OUR RESEARCH TAKES WING
NEW FUNDING FROM HRC, MARSDEN & THE EU
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Professor Merryn Gott

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In these pages you’ll find out more about these projects as well as about ones already underway. Dr Teryynn Clarke reports on the third wave of the European Union (EU), HRC & the Marsden Fund: major funders are supporting new SoN research

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Marsden Fund winner

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YOUTH ‘12 OVERVIEW
NATIONAL REPORT

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

The Adolescent Health Research Group welcomes inquiries from NZ-based and international researchers interested in using the data from the survey for secondary analysis. The Group is also interested in hearing from those who would like to utilise the data for publications or Masters/PhD projects. Information about how to access data is available on our website. The study was funded by Ministries of Youth Development, Social Development, Health, Education and Justice, the Department of Labour, the Families Commission and the Health Promotion Agency.

A copy of the Youth ‘12 Overview, and the Youth ‘12 Prevalence Tables report may be downloaded from the AHRG website: www.youthresearch.auckland.ac.nz
REPORT FINDS NEW ZEALAND HAS UNIQUE SYSTEM FOR PROTECTING RIGHTS

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

Currently there are 34 DIs and 1 Senior Advisory DI in New Zealand. “Research suggests the DI role is unique to New Zealand,” says Dr. Katey Thom, principal investigator. “We found that overseas jurisdictions have different safeguards in place that do not statutorily require lawyers to undertake such a watchdog role.”

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

Recommendations listed in the report included 1) investigating how DIs can be supported to respond to patients in the community and vulnerable people who reside in residential facilities, particularly older adults; 2) supporting new DIs with a formalised ‘buddy system’ with continued and regular contact by experienced DIs and 3) improving information about the role of DIs for services users.

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

GROUND BREAKING CONFERENCE JOINS MENTAL HEALTH & ADDICTIONS NURSES


Mental health and addictions nurses from New Zealand, Australia, the US and the UK met for three days to discuss issues such as homelessness, trauma and abuse that form the care of much of their work.

Convened by Te Ao Maramatanga New Zealand College of Mental Health Nurses and DANA (Drug & Alcohol Nurses of Australia), it was the first conference in New Zealand geared to both disciplines. The School of Nursing staff played a major role in hosting the conference. Dr Kate Prebble served as co-convenor and Dr Helen Hamer and Debra Lampshire were plenary session speakers. Tony O’Brien chaired the abstract selection committee and presented a paper, Jane Barrington and Michele Yeaman also presented papers.

Kate explained that involving service users in all aspects of the conference was a top priority. “One of the aims of the conference was to highlight the importance of clinician-service user partnerships in practice, education and research. Service users not only contributed to the programme but also served on the organising committee and the abstract selection committee.”

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

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

Already the field research team of Dr Tess Moeke-Maxwell (Nga Taiki Tamaki and Ngati Pakeku) Stella Black (Tuhoe) and Dr Lisa Williams have conducted a dozen interviews. The goal is to talk to the families and whanau of up to sixty Māori and non-Māori older people who were enrolled in the Living and Dying in Advanced Age cohort study in New Zealand (LiLACS) study. LiLACS NZ is a longitudinal project begun in 2009 that is investigating successful ageing for people over age 85. Although linked to LiLACS, NZ Te Pakeketanga is a separate and independent project.

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

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

ACC teams with the School of Nursing and Waikato DHB

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

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

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

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

School of Nursing researchers Dr John Parsons and Prof Matthew Parsons are the PIs. The rest of the team includes Christine Smith (study manager), A/Prof Tim Kenagy (Primary Care), A/Prof Paul Rouse (Economics), Rochelle Parsons (Researcher) and Avinesh Pillai (Biostatistician).
1ST SPECIALIST STROKE NURSING COURSE

Capitalising on Dr Julia Stark’s research expertise, the SoN will be up-skilling registered nurses with NZ’s first specialist stroke nursing course in 2014. It will take place over six days in the first semester and will be open to any registered nurse with an interest in stroke.

“We’re responding to increasing demand,” she says. “The need for specialist knowledge is really growing. Partly because of New Zealand’s ageing population, partly because stroke as a nursing specialty is new to New Zealand.”

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

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

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

Growing nurse leaders in the Waikato

The Nursing Honours programme has been available at The University of Auckland for over a decade. The programme has allowed students to ‘fast-track’ to doctoral studies. However, invariably those individuals who achieve high grades in academic studies also succeed in both the clinical and academic tracks.

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

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

KIT FOCUSES ON RIGHTS FOR RAINBOW OLDER PEOPLE

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

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

The kit was created in collaboration with a working group drawn from the aged care sector and the Auckland LGB community. It was developed in response to the recognition that New Zealand, like many countries, has an ageing society that includes an older LGB populace.

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

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

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

New project links NZ to European Union

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

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

Health Technology Assessment (HTA) is a multidisciplinary field of policy analysis. It studies the medical, social, ethical and economic implications of development, diffusion and use of health technology. Complex health technologies, such as palliative care delivery, are imperative for matching the rise in chronic diseases in ageing populations. HTA is currently sub-optimally equipped for the assessment of complex technologies, despite considerable achievements in recent years.

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

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

For more information: http://www.integrate-hta.eu/
Koren: Grounded Theory differs to other forms of qualitative data analysis by taking the reader one step further in presenting the findings. This further step is achieved by a process of abstraction which is (very superficially) defined as ‘deep thought’. The theory that is constructed from the categories produced out of the data and ‘deep thought’ must be truly grounded in participants’ voices. By writing a storyline narrative about the phenomenon under examination, the analyst then has the ability to ensure that all components of the story are underpinned with data.

Kim has had her breakthrough with a core category in her PhD research by identifying a recurring comment by participants. This category was termed ‘clinical skills to the new graduates’. Kim has had her breakthrough with a core category in her PhD research by identifying a recurring comment by participants. This category was termed ‘clinical skills to the new graduates’. Kim: Grounded Theory gives you a way to look at the mundane or everyday – the hidden moments where people’s lives really happen – and explain not only what happens for them but how to solve a research problem. It is a process of abstraction, which is an art, but it requires a lot of thought and effort. The outcome is grounded in their world, their lives and their experiences.

Grounded Theory lets you conduct research in such a fluid, creative and dynamic way. It’s almost magical the way the moments of insight and clarity happen; they leap out of the data at you. Yet it’s not a wishy-washy process. For example, Grounded Theory is trustworthy because you always examine what you are thinking by recording the research process and the decisions made along the way. Such recording (memoing) acts as a check and balance by allowing others to interrogate your theory development to ensure it remains grounded in the participants’ words and not the researchers’ imposed ideas.

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

Catherine: My motivation for undertaking the study was my feeling that we didn’t have the full picture of what was going on with skin infections in young people in NZ. So I had a clear idea of what I wanted to research, but no idea what methodology to use. Initially, I did A LOT of reading on various methodologies, eventually narrowing it down. The things which attracted me to Grounded Theory were its usefulness in social justice research and in challenging prior assumptions.

The concept of staying close to the data appealed to me as well, I had confidence interviews with school nurses would yield great data. If you feel like you are moving forward, it will be more than you think.

Fortunately, I was able to access literature aimed at providing researchers with an initial understanding of what Grounded Theory is, and Karen was able to point me in the right direction, discussing the harder concepts with me. Catherine: Becoming familiar with the various terminology and viewpoints around GT was challenging. Writing the methodology chapter was essential in clarifying these issues for me. Once I started the research, everything went really well, and I found the interviews and analysis really enjoyable. Memo writing was also a pleasure, as it was a great way to take a break from academic writing and just write down ideas and thoughts throughout the project.

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

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

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

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

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

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

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

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

I think this made getting quality data easier, and made the whole process of data generation more relaxed. I tried to do at least some work each week. So even if you are waiting for feedback or ethics approval, do something each week to draft the next chapter, write memos or re-edit previous work. It helps to always feel like you are moving forward.

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

**RESEARCH FEATURE**

**GROUNDING THEORY**

**DIGGING DEEPER INTO THE DATA**

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

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

Bed making was important. Grace Benson explained how essential it was to get it right; ‘In fact, we used to go back at nights, Audrey and I, to make more beds, to get them perfect and make them in three minutes…’ Margaret Faulkner commented that when she came into contact with nurses who trained around the world, what struck her was ‘everyone made a bed a different way’. Pat Oettli told the story of how, when she was a tutor at Green Lane Hospital and had to train a class for different way’. Pat Oettli told the story of how, when she was a tutor at Green Lane Hospital and had to train a class for probationers, they were expected to clean the pans and potties. She related the story of how one day the sub-matron, Miss Smallbones, came into the sluice room and said, ‘Oh nurse, your potties do look nice!’

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

Diana Masters mentioned a particularly scary ward sister – ‘She terrified me’ – but also noted occasional acts of kindness by ward sisters. On one occasion Sister Burtan noticed that she was feeling unwell, put her to bed in the doctor’s room and gave her a cup of tea. ‘I will never, never forget it.’ Most interviewees mentioned that clinical teaching consisted primarily of role modelling and learning by doing, ‘on the job’. Kamira Gasman recalled that ‘Most of the learning came just before you did these things or while you were doing them’. The individual ward sisters had a big influence on the learning environment. Gasman reflected, ‘It depended on the charge nurses where you were’. Masters noted that ward sisters did a lot of teaching but there was no correlation between the classroom learning and ward learning.

The interviewees invariably commented that they were given huge responsibilities, especially on night shift. Smale described a particularly frightening night shift at the end of her first year, when she had to manage multiple responsibilities, including caring for a man in a diabetic coma. She reflected that, ‘Many things were beyond our experience or our knowledge’. Brooker related how as a senior student nurse, ‘a third striper’, she had been placed in charge of a gynaecological ward by herself at night, calling it a ‘quite extraordinary responsibility’.

Trainee nurses were not expected to engage therapeutically with their patients. Oettli told a story of how, when she was working in a woman’s ward with six patients in one room, ‘one of them was crying all the time’. It was only after six weeks that she found out that the woman had had a heart attack; apparently her husband had got such a shock that he had died of a heart attack himself! Oettli explained ‘I didn’t know she had just lost her husband… if I had known I wouldn’t have known what to say… [We] really nursed in ignorance’. Nevertheless the interviewees also recalled that as junior nurses, as Mary Wentworth said, ‘patients often talked to you… [we] sometimes learned things they hadn’t told the senior nurses’.

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

Looking back on their trainee years, most nurses reflected positively on their experience, even on the strict hierarchy. As Diana Masters commented, ‘you knew exactly where you were, what you could do and what you couldn’t do… maybe [that] wasn’t such a bad idea’. Dr Kate Prebble reports on the ongoing Nurses Education and Research Foundation (NERF)-funded Nursing Oral History Project. Professor Linda Bryder from the Faculty of Arts Department of History is the principal investigator. School of Nursing Honorary Associate Professor Margaret Horsburgh and independent researcher and historian Debbie Dunford are also members of the research team.

The aim is to interview 60 women and men who started nursing in the 1950s-1960s. The recordings will be added to the Alexander Turnbull Library’s large nursing oral history collection and will form the basis of an oral history website. Interviews and photographs will be available for nurses, researchers and the public for many years to come.

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Why did young women choose to start nursing? What were their work and living conditions? What was their education experience? How did they socialise?
Older people: How the media portrayed them

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

Principal investigator Dr Kathy Peri, summer student Richard Chen, and research assistant Gabriella Trussardi studied newspaper and TV current event reports to examine how media framing may contribute to perceptions of older adults. Their content analysis revealed that the media generally used negative emotive language to describe older adults, calling them vulnerable, frail, fragile, trapped in their homes or suffering from heart attacks, strokes and health issues that impacted both their physical and emotional wellbeing. However, negative quality of life outcomes following disaster are linked to existing health conditions and socioeconomic status, not to age.

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

The volunteer coordinator said, “they’re real sweeties”. “This infantilizing ‘elderspeak’ is a form of benevolent ageism,” said Kathy. “Such language frames intelligent, independent and confident adults as more akin to children.”

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

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While media do not create the stereotype of old age as tragedy, they provide imagery and language that contribute to it. “We see an opportunity for media in New Zealand to be mindful of the ways they select and frame stories that contribute to a devaluing of older adults,” said Kathy.

“Instead, they could position the active participation of older adults in society as normal and unexceptional.”

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

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

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

I had some senior nurses who couldn’t go home, and a couple of others on our Vulnerable Person’s response team who also couldn’t go home. I took them to my house, which was just over the river from Princess Margaret Hospital, and we stayed there for the next week we were out and about in our cars, showered for a week. The following day after the earthquake I got them into bed, and I said, ‘I’m leaving the front door open just in case something happens.’ You’ve got to remember that all this time we’re having very, very severe aftershocks.

We had no toilets, we had no showers in fact, none of us could go home. I took them to my house, which was just over the river from Princess Margaret Hospital, and we stayed there for the next week. The following day after the earthquake I got them into bed, and I said, ‘I’m leaving the front door open just in case something happens.’ You’ve got to remember that all this time we’re having very, very severe aftershocks.

Behind the scenes: Nursing during the ‘quakes

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

Our hospital, which was not an A&E department whatsoever, suddenly became one with very serious trauma victims. And so we just built this triage trauma centre down in the day hospital and used house surgeons and our senior nursing staff to run it. We had very, very unwell and injured people turning up, and the ambulances were bringing them as well. Christchurch Hospital was quite damaged, and at first you couldn’t get through – what would have normally been a 10 minute trip took up to three hours, because of the liquefaction and cracks in the road.

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At about two o’clock in the morning, this cattle truck arrived, and it was the first of the patients from Christchurch Hospital...
Researchers bring strengths in palliative care research, Kaupapa Māori, critical theory and addiction research

Clare Gardiner

Tess Moeke-Maxwell

Gabriella Trussardi

Claire Meehan

Early warning: Nurses’ response to patients in crisis

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

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

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

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

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

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

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

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

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

Although the majority of nursing staff surveyed were aware of the guidelines they should be following in medication administration, they did not always follow them. It is this human factor that makes the online survey when this was compared to their measured practice in the baseline clinicalaudit. Despite more than 80% agreeing that medication labels decreased errors in the survey, half the syringes audited at baseline were not labelled.
Alternative Education (AE) is meant to help students alienated from mainstream NZ education. It is targeted to at-risk youth ages 13-16 who meet certain criteria, such as having been out of school for two terms or more, having multiple suspensions from different schools, or having a history of dropping out of mainstream or correspondence schools. Because of her experience working with AE, Jodi had seen firsthand its benefits for students. But did AE truly make a lasting difference? To find out, she interviewed 13 former AE students (between 18-26 years old) to gauge their perspective on the influence, if any, AE had on their wellbeing and life course. Her results captured their views on 1) their disenfranchisement from mainstream education, 2) how AE helped them reconnect to learning 3) their transition out of AE and 4) the ongoing impact of AE after they left it.

"What the findings show is that AE provides a place of belonging," Jodi says. "Participants experienced unity with other students and found a sense of family or whānau." Tutors made a tremendous difference in students’ lives, and students credit their commitment with prompting them to persevere.

Transferring out of AE provided difficult, however. Since alternative education in New Zealand only extends to age 16, students must exit it before their high school education is complete. Only 4 of the 13 participants described a successful transition into another course. As a result of her study, Jodi developed recommendations that centred on increasing funding and support for AE. "Young people in AE shouldn’t be further disadvantaged by having less access to academic opportunities than those in mainstream schools," she says.

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

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

The service AE provides could be improved through increased collaboration with other education, social and health services who work in partnership with the tutors and students, Jodi says. She suggests that health care professionals develop strong, trusting relationships with tutors and students in order to provide a comprehensive and holistic health service.
Postgraduate Research

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

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

While on rounds with Whakatāne Hospital’s post-operative pain service, Jen Boudreau noticed Māori patients were suffering from intrathecal morphine induced (ITMI) pruritus more frequently than NZ European patients. Sparing her research on the topic, investigating whether ethnicity, age or gender influenced the incidence of ITMI pruritus. A second aim of her research was to explore how other nurses’ experiences of ITMI pruritus differ.

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

Māori suffer more, receive less treatment

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

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

Implications for practice

Among the survey groups acknowledged that ITMI pruritus did occur, however management of pruritus was not considered a priority for post-op nursing management. Post-operative hypotension was more likely to receive treatment for pruritus than NZ European. Jen’s results indicated that NZ Māori have a significantly increased incidence of ITMI pruritus compared to NZ Europeans. At higher doses of morphine less than 201 mgcs and 300 mgcs produced no adverse effects in either population however, pruritus was experienced above 301 mgcs in both groups. Nineteen (47.5%) of the 40 New Zealand Māori and 11 (19.6%) of the 56 New Zealand Europeans experienced ITMI pruritus. Further exploration of her data revealed that at lower doses compared to NZ European, more than half the NZ Māori scored their pruritus as moderate to severe. More importantly the results showed that NZ Māori were less likely to receive treatment for pruritus than NZ European.

The SoN 2013 Publication List

Over the past year researchers within the School of Nursing have been busy writing up. We have included a selection of our newest publications below. Please remember to check out our website for staff member’s listings all their projects and publications.

You can find us online at www.fmhsc.auckland.ac.nz/srn/research.


The marginalisation of, and reasons for ‘inappropriate’ hospitalisations amongst patients with palliative care needs: a qualitative exploration of the views of generalist palliative care providers. Palliative Medicine, 27(8): 747-756.


Jacobs, S., Rouce, P. and Parsons, M. (2013). Leading change within health services: The theory behind a systematic process for leading the implementation of new services within a network structure. Leadership in Health Services, (December).


