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# Kai Tiaki Nursing Research


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# Kai Tiaki Nursing Research

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# GUEST EDITORIAL: **Jai Chung**

## Assessing research is a vital skill in new masters-level nursing pathway

***Jai Chung, RN, BN, GradDipSci BiolSci, MHSci,*** *is a staff nurse at Canterbury District Health Board.*



**Jai Chung**

Research is vital for nursing. In contemporary practice, nurses need to be able to justify decision-making by providing rationales based on evidence. I am a graduate of a new initiative in nursing education – a graduate-entry nursing pathway that combines the requirements for a bachelor of nursing with a masters-level nursing programme. This pathway provides a post-graduate bridge between previous degrees and a bachelor of nursing. It offers an intensive nursing curriculum, which prepares nurses to implement evidence-based practice.

Having a science background in my previous degree, I see this intensive programme as preparing registered nurses to think broadly and critically to integrate both science and art into optimal nursing care. Learning how to search for appropriate literature, and use critical appraisal skills to evaluate evidence for practice, contributes to effective nursing care for health consumers. The art of nursing is in being able to judge how this best evidence is consistent, or not, with health consumers' needs and preferences.

The professional and legal requirements of contemporary nursing practice oblige nurses to provide health consumers with optimal care and to ensure they are empowered to making informed choices about their care (Mazurek et al, 2014; Spruce, 2015). Having an intellectual curiosity about research offers nurses an exciting opportunity to explore the implications of using evidence-based practice in daily nursing care.

Use of evidence-based practice has the potential to become a bridge connecting nurses, health consumers and other health professionals. It can provide continuous refinements to nursing practice, and may lead to a growing confidence and maturity in the profession, along with an improved multidisciplinary team approach to providing care.

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

## Contemporary issues for nursing in New Zealand



**Patricia McClunie-Trust**

Future approaches to nursing education and professional development need to look beyond existing models that have served past health-service needs. Demographic and epidemiological challenges in New Zealand's population, including population growth and extended life expectancies, will require different nursing relationships, knowledge and skill sets to support the health and well-being of more diverse populations across the lifespan (Wheeler, Fisher & Wing-sum Li, 2014). Health consumers are now more socially and culturally diverse, and often better informed than in previous decades. Some populations are living longer, with more complex health conditions, and are more proactive in their health-seeking behaviours. However, other disenfranchised populations have greater morbidity and mortality, and require more connected and culturally responsive health practitioners and services.

The World Health Organization (WHO, 2017) identifies the importance of *"transformative, high-quality education and lifelong learning so that all health workers have skills that match the health needs of populations and can work to their full potential"* (p12). Transformative approaches require developing leadership, critical thinking and teamwork attributes among both currently practising and new-graduate nurses, to enable them to act as effective agents of change who will engage with communities in respectful, culturally responsive and generative ways (Frenk et al, 2010). Strategies for innovation include entry to nursing via graduate-entry programmes, and undergraduate nursing programmes that mindfully engage students in novel and culturally responsive, research-based learning experiences. Transforming the knowledge and skill-base of our current nursing workforce also requires creative approaches to ongoing professional education that is responsive to our ageing nursing workforce and changing population health needs. The papers in this issue of *Kai Tiaki Nursing Research* focus on nursing workforce concerns, undergraduate nursing education, professional relationships in nursing, and practice innovations.

## Nursing workforce

Like many other countries, New Zealand has an ageing nursing workforce, with the majority of nurses having at least 15 years' experience (Ministry of Health, 2016). As the workforce ages, and nurses begin to think about retirement, thought needs to be given to how experienced nurses might be retained in the workforce for as long as they remain able to safely and competently practice. Walker, Clendon and Willis examine whether the reasons reported in the international literature as the intention to leave nursing match those given by New Zealand nurses leaving the profession before retirement age. Retaining or delaying the retirement of older nurses has the potential to alleviate future nursing shortages. However, nursing management needs to consider what impact working conditions have on decisions by older nurses to leave the profession before retirement age.

## Nursing education

Sound ethical judgement is a fundamental component of competent nursing practice. However, there is little evidence to suggest that, in the growing complexity of contemporary health care, newly graduated nurses are any more able to make sound ethical decisions than their historical counterparts. Song explored the experiences of a group of nurse educators teaching ethics in an undergraduate nursing programme. The findings of this research reiterate the importance of promoting undergraduate nursing students' ethical awareness through teaching and learning activities in both theory and practice. Nurse educators also need to highlight more culturally specific ethical views that genuinely address the interests, values and aspirations of Māori and Pacific people. Nurse educators also have a key role in supporting students' learning in clinical practice, particularly in challenging situations. Undergraduate nursing students have limited situational or ready-to-hand knowledge about how to manage complex clinical situations. The paper by Proverbs and McClunie-Trust reports the findings of research exploring third-year nursing students' experiences of dialogue with nurse educators during clinical practice placements. The findings of this research suggest that the supportive aspect of dialogue with nurse educators is highly valued by students, particularly in enhancing learning through listening to, and interpreting, students' experiences and guiding them in making sense of clinical situations.

## Nursing practice innovation

Innovations in nursing practice help to bridge gaps between health consumers and care providers by providing more accessible, appropriate and continuous delivery of health-care services. Innovative approaches involve deploying organisational, clinical and human resources in new ways to better manage demands related to population ageing and the prevalence of chronic illness (Longpré & Dubois, 2015). Kumari, Ritchie, Thomas and Jull examined patients' experience of care provided by an outpatient intravenous antibiotic (OPIVA) service. OPIVA services enable health consumers requiring long-term antibiotic treatment to receive some, or all, of their treatment at home, creating less disruption to their lives. The findings of this study suggest that OPIVA was well-regarded by the majority of the health consumer participants, though opportunities were identified for improvements, including better discharge information, more education for community nurse teams and health consumers, and the possible provision of after-hours services.

## Research briefs

The research briefs in this issue provide limited reports on research that has implications for practice. Hughes, Kirk and Dixon researched enrolled nurses' (ENs) and registered nurses' (RNs) perceptions of their everyday experiences of delegation and direction. The findings of the study show the need for up-to-date, clear policies about the roles and responsibilities of ENs in the workplace and expectations about how delegation will occur in practice. Palmer's research brief reports on an integrative review undertaken to ascertain best practice for wound dressings following lower-limb amputation. The review concludes that, overall, rigid removable dressings applied immediately post-operatively were associated with improved wound healing, reduced oedema and faster time to prosthesis fitting.

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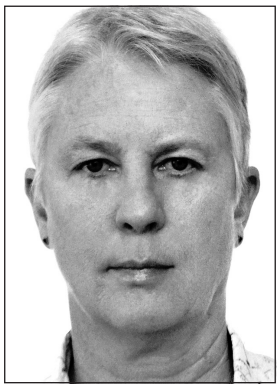
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# WHY OLDER NURSES LEAVE THE PROFESSION





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## ABSTRACT

**Aims:** The aim of this study was to examine whether reasons reported in the international "intention to leave nursing" literature match those given by New Zealand nurses who left the profession before retirement age.

**Background:** Concerns about nursing shortages have produced a rich literature on early nurse retirement. While causes of intention to leave have been reported previously, understanding more about the impact of these could guide retention strategies.

**Method:** An online survey of nurses who had left the New Zealand Nurses Organisation (NZNO), citing they were leaving the profession, was conducted in September/October 2016, asking them about the factors leading to their decision, their decision-making processes, and workplace changes that may have helped them remain. Results were analysed by age cohort.

**Results:** This paper reports results from 459 nurses aged 55-65 who had left nursing before the official retirement age. Issues previously reported in the literature also emerged as factors among this cohort. Key among these were workplace/organisational issues, and personal challenges related to health or burnout. Although reported by small numbers of respondents, previously unreported issues of loss of confidence, over-onerous professional development requirements and intergenerational tensions were also described.

**Conclusion:** Issues identified in the "intention to leave" literature also figured highly as contributing to New Zealand nurses' decisions to actually leave. Many of these issues relate to the intensification of nursing (higher acuity and bed occupancy), and the need for sufficient nursing resources, flexible management and better support for older nurses.

**Implications for nursing management:** Retaining, or delaying the retirement of older nurses could lessen impending nursing shortages. Adequate staffing, flexible working conditions, attending to difficulties with shift work requirements, and good nursing leadership to support a positive work culture, are required.

## KEYWORDS

Nurses, attrition, early retirement, New Zealand.

## INTRODUCTION

There is evidence that nursing has shifted from being a "career for life" to being just one option in a career portfolio, with increasing reports of large numbers of nurses intending to leave the profession. Nursing shortages, caused by the demographic impacts of an ageing workforce and population, and changing workforce patterns, will be compounded if strategies to delay attrition and retirement are not implemented. Understanding why nurses do leave the profession, and what could be done to support them to remain for longer, may help guide the development of interventional strategies to address forecasted shortages. Using records of nurses who had resigned their NZNO membership, indicating they had left nursing, this study aimed to examine factors contributing to nurses exiting the nursing workforce and what interventions may have helped reduce or delay such attrition.

## BACKGROUND AND LITERATURE REVIEW

For more than two decades, nurse attrition has been identified as a risk to workforce planning (Lum et al, 1998). In many developed

countries, concerns about looming nursing shortages are leading to a new focus on preventing workforce attrition (Leineweber et al, 2016; Ryan, Bergin, & Wells, 2017). The ageing of the nursing workforce, the options available for migrating nurses, and changing career patterns of younger generational cohorts have been widely identified as adding impetus to the need for better workforce retention (Nantsupawat et al, 2017).

In New Zealand, more than 43 percent of the nursing workforce is now aged over 50 (Nursing Council of New Zealand, 2015a) and up to 50 percent are expected to retire over the next 10 to 15 years (Walker & Clendon, 2013). There is evidence of increasing *intention* among nurses to leave the profession early (ie before the age of 65), which, if carried through, would cause substantial nursing shortages (Walker, 2017). On top of this, international shortages of skilled nurses may alter the patterns of nurse migration into and out of New Zealand, further exacerbating the problem.

More than 25 percent of nurses registered in this country initially qualified overseas, and nurses registered in New Zealand are automatically eligible to nurse in Australia. This makes New Zealand particularly vulnerable to the up and downturns of international nurse migration. Recent statistics show internationally qualified nurses (IQNs), who used to come predominantly from anglophone countries, are now more likely to come from Asia. The younger age profile of Asian IQNs may improve New Zealand's ageing nurse profile (Nursing Council of New Zealand, 2015a). However, research into this Asian cohort shows many consider New Zealand a stepping stone to careers in countries such as Australia and the United States (Walker & Clendon, 2015; 2016). Additionally, many others may leave nursing altogether due to family responsibilities (Walker, Clendon & Cheung, 2016). Population growth, growing demand for health services, and an ageing international nursing workforce will all increase the demand for nursing services throughout the world. Retaining nurses in New Zealand will be essential to meet this growing demand, yet little work has been done to explore why nurses who carry through their intent to leave the profession have done so.

Nurses who leave the profession are difficult to contact for research purposes: they are no longer members of professional organisations, and frequently no longer hold practising certificates. Internationally, there is research examining the phenomena of nurses' intent to leave nursing for reasons other than retirement. Reasons for this intent can be categorised into groups: workplace concerns; personal challenges; career factors; and family reasons (Ryan, Bergin & Wells, 2017). Workplace concerns include high workload, inadequate staffing, shift work, bullying and violence, inconvenient scheduling of shifts, and a lack of support (Black, Spetz & Harrington, 2008; Bogossian, Winters-Chang & Tuckett, 2014; MacKusick & Minick, 2010; Sjögren, Fochsen, Josephson & Lagerström, 2005; Tuckett, Winters-Chang, Bogossian & Wood, 2015). Personal challenges include burnout, stress, the physical demands of the job, fatigue, exhaustion, health reasons and emotional distress related to patient care ( Black et al, 2008; MacKusick & Minick, 2010; Sjögren et al, 2005). Career factors include remuneration seen as low for the difficulty of the work and when compared to other professions, dissatisfaction with nursing as a career, and lack of professional development (Bogossian et al, 2014; Drennan, Halter, Gale & Harris, 2016; Sjögren et al, 2005). Family reasons include child-care demands and family obligations such as caring for older relatives (Walker & Clendon, 2013; 2015).

New Zealand research into the topic is limited, though Bogossian et al (2014) reported on a large cohort of New Zealand and Australian nurses recruited to the E-Cohort study. This qualitative work exploring currently practising nurses' perceptions of intention to leave the profession found workload, shift work, violence, remuneration, lack of support and undervaluing of the nurse's role were all contributing factors to nurse attrition (Bogossian et al, 2014). A recent New Zealand cohort study followed 2596 registered nurses for the first eight years after registration and found 42 percent were no longer practising (Nursing Council of New Zealand, 2015b). There are no details on why these nurses are no longer working as nurses. Other research has identified that the career requirements of younger nurses may differ from those of previous generations (Clendon & Walker, 2012) and that there can be conflict between these generations in the workplace, in part based on those different requirements (Burke, Walker & Clendon, 2015).

As reported by O'Connor (2015) in the NZNO membership magazine, New Zealand nurse leaders report family considerations, overseas travel, further study, and a change in career may contribute to nurses leaving nursing. However, to date there has been no study of nurses from New Zealand who actually left nursing and their reasons for doing so.

## METHOD

### Design

An exploratory descriptive study, using an online survey, was conducted to examine the views of New Zealand nurses across all scopes of practice who had chosen to exit the nursing workforce. Review of the literature suggested that the most common factors contributing to leaving the profession were workplace concerns, personal challenges, career factors, family reasons and retirement. Accordingly, these factors formed the initial basis for investigation in the cohort.

### Ethics

Ethics approval was obtained from the Victoria University of Wellington's human ethics committee (#23547). No conflict of interest is noted for any of the authors.

### Sample and setting

The New Zealand Nurses Organisation (NZNO) is a professional and industrial organisation with a total membership of more than 49,000 nurses, midwives, health-care workers and students (NZNO, 2017). Reasons for resignation are invited and recorded, and data held for 10 years post-resignation. Many resigning members select "left nursing" as a reason, suggesting the opportunity existed to ascertain why they left the profession and what, if anything, could have been done to support them to stay. Sampling was performed by sequential examination of the membership database – selecting regulated nurses who self-identified as having resigned from NZNO between July 31, 2013, and July 31, 2016 – a period of three years. An online survey, hosted on the Survey Monkey (Pro) platform, was sent by email to the last recorded address of these 4170 registered and enrolled nurses and nurse practitioners. This paper reports the findings from the older nurse cohort aged 55 to 65.

**Table 1. Demographics**

| | | % | n |
|---|---|---|---|
| **Gender** | Female | 98.0 | 444 |
| | Male | 2.0 | 9 |
| **Age** | 55-59 | 11.6 | 53 |
| | 60-64 | 21.4 | 98 |
| | 65-69 | 47.5 | 218 |
| | > 70 | 19.6 | 90 |
| **Ethnicity** | NZ Māori | 5.5 | 25 |
| | NZ European | 87.7 | 398 |
| | Other European | 8.4 | 38 |
| | Pacific | 4.8 | 22 |
| | Asian | 6.4 | 29 |
| | Other | 5.1 | 23 |
| **Initial nursing qualification** | Enrolled nurse qualification | 17.1 | 74 |
| | Registered nurse – hospital trained | 66.5 | 288 |
| | Bachelor of nursing | 21.71 | 94 |
| | Nurse practitioner | – | 0 |
| **Employment prior to leaving** | Full time | 21.9 | 99 |
| | Part time | 73.01 | 330 |
| | Scheduled and rotating shifts | 28.8 | 130 |
| | 'Office hours' | 25.4 | 115 |
| | Permanent night shift | 7.3 | 33 |
| **Work sector prior to leaving** | District health board (DHB) | 40.5 | 183 |
| | Primary health care | 23.9 | 108 |
| | Aged care | 19.9 | 90 |
| | Private hospital and hospice | 11.3 | 51 |
| | Nursing education | 5.3 | 24 |
| **Number of years nursing prior to leaving** | 0-10 | 3.1 | 14 |
| | 11-20 | 6.3 | 28 |
| | 21-30 | 16.3 | 73 |
| | 31-40 | 16.7 | 75 |
| | > 40 | 57.6 | 258 |

## Survey instrument

The short survey (previewed by four senior nurse advisors) introduced the purpose of the survey, and explained how recipients had been selected to take part. Initial screening questions checked that the recipient was no longer nursing. The characteristics of the last nursing role they had held (sector, shift type, full-time/part-time and the field of nursing practice), were followed by standard demographic questions including gender, age, qualifications and ethnicity. Questions then asked why they had decided to leave nursing (comprising items from the literature and a free-text option), whether they planned to return, and a free-text question asking what, if anything, would enable them to return. Questions then explored the process, time and consultation underpinning the decision to leave, and sought more detail on the factors leading to the decision. Participants were asked what factors would enable them to remain in nursing (with options based on items from the literature, plus a free-text option). Final free-text questions invited comments on their experience of working as a nurse, or on their nursing career.

## Data collection

Data were collected between September 9 and October 25, 2016. One reminder was sent, three weeks after opening the survey. A total of 1260 responses were received, representing a 30.3 percent response rate, once email "bounce backs" were discounted.

## Data analysis

Responses were sorted to remove those who were still nursing but had not rejoined NZNO (n=382), and 220 incomplete responses were excluded. Nurses who exited nursing before age 55 were analysed separately as part of an "early attrition" cohort (n=204). This left 459 valid responses from nurses who had "left nursing" aged ≥ 55 years, including those who had retired before the nominal retirement age of 65, and it is these results that are presented here. The quantitative responses were analysed descriptively using Microsoft Excel. Free-text data were explored thematically using Nvivo, guided by the literature.

# FINDINGS

## Demographics

Table 1 (left) outlines demographic information about survey respondents. Note, not all figures total 459, as some question sets allowed multiple answers (specifically: ethnicity, qualifications and employment), and some questions were not answered by all respondents. Government-funded superannuation is available in New Zealand from 65 years of age, meaning 65 years is the nominal retirement age. In our survey, 47 respondents under the age of 65

**Table 2. Categories promoting attrition**

| Major categories | Exemplar quotes | n |
|---|---|---|
| **Workplace concerns:** High workload, inadequate staffing, shift work, bullying and violence, inconvenient scheduling of shifts, lack of flexibility, fundamental system issues eg poor management, too much paperwork, change in nursing approach, unsafe working environment, lack of time to care for patients, lack of support. | *'My workplace was toxic and I was beginning to have anxiety whenever I thought about work.'*<br><br>*'It became an unsafe environment to work in. No managerial support. The culture was not one of working as a team. Finger-pointing culture.'*<br><br>*'No support from management. Huge amounts of paper work. Work chaotic and complicated. Bullying from another staff member. Frustration, frustration!!!'*<br><br>*'In the latter years of my employment, I noted the increasing pressures faced by nurses with the diminishing numbers of staff rostered on due to less nurses being employed. I believe this compromised optimum patient care. Also increasing amounts of documentation.'* | 97 |
| **Personal challenges:** Burnout, stress, the physical demands of the job, fatigue, exhaustion, emotional distress related to patient care, health reasons such as injury or illness. | *'I found it hard to work with the callers to the mental health line where I worked. It became overwhelming for me.'*<br><br>*'Expected to do a lot of night shifts, which I really struggled with.'*<br><br>*'Following shoulder surgery I wasn't sure whether this would be fully functional and I felt it unfair on my colleagues to 'carry' me in tasks I couldn't manage.'* | 75 |
| **Career factors:** Lack of professional recognition, intergenerational differences, low remuneration, dissatisfaction with nursing as a career, lack of professional development, lack of career progression, lack of job satisfaction. | *'No progression of career. No acknowledgment for upskilling and working in a highly stressful job.'*<br><br>*'I felt undervalued, isolated and unchallenged.'*<br><br>*'No scope for advancement in aged care. Poor wages. Very minimal clinical support after hours. Too much responsibility for whole retirement village after hours.'* | 38 |
| **Family reasons** Child-care demands, family obligations such as caring for older relatives or spouse. | *'My husband required care.'*<br><br>*'I left because: a) family bereavement, b) returned to home town with family.'* | 28 |
| **Retirement** | *'Time to retire and enjoy freedom.'*<br><br>*'My husband has been retired for eight years already and though I am younger, it was time for us to do other things together.'* | 125 |
| **Other categories** | **Exemplar quotes** | **n** |
| Lack of confidence (in self and in practice) | *'I was not performing to my own expected level of ability, nor did I feel capable of working in the areas I was interested in.'*<br><br>*'I had reached the end of the road, and felt it was better to go before I started making mistakes.'*<br><br>*'I was finding it harder to keep up with the knowledge required to nurse safely in that area.'* | 9 |
| Leaving for overseas (for travel or work) | *'I wanted to have more time with my husband, who is European, and have the freedom of travelling for two or three months at a time.'*<br><br>*'To pursue another opportunity overseas.'* | 5 |

*Table continues next page* ⇨

| Other categories | Exemplar quotes | n |
|---|---|---|
| Unwillingness or inability to complete education requirements | *'I came to the conclusion that I no longer wanted to submit to the constant need to prove oneself capable of doing the job that I had done for so long, and so well.'*<br><br>*'I wasn't able to maintain the hours and professional development required to keep my practising certificate within the three-year period. So left and let my certificate lapse.'* | 5 |
| Change in career | *'Career change, opened a restaurant.'*<br><br>*'Having gone through yet another restructure process, I decided I was undervalued and had the means to take a different direction in life – so I did.'* | 56 |
| Work/life balance | *'I just want to have some normality in my life. To be stress-free and wanted more time to pursue activities.'*<br><br>*'I had the choice to stop paid employment and switch to a variety of voluntary jobs requiring much reduced hours and enjoying other aspects of my life.'* | 2 |
| Unable to find nursing work (unemployment or redundancy) | *'I am still a registered nurse, but for the moment I have stopped nursing because I was unable to get a job.'*<br><br>*'I have had many interviews over the last two years and all of them have said the same: Good interview, great CV. We will get back to you. I never once have heard back from any application interview I have had. They see me and my age and that is as far as they will take it.'* | 15 |

at the time of answering (14.6 percent) had retired, though it is not possible to calculate how many of those over the age of 65 at the time of the survey had also retired prematurely within the five-year span of the sample selection.

## Characteristics of those who had left nursing

Some 66 percent (n=297) of the cohort of nurses in this study leaving the profession were hospital-trained and 22 percent (n=99) held a nursing degree. More than half of those leaving the profession (57.6 percent, n=259) had worked in nursing for more than 40 years, and an additional 16.7 percent (n= 75) had completed 30 years in the role. Almost three quarters (73 percent, n=328) of nurses over 55 who left the profession had been working part-time, with around a quarter of respondents working office hours only. The most common fields of practice for the oldest cohort were primary health care and aged care. When examined by reasons for leaving, older nurses were more likely to cite retirement, family reasons, seeking better work-life balance, or a loss of confidence. Frustrations with paperwork, loss of job satisfaction related to workload and less time for patient care figured prominently in free-text comments.

Respondents were asked if they intended to return to nursing at a later date. Of 454 who replied, 2.2 percent (n=10) indicated they intended to return. Of note, four of these had left nursing to travel, and a further four had left to care for family members. Eighty-five percent (n=386) had no intention of returning and 12.8 percent (n=58) were unsure. Despite their intention not to return to nursing, more than a quarter (28.4 percent) of respondents still held a nursing registration.

## Post-nursing activities

Since resigning from their last nursing position, 342 (82.2 percent) had retired. Of these, 308 were at or over the nominal retirement age at the point of returning the survey (though some may have been under 65 at resignation). Of the 87 (21 percent) individuals who were employed, only 13 individuals had accepted another nursing role. Around 20 percent of participants answering this question were involved in unpaid activity such as studying, or care of family. Respondents were allowed to choose more than one option.

## Reasons for leaving nursing

Respondents were asked to identify their reasons for having left nursing. Of the 303 who answered the question, 14.4 percent (n=44) left due to illness or injury, and 26.3 percent (n=79) simply no longer wanted to nurse. A follow-up question explored these reasons in more detail. This was a free-text question that was then coded into themes based on the categories developed from the literature: workplace concerns; personal challenges; career factors; family reasons; and retirement. This approach enabled calculation of thematic coding frequency.

Many respondents identified multiple contributing factors. Reasons given that did not fit within the categories developed from the literature were also identified and recorded as "other" categories. Descriptions, coding frequencies and exemplar quotes for all the categories identified are shown in Table 2 (left and above).

The greatest concerns were expressed about issues in the workplace, with inadequate nurse staffing, a lack of time to deliver appropriate patient care (especially due to increased "paperwork"),

and a culture of bullying all contributing to poor work experience and the desire to leave.

In the final comment section, 52 percent (n=162) of this cohort, while also expressing the concerns above, were very positive overall about nursing when looking back on their career. Of 81 nurses who had retired before the age of 65, 15 percent (n=12) also expressed very positive sentiments about nursing as a career.

### Decision-making process

Nurses reported seriously contemplating leaving for some time before making the decision, with nearly half taking more than six months to decide. Free-text comments showed that planned age-related retirement sometimes changed at short notice due to financial constraints (need to remain) or health issues (need to leave) intervening. While partners were most commonly involved in the decision process, around 30 percent discussed their plans with colleagues, and 20 percent with their managers some time before resigning.

Participants were asked to identify which of the factors identified in the literature might have helped them remain in nursing. This relative importance is illustrated in Table 3 (right). They have been grouped together post-survey for analytical purposes.

**Table 3. Factors aiding retention**

| Factors | % | Mean for group |
|---|---|---|
| **Patient-related** | | |
| More time for patient care | 52.6 | 49.8% |
| Less paper work | 52 | |
| More staff | 44.9 | |
| **Support-related** | | |
| More support from an immediate manager | 41.1 | 32% |
| More support from employing organisation | 35.6 | |
| Better support from colleagues | 19.5 | |
| **Career related** | | |
| Greater recognition of my skills | 47.4 | 23.2% |
| Less demand for professional development | 44.9 | |
| Better pay | 27.9 | |
| Better career prospects | 8 | |
| Being given more responsibility | 7.1 | |
| Greater professional challenges | 4.0 | |
| **Work/life integration** | | |
| More flexible working hours | 23.8 | 9.3% |
| More leave | 9.3 | |
| Better access to elder care | 2.8 | |

## DISCUSSION

The findings from this study confirm that older nurses do leave the nursing profession for many of the same reasons identified in the "intention to leave" literature. These included the previously known factors of workplace concerns, personal challenges, career factors, family reasons and retirement. However, for a minority of respondents, lack of confidence, seeking greater work/life balance, changes to professional development demands perceived as onerous and bureaucratic (rather than being relevant to improving patient care) and simply wanting a change in career were also offered as reasons for leaving nursing.

Workplace concerns, including workplace culture, workload and staffing numbers, were the most common reason given for leaving nursing in this study, which also reflects existing literature (Ryan, Bergin & Wells, 2017). Dissatisfaction with the nursing workplace was also the most common reason given for nurses working outside of nursing in studies by Black et al (2008) and Sjögren et al (2005). Findings from qualitative studies also indicate workplace concerns are one of the biggest reasons for nurses leaving nursing (Bogossian et al, 2014; MacKusick & Minick, 2010; Tuckett et al, 2015). The high importance placed by these respondents on workplace culture echoes the findings of others (Moseley, Jeffers & Paterson, 2008; Tourangeau & Cranley, 2006). The requirement for greater support and recognition from managers and colleagues alike was identified by participants in this study as particularly important. This is a specific characteristic of the generation known as baby boomers (those born between 1945 and 1964) for whom the possibility of retirement is rapidly approaching. Many of those who are now coming through as managers may come from different age cohorts, who have other characteristics and priorities. Specialist human resources expertise and management training may be needed to help bridge such intergenerational differences (Burke, Walker & Clendon, 2015).

Older participants particularly noted many health-related challenges to continuing their nursing career. This confirms other reports of difficulties due to the physical, cognitive and emotional demands of nursing in older age (Clendon & Walker, 2015). Shift work in particular is reported to be very challenging for many aged over 50 (Clendon & Walker, 2013; Winwood, Winefield & Lushington, 2006). Loss of confidence, as a prompter for leaving nursing, may have roots in reality: for example, inability to respond to changes in technology or nursing practice. However, confidence may also be damaged by loss of seniority, as older nurses cut their hours or move to new areas of practice to improve their work/life balance or attend to family support needs. This, combined with non-supportive work cultures, may also undermine confidence.

## IMPLICATIONS FOR NURSING MANAGEMENT

Systemic issues (staffing levels, professional development mechanisms and relationship management, especially of tensions and bullying at all levels) lie at the heart of much dissatisfaction in the workplace. While some of these issues depend on funding and other

factors outside immediate management control, many others do not.

Evidence from this study shows many older nurses go through a long "contemplation of leaving" stage, with little involvement of managers in this planning and decision-making process. This would imply that if managers were more proactive in exploring workplace issues important to older nurses, this could provide opportunities to delay or prevent their retirement – particularly early retirement. Using flexibly deployed, experienced older nurses to mentor less experienced nurses could help address skill shortages while providing a more satisfying end of career.

## LIMITATIONS

As with all surveys, sampling bias and response bias may have influenced the findings. Recall bias too, over a five-year time span, may have meant that painful details had become magnified or reduced with time. While the degree of concordance with previous literature indicated the results may have general applicability, the use of such literature to guide the closed question options may have contributed to a circular argument.

## CONCLUSION

More than two decades of research across the world has consistently identified common issues and suggested remedies for the problem of older nurses retiring early from the profession. The picture in New Zealand appears similar. The need to support and retain older nurses to remain in the workforce may emerge as one of the most important and complex challenges for nursing management. Further research is needed to explore the introduction and outcome of initiatives to improve workplace culture.


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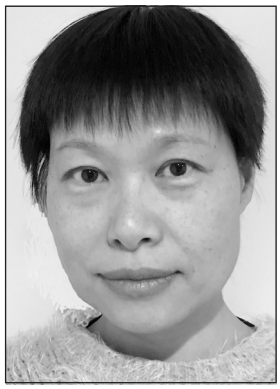
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# ETHICS EDUCATION IN NURSING: CHALLENGES FOR NURSE EDUCATORS

## ABSTRACT

**Aim:** The aim of this research was to explore the experiences of a group of nurse educators responsible for teaching ethics to undergraduate nursing students, and to discuss the ethical challenges they encountered in their classroom practice.
**Background:** Nurses face ethical issues daily in practice and, because of the growing complexity of nursing, there have been calls internationally to strengthen the teaching of ethics to nursing students. The growing literature on moral distress experienced by practising nurses suggests that nursing educators are facing greater challenges teaching ethics in undergraduate nursing programmes.
**Methods:** A case study approach was used to explore the experiences of seven nursing educators working at a large tertiary institution. The participants were interviewed to ascertain their experiences of teaching ethics to nursing students, and to explore challenges they faced and how best these challenges could be overcome.
**Findings:** The participants agreed there was a need to have ethics taught throughout the whole undergraduate nursing curriculum. One of the major challenges they identified in teaching a culturally diverse student body was the dominance of the Western philosophy of individualism embedded in New Zealand nursing's *Code of Ethics*. Despite such hurdles, the nurse educators in this study were confident teachers who all had positive experiences teaching ethics to students.
**Conclusion:** The participants in this study agreed that ethics education needed to be embedded throughout all nursing courses in their institution. Teaching ethics should not be the responsibility of only some nurse educators – it should be taught across the three years of the programme, by all nurse educators involved in both theory and clinical practice. In addition, all teaching staff needed to recognise the multifaceted issues that influence students' understanding of ethical issues, and to integrate cultural safety principles into their teaching.

## KEYWORDS

Nursing ethics, undergraduate nursing education, case study, nursing students.

## INTRODUCTION

Nursing ethics is an indispensable element of the undergraduate nursing curriculum because developing sound ethical judgement, both within the classroom and in practice, lies at the heart of nursing (Benner, Tanner & Chesla, 2009; Gibbons & Jeschke, 2016; Yeom, Ahn & Kim, 2017). Although the significance and centrality of ethics in nursing education has consistently been acknowledged, there is little evidence to suggest that newly-trained nurses are any better at making sound ethical decisions in their practice now than were their historic counterparts (Woods, 2005). What is clear is that nurses now face greater ethical challenges than they did in the past – an increasing number of studies in the field of nursing ethics have confirmed that nurses today suffer from "moral distress" as a result of conflicting demands made of them within today's complex health-care settings (Burston & Tuckett, 2013; de Casterlé, Izumi, Godfrey, & Denhaerynck, 2008; Jameton, 2013; Woods, Rodgers, Towers, & La Grow, 2015).

Given these difficulties, the purpose of this research was to shift the focus of inquiry to nurse educators; that is, to identify and explore what experiences and challenges nurse educators have encountered teaching nursing ethics to nursing students in a tertiary education environment. The research question posed was: What are the experiences and challenges of nurse educators in teaching nursing ethics to undergraduate nursing students?

## LITERATURE REVIEW

A review of a range of national and international empirical studies of nurses' experiences in their practice found that nurses frequently experienced ethical challenges in situations such as where they were unable to provide all the care patients needed (Cameron, Schaffer & Park, 2001; Park, 2009). Ethical conflict, and the resulting moral distress caused by having to make moral compromises, have become a growing area of international research (Jameton, 2013; Ulrich et al, 2010; Woods et al, 2015). This is why "ethics education"

in nursing has received increasing attention.

Studies have consistently concluded that ethics education has a significant impact on the development of nursing students' moral sensitivity and moral judgement skills (Grady et al, 2008; Numminen, van der Arend, & Leino-Kilpi, 2009; Park, Kjervik, Crandell, & Oermann, 2012). As health-care ethicist Professor Megan-Jane Johnstone has argued, there is now a much greater need for equipping nursing students with a solid foundation for ethical decision-making, because of what she sees as *"contexts where the health security of people is being threatened by ideologically driven public policy"* (Johnstone, 2017, p19). Comprehensive health-care programmes around the world are under attack from budget cutting, so it is vital to explore what student nurses are taught about ethics, and how they are taught it, to enable them to deal with the consequent pressures on their practice (Johnstone, 2017).

Research on the challenges involved in teaching nursing ethics has documented three key components for greater student success: a well-balanced combination of theory and practice (case studies, or personal narratives, to illustrate theory); pragmatic considerations, such as the time devoted to teaching and learning; and the degree to which ethical issues are embedded in the overall curriculum (Cannaerts, Gastmans & Casterlé, 2014; Numminen et al, 2009; Parsons, Barker & Armstrong, 2001). In light of nursing education's growing reliance on internet resources, more recent researchers have explored the best manner in which ethical issues should be taught – whether online, face-to-face, or in combination (Trobec & Starcic, 2015; Yang, Chang, Clark, & Chao, 2017). In some studies, educators felt they faced greater challenges due to a lack of teaching resources (Solum, Maluwa, Tveit, & Severinsson, 2016). Other research has found the educator's level of experience and training contributes to the quality of ethics training (Dekker-Groen, van der Schaaf, & Stokking, 2011).

In terms of theoretical approaches to teaching ethics, Russell (2014) contends that virtue ethics can shape the values of students to align with the values of the nursing profession, using theory-based strategies. Benner, Sutphen, Leonard and Day (2010) have argued that more clinical practice observations are needed in nursing education to help nurses bridge the theory-practice divide, especially in relation to ethical practice. The problems encountered by nurses in their practice can be traced back to the principle-based way ethics is sometimes addressed in nursing education and "contained" within narrow boundaries of rationality (Benner et al, 2009). According to Rubin (2009), qualitative and ethical distinctions in nursing practice are impeded by a narrowly constructed rational approach adopted by many nurses, regardless of the nature of various clinical problems. They have become "stuck in an unchanged form of practice", which contributes to what Rubin (p174) calls "ethical blindness".

Regarding the essential content of ethics in undergraduate nursing education, Corley (2002) and others (Doane, 2002; Johnstone, 2017; Parsons et al, 2001) have argued that a principled approach to teaching nursing ethics can lead to a justification of unwise nursing actions, rather than to the development of sound ethical judgements. Nursing students are taught to think dogmatically about ethical principles and, as a result, cannot easily negotiate their way through the complex ethical situations they meet in their everyday practice (Benner et al, 2009; Johnstone, 2017). For example, Görgülü and Dinç (2007) examined students' reaction to ethics courses in Turkish nursing education programmes and noted that ethics courses were teacher-led and principle-based, with students having limited opportunity to contribute meaningfully to the course.

Much literature has argued that new ethical issues emerge because of changing socioeconomic and cultural contexts, such as advances in medical technologies, improved information technology, and the emergence of multicultural societies (Epstein & Turner, 2015; Gibbons & Jeschke, 2016; Harding, 2013; Heikkinen et al, 2006; Numminen, Leino-Kilpi, van der Arend, & Katajisto, 2010; Sellman, 2011). Some changes in nursing philosophy and the culture of nursing – such as shifting from a disease-centred approach to a focus on patient-centred care – reflect an ethical shift from treating people as passive consumers of health-care services towards establishing a respectful and equal relationship with clients (Cribb, 2013). Ironically, this change of emphasis brings more complex ethical challenges for nurses in practice.

Studies conducted in New Zealand have shown that moral distress among nurses is an issue of great concern, requiring more attention from nursing educators in course programmes. Woods et al (2015) conducted a national survey and found high levels of ethical conflict a reality across all settings. This conclusion was confirmed by Sinclair, Papps and Marshall (2016), who argued that nursing students in New Zealand faced significant ethical issues, such as suspected neglect of patients and unsafe nursing practice environments.

Cultural safety has been widely practised in health services in New Zealand, focusing on promoting positive changes to the health status of indigenous Māori (Nguyen, 2008). The concept of cultural safety has become a key issue in all ethics courses, in response to a rapidly growing bicultural and multicultural society. Woods (2010) suggests that a greater emphasis on cultural safety in ethics education will ensure nurses are competent in providing culturally-safe nursing practice. Because ethical values in nursing are shaped by sociocultural contexts (Johnstone, 2016), nurse educators need to critically examine the content of undergraduate nursing curricula and extend cultural safety into their teaching (Harding, 2013; Richardson, Yarwood, & Richardson, 2017; Woods, 2010).

These arguments beg the question as to the quality of the nursing ethics programmes being offered. This was the reason for conducting this case study, to determine what issues nursing educators in a large tertiary institution in New Zealand considered difficult in teaching ethics and how they negotiated such issues. Given the prominence in the literature of the problematic nature of teaching narrowly to principle-based codes, questions were prepared to find out the educators' experiences of teaching the New Zealand Nurses Organisation *Code of Ethics* (NZNO, 2010).

## METHODS

This study was conducted as a qualitative analysis, using a case study approach. As Stake (2005) suggests, a case is studied to facilitate insight into an issue by scrutinising the case's contexts and detailed activities. Following ethics approval from Waikato University's Faculty of Education research ethics committee, an information sheet for participants was sent to all nursing lecturers (n=22) at a selected tertiary institution. All nursing lecturers who have been involved in teaching nursing ethics at this institution became potential participants. A self-selecting sample of seven nursing educators was recruited and interviewed. All participants were female, and each had more than 20 years' working experience as a registered nurse (RN) and more than five years' teaching nursing.

Semi-structured interviews with open-ended questions were used to collect data. Five descriptive themes emerged through use of interpretive thematic data analysis. Pseudonyms were used to protect the identity of participants.

## FINDINGS

This study was devised to explore nursing educators' experiences of teaching ethics, looking especially at the difficulties they had encountered in their teaching. Key concepts and ideas from the interviews were compared and contrasted, using thematic analysis, to identify patterns. The results revealed that nurse educators experienced multifaceted challenges. Five themes emerged. First, every participant agreed how vital it was to teach nursing ethics in the nursing programme. Second, all seven respondents voiced their concern about using a principle-based approach to teach nursing ethics. They all challenged the Western principles embedded in the *Code of Ethics*, the premise of universality inherent in it and its blindness to cultural difference. Third, each participant acknowledged how difficult it was to teach ethics in a changing nursing context. The points they raised related to the multicultural nature of society and the need for continuous professional development. Fourth, the participants reiterated that ethics was fundamental to nursing practice and could not be treated simply as content confined to a single course. The final theme that emerged was the insistence that encouraging and supporting students to examine their own values and beliefs through reflection on personal experience was the starting point in bridging the divide between the theory of ethical conduct and the reality of practice.

### Ethics as the core of nursing

The participants saw nursing ethics as the corner-stone of the nursing profession. Through contemplation of their professional responsibilities, students started to understand who they were, how they fitted into the society, and how they acted as professional nurses. One participant, Frances, insisted that, *"as students become educated nursing professionals, it is essential [to teach ethics] in terms of the professional requirement of understanding what professional ethical nursing is".* One example was the use of social media. Adele pointed out that social media – such as Facebook, Twitter and YouTube – were popular among nursing students and it was important they were aware of their professional responsibilities when using these platforms.

### Code of Ethics necessary, but not sufficient

All participants believed the *Code of Ethics* (NZNO, 2010) was not a sufficient framework for teaching nursing ethics. Although it provided principles for nurses to guide their practice, all the respondents reflected on the limitations of using a principled approach to teaching ethics. The participants gave a variety of reasons for their views.

Frances described the challenges of teaching ethical principles in terms of their ambiguity.*"…[I]f you look at the principle of 'doing no harm', it says you will not do future harm. So it means, doing no harm and any future harm. It is quite challenging in terms of what is the intention versus what is the outcome."*

The participants agreed that principle-based ethics needed to be used with caution, because the universality of ethical principles was problematic. Amy argued that all kinds of cultural factors affected people's understanding of ethical issues and, therefore, culturally safe nursing practice must be promoted and included in ethics education. She gave an example of the principle of confidentiality from a Māori perspective: *"We may feel that we breach confidentiality by discussing patients' information with family members, but for some patients we are caring for, this is what they would like us to do."*

The participants all noted that the principles of nursing ethics consisted of values and beliefs that could differ from the students' own cultural norms. Tensions would arise if nurse educators did not help students understand these dynamics. For all participants, cultural safety issues formed an important component of nursing ethics and needed to be addressed in ethics education.

### Rapid social change

Participants shared concerns that there was the potential for ethical conflict to arise because of advances in technological capability to treat illness. They considered that the difficulty in teaching ethics lay in the changing nature of the world. Cathy commented that ever-changing health-care environments and *"particularly the change of cultural and social parameters . . . affect nursing students' understanding as well as teachers' own understanding of ethics".*

The participants noted the multicultural nature of New Zealand society. Amy suggested *"adding cultural safety to the code might be appropriate, as society is changing and nursing is changing"*. Daisy went further and suggested RNs might need to regularly update their clinical practice to maintain ethical competence.

### The need to embed ethics in all course offerings

Participants emphasised the importance of embedding ethics across the nursing curriculum. Cathy said it was important to introduce ethics alongside other nursing topics, such as the professional self, dementia, the power of attorney, professional boundaries, nursing care plans and therapeutic communication. Ray, a senior nursing educator, said ethics *". . . needed to be woven throughout the whole nursing programme".*

The participants all shared the concern that teaching ethics to first-year students could be challenging because of the absence of any practice experience. As Adele noted, most first-year students had a limited grasp of the complexities of a nursing workplace. Cathy added, *" . . . ethics is a contextual topic. So, understanding ethics in nursing practice may not be the same as in other practice situations".* The consensus was that story-telling was essential in teaching ethics, because narratives provided the context in which ethical practice happened and made the abstract "real".

### Bridging the divide between theory and practice

Offered narratives of varying levels of complexity, students were better able to understand the contexts and attributes of situations they would meet. Such scenarios were a way to bridge the theory/practice divide. As Adele stressed, it was the best way to convey important ethical lessons to those who did not have many clinical experiences. Molly commented that ethics education in nursing had to be practical for students, so they could convert their theoretical knowledge into practical skills.

The participants also stressed the crucial role ethical concepts and ideas played in the development of the students' "professional self". All participants saw "reflection on action" as key in learning ethics; they underscored the value of self-reflection as a transformational process, either using reflective writing, or group discussion.

All participants agreed that ethics education in undergraduate

nursing programmes needed to be taught by nurses with extensive practical experience, rather than by experts who could teach ethical principles, but not from a nursing perspective. They said it was exciting to see students having good, robust discussions on ethical issues – such as end-of-life care and whether to treat or not to treat patients – in class and during clinical debriefings. All participants in this study were confident in their ability to teach ethics from a nursing perspective.

## DISCUSSION

The nurse educators felt passionately about ethics as a topic and also felt a strong sense of responsibility towards students' achievement. They all recognised the significance and relevance of the *Code of Ethics* (New Zealand Nurses Organisation, 2010) as a guide for nursing practice. This finding was consistent with research that suggests codes endorse professional responsibilities and function as a guide for conduct (Benjamin & Curtis, 2010; Butts & Rich, 2008; Jansen & Roodbol, 2014).

Importantly, however, what this study has shown is that although a code of ethics is a necessary reference in a nursing programme, it is not sufficient for teaching nursing ethics; although it provides principles for nurses to guide their practice, its universalistic perspective cannot be justified in our contextually variable world. Codes of ethics posit a view that an ideal nurse is one who can freely exercise choice in the light of universal ethical principles, such as autonomy, beneficence and non-maleficence (Heikkinen et al, 2006; Pattison, 2001). However, principle-based ethics need to be used with caution – codes of ethics present these principles as universal, when in fact they are based on Western attitudes and may be at odds with the beliefs and preferences of nurses and patients of other cultures.

Parsons et al (2001) and others (Corley, 2002; Benner et al, 2009) have argued that nurse educators need to pay attention to everyday ethical comportment and recognise the importance of fostering students' analytical skills in developing their capacity as moral agents. Harding (2013) suggests the globalisation of nursing education has led to Western values being embedded in nursing curricula. For example, the values of informed consent and advance directives are based on the culturally constructed value of individualism. Harding says the cultural context in which ethics are constructed is important, and argues that the ideology of individualism places the individual as the fundamental unit in most Western countries, while the family or community is placed at the centre in Māori and Pacific cultures and in countries such as China and Japan. As a result, the values of minority groups in New Zealand such as Māori and Pacific people may be overlooked.

Likewise, because the dominant international language in most professional and academic interactions is English, the values of both English and American cultures have influenced nursing education worldwide. Nurse educators must be aware that culturally constructed ethical values are not universal values, but are hegemonic cultural norms, reflecting a predominantly European worldview (Harding, 2013). Within health literature, the importance of culturally safe practice has been widely addressed, emphasising that cultural awareness, cultural sensitivity and cultural competence are keys to ensure culturally safe care (Arieli, Friedman, & Hirschfeld, 2012; Oda & Rameka, 2012).

Given that most nursing students will have had no or limited clinical experience, there is a consensus that nursing educators need to offer more narrative approaches to help students understand the contextual features and attributes of situations they will meet. Sullivan and Benner (2005) argue that ethical nursing identity is initially fostered in the academic setting and that the classroom often represents the professional world for students. Although it is desirable for students to act consistently with ideals, moral development is a dynamic process, and students will live in a state of uncertainty when dealing with ethical conflict in their practice (Russell, 2014). The role of educators is to help students navigate through this uncertainty and to create opportunities for them to understand the uncertainty as part of their moral action (Doane, 2002). Approaches to teaching should therefore emphasise deep understanding through reasoning and critical thinking (Doane, 2002).

Vanlaere and Gastmans (2007) also emphasise the importance of self-reflection, asserting that a positive outcome of teaching is the transformation of the learner from a passive recipient of others' thoughts to an active constructor of meaning through reflective activities and critical thinking. The development of professional ethical identity requires the student to integrate classroom teaching into clinical practice, as well as develop cognitive capacities and critical thinking skills to address the inescapable moral elements underlying all nursing practice (Benner et al, 2010).

All the participants mentioned they were confident in their teaching of ethics to students. Görgülü and Dinç (2007), however, found most nursing educators were not confident in teaching ethics, indicating many educators lacked confidence in their own knowledge of ethics. Nurse educators in this study, however, had extensive nursing and teaching experience and their confidence came from engaging in post-graduate study about ethics topics, as well as work experience in nursing and teaching fields. Some of the respondents had sat on ethics committees as expert nurses. They all had a great deal of practical knowledge and quite sophisticated reasoning skills. They also voiced strong opinions about respecting human rights and exercising social fairness. In this sense, they were a particularly strong group of ethical leaders in their institution.

## LIMITATIONS

This research was conducted at only one tertiary education institution in New Zealand, with a limited sample of participants, which limits the generalisability of the findings. The convenience sampling method may also have limited generalisability, as the self-selecting participants may have been those who were more confident teaching ethics to nursing students. The small sample size may also not be representative of nurse educators in New Zealand as a whole. That said, qualitative researchers use "cases" to more intimately understand a social phenomenon within a particular historical, cultural and social context – rather than emphasising the generalisability of the findings. What would be fruitful now would be to initiate a larger study to make comparisons among different nursing schools on nursing educators' views about teaching ethics.

## CONCLUSION

The findings of this research reiterate the importance of promoting undergraduate nursing students' ethical awareness and the importance of teaching ethics in a nursing programme. Nurse

educators in this study expressed their overall confidence in teaching ethics, while acknowledging some difficulties. The challenges of teaching ethics in bicultural and multicultural New Zealand imply there is insufficient emphasis on cultural safety in the NZNO (2010) *Code of Ethics*. As this study has shown, Western philosophical ideas of individualism embedded in ethical principles are a major challenge in teaching ethics to a culturally diverse student body. As the nurse educators in this study have suggested, although the *Code of Ethics* is central to teaching ethics, teachers also need to highlight more culturally specific ethical views that genuinely address the interests and aspirations of marginalised cultural groups, such as Māori and Pacific people.

The study findings highlight challenges to teaching ethics in the changing context of nursing, as well as the changing context of the field of ethics itself. Nursing ethics is situated in the real world, which is made up of multi-layered social and cultural elements. This implies that ethics education needs to be relevant to the realities of contemporary nursing practice. It must be taught in a way that bridges the divide between abstract ethical theory and practical experiences – especially given the age range and inexperience of the first-year student body. A narrative approach, with a variety of teaching methods – such as group discussion and reflective writing – may be worth considering. The need to use supportive strategies to scaffold learning and move nursing students towards a deeper understanding of nursing ethics is an important finding of this study.

## RECOMMENDATIONS

The following recommendations arise from this study:

1) Nursing ethics education is best addressed by threading ethical issues throughout the nursing programme, in addition to specific ethics courses.

2) Nursing educators must create a learning environment that better reflects professional nursing practice. A narrative approach to teaching ethics, with a variety of case-based teaching methods, is recommended.

3) Moral development is a dynamic, ongoing process for students and teachers alike. In recognition of this process, nurse educators must use supportive scaffolding strategies to promote students' critical self-reflection on ethical issues, and to provide a safe learning environment to move students towards a deeper understanding of nursing ethics.

4) Nurse educators must recognise the multifaceted issues that influence students' understanding of ethical principles and integrate cultural safety principles into nursing ethics.

## ACKNOWLEDGEMENT

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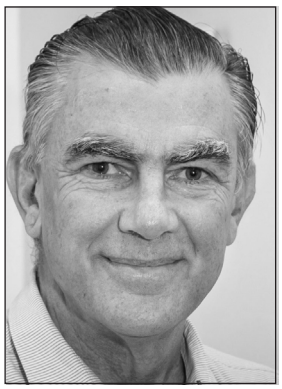
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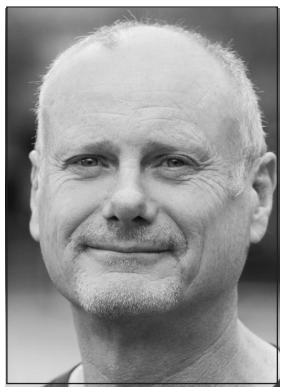
# THE PATIENT EXPERIENCE OF CARE DELIVERED BY AN OUTPATIENT INTRAVENOUS ANTIBIOTIC SERVICE





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## ABSTRACT

**Aim:** The aim of this research was to survey patients' experience of the care provided by the outpatient intravenous antibiotic (OPIVA) service at Auckland City Hospital.

**Background:** Research in Australia has demonstrated that OPIVA is a safe and effective option for managing selected patients who require a long period of intravenous antibiotic treatment.

**Methods:** In this cross-sectional study, 101 patients were invited to participate, and 75 (74 percent) completed the questionnaire. Most of the respondents were male, New Zealand European, and most (73/75, 97percent) had received intravenous antibiotic therapy as an inpatient and then completed their antibiotic treatment in the community.

**Results:** The survey responses were positive about the overall provision of OPIVA care (99 percent), communication with the OPIVA nurses (97 percent) and doctors (96 percent), and the written information provided about the OPIVA service (99 percent). Responses were mostly positive about the training for home antibiotic administration (90 percent) and the convenience of attending the OPIVA clinic (87 percent). Areas identified for improvement fell under two overarching themes: inconvenience associated with health-care delivery and issues about the management of central venous access devices (CVAD).

**Conclusion:** OPIVA therapy was well-regarded and met the expectations of the majority of respondents in this survey. Improvement opportunities include better discharge information, more education opportunities for community nursing teams, collaboration between different teams, training sessions for staff and patients, and the availability of the service after hours.

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## KEYWORDS

Outpatient parenteral antibiotics, OPIVA, outpatient antibiotic therapy, OPAT, hospital in the home, HITH, peripherally inserted central catheter (PICC), PICC line, elastomeric pump, patient experience.

## INTRODUCTION

Outpatient intravenous antibiotic (OPIVA) services allow patients who require prolonged intravenous antibiotic treatment to receive some or all of their treatment at home (Abusalem, Myers, & Aljeesh, 2013; Candel, Julián-Jiménez & González-Del Castillo, 2016; Kieran et al, 2009). OPIVA services, also known as outpatient parenteral antimicrobial therapy services, are widely available due to their utility in the treatment of patients with a wide range of infectious diseases (Baker et al, 2012). OPIVA services usually use one of three methods to administer intravenous antibiotics (Candel et al, 2016; Upton, Ellis-Pegler & Woodhouse, 2004). The first method requires the patient to attend an infusion centre or clinic to receive their intravenous antibiotics and have regular care of their central venous access device (CVAD). This method is commonly used for antibiotics with a long half-life, which only need to be infused once a day. The second method involves community nursing services visiting patients' homes to connect them to an intravenous infusion device and to provide CVAD care. The third method involves the patient and/or their family members administering boluses of the intravenous antibiotics, with regular visits from community nurses to provide CVAD care (Candel et al; Upton et al).These two methods are commonly used for antibiotics that have shorter half-lives and therefore need to be administered either by continuous infusion or by repeated boluses.

At Auckland District Health Board (ADHB), the OPIVA service started in 1979 and mainly used the third model of care until elastomeric infusion devices were introduced, which made self-administered infusion easier. The ADHB OPIVA service now cares for 150-200 patients annually. The Auckland City Hospital infectious diseases department previously published a study of the ADHB OPIVA service from the era before elastomeric infusion devices were widely used, but it did not take the views of patients into account (Upton et al, 2004). The current study was performed to understand patients' experiences of the OPIVA service and to identify areas for potential improvement.

## BACKGROUND

OPIVA services were first introduced in the United States (US) in 1974 to treat patients with cystic fibrosis and exacerbations of pneumonia that required prolonged courses of intravenous antibiotics. Clinicians faced several challenges when treating respiratory tract infections in these patients, including lack of response to antibacterial therapy administered orally and the lengthy hospital stays required for parenteral drug administration. An early report on the use of OPIVA in the treatment of acute and chronic respiratory tract infection in children with cystic fibrosis reported an increased survival rate and that patients became skilled in self-administration of intravenous antibiotics. Patients avoided hospitalisation, with reduced medical expenses for patients and their families, less disruption of family routine, and a more rapid return to school or work (Seaton & Barr, 2013; Williams et al, 2015). In the 1980s and 1990s, OPIVA was progressively introduced in many parts of the world, including the US, the United Kingdom (UK), Canada, Australia and New Zealand. In the last 30 years, OPIVA has become increasingly popular as a cost-effective strategy for infections that require lengthy treatment (Lane et al, 2014). A survey of infectious diseases physicians in the US in 2006 indicated that 94 percent of patients requiring treatment with antibiotics in the longer term were discharged from hospital on OPIVA therapy (Lane et al). In the UK, OPIVA therapy was initially available only in a small number of specialist centres, but its use expanded with increasing recognition of the benefits for both patients and health-care services (Chapman et al, 2012). Research in Australia has shown that OPIVA is a safe and effective option for management of selected patients who require a long period of intravenous antibiotic treatment (Subedi et al, 2015).

Many public hospitals in New Zealand have developed OPIVA services that have changed the concept of service delivery in the hospital and primary health care sector. Auckland City Hospital formally introduced its OPIVA service in 2000 (Upton et al, 2004), allowing many patients to receive intravenous antibiotics at home by self-administration, with daily assistance from district nurses if needed. The intensive input needed from district nurses was decreased when elastomeric infusers were introduced in 2001. Until then, patients were receiving their medication as a bolus and needed to wake at night to administer their antibiotics, and some needed to administer their medication up to four times daily. The elastomeric infusers allowed antibiotics to be administered continuously over 24 hours, with only one bottle change daily. This meant more patients could be taught to self-administer their antibiotics, which was much simpler and more time-efficient (Upton et al, 2004).

## LITERATURE REVIEW

A search of the Medline, CINAHL, Web of Knowledge, Scopus and PubMed databases was undertaken in June 2016 to identify studies of patient experiences of OPIVA. Google Scholar was also searched to identify relevant articles that may have been presented at seminars or conferences or published in a report not easily accessible in other search engines. The reference lists of the retrieved articles were searched manually to identify any further relevant papers.

The search was conducted using the search terms "outpatient intravenous antibiotics", "OPIVA", "outpatient antibiotic therapy", "OPAT", hospital in the home", "HITH", "parenteral", "intravenous", "outpatient setting", "home dialysis", "home care services", "peripherally inserted central catheter"(PICC), "PICC line", "elastomeric pump", "patient experience", and "patient satisfaction" (see Table 1, below). The search yielded limited literature on the patient experience of OPIVA. Forty-one articles were found that

**Table 1. Search terms used and yield of literature search**

| Subject | Search terms | Results |
|---|---|---|
| Patient experience/satisfaction or similar | OPIVA, OPAT, HITH, intravenous parenteral | 20 |
| Patient satisfaction/experience<br>Studies in other areas | Chemotherapy, home dialysis, home care service | 13 |
| Patient satisfaction/experience<br>Studies in other areas | PICC line/elastomeric pump | 7 |

**Abbreviations:** HITH – hospital in the home OPAT – outpatient parenteral antimicrobial therapy OPIVA – outpatient intravenous antibiotic PICC – peripherally inserted central catheter

discussed the patient experience of outpatient intravenous therapy in other settings, including oncology and renal medicine. The abstract for each identified article was assessed using the Survey, Question, Read, Recall and Review (SQ3R) technique (Sapsford, 2007) to glean a general idea of the content of the paper and whether it was relevant to this study. The full-text version of each paper was then obtained and assessed for relevance to the research topic.

Four studies measured the quality of outpatient experience of OPIVA – these included a study on patients transitioning from hospital to home, a case report of a single patient, and two reports based on a telephone-administered structured interview or a face-to-face semistructured interview. Two of the 20 papers included in this literature review were randomised controlled trials, 12 were surveys, and one was a prospective clinical evaluation. Nine of the 12 surveys identified addressed patient satisfaction with an OPIVA service and the remaining three assessed quality of life in patients participating in an OPIVA programme and patient experience of the PICC line and elastomeric infusers.

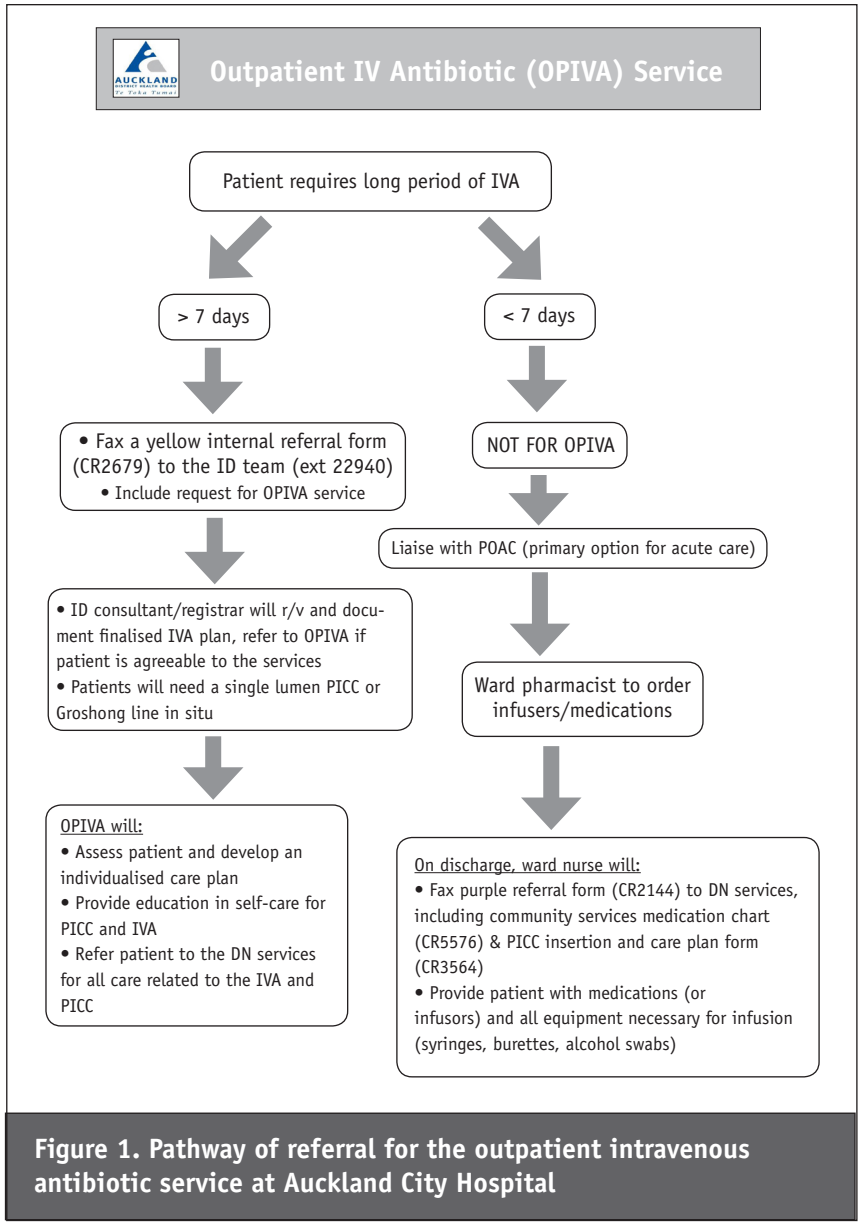



**Figure 1. Pathway of referral for the outpatient intravenous antibiotic service at Auckland City Hospital**

## MATERIALS AND METHODS

### Design, setting and participants

Auckland City Hospital is an 850-bed teaching hospital that provides secondary care for approximately 478,000 people who reside in central and eastern Auckland, and tertiary care to residents of the Auckland District Health board (ADHB) region and of many other DHBs. The ADHB OPIVA service is managed by the adult infectious disease service, which receives referrals from within the hospital and from the community. Study participants were consenting adults (≥15 years of age) treated with intravenous antibiotics by the OPIVA service. All patients cared for by the service between January and June 2016 were invited to participate in the survey. No exclusion criteria were applied. The objective, study outline, and the benefits were explained in the participant information sheet (PIS) that was attached to the questionnaire and given to each patient in a sealed prepaid envelope. Participants were asked to either place their completed survey form in a collection box at the outpatient clinic reception desk, or to post it to the study coordinator, using the self-addressed envelope provided with the questionnaire.

### The survey

A self-administered questionnaire, which consisted of 35 questions across three sections, was designed for this study. The first section encompassed socio-demographic and clinical features, including age, gender, ethnicity, referring service, type of CVAD and mode of antibiotic administration. The second section asked about the patient's experiences, and included questions about communication, information, education, whānau/family involvement, organisation and coordination of care. Questions in this section were informed by the outpatient experience survey used at ADHB, and most survey questions were answered using a five-point Likert scale ranging from "strongly disagree" to "strongly agree". The third free-text section invited participants to record any positive or negative experiences they encountered during their OPIVA treatment. We focused on the negative comments to identify potential areas for improvement of the OPIVA service.

## STATISTICAL ANALYSIS

Quantitative data were descriptively analysed using Statistical Package for Social Sciences v16.0. Qualitative data from free-text comments were analysed using a general inductive process and NVivo version 10 software.

### Ethical approval

Ethical approval was obtained from the University of Auckland human participants ethics committee on December 14, 2015.

**Table 2. Demographic and clinical features of OPIVA participants**

| Characteristic | Number (%) |
|---|---|
| **Mean age** (std dev) | 58 (19) |
| **Gender** | |
| Male | 49 (65) |
| Female | 26 (35) |
| **Ethnicity** | |
| NZ European | 48 (64) |
| NZ Maori | 8 (11) |
| Pacific people | 10 (13) |
| Asian | 7 (9) |
| Other | 2 (3) |
| **English as first language** | |
| Yes | 60 (80) |
| No | 12 (17) |
| Missing data | 2 (3) |
| **Lives alone** | |
| Yes | 11 (15) |
| No | 60 (81) |
| Missing data | 3 (4) |
| **Central venous access device** | |
| Peripherally inserted central catheter | 71 (95) |
| Tunnelled central venous catheter | 1 (1) |
| Missing data | 3 (4) |
| **Person responsible for antibiotic administration** | |
| Patient and district nurse (DN) | 6 (8) |
| DN | 35 (47) |
| Patient | 31 (41) |
| Missing data | 3 (4) |

## RESULTS

Completed questionnaires were provided by 75 (74 percent) of the 101 OPIVA patients who were invited to participate in the study. The majority of the participants were male, with a mean age of 58 years (range 16-96) (see Table 2, left). Seventy-one (95 percent) of the 75 participants had received OPIVA via a PICC and 31 (41 percent) were independently disconnecting and reconnecting their infusers or administrating boluses of their antibiotics.

The overwhelming majority of participants reported that their overall experiences of the OPIVA service were positive (see Figure 2, below). Seventy-two of 74 (97 percent) reported that communication with the OPIVA and district nurses was excellent; and 43 out of 48 (90 percent) reported their antibiotic training was adequate. The patients' assessment of the adequacy of their antibiotic training did not differ between those participants who self-administered their antibiotics and those whose antibiotics were administered by a district nurse.

Thirty-six (48 percent) of the 75 participants provided free-text comments that reflected both positive and negative experiences (see Figure 3, p22). Six participants included negative comments that could be grouped into two overarching themes: inconsistencies in care between service providers and inconvenience associated with aspects of the health-care delivery. Participant reports of inconsistent care revealed service providers' lack of knowledge about management of central lines. Examples of inconsistent care included variation between the discharge information provided by the OPIVA service and by the inpatient service, and incomplete discharge information provided by one of the OPIVA nurses.

*"I found that trying to receive this treatment which I desperately needed was difficult, to say the least! Had it not been for another specialist involvement, I do not believe would have received it, has*

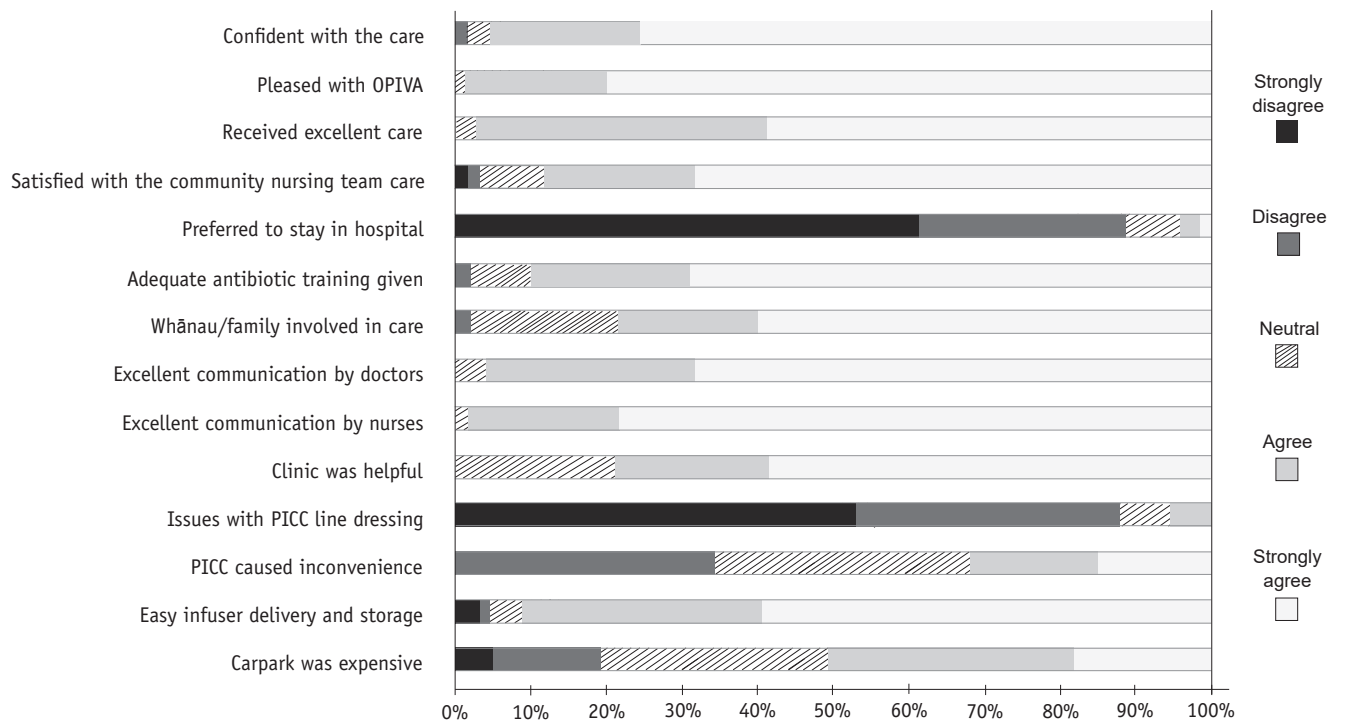



**Figure 2. Participants' (n=75) Likert scale responses regarding care delivered by the OPIVA service**

*achieved/eradicated the bacteria from its target area so far, but i believe that i am still not out of the woods so to speak. This was all due to a lack of knowledge by doctors in the areas of my infection."*

*"The district nurses were inconsistent. The last nurse took PICC line out too early – much inconvenience to myself but overall were reasonably okay."*

*"I found the service good most times, just that was not given enough information or help with managing to get to appointments from the team and parking costs was a disappointment."*

Examples of inconvenience to patients related to the PICC line and/or the elastomeric infusers:

*"More regular PICC line dressing changes would have been good as I struggled to keep them on for a week . . . "*

*"No problems at all, except for the inconvenience of having to carry antibiotics around in bag but cannot be avoided."*

Several participants made suggestions that might improve the OPIVA service. Examples were:

*"Compared to the option of further time in hospital, the OPIVA service is very good. On call OPIVA service for weekends would be helpful in conclusion… "*

*"Internet online may be a good idea but in my case having access to OPIVA nurse and all the other OPIVA nurses meant I had no need to go online."*

*"Only issue is that the nurses seem to be run off their feet – maybe more resource is required, otherwise excellent."*

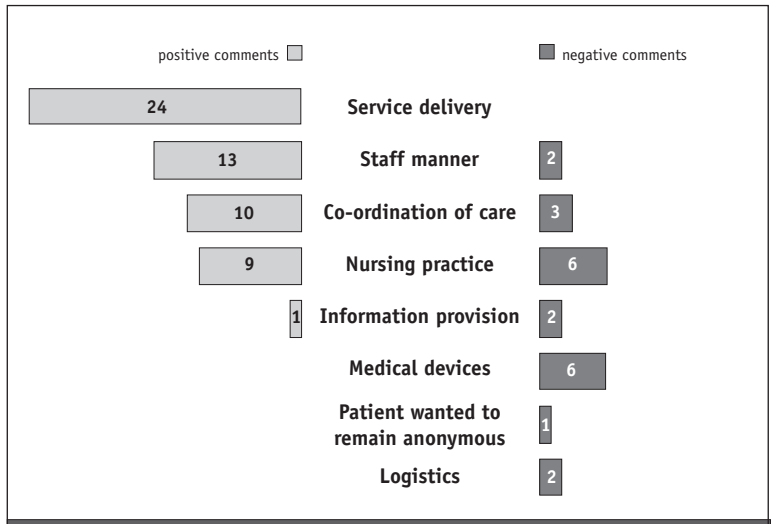



**Figure 3. Themes of participants' positive and negative comments on the OPIVA service**

## DISCUSSION

OPIVA, which was developed in the 1970s initially for the treatment of respiratory tract infections in patients with cystic fibrosis, is now widely used in many countries for patients with a diverse range of infections (Baker et al, 2012). OPIVA treatment enables patients to either avoid, or have a reduced period of hospitalisation while maintaining safe, structured follow-up care from a specialised infectious diseases team (Rucker & Harrison, 1974; Seaton & Barr, 2013; Upton et al, 2004). Some of the essential drivers of OPIVA are that it improves patients' quality of life and gives them the option of being treated at home, thus allowing shorter hospital stays, reduced inpatient costs, and fewer incidents of health-care associated infections (Abusalem et al, 2013; Ansari, 2013; Corwin et al, 2005; Davis & Woodhead, 2016; Dubois & Santos-Eggimann, 2001; Eron & Passos, 2001; Goodfellow et al, 2002; Hitchcock, Jepson, Main & Wickens, 2009; Kieran et al, 2009; Leff et al, 2006; Marra et al, 2005; Montalto, 1996; Sims et al, 2013; Wilson, Wynn, & Parker, 2002). The availability of newer antibiotics with prolonged half-lives, in conjunction with the development of more refined vascular access devices, have further facilitated OPIVA delivery (Richards et al, 2005). A number of studies have examined patient satisfaction with OPIVA services and found home delivery of intravenous antibiotic therapy is more acceptable, safe, efficient and patient-centred than delivery of antibiotic therapy to inpatients (Ansari, 2013; Candel et al, 2016; Goodfellow et al, 2002; Kieran et al, 2009; Seaton & Barr, 2013; Sims, Baker, Bellamy & McMurtry, 2013; Upton et al, 2004; Wilson et al, 2002).

Overall, almost all participants reported high levels of satisfaction with their OPIVA care. These findings are similar to those from other published studies (Ansari, 2013; Corwin et al, 2005; Davis & Woodhead, 2016; Eron & Passos, 2001; Kieran et al, 2009; Lemelin et al, 2007; Marra et al, 2005; Richards et al, 2005). The findings from a prospective cohort study showed that OPIVA treatment was associated with significant improvements in patients' health-related quality of life in domains such as psychosocial stress, social functioning and physical functioning (Goodfellow et al, 2002). While our study was not designed to measure the health-related quality of life of our patients, the findings suggest that similar improvements in health-related quality of life have occurred in our patients.

A small number of patients in our survey commented on issues which could have been improved. These included inconsistencies in the care provided by different medical and nursing teams, inconvenience arising from the medical devices, and other logistical problems including those related to attending clinics. Standardising the education and training of OPIVA care providers may minimise inconsistent care, and prioritising patient-centred care during decision-making may minimise inconvenience to patients in their daily life (Evans et al, 2016).

There were two key findings in this survey. First, most participants in our survey regarded the OPIVA service highly on overall performance. The survey responses were strongly positive towards provision of OPIVA care (99 percent), communication by nurses (97 percent), communication by doctors (96 percent), provision of adequate education (90 percent), provision of adequate information (99 percent), and the convenience of attending clinics (87 percent). Second, two major themes were identified that brought to light opportunities for improvement of the OPIVA service. These themes were inconsistent care between service providers, and the inconvenience of the medical devices and logistical issues affecting patients.

A detailed review of the literature found that all papers measured patient satisfaction with OPIVA, but found no studies of patient experience with OPIVA . This is the first study of patient experience in New Zealand. Our findings are similar to those of other published studies (Ansari et al, 2013; Kieran et al, 2009; Lemelin

et al, 2007; Marra et al, 2005). Two previous randomised controlled trials conducted in New Zealand found that patients with cellulitis or community-acquired pneumonia (CAP) could be safely managed at home with OPIVA and appropriate co-ordination of care (Corwin et al, 2005; Richards et al, 2005). Both these randomised controlled trials highlighted that patients preferred treatment at home rather than in hospital.

Administration of intravenous antibiotic therapy at home is well accepted by patients (Corwin et al, 2005). From our survey findings, 89 percent of patients preferred not to continue their antibiotic treatment in hospital and only a small minority (4 percent) would have preferred to do so. Again, only a small minority (4 percent) reported being anxious on discharge. The findings of our survey indicated that the majority of patients preferred to be treated by the OPIVA service. This finding is similar to the results of earlier randomised controlled trials from Christchurch Hospital (Corwin et al, 2005; Richards et al, 2005), one of which reported that one in three patients who were treated in hospital would have preferred the OPIVA service and that only one in 20 patients who were transferred to OPIVA would have preferred to remain an inpatient and continue their treatment in hospital (Corwin et al, 2005). Similarly, patients in the prospective cohort studies reported by Alawi et al (2015) and Ansari (2013) preferred to be treated by the OPIVA service and expressed high satisfaction with the delivery of care. Other studies have also reported patients being highly satisfied with their experience of the care delivered by an OPIVA service (Ansari et al, 2013; Dubois & Santos-Eggimann, 2001; Hitchcock et al, 2009; Montalto, 1996).

The findings of a cross-sectional prospective cohort study in Canada showed that patients who received OPIVA experienced a significant improvement in their health-related quality of life in domains such as psychosocial stress and social and physical functioning (Goodfellow et al, 2002). While our study was not designed to explore health-related quality of life after discharge from hospital, the delivery of a well-received OPIVA service could be expected to improve patients' overall health. Therefore, any improvement or further development of our current OPIVA service, with integration of the recommendations made by the respondents in our study, may yield more patient satisfaction and better patient experiences, reduce hospital costs and improve patients' quality of life. A prospective clinical trial performed in Australia noted that both patients and family members reported high levels of satisfaction with the delivery, comfort, and convenience of OPIVA care (Leff et al, 2006), which is similar to the findings of this study.

Like other studies, a multi-method review of home-based chemotherapy found that standardising education and training for care providers may minimise the risk of inconsistent care between health-care providers (Gorski & Grothman, 1996). Further, if health professionals keep patients at the centre of their decision-making about care, this may help minimise inconvenience to patients in their daily life.

Surveys of patient satisfaction with OPIVA have consistently found high satisfaction with provision of this service. Eighty-three percent of patients in a study by Lemelin et al (2007) rated OPIVA as an appropriate service for their illness and 64 percent rated the overall care received as good (Lemelin et al, 2007). However, 37 percent expressed concern about being left alone at home with no hospital surveillance, especially in the evenings and at night. In our study, 77 percent of patients reported that they would have been disappointed if there was no OPIVA service available, which is similar to the findings of others (Marra et al, 2005). Marra et al (2005) reported that 89 percent of the patients in their study preferred treatment at home and 82 percent were willing to pay for OPIVA in order to be discharged home sooner. They explained that co-ordination of care was pivotal to a well-functioning OPIVA service.

Some respondents in our survey complained of inconsistencies in the co-ordination of care between different specialties and expressed their dissatisfaction when the two teams had not been liaising with each other. However, when questioned about "co-ordination of care", 97 percent of patients agreed that they had received excellent care. This finding is similar to that in the study by Lemelin et al (2007), although in their study 60 percent of patients felt that their care was appropriately co-ordinated.

A minority of patients treated by OPIVA services self-administer their antibiotics, and the remainder have the antibiotics administered via an infuser device. Educating patients who will be self-administering their antibiotic regimen how to do this is another crucial phase in the OPIVA process (Amodeo et al, 2009). Pajarón et al (2015) studied patients who were self-administering antibiotics as treatment for infective endocarditis, and found that patient or carer administration of antibiotics was safe and effective. Eaves et al (2014) found that retention of information by patients and carers was excellent, with 92 percent (35/38) of patients and carers fully competent and confident after training had been provided. Our key finding from training patients to self-administer antibiotics was that 90 percent of patients were satisfied with the written, visual and practical demonstration of antibiotic administration.

Eighty-seven percent of patients found the OPIVA clinic to be useful. Seventy-eight percent of our respondents disagreed they had to wait for a long time at the clinic, 89 percent agreed their concerns were well addressed, and 70 percent disagreed that their clinic appointments were too frequent. These findings suggested patients receiving OPIVA experienced minimal logistical issues. A similar pattern of responses was seen in a patient satisfaction survey conducted in a breast-cancer clinic, where patients reported brief waiting times, consistent continuity of care from physicians, and good interpersonal skills on the part of nurses and physicians. A high proportion of respondents in that survey felt their questions were answered and their expectations met (Bergenmar et al, 2006).

In contrast with the above findings, thematic analysis of our survey results showed that a few patients did experience some degree of inconvenience. However, most of our patients had no problems with the PICC dressings and did not experience inconvenience with the PICC line in their arm or any irritation from the dressings. In a clinical audit of patient experience of a PICC line inserted for chemotherapy by Harrold et al (2016), 65 percent of 48 patients reported no complications with the line. Chambers, Pabia, Sawyer & Tang (2017) reported that the complete or partial occlusion rate for PICC lines was low (8.2 percent), which is consistent with the findings of Harrold et al (2016).

Eighty-eight percent of the respondents in our survey disagreed they had issues with the PICC line, confirming a low number of issues with this type of line. Harrold et al (2016) reported that none of their study participants reported complications with activities of daily living, such as showering with a PICC line or coping at home with an elastomeric infuser bottle attached to the belt bag. In contrast, a small percentage of patients in our survey experienced issues with the PICC line, including showering, keeping the dressing dry, allergic

reactions and the need for regular dressing changes. However, the clinical audit by Harrold et al (2016) was undertaken in patients receiving chemotherapy with a catheter dwell time ranging from seven days to 20 months, whereas our patients receiving OPIVA had a catheter dwell time of seven days to six weeks. Our findings suggest that when the catheter dwell time is shorter, it may be more difficult for patients to adjust to the presence of a foreign body in a vein. Ninety percent of patients in the study by Harrold et al (2016) reported that they would recommend a PICC to others, including five patients who rated PICC insertion as very painful but would still recommend it to others because it made the treatment journey easier. In the study by Goodwin et al (2002), a minority (10 percent) of patients used a PICC line, whereas the majority (95 percent) of our patients did so.

A recent international cross-sectional descriptive study, designed to identify current site management for CVADs, to clarify practice for central lines when the skin is impaired, and to describe current training for CVAD management across 34 countries (Broadhurst et al, 2016), found variations in recommended best practice between health-care clinicians, patient populations and countries. In our study, one of the common themes in the open-text comments was inconsistent PICC dressing changes. The findings of the larger-scale study by Broadhurst et al (2016) are similar to ours in regard to lack of consistency of PICC dressing changes, nursing practice and management of skin allergies.

Elastomeric infuser bottles were also discussed in the open free-text component of our survey. Ninety-two percent of patients were satisfied with the delivery of the infusers and their storage requirements and 78 percent disagreed that they had to wait for a long time to be discharged home. Our findings are consistent with those of Factor et al (2007), who reported that patients preferred an elastomeric infuser as part of their treatment. Only one patient in our study found the infuser bottle inconvenient to carry around in the belt bag.

In a multi-method review of home-based chemotherapy, Evans et al (2016) found that patients perceived a number of advantages in being treated at home, including privacy, a familiar environment, reduced waiting times, less disruption to daily life, more involvement of family members in their care, fewer transport difficulties, independence and personalised care by nurses in the home. Most of our survey respondents considered that the OPIVA clinic was very convenient and they felt comfortable being treated at home by the district nurses. A few reported fear of infuser pump malfunction, lack of hospital surveillance, the ongoing commitment of caregivers, adjusting to wearing the portable pump, which restricts activities of daily living, and less opportunity to share experiences with other patients. None of our respondents mentioned any instances of infuser pumps malfunctioning. However, patients felt that wearing the belt bag to store the infuser bottle at all times was inconvenient and, for some, was a source of anxiety with regard to explaining it to others.

In contrast, in a semi-structured interview, patients with advanced cancer receiving home parenteral nutrition and their family members felt frustrated, powerless, and unable to cope with nutritional support at home (Orrevall et al, 2004). Home parenteral nutrition uses a model of care similar to OPIVA – patients receive nutrition through a vein using a PICC line. However, these patients and their family members accepted home parenteral nutrition because of the severity of their condition, and still regarded home-based treatment as a positive alternative to hospitalisation.

A study of patients' experience of home dialysis in Wellington, New Zealand, which included face-to-face interviews, reported that the relationship between the patient and machine was ambivalent; however, dialysing in hospital was described as negative because of the restrictions imposed on lifestyle and the loss of personal autonomy when compared with home dialysis and peritoneal dialysis (Shaw, 2015). This study found that patients who dialysed at home took responsibility for self-management, which is similar to our finding that 41.3 percent of patients took full responsibility for self-administering their own antibiotics and care of their PICC line.

A qualitative ethnographic study in the UK, investigating the experiences of patients on peritoneal dialysis at home, described four major themes: feeling medicalised at home, rigid timetables, uncertainty about managing a crisis, unavoidable deterioration, and still seeking a kidney transplant in the hope of freedom (Baillie & Lankshear, 2015). The findings of that study are clearly different from ours, because of the greater challenges posed by peritoneal dialysis. However, these patients on dialysis were still grateful to be at home and to be given the opportunity to self-manage, as was the case in our patients who experienced OPIVA.

## LIMITATIONS

Several limitations were identified for this study. The major limitation was the small number of participants, arising from the duration of the data collection period (six months). Given that the OPIVA service treats 150-200 patients per annum, the response rate represented about 40-50 percent of those treated over a year, although it was 75 percent for the six-month period. The results we obtained were very consistent and were unlikely to have changed substantially by increasing the number of respondents. The other limitation of this survey study was the possibility of memory recall bias. However, the participants were given the patient experience survey on the very last clinic appointment, so the experience was recent and easy to remember. Lastly, the results of the thematic analysis, focused on negative comments, included only a small number of comments from participants. However, each of the negative comments was carefully analysed to be able to understand the root of the patient's dissatisfaction.

## RECOMMENDATIONS

The following recommendations are proposed for improving the delivery of the OPIVA service:

- Increased consideration of the patient's choice for the method of intravenous antibiotic delivery.
- Improved standardisation of education for antibiotic administration.
- Increased provision of information about PICC lines and better consistency between district nurses.
- Increased whānau/family involvement.
- Improved provider training, co-ordination and teamwork.
- Extending availability of OPIVA resources, including creation of an OPIVA website.
- Improving access to OPIVA team members overnight and during weekends.

## CONCLUSION

The aim of this project was to explore patient experiences of the care provided by the OPIVA service for patients prescribed a prolonged course of intravenous antibiotics therapy at Auckland City Hospital.

We found that the majority of the patients were satisfied with the way the OPIVA team communicated, provided training on antibiotic administration, gave information and co-ordinated care. Improvement opportunities include better discharge information, more education opportunities for community nursing teams, collaboration between different teams, training sessions for staff and patients, and the availability of the service after hours.

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# BACHELOR OF NURSING STUDENTS' EXPERIENCE OF DIALOGUE WITH NURSE LECTURERS



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## ABSTRACT

**Aim:** Learning in clinical environments is a key aspect of the bachelor of nursing (BN) pre-registration programme. This article reports the findings of research exploring third-year BN students' experiences of dialogue with nurse lecturers during clinical practice placements.

**Background:** Third-year BN students have limited situational and ready-to-hand knowledge of how to approach clinical situations and nurse lecturers have an important role in helping them acquire knowledge in clinical practice. This research explores student experiences of interactions and conversations with nurse lecturers in clinical practice to understand more about how learning is supported through this relationship.

**Methodology:** The research used an interpretive approach informed by Heideggarian phenomenology. Exploring students' interpretation of interactions with nurse lecturers enables a deeper understanding of the meaning of dialogue in supporting learning in clinical practice. A purposive sample comprised three third-year nursing students from two different schools of nursing in New Zealand.

**Findings:** Dialogue with nurse lecturers provides a significant source of support for BN students, especially when faced with challenging situations in practice. "Being a learner" emerged as the central theme, with three sub-themes evident: "experiencing the unfamiliar", "being good" in clinical environments, and "professional sense making".

**Conclusions:** Nurse lecturers enhance BN students' learning by listening to their experiences and providing strategies to help them make sense of clinical situations. Lecturers encourage growth and enhance the reflective skills of students using ready-to-hand situational clinical knowledge. Nursing education providers who prepare nurse lecturers sufficiently will enhance students' learning during clinical practice experiences.

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## KEY WORDS

Student nurse, nurse lecturer, practicum, phenomenology, clinical learning, reflection.

## INTRODUCTION

Learning in clinical environments is a key aspect of the three-year bachelor of nursing (BN) pre-registration programmes in New Zealand. This article reports the findings of research exploring third-year BN students' experiences of dialogue with nurse lecturers during clinical practice placements. The research was conducted with third-year BN students from two schools of nursing in New Zealand. Research highlights the importance of the clinical preceptor's role as teacher for the nursing student (Spence, Vallant, Roud & Aspinall, 2012; Haitana & Bland, 2011; Levett-Jones & Lathlean, 2009). However, research is limited on the role of nursing lecturers and their interaction with students during clinical practicum. As nurse lecturers are seen as "teachers", or as providing guidance in clinical practice, this research explored how these teaching skills and support were experienced by students.

## BACKGROUND

Clinical placements, or work-integrated learning experiences, are a central element of educating students in bachelor of nursing (BN) pre-registration programmes (Levett-Jones, Reid-Searl & Bourgeois,

(2018). BN programmes in New Zealand consist of both theoretical classroom-based and online learning, and clinically-based learning experiences (Spence et al, 2012). The Nursing Council of New Zealand ([NCNZ] 2012) stipulates that undergraduate nursing students are to gain a minimum of 1100 hours of clinical experience prior to registration as a nurse. The organisation of relevant and appropriate clinical placements for BN students is complex and multifaceted (Henderson, Forrester & Heel, 2006). Within the required minimum of clinical practice hours, students are expected to experience a variety of settings, including acute medical/surgical, community and primary care, continuing care, and mental health (NCNZ, 2014).

Learning opportunities are identified by nurse lecturers through dialogue with students during clinical placements. For the purpose of this study, nursing lecturers are defined as masters-prepared registered nurses (RNs), who are employed by a university or institute of technology to oversee and integrate the academic components of students' clinically-based learning experiences (Henderson et al, 2006; Henderson & Trede, 2017). RN preceptors, employed by the service provider where the student is placed, also provide clinical supervision to oversee the delivery of patient care, in collaboration with the nurse lecturer. While BN students are responsible for their own learning during clinical experiences, guidance and support from nursing lecturers maximises learning opportunities. Exploring how students experience guidance through dialogue with lecturers assists in understanding how dialogue contributes to acquiring knowledge.

BN students have limited situational and "ready-to-hand" knowledge about how to manage clinical situations. Clinical learning experiences help students understand contextual factors that influence nursing care, and recognise patterns in client presentations (Nielsen, Noone, Voss & Mathews, 2013). BN students' development of critical reflection skills depends on being taught what is important to pay attention to (Benner, Hughes & Sutphen, 2008).

Experiential learning emphasises the process of how knowledge is acquired through experience. Reflection and de-briefing, or sharing narratives (Diekelmann, 2001; Ironside, Brown & Wonder, 2017) from clinical practice, is a powerful way of building knowledge by giving meaning to clinical situations. Facilitating reflective conversation or dialogue, involves "learning together" (Diekelmann, 2001), in "walking a path" with students (Burnard, 2002). Dialogue in clinical practice involves interaction and communication between the student and lecturer. This dialogue is relational and purposeful, supporting the student's learning through reflection on practice experiences. Understanding of how students experience this dialogue with lecturers, helps the educators appreciate how students experience this learning support during clinical practice experiences.

## LITERATURE REVIEW

Starting new clinical placements regularly throughout the BN programme can be challenging for students, due to the complexity of health-service settings. "Belongingness" is a term that embodies students' feelings of effective socialisation into clinical environments (Borrott, Day, Sedgwick & Levett-Jones, 2016; Levitt-Jones, Lathlean, Higgins & McMillan, 2009; Levett-Jones et al, 2018). However, it is not uncommon for them to feel isolated and disorientated during clinical placements; students may feel apprehensive about entering a clinical setting where they feel exposed and alone (Paton, Martin, McClunie-Trust & Weir, 2004). McBrien (2006) also acknowledges the challenges for BN students entering unfamiliar clinical environments, where they need to overcome fears and anxieties that can undermine their potential for learning. Interpersonal relationships formed by students with staff RNs have an important influence on students' sense of "belongingness". Levitt-Jones et al (2009) also suggest that once students have confidence in the staff they work with, they can more ably focus on learning.

Brown, Herd, Humphries and Paton (2005) found that students' sense of belonging was also enhanced through the presence of a nurse lecturer, whom students consider part of their "team". Students place a high premium on support systems (Liljedahl, Björck, Kalén, Ponzer & Laksov, 2016), including the support available from nurse lecturers, particularly the lecturer's physical presence when visiting the clinical practice site (Gibbons, Dempster & Moutray, 2007). Gibbons et al suggest that students' perception of support is a critical factor in determining their stress levels, consequently influencing their ability to fully participate in learning during clinical practice. Nurse lecturers have an important role in nurturing reflection during clinical practice experiences, where students feel free to explore hunches and seek solutions to complex problems (Ireland, 2008). Reflection, in dialogue with nurse lecturers, improves learning in clinical practice, especially when students feel their voices are heard and experiences understood (McAllister, Tower & Walker, 2007; Ryan & McAllister, 2018). Opportunities for deeper learning are facilitated through guided reflection on practice (Vanderheide & Walkington, 2009), including exploring how students interpret and assign meaning to experiences (Twibell, Ryan & Hermiz, 2005).

BN students possess unique individual histories and experiences that nurse lecturers need to honour within the context of learning in clinical practice (Myrick & Tamlyn, 2007). Standing (2007) suggests that past life experiences inform nursing students' approach to clinical reasoning. Nurse lecturers who listen and co-interpret stories of clinical practice with students, and appreciate the complexity of learning associated with this process, are then best able to shape how students interpret future situations (Diekelmann, 2001). McAllister et al (2007) also suggest that using a transformative learning approach, where students are able to question and challenge the status quo in relation to best practice, increases the value of the knowledge they acquire. Nurse lecturers can model creative and critical thinking skills, encouraging students' enthusiasm for scrutinising issues during clinical practice.

## DESIGN AND METHODOLOGY

This research used an interpretive phenomenological approach, drawing on the philosophical influences of Martin Heidegger (1889-1976) and Max van Manen (1942- ). Heidegger (1962) saw interpretive phenomenology as a study of being in the world, suggesting that we are always somewhere, therefore always being. These ideas come from the ontological approach to philosophy – that we have prior knowledge that guides our actions or responses to all moments, whether these things have been experienced previously or not. Essentially, the way we understand events depends on our own historical knowledge. To attach meanings to specific experiences, the interpreter must consider ontological factors potentially influencing our unique understanding of such experiences. This suggests that the researcher has pre-existing assumptions about the subject under investigation (Heidegger, 1962). Different individuals can interpret

similarly-experienced situations in different ways, depending on the meaning of the situation to those individuals. However, it is impossible to be detached as a researcher when interpreting other people's experiences (Heidegger, 1962). Previous life experiences influence the meaning we place on new situations.

Phenomenology uses "an open approach" (Miller, Buys & Woodbridge, 2012) to elicit and explore participants' personal experiences, including the meanings and beliefs created as they interpret these experiences. Phenomenology provides researchers with the opportunity to enter other people's worlds, to interpret the meaning of their experiences, and to understand others' perspectives. The participant is understood as the "knower", and the researcher seeks to interpret unique experiences as lived by that participant (Streubert & Carpenter, 1999). Phenomenology pays attention to lived experiences, considering temporality, comportment and rationality as central elements of the participant's lifeworld (Creswell, 2013). Through this process, "The researcher enables the participant to openly discuss the phenomenon and, with this, the researcher gains access to the experience while moving into the participant's reality" (Paton et al, 2004, p178). Understanding how it is to "be-in-the-world" of the student in clinical practice enables a rich and insightful phenomenological interpretation of the meaning of BN students' dialogue with nurse lecturers.

### Ethics

Ethical approval to conduct the research was obtained from the Wintec human ethics research committee. Students were not recruited from the school of nursing where the researcher is based as a lecturer, in order to avoid potential dual relationships with BN student participants. Fictitious names were assigned to each participant to protect their identity.

### Participants

The study used purposeful sampling to recruit three students in the third year of the BN programme from two schools of nursing in New Zealand. Criteria for selection included being a full-time student undertaking clinical experience in the third year of a BN programme. A further criterion was that participants had attended the same school of nursing throughout their BN programme and had been exposed to clinical placements where they were supported by nursing lecturers.

### Data collection

Data was collected through face-to-face interviews with the participants. Each participant was interviewed for approximately 90 minutes, with follow-up phone calls and emails to clarify aspects of their stories and to gain consent to using specific information from the verbatim interview transcripts.

## DATA ANALYSIS

For phenomenologists, data analysis is a reflective process and involves being sensitive to the meaning of experience (Morse, 1994). The data analysis framework used in this research was derived from Diekelmann et al (1989), allowing for an interpretive process that enabled the researcher to synthesise descriptions and develop themes derived from the participants' narratives about their clinical practice experiences (LoBiondo-Wood & Haber, 2006). This approach enables nurse researchers to elicit rich and meaningful data from their participants and allows for a collaborative approach to gaining a mutual understanding of experiences. The stages described below were adapted from Diekelmann et al (1989):

1. Reading all transcripts for an overall understanding of the participants' experiences.
2. Preparing interpretive summaries of each interview, and clarifying these summaries with the participants.
3. Analysing selected extracts of transcribed text that have common themes among the interviews.
4. Resolving conflicts between interviewees and researcher about interpretation of the data through discussion and amendment of the transcription.
5. Identifying and justifying recurring themes that reflect common meanings between participants.
6. Identifying relationships emerging between the themes, including correlating factors.

## FINDINGS

### 'Being a learner'

"Being a learner" encapsulates the overall theme or central meaning of students' clinical practice experiences – it is the students' ambition to learn during clinical placements. Sub-themes were identified as "experiencing the unfamiliar", "being good" and "professional sense-making". The theme "experiencing the unfamiliar" relates to BN students seeking a sense of safety with someone familiar to them. The second theme identifies students' sensing the need to "be good" during clinical practice experiences and seeking guidance from lecturers to manage challenging situations. The third theme, "professional sense-making", shows how students give value to the nurse lecturer's input relating to professional and practical learning. This includes their reliance on lecturers to make sense of clinical practice and professional experiences.

### 'Experiencing the unfamiliar'

Students feel a sense of being on their own in an unfamiliar clinical environment, where they do not always know how to respond to challenges. Dialogue with nurse lecturers gives students a lifeline, a sense of safety, in an environment that feels unknown and sometimes unsafe. The students felt safer when dialogue and support from nurse lecturers was provided. They described the availability of the nurse lecturer as making them feel safer, even if their support and guidance was not deemed immediately necessary. Here, Alice recounts her first clinical experience and the support received from nurse lecturers:

*"They [nurse lecturers] knew the layout and the set-up and most of them knew the nursing managers and things like that, so we felt quite safeguarded. We felt safe, but it was still quite a challenging experience just to get in there [clinical practice] and get face-to-face with people."*

Relationships between nurse lecturers and staff RNs in the clinical placement settings are noticed by students, and this appears to contribute towards a feeling of safety. Seeing a positive professional relationship between lecturers and RNs promotes a sense of comfort for the students. This sense of being safe presented itself in various ways. When confronted with a challenging event, such as a death of a client, during her practicum, Jane said:

*"I think I really appreciated the fact that someone [a nurse lecturer] was looking out for me, and it was just to highlight that you are part of the team and they [nurse lecturer and clinical preceptor] are there to support, and you are not on your own and dealing with that sort of situation, that was quite helpful."*

In terms of comportment, Jane reflected on her prior experience of being a health-care assistant as helping her deal with such challenging situations. Learning from past exposure to similar events helped her deal with these experiences. Students also appreciate being able to seek guidance from someone who already knows them. Assigning a new nurse lecturer to a clinical environment appears to add a new dimension of difficulty for the student, who feels they need to prove themselves not only to the clinical preceptor, but also to the new nurse lecturer. Alice noted:

*"You kind of get a bond with a [nurse lecturer] and it's good, and they go, and then you get a new one and you don't know them, and it is quite disruptive. You get used to teaching styles from those different lecturers, and you get new ones coming in and you have to settle in all over again, like you're first years all over again. I think that long-term relationship is really important."*

Alice found it was like starting over again when a new nurse lecturer was assigned to her. Starting over requires the student to invest in building another relationship when they are already feeling vulnerable in an unfamiliar context. Dialogue with the new nurse lecturer could be seen as less meaningful for the student, due to a lack of trust in the relationship. The participants described feeling a sense of being abandoned when their communication with nurse lecturers was limited. This seemed apparent when Rose recalled her clinical experience where support was initially not in place:

*"In one placement, we had a mixed group of tutors, I don't even think we had one for the first couple of weeks, so it was only the last two weeks we had someone come, which was not great."*

Rose appeared to need reassurance that she was learning the right skills, clearly stating a need to confide in someone who was a trusted, safe, go-to person. On the whole, a sense of abandonment and isolation appears to be experienced as the third year of the BN course progresses. While the participating students acknowledged the need for their independence to be fostered, they sensed support being withdrawn suddenly during clinical practice experiences in their third year. Jane recalled a challenging situation in her third year, and when she sought guidance from a nurse lecturer, felt it was not as forthcoming as previously.

*"I just feel like anytime I could speak to them, and now, I'm really conscious that they are doing a referral for me to Nursing Council and for ACE [post-registration employment process], and if I rock the boat, because I have already had some support, I don't want to look like I'm needy or I'm not competent, which is silly because you are supposed to get support if you are struggling."*

Jane's student-world appeared consumed by factors other than learning. Demonstrating a competent persona took priority, mainly influenced by impending future employment prospects. With her need to obtain good references, the ability to ask for support was greatly reduced, and her hope of protecting any future employment aspirations compromised her usual safety strategy.

## 'Being good'

The participants identified tensions between balancing tasks in the clinical environment and experiencing learning opportunities – being a "good worker" or being a "good learner". Being seen by RNs as a good worker sometimes took precedence over being a learner, and this interfered with their learning focus. However, "being seen to be doing the work" appeared to help students feel accepted by the clinical staff. Rose reflected on the challenges she experienced in knowing which role to adopt:

*"I think without a nurse lecturer there to help you, it's a lot easier to fall in to the health-care assistant role and not learn nursing skills. So you would be going off to do the beds and helping to toilet patients, and I guess it is easier to take the easier way out."*

Engaging in dialogue with a nurse lecturer guides the learning focus for students, giving meaning to the "learner role". Rose's story implies a struggle to understand her role in the clinical environment, illuminating challenges to students' perception of clinical experience as time to learn. Ongoing guidance through dialogue with a nurse lecturer enabled this student to share her world, meaning that frustrations and confusion over her role identity could be managed. Another student, Alice, recalled how sometimes she was immersed in practicum and had little time for dialogue with nurse lecturers.

*"You didn't mind if it was quick [the dialogue], cause it was like, 'ah yeah, I've got to go back to this patient'. They [nurse lecturers] make you feel reassured and that you still need to focus on your practice, and be able to step back. It's really strange as a student because I haven't personally been able to give it a true rationale for what I'm doing and how I'm doing it . . . "*

Reflecting on this dialogue, the idea of "stepping back" may show how the nurse lecturer also recognises this challenge to a learning focus, attempting to encourage a student to experience practice rather than engaging in a work role. However, sometimes it appears the RNs in the clinical environment dictate the role of students according to their understanding of what constitutes learning experiences. Rose recalls an experience during practicum in a residential-care facility during her third year, with limited nurse lecturer support:

*"Sometimes they have one or two nurses for like 40 residents, they can be really, really busy, and you want to get on-side with the team and feel like you are forming those bonds, because you can't just be standing around doing nothing. If you are just doing basic health-care assistant things, you are still getting a benefit from it, I get that, and I guess the better relationship you have with the staff and the residents, they are more likely to let you do things, like, 'ah, this person is trying really, really hard, I'll let her help.' "*

Seeking a balance between "being good" and "being a learner" is challenging for students, especially when there is no nurse lecturer to help guide this process. The loss of nurse lecturer dialogue meant that Rose had less opportunity to discuss her role conflict. Therefore, she adopted a strategy allowing herself to be part of the team, or even part of the workforce, knowing that it might have both positive and negative implications for her learning.

Students sometimes experienced a sense of powerlessness in certain situations, and dialogue with nurse lecturers had a major influence on their perceptions of these experiences. Feeling powerless

was sometimes due to the student's sense of not feeling welcome in the clinical environment, and sometimes a feeling of "being in the way". Recounting her dialogue with a nurse lecturer, Alice took comfort in how the nurse lecturer helped her identify what she was experiencing:

*"She [nurse lecturer] sat me down and, said to me, 'You've done well so far not to walk out', and . . . she just talked me through it, and said, 'Look, this is a good chance for you to learn resilience because you will come across this sort of behaviour, it looks close to bullying', and just taught me different ways of dealing with it and how to confront and stand up for myself as a professional, but also to seek support from senior clinical staff. I was feeling quite incompetent because of what had happened; she said, 'It's not you, don't let them make you feel that way, don't take it to heart', it was quite horrible."*

For students, dealing with stressful workplace relationships can be a daunting prospect. The sense of powerlessness they feel decreases when someone familiar to them helps to interpret and mediate their feelings about challenging situations. The importance of the opportunity for dialogue with the nurse lecturer is demonstrated here, in helping the student make sense of a situation and to recognise unprofessional behaviour towards her. Alice also recognised the importance of understanding power relationships between herself and the clinical staff, and the importance of using the support systems available to her. Understanding that nurse lecturers recognise this sense of powerlessness allows students some degree of empowerment, knowing they are not alone when confronted with challenging workplace relationships during clinical placements.

### Professional 'sense-making'

Dialogue between students and nurse lecturers focuses on reflection and post-event analysis. This reflection is not always directed at clinical judgements, but sometimes addresses professionalism and work-based issues. Conversations with nurse lecturers help students make sense of interactions with clinical staff, including how to approach situations in a professional way. Jane reflected on how her knowledge of resilience had developed over the three years of the BN programme and identified how dialogue with nurse lecturers influenced this development:

*"I actually think that talk about resilience taught me to stand my ground, be quite clear and firm with people when something is not quite right. Then that confrontation thing for me . . . yeah, it did help . . ."*

Standing one's own ground and developing confidence in challenging staff situations illuminates how knowledge is acquired through experience. For students, resilience appears to develop over the course of the three years of the BN programme, based on previous experiences of managing similar situations. Acquiring knowledge is more than physical, task-based nursing. Empowering students to self-manage situations that challenge them supports professional development and a sense of professional accountability.

Nurse lecturers do not work alongside students in the clinical environment – the focus of their dialogue with students is on helping them make sense of the situations they encounter, thus acquiring situational knowledge. Drawing on the students' experiences, lecturers help them recognise conceptual patterns in the practice situations they encounter. This is apparent in experiences recounted by Alice, who described coming to understand why these strategies are used to support her acquiring knowledge:

*"They have given us ideas and a lot of thoughts about why you are doing this, that basic question about why you are doing things this way, and you have to come up with a rationale, and that's when they question you, 'Is that rationale going to work? Is that rationale of whether it's for the betterment of the person or because it's easier for you?' "*

This approach used by the nurse lecturer provides the opportunity for students to reflect, interpret and offer rationales for their actions. Developing practice knowledge through reflection and critical analysis becomes a central focus for the dialogue. A sense of the students developing as practitioners is apparent here, as they notice how they are developing clinical reasoning skills through dialogue. Students can find the amount of information they are exposed to during practicums overwhelming and this sense of being overwhelmed hinders learning. Nurse lecturers encourage students to "step back" during dialogue, which helps them make sense of clinical situations and recognise patterns in assessment data. Alice recounted an experience in an emergency department (ED):

*"It [the dialogue] helped you step out of that moment. I got to a point where I would just freeze, because there was so much going on, you just couldn't process it all. There would be things like pain, or UTIs [urinary tract infections], and how people act with delirium. So, you've got a patient who has come into ED acting 'la', and you get a urine sample and go and test it. That would be the kind of time where they [nurse lecturer] would give you little pointers because they have had the experience, and it would make the brain unfreeze . . . "*

Dialogue focused on reflection strategies helped Alice make sense of the responses that were required in this situation. Alice's ability to consider all that was happening in this situation was limited due to having little practice experience. Dialogue about practice experiences helps students to own their learning and understand reflection as part of the process they need to engage in to develop their nursing knowledge and perform capably in practice.

## DISCUSSION

Nurse lecturers guide and support students' socialisation into clinical environments, often using the lecturer's own existing relationships and experience. Students appear to highly value the benefits that this interaction with and support from nurse lecturers brings to their learning (Croxon & Maginnis, 2009; Brown et al, 2005), including supporting their social integration into the clinical environment (Levett-Jones & Lathlean, 2007; Levett-Jones et al, 2018). Knowing nurse lecturers are in the background during clinical placements gives students a sense of safety and this feeling is fostered through various forms of communication. Access to a familiar face, someone who knows the student, provides a sense of security and safety, whether their input and guidance is required or not (Brown et al, 2005). As Ryan and McAllister (2018) suggest, students feel secure in knowing a nurse lecturer is accessible during clinical experiences, because of their expertise and familiarity.

Visits to individual students by nurse lecturers during clinical practice experiences, allows a process of scaffolding knowledge to occur with students. These visits also have the potential to enhance relationships between clinical preceptors and nurse lecturers (Liljedhahl et al, 2016). A sense of being part of the team supports students'

socialisation and learning. Paton et al (2004) identified how students observe nurse lecturers' and clinical preceptors' interaction, and a collaborative approach between them enhances students' motivation to learn, and their sense of security. This collaboration reduces the student's sense of being an outsider in the clinical environment. Levett-Jones et al (2018) propose that this perceived investment of interest in the student's learning experience in the clinical environment enhances learning potential for the student. However, if students do not feel this support, learning opportunities may not be fully utilised (Borrott et al, 2016; Bradbury-Jones, Irvine & Sambrook, 2010).

The timing of dialogue during clinical placements was also identified by students as having an effect on their clinical experience, as was the ability of the education provider to facilitate nurse lecturer cover. Poorly-timed dialogue with the nurse lecturer, even when dialogue was requested, had a negative impact on clinical experiences. The dialogue with the nurse lecturer in the final year of the BN programme appears to be just as important as in the earlier years, given the increased complexity of situations students are required to interpret and respond to (Brown et al, 2005; O'Mara, McDonald, Gillespie, Brown & Miles, 2014). Preparing students to practice as RNs involves fostering independence and providing space for them to practise their new knowledge and skills to gain personal confidence (McAllister et al, 2007). However, in fostering independence, there is a balance that needs to be considered, to manage students' anxiety. Support through dialogue with nurse lecturers helps students develop resilience through negotiating stressful workplace relationships, enabling them to learn professional approaches to conflict resolution. Students are also reassured when they have the opportunity to discuss feelings of powerlessness (Bickoff, Levett-Jones & Sinclair, 2016; Courtney-Pratt, Pich, Levett-Jones & Moxey, 2018). Tensions between being required to learn during clinical placements, and being seen to "do the work" were felt acutely by students. When the work role takes dominance over learning, students feel more like healthcare assistants, rather than learners (Brammer, 2008). Guidance from nurse lecturers helps students to develop clarity about their role in clinical settings and supports professional ways of asserting this in practice. However, Brown et al (2005) said that if students perceived no-one was guiding their clinical learning, they would potentially fall into a non-learning role. This is especially apparent in some clinical settings, particularly where there is a low RN-to-student ratio – this diminishes the learning value of the student's clinical experience (Croxon & Maginnis, 2009). Lecturers' mediation role is seen by students as enabling, giving them strategies to manage challenging situations. Best (2005) highlights how the perceived power difference between students and clinical nursing staff can create conflict. Students appreciate the opportunity to use the lecturer as a reflective tool, to clarify their thought processes and reasoning skills. According to Bradbury-Jones et al, (2010) reflection and building problem-solving skills for increasingly complex situations enables students' professional development through references to practical experience. This process, when guided expertly by lecturers, enhances experiential learning. Ongoing reflective dialogue can help to reveal and define clinical problems that sometimes may not be obvious to the lone reflector (Duffy, 2008). Brown et al (2005) highlight the role of lecturers in clinical practice as a "sounding board". In this sense, the task of the lecturer is to nurture habits of the mind that cultivate reflection on practice (Ireland, 2008). Encouraging students to look more deeply into their clinical experiences facilitates the progression towards more critical thinking (Levett-Jones, 2013). As Levett-Jones suggests, questioning by lecturers during dialogue in practicum enables students to discover their own meaning of situations and develop their own understanding of nursing practice.

Health professionals use reflection to translate complex learning experiences into practice knowledge. Striking a balance between supporting students and enabling them to self-discover knowledge is sometimes difficult. Opportunities to reflect on situations and clarify thinking and reasoning are highly valued by students (Lowe, Rappolt, Jaglal & McDonald, 2007), emphasising the importance of dialogue with nurse lecturers. Having guidance enables students to formulate critical skills in nursing, by learning to notice what information is important, and what is not, in nursing situations. The lecturer uses their practice wisdom to help students learn by interpreting the context in which practice situations occur. Sometimes learning opportunities are not recognised by students until dialogue has taken place with the nurse lecturer.

## RECOMMENDATIONS

The central themes in these findings call attention to some important considerations for how clinical practice experiences are managed within complex and rapidly changing clinical environments. They also show how students' ongoing need for support from nurse lecturers is required through the differing levels of BN programme to help them successfully navigate clinical learning experiences.

- Students doing clinical placements in their final year require lecturer support to help them reflect on complex clinical situations. Providers of nursing education need to clarify the focus and purpose of the nurse lecturer role during each year or stage of the BN programme.
- Close collaboration and relationships are needed between nursing education providers and clinical placement providers to enable maximum learning opportunities for BN students.
- Providers of nursing education need to be mindful that nurse lecturer continuity is important for students, providing them with a consistent familiar face in unfamiliar learning environments.
- Nurse lecturers need to teach students negotiating skills when they need them, including techniques for resolving conflicts, while also promoting students' resilience, where they encounter stressful workplace relationships.
- Students appreciate nurse lecturers who help them use a reflective approach to making sense of clinical environments.Therefore, preparing lecturers to facilitate this process provides a safe learning partnership.

## LIMITATIONS

The findings presented in this research have been generated from a small sample size, therefore it may be assumed they do not fully represent the breadth of nursing students' experiences of dialogue with nurse lecturers. While the three students' narratives about their experiences provide a rich insight into the student world, and the ways in which they comport themselves within this world, the generalisability of these findings may be limited.

## CONCLUSIONS

The supportive aspect of dialogue between nurse lecturers and students is highly valued by students to help their learning. These findings suggest that dialogue is appreciated by students, even in the later stages of the BN programme. Student learning is centred on many aspects of nursing, ranging from clinical scenarios to professionalism within the workplace. In guiding and supporting student learning, nurse lecturers are a crucial tool for students, especially when they are seeking clarification about what they observe and experience during clinical practice.

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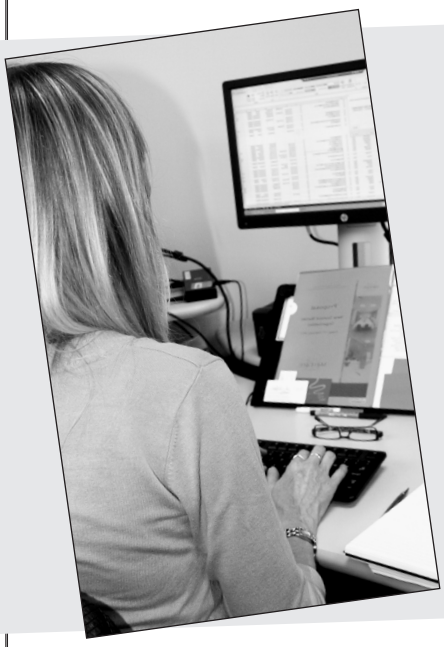
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Research brief

# DIRECTION AND DELEGATION FOR NEW ZEALAND NURSES



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## Aim and background

DIRECTION AND delegation is a professional competency required of all New Zealand nurses (NCNZ, 2011a; 2011b). Nurses attest to understanding direction and delegation on their annual competency-based practising certificate application (NCNZ, 2007; 2012). The purpose of this study into how enrolled nurses (ENs) and registered nurses (RNs) communicate during direction and delegation was to explore nurses' perceptions about their everyday direction and delegation experiences. The study joins the discussion found in the overseas nursing literature about delegation (Bragadottir, Kalisch, Smaradottir & Jonsdottir, 2016; Kalisch, 2011; Parsons, 1997; 1998; 1999; 2004). This study adds a new perspective on how New Zealand nurses make sense of this professional obligation.

## Methods

Nurses use stories on a daily basis as a vehicle to share information, when informing other nurses in handovers and progress notes, when communicating health information and education to clients and when contributing to interdisciplinary meetings. The stories told by ENs and RNs for this study, about their direction and delegation interactions, are an extension of these nursing roles and responsibilities. Clandinin and Connelly's narrative inquiry method was used to capture the nurses' experiences as stories (Clandinin, 2013; Clandinin & Connelly, 2000; Clandinin & Huber, 2010). The stories provided plot lines, which made visible the nurses' beliefs, values, decision-making and motivations. The purposively selected participants included 19 ENs and 17 RNs. Ethics approval was granted in 2013 by the University of Canterbury Ethics Committee and the Ara Human Ethics Committee.

## Findings

While the narrative inquiry approach privileged each of the nurse's individual stories, some shared understandings emerged from the nurses' experiences. Taken together, the major patterns that came into focus showed that the main concern for all the nurse participants was to keep the patient safe, and to ensure they worked within their scope of practice. However, both the ENs and RNs were confused about how to "do" direction or delegation, about the difference between direction and delegation, and about who was accountable for the EN's practice. There was also confusion about where to obtain information about these two different roles. In addition, most of the EN and RN participants expressed concerns about a lack of nursing leadership. Nursing leadership was defined as any RN in a position of authority who could provide information, and the necessary time and guidance, to help RNs and ENs carry out direction and delegation well.

Differences which emerged from the 36 EN and RN stories were presented as eight narrative plots. ENs spoke of the need to **"work together"** and **"communicate well"**. **"Working together"** meant that ENs needed RNs who were famliar with the nursing specialty workplace they were working in before delegation interactions could occur. This had implications for agency and casual nurses who were unfamiliar with an area. The **"communicating well"** plot-line captured the perspectives of ENs who said communication between them and RNs needed to include the way an EN was welcomed into the workplace. It included the tone and the way interactions were handled, not just what was said.

Some of the EN participants described having to work hard to obtain direction or delegation input – these views were categorised as **"seeking delegation".** Another EN view was that delegation was a two-way relationship – **"delegation as a relationship"** – that required fair and respectful input from both levels of nurse.

RN participants shared their stories about **"working as a team".** Their experiences made clear the difference between working "as a team" and working "in a team", and that nurses needed both of these models to support safe and effective delegation interactions. Their experiences related to **"communicating professionally"** illustrated the need for an advanced and sophisticated understanding of communication interactions, and the need for more information about the EN role. RNs also require an understanding of the EN's need to be able to self-assess before accepting a delegated task or skill. Having the necessary **"skills for delegation"** – such as leadership, assessment and communication skills – contributed to "good" delegation practice. The nurses' experiences categorised as **"doing delegation"** showed that sometimes neither delegation nor direction were occurring when they should have been. This meant that in these cases, both ENs and RNs were **"working outside their scopes of practice"**.

## Conclusions

This narrative research study has provided unique and individual perspectives, related to direction, delegation and accountability, from 36 nurses working in a variety of settings. These included inpatient and outpatient services, private and public clinical workplaces, and education, leadership and management settings. There are significant implications concerning nurses' access to in-service education. Direction and delegation is as important as

falls prevention, smoking cessation and ISBAR (the mnemonic for Identify, Situation, Background, Assessment and Recommendation, used to ensure safe transfer of critical information) which are often the subject of compulsory in-service courses. RNs need to be given the same sort of learning opportunities to upgrade their skills and knowledge on delegation and the EN role within their specialty area.

Recommendations from the study included the need for health services to provide up-to-date and clear policies about the EN role and responsibilities within particular workplaces. These policies should include concise guidelines on how to direct and delegate and how to be directed and delegated to, and include a clarification and definition of "team". Also, the content, theory, simulation and clinical practice taught in both undergraduate and post-graduate nursing programmes needs to be reviewed to ensure all emerging ENs, who will be expecting to be delegated to, and new RNs, know and understand not only what direction or delegation is, but how to do it, and the skills required.

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Research brief

# THE BENEFITS OF RIGID DRESSINGS FOLLOWING LOWER-LIMB AMPUTATION

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**Jeni Palmer**

## Aim

THE AIM of this integrative review was to explore the benefits of using rigid dressings following lower-limb amputation for people with compromised circulation. The research question was: "What are the benefits of using rigid dressings following lower-limb amputation?"

## Background

Amputation of a lower limb is usually a last-resort measure, after attempts to salvage the limb to improve circulation and tissue perfusion – such as angioplasty and surgery – have failed (Duwayri et al, 2011; Jones et al, 2013; Moxey et al, 2010). Patients may have had severe ischaemic pain for some time, and analgesia has not been effective in managing it (Melsom & Danjoux, 2011). Tissue loss, such as ulceration, is often present and this may have led to infection in the limb or systemically (Ali et al, 2013). In some cases, infection leads to sepsis and can be life-threatening (Melsom & Danjoux, 2011). People who have amputations due to dysvascular causes tend to be elderly and have multiple co-morbidities, a significant proportion of them with diabetes. Amputation is a last resort when ischaemia had led to pain, tissue loss and infection. The impact of amputation on the person, their family and the wider community is significant. Having a lower-limb amputation has a profound impact on patients and their whānau (Moxey et al, 2010). Pain may be present only in the immediate post-operative period, or more long term (Yoo, 2014). Reduced mobility often leads to changes in the person's living environment, sometimes requiring residential care. Psychological, economic and social effects of lower-limb amputation can require a long period of adjustment, with high rates of depression being common (Sheehan & Gonod, 2014; Yoo, 2014).

Following amputation, a non-adherent dressing is applied directly to the surgical incision site and some kind of secondary dressing is applied over this. The aim is to keep the incision free from infection and to promote skin healing (Latlief et al, 2012). There are two main options commonly used for secondary dressings for patients who have had lower-limb amputations – soft dressings and rigid dressings. Traditional soft dressings are usually crepe or elastic bandaging. Rigid dressings may be made from a range of materials, such as plaster of Paris, fibreglass or plastic, or may be vacuum dressings or other rigid wraparound styles (Schnur & Meier, 2014). Plaster of Paris dressings are not able to be removed and reapplied easily, but the other types generally are. Some hospitals use an immediate post-operative prosthesis (IPOP), which is a type of rigid cast applied in the operating theatre, which allows a prosthetic device to be fitted to the cast and the patient can be up on two "legs" as early as the day after surgery (Ali et al, 2013).

## Methods

An integrative review is the broadest type of review, which summarises literature that can be both quantitative and qualitative for a more comprehensive understanding of a problem. The structured stages of an integrative review include problem formulation, literature search, data evaluation, data analysis and presentation (Whittemore & Knafl, 2005). Databases searched included EbscoHost, ScienceDirect, ProQuest, Pubmed, Elsevier and Researchgate. Search terms used were: amputation, dressing, amput* (which picked up amputee/s, amputations, amputate), lower limb, dysvascular, transtibial, below knee, rigid dressing and rigid removable dressing in varying combinations. The timeframe for the search was 2004 to 2016. From 39 possible primary studies that were screened, 10 were evaluated as meeting the selected criteria for the review. Five studies of these were randomised control trials and a further five were retrospective case analyses.

## Finding

Key benefits of the use of rigid dressings in the studies reviewed included reduced time to prosthesis fitting, protection of the wound from trauma, and fewer complications, and that they have a higher degree of acceptability for patients. Use of rigid dressings resulted in a shorter time to the first fitting of a prosthesis, compared to use of soft dressings post-operatively. Van Velzen, Nederhand, Emmelot and Ijzerman (2005) found the average length of time to fitting for those who were given a rigid dressing immediately post-operatively to be 50 days, as opposed to 110 days for those with a soft dressing. Ladenheim, Oberti-Smith and Tablada (2007) also showed significantly shorter times for prosthesis fitting for rigid dressings at 58 days, compared to 84 for soft dressings. Similarly, Sumpio, Shine, Mahler and Sumpio (2013) found the length of time to prosthesis fitting to be 43 days for rigid dressings compared to 75 days for soft dressings. The use of rigid dressings also reduced time for wound healing and was consistent with less stump oedema.

The rigid dressing was found to protect the stump wound from trauma. Patients who have had lower-limb amputations are at high risk for falls, particularly when they first begin to mobilise. Ali et al (2013) reported that the group using rigid dressings had half as many falls and suffered less trauma when falling than patients with soft bandaging. Deutsch et al (2005) reported four patients with rigid dressings in their study had falls, but reported no stump damage, whereas six soft-dressing patients had falls, and three of these patients required revision surgery. Patients with rigid dressings reported more confidence with exercising, as they felt their stump was more protected and they found transferring from one position to another easier.

Complications of lower-limb amputation were also reduced with rigid dressings. Preventing joint contractures is important to enable the patient to be able to use a prosthesis effectively. Some

rigid dressings, such as the IPOP, fit over the knee and keep it positioned in extension, avoiding contractures (Ali et al, 2013). The rigid dressing also forms a conical shape, which is better suited for a prosthesis than bandaging, with less likelihood of "dog ear" skin flaps (pointy pieces of tissue on the end of the stump) (Hidayati et al, 2013).

The rigid dressing had a higher level of acceptability than stump bandaging for both patients and health professionals involved in their care. The majority of patients surveyed post-operatively preferred to continue using the rigid dressing (Woodburn et al, 2004), which may also, according to Ali et al (2013), have some psychological and physiological benefits for patients. A survey of surgeons, nurses and physiotherapists indicated that rigid dressings were an improvement and they would prefer patients to use them. The majority of clinicians were in favour, though some had reservations about the heaviness of plaster casts as opposed to bandaging, and the need for skilled staff to apply them (Woodburn et al).

## Conclusions

This review concludes that overall, rigid removable dressings are associated with faster time to first fitting of a prosthesis, faster wound healing and reduced oedema, as well as offering protection to vulnerable stumps. Rigid dressings should be applied immediately post-operatively, which means that skilled staff need to be available to apply them in the operating theatre.

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# HOW TO PEER REVIEW A RESEARCH ARTICLE

Nurse researchers and expert clinicians have an important role as peer reviewers.

By Kai Tiaki Nursing Research
editor-in-chief Patricia McClunie-Trust

NZNO's annual research journal, *Kai Tiaki Nursing Research*, publishes research relevant to New Zealand nursing practice, education and management. Sharing the findings of research is important for the continuing development of professional knowledge and to provide best evidence for nursing practice. It is also important for both emerging and established researchers to have the opportunity to contribute to dialogue about professional issues and practice development in nursing. Nurse researchers and expert clinicians have an important role to play in acting as peer reviewers in the publication process, particularly in evaluating the reliability, credibility and significance of research for the journal. Acting as a peer reviewer enables researchers and clinicians to contribute to the profession's body of knowledge, to help authors get published, and to further develop expertise in their own field of practice (Ali & Watson, 2016).



**The role of the reviewer is to act as a 'consultant' to the journal and to provide feedback to authors about ways to improve the presentation of their manuscript.**

## What is a peer review?

*Kai Tiaki Nursing Research* uses a blind peer-review process to establish the quality and relevance of research for its readership. The aim of peer review is to ensure the accuracy and quality of published research and literature through constructive peer critique (Nicholas & Gordon, 2011). Peer review enables articles submitted to *Kai Tiaki Nursing Research* to be evaluated by independent nurse researchers and clinical experts, who are associated with the particular research methodology and/or area of practice that is the focus for the submitted article. The researcher reviewers focus on the quality and rigour of the research process, while the clinicians evaluate the implications of the research as evidence for practice. The peer reviews help the editor assess the suitability and relevance for publication in the New Zealand context. Like most international nursing journals, *Kai Tiaki Nursing Research* uses a double-blinded peer review process, where neither the author nor the reviewers know the identity or institutional affiliations of the other (Ali & Watson, 2016). Peer reviewers are selected by the journal editor according to prior research on the topic and publication record, and/or level of expertise within their area of practice. Clinicians are likely to be either nurse practitioners or master's-prepared clinical nurse specialists.

## The peer reviewer role

The peer reviewer role is an important academic and professional activity for nurses working in academic and advanced clinical roles. The role of the reviewer is to act as a "consultant" to the journal and to provide feedback to authors about ways to

improve the presentation of their manuscript (Lovejoy, Revenson & France, 2011). Peer reviewing enhances reviewers' knowledge about research and the publication process and requires them to develop important analytical and relational skills to provide constructive and accessible feedback to authors (Ali & Watson, 2016). It also enables reviewers to critique their own writing and presentation style in developing research articles, review best practice for clinical articles, and contribute to the profession as a member of their academic or clinical community (Pierson, 2015).

## Professional responsibilities in peer review

There are particular requirements that peer reviewers need to consider in undertaking review (Nicholas & Gordon, 2011). The Committee on Publication Ethics (COPE) Council (2017) ethical guidelines for peer review identify key responsibilities for reviewers:

- Agree to only review manuscripts that are within your area of expertise, and declaring a conflict of interest where this occurs, given that New Zealand is a relatively small nursing community.
- Ensure timely responses and return of reviews and only agree to review when you know you can fit it into your workload.
- Respect confidentiality in the review process and avoid using information obtained through the review process for any other purpose.
- Engage in careful reading and interpretation of the manuscript, and if you are not clear about the scope of the article or submission requirements for the journal, check with the editor.
- Provide unbiased, constructive and objective written feedback that is accessible and helpful to the author for further development of the manuscript.
- Ensure that the ethical requirements for the conduct of research have been identified within the manuscript.

## Peer review process

*Kai Tiaki Nursing Research* uses a checklist with criteria that guide the reviewer in evaluating the scope, presentation, methodological rigour and suitability of manuscripts for publication. Publishers generally suggest that a critical reading of a manuscript has at least two stages – first an overall read-through for "readability" and to establish whether or not the topic fits within your area of expertise. A second read-through enables closer attention to the detail of the manuscript, where the reviewer may find it helpful to skim through other published research on the topic to ascertain how the manuscript fits within this field (Nicholas & Gordon, 2011; Pierson, 2015). The review checklist requests feedback on the overall content of the manuscript, and general presentation and logical flow of ideas, including referencing. The review of the research approach requires feedback on: whether the title fits the focus for the research, the research aims, review of the literature and presentation of research methods or design, including ethical requirements. Consistency throughout the research process, and reliability or validity and contextualisation of findings within the professional or clinical context for practice are also evaluated. Paying particular attention to the accuracy and relevance of tables or diagrams is also important, particularly in terms of what they add to or clarify in the manuscript (Lovejoy et al, 2011). Lastly, the checklist requires reviewers to evaluate whether the manuscript is suitable for publication in the journal or requires amendments. It is also worth noting whether the research makes a significant or innovative contribution to the research field or area of practice.

## Giving written feedback

Including some well-focused written feedback is invaluable to authors, particularly in qualifying how the reviewer has evaluated the manuscript. Constructive, detailed feedback can show authors how to edit and re-craft elements of the manuscript into a more suitable form for publication. This can include identifying relevant references that would enhance the quality of the research (Lovejoy et al, 2011). The COPE Council (2017) guidelines reiterate the importance of commenting on the quality and rigour of the manuscript, and that it is important not to ask the author to extend the work beyond its current scope; any additional support that is needed to strengthen presentation of the research should be clearly identified. Written feedback to authors should be a key component of reviews, with comments numbered so that authors can refer to specific points when resubmitting the manuscript.

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# SUBMISSION GUIDELINES

Guidelines for submitting articles to *Kai Tiaki Nursing Research*

## SCOPE

THE EDITOR-IN-CHIEF of *Kai Tiaki Nursing Research* welcomes research papers and reviews on nursing (including clinical, research, education or management topics) with implications for nursing practice and health and social care policy. Authors should present original research, or new and original analysis of existing research. *Kai Tiaki Nursing Research* particularly encourages submission of research manuscripts that take account of health inequities and injustice, and enhance the health of the diverse ethnic populations of Aotearoa/New Zealand.

*Kai Tiaki Nursing Research* is an internationally double-blinded peer-reviewed research journal that publishes original, full-length research manuscripts from New Zealand-based nurse researchers (or other researchers where the research can be shown to have particular relevance to nursing in New Zealand). In addition to research manuscripts, the journal will also publish letters to the editor, commentary and research brief articles. All research manuscripts and other articles will be subjected to the same robust review procedure.

The aim of the journal is to promote practice-related scholarship which contributes to the professional knowledge and evidence base for nursing. The language of the journal is English.

*Kai Tiaki Nursing Research* is available in the following databases: CINAHL Complete (Ebsco), Academic OneFile, Health Reference Center Academic, Nursing and Allied Health Collection and Nursing Resource Center (Gale), Health Collection and New Zealand Collection (Informit).

## SUBMISSION GUIDELINES

### Editorial procedures

The editor-in-chief is responsible for assigning a submission to appropriate reviewers. Manuscripts considered unsuitable for a full review will be returned to the author(s) with a minimum of delay.

The policy of *Kai Tiaki Nursing Research* is that each paper is independently reviewed by two people, in addition to the editor-in-chief, using a double-blinded process. In some cases (for example where reviewers differ in their recommendations regarding publication, or for highly technical submissions), a third expert referee may also be consulted. For some general presentation issues, the advisory committee is consulted.

The double-blinded process ensures all manuscripts are handled confidentially. At no time will authors or co-authors have access to the names of the expert referees responsible for the review of their papers and at no time will reviewers have access to the names of the authors. Where reviewers know or suspect who the authors are, conflict of interest will be declared and alternative reviewers appointed, if appropriate, at the discretion of the editor.

The final decision for publication rests with the *Kai Tiaki Nursing Research* editor-in-chief. It is the aim of the editorial review panel that authors should receive an editorial report within eight weeks of receipt of the complete manuscript in the NZNO publications office. Authors should note that when more than one paper is submitted at the same time, the review process may take longer.

### Author conflict of interest policy

Authors are required to disclose in the covering letter any financial support for the conduct of the research and the role of sponsors in the decision to submit an article for publication. Where such information is not already disclosed in the manuscript, it will be held in confidence during the review process. Should the article be accepted for publication the relevant information must be acknowledged.

### Ethical standards

Research involving patients or other participants requires Health Research Council of New Zealand ethics committee approval and informed consent, which must be documented in the article. Authors should provide full information on the ethical approval process undertaken and sufficient information about the methodology to allow readers to appreciate the extent and need for the procedures described. Visit www.hrc.govt.nz/ethics-and-regulatory for guidance. Specific ethical considerations within the context of the research should also be noted.

### Authorship and acknowledgements

Authors should note that *Kai Tiaki Nursing Research* adheres to the definition of authorship set by the International Committee of Medical Journal Editors (ICMJE). It is required that all authors have been accredited appropriately upon submission of the manuscript. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis. Contributors who do not qualify as authors should be mentioned under Acknowledgements.

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## Publication costs

*Kai Tiaki Nursing Research* does not impose submission or page charges. All illustrations and graphs must normally be submitted in black and white. Authors who consider colour is essential for clarity of understanding would be liable for extra printing costs attributable to colour, and prior consultation with the production editor should be held.

# MANUSCRIPT TYPES ACCEPTED

## Research manuscripts

Original research papers should be 3000-5000 words in length for the main text, excluding abstract, tables and references, and be organised in logical subdivisions appropriate to manuscript type. In addition to those headings suitable for each study, all manuscripts should also contain:

**Title page:** On the first page of the manuscript please include the title; names and qualifications of all authors; affiliations and full mailing address including email addresses, fax and a contact phone number. An author should be identified who is the agreed correspondent. The title should be concise, specific and clear. Normally a title would be no more than seven to nine words. Please ensure the author's name (or authors' names) appears only on the title page and that there are no identifying comments on all other pages.

**Abstract:** This should appear on the first page following the title page, and should be limited to approximately 250 words. The information should be substantive, not descriptive, and include the following headings: Aims (of the paper), Background, Methods (including year of data collection), Results/Findings, and Conclusion.

**Key words:** This should consist of up to six key words which appear within the abstract.

## Letters to the editor

Submitted letters should address academic points arising out of a recent paper published in *Kai Tiaki Nursing Research*, such as interpretation of data and methodology. Authors of published papers to which a letter may refer have a right of reply, to be published with the original letter. Letters and replies will be published at the discretion of the production editor in collaboration with the editor-in-chief.

A letter should be submitted as a Word file attachment to an email addressed to kaitiakiresearch@nzno.org.nz and it should not exceed 1000 words. The letter will be forwarded to the production editor and the editor-in-chief for a decision.

## Commentary

*Kai Tiaki Nursing Research* invites the submission of commentary on papers published in previous editions. Commentaries should be 1000 to 1500 words in length and provide a frank, honest review on the research article. Original authors will have the opportunity to respond to commentaries prior to publication.

## Research briefs

Research briefs are limited reports (1000-1500 words) featuring research with important implications for practice. Submissions should include the research topic and context, a brief overview of the methodology, including ethical requirements and procedures for data collection and analysis. A succinct précis of the findings should include implications for practice and future research.

## Referencing

*Kai Tiaki Nursing Research* uses the APA 6th edition referencing system. Refer to the APA Publishing Manual (2010) for further details.

# ADMINISTRATIVE PROCEDURES

## Submission of manuscripts

All manuscripts must be submitted electronically. Full instructions are given on the website (www.nzno.org.nz/ktnr). To avoid excessively large files, which are time-consuming for both uploading by the authors and downloading for the reviewing process, no file should be larger than 5MB (5000KB).

All manuscripts submitted to *Kai Tiaki Nursing Research* should include a covering letter stating, on behalf of all authors, that the work has not been published previously and is not being considered for publication elsewhere. Please ensure authors' names appear only on the title page and that there are no identifying comments on all other pages.

Enquiries should be sent to:
Kai Tiaki Nursing Research
Publications Office
New Zealand Nurses' Organisation
PO Box 2128
Wellington
Tel: 0800 28 38 48
kaitiakiresearch@nzno.org.nz

Before submitting your manuscript, please adhere to the following guidelines and instructions to authors. Manuscripts should be submitted initially as a Word file; numbered figures and tables should be included in the Word file in the first instance. To facilitate the reviewing process, the submitted manuscript should be formatted with the body text in 12 point Times New Roman with line spacing of 1.5. Text should be left-aligned and surrounded by 3cm margins.

High-quality figure files will be requested if necessary. See detailed guidelines on the website. A signed Exclusive Licence Form will be required upon acceptance. Both forms are available on the NZNO website. Provided these forms have been scanned and emailed, or faxed to the publications office, it is sufficient to send the originals by regular mail.

## Correspondence

Following submission of a manuscript, all correspondence, up to the stage of acceptance, is attended by the editor-in-chief (Patricia.McClunie-Trust@wintec.ac.nz) and will be by email. After acceptance, all matters related to printing will be dealt with by the production editor (KathyS@nzno.org.nz).

NZNO cannot accept responsibility for loss of submitted files. Contributors are advised to keep copies of all text and figure files.

## Date of receipt

The date of receipt of each paper will be printed and is the date on which the completed manuscript is first received by the editor-in-chief. Papers submitted without all the information specified in these instructions will not be considered complete nor given editorial consideration until it has been provided. An author is expected to respond with requested revisions within the requested time frame (usually one month).

## Proofs

Proofs should be corrected and returned promptly. Publication will be in order of receipt of corrected proofs. Excessive alterations by the authors of the accepted proofs may result in the need for further editorial review.

A complimentary copy of the relevant issue of *Kai Tiaki Nursing Research* will be sent to all corresponding authors, together with a PDF file of their paper.

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