KORERO HAUORA HEALTH TALK

2015 | A celebration of nursing & midwifery projects & achievements in Taranaki

TARANAKI DISTRICT HEALTH BOARD

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga

Contents

Chief Nursing Advisor - Rosemary Clements

Welcome to this years newsletter. It seems incredible that we are celebrating International Nurses Day again so soon; it seems only yesterday we enjoyed the quiz night! It has certainly been a busy 18 months since the last newsletter with many staff making changes in their working lives sometimes without taking the time to realise or appreciate what has occurred.

As I move about the organisation I see great changes in the way nursing care is delivered. These changes and improvements have been brought about predominantly through nurses efforts. New pathways of care, improved patient delivery, CCDM and releasing time to care are but a few examples of this. Technology has become a great enabler for nurses and looks set to becomes even more so into the future.

Over the last 18 months many people have made choices to continue with their studies, make innovations in their practice and they continue to provide stunning care in a huge variety of clinical settings.

The following pages contain some examples of the many achievements from our nurses and midwives who make up the Taranaki DHB workforce.

I would like to acknowledge and congratulate those who have contributed to this newsletter and wish to thank the nurses and midwives in Taranaki for their hard work and commitment to providing the high quality of care that the people of Taranaki deserve.

Rosemary Clements
Chief Nursing Advisor

Rosemary Clements Chief Nursing Advisor

Advance Care Planning and Hospice Taranaki Staff

Heather Koch, Director of Nursing, Hospice

The process of Advance Care Planning (ACP) is gaining momentum within the Taranaki region and has been embraced by the District Health Board (DHB) and Hospice Taranaki staff. In 2014, Hospice Taranaki hosted two community forums called "Let's Talk: Let's Plan" which were aimed at gaining feedback from community members about what was important to them when considering end of life care. Only small numbers of the public attended but there were clear and consistent messages received during these discussions.

This year, on 16 April a national promotion "Conversations that Count Day" was held by the National Co-operative for Advance Care Planning (ACP) to encourage discussion about advance care planning between health professionals, members of the public and within families. Locally the promotion included displays, promotional material and staff available to discuss ACP with peers and the public.

Although ACP is not a 'nursing only' task, often nursing staff are in the prime position of having a close relationship with the patient, being at the bedside or in the home when conversations begin about what a patient may want at the end of life. It is very important that this information is documented to help determine possible care interventions in the future. With this in mind, Dr Tom Bull developed an ACP/Plan for Emergencies form which has been trialled in the inpatient unit at Te Rangimarie Hospice in late December 2014 to the end of March 2015. Although medical staff were mainly involved in the completion of the form, nursing staff often heard comments from patient's involved in the pilot about how relieved they were that they had the opportunity to talk about their wishes in advance and that family members were also aware. Research into ACP has shown the benefits for all when decision-making in crisis situations needs to occur.

As nursing staff, it is very important that we have the skills to identify opportunities for ACP discussion as they arise and not shy away from this. There is the opportunity for nurses to partake in an e-learning module on the National ACP website which helps to teach skills in managing ACP conversations. Nurses learn to recognise the 'cues' that can assist in facilitating open communication to allow the patient to describe what they would like to happen. Hospice Taranaki nurses have had the opportunity to learn about ACP during their annual refresher day in 2014 and in 2015 and with the evaluation of the recent pilot project, they plan to build on these skills. It is envisaged that more nursing staff will feel confident to complete ACP forms with palliative patients and their families/whanau. As the ACP form is scanned into the electronic patient records (PalCare) and listed on the Taranaki DHB electronic patient record system as an alert, all staff will have ready access to this pertinent information should a patient present to the emergency department or within the hospital environment. We look forward to the outcome of the evaluation of the pilot project as early indications show positive results.

Heather Koch explaining the details of Advance Care Planning

Associate Director Of Nursing - Gail Geange

International Nurses Day provides an opportunity to acknowledge the important contribution nurses make to patient care and the health service.

Looking back over the last twelve months the following highlights come to mind.

This year's professional development programme has a focused approach and covers key areas of education the planning team envisage will support nurses. Our current education on offer uses a blended learning approach through the use of eLearning modules. An example of this is the change to CPR training with the theory component of anaphylaxis being completed through the use of the Anaphylaxis eLearning model. This eLearning model has been well supported with over 400 nurses enrolling in this module.

There are a number of other eLearning modules available or currently being developed.
Check the Midland eLearning site for details, **http://midlandlearning.elearning.ac.nz** You will need to create a new account if you have not visited the site previously. I plan to have venepuncture and cannulation, male catheterization and manual handling modules available shortly.

The Professional Development and Recognition Programme (PDRP) continues to be supported across the region. All nurses applying for Health Workforce New Zealand funding are expected to have a current PDRP portfolio. As well ePortfolios are now available for nurses in the hospital wanting to complete a portfolio at competent level. ePortfolios may be extended into the primary sector in the future.

You may have noticed changes at the clinical skills lab. The various rooms have been redesigned with improved layout and signage to allow for flexibility of the facility. Currently the equipment at the centre is being reviewed and will be updated or replaced as funds permit.

International Nurses Day provides an opportunity to say thank you to our amazing nurses, well done.

Associate Director Of Nursing - Glenda Butturini

It is hard to believe another year has gone by so fast! There have been lots of ups and downs over the past year – hopefully more ups than downs!

The re-launch of Care Capacity Demand Management has been a big piece of work for all concerned. I know the data collection in wards 2A, 3A and 3B added to already busy work days however it has given nurses the opportunity to step back and have a look at everything they do. This information will give the opportunity for changes to be made by nurses in day to day practice to improve nurses work environment and satisfaction which will flow on into improvements in patient care. Ward 2A is already working on some ideas for the future and the surgical floor data will be available soon for them to have a look at.

Post graduate study has been popular this year, unfortunately we did not have enough funding to meet demand so some folk were unable to be funded. There are still some people deciding not to study in second semester so those of you still hoping for funding might just get lucky!

Donor Liaison Coordinator

Aleisha Moffatt

It has long been recognised that a kidney transplant is the best form of treatment for people living with kidney failure. Offering the recipient a marked improvement in quality of life, improving health outcomes and increasing their long term survival, while also being more cost effective by decreasing health care costs in the long term.

It is estimated that one in eight people have kidney dysfunction, creating a large demand for renal replacement therapy. For those that are clinically suitable, transplantation is the best therapy choice. However there are currently over 600 people on the deceased donor waiting list for a kidney transplant. Unfortunately only about one third of these people will receive a transplant before they die.

The Ministry of Health has recently endorsed a new National Kidney Transplant Service, with the aim of increasing the number of live kidney transplants within New Zealand by around 10% per annum. As part of this service, a new role, 'donor liaison coordinator', has been established within each renal unit throughout New Zealand.

Within Taranaki the donor liaison coordinators are Aleisha Culpan and Lynette Knuth. This new position involves working with both recipients and live donors to achieve the Ministry of Health's targets.

The role starts before the patient reaches dialysis (pre dialysis stage), with education, to ensure early acceptance onto the transplant list, this period is fully focused on transplantation before the patient requires dialysis. Within this period the patient would be encouraged to identify potential donors.

Once a potential donor is identified and they make contact with the coordinators, they can be provided with information and education around donation and transplants. All donors need to be referred to the service by their GPs after which a screening questionnaire is completed to ensure they meet criteria. Then the donor evaluation process can begin, which involves a series of tests and investigations. These are done to ensure that the donated kidney is a good match for the recipient and to check for any medical problems that may prevent the donation or cause harm to a potential donor.

For recipients, donors and their families the process of having a transplant or donating can be very stressful. The coordinators are here to support and help them through this, by reducing delays and working towards increased live kidney transplantations ensuring the best clinical outcomes are achieved for these patients.

Nurse Practitioner Cardiac

Q&A Brigitte Lindsay

Q. How did your career lead to you achieving nurse practitioner status?

A. I was working in cardiology rehab and cardiac care and although I really enjoyed the work I needed more stimulation, so in 2003 I started post graduate studies. I was able to study as a distant learner and this made it much easier for me. I found the papers that I had chosen broadened my knowledge and stimulated my thinking.

As I started papers towards my Masters Qualification my career pathway was to become a cardiac nurse specialist. I had met the nurses who led the nurse led clinics at Hutt Hospital and this helped to inspire me. I completed my masters within three years and then spent the next six months putting together my nurse practitioner portfolio. I achieved nurse practitioner status at the end of 2006. At this time I was the first nurse practitioner in Taranaki and needed to negotiate a job with the DHB. My initial role nurse practitioner

heart failure began in July 2007. By 2009 I was also working one day a week for a general practice providing general cardiology services.

Q. What does your current role cover?

A. My current role in the DHB includes working with complex cardiac failure patients who often have multiple co-morbidities. I often need to work a patient up to ascertain causes of/contributing conditions to their heart failure. I need to investigate and manage cardiac conditions such as ischaemic heart disease, atrial fibrillation/rhythm disturbance valvular heart disease in order to fully manage their heart failure. In working up patients I need to consider differential diagnoses or contributing conditions that impact on their heart failure such as respiratory disease, diabetes, renal failure, arthritis, gout anaemia. I need to prescribe in the context of these co-morbidities, refer out if indicated and consider wider management strategies. Many of my patients are palliative and so I work closely with the hospice team. I provide this service both within the hospital and primary sector.

Q. You have recently had your area of practice extended, what does this mean?

A. I could see that the Nursing Council was wanting nurse practitioners to have a broader scope and decided that there was a need to extend my practice into primary care. In 2014 I started working towards an extended practice by gaining further clinical experience through attending specialised clinics with the intention of extending my area of practice into adult conditions. Having an extended area of practice now allows me to prescribe for other conditions when patients attend the heart failure clinic and therefore provides an improved service for my patients because prescribing at point of care makes their journey more efficient and improves access to treatment. For example, I may discover some of their breathlessness is due to COPD or chest infection so I can now prescribe inhalers or antibiotics. I am also working one day a week for the Waitara Health GP practice as nurse practitioner adult conditions, which is giving me the opportunity to also use my broader nurse practitioner prescribing rights.

Q. What advice would you give to nurses thinking about nurse practitioner status?

A. Nurses will have a specialty area of interest but they need to ensure their prescribing practicum and defined area of practice is sufficiently broad to safeguard their future prescribing options. The Nursing Council is proposing all nurse practitioners prescribe in a broad area of practice.

It is important to have a clear career goal and focus on further professional development. I found it important to aim for good academic grades as in-depth knowledge is very important for future role development. I would advise nurses to make early contact with key stake-holders in the organisation such as managers, nursing directorate, supporting doctors or nurse practitioners to discuss career goals. Ideally all nurses working towards nurse practitioner need to be well supported and obtain an internship which should then lead into employment as a nurse practitioner.

Q. What do you like most about your job?

A. I really enjoy the autonomy of the position and being able to make independent treatment decisions. I also enjoy collegial rapport and clinical and academic discussion during individual case review. I enjoy the mental stimulation the role provides and the opportunity to work at a high level of practice.

Q. What do you like least about your job?

A. Politics. I guess this goes with advanced roles and the fact I was the first cardiac nurse practitioner in the country and the fact that some people do not understand what a nurse practitioner does nor the skill sets that I have. Nurse practitioners often have had barriers to getting roles thought politics, funding issues etc. I am hopeful things are going to be better in the future as more people realise the value we add to the health services.

Q. What do you do to try to keep fit and healthy?

A. I enjoy running and recently completed the Taranaki six hours adventure race. I enjoy a range of outdoor activities including tramping, skiing, biking riding and boating. I even tried surfing for the first time this summer. I love spending time with family.

Q. What are your future career plans?

A. I would like to continue to broaden my nurse practitioner prescribing skills and further develop by cardiology knowledge. I still believe there is a lot more I can offer if given the opportunity to do so.

HoverMatt

Cathy Thomson, Clinical Nurse Specialist Product Evaluation

Taranaki DHB bought a HoverMatt last year for the comfort and dignity of patients and to ensure the safety of health care workers during lateral transfers.

A lateral transfer is when the patient is in a supine position and is moved from one surface to another for example from a bed to a stretcher. Lateral transfers have been identified as a high risk task in patient handling because it uses the weaker muscles of the caregiver's arms and shoulders as primary lifting muscles, rather than the stronger muscles of the legs.

With the increasing size of our patients and the 'No Lifting Policy', the HoverMatt has been beneficial in manual handling.

The technology is in two parts – a flexible mattress which is placed under a patient and a portable air supply that is used to inflate the mattress. Air flows through perforations in the underside of the mattress and the patient is moved on a cushioned film of air allowing caregivers to transfer patients with less effort.

The HoverJack is a transportable part of the kit. This is a flexible mattress consisting of three sections that are inflated to reach the height of the patient's bed. If the patient falls on the floor the HoverMatt and HoverJack can be rolled under the patient and inflated. The patient is then able to be transported on the HoverJack and back to the patient's bed.

Cameron Grant-Fargie and Sharon Crowe demonstrate the HoverMatt.

Specialty Clinical Nurse, Occupational Health

Jackie Heapy

Hi everyone, my name is Jackie Heapy, and I recently joined the team in Quality and Risk in the specialty clinical nurse, occupational health role. I'm very excited to join Taranaki DHB in this role, and I'm looking forward to contributing to initiatives that help make sure that when you come to work – you also go home safely without being injured or made ill from the work that you do.

I have been working in occupational health since 2004, and have experience in fields such as chemical engineering, manufacturing, industrial painting, and the oil and gas industry. I have a particular interest in workplace rehabilitation, injury prevention and the promotion of staff wellness and wellbeing.

My role at Taranaki DHB is to assist with the implementation of the Health and Safety programme, and promote health and wellbeing in the workplace. Over the coming year I will have a specific focus on musculoskeletal injuries, and safe moving and handling practices. If you want to call by and say hello, I'm based in the Quality and Risk Unit. I'm happy to stop and have a chat at anytime, and I look forward to working with you.

Graduate Nurse Update: One year on

Louise Bennett, Registered Nurse

Twelve months ago new graduate nurse Louise Bennett featured in the Pulse magazine, commenting on her experience 12 weeks into her nursing career. We now check in with her one year on …

The new graduate year really flew by, the combination of an encouraging working environment and well-structured Nurse Entry to Practice (NETP) programme, it was really enjoyable. Through the structured support from programme co-ordinators and clinical preceptors, being included in the NETP programme provided us new graduate nurses with the skills needed to be safe, competent and more confident in practice.

Congratulations to those on the 2015 programme, and as you are undoubtedly working out where to add in extra study and assignments to the balance of work and home life, I can tell you it is worth it in the end!

As my new graduate year concluded, I was (extremely) fortunate to have filled a permanent position within the mental health acute intervention service.

The nursing roles across acute intervention service encompass Te Puna Waiora (inpatient), crisis team, acute home base team and night triage; varied clinical settings which allow for a good range of area-specific skills to be acquired.

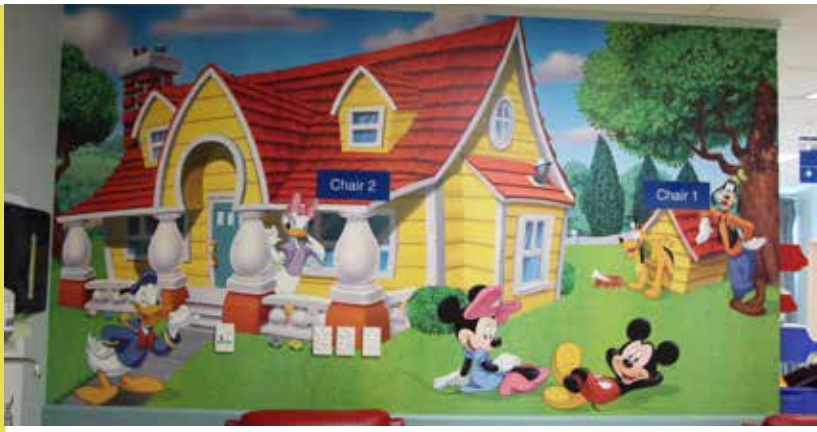
As part of my structured orientation, I have spent the past few months working alongside the crisis team, it has unquestionably been the most valuable and enjoyable experience any new nurse could hope for. The post graduate study also continues, now with specialist mental health papers, which is providing a nice theoretical backdrop to practical experiences, and I feel fortunate to be supported by Taranaki DHB to work towards further post graduate qualifications.

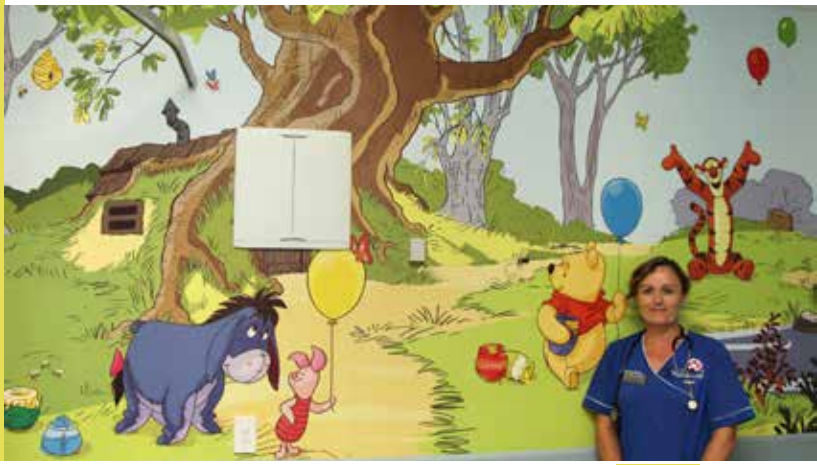
Once again, all the best to those on the 2015 NETP programme, I hope you enjoy the challenges and rewards ahead of you this year and in the future.

Brightening up the Emergency Department

Suzie Price, Registered Nurse

My name is Suzie Price and I am a staff nurse working in the emergency department. My project was to make our department more paediatric friendly. My background is paediatrics and I have worked in the UK and on the children's ward here. I applied for a grant from the Toko Lions Club and they gave me $400.00. We wallpapered one room with Winnie the Pooh and we have an area with some chairs with Mickey Mouse. We have had lots of positive comments from children and their families. Little things can make big differences.





Matilda Carrell, physiotherapy student

Patient Safety and Falls Prevention

Gail Geange, Chair, Falls Prevention Steering Group

Nurses and other health professionals are congratulated on the work they are doing to reduce harm from falls. Reducing harm from falls is a focus for the Open for Better Care national patient safety campaign led by the Health Quality & Safety Commission.

A fall can have a devastating impact on elderly people and their loved ones. In 2013, 410 people aged over 50 were hospitalised in Taranaki as a result of a fall. As you are no doubt aware, many falls are preventable and we need to continue to work towards reducing harm from falls.

Our statistics show that 50% of reported falls in 2014 resulted in no harm to the patient, however some patients in 2014 did sustain injury, including serious harm. The ongoing challenge for all staff is to continue reducing the harm from falls by implementing individually tailored interventions in a timely manner.

The Falls Prevention Steering Group continues to develop initiatives. These include a focus on early patient assessment, tailored interventions and the use of non-slip socks. Our latest initiative is a trial in Trendcare of the Falls Risk Assessment. Although this trial had produced very good results, issues with the reporting functionality have been identified and are currently being addressed.

Last month was 'April Falls' month. Taranaki DHB, New Plymouth Injury Safe and ACC worked together to promote strength and balance exercises and Vitamin D supplements to help reduce the risk of falls as part of the national 'Stand up to Falls' campaign launched in April.

The messages from this campaign that we all need to continue to promote are:

- Falls can be prevented by regular exercise that improves muscle strength, balance and fitness. Encourage older patients to get active - a green prescription may help.
- Vitamin D is a cost effective and simple way of reducing the risk of falls by helping to maintain bone health and improve muscle function. Check if a Vitamin D supplement is right for patients aged over 50.

Falls prevention is a learning journey and the data we collect from the reporting of falls and audits assists us to ensure we continue to reduce harm from falls.

Midwives in New Zealand

Belinda Chapman, Associate Director of Midwifery

As a midwife leader in maternity I would like to signal my support for graduate midwives educated in New Zealand.

These midwives come to the workforce following a four-year degree programme that includes both academic learning and supervised clinical practice. Much of the final year of study is spent working in our maternity hospitals where students develop both clinical and analytical skills.

The first year of midwifery practice, which is compulsory for all new graduate and overseas new graduate midwives to complete, is recognised as a critical time for newly qualified midwives to consolidate their learning and experience. It is supported by the wider profession, including having a mentor and assistance to attend further education.

International comparison of maternity outcomes in New Zealand over a range of indicators has shown that having a baby in New Zealand has never been safer and compares favourably with Australia, the UK and the USA. Midwives work collegially as part of the maternity service to provide the best care possible, the recent National Institute of Clinical Excellence UK has recently published guidelines for safe midwifery staffing and these recommendations include the key features of our maternity system which are women and baby centred care and 1-2-1 care in labour and birth.

The practice of midwifery requires a health professional with a skill set that includes excellent theoretical and clinical skills matched with patience, endurance and humility. Our midwives in New Zealand are well prepared for this role and are also required to continue maintaining such skills throughout their professional lives as a result of regulation. The DHB midwifery leaders are proud of their colleagues. "We are always learning from unexpected outcomes and working to continuously improve services for women and their babies. Midwives work so hard to maintain the internationally high quality of service and outcomes for New Zealand women and their babies ".

Mental Health and Addictions (MHAS) New Graduates

Ronel Marais, Associate Director of Nursing, Mental Health and Addiction Service

This year has seen a significant change in the way Mental Health and Addictions Service (MHAS) support and develop new grads into the field of mental health nursing. Two new recruits were enrolled in the New Entry to Specialist Practice (NESP) rather than the New Entry to Practice (NETP) Programme. Both Mariana and Tracey have completed their undergraduate studies at WITT, commencing their studies in 2012 as the first group of students on the revised concept-based curriculum, pioneering the way to the future.

NESP is for registered nurses new to mental health and addiction nursing, including new graduates and registered nurses entering (new to) the field of mental health and addiction nursing. The programme supports nurses to develop their professional practice while acquiring the specific skills needed for the speciality field of mental health and addiction nursing. The programme aims to facilitate progression from graduate registered nurse to competent registered nurse on the Taranaki DHB Professional Development Recognition Programme (PDRP).

Graduates complete a post-graduate certificate through the University of Auckland, delivered on the Hamilton Campus, to extend theoretical mental health and addiction nursing knowledge, including physical health aspects. The Post Graduate Certificate in Health Science (mental health nursing) is a masters level certificate consisting of two clinically focused papers (Nursing 753 & Nursing 756), completed respectively in semester 1 & 2. The certificate can be credited toward the Post Graduate Diploma in Health Sciences (mental health nursing), and toward a Masters degree. The programme runs from February to January and involves classroom teaching, online and self-directed learning, as well as experience-based learning within the clinical setting, supported by clinical preceptoring and supervision.

The NESP programme is funded through Te Pou O te Whakaaro Nui, the national MHAS Workforce Development Organisation.

School of Nursing and Health, WITT

Diana Fergusson, Head of School of Nursing

The school has had a busy 2014 with the roll-out of the third year of the new Bachelor of Nursing curriculum. The photo shows our new curriculum 'trailblazer' graduates as they prepared to sit State Final exams and then to secure employment. WITT was highly successful in State Final pass rates and currently sits at 98% employment of the graduates.

The following student's articles have been published:

Chamberlain, J. (2014) How safe are dementia units for Māori? Kai Tiaki Nursing New Zealand, 20(10) p24-25
McCracken, D. (2014). Nursing in a bicultural society. Kai Tiaki Nursing New Zealand, 20(1) p28-29.
Murray, K. (2014). Caring for a patient with Still's Disease. Kai Tiaki Nursing New Zealand, 20(1) p14-16.
Lousich, C., Wilson, A., Brophy-Burden, N., Ewart, M., Scott, M. and Richardson, J. (2014) Investigating diabetes and depression. Kai Tiaki Nursing New Zealand, 20 (8) p20.

Some of our staff achievements this year:

Qualifications:
Su Greensill completed her Master of Philosophy degree
Wendy Walsh, Helen Bingham and Su Greensill completed Diploma of Teaching and Learning.

Our staff have had the following articles published:

Publications:
Bingham, H. (2014). Modern apprenticeship in action. Kaitiaki, Nursing New Zealand, 20 (6) 17-19.
Bingham, H. (2014). Book review for revised 2014 edition: Wepa, D. (Ed.). (2005). Cultural safety in Aotearoa New Zealand. For Cambridge University Press.
Christenson, M. and Knight, J. (2014) Nursing is no place for men - A thematic analysis of male nursing students experiences of undergraduate nursing education. Journal of Nursing Education and Practice, (4), 12, p 95-104 Smith, B. Symposium Reviewer: SINO NZ Symposium 2014 between the New Zealand and Chinese Ministries of Education.

Research Project:
A survey of third year undergraduate nursing students readiness for registration. Joint project with Queensland University of Technology School of Nursing.

Research Project:
A collaborative project between the School and Likeminds Taranaki "The investigation of the effectiveness of the learning pedagogies used in the Modern Apprenticeship programme to facilitate the development of a beginning mental health nurses knowledge, skills and professional behaviour'.

Simulation:
Developing effective teaching and learning strategies to support health care education has been a key focus this year and Jess Knight and Suki Bishop attended the Mask Education Simulation workshop – SIT, Invercargill. Significant work has been undertaken in the WITT / Taranaki DHB clinical skills lab including the installation of the mock bedroom. On the WITT site the adaptation of a simulation viewing area and an upgrade on the Manikin telemetry module has been installed. Additionally, a SIM man QCPR manikin has been purchased. This QCPR is a new national teaching and learning tool with regards to effective digital information on reaching 100% effectiveness during CPR. Plans are afoot to roll out student and staff CPR training using this equipment. The School of Nursing is also involved in a national initiative to develop national Year 3 simulation standards.

Visiting Academics

Academic Visitor: Mary Gillespie from British Columbia, Canada
Mary is the researcher behind the development of the Oxygen Supply and Demand framework and we are introducing this as a biological science teaching tool in the Bachelor of Nursing.

Other activities

The school of nursing have also run the following courses in response to clinical partner requests:

- IV Cannulation course
- Diabetes Care and Management course
- Urine Collection and Drug Testing course
- Preceptorship courses

The School of Nursing and Taranaki DHB have been working with the aged care sector to explore how we can support the education, training and professional development of health care workers in this sector. Acknowledging the increasing complexity of residents and clients in the older person industry, our students now undertake clinical experience there in their third year, rather than in year 1.

We have been working with the Taranaki DHB Māori Health Unit to support the Whyora Whakatipuranga Rima Rau programme; supporting and encouraging more Māori into healthcare. Students from all the high schools come to WITT for a workshop on health professions and have an opportunity for a workshop in the simulation centre.

We also provide 'taster' sessions in the simulation centre for all high school students who are interested in nursing. This is a fun workshop where they are able to undertake some simple health skills such as hand washing and vital signs.

Clinical practice learning is central to the programme and this year has highlighted a number of areas that require further development for us to support student learning, including the clinical practice tutor role in supporting preceptors and students. This work will continue to develop in 2015 as we refine and streamline the model.

The School of Nursing would like to thank our clinical practice partners as it is their commitment to working alongside us to determine what their workforce needs are that inspires us and keeps us on track. Please do not hesitate to contact us if you would like to talk about any of the school's activities.

The School of Nursing Staff Team:
Head of School: Diana Fergusson (Paediatric critical care)
Associate Head of School: Jessica Knight (Neurology and spinal)
Lecturer: Su Greensill (Neonates)
Lecturer: Wendy Walsh (Surgical)
Lecturer: Brian Smith (ICU)
Lecturer: Helen Bingham (Mental health)
Lecturer: Helen Lelean (Cardiac)
Lecturer: Dee-Anna Ritae (community and midwifery)
Lecturer: Rebecca Fairclough (Paediatrics)
Lecturer: Tara Malone (Mental health)
Clinical Lecturer: Bronwyn Robinson (Surgical)
Casual staff to support the programme: Bernadette Jull, Sharon Phillips, Sharon Jones
All our guest lecturers who have given their expertise to the student learning journey

Diana Fergusson, Head of School of Nursing and Health
d.fergusson@witt.ac.nz

Negative Pressure Wound Therapy (NPWT) Conference and Wellbeing Forum

Suzanne Smith, Wound Clinical Nurse Specialist

In March of this year Smith and Nephew kindly sponsored myself and Helen Leppard to attend their Negative Pressure Wound Therapy (NPWT) Conference and Wellbeing Forum in Sydney, Australia. Populated with international key note speakers from the professor to the nurse on the floor, presentations provided excellent research studies and evidence based information supporting practice through to practicalities on the floor.

The NPWT Conference was of particular value providing a deeper understanding on the mechanisms of NPWT and its mode of action from the dispersement of mmHg from the wound bed into the deeper tissue and the differences in healing across the various settings. The use of NPWT in burns and the management of the diabetic foot, the appropriate use of interfaces, the economic efficiency of NPWT, all supported by scientific studies, were also presented.

Of particular interest was a workshop on wound bed debridement. This is becoming very popular as a nurse led intervention and is associated with not only an increase in healing, but a reduction in surgery and subsequent hospital stay and a huge saving of the health care dollar. Local New Zealander Emil Schmidt led this workshop which focused on the European Wound Care Society guidelines for debriding. Emil also presented on the Sonaca ultrasound debrider that Canterbury have recently purchased. This is a painless process where chronic sloughly ulcers for example, can be debrided back to healthy tissue very quickly so that healing can begin. Emil has started a three year study on its effectiveness which he will eventually publish.

The Wellbeing Forum was also very interesting covering care from a patient's perspective, the psychological impact of wound and general health care on patients, interventions to promote wound and health care to improve patient outcomes, while also providing a distinct health economics focus. A study at Horsham Hospital in Victoria was particularly motivating where a quality improvement programme reduced pressure injuries by 60%. Presentations and discussions around health economics were also interesting. Australia has historically not been wanting when it comes to health funding but with a recent drop in the economy funding is now limited and providers are accountable for every health dollar spent. New Zealand however went through this process a few years ago with case weights and key performance indicators determining funding and care planning. Conferences also provide the opportunity for New Zealand to determine how it stands in health care in comparison to its counterparts. Consistent with other conferences, New Zealand does appear to be ahead in care planning based on evidence based key performance indicators which in turn accounts for the health dollar, and care initiatives at the coal face.

Helen and I were very impressed with how the importance of research and scientific studies permeated all presentations. All speakers supported their presentations with evidence and research and evaluation of new wound care initiatives. Whether it be NPWT, silver dressing, or surgical site infections, wherever whenever there is a change in the delivery of wound care, evaluation and research is a culture that accompanies the introduction, investigation or management of the same in many clinical areas throughout Australia. Furthermore, results were published to share information with others.

While the conference and forum provided Helen and I with plenty of ideas, the main take homes were:

- a more proactive focus on the efficacy of NPWT
- the promotion of wound debridement
- developing standardised wound care plans on evidence and key performance indicators
- the importance of research behind and evaluation of nurse led clinical interventions with the vision of sharing through publication.

I Never Believed I Could But I Did!

Carol Wells, Midwife

I emigrated to New Zealand from the UK 17 years ago. Initially I trained as a Nursery Nurse (NNEB) and worked in the maternity wing at my local hospital, a job I loved. Circumstances led me to train as a registered nurse, by default, so to speak, as the midwife manager wanted more midwives on the unit and wanted nursery nurses out. I thank that midwife manager, as I would have never trained as a nurse had it not been for her. Once again further down the track, circumstances led me onto my training as a midwife (a colleague suggested I would make a good midwife), a career which eventually took me overseas to New Zealand, with my then husband and my two children.

Initially I worked briefly as a core midwife in Taranaki. Once again a colleague was the kick into gear I needed to encourage me to work as a self employed midwife. I joined the group she was in, known as the "Birthrites Group" and blossomed as a midwife. That same colleague had a vision and I became part of that vision and set up in business with her and four other midwives providing Lead Maternity Care (LMC) services for the women of Taranaki, calling ourselves "Partners in Pregnancy" (PIP). I learnt so much in my seven years as a PIP midwife and business woman.

This same colleague, Belinda Chapman, now the Associate Director of Midwifery (ADOM), approached me and asked if I wanted to do the Complex Care Course last year. As a self employed midwife the course would be funded, not only for the course fees, but also for backfill for the study days and study time. I remember thinking I wouldn't be able to do this Post Grad course, because my midwifery course had not been degree level, and also because I am not an academic. I see myself more as a practical person and if honest felt I had achieved a lot since qualifying as a nursery nurse, why should I think I was capable of anything more.

For some reason Belinda persuaded me to look into it, which I did. At the time doing the Complex Care Course would have not fitted in too well with my LMC work and would have put extra strain on my colleagues so I decided not to pursue it. Belinda suggested I speak with Robyn Maude from Victoria University and the next thing I am enrolling to do a Post Grad certificate in Real World Midwifery. My course fees were funded through HWNZ and I chose to take the study days as part of my personal study time so as not to disrupt work too much and away I went.

I never thought I would say this but I really enjoyed the course. I loved being part of a group of midwives from different walks of life and who work in different areas. We laughed together, stressed together and some of us bonded and secured friendships that will continue on. I learnt so much about myself and realised how capable I was at achieving a post grad qualification. I learnt to do successful literature searches, critique research and to write about my passions. There is no denying it was hard work and it consumed mine and my partner's life at the time but in return I gained so much knowledge and confidence and I am so proud of my achievement.

I now work as a postnatal co-ordinator at the DHB and am lucky to be able to continue my study this semester doing the Complex Care Course which will enhance my work as a core midwife working with our complex clients. I now have a five year career plan and am well on the way to achieving this. I hope to do the Clinical Reasoning and Assessment module next year which will give me a Post Grad Diploma and who knows what next!!

I am very thankful to people like Belinda Chapman who encourage and support Post Grad Study and I would like to acknowledge what an amazing relationship we have with Victoria University and not forgetting how lucky we are having the funding to undertake these courses. I would encourage anyone to undertake Post Grad Study and can hardly believe I am advocating how great it is when at the start of last year I never wanted to do it let alone thought myself capable.

Acute Intervention Mental Health Services

Josie van Hoof, Associate Clinical Nurse Manager, Mental Health Acute Intervention Services

"Have you ever wondered how it feels to wage war upon yourself? This is the dark metaphorical truth for anyone suffering from a mental illness. No one of us is the same, therefore each sufferer will experience their own personally tailored degree of suffering, and it is an unpleasant feeling at its utmost level. Depression is a common demon. It brings worthlessness, hopelessness, but most of all lies to the mind of its victim. Essentially if a depressed person doesn't arm themselves with the right tools to fight off all the negativity thrown at them, they will let it consume them. It is relentless like a samurai sword in the firm grip of a ninja assassin. Some of us put on a mask and attempt to fight this ferocious battle alone. A healthy minded person may ask why on earth somebody wouldn't want anyone to know what they're going through. The answer is simple. You are ashamed of your mentality; the lies keep rolling in like waves, set after set, onto the now brittle shore that is your mind. Crash – you are weak, crash – you are a burden, crash – you are guilty of all the feelings that overwhelm you. You try hard to put on a mask and carry on. DON'T forget to smile…The mask or 'fake it till you make it' idea goes against our nature as humans. Think about it from a physical point of view. What do we typically do when we break a bone in our body? Do we carry on as we would and ignore the pain? No, we ACKNOWLEDGE the ailment and seek medical attention from the professionals that are capable of guiding us toward restoration of our original healthy state!"

This is part of an excerpt written by a young man in his twenties when expressing the sadness of losing his friend to suicide. So the medical attention he refers to looks somewhat like this; like most areas in our country Taranaki has acute intervention mental health services available as an option of contact if a person is feeling mentally unwell and experiencing some level of personal risk or feelings of risk toward other people. As public awareness is raised more and more people are utilising their GPs as a point of contact for the things troubling them on a mental and emotional level and not only seeing GPs as the doctors to fix the body. Our GPs are well equipped to treat and offer a wide range of services to those needing help with their mental health.

However, if risk is a factor in the way a person is feeling and thinking then a phone call either from the person themselves or a significant other or a referral from a wide range of other sources make their way to our Crisis Team at Taranaki DHB for advice.

The Taranaki DHB crisis team is a team of mental health nurses and is a 24-hour service. There are two Registered Nurses (RN) on each duty (am and pm) and one RN overnight. Our nurses answer calls, or messages left on an answer phone, and discuss with the caller what the issues are at hand.

Sometimes our nurses find callers are unaware of the role our GPs play in the diagnosis and treatment of mental health issues so after some discussion they may be happy to be directed back to discuss issues with their GP of choice. Often there are risk issues elicited and depending on the acuity of the risk issues the crisis team nurses will respond accordingly.

If the risk to self or others is an acute risk then the team will arrange to see the person for a face to face assessment. This may happen in a person's home, or if a GP has called regarding a person needing extra attention due to risk, this may happen in a GP surgery.

If a person has already been found to have harmed themselves in some way they may be directed to the emergency department and would be seen by our mental health consult liaison, RN or crisis team after hours. People are seen by our crisis team nurses in a variety of settings in the community.

The police are also our community safety officers by intervening in an emergency where a person is at imminent risk of harming themselves or others and keep our public in a safe place to be seen by our nurses.

Our crisis team nurses respond to people with compassion and are adept at listening to the story of the event, asking the right questions and looking at certain queues as to perform a robust mental state examination and a judgment of risk in all cases of face to face contact.

From the assessment there are many pathways of further care that may be used. A person may need to see a psychiatrist so the nurses will arrange for a consultation.

The DHB also have a team of nurses working with clients after a crisis event for a resolution of the crisis or if persons need extra intensive contact in the community. Our acute home based treatment team of nurses work for up to two weeks with people by both phone calling and visiting in the home, ongoing assessment of mental state and linking persons in with community supports as needed.

Our nurses provide this home-based service to people experiencing a severe mental health crisis, as an alternative to an inpatient admission. This is less disruptive and aims to minimalize disruption to daily lives and social networks. The service may also accept referrals for intensive brief follow-up when people are discharged from the Mental Health Inpatient Unit.

Our nurses are learned and compassionion in their interactions with those who are compromised and feeling the need for help, sometimes not even being able to identify what help they actually need. Our nurses have many resources at hand to share with clients and families/significant others. They engage in a very therapeutic way with clients and their families/ significant others and enable those involved in their private pathway toward holistic health.

Handover Module for Releasing Time To Care

Antony North, Registered Nurse

The idea for doing a video was discussed at the meeting for this module, and we here in Ward 3B, wanting to help support positive change in our workplace and put our hands up to be involved.

The challenges we faced seemed insurmountable, mainly because no one wanted to be on camera. But once we came to a decision on that particular point, everything else fell into place with relative ease. Several options were discussed including how to film camera angles etc., and we only really had one bad try at filming before Kareen had the masterstroke of pulling in Mr Grant-Fargie. He very quickly had us ticking and came in with some good ideas, which were incorporated into the final cut. One of the hardest things I found was that I seemed to say "ummm" quite a bit. Trying to put a stop to this was not very easy, but I think/hope I did relatively well to not do this too much. As far as the script was concerned, it was pretty straight forward, as we took it from the module guidelines and then added our own flair to make it more realistic.

Not having a huge amount of knowledge about the RTC handover module prior to being involved, I actually learnt quite a bit from doing the video. Even the simple things, like realising how much the patient feels involved with their care doing the bedside handover.

I also think that the video has helped our nursing staff to understand what is required, as a good percentage of us seem to be visual learners, and seeing such an excellent handover has given them an outstanding standard to aspire to. The other way I believe it has helped, is that it has presented a different means of educating staff. Rather than having someone stand in front of a group and drone on with maybe a handout and a pie chart, it has given people something informative and interesting to watch.

As far as improvements on the ward so far, we are getting there. Up until this point it has taken a bit of pushing to get people to change their thinking and attitudes towards this new process, but things are improving and it is positive and for the benefit of all our patients.

Finally, I have come to realise my true calling... nursing, this acting gig is not for me. Too much ridicule, but I am happy to arrange a time for a meet and greet and I am also happy for my agent to send you a signed photo, let me know.

A Nursing Dilemma

The tension between the RN role to promote independence and autonomy vs the Mental Health (Compulsory Assessment and Treatment) Act 1992

Bruce Jackson and Lauren Cameron, Clinical Nurse Specialists, Mental Health Acute Intervention Service

Mental heath nurses practise in a complex professional environment which is often characterised by tensions between the caring imperative of nursing, and the custodial functions which are embodied in mental health legislation.

This tension can leave nurses feeling that the therapeutic relationship, which is considered to be the essential component of mental health nursing, is compromised by actions that are more consistent with a custodial role.

The concept of the therapeutic relationship concept is considered fundamental to mental health nursing. This interpersonal process underpins the nurse-patient relationship and its central tenets support the patient towards independence and autonomy.

The notion of the mental health nurse as custodian is a concept with origins in the period of asylum care.

Although the role of the mental health nurse is most often described as that of therapeutic agent, this concept is fraught with difficulties as mental health nurses continue to blend custodial role and therapeutic roles, notably in inpatient care and in their roles implementing the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

Roles and Responsibilities created by the Mental Health (Compulsory Assessment and Treatment) Act (1992) – generally undertaken by nursing staff:

- Duly Authorised Officer (DAO)
- 2nd health professional

Mental Health Legislation is often considered by patients to promote coercive and controlling practices, and nurses acting within these legally defined roles can find themselves acting against patients' expressed wishes- especially in the context of the court hearing, which is often perceived by patients to be adversarial.

For example; a nurse whose opinion supports the patient continuing to remain in hospital may be perceived by the patient to be acting in a custodial rather than a therapeutic role.

Patients generally believe the main purpose of the MHA is to ensure they take medication, often initially in a controlling inpatient environment.

2015 Korero Hauora - Health Talk

These thoughts are often compounded by the acute nature of the problems patients are experiencing at these times.

Clinicians, including nurses, believe that (if used properly in most cases) implementation of the MHA can provide a structure for treatment, support continuing contact and produce a period of stability for patients during which other therapeutic changes can occur.

To counter these perceived tensions, it is generally considered for nurses to continue to promote and implement the therapeutic relationship.

- Acknowledge and facilitate discussion on the conflicting roles
- Keep patients informed of the reasons for a decision to invoke the provisions of the Mental Health Act to enable compulsory admission to hospital
- Promote and encourage the patient towards dialogue and participation in their care
- Make explicit to the patient the information that will be presented to the Judge at a hearing, and explain as much as possible the basis for their assessment - the alternative of non-disclosure seems more likely to lead to a perception that the nurses' role is custodial rather than therapeutic.

Overall, whilst nurses consider that their roles in implementing the MHA can potentially harm therapeutic relationships, especially in the short term; when used appropriately the overall benefits can outweigh the perceived coercive impacts for the patient, particularly when the therapeutic relationship remains a central principle of nursing care. The goal of supporting people in the least restrictive and least invasive environment, whilst preserving life and maintaining hope and dignity remains paramount.

Uro-Oncology Co-Ordinator Taranaki DHB

Jenny Corban, Registered Nurse

My name is Jenny Corban, I have been a registered nurse for 23 years and have worked in a number of surgical and outpatient settings across New Zealand and in Perth. Whilst many would know me as an orthopaedic nurse, most recently working in OPD as a plaster nurse, I also have many years of experience in urology as well as several years in oncology giving chemotherapy. I am excited to be in this new and exciting role, making a difference to the patient experience within the urology service. My role follows patients with urological cancers (kidney, bladder, prostate, testicular and penile cancers) along the rollercoaster that is the cancer journey, with its many twists and turns; ups and downs. I work with both the urology and oncology departments to ensure the smooth transition between services and provide emotional support for the patient and whanau along the way.

In 2012, the Ministry of Health (MOH) announced a new health initiative, Faster Cancer Treatment (FCT). The programme aims to improve equity of access to services so that all cancer patients have access to quality care in a timely manner, regardless of their location. My role as uro-oncology coordinator has been created to ensure our Taranaki population is benefiting from the MOH guidelines of care, and that there are no barriers to achieving these equitable timeframes.

The urology service in Taranaki DHB is a contracted service managed by nine urologists, all but one based outside of Taranaki. This variety of clinical experience and expertise is immensely valuable, however with our clinicians changing week to week it is highly likely that our patients see a different clinician every time they present for an appointment. This can make it very difficult to form trusting and quality relationships at a time where anxiety and stress are high and life is full of uncertainty. It is recognised that clinical risk increases with multiple clinicians involved in patient care, as well as an increased risk of unnecessary delays in diagnosis and treatments.

My role is to coordinate the cancer pathway for the patient. I am the key contact for both patient and clinician, providing increased continuity. I develop pathways / procedures so that every patient's journey is seamless and no-one is overlooked. I will coordinate between departments, organise appointments and investigations, making sure they happen in a short timeframe and ensure results and other information is available to clinicians at subsequent visits. I provide education to patients and whanau to ensure they understand the process, treatments and investigations, and that they are able to ask questions and express concerns. I troubleshoot any issues that arise along the way and offer emotional support to help families cope with the stress and grief that a cancer diagnosis and treatment can bring, and involve other members of the MDT as appropriate.

My job will also involve evaluation of the patient pathway as it exists currently and to recommend ways we can improve on our current systems to reduce process delays and increase communication between departments and services to ensure the cancer journey is as smooth as possible.

The pathway for a person dealing with a cancer diagnosis is confusing and overwhelming. The best part of this job is the possibility that I can make a difference. Helping people and their families through the journey by making things a little easier for them is such a privilege. When you meet someone in a great deal of distress you assess their needs and structure care delivery and services to best serve them, give explanations, remove confusion and offer emotional support, you provide them some relief and their ability to withstand the rigors of treatment improves and you have made a really big difference to their experience. It is then that you remember why you became a nurse! This is a job that really makes a difference and I feel so lucky to be doing it.

Sharon Howe at the First Midwifery Practice Day held in Taranaki in 2014 after completing her Level 5 Certificate in Adult Education.

Become a Midwife Educator

Sharon Howe

I qualified as a RCpN in 1986 at Taranaki Polytechnic (now WITT) and I became a Registered Midwife after completing my training at the Royal Darwin Hospital in 1992 and moved back to Taranaki in 1994 with my family to take up a midwifery position at Taranaki Base Hospital.

I have always had an interest in education and mentoring, providing in services and education sessions to colleagues, patients and through necessity to families in my remote rural area, throughout my career as a psychiatric nurse, a Northern Territory aerial medical services remote rural nurse, Well Child/Tamariki Ora nurse and as a midwife. I have been part of the New Zealand College of Midwives Midwifery First Year of Practice mentoring programme since its inception in 2007- having mentored six new graduate midwives in this time and tutored AUT satellite midwives in the early 2000's.

In June 2013, I was working as the postnatal co-ordinator for Taranaki Base Maternity Unit. Our temporary clinical nurse specialist was leaving for greener pastures in Australia and I was asked if I would be interested in taking over the midwife educator role for maternity. I was thrilled with the prospect despite no formal education training. After orientating to the role I began my new life in the revamped position of midwife educator for Taranaki DHB.

I was approached by Belinda Chapman ADOM and Astrid Haesli to enroll in the Southern Institute of Technology's Level 5 Adult Education Certificate programme which while based in Southland, had satellite tutors throughout New Zealand, which meant I did not have to travel for education.

The first session was held here at Taranaki Base Hospital and the following lectures were held at PIHM's in Bell Block. PIHM's had enrolled all their employee's with the purpose of ensuring all their employee's from office staff to lecturers had this Level 5 Adult Education

Certificate so all staff had a base level at least of education. So along with their 72 participants, I became enveloped in the world of learning templates, teaching plans, development plans, unit standards, theoretical models of adult learning, behaviorism, cognitivism, constructivism, Vark, Honey and Mumford, designing and facilitating interactive learning sessions, evaluation and mediation-whew!

What a learning curve and mind shift. After years of holistic nursing and midwifery practice, my poor left brain took a hammering. A completely different life experience from my midwifery/nursing way of life and thinking. Instead of medical or midwifery models, I was working with unit standards, Dunn and Ardvark!

What an enjoyable experience it was. I looked forward to each session and to actually completing my assignments. I loved spending time with non nursing/midwifery colleagues and found them to be a supportive, up lifting bunch of chatty if not sometimes rowdy people. I really enjoyed learning how to make a perfect cup of coffee and how to perfectly make a bed suitable for a five star hotel room on Hayman Island. I am sure, however they did not enjoy my lesson plan explanations of how to suture a perineum or birth a baby who was breech!

I learnt so much about myself and the importance of providing education to all learning styles. I soon realised the importance of completing a lesson plan and learning objectives, to save valuable educator time for future courses. Most of all I came to the realisation that I love what I do and with the experience gained from completing the certificate, I look forward to continuing educating the wonderful Midwives of Taranaki for many years to come. I would like to thank Belinda, Astrid, my midwifery colleagues and my new friends at PIHM for encouraging me to take the course and giving me a continued educated passion for education!

Midwifery New Graduate

Tawera Trinder

Te Atiawa the Iwi
Puketapu te hapu
Taranaki te maunga
Ko Tawera Trinder te ingoa

I am a new graduate Maori midwife who graduated in November 2014. My three years of study included many aspects that inspired, changed and challenged me. As a solo mother of two beautiful children I took the step to commence tertiary study. I was truly inspired by the women, babies and midwives that contributed to my growing passion and inspiration toward my midwifery profession. In particular I was financially challenged, due to solo motherhood, continuous long distance travel, accommodation and the constant pressures of tertiary study. I was awarded two scholarships through the Taranaki DHB that eased a lot of the financial burden I experienced. Not only did I have financial support from the Taranaki DHB, I carried out the majority of my practical and clinical training in the maternity unit. I worked with many core midwives, and doctors that supported me through developing my clinical competence and skills. I also worked alongside many self-employed midwives that shaped my midwifery practice today.

On 21 January 2015 I received confirmation that I passed the national midwifery exam gaining registration. I am currently in my seventh week of practice as a core midwife at Taranaki DHB. The transition from student to midwife was gradual. Not only having the responsibility of women and babies in my care I had to learn the behind the scenes administrative processes and daily running of both the labour and postnatal ward. Both staff and my preceptor through the Taranaki DHB helped me through a lot of the tasks I needed to learn and carry out. I wish to work with the Maori community in my future practice.

I am currently on the Midwifery First Year of Practice programme consisting of one-on-one mentor support, financial support of both compulsory and elective education and facilitates the new graduate into a competent midwife. In addition, this programme provides extensive support for the new graduate with the Midwifery Practice Support person consisting of another named midwife who supports not only the new graduate in general practice but in a clinical supportive role. I have found this programme has supported me immensely in the transition to a midwife. I have found my mentor support has been outstanding especially in the times needed after a challenging shift, I am able to debrief with my mentor which develops learning and reflection. Knowing I can call upon my midwifery practice support person allows me to have confidence in situations I feel I am challenged with or would like that practice support when a situation is anticipated such as a woman birthing under secondary care in my care on the labour ward.

Through the support of both the Taranaki DHB and Midwifery First Year of Practice programme I am developing and growing into a confident practicing midwife in Taranaki.

Nurse Entry to Practice (NETP)

Cameron Grant-Fargie, Nurse Educator, NETP Coordinator & WITT Liaison

The end of 2014 saw the successful conclusion to another first year of practice for the Nurse Entry to Practice (NETP) programme at the Taranaki District Health Board.

There were 21 nurses completing the programme in Taranaki and they were presented with certificates and a glass of sparkling grape juice at the ceremony held in December.

The group can feel a strong sense of achievement and pride in what they have undertaken in 2014. The programme supports nurses by providing a structured preceptorship and education programme including a university paper.

It is always exciting to adjust from being a student to becoming a registered nurse and the responsibility that entails. This programme is designed to make this as safe and efficient as possible.

In 2015 the programme has developed further with three age

care facilities, two general practices and a new grad from Southern Cross involved in the programme. Taking the total new graduates on the NETP programme to 26 participants. We have extended the programme to include district nursing in South Taranaki and those working in Mental Health undertaking specific training with their counter parts in the Waikato.

Credit must be paid to the preceptors, staff and managers who support the new graduate nurses on the first year of practice journey. Support is the most critical factor for success any newly graduated health professional.

Cardiac Arrest Scenarios

Helen Leppard, Clinical Nurse Coordinator

One of the most stressful and dreaded situations on a ward is when a patient deteriorates rapidly and then cardiac arrests. We all attend the required CPR study days but this does not always ensure confidence when an arrest occurs on the ward.

So with this in mind a little over 18 months ago Kareen Mcleod began running an arrest scenario in the ward each month. At first this was very intimidating for staff, in particular for senior staff, as there was a real fear that this would show up gaps in knowledge. So we all attended the first session feeling very wary and determined not to make eye contact with Kareen as this would only encourage her to ask us questions or even worse get us to demonstrate something.

I am pleased to report that exactly the opposite occurred, rather than highlighting our gaps in knowledge, it confirmed that we were indeed competent in an arrest situation. As each scenario took place it was awesome to see the confidence of the staff grow, we have had a wide variety of scenarios, from a patient in the bathroom to an emergency situation caused by a chest drain falling out, even a visitor in the lounge arresting, each situation challenging the staff in different ways.

The success of these scenarios, I believe, is seen most when an arrest occurs on the ward, staff react in a much more calm and efficient way, staff know their roles and perform these to a very high level. I even have staff ask if they could be rostered on when the next scenario is planned so they can be part of it. There is no substitute for practice and this is exactly what these scenarios have provided for us on a regular basis.

New Nursing Initiative to Reduce Seclusion and Restraint 'Intensive Nursing'

Hayley Scott and Glenda Schumacher, Clinical Nurse Specialists, Inpatient Unit

One of the new initiatives in Te Puna Waiora acute mental health inpatient unit is intensive nursing. This is an intervention that is often misunderstood due to familiar interventions of 'being specialed' or placed on 'constant observation'. Intensive nursing is a planned coordinated and intensive level of direct care, typically in a 1:1 ratio of nurse to service user however on occasion this level may increase or decrease to 2/3:1 or even 1:2. This designated level of care occurs under the direction of the clinical nurse specialist or shift coordinator where the person's safety and well being are considered at high risk and recovery might otherwise be compromised. The goal of this intervention is to maintain safety and minimise the potential of restraint and seclusion by working intensively with the person. It also decreases the need to automatically transfer to IPC as anecdotally we know that once a person is transferred to IPC the chance of seclusion increases. Rather than rely on environmental factors, intensive nursing relies on the skill of the nurse.

The decision to initiate intensive nursing is made in recognition of Te Puna Waiora striving to minimise seclusion and maximise care in the least restrictive environment. Embedded in such decisions is an understanding of trauma informed care, therapeutic relationship and interventions working in partnership with service users. Many studies have highlighted problems with hospitalisation into an acute mental health unit which include excessive use of coercive measures and lack of involvement of mental health consumers and their families in planning treatment (Cleary 2004; Deacon et al., 2006; O'Hagan, 2006). Intensive nursing is one way of addressing this imbalance.

The following cases highlight how an intensive nursing approach impacted positively on outcomes for service users.

Prior to the introduction of intensive nursing, this service user had numerous admissions under the Mental Health Act (MHA) directly into the IPC (locked) area. Based on previous history, high risk presentation and suicide attempts, this person had all personal property removed, dressed in a safety stitched gown and nursed on a constant with a strict inflexible clinical management plan.

When this person was readmitted (twice) in times of acute crisis, she was given the option of voluntary admission and intensive nursing, allowing the clinical management plan to be more flexible, holistic, and client centred. IPC has not been used and there have been no seclusions or restraints since this plan of intensive nursing has been put in place.

Usual practice was to admit service users to IPC under the MHA when they require rapid tranquilization during periods of acute psychosis and relapse. Now however we are able to deliver this same intervention utilising the least restrictive environment either in the quiet or open areas of the ward with an intensive nursing approach with minimal use of the MHA.

Service user with psychosis under MHA initially admitted to the open area became increasingly aggressive throughout the admission, voicing feelings of claustrophobia and frustration with threats of wanting to leave and self harm. She was transferred to the quiet area and intensively nursed, utilising sensory modulation and supervised access to isolated courtyard to allow her to vent frustrations and release physical tension in safe and supported environment.

Why Intensive Nursing?

In general, observation is an important nursing skill, and is imperative to safety in the acute phases of mental illness, when some people become a risk to themselves or others. The objective is to prevent potentially suicidal, violent or vulnerable patients from harming themselves or others. In Te Puna Waiora there are several levels of observations ranging from 15/60's where the person's whereabouts is checked on every 15 minutes. This is usually allocated to non registered health professionals such as Psychiatrist Assistants (PA) or Healthcare Assistants (HCA) to do under direction and delegation of the registered nurse. Alternatively it may be deemed appropriate to have a PA or HCA with the person continuously, either in the same room within eye-sight, or in some situations within arms reach. However 'observation' is not simply a custodial activity. It is an opportunity for on-going assessment, engagement of the service-user and development of a therapeutic alliance. Engagement with the service user is at the heart of establishing a trusting therapeutic alliance and registered nurses are ideally situated to do this. Intensive nursing relies on the nurse to have the skills to develop a therapeutic alliance, utilise de-escalation skills (specific training available) and various approaches including talking therapy modalities such as motivational interviewing, cognitive behavioural therapy, brief solution focused therapy, mindfulness and sensory modulation and distraction techniques.

Acute mental health nursing relies on the skill of the nurse. Knowledge, experience and expertise are the tools. The very nature of acute mental health nursing is multi-faceted and complex. We work within a physical environment that poses incredible challenges, the people we work with are often at their most vulnerable and often problematic behaviours such as severe self care deficits, self harm or aggressiveness that are often a result from the acute phase of mental illness and requires nurses to be proactive in assessing client's individual requirements. Intensive nursing occurs because nursing staff determine that the balance of risk associated with seclusion is unacceptable despite this intervention possibly being indicated to reduce the risk. This is a critical point in the decision making process. There is much more emphasis on reducing seclusion and restraints. Mental health and intensive nursing requires specialised skills in order to develop and maintain therapeutic relationships with service users and to work within a 'recovery approach' paradigm. Recovery is a familiar discourse within mental health services in New Zealand and underpins mental health policy and service delivery. Recovery based practices are based on empowering service users , maximising opportunities to develop the person's own resources, ensuring their rights are met, activating the right supports to meet their needs and nurturing hope. This approach also emphasises the need for treatment to occur in the least restrictive environment, minimise disruption to people's lives, and empower mental health consumers to fully participate in decisions around their treatment.

As has already been mentioned, the therapeutic relationship and engagement is very much at the heart of intensive nursing and is the nurse's responsibility and depends on the nurses communication skills, knowledge and experience. Whilst we acknowledge delivery of quality care is a consistent expectation across all specialties, these concepts are understood somewhat differently within mental health. At the very heart of mental health nursing care is the therapeutic relationship, from which all care planning related activities arise. Mental health nurses utilise foundational interpersonal skills including empathy, trust, and respect to develop rapport with the person and engage therapeutically in order to support the individual in moving towards self-identified goals.

The therapeutic relationship is critical in supporting a safe environment where access to nurses is required to assess mental state and risk, including suicidal, homicidal, violence, vulnerability and other risks and intervene as appropriate. The priority is to identify and act early to minimise relapse, prevent near-miss suicide attempts and de-escalate violent behaviour to avoid harm to the individual and/or others. The complexities of environmental challenges requires the nurse to have a higher level of skill when managing complex and potentially volatile situations which can be overcome with a therapeutic alliance and de-escalation skills. The undertaking of a mental health and risk assessment as a discreet process is a highly developed skill utilised by mental health nurses. Likewise, certain features of 'understanding' and empathy also require highly developed skills. The ability to understand a person's needs from non-verbal cues and to attribute meanings to behaviours is a skill that mental health nurse's use and the ability to maintain empathy for a person who may be projecting aggressive verbal attacks or disclosing disturbing and/or sensitive information.

In order for service users/Tangata Whaiora to receive the maximum benefit from their period of acute inpatient treatment and to minimise the risk of disruption to their treatment plan we promote continuity of care by trying to organise the same nurse to provide intensive nursing where possible.

It is acknowledged that this change to the model of care for high risk service users is likely to require an increase in staffing to facilitate this level of intensive care. Often when liaising with allocations and DRN's we have been asked "what does intensive nursing mean? As you can see it is more than just observation and we have a clear mandate to avoid seclusion and restraint if at all possible.

"The caring and respectful way all staff performed their duties (doctors, nurses, orderlies, therapists, cleaners, and health care assistants, often with a sense of humour and way of making patients feel valued."

"Friendly and caring"

Thank you

Our heartfelt thanks to all our nurses and midwives who work tirelessly to provide around the clock care and support to our patients. Your valued contribution is appreciated and makes a huge difference to the lives of so many.

Happy International Nurses Day and International Midwifery Day 2015

"Nothing was any bother"

"Couldn't do enough for me"

"Always a smile"