inquiry into aged care in New Zealand by the New Zealand Labour Party, the Green Party of Aotearoa and Grey Power showed that many of the issues mentioned in a 2010 report remained (Duff, 2013; Duff & Blundell, 2013; New Zealand Labour Party, Green Party of Aotearoa, & Grey Power, 2017; Wilson, 2014). This raises the question whether evaluating the compliance with the standards provides enough assurance to the public that ARC facilities care for the elderly in a respectful and dignified way (Carryer, 2016).

There are several formal ways for the public to complain when rest-home residents receive suboptimal care. People can talk directly to the management, write to the DHB in which the rest home is located, write to the Ministry of Health or complain to the Health and Disability Commissioner. The fact that there are multiple complaint avenues can confuse people and encourage them to take the path of "least resistance" (ie least effort), which is not necessarily the most effective one. This may be one of the reasons people approach newspapers or other media outlets, as the media are usually quick to respond to this kind of news. Different agencies may deal differently with the complaints they receive and it becomes difficult to rule out duplication, ie when the same complaint is sent to different agencies (Davidson et al., 2016). One of the suggestions made by the Productivity Commission to overcome these pitfalls is to create a shared contact point (an 0800 number) where complainants can be referred to the most appropriate organisation.

A relevant question, however, is what can be done to close the gap between what the sector is doing to improve compliance with standards of care and what the public experiences. Castle and Ferguson (2010) argue that measuring the quality of care in an ARC setting is not straightforward when aligning it, for example, with the Institute of Medicine's definition of quality: *"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with professional knowledge"* (Lohr, 1996). Putting such a definition into operation, to create quality of care measures for ARC facilities, is problematic, especially when you want to focus on person-centred care (Grabowski et al., 2014). Castle and Fergusson (2010) suggest that rather than looking at one or more quality **measures** for ARC facilities it might be more appropriate to focus on quality **indicators**. Although they are less precise, they denote the quality of care provided. Using the Donabedian quality framework (Donabedian, 1985) of structure, process and outcome (SPO) helps to organise which quality indicator fits under which heading. Although the SPO model was not specifically designed for rest homes, it has a built-in logic that may resonate with the experiences of the public: good structure facilitates good processes, which facilitate good outcomes. Comparing the SPO approach with the current audit system in New Zealand, it is evident that the current standards focus mainly on structure, to a limited extent on process, and not on outcome.

In the complaints that have been aired in the media and submitted to the Health and Disability Commissioner, a substantial number of issues relate to health outcomes such as incontinence, pressure injuries, malnutrition, pain, falls and wound care (Davidson et al., 2016). In the last 20 years, the predominant thinking has been that to improve the quality of care in ARC facilities, the focus should be more on these type of quality indicators (Castle & Ferguson, 2010). This view is echoed in the most recent Labour, Greens and Grey Power report (New Zealand Labour Party et al, 2017). There are also international examples of standards regimes for which facilities are required to report on specific quality indicators (Australian Government Department of Health, 2016; Agency for Healthcare Research and Quality, n.d.; European Commission, 2010).

Based on these national and international developments, the way to close the gap between what the public experiences and what facilities do to create a safe and a high-quality care environment is to add important quality indicators (process and outcome) to the current audit process. The findings of the Health and Disability Commissioner report can be a guide to which process/outcome indicators are currently relevant (Health and Disability Commissioner, 2016). There are a number of ways to facilitate this change, one of which is that facilities take part in external accreditation programmes that include these in their accreditation process. Williams et al (2017) found that rest homes in the United States that took part in the Joint Commission's external accreditation programme had fewer deficiencies compared to those that did not take part (Williams, Morton, Braun, Longo, & Baker, 2017). The Nursing Home Compare quality measures data set, which looks at 18 process and outcome quality indicators, is part of this accreditation programme (Centers for Medicare and Medicaid Services (CMS), 2018).

One external accreditation programme that already exists in New Zealand is EQuIP (evaluation and quality improvement programme). EQuIP is owned by the Australian Council for Healthcare Standards and is based on principles which support best practice and which are designed to facilitate a culture of continuous improvement. These principles can be applied to all aspects of service in a health-care organisation. This quality assessment and improvement programme supports excellence in aged care. The EQuIP standards comprise a series of criteria and elements, arranged under grading ratings that

reflect increasing maturity of an organisation's quality improvement activities.

Another existing international programme which connects well with the current audit process is the National Care Indicator Programme (NCIP) (Carryer et al., 2017). This programme focuses on pressure injuries, malnutrition, continence and falls, with an option to add an additional module for wound care/wound infection and pain management. These are also the issues about which the Health and Disability Commissioner receives the most complaints (Health and Disability Commissioner, 2016). Addressing these issues and publicly sharing the results for each facility could increase the public's confidence that all is done to make sure loved ones receive the care they need.

LIMITATIONS

This study has a number of limitations. We evaluated the audit results of 185 facilities that had an audit performed and reported in 2016. From the table that we used to select the facilities, the licence end date was sometimes different from the actual date of the audit. This was particularly the case for facilities that had their audit done around the start of the year. It is possible that because of this we missed the audit results of a few facilities.

Another limitation is that full audit reports only became available after August 29, 2013. Therefore we have no indication of the number of CARs and CIs in the 2012-2013 period for those facilities that had longer certification periods (three to four years). Therefore, facilities for which we were able to evaluate the number of CARs and CIs may have had a shorter certification period, possibly indicating there were compliance issues in a previous report.

It should also be acknowledged that compliance audits – while robust and involving triangulation of evidence, including interviews with staff, residents, family members and management, and observation of care practice and its associated documentation – are only one tool in a toolbox that monitors quality of care. Audits assess and test the resilience of systems that support the delivery of care. The auditors are on site for about two days, every 18 months or so. Between audits, those systems can change or be eroded. The most significant thing that can affect the resilience of these systems is a change in ownership or, even more significantly, a change in management or leadership. Auditing is necessary for monitoring the aged-care sector, but it is not a guarantee of perfection.

CONCLUSION

This evaluation demonstrates that there is an increased compliance with the audit standards in facilities that were audited in 2016, compared with their previous audit. This is good news as it indicates the sector is putting an effort into increasing the quality and safety of the care it provides. Unfortunately, such a finding does not always go hand-in-hand with the New Zealand public's experience of the quality of care provided by ARC facilities. A way forward is to include in the audit process the results for quality of care indicators that resonate with the public. The types of complaints submitted to the Health and Disability Commissioner's office can give guidance on which indicators to include.

CONFLICTS OF INTEREST

Nil.

REFERENCES

Agency for Healthcare Research and Quality. (n.d.). *Nursing Home Quality Measures Compared to Achievable Benchmarks.* Retrieved from https://nhqrnet.ahrq.gov/inhqrdr/National/benchmark/summary/Setting_of_Care/Nursing_Home

Australian Department of Health. (2016). *Residential aged care quality indicators.* Retrieved from *Ageing and Aged Care* website: https://agedcare.health.gov.au/ensuring-quality/quality-indicators/residential-aged-care-quality-indicators

Carryer, J. (2016, June 12). *Aging with dignity is a basic right.* Massey University. Retrieved from http://www.massey.ac.nz/massey/about-massey/news/article.cfm?mnarticle_uuid=30A68D0E-BBB1-00BB-9201-A0D821C0AFFA

Carryer, J., Weststrate, J., Yeung, P., Rodgers, V., Towers, A., & Jones, M. (2017). Prevalence of key care indicators of pressure injuries, incontinence, malnutrition, and falls among older adults living in nursing homes in New Zealand. *Research in Nursing & Health, 40*(6), 555–563. https://doi.org/10.1002/nur.21835

Castle, N. G., & Ferguson, J. C. (2010). What Is Nursing Home Quality and How Is It Measured? *The Gerontologist, 50*(4), 426–442. https://doi.org/10.1093/geront/gnq052

Centers for Medicare and Medicaid Services (CMS). (2018). *Design for Nursing Home Compare Five-Star Quality Rating System: Technical user's guide.* Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

Controller and Auditor-General. (n.d.). *Map of the four health sector regions and their district health boards.* Retrieved from https://www.oag.govt.nz/2013/regional-services-planning/part1.htm

Controller and Auditor-General. (2009). *Effectiveness of arrangements to check the standard of services provided by rest homes.* Wellington, NZ: Office of the Auditor-General.

Controller and Auditor General. (2012). *Effectiveness of arrangements to check the standard of rest home services: Follow-up report.* Wellington, NZ: Office of the Auditor-General.

Davidson, N., Elkin, K., & Carey, D. (2016). *Complaints to the Health and Disability Commissioner about Residential Aged Care Facilities: Analysis and Report 2010–2014.* Auckland: Health and Disability Commisioner.

Donabedian, A. (1985). Twenty years of research on the quality of medical care: 1964-1984. *Evaluation and the Health Professions, 8,* 243–265.

Duff, M. (2013, September 25). *Flood of rest home complaints.* Retrieved from http://www.stuff.co.nz/national/9205004/Flood-of-rest-home-complaints

Duff, M., & Blundell, K. (2013, February 9). *Rest home failed all its residents, ministry says.* Retrieved from http://www.stuff.co.nz/dominion-post/news/9117225/Rest-home-failed-all-its-residents-ministry-says

European Commission. (2010). *Measuring Progress: Indicators for care homes.* Retrieved from http://www.euro.centre.org/data/progress/PROGRESS_ENGLISH.pdf

First Do No Harm. (2012). *First, Do No Harm website goes live.* Retrieved from https://www.hqsc.govt.nz/our-programmes/other-topics/news-and-events/news/392/

Grabowski, D. C., O'Malley, A. J., Afendulis, C. C., Caudry, D. J., Elliot, A., & Zimmerman, S. (2014). Culture change and nursing home quality of care. *The Gerontologist, 54*(Suppl 1), S35–S45.

Grant Thornton. (2010). *Aged Residential Care Service Review.* Retrieved from https://nzaca.org.nz/assets/Documents/ARSCR-Full-Report.pdf

Health and Disability Commissioner. (2016). *Complaints to the Health and Disability Commissioner about Residential Aged Care Facilities: Analysis and Report 2010–2014.* Auckland: Author.

Lohr, K. N. (1990). *Medicare: A strategy for Quality Assurance.* Washington, DC: National Academy Press.

Ministry of Health. (2013). *Rest home certification audits.* Retrieved from https://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits

Ministry of Health. (2015). *More about audit reports.* Retrieved from https://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits/more-about-audit-reports

Neville, S., Wright-St Clair, V., Healee, D., & Davey, J. (2016). *Improving Outcomes in Age Residential Care.* Auckland, New Zealand: Auckland University of Technology.

New Zealand Labour Party, Green Party of Aotearoa New Zealand, with Grey Power. (2010). *A Report into Aged Care. What does the future hold for older New Zealanders?* Retrieved from https://home.greens.org.nz/sites/default/files/Aged_Care_Report_for_email.pdf

New Zealand Labour Party, Green Party of Aotearoa New Zealand, with Grey Power. (2017). *Inquiry into Aged Care.* Retrieved from https://www.greens.org.nz/sites/default/files/policy-pdfs/Aged%20Care%20Report%20Sep17.pdf

Organisation for Economic Co-operation and Development (OECD). (2017). *Health at a Glance 2017* (p135). OECD Publishing. https://doi.org/10.1787/health_glance-2017-en

Productivity Commission. (n.d.). *Case Study: aged care regulation.* Retrieved from https://www.productivity.govt.nz/assets/Documents/c0f792dc6f/Case-study-Aged-care-regulation.pdf

Williams, S. C., Morton, D. J., Braun, B. I., Longo, B. A., & Baker, D. W. (2017). Comparing Public Quality Ratings for Accredited and Nonaccredited Nursing Homes. *Journal of the American Medical Directors Association, 18*(1), 24–29. https://doi.org/10.1016/j.jamda.2016.07.025

Wilson, J. (2014, August). Compromised care. Rest home audits continue to show failings in care. *Consumer New Zealand,* 12-14.

Woods, M., Phibbs, S., & Severinsen, C. (2017). 'When morals and markets collide': Challenges to an Ethic of Care in Aged Residential Care. *Ethics and Social Welfare, 11*(4), 365–381. https://doi.org/10.1080/17496535.2017.1287210

Literature review

FORENSIC CLINICAL NURSES IN EMERGENCY DEPARTMENTS: AN EMERGING NEED FOR NEW ZEALAND

Andrea Donaldson

About the author: *Andrea Donaldson, RN, MSc, PhD, CATE, is an academic staff member at the Centre for Health and Social Practice, Waikato Institute of Technology, Hamilton, New Zealand. Her correspondence address is: andrea.donaldson@wintec.ac.nz*

This article was accepted for publication in September, 2019.

ABSTRACT

Aim: This article reports on a systematic review of the literature, undertaken to gather evidence to support the establishment of clinical forensic nurse specialist roles in New Zealand emergency departments.

Background: Violence is a significant and increasing health problem in New Zealand. One consequence of this is the need for New Zealand nurses to be able to recognise forensic situations in emergency departments and to apply clinical forensic principles and practices.

Method: A systematic review of the literature was undertaken, using the Medline, Ovid, EBSCOHost and Proquest databases, to synthesise the findings of 23 internationally published articles on the role, function and purpose of the clinical forensic nurse in emergency departments. A thematic approach was used to analyse the information in the articles.

Findings: Themes that emerged focused on the qualities and skills forensic nurses possess, and the level of specialist knowledge required to ensure patients receive the best medico-legal care. Key qualities and skills clinical forensic nurses possess include effectively identifying, collecting, documenting and preserving evidence from patients who are victims of violence, as well as educating and mentoring nursing colleagues and other health professionals about forensic evidence. These nurses require specialist knowledge to enable them to care for some of the most challenging patients, many with complex psychosocial, psychological and physical health-care needs, all while upholding ethical and legal principles.

Conclusion: A role for clinical forensic nurse specialists in New Zealand emergency departments is clearly indicated. Emergency departments also lack protocols to support nurses caring for and treating victims of violence or unexplained death. The review also found that nurses lack the confidence, skills and education needed to meet medico-legal obligations to their patients and to fulfil their duty to *"do no harm"*.

KEYWORDS

Forensic nursing, forensic nursing skills, forensic nursing education, forensic nursing specialization, emergency department.

INTRODUCTION

Every day, in emergency departments around the world, skilled nurses provide care to patients presenting with injuries caused by trauma and violence. Violence is a major public health problem worldwide. Each year, millions of people suffer permanent disabilities, live with physical and psychological scars and die from injuries related to violence (Butchart & Mikton, 2014). The World Health Organization (WHO) cites violence and crime as a significant health issue and the fourth leading cause of death among adults (Butchart & Mikton, 2014). Trauma and violence injuries occur in a wide variety of ways, including through motor-vehicle crashes, burns, interpersonal violence, mass disasters and terrorist acts. Victims of violence require complex care from health professionals with trauma-informed, evidence-based expertise which is medically and legally sound. People who experience intimate-partner violence, child and elder maltreatment, strangulation, physical assault, and sexual violence, often face substantial short and long-term health and legal consequences (Anda, 2018; Fanslow & Robinson, 2004; Koss & Heslet, 1992; Loxton et al, 2017; SAMHSA, 2014). The hospital emergency department is the first place a victim and/or perpetrator of violence is brought for medical treatment. Most of these patients survive; some do not. Emergency nurses are uniquely positioned to identify, evaluate and treat these patients. They are also obliged to preserve and collect any potential forensic evidence that may be on or with the patient, as well as maintain the chain of custody (documenting the handling of evidence) and notify the appropriate authorities.

When an emergency nurse provides care to victims of violent events, that nurse is providing forensic nursing care. In New Zealand, violence is a significant and increasing health problem (Boshier, 2011). One result of this growing problem is the need for New Zealand nurses to recognise forensic situations and apply clinical forensic principles and practices in emergency departments. Currently there are few, if any, nurses specifically trained in forensic skills working in emergency departments in New Zealand (Williams, Richardson, O'Donovan & Ardagh, 2005), nor is there any current postgraduate education in forensic science principles for nurses in

this country.

This article reviews the literature describing the clinical forensic nurse's role and offers reasons why they are needed in New Zealand.

BACKGROUND

The rate of domestic violence in New Zealand has risen (Boshier, 2011) and has seen described as *"an epidemic"* (Hand et al, 2001). In fact, New Zealand has the highest rate of family violence in the developed world (*New Zealand Herald*, 2016). In 2014, 60 percent of all female homicides in New Zealand were committed by a family member (New Zealand Family Violence Clearinghouse, 2017). One in three (35 percent) ever-partnered New Zealand women report having experienced physical and/or sexual intimate partner violence in their lifetime. When psychological/emotional abuse is included, 55 percent report having experienced intimate partner violence in their lifetime (Fanslow & Robinson, 2011).

One in three New Zealand women and one in 10 men report having experienced child sexual abuse. Twenty percent of female secondary school students and 9 percent of male secondary school students report having experienced unwanted sexual contact in the previous 12 months. *"There were 2163 reported events involving the sexual victimisation of a child aged 16 years or under in 2016".* (New Zealand Family Violence Clearinghouse, 2017). On average, 525,000 people are harmed each year due to domestic violence, with 80 percent of these cases going unreported to authorities (*New Zealand Herald,* 2016).

It seems inevitable that both victims and perpetrators of violence will be assessed and treated in this country's emergency departments. This supposition is supported by research showing that those who experience abuse access the health-care system two to 2.5 times as often as those not exposed to abuse, and that care could be improved if health professionals were able to identify the signs of abuse underlying the patient's presentation (Fanslow & Robinson, 2004; Koss & Heslet, 1992). Additionally, research has shown that women with a lifetime experience of moderate or severe physical intimate partner violence were more likely to have consulted a health-care provider within the previous four weeks, more than twice as likely to have been hospitalised within the previous 12 months, and more than 2.5 times as likely to report current symptoms of emotional distress and suicidal thoughts in their lifetime, compared to women who had not experienced any violence (Fanslow & Robinson, 2004; Fanslow & Robinson, 2011). These findings have considerable implications for health-care delivery, highlighting the need for specialist skills in identifying current and past victims of violence and abuse in the health sector.

Violence is also becoming more visible in other ways, with front-line health-care staff, such as doctors and nurses, being assaulted (Swain, Gale & Greenwood, 2014; Wilson, 2009), ethnic groups being victimised, and ordinary people under threat from terrorism (Hawi, Osbourne, Bulbulia, & Sibley, 2019). Despite violence becoming more visible, health professionals, like the general public, are reluctant to report violence against themselves at work. Failure to report has the potential to influence cultural norms by hiding the true extent of violence in society (Richardson, Grainer, Ardagh & Morrison, 2018). Not reporting violence reinforces the notion that violence is acceptable. If violence is not reported, how can nurses and other health professionals work to reduce the impact of it for people in our communities? It is this question that prompted this review of the literature on the role of the clinical forensic nurse and the potential for such a role in emergency departments.

AIM

The aim of this systematic review was to gather evidence to support the establishment of clinical forensic nurse specialist roles in New Zealand emergency departments.

METHOD

A search of the literature was conducted using digital databases, including Medline, Ovid, EBSCOHost and ProQuest. Manual searches were also made using the reference list from recovered articles and textbooks. Key words used for the database searches were *"forensic nursing"*, *"forensic nursing education"*, *"forensic nursing research"*, *"forensic nursing specialization"*, *"emergency department"*, *"forensic medicine"* and *"forensic science"*. The search located 121 studies from 80 different journals, books and theses. Only literature that discussed forensic nursing in emergency departments was included in the review. Literature which discussed forensic nursing in general, or in other areas such as forensic mental health, was excluded. This narrowed the suitable studies down to 23 journal articles or textbooks.

A thematic approach (Braun & Clarke, 2012) was used to analyse the information in the articles. This approach uses six levels of analysis: familiarising oneself with the data, generating initial codes from the data, searching for themes, reviewing potential themes, defining and naming themes, and producing the report. Descriptive themes covered the qualities and skills forensic nurses possess, and the level of specialist knowledge required to ensure patients receive the best medico-legal care.

FINDINGS

The following section identifies the key themes identified by thematic analysis of the 23 reviewed studies.

Clinical forensic nurses possess specialist skills and knowledge, allowing them to identify, collect, document and preserve evidence from patients who are victims of violence. They also educate and mentor nursing colleagues and other health professionals on dealing with evidence associated with such patient presentations. Such evidence could include the circumstances surrounding the injury, the type of weapons involved, the length of time between the injury and treatment, the nature of the injury and whether there were any witnesses. Clinical forensic nurses also give legal testimony in court and write policies and guidelines on the collection and documentation of forensic evidence in public health services. Their specialist knowledge must equip them to care for some of the most challenging patients, who may have complex psychosocial, psychological and physical health-care needs, all while upholding ethical and legal principles.

Defining forensic nursing

The term "forensics" is derived from the Latin word *"forensis"* , meaning "forum", which described the marketplace where lawyers met to debate (Saunders, 2000). In modern use, "forensics" is a synonym for "legal" or "related to courts". Today, the term is used to describe the field of forensic science. Forensic science principles have become intertwined with other professions, including those in health care. These professions include forensic medicine, forensic pathology,

clinical forensic practice, and – the most recent addition – forensic nursing science (Lynch & Duvel, 2011; Lynch, 1996; Lynch, 1997).

The concept of forensic nursing emerged from the practice of clinical forensic medicine (Lynch, 1996). Clinical forensic medicine is defined as a medical specialty that applies the principles and practices of clinical medicine to the elucidation of questions in judicial proceedings for the protection of the individual's legal rights before death (Eckert et al, 1986, cited in Lynch, 1997). Until recently, practitioners of clinical medicine had largely ignored forensic issues in the care of the living patient (Lynch & Duvel, 2011; Smock, 2006). This lack of recognition led to the development of clinical forensic practice, which is defined as the application of medical and nursing sciences to the care of living victims of crime or liability-related accidents, as opposed to forensic pathology, which focuses upon the deceased (Lynch, 1993; Lynch & Duvel 2011).

Forensic nursing was first established in the United States (US) in the 1970s (Lynch & Duvel 2011; Sekula, 2016). It is now a growing nursing specialty in many other countries around the world (Lynch, 2011). Recognition as a nursing specialty was first acknowledged in 1995 by the American Nurses Association, after the International Association of Forensic Nurses (IAFN) was formed (Kent-Wilkinson, 2013). Canada very quickly followed with recognition in the late 1990s. In Australia, forensic nursing is a small but established specialty that is beginning to expand, thanks to the growing number of courses being developed and recognition of the role nurses can play in helping victims of crime and assisting the course of justice (Michel, 2008; Prebble, 2001; Saunders, 2000).

According to Lynch and Duvel (2011), there is now a greater focus on the needs of forensic patients, and not just the incarcerated, the mentally ill or the deceased. This is occurring as the public become more aware of their medical and legal rights, which adds pressure on hospital staff. Health-care staff struggle to manage the collection and documentation of forensic evidence when few hospitals have guidelines on how to do so (Williams, Richardson, O'Donovan & Ardagh, 2005) and there are no forensic nursing specialists to guide the process and ensure patients' legal rights and needs are met.

The clinical forensic nursing role

Forensic nursing in the emergency department is a nursing specialty that focuses on the identification of patients whose illness, injury or death stems from acts of violence. It involves providing the best medical and legal care, through effectively identifying, collecting, documenting and preserving evidence that can be handed over to law enforcement authorities, to be used in the investigation and prosecution of a case. Roles for clinical forensic nurse specialists in the area of interpersonal violence have become the norm in the US. There, nurses lead multidisciplinary teams in assessing child abuse, elder abuse and spousal abuse, and advise on related laws and policies (Kent-Wilkinson, 2011).

Forensic nurses also liaise between the emergency department and law enforcement authorities and give expert testimony in court (Goll-McGee, 1999; Kent-Wilkinson, 2009; Lynch & Duvel, 2011; McGillivray, 2005; Pyrex, 2006; Sekula, 2016). They not only provide life-saving management, resuscitation, and health care, which is the primary focus of the emergency nurse (McCracken, 1999; Pyrex 2006; Sullivan 2005); they also identify and collect evidence, including the circumstances surrounding the injury, the type of weapons involved, the length of time between injury and treatment, the nature of the injury and whether there were any witnesses (Lynch & Duvel, 2011; Kent-Wilkinson, 2009; McGillivray, 2005; Pyrex, 2006; Sekula, 2016).

Table 1. Forensic ABC mnemonic

Trauma ABCs	Forensic ABCs
Airway	**A**ssessment
Breathing	**B**ridge the gap (involving other agencies)
Circulation	**C**hain of custody
Disability	**D**ocumentation
Expose	**E**vidence
Fahrenheit	**F**amilies
Get vital signs	**G**oing to court
History and head to toe	**H**ospital policies and guidelines

Adapted from McCracken (2001)

One of the basic concepts of clinical forensic nursing is the idea of the *"body as a crime scene"* (Pyrex 2006). Sullivan (2005) describes the importance of recognising and collecting evidence, and accurate documentation. More recently, Foresman-Capuzzi (2014) stressed the importance of evidence collection in the emergency department and introduced the basic skills of collecting evidence and preserving the chain of custody for that evidence. Given the necessity of these skills, it is important that clinical forensic nurses practise in emergency departments, and that they have access to specialist postgraduate education (Lynch & Duvel, 2011; Kent-Wilkinson, 2009; Lynch, 1996; McGillivray, 2005; Pyrex, 2006; Sekula, 2016; Sullivan, 2005). Research has shown that emergency nurses are aware of forensic patients in their departments, but lack the knowledge, training or confidence to adequately care for them (Cucu et al, 2014; Michel, 2008). In some cases, there may be a legal mandate to gather evidence, eg in the case of motor-vehicle accidents or abuse of a child, and ethical considerations must always be considered, especially in relation to consent, invasiveness of evidence collection and loss of privacy. Williams et al (2005) discuss ethical considerations in forensic nursing, explaining how not collecting evidence could be to the detriment of the ethical principles of beneficence and non-maleficence, as well as to the pursuit of justice.

Another part of the role of the clinical forensic nurse involves educating and supporting other nurses and health professionals on how to identify living forensic patients and how to provide these patients with specialised medico-legal care. This care requires the collection and preservation of forensic evidence, and meticulous documentation and legal processes (Goll-McGee, 1999; Kent-Wilkinson, 2009; Lynch, 1996; Lynch & Duvel, 2011; McGillivray, 2005; Pyrex, 2006; Sullivan, 2005). Shapiro (2011) notes that when emergency nurses are educated about, and trained in, basic evidence collection, the practice can become an automatic and integral part of patient care that does not delay treatment.

To help clarify forensic nurses' responsibilities in the emergency department, McCracken (2001) devised a mnemonic for clinical forensic nurses, based on the well-known and internationally accepted ABC of trauma care (see Table 1). This works by applying logical steps to each letter of the alphabet to ensure safe, standardised, effective care.

While forensic victims of violence present at emergency departments in increasing numbers, it should not be forgotten that sudden or unexplained death may also require specialised clinical forensic nursing input, especially in terms of evidence collection, documentation and legal testimony (Lynch & Duvel, 2011; Pyrex, 2006; Sullivan, 2005).

DISCUSSION

The need for a clinical forensic nursing role in New Zealand

Nurses have a role in communicating, educating and acting as catalysts for change in public health (Castledine, 2002). They are educated to use evidence-based practice and can help design and implement specific interventions to give the best care to victims of domestic violence (Hegarty & Taft 2001; Spangaro, 2017). Nurses and doctors increasingly report that they lack the knowledge to deal with domestic violence issues with their patients (Biresch, 2011). Clinical forensic nurses have the skills to provide the specialised care these patients need.

Sadler (2002) says health professionals who work in emergency or acute care are more likely to find forensic or legal situations a cause of considerable uncertainty and anxiety. This is true in the New Zealand context, where Fanslow, Norton, Robinson and Spinola (1998) and Spangaro (2017) describe how New Zealand health-care professionals are concerned with addressing the issue of abuse due to fear of *"opening Pandora's box"*, fear of offending, a sense of powerlessness, time constraints and privacy issues.

Lynch (1997) also describes nurses as lacking knowledge about and awareness of forensic issues. Research by Hinderliter, Doughty, Delaney, Pitula and Campbell (2003) supported this point – they identified a lack of nursing competence and confidence in their ability to screen patients for domestic violence. The American Nurses Association and Sadler (2002) both highlight a lack of education and clinical preparation, in both undergraduate and postgraduate education, on dealing with violence and legal investigations. This is also true in New Zealand nursing education, where education and clinical preparation on violence and legal investigations is limited in both undergraduate and postgraduate nursing programmes.

Another barrier to nurses screening patients for family violence is the nurse's own experience of the issue. If one in every three females in New Zealand is affected by family violence (Ministry of Health, 2016), the predominantly female nursing workforce is likely to include a significant number who are themselves victims of abuse (Davis, 2007). It is essential, therefore, that the nursing profession take the guesswork out of forensic patient care for emergency department nurses (and other health-care professionals), to ensure appropriate and effective interventions, justice and professional accountability. Therefore, forensic education and resources are needed to prepare nurses for the specialist clinical forensic role.

Once nurses were educated for this specialty, the role could expand to include liaising with law enforcement, developing hospital forensic protocols, and serving as onsite role models in providing the best medical and legal care for patients in the emergency department.

The need for forensic nurses in New Zealand emergency departments was recognised nearly a decade ago, but has not been acted on (Williams, Richardson, O'Donovan & Ardagh, 2005). With the New Zealand Government announcing additional funding for family violence services for the first time in 10 years, and stating that the money will be split between *"stabilising current services and filling gaps in service delivery"* (New Zealand Family Violence Clearing House, 2019), the time is right for nurses to demand specialised postgraduate forensic nursing education. The development of a specialist clinical forensic nurse role in hospitals will help promote safer communities, address inequality and lower the significant health effects of violence, all while assisting the course of justice.

CONCLUSION

From this literature review, it is apparent there is a significant need for clinical forensic nurse specialists in New Zealand emergency departments. Violence is a significant health concern and New Zealand has among the highest rates of domestic violence in the world. Emergency departments lack protocols to support nurses and other front-line personnel to care for and treat the victims of violence or unexplained death. Currently, the medico-legal needs of these patients are not being sufficiently addressed. This review also indicates nurses may lack the confidence, skills and education to meet medico-legal obligations to forensic patients and to fulfil their duty to "do no harm". Tertiary education needs to offer clinical forensic nursing training. Also, emergency departments need to develop the clinical forensic nurse specialist role, not only as a resource and role model for other emergency department nurses, but also to help develop forensic protocols, to liaise with law enforcement and to ensure patients' legal rights and the needs of justice are met.

REFERENCES

Anda, R. (2018). T*he role of adverse childhood experiences in substance misuse and related behavioral health problems.* SAMHSA. Retrieved from https://preventionsolutions.edc.org/sites/default/files/attachments/The-Role-of-Adverse-Childhood-Experiences-in-Substance-Misuse-and-Related-Behavioral-Health-Problems_1.pdf

Biresch, J. (2011). Assessing domestic violence in the healthcare setting. Article one in a five-part series on DV. *The Pennsylvania Nurse, 66*(2), 6-10. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21928550

Boshier, P. (2011) Family Law: Family Violence. *Family Matters, No. 88*, 27-30. https://aifs.gov.au/publications/family-matters/issue-88/family-law

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57-71). Washington DC, US: American Psychological Association. http://dx.doi.org/10.1037/13620-004

Butchart, A., & Mikton. C. (2014). *Global status report on violence prevention 2014*. Geneva, Switzerland: World Health Organization.

Castledine, G. (2002). The development of the role of the clinical nurse specialist in the UK. *British Journal of Nursing, 11*(7), 505-507.

Cucu, A., Ion, D., Paduraru, D., & Galan, A. (2014). Forensic nursing emergency care. *Romanian Society of Legal Medicine, 22*, 133-136. doi:10.4323/rjlm.2014.133

Davis, G. (2007). Family Violence in New Zealand: A Primary Healthcare Nursing Perspective. *Whitireia Nursing Journal, 14,* 7-16.

Fanslow, J., & Robinson, E. (2004). Violence against women in New Zealand:

prevalence and health consequences. *New Zealand Medical Journal, 117*(1206), 1-12.

Fanslow, J. L., & Robinson, E. M. (2011). Sticks, stones, or words? Counting the prevalence of different types of intimate partner violence reported by New Zealand women. *Journal of Aggression, Maltreatment & Trauma, 20*(7), 741–759. https://doi.org/10.1080/10926771.2011.608221

Fanslow, J. L., Norton, R. N., Robinson, E. M., & Spinola, C. G. (1998). Outcome evaluation of an emergency department protocol of care on partner abuse. *Australian New Zealand Journal of Public Health, 22*(5), 598–603.

Foresman-Capuzzi, J. (2014). CSI & U: Collection and Preservation of Evidence in the Emergency Department. *Journal of Emergency Nursing, 40*(3), 229-236. https://doi.org/10.1016/j.jen.2013.04.005

Goll-McGee, B. (1999). The role of the clinical forensic nurse in critical care. *Critical Care Nursing Quarterly, 22*(1), 8–18.

Hand, J., Elizabeth, V., Rauwhero, H., Selby, S., Burton, M., Falanitule, L., & Martin, B. (2001). *Free from abuse: What women say and what can be done.* Auckland: Auckland District Health Board. https://nzfvc.org.nz/sites/nzfvc.org.nz/files/free-from-abuse-2002.pdf

Hawi, D., Osbourne, D., Bulbulia, J., & Sibley C. G. (2019). Terrorism anxiety and attitudes towards Muslims. *New Zealand Journal of Psychology, 48*(1), 80-89.

Hegarty, K. L., & Taft, A. J. (2001). Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Australian and New Zealand Journal of Public Health, 25*(5), 433-437. doi:10.1111/j.1467-842x.2001.tb00288.x

Hinderliter, D., Doughty, A., Delaney, K., Pitula, C., & Campbell, J. (2003). The Effect of Intimate Partner Violence Education on Nurse Practitioners' Feelings of Competence and Ability to Screen Patients. *Journal of Nursing Education, 42*(10), 449-454.

Kent-Wilkinson, A. (2013). Forensic nursing education: developments, theoretical conceptualizations and practical applications for curriculum. In R. M. Hammer, B. Moynihan, & E. M. Pagliaro (Eds), *Forensic Nursing: A handbook for practic*e (pp. 463–471). Burlington, MA: Jones & Bartlett.

Kent-Wilkinson, A. (2011). Forensic nursing educational development: An integrated review of the literature. *Journal of Psychiatric and Mental Health Nursing, 18,* 236-246. doi:10.1111/j.1365-2850.2010.01667.x.

Kent-Wilkinson, A. (2009). The unique knowledge of forensic nursing: implications for interprofessional education. *International Journal of Interdisciplinary Social Science, 4*(7), 171-182.

Koss, M. P., & Heslet, L. (1992). Somatic consequences of violence against women. *Archives of Family Medicine, 1*(1), 53-59.

Loxton, D., Dolja-Gore, X., Anderson, A. E., & Townsend, N. (2017). Intimate partner violence adversely impacts health over 16 years and across generations: A longitudinal cohort study. *PLoS ONE, 12*(6), e0178138. doi:10.1371/journal.pone.0178138.

Lynch, V., & Duvel, J. B. (2011). *Forensic Nursing (2nd ed)*. New York, NY: Mosby.

Lynch, V. (1993). Forensic nursing diversity in education and practice. *Journal of Psychosocial Nursing, 31*(11), 7-14.

Lynch, V. (1996). Advances in forensic nursing: New dimensions for the 21st century. *Journal of Psychosocial Nursing, 34*(10), 6-7.

Lynch, V. (1997). *Clinical Forensic Nursing: A new perspective in trauma*. Ft. Collins, CO: Bearhawk Consulting Group.

Lynch, V. (2011). Forensic Nursing Science: Global strategies in health and justice. *Egyptian Journal of Forensic Sciences, 1,* 69-76. https://doi.org/10.1016/j.ejfs.2011.04.001

McCracken, L. M. (1999). Living forensics: a natural evolution in emergency care. *Accident and Emergency Nursing, 7,* 211-216.

McCracken, L. M. (2001). The forensic ABCs of trauma care. *Canadian Nurse, 97*(3), 30-33.

McGillivray, B. (2005). The role of Victorian emergency nurses in the collection and preservation of forensic evidence: a review of the literature. *Accident and Emergency Nursing, 13*, 95-100.

Michel, C. M. (2008). *Implementing a forensic educational package for registered nurses in two emergency departments in Western Australia.* (Thesis) Fremantle, Australia: University of Notre Dame.

Ministry of Health. (2016). *Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence* (2nd ed). Wellington: Author.

New Zealand Family Violence Clearinghouse. (2017, July). *Data Summaries 2017.* Retrieved from https://nzfvc.org.nz/sites/nzfvc.org.nz/files/Data-summaries-snapshot-2017.pdf

New Zealand Family Violence Clearinghouse. (2019). *New government funding for family violence services.* Retrieved from https://nzfvc.org.nz/news/new-government-funding-family-violence-services

New Zealand Herald. (2016, May 9). *Family violence: 525,000 New Zealanders harmed every year.* Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11634543

Prebble, K. (2001). On the brink of change? Implications of the review of undergraduate education in New Zealand for mental health nursing. *Australian and New Zealand Journal of Mental Health Nursing, 10*(3), 136-144. doi:10.1046/j.1440-0979.2001.00204.x

Pyrex, K. M. (2006). *Forensic Nursing.* Boca Raton, Florida: CRC Press.

Richardson, S. K., Grainger, P. C., Ardagh, M. W., & Morrison, R. (2018). Violence and aggression in the emergency department is under-reported and under-appreciated. *New Zealand Medical Journal, 131*(1476), 50-58.

Sadler, D. (2002). Forensic skills for nurses. *Nursing Times.* Retrieved from https://www.nursingtimes.net/forensic-skills-for-nurses/197703.article

SAMHSA. (2014). *Trauma-informed care in behavioral health sciences.* Retrieved from https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

Saunders, L. (2000). Forensic nursing. Formalising a new role or recognising existing practice? *Australian Nursing Journal, 8*(3), 49-50.

Sekula, L. K. (2016). What is Forensic Nursing? In A. Amar, & L. K Sekula (Eds.), *A Practical Guide to Forensic Nursing: Incorporating forensic principles into nursing practice* (pp 1-15). Indianapolis, IN: Sigma Theta Tau International.

Shapiro, P. (2011). Forensic first response: approach for emergency medical personnel. In V. Lynch, & J. Duval (Eds.), *Forensic Nursing Science* (2nd ed, pp. 123-133). St Louis, MO: Mosby.

Smock, W. S. (2006). Genesis and development. In V. Lynch (Ed), *Forensic Nursing* (pp. 13-15). St Louis, MO: Mosby.

Spangaro, J. (2017). What is the role of health systems in responding to domestic violence? An evidence review. *Australian Health Review, 41,* 639-645. https://doi.org/10.1071/AH16155

Sullivan, M. K. (2005). Opportunities and Challenges in forensic nursing. In V.A Lynch (Ed.), *Forensic nursing in the hospital setting. St Louis.* MO: Mosby

Swain, N., Gale, C., & Greenwood, R. (2014). Patient aggression experienced by staff in a New Zealand public hospital setting. N*ew Zealand Medical Journal, 127*(1394), 10-18.

Williams, T., Richardson, S., O'Donovan, P., & Ardagh, M. (2005). The forensic nurse practitioner role (emergency nursing) – A potential response to changing health needs in New Zealand. *Medicine and Law, 24,* 111-123.

Wilson, D. (2009). Workplace violence experienced by registered nurses: A concept analysis. *Nursing Praxis in New Zealand, 25*(3), 37-50.

Research brief

ASSESSING ENGLISH LANGUAGE SKILLS OF INTERNATIONALLY QUALIFIED NURSES IN NEW ZEALAND

About the author: *Jenny Wraight, RN, BN, MNSc, PGCert ClinEd, is a nursing tutor and clinical educator at Nelson Marlborough Institute of Technology, Nelson, New Zealand.*
Her correspondence address is jenny.wraight@nmit.ac.nz

Jenny Wraight

Key words
Internationally qualified nurses, clinical communication, English as an additional language, communication assessment.

Aim
Clinical communication assessment guidelines (San Miguel & Rogan, 2015) were developed in Australia to assess nursing students' English language proficiency. Nurse educators at Nelson Marlborough Institute of Technology adapted these guidelines for New Zealand use, calling them the clinical communication assessment framework (CCAF). The purpose of this framework was to assess the English language proficiency of nurses with English as an additional language (EAL) in the clinical nursing environment. This research reports on an assessment of nurses using this framework, performed before the competency assessment programme (CAP) four-week clinical nursing placement. It describes the first application of this clinical communication assessment tool in New Zealand.

Background
Shifting global demographics are resulting in large numbers of internationally qualified nurses (IQNs) with EAL working in English-speaking countries such as New Zealand (Habermann & Stagge, 2010; Jones & Sherwood, 2014). Out of 49,933 practising registered nurses on the New Zealand register, 27 percent had received their initial training overseas (Nursing Council of New Zealand, 2018). The clinically-focused English language ability of IQNs remains a concern (Bland, Oakley, Earl, & Lichtwark, 2011; Meek, 2015; Olson, 2012; Philip, Manias, & Woodward-Kron, 2015; San Miguel & Rogan, 2015). This concern remains, despite these nurses passing English language competency tests such as the International English language testing system (IELTS) or the Occupational English Test (OET) (O'Neill, Buckendahl, Plake, & Taylor, 2007; Shen et al, 2012). These tests are used internationally and are required by the Nursing Council of New Zealand (Nursing Council) for entry to nursing programmes such as CAP, at NMIT (Nursing Council of New Zealand, 2011).

IELTS assesses the IQN's basic, generic English language skills, as opposed to comprehensive nursing-focused clinical communication (Ho, 2015; Lu & Maithus, 2012; O'Neill et al., 2007). The Nursing Council requires IQNs to have an OET score of B, or IELTS of 7, over three test sittings. NMIT requires the same level for OET and IELTS; however the IQN candidate must achieve these grades in one sitting (Nelson Marlborough Institute of Technology, 2019). IELTS is more commonly used by IQNs as the entry English test, as it is less expensive, is recognised internationally and is more accessible as it is held more often than OET and is available in IQNs' countries of origin (Rumsey, Thiessen, Buchan, & Daly, 2016). OET focuses more on simulating the professional context, and is recognised as a language test for overseas-qualified health professionals (Lynch, 2016). However, an OET-IELTS benchmarking report identified discrepancies between the two tests, with some students passing the OET and failing IELTS, and others doing the opposite (Elder, 2007), leading some researchers to question the appropriateness of these English language tests as tools to prepare IQNs for registration (Sedgwick & Garner, 2017).

Clinical educators and nursing assessors at NMIT have reported that CAP students with EAL struggle with communication during clinical placements. This deficiency meant IQNs with EAL needed to be given extra clinical time (Riden, Jacobs, & Marshall, 2014) to ensure they were able to communicate effectively in English in clinical situations (Nursing Council of New Zealand, 2011). No clinical communication assessment tool is used in New Zealand nursing education. NMIT nursing educators developed the CCAF by identifying an Australian tool for assessing clinical English language ability (San Miguel & Rogan, 2015) and adapting it for use in New Zealand. This pilot study was conducted to evaluate the suitability of this new framework for determining IQNs' communication abilities.

Methods
Ethical approval was obtained from the NMIT research and ethics committee and informed consent obtained from each participant. Inclusion criteria were that the participant:

1) had English as an additional language,
2) was an IQN,
3) had passed IELTS or OET, and
4) was a student on CAP at NMIT.

Before doing CAP clinical placements, participants were assessed by a nursing assessor, using the CCAF, at five objective simulated clinical assessment (OSCA) stations. This assessment involved the participant performing the required clinical assessments while communicating with a "patient" (an OSCA volunteer). Scores – "unsatisfactory" , "needs development" or "satisfactory" – were recorded for spoken English, vocabulary, pronunciation, asking for clarification and demonstrating understanding. An aggregate clinical communication score was calculated.

Findings
Participants, all from the same CAP course, consisted of nurses from the Philippines (n=6) and India (n=4). These nurses had 5.2 ± 0.5 years of experience of nursing in their country of origin, and 1.8 ± 0.4 years of experience using English as a language when nursing (all data are reported average ± SEM – the standard error of the mean). Of these 10 participants, 25 percent scored "unsatisfactory",

30 percent "needed development" and 45 percent scored a "satisfactory" standard of clinical communication. While no correlation was found between participants' years of nursing experience and their aggregate clinical communication score (R=.48; P=.16), a significant positive correlation was identified between years of nursing using English and aggregate clinical score (R=.68; P=.032). This finding suggests the first years of nursing in an English-language environment facilitate critical communication growth, allowing IQNs to be effective nurses (Crawford & Candlin, 2013; O'Neill et al, 2007). Students achieving an "unsatisfactory" mark were given additional clinical communication training by the CAP nurse lecturer. The strategies outlined by San Miguel and Rogan (2015) – such as asking students to give a patient hand-over, or to practise talking to patients while carrying out a skill – were used to ensure they received suitable support to improve their clinical communication skills. The CAP students who received additional training were reassessed, and, before placement in the clinical environment, all scored above the "unsatisfactory" level.

Conclusion

English language proficiency is required for IQNs to achieve Nursing Council registration (Nursing Council of New Zealand, 2011). Despite all participants in this study passing IELTS, some required additional English-language training before starting their CAP clinical placement. The CCAF assessment tool, adapted from the San Miguel and Rogan (2015) guideline, allowed easy identification of the specific clinical English-language training needs of IQNs, to ensure their success in the clinical environment, beyond the minimal requirements for registration. This research was conducted as a pilot study in a simulated environment, to assess the usability of the CCAF with IQNs who identify as EAL students in the CAP course. Further research assessing larger numbers of nurses from more diverse language backgrounds will determine the broader applicability of the CCAF to assess IQNs who have English as an additional language.

Recommendations

The CCAF is a promising tool to identify IQNs requiring additional English language training before clinical placement. Due to the initial success of its use, NMIT has integrated this assessment tool into the OSCA and the clinical curriculum for all IQNs who have EAL. This change provides a consistent method of assessing clinical English language proficiency, and efficient use of resources to provide additional training when required to prepare IQNs for clinical placement. Subsequent work will compare the CCAF and clinical communication in greater detail through a larger cohort of approximately 45 IQNs. The CCAF is a practical, efficient and straightforward tool that can be integrated into both simulated and clinical environments to assess the clinical English-language ability of IQNs.

References

Bland, M., Oakley, D., Earl, B., & Lichtwark, S. (2011). Examining the barriers to RN transition for students on competency assessment programmes. *Kai Tiaki Nursing New Zealand, 17*(5), 18-21.

Crawford, T., & Candlin, S. (2013). A literature review of the language needs of nursing students who have English as a second/other language and the effectiveness of English language support programmes. *Nurse Education in Practice, 13*(3), 181-185. https://doi.org/10.1016/j.nepr.2012.09.008

Elder, C. (2007). *OET-IELTS benchmarking study report*. Australia: Language Testing Research Centre, University of Melbourne.

Habermann, M., & Stagge, M. (2010). Nurse migration: a challenge for the profession and health-care systems. *Journal of Public Health, 18*(1), 43-51. https://doi.org/10.1007/s10389-009-0279-0

Ho, Y.-Y. C. (2015). Investigating internationally educated Taiwanese nurses' training and communication experiences in the United States. *Journal of Continuing Education in Nursing, 46*(5), 218-227. https://doi.org/10.3928/00220124-20150420-02

Jones, C. B., & Sherwood, G. (2014). The globalization of the nursing workforce: Pulling the pieces together. *Globalization of the Nursing Workforce, 62*(1), 59-63. https://doi.org/10.1016/j.outlook.2013.12.005

Lu, H., & Maithus, C. (2012). Experiences of clinical tutors with English as an additional language (EAL) students. *Nursing Praxis in New Zealand, 28*(3), 4-12.

Lynch, T. (2016). Is English language background an indicator of success in the English tests required for nursing registration in Australia? *International Journal of Arts & Sciences, 7*(5), 539-570.

Meek, G. (2015). Teaching physical assessment skills to international nursing students in New Zealand. *International Journal of Nursing Education, 7*(1), 230-234. https://doi.org/10.5958/0974-9357.2015.00047.1

Nelson Marlborough Institute of Technology. (2019). *NMIT Certificate in Nursing Competence Assessment Programme*. Retrieved from https://www.nmit.ac.nz/study/programmes/certificate-in-nursing-competence-assessment-programme-level-7/

Nursing Council of New Zealand. (2018). *The New Zealand Nursing Workforce: A Profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2016–2017*. Retrieved from https://www.nursingcouncil.org.nz/Public/Publications/Workforce_Statistics/NCNZ/publications-section/Workforce_statistics.aspx?

Nursing Council of New Zealand. (2019). *Registration standard: English language. English language assessments*. Retrieved from https://www.nursingcouncil.org.nz/Public/Nursing/Registration_for_International_Nurses_/NCNZ/Registration-section/Registration_for_International_Nurses_.aspx

Olson, M. (2012). English-as-a-second language (ESL) nursing student success: A critical review of the literature. *Journal of Cultural Diversity, 19*(1), 26–32.

O'Neill, T., Buckendahl, C., Plake, B., & Taylor, L. (2007). Recommending a nursing-specific passing standard for the IELTS examination. *Language Assessment Quarterly, 4*(4), 295–317. https://doi.org/10.1080/15434300701533562

Philip, S., Manias, E., & Woodward-Kron, R. (2015). Nursing educator perspectives of overseas qualified nurses' intercultural clinical communication: barriers, enablers and engagement strategies. *Journal of Clinical Nursing, 24*(17/18), 2628–2637. https://doi.org/10.1111/jocn.12879

Riden, H., Jacobs, S., & Marshall, B. (2014). New Zealand nurses' views on preceptoring international nurses. *International Nursing Review,* 61(2), 179–185. https://doi.org/10.1111/inr.12087

Rumsey, M., Thiessen, J., Buchan, J., & Daly, J. (2016). The consequences of English language testing for international health professionals and students: An Australian case study. *Language and Communication Issues in Health Care – International Journal of Nursing Studies, 54,* 95–103. https://doi.org/10.1016/j.ijnurstu.2015.06.001

San Miguel, C., & Rogan, F. (2015). Assessing students' English language proficiency during clinical placement: A qualitative evaluation of a language framework. *Nurse Education Today, 35*(6), 771–776. http://dx.doi.org/10.1016/j.nedt.2015.02.014

Sedgwick, C., & Garner, M. (2017). How appropriate are the English language test requirements for non-UK-trained nurses? A qualitative study of spoken communication in UK hospitals. *International Journal of Nursing Studies, 71,* 50–59. https://doi.org/10.1016/j.ijnurstu.2017.03.002

Shen, J., Xu, Y., Bolstad, A., Covelli, M., Torpey, M., & Colosimo, R. (2012). Effects of a short-term linguistic class on communication competence of international nurses: Implications for practice, policy, and research. *Nursing Economics, 30*(1), 21–28.

Research brief

FACTORS INFLUENCING NURSES' CHOICE TO WORK IN MENTAL HEALTH SERVICES FOR OLDER PEOPLE

About the author: *Krizia Ledesma-Libre, RN, PGDipHSc, MN, works as a registered nurse at Puawai, the Midland Regional Forensic Psychiatric Service, Waikato District Health Board, Hamilton, New Zealand. Her correspondence address is Krizia.Ledesma@waikatodhb.health.nz*

Krizia Ledesma-Libre

Keywords

Older people, mental health services, perceptions, motivations, nurses.

Aim

The aim of this study was to identify factors influencing nurses' choice to work in mental health services for older people (MHSOP) and to explore the perspectives of nurses who did not actively choose to work in MHSOP but who have stayed in this service. In MHSOP and dementia services, there are concerns about recruitment and retention of nursing staff, and the need to plan for an ageing workforce. This research explored the factors influencing nurses' decision to work in this field, including their positive and negative perceptions of MHSOP. It also explored whether they had considered leaving MHSOP and what supported their motivation to work in the specialty. The research question was: *"What is the motivation and perception of nurses as to working in, staying, or leaving MHSOP in New Zealand?"*

Background

In many countries, the number of people aged 60 years and over is increasing rapidly, compared to other age groups. This increase in the proportion of older people is attributed to a longer lifespan, and decreasing fertility rates (World Health Organization, 2016a). The ageing of the population can be seen as both a positive and a challenge. Worldwide, it is projected that from the years 2015 to 2050, the proportion of the older population will double from 12 percent to 22 percent. It is anticipated that by 2020, there will be more older people than children five years and younger. At 2050, the number of older people aged 60 years and over is estimated to reach 2 billion, from only 900 million in 2015. By 2050, 80 percent of the older population will be living in low and middle-income nations. All nations experience obstacles to providing health and social systems that are equipped to face this demographic shift known as "population ageing" (World Health Organization, 2016b). In New Zealand, the number of older people aged 85 years and over is predicted to increase substantially by 2051; by 2026, nearly 18 percent of the entire population will be aged 65 years and above (Ministry of Health, 2011).

Few researchers see older people nowadays as being healthier in their old age than their parents. The prevalence of severe disability in older people has decreased in higher-income nations in the last 30 years, but there has been no marked improvement in mild to moderate disability over the same period (World Health Organization, 2016b). If older people can live out their longer lifespan in good health, and if they live in a supportive environment, their capacity to perform activities they find meaningful will enable a better quality of life. However, if these latter years involve physical and cognitive decline, the implications for older people and for civilisation are more discouraging (World Health Organization, 2016b).

Methods

The qualitative approach for this research was process-oriented, with a focus on participants' perceptions and descriptions of their experiences. Data were collected via moderated focus group discussions with 30 mental health nurses, and then treated to thematic analysis. As moderated group discussions, focus groups allow participants to talk, discuss, agree or disagree about views, ideas, attitudes and experiences (Curtis & Redmond, 2007; Kevern & Webb, 2001; Kitzinger, 1995; Parahoo, 2007). Focus groups are an effective way of extracting the viewpoints or attitudes of people on difficult, under-investigated matters (Barbour, 2005). In this study, the focus-group approach was used to enable nurses to freely discuss, agree and disagree with colleagues regarding their motivations and perceptions of working in, staying in or leaving MHSOP.

Setting

The study was carried out in the MHSOP of three New Zealand district health boards (DHBs). These DHBs employ nurses in both inpatient and community settings within the service.

Ethics

The study was given ethical approval by the University of Auckland Human Participants Ethics Committee, ref. 017730, and by the ethics committees of each participating DHB.

Findings

Data analysis revealed three over-arching themes, including:
(1) Mental health nurses vs general nurses: Nurses in MHSOP wanted to be able to use all their skills, in both mental and physical health care.
(2) The work environment: Whether it is a supportive, pleasant place to work; if there is conflict within or between services; the style of management; other challenges encountered in the service.
(3) Characteristics of a MHSOP nurse and what motivates them.

1) Mental health nurses vs general nurses: Nurses in the focus group felt it was important that they be able to use all their skills to provide the most comforting and therapeutic environment for their patients. Some noted that the role of the MHSOP in two of the DHBs was "delimited", ie if a patient became physically unwell, they had to be transferred to a general ward. They said DHBs were employing new-graduate nurses who have comprehensive registration, and are therefore able to practice in a broad variety of clinical contexts (NCNZ, 2010), but were missing out on using their skills on complex physical procedures because of the limited nature of the MHSOP. Some participants, however, felt fortunate that they were able to

exercise their comprehensive range of nursing skills in the service. In the future, quality nursing practice will need flexible nurses who can provide holistic, patient-centred care (Potgieter, 1999). To provide such service, nurses need to be comprehensive in their approach, and knowledgeable in both mental health and general nursing.

2) The work environment: Nurses found work environments supportive where there was cohesion and teamwork, and where nurses showed an awareness of and sensitivity to each other. Having autonomy, in terms of being able to pursue their own professional interests in nursing; having access to ongoing education; and participating in a variety of roles were other important aspects of a positive work environment. Having the opportunity to care for and respect patients, and being appreciated by patients, families, and colleagues, added to their job satisfaction. Feedback showing they are appreciated for the job they do and for their accomplishments, effective communication, and being shown respect are some of the key motivators for nurses at work (Global Health Workforce Alliance, 2008). Nurses want to feel independent, proficient and connected (Ryan & Deci, 2000); to achieve self-actualisation and success (Oldham & Hackman, 2010); to do meaningful work; and to experience positive outcomes from their own hard work (Oldham & Hackman, 2010). Supportive, helpful employers, and attention to workplace health and safety, are some of the key motivating circumstances for jobs in hospitals (Global Health Workforce Alliance, 2008).

However, nurses participating in this study also experienced challenges in their jobs. These included: conflict with management; not being listened to; no clear leadership; and lack of communication and inconsistency from the management team. Short staffing, inappropriate staff mix, rapid staff turnover, high-acuity workloads, and dealing with challenging behaviours of mental health patients, were all identified as challenges for nurses working in MHSOP. Retention of nurses in mental health is important for the maintenance of a skilled and knowledgeable workforce. Alexander, Diefenbeck and Brown (2015) concluded that nurses who remain working in mental health do so by overcoming negative attitudes towards their career specialty (often propagated by other nurses or health-care staff) and by fostering pride in their distinctive skills. Given these findings, management could use education, motivation programmes, and mentoring/coaching sessions to promote the self-worth and morale of mental health nurses.

3) Characteristics of a MHSOP nurse and what motivates them: The third theme identified the characteristics of a MHSOP nurse. According to the focus group nurses, these characteristics include *"being real"*, not taking things personally, being self-motivated, having a good support system, being internally motivated, having a work-life balance, getting support with training and education, and treating patients as if they were their own parents. Nurses' job motivation has been recognised as vital to their intentions to remain in the nursing workforce (Brewer, Kovner, Greene, & Cheng, 2009). It gives nurses the bearing and determination to work. However, motivational factors may differ for each individual in different stages of their career. The participants in this study talked about the variety of different motivational factors (both internal and external) they had for working in MHSOP. Alexander et al (2015) pointed out that mental health nurses who stayed in mental health had learned to modify their expectations for clients, and how they perceived achievement; and had faith that they were making a positive difference in the lives of their patients.

Conclusions

This research found that nurses working in MHSOP saw it as both rewarding and challenging. It was found to be a mostly positive experience for nurses who were personally motivated and committed to work with their patients. However, mental health and general nurse specialists and educators need to collaborate to support MHSOP nurses who are interested in improving and developing their physical nursing skills. This might involve MHSOP nurses working one day a week in a general setting to hone their physical nursing skills, and general nurses working in mental health to improve their mental health nursing skills. MHSOP nurses also emphasised their unique qualities: being passionate, flexible, innovative, empathetic and holistic; providing individualised patient care, and being patient-centred and patient advocates. The findings of this research suggest that despite the challenges encountered in the DHB setting, MHSOP nurses are motivated to continue working in this specialty.

References

Alexander, R. K., Diefenbeck, C. A., & Brown, C. G. (2015). Career choice and longevity in US psychiatric-mental health nurses. *Issues in Mental Health Nursing, 36*(6), 447–454. https://doi.org/10.3109/01612840.2014.994078

Barbour, R. S. (2005). Making sense of focus groups. *Medical Education, 39*(7), 742–750. https://doi.org/10.1111/j.1365-2929.2005.02200.x

Brewer, C. S., Kovner, C. T., Greene, W., & Cheng, Y. (2009). Predictors of RNs' intent to work and work decisions 1 year later in a U.S. national sample. *International Journal of Nursing Studies, 46*(7), 940–956. doi:10.1016/j.ijnurstu.2008.02.003

Curtis, E., & Redmond, R. (2007). Focus groups in nursing research. *Nurse Researcher, 14*(2), 25–37. doi:10.1016/j.outlook.2012.02.001

Global Health Workforce Alliance. (2008). *Guidelines: Incentives for health professionals.* Geneva: World Health Organization. Retrieved from http://www.who.int/workforcealliance/knowledge/publications/alliance/Incentives_Guidelines%20ENG%20low.pdf?ua=1

Kevern, J., & Webb, C. (2001). Focus groups as a tool for critical social research in nurse education. *Nurse Education Today, 21*(4), 323–333. doi:10.1054/nedt.2001.0563

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal, 311*(7000), 299–302. doi:10.1136/bmj.311.7000.299

Ministry of Health. (2011). *Mental Health and Addiction Services for Older People and Dementia Services: Guideline for district health boards on an integrated approach to mental health and addiction services for older people and dementia services for people of any age.* Wellington: Ministry of Health.

Nursing Council of New Zealand (NCNZ). (2010). *New Zealand Gazette 108, 2916.* Retrieved from https://www.nursingcouncil.org.nz/Public/Nursing/Register_as_a_nurse/NCNZ/nursing-section/Register_as_a_nurse.aspx?hkey=e0112781-d117-4cff-89b6-979dc4025ff7

Oldham, G. R., & Hackman, J. R. (2010). Not what it was and not what it will be: The future of job design research. *Journal of Organizational Behavior, 31*(2–3), 463–479. doi:10.1002/job.678

Parahoo, K. (2007). Focus groups are enjoying increased in popularity as a research method. *Nurse Researcher, 14*(2), 4–6. doi:10.1080/1740462042000339203

Potgieter, E. (1999). The Whole Brain Creativity Model: Implications for nursing education and practice. *Curationis, 22*(4), 41–48.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*(1), 68-78. doi:10.1037/0003-066X.55.1.68

World Health Organization. (2016a). *Ageing.* Retrieved from http://www.who.int/topics/ageing/en/

World Health Organization. (2016b). *Ageing and health.* Retrieved from http://www.who.int/mediacentre/factsheets/fs404/en/

Methodology

USING FOCUSED ETHNOGRAPHY IN NURSING RESEARCH

Ruth Crawford

About the author: *Ruth Crawford, RN, PhD, is director of the School of Nursing, Health & Wellness, at Western Institute of Technology at Taranaki, New Plymouth, New Zealand.*
Her correspondence address is: R.Crawford@witt.ac.nz

Research methodology is concerned with the questions *"How did you do it?"* and *"How did you know?"* Both these questions underpin a further question constantly asked when undertaking qualitative research: *"Are you sure?"* (Morse, 1994). According to Morse, the soundness of qualitative research, the certainty of the methodology, is imperative. In this paper, I establish how I addressed these issues in my PhD research. My use of focused ethnography is detailed, providing the reader with an auditable route of the study process, along with a discussion of the rigour of the study. The strength of the ethnographic method in uncovering hidden, taken-for-granted assumptions of the participants is revealed.

Nurse-parent emotional interaction was the central focus of my research. I investigated nurses' and parents' experience of emotional communication in the context of a children's unit of a regional hospital in New Zealand. In this paper, emotional communication is defined as communication between the nurse and the parent which focuses on the parent's feelings and affective responses in relation to their child's hospitalisation.

As researcher, I was particularly interested in what was going on behind the nurse-parent interaction (the hidden aspects), as well as exploring the front (the observable aspects) of the interaction. I wanted to understand the cultural context of the interaction, to uncover not only what happens, but also why and how it happens, when nurses and parents of hospitalised children communicate and interact in relation to parents' emotions.

Method

I required a method which would allow me, as the researcher, to look under the observable surface of the nurse-parent interaction to cultural factors influencing nurse-parent communication. I wanted to understand the context in which the interaction takes place, in this case a hospital unit. Hospital units have cultures that are unique to each setting and I needed a method which would allow me to first observe the relationship as an outsider looking in, thus attempting to understand what was going on from nurse and parent perspectives. Ethnography was chosen to enable an uncovering of the hidden, taken-for-granted assumptions (Kleinman, 1988; Mulhall, Le May & Alexander, 1999) of nurses and parents in the health-care environment. Ethnographic methods are designed to explicate and unravel elements in a culture (Ersser, 1996; Lambert, Glacken & McCarron, 2011), such as the culture of communication in the nurse-parent relationship. The ethnographic approach (Higginbottom, 2011; Holloway & Wheeler, 2010; Liamputtong, 2010) was an appropriate and logical choice.

Ethnography

Contemporary ethnography as a research method originated in the discipline of social anthropology in the early 20th century. Hammersley (1990) notes that ethnography as a methodology has some common features, including studying people's behaviour in everyday contexts; gathering data from a range of sources, particularly observation and informal conversations; an unstructured approach to data collection; a focus on a single setting or group; and analysis involving interpretation of meanings and functions of human actions.

The aim of ethnography is to discover cultural and contextual patterns of knowing, to better understand social and health issues (Duffy, 2005) – not only the "what", but also the "why" and the "how". Using an ethnographic method, the researcher participates in people's daily lives for a period, watches what happens, listens to what is being said, asks questions through formal and informal interviews and collects documents and artefacts (Hammersley & Atkinson, 2007).

Reflexive practice, a central aspect of ethnography, is the acknowledgement of the place of the researcher within the context of the group being studied. Reflexivity is a process that is used to recognise that the researcher is an integral part of the social world being studied (Ersser, 1996; Hammersley & Atkinson, 2007). Ethnography consists partly of participant observation and partly of conversation or interview; it is the mix of these two that leads to reflexivity (Boyle, 1994). Mulhall et al (1999) suggest the reflexive conversation asks the researcher these questions:

1) How have I affected the process and outcome of the research?
2) How has the research affected me?
3) Where am I now?

As part of the reflexive process, researchers need to be aware of their own effects on the research process by identifying any biases brought into the field and their emotional response to their experiences (Roper & Shapira, 2000). Rather than studying people, as a reflexive researcher, I aimed to learn from people, trying to grasp the emic point of view (Morse & Field, 1996). Closely aligned to reflexivity, a further distinguishing feature of contemporary ethnography is the emic/etic perspective.

Emic and etic perspectives

The emic (participant/insider) and the etic (researcher/outsider) perspectives are a significant characteristic of ethnography. The researcher is always going to be the outsider in the relationship,

with participants always having an inside view; how the researcher bridges the divide between the two is key. Ethnography is a research approach which is neither subjective nor objective *"but rather mediating two worlds (audience and group studied) through a third (ethnographer)"* (Lambert, Glacken & McCarron, 2008, p. 3093). Having one foot inside the culture being studied and one foot outside it enables the researcher to understand social structures taken for granted by the participants (Kleinman, 1988).

Trying to understand the emic/participant's perspective helped me shape the questions I asked of participants, the selection of interview participants, and who I engaged in informal conversations during field work, for example. The strength of the ethnographic method became apparent when trying to understand and explain behaviour and cultural patterns; there was a difference between what people said they do and what they actually did, and both of these perspectives are captured in ethnography (Morse, 1994). The ability to compare data sources exposed discrepancies between stories nurses and parents told me, and the observations I made during field work.

As a researcher, my responsibility was to observe nurse-parent interaction (etic), ask participants questions about what was going on (emic), then interpret the etic and emic perspectives, creating a third dimension to round off the ethnographic picture. That picture was my interpretation of what was happening. The interpretations were then continually reported and discussed with the participants, to check that my understanding was also their understanding.

Focused ethnography

Ethnography can take a number of forms, from a global (macro) ethnography where researchers spend several years in the field undertaking extensive study, to a more focused (micro) ethnography where the researcher studies a subculture such as a single unit or group of specialist nurses (Holloway & Wheeler, 2010). Features of focused ethnographies include: a single researcher; focus on a discrete community; focus on one problem in a specific context; limited number of participants; participants holding specific knowledge; and episodic observation of participants (Higginbottom, 2011). Boyle (1994) notes that focused ethnographies help nurses *"understand cultural rules, norms, and values and how they relate to health and illness behaviour"* (p.172). Focused ethnography has a practical application which is appealing to nurses – exploring one problem or topic over a short time period, targeting data collection and carefully selecting participants with knowledge of the study topic (Bikker et al, 2017).

This study was a focused ethnography as the aim was to examine the nurse-parent interaction, specifically emotional communication, in the context of a hospital unit.

Ethnography and nursing research

Ethnography has been widely used in nursing research since the latter half of the 20th century. Nurse ethnographers have argued that the method suits nurses because they possess well-honed observational, documentary and analytica; skills (Oliffe, 2005).

Holloway and Wheeler (2010) believe that ethnography in the nursing context allows the *"examination of behaviours and perceptions in clinical settings, which leads to an improvement of care and clinical practice"* (p.156). Addressing the insider (emic) view versus the outsider (etic) view, Simmons (2007) noted that nurse researchers already have an emic view, enabling them to quickly immerse themselves in the culture and context of the field as participant observers. This can be an advantage. However, a drawback may be that the nurse researcher enters the field with preconceived notions of how people may behave and think (Fetterman, 1989). Documenting assumptions and biases in field notes and reflexively observing thoughts and interpretations help the researcher to manage this process.

Setting

The predominant dedicated space for nurse-parent interaction when a child is hospitalised is a hospital children's unit. Consequently, the field work component of this study was undertaken within a single setting – one unit of a regional hospital in New Zealand. Institutional access to the hospital to conduct the study in a unit over a period of time was negotiated and agreed upon with the director of nursing at the district health board. The charge nurse of the children's unit also gave approval for access.

Field work: participant observation

The key characteristic of an ethnographic study is observation of the participants in the study, to study people's behaviour in everyday contexts (Hammersley, 1990). Observation requires the researcher to participate in unit activities at some level. Simmons (2007) advises participation can be chosen from four levels. These are: complete participation; moderate participation to observe and learn about behaviour; passive participation, predominantly observing with limited participation; and complete observation, with no interaction. I am a registered nurse (RN) with experience of working in an inpatient children's unit in another region. As I had some knowledge of the context of the environment, but no knowledge of this particular setting, the most appropriate level for me was as a moderate participator/observer (Simmons, 2007). As a moderate observer, I collected written data, such as field notes, by observing events directly in context, and could assist with nursing care under the direction of an RN where appropriate, thus maintaining my identity as a nurse. Maintaining the distance of a researcher gave me time and space to record observations and ask questions (Simmons, 2007). I mainly observed nursing practice, rather than participating in it.

Handwritten field notes based on participant observation was the primary means of data collection. The observation took three forms (Angrosino, 2005a). The first form was descriptive – all details observed were recorded in a naïve manner, taking nothing for granted. In this early stage, I mapped out the physical elements of the ward space, as an understanding of the environment gives a sense of the cultural patterning of participants. The second form was focused observation, for which only material closely related to nurse-parent interaction was observed, concentrating on specific categories of interactions. The third form was selective observation, focused more specifically on rituals and patterns (Angrosino, 2005a).

Data sources: informal conversations

Consent was ongoing during field work. This meant I checked consent every time I shadowed a nurse, even if they had previously consented, or met with a parent. During the first few weeks of field work I based myself in the central nurses' station and would accompany individual nurses when they left the station to attend to their work. However, I found this process disjointed and chose instead to start each visit to the unit with a unit handover to gain an overview of what was happening, and then asked one nurse if I could

accompany them for the entire shift. All the nurses I asked agreed to this. Thereafter, I would shadow the same nurse during that visit. Informal conversations with nurses also gave me opportunity to continually share my own observations and interpretations and to receive feedback on my initial interpretations.

After the initial weeks of orientation to the unit, I started undertaking informal conversations with parents. Each visit, I introduced myself to any parent on the ward whom I had not previously met, gave them a parent participant information sheet, and asked to speak to them informally at a time convenient to them. If a child who was able to read was present when I met the parent, I gave the child a child participant information sheet to ensure the child understood my presence. If the child was pre-reading, I explained to the child in plain language what I was doing in the ward. Following verbal consent, conversations with parents usually occurred at the child's bedside; occasionally if the child was asleep, the parent and I would find a quiet place on the ward to talk, such as the parents' lounge, or an empty room. If I had met the parent previously, I would again visit, check consent was ongoing, and ask if there was anything else they would like to discuss with me.

Data sources: written documentation

Supplementary data sources were accessed as part of data collection (Speziale & Carpenter, 2003). All written documentation on the unit was extensively read and noted in field notes to gain further insight into nurses' responses to parents, and the cultural context of the unit. The documentation I reviewed included public notices, unit notices, literature in the unit, staff folders, policies and procedure manuals and children's medical notes (in which nurses documented their patient care).

Data sources: field notes

Field notes were taken as a record of my data collection. During field work, I carried a hard-cover notebook with me and made notes of every interaction, observation and my reflections as the visit progressed. Field notes were taken throughout field work and included observations, copies of data sources, personal reflections and my responses to what I observed. It was important that during the research, participants' experiences took precedence over my own expectations (Roberts, 2007). Therefore I focused on aspects of the interaction/relationship that participants appeared to find difficult to articulate or seemed to be unaware of.

The notes incorporated everything I observed, using all senses. I noted initial impressions, the sounds of the ward, the smell, the colours, and the look and feel of the locale and people (Emmerson, Fretz & Shaw, 1995). I recorded details about the big picture, such as how many people were in the unit, who they all were, and what they were doing at any one time. I noticed who was interacting with whom and what they were discussing. At other times, my view was narrowly focused on an interaction between two or more people, observing body language, content and tone of voice.

I retreated to write my notes as soon as possible after an observation or a conversation, using either a seat in the nurses' station, or preferably a parent chair in a vacant room, as the latter was quieter. Emmerson et al (1995) advise that the timing of writing field notes depends on the relationship between the researcher and participants in the field. I was constantly intent on noting and noticing everything I observed, as well as my reflexive responses to my observations and interpretations.

Interviews

To gain a deeper understanding of underlying cultural norms and structures within the setting (Holloway & Wheeler, 2010), I invited 10 parents and 10 nurses, with whom I had interacted in the field and who were willing to talk to me, to be interviewed following field work. At the time of the interviews, the parents were no longer in hospital as their child had been discharged. Semi-structured interviews with parents and nurses enabled me to take my initial interpretations and thoughts to the participants to check for accuracy – the member checking process (Sandelowski, 1993). This process gave participants an opportunity to validate, refute or elaborate on the findings, and added another layer/level to the data collected.

Reliability

LeCompte and Goetz (1982) note that ethnographic research has been considered unreliable, and suggest that ethnographers address validity and reliability from an ethnographic perspective. To enhance reliability, LeCompte and Goetz recommend recognising and managing five problems: researcher status position, informant choices, social situations and conditions, analytic constructs and premises, and methods of data collection and analysis.

Researcher status position addresses the extent to which the researcher is a member of the studied group and the position they hold. Documentation about the research made public in the unit identified my previous roles. In my verbal introductions to all participants, I identified myself as a researcher first, then as a nurse. I was careful not to be seen as a nurse on the ward, wearing different clothes to the hospital staff, having a name badge clearly identifying me as a PhD student, and a hospital identification card which stated my honorary staff status.

How participants are chosen influences the results of the study. In this study, all parents who were in hospital with their children were approached to participate in the study. All RNs were also participants. I deliberately sought out a wide range of participants, in age, gender, ethnicity and socio-economic background, to provide variety and to reflect the diversity of the ward population.

Social situations and conditions influence the content of ethnographic data, as participants may feel restrained discussing their experience in social situations. During informal conversations on the unit, I ensured they were held in private where possible. Conversations with nurses were occasionally held in the nurses' station, and sometimes involved more than one nurse. The length of time in the field, the level of immersion and the relationship between myself and participants enabled me to experience nursing practice in its authentic state.

There are other ways of establishing rigour in ethnographic research. Stewart (1998) suggests that ethnographic researchers aim for objectivity, rather than reliability, as it is impossible for an ethnographic study to be replicable as required for reliability. Further, Stewart argues that ethnographers need to aim for objectivity, as in being *"alert, and receptive to the views of others, having empathy and being open-minded"* (Stewart, p. 16). The question for the researcher related to objectivity is: *"How well does this study transcend the perspectives of the researcher/informants?"* (Stewart, p.16).

Data analysis

One of the features of an ethnographic study is the copious amounts of notes collected, including the researcher's observations and

reflections, interview transcripts, and documentary data (Roper & Shapira, 2000). Data collection and analysis occurred simultaneously, as data were interpreted throughout its collection. This process involved transcribing all field notes from notebooks into a Word document, then uploading that document into a computer programme NVivo (QSR International, Victoria, Australia) – qualitative data management software, which enabled me to store, manage, classify and order data.

An inductive process was followed, paying close systematic attention to the data, then generating as many issues, topics and themes as possible (Emmerson et al, 1995). From the initial multiple sources of data, 189 "parent" nodes were established using NVivo. Nodes are descriptive labels given to *"chunks of words, sentences or paragraphs"* (Roper & Shapira, 2000). The focus of the labels was always trying to answer the questions driving this study, explicitly: emotional communication between nurse and parent and the environmental and cultural context of the nurse-parent interaction.

I used a process described by Bernard (1988, p. 320) as a *"constant validity check"* to illuminate my own emic understanding, moving back and forth between the etic perspective (my assumptions, ideas and questions) and the emic viewpoint (observations, participants' reports, and interviews) and testing the etic against the emic. I wrote up my field notes following field work, and then checked my interpretations and ideas with participants next time I was in the field.

A final stage of the analysis was the generation of major findings which were constructed inductively from the analytical, iterative process. These findings represented interpreted meanings of the culture of the unit, and how the participants understood emotional communication (Roper & Shapira, 2000).

Ethical issues specific to ethnographic research

There are ethical issues specific to ethnographic research. These relate to the ongoing interaction between the participants and the researcher, and the fact that the researcher is the primary data collector.

Ersser (1996) notes four major areas of ethical consideration arising from ethnographic research. These are noted below in bold, followed by my explanation of how I managed these in this research. The first is **avoiding or limiting deception**. I was transparent about the research purpose, with documentation, flyers and ongoing verbal discussions with those interviewed, and for the children of parents who participated in the research.

The second area noted by Ersser (1996) is **protecting the autonomy of the participants**. Autonomy of the participants was protected by ensuring they were informed about the nature of the research and any implications for themselves of participating, such as time and distraction. Consent was informed and freely given and was continually negotiated.

Avoiding or limiting intrusion/respecting the welfare of participants was the third area noted by Ersser (1996). As Ersser suggests, ethnography involves making public things that are said and done in private. As researcher, I had an obligation to the participants to be as unobtrusive as possible, and to maintain the balance between pursuing the meaning of observations and not unduly disrupting the ordinary quality of the exchanges observed. As a nurse researcher, I endeavoured not to interfere with any nursing care.

The final area noted by Ersser (1996) was **encouraging the ethical use of research findings**. Confidentiality was assured using identification codes throughout data collection and analysis. The context of the unit environment was extensively detailed to remain true to the ethnographic method, which aims to understand the context of behaviour, not simply the content of that behaviour (Angrosino, 2005b).

Conclusion

This paper details the decision processes involved in choosing and then using focused ethnography for a research project. Salient features of this study were the various sources of data, use of informal conversations and formal interviews, and a lengthy analysis process. This process ensured I represented the participants' world as it was, as understood by the participants' emic perspective and my etic perspective, which then determined a third view – my interpretation of the culture of the ward. Regarding my interpretations, I have continually asked myself: *"Are you sure?"* and constantly sought validation of my interpretations with the participants. A further feature of this study is its reflexive nature – always trying to learn from participants, to understand their point of view, while simultaneously acknowledging my own biases and assumptions, and the effect I have had on the data collected.

As a research method, focused ethnography has proved capable of uncovering and illuminating knowledge about nurse-parent interactions, and specifically the cultural processes surrounding those interactions. With lengthy observation of participants, and informal and formal conversations, I was able to unravel the difference between what people said they do and what they actually did.

References

Angrosino, M. V. (2005a). Recontextualising observation: Ethnography, pedagogy, and the prospects for a progressive political agenda. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed, pp.729-745). Thousand Oaks, CA: Sage..

Angrosino, M. V. (2005b). *Projects in ethnographic research*. Long Grove, Il: Waveland Press.

Bernard, H. R. (1988). *Research methods in cultural anthropology*. Newbury Park, CA: Sage.

Bikker, A. P., Atherton, H., Brant, H., Porqueddu, T., Campbell, J. L., Gibson, A., McKinstry, B., Salisbury, C., & Ziebland, S. (2017). Conducting a team-based multi-sited focused ethnography in primary care. *BMC Medical Research Methodology, 17,* Open Access. Retrieved from https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-017-0422-5

Boyle, J. S. (1994). Styles of ethnography. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 159-186). Thousand Oaks, CA: Sage Publications.

Duffy, L. (2005). Culture and context of HIV prevention in rural Zimbabwe: The influence of gender inequality. *Journal of Transcultural Nursing, 16*(1), 23-31.

Emmerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). *Writing ethnographic field notes*. Chicago, Il: University of Chicago Press.

Ersser, S. (1996). Ethnography in clinical situations: An ethical appraisal. In L. De Raeve. (Ed.), *Nursing Research: An ethical and legal appraisal* (pp. 42-56). London, UK: Bailliere Tindall.

Fetterman, D. (1989). *Ethnography, step by step*. Newbury Park, CA: Sage.

Hammersley, M. (1990). *Reading ethnographic research: A critical guide*. London, England: Longman.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed). New York, NY: Tavistock.

Higginbottom, G. (2011). The transitioning experiences of internationally-educated nurses into a Canadian health care system: A focused ethnography. *BMC Nursing, 10*(1), 14. Retrieved from https://bmcnurs.biomedcentral.com/articles/10.1186/1472-6955-10-14

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed). Chichester, UK: John Wiley & Sons.

Kleinman, A. (1988). *The illness narratives: Suffering, healing and the human condition*. New York, NY: Basic Books.

Lambert, V., Glacken, M., & McCarron, M. (2008). 'Visible-ness': The nature of communication for children admitted to a specialist hospital in the Republic of Ireland. *Journal of Clinical Nursing, 17*, 3092-3102. https://doi.org/10.1111/j.1365-2702.2008.02462.x

Lambert, V., Glacken, M., & McCarron, M. (2011). Employing an ethnographic approach: Key characteristics. *Nurse Researcher, 19*(1), 17-23. doi:10.7748/nr2011.10.19.1.17.c8767

LeCompte, M. D., & Goetz, J. P. (1982). Problems of reliability and validity in ethnographic research. *Review of Educational Research, 52*(1), 31-60.

Liamputtong, P. (Ed.) (2010). *Research methods in health: Foundations for evidence-based practice*. Melbourne, Australia: Oxford University Press.

Morse, J. M. (Ed). (1994). *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage.

Morse, J. M., & Field, P. A. (1996). *Nursing research: The application of qualitative approaches* (2nd ed). London, UK: Chapman & Hall.

Mulhall, A., Le May, A., & Alexander, C. (1999). Bridging the research-practice gap: A reflective account of research work. *Nursing Times Research, 4*(2), 119-131.

Oliffe, J. (2005). Why not ethnography? *Urologic Nursing, 25*(5), 395-399.

Roberts, D. (2007). Ethnography and staying in your own nest. *Nurse Researcher, 14*(3),15-24.

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1-8.

Simmons, M. (2007). Insider ethnography: Tinker, tailor, researcher or spy? *Nurse Researcher, 14*(4), 7-17. doi:10.7748/nr2007.07.14.4.7.c6039

Speziale, H. J. S., & Carpenter, D. R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia, PA: Lippincott, Williams and Williams.

Stewart, A. (1998). *The ethnographer's method, Qualitative research methods series, 46*. London, UK: Sage.

Methodology

PERSONAL EXPERIENCE OF USING A CASE STUDY FOR A DOCTORATE

Raewyn Lesa

About the author: *Raewyn Lesa, RN, MN, PhD, is a lecturer at the Centre for Postgraduate Nursing Studies, University of Otago, Christchurch, New Zealand. Her correspondence address is: raewyn.lesa@otago.ac.nz*

Abstract

Case studies are increasingly used as a research approach in the social sciences. A research case study differs from a teaching case study because it follows a rigorous process of design, data collection, analysis and reporting. Drawing on personal experience of using a case study for my doctorate, this paper presents practical insights into the process of designing a credible research case study. The case for my doctoral study was the experiences of third-year nursing students in simulation and clinical practice.

Key words

Case study, research methodology, simulation, nursing students' experiences.

Introduction

This paper draws on my doctoral experience to offer beginner researchers some practical insights into the process of designing a research case study. The paper presents a brief overview of my research and a discussion as to why case study was selected. For a novice researcher, this discussion may be helpful as a research case study can be confusing. This is because it differs from the clinical cases used by educators to generate discussion among learners. A section about designing a study to promote trust in the research outcomes concludes the paper.

The research

My experiences as a lecturer of undergraduate nursing students informed my doctoral study, which commenced in 2014. Two incidents in the simulation environment led to the research inquiry. First, a student with excellent feedback from her clinical placements burst into tears during a debriefing session. When talking with her after this incident, she explained she experienced extreme anxiety in simulation and believed she could not demonstrate her knowledge in this environment. The second incident occurred towards the end of another simulation. The patient [simulator] was crying, saying she did not want to have another operation. One objective of this simulation was for the student to provide comfort to a distressed patient. However, two students stood back and hesitantly observed the patient. When we reflected on their reaction to the distressed patient, they explained that comforting a manikin felt awkward.

At a similar time, nurse educators were beginning to explore the potential of substituting a proportion of a student's hours spent in the clinical environment with simulations. However, based on my involvements as an educator and nurse, students' experiences differed between the simulation and clinical environments. Consequently, I became increasingly interested in students' experiences in simulation and how these compared to their clinical experiences.

My doctoral study considered two research questions:

1) How do nursing students experience simulation as an environment for learning?

2) How do nursing students' learning experiences in simulation and clinical practice influence their development of clinical judgment skills?

Why case study?

Case studies are increasingly used as a research approach in the social sciences (Yin, 2017). A research case study differs from a teaching case study because it is a research inquiry that follows a rigorous process of design, data collection, analysis and reporting (Stake, 1995). Yin (2017) suggests that "what" or "how" questions fit a case study design because the researcher is seeking to explore or explain a phenomenon (for my case study, this was students' experiences). The findings from a case study can add knowledge about a programme, process or social unit (Merriam, 1998) that is of interest to a researcher's area of practice (Daniel & Harland, 2017).

A case study may be a *"single holistic design"* or a *"multiple embedded design"* (Yin, 2017, p. 46). While designing my study, I considered whether to select a single case at one nursing school or choose multiple cases at several nursing schools. A single case was chosen because simulations are implemented differently in New Zealand nursing schools (Lesa & Daniel, 2016). Selecting a single case removed curriculum variables and enabled focus on students' experiences in one simulation programme and one year level to provide a *"rich and holistic account"* of their experiences (Merriam, 2009, p. 49).

The purpose of a research case study may be descriptive, exploratory or explanatory (Yin, 2017). My case study was both descriptive and exploratory, as the aim was to describe and explore the students' experiences within the contexts of simulation and clinical practice. Case study research may also use qualitative, quantitative or mixed-method approaches (Stake, 1995) and this is guided by the overall aim of the research. A qualitative approach was chosen for my case study for two reasons. First, my epistemological view is that nursing students experience multiple realities. Capturing these different realities requires interactions with the students to

understand how they experience simulation and the meaning they ascribe to the learning experience. Second, different realities mean students' realities may differ from those who design and facilitate simulations. A qualitative approach could highlight the student voice to raise awareness of what it is like to be a nursing student in simulation and thus enhance future simulation practices.

Case-study design also offered the opportunity to collect data from multiple sources, to view students' experiences through different lenses (Yin, 2017). For example, the case for my research was the experiences of 12 third-year nursing students in one nursing programme. These students were observed participating in simulations, interviewed twice (after their simulations and after clinical placement) and they provided stories from their clinical practice. Documents pertinent to the simulations were also reviewed. This data could then be analysed together to provide a comprehensive understanding of the students' experiences (Merriam, 1998).

Data analysis

Several researchers provide recommendations on how to analyse case-study data (Merriam, 1998; Stake, 1995; Yin, 2017). For my study, a general inductive approach (Thomas, 2006) was selected to analyse the data. This approach aligns with a qualitative inquiry seeking to present descriptive themes. The aim of a general inductive approach is to categorise and derive key themes from the raw data. The research questions are kept at the forefront of the analysis and the researcher decides which data is important and relevant to answer these questions. The process of deriving themes commences with labelling categories from the data, describing what these categories mean and then illustrating the meaning of the category by assigning text. The categories are then linked according to commonalities and themes, which may be incorporated into a model, theory or framework (Thomas, 2006).

For my case study, the first broad level of data coding from the two interviews resulted in 42 codes. These codes were developed from the simulation literature and the meaning I ascribed to the text. Each initial code was then reviewed with other codes for commonality in meaning, significant or frequent themes, and contradictory points of view. During this process, the interview transcripts were revisited to check the context of the student's comment. The clinical stories were tabled into a document according to the situation and the meaning I attributed to the story. The stories were then brought together with the interview codes to derive key themes. The final themes were the result of a continual refining process, which involved looking for similarities in meanings and possible hierarchies. The result was the creation of 11 themes and nine subthemes, which summarised the key findings in relation to the research questions.

The findings highlighted that learning in simulation is complex and influenced by what the student brings to the experience, the facilitation of the simulation, and the learning context. The students' experiences in clinical and simulation settings were quite different, yet both environments offered valuable learning. Educators must therefore continue to explore effective teaching and learning practices in both the simulation and clinical environments to provide the best possible learning outcomes for nursing students.

Designing a credible research case study

Case study as a research approach is not without its critics. For example, case studies are thought to require an extended amount of time and the case may provide large amounts of data that is difficult to manage and analyse (Yin, 2009). Yet, as Yin contends, a researcher can produce a quality case study without using time-consuming methods such as ethnographic or observational studies. Collecting data via the telephone, surveys or the internet may be sufficient. There may also be a misunderstanding that case studies are more useful in the beginning stages of the research process to generate a hypothesis, and less useful for building theory (Flyvbierg, 2006). However, Flyvbierg counters this notion by explaining a case study provides an in-depth investigation and context-specific knowledge, which is useful to the human sciences.

Another criticism aimed at case-study design relates to the notion that one cannot generalise from a single case, so it *"cannot contribute to scientific development"* (Flyvbjerg, 2006, p. 1). However, a qualitative inquiry does not seek to generalise, and as Flyvbjerg points out, readers may underestimate the strength of a single case. Other criticisms of a qualitative case study are similar to that of most qualitative inquiries in that because the researcher collects and interprets the data, there is the potential to confirm prior notions, which may compromise the integrity of the findings (Flyvbjerg, 2006; Stake, 1995). However, this potential exists in all forms of research inquiries, which is why reflexivity, credibility and trustworthiness throughout the research process are essential.

The concepts of reflectivity, credibility and trustworthiness were quite difficult to understand at the beginning of my doctoral journey. However, as the research progressed, the importance of these concepts to promote trust in the research outcomes became clearer. To establish trust in my case study, I applied the four qualitative dimensions of trustworthiness, auditability, credibility and dependability (TACT) (Daniel & Harland, 2017).

Trustworthiness: In qualitative research, trustworthiness requires the researcher to demonstrate reflexivity (Daniel & Harland, 2017). The main purpose of reflexivity is to help the researcher bring to consciousness what they believe, and be mindful of potential assumptions during the analysis and interpretation of the research findings. Lincoln and Guba (2002) describe this process as reflecting critically on yourself as a researcher. One way for a researcher to practise reflexivity is to describe the circumstances that led them to the research inquiry and therefore their possible assumptions (Daniel & Harland, 2017). For example, in my case study I described an incident during my nursing training that shaped my teaching and learning philosophy, and the influence of this on my motivation to set up a simulation suite. This reflection was helpful during interpretation of the data because it enabled me to remain open about the meaning of the data and consider alternative explanations. By me acknowledging that my personal beliefs ("a teacher must be positive and supportive") and experiences as an educator informed and shaped the research inquiry, the reader can decide for themselves if the research findings are trustworthy.

Another way qualitative researchers seek to enhance trustworthiness is to position the findings within the view of the participants, and with enough detail, so that the conclusions make sense (Merriam, 1998; Daniel & Harland, 2017). To demonstrate this in my case study, the themes in the findings chapters of the research report were supported by appropriate quotations from the students' transcripts and clinical stories, to illustrate their perspectives.

Auditability: Auditability is the process of documenting the research process in enough detail to help the reader understand the conclusions from the research and how these align with the research

design (Daniel & Harland, 2017). Auditability requires the researcher to describe clearly each step of the research process. The research design is usually presented in either the methods section of a paper, or a chapter in a thesis. All data collected from the study should also be stored securely and be retrievable if required.

Credibility: Credibility requires the researcher to show the findings are *"credible, relevant and congruent"* (Daniel & Harland, 2017, p. 116). One way to establish credibility is to triangulate data sources during analysis to interpret and confirm findings (Yin, 2017). The data collected in my case study was triangulated during interpretation, analysis, and reporting of the data. An example of this triangulation in the case of one student, was that the interview and observational data supported the finding that she enjoyed role play. Another student's experience in clinical practice was triangulated with the objectives on the simulation design template, and this raised questions about whether she had transferred her simulation learning into clinical practice.

Another way credibility was addressed in my case study was that students were interviewed twice, which enabled member validation (Guba & Lincoln, 1994). For example, in the first interview, my observation notes were discussed with the student. In the second, they were given a copy of their transcript from their first interview and asked if they wanted to add anything or if any initial thoughts had changed. The students were also invited to read their summarised transcript and make contact if they wished to clarify anything or, if they were concerned about the portrayal of their data.

Transferability: While qualitative research is not intended to be statistically generalised, the study should be presented with enough detail so readers can decide if the research applies to their situation (Merriam, 1998). This concept is referred to as transferability (Daniel & Harland, 2017). For my case study, detailed descriptions of the nursing school's simulation programme and student demographics were presented. The purpose for this was to offer readers the opportunity to determine if the principles underlying the themes in my case study could be transferred to their educational setting.

Conclusion

Employing a case-study design for my doctoral study offered the opportunity to explore in depth the experiences of third-year nursing students from one nursing programme. Multiple sources of data were collected and triangulated to offer those in the simulation field insights about students' experiences and in doing so, add to the body of knowledge about simulation practices. A key lesson from my case study was the importance of promoting trust in the research outcomes. This was particularly important for my case study because I brought to the research a significant amount of educational experience in both simulation and clinical practice. This insider position was both a strength and a potential limitation of the research (Patton, 2002). It was a strength because my experience provided context to interpretation of the data; it was a limitation in that insider experience could cast doubt on the credibility of the research findings if not acknowledged (Merriam, 1998). Therefore, critically reflecting on myself as a researcher was necessary to design a credible and trustworthy case study.

References

Daniel, B. K., & Harland, T. (2017). *Higher Education Research Methodology: A Step-by-Step Guide to the Research Process*. Abingdon-on-Thames: Routledge.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry, 12*(2), 219-245.

Guba, E. G., & Lincoln, Y. S. (1994). *Competing paradigms in qualitative research* (Vol. 2). London: Sage.

Lesa, R., & Daniel, B. (2016). Simulations in undergraduate nursing programmes in New Zealand: current status and next steps. *BMJ Simulation and Technology Enhanced Learning, 2*(4), 118-123.

Lincoln, Y., & Guba, E. (2002). The only generalization is: There is no generalization. In R. Gomm, M. Hammersley, & P. Foster (Eds.), *Case study method* (pp. 27-44). London: Sage.

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education*. San Francisco, CA: Jossey-Bass.

Merriam, S. B. (2009). *Qualitative case study research*. San Franciso, CA: Jossey-Bass.

Patton, M. (2002). *Qualitative research & evaluation methods*. Thousand Oaks, CA: Sage.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks: Sage.

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237-246.

Yin, R. K. (2009). *Case study research: Design and methods (applied social research methods)*. London: Sage.

Yin, R. K. (2017). *Case study research and applications: Design and methods*. Thousand Oaks: Sage.

Kai Tiaki
Nursing Research
Published by the NZ Nurses Organisation
Vol 10 No 1 October 2019
ISSN: 1179-772X