

# TE PUAWAI

*The Blossoming*



The Professional Update for Registered Nurses

April 2016

# TE PUAWAI

*The Blossoming*

## **Whakatauki**

***Kia tiaho kia puawai te maramatanga***

***“The illumination and blossoming  
of enlightenment”***

This whakatauki highlights the endeavours of the College of Nurses as an Organisation which professionally seeks enlightenment and advancement.

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**PO Box 1258, Palmerston North 4440**

**[www.nurse.org.nz](http://www.nurse.org.nz)**



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# Editorial

**Professor Jenny Carryer RN, PhD, FCNA(NZ) MNZM  
Executive Director**



*Jenny Carryer*

Lately I have been thinking a great deal about the conundrum of clinical leadership. Since the National Government came to power in 2008 there has been increased political rhetoric about the value and importance of clinical leadership. This could be seen as an ironic reversal of the steady implementation of generic management under the National Government of the 1990s.

Firstly I am never 100% sure when politicians or policy makers refer to clinicians or clinical leadership, whether or not they are actually thinking about nursing alongside medicine. Probably some are and probably many are not. But more importantly I have become increasingly aware of the challenges for clinical leaders to genuinely impact the decision-making processes where there is a substantial management presence.

Recently I was privy to the distress of a senior nurse clinician. After some years of sharing disturbing audit data with appropriate management to no effect, she shared the data in a conference presentation as an example of the pitfalls of the audit process. Suffice to say that a fairly punitive response quickly followed. With courage and commitment she continues in her current role but without any particular changes to the level of service being provided to her patient group despite the obvious evidence based need.

Inherent in clinical leadership is the ability to assess patient need and ensure that a service is responding safely and effectively. Clinical outcomes and patient safety are the overriding focus of clinicians of any ilk. In order to actually make such changes one needs budgetary authority and control of staffing decisions. Alternatively one needs to know that one's advice will be taken seriously by those who do control the budget or hold the power to alter staffing levels.

But those who most often hold that power are frequently focused on the need to address the "bottom line", meet imposed targets and ensure that the organisation is not brought into disrepute through failure to meet external and often public accountabilities. District Health Boards are deeply risk averse but it seems to me as an outside observer that they are focussing on the wrong kind of risk and thus generating much more significant risks in the process.

If we genuinely valued clinical leadership then the activity of the clinician described above would be celebrated and applauded. Her only driver was patient safety. Theoretically it is what we all care about most! And theoretically it is the whole point of clinical leadership.

# Pressure Injuries

Article Supplied by: Dr Jan Weststrate

## History

Pressure injuries have been around for many years. The oldest pressure injury wound that we know of dates back to 1000 BC and was discovered by Thomson Rowling on the mummy of an Egyptian priest (Rowling, 1961). The Dutch surgeon Frabricus Hildanus described for the first time in 1593 the clinical characteristics of a pressure injury which he called at that time “Gangraene” (Defloor, 1999). At a later stage (1777) Wohlleben added the word decubitus to and called it “gangrene per decubitus” (tissue necrosis by laying down) (Bouten, 1996). In his opinion, the three most contributing factor in the development of pressure injuries were: natural external factors, supernatural internal factor and interruption in the blood supply.

From a nursing perspective Florence Nightingale was the first nurse that we know of that commented on the role that nurses have in the prevention of pressure injuries. In her famous book “ notes on nursing she writes; “If he (the patient) has a bed sore, it is generally the fault not of the disease, but of nursing” (Nightingale, 1860). She was also aware that having a pressure injury is a serious condition as she writes. “another who cannot move himself may die of bed-sores”. Overtime these statements have been used to blame nurses for the development of pressure injuries which is of course a very one sided view on the topic (Zuelzer, 2011).

In the last twenty five years it has become evident that most pressure injuries can be prevented (Black et al., 2011). Registered nurses and health care assistants as frontline staff play a pivotal role in this. The question is whether the healthcare system allows them to provide the care clients need to prevent the development of pressure injuries? With an increased fragmentation of care providers and increased pressure on reduced staffing levels the “acute” often triumphs over the “long term” priorities”.

## Pressure injuries as a Nurse sensitive indicator

Pressure injuries are regarded as a nurse sensitive indicator in the literature (Heslop & Lu, 2014). There are several definitions provided for nurse sensitive indicator or surrogated terms (Outcome indicators, nursing performance indicators, patient safety indicators and outcomes potentially sensitive to nursing). For this article I use the definition given by the National Quality Forum (2004) (Heslop & Lu, 2014).

*“A nurse sensitive performance measure as processes and outcomes-and structural proxies for these processes and outcomes( e.g. Skill mix, and staffing hours) that are affected, provided and / or influenced by nursing personnel but for which is nursing not exclusively responsible”.*

This definition acknowledges two important aspects in providing optimal care in the prevention of pressure injuries.

1. Nursing has a responsibility in the prevention of pressure injuries
2. Nursing is not exclusively responsible for the prevention and / or development of pressure injuries

The definition acknowledges that nursing is working within a wider healthcare system that influences the quality of care of the nursing profession produces. This theory connects with the model for delivery quality of care which was first developed by Donabedian in 1966 (Structure process and outcomes) (Donabedian, 1966). The model describes “structure” as how we organise care, “process” what we do and “outcomes” are what we achieve (Makary et al., 2006)

In a concept analysis “Nursing sensitive Indicators” Hislop and Lu (2014) conclude that there is support in the literature to use the prevalence of pressure injuries (among other clinical topics: falls, falls with injury, nosocomial elective infection and patient / family satisfaction with nursing care) as an outcome measure (Heslop & Lu, 2014). Here the structural attributes of the concept were deemed to be hours of nursing care per patient day and nursing staffing (staff & skill mix and staff ratio). No particular process attributes could be identified which is not surprising considering the variety of clinical topics affected. All this suggests that when measuring a nurse sensitive indicator such as pressure injuries it must include measuring structural, process and outcome components.

## Structural indicators

Making sure the structural indicators of pressure injuries are in place is a managerial responsibility. Those who work at the bedside should be provided with the tools that enable them to provide optimal care in the prevention of pressure injuries. These structural indicators first need to be supported by the MoH, then disseminated throughout the different DHB, hospitals, aged care facilities and private hospitals arriving ultimately at department level. Examples of structural best practice indicators are:

- ◆ The presence of a multidisciplinary pressure injury prevention committee in the facility
- ◆ The presence of approved protocols for the prevention and treatment of pressure injuries
- ◆ Conducting regular audits to ensure compliance with protocols and guidelines
- ◆ A pressure injury prevention information brochure for family / care givers
- ◆ A standard handover policy during admission and discharge of a client with pressure injuries

Within the New Zealand healthcare context there is evidence some of these structural indicators are not in place at DHB level. A 2012 survey across all DHB's showed that 15 of the 20 DHB's had a pressure injury prevention committee in place and eleven never carried out pressure injury prevalence audits (Blake, 2012). The 2014 edition of the National Survey Care Indicators (NSCI-NZ) carried out in the six DHB's of the lower North Island showed that 5 of the six DHB had a

pressure injury committee in place and 1 DHB had a pressure injury prevention information leaflet available (Weststrate, 2015).

## Process indicators

Measuring compliance with process is the second important aspect in pressure injury prevention. The new 2014 pressure injury guidelines provide us with the most up to date information about what should be included in the pressure injury prevention process and what to avoid (Haesler (Ed.), 2014). An example of this is the guideline to “use a structured approach to risk assessment that is refined through the use of clinical judgment and informed by knowledge of relevant risk factors”. This highlights that clinical judgement is a critical factor in the risk assessment process beyond ticking boxes on the pressure injury risk assessment scale. The aspects of the process are the use of pressure reducing material like cushions and mattresses, providing the client with information, checking the nutritional and hydration status, the need for regular turning schedules etc.

These general guidelines need to be translated to the day to day practice for the individual ward on which they will be used. Measuring compliance with the prevention process is critically important to explain the outcomes.

## Outcome indicators

Measuring the outcome is important as it tells us whether we achieved what we predicted in the first place. Without connecting outcome to the structure and process indicators, they are all disconnected bubbles floating in the air, open to random interpretations. The danger is that quality outcome indicators are going to act as performance outcome indicators which ignores asking WHY?

There are a number of outcome indicators to focus on in the prevention of pressure injuries. Internationally a difference is made between category I pressure injuries and category II,III and IV pressure injuries. With category I pressure injuries the skin is intact and by relieving the pressure the non-blanchable erythema is still reversible. At category II and higher the skin is broken down and treatment is needed. Other outcome indicators are deterioration of the pressure injury category. This may highlight that the method of prevention is not effective for this client.

## New Zealand

Are pressure injuries a burden for the New Zealand healthcare system? It all depends on who you ask. The wound care specialist will acknowledge the problem is huge. ACC received 349 treatment injury claims during the years 2012-2013, the 2014-2015 serious adverse event report shows that 19 pressure injuries are reported as serious adverse events (Health Quality & Safety Commission, 2015). The interRAI data tells us a pressure injury prevalence of 8.4% on the 31.000 residents that

were assessed (KPMG, 2015). Pressure injuries are recorded in the National Minimal data set. Between 2008 and 2011 coders recorded 12,485 pressure injury events (Blake, 2012).

These variations in outcomes tell us that we actually have no idea whether or not pressure injuries are a burden for the New Zealand healthcare system. We also conclude that to some authorities there is an under-reporting, particularly to those who have the obligation to report publicly. These differences in outcomes are confusing, inhibit learning and encourage us to keep pressure injuries “literally under the covers”.

### **Suggestions for moving forward**

Before we are able to move forward we need to know where we are. This requires the collecting of reliable data on pressure injuries. Without repeating the discussion about measuring the burden of pressure injuries by prevalence or incidence, it is evident from the literature that prevalence is the most frequently used method to do so. Pressure injury prevalence studies are carried out in a number of DHBs in New Zealand but what is lacking is agreement to adhere to a robust national data collection method and analysis strategy. This is of critical importance to create a national pressure injury data set from which learning can take place to benefit the whole health care system rather than a few facilities or DHBs.

Moving forward also includes following Donabedian’s model and measuring pressure injury structure, process and outcome indicators. Focussing purely on outcome at a national level brings polarisation between those that do well and those that do not do so well. Answering the why question remains the most important ingredient for motivating change. There might be a difference in frequency in measuring the different types of indicators. At structural level changes will not happen as quickly as they do at client level. In order to answer the “why” question effectively, outcome measures always need to be accompanied by process measures. The level of adherence to pressure injury prevention protocols assists in explaining the effectiveness of the prevention strategy.

A recent NZ proposal to use the NHS Safety Thermometer as an instrument to measure the burden of pressure injuries for New Zealand violates this principle as it only measures the outcome. We note a recent published critique comparing a number of pressure injury reporting systems in the UK which included the NHS Safety Thermometer. All showed a high level of under-reporting when audited according to the golden standard (full skin inspection of the client by two independent qualified clinical members of staff) (Smith, Nixon, Brown, Wilson, & Coleman, 2016). This again relates to adhering to the importance of a robust method of data collection.

Moving forward includes transparency. Transparency for health care consumers but also for Health Care Professionals. Consumers need to know which facilities adhere to pressure injury structure and process best practices that are supported by the guideline and which haven’t. Many consumers are becoming more and more healthcare literate and by providing them with real information the system treats them respectfully.

As the prevention of pressure injuries is a nursing care indicator, it seems logical to let the nursing profession lead a national pressure injury prevention program. The nursing profession understands as no other health care professional the tension in providing optimal care to the client.

Connecting with other similar international pressure injury prevalence programs is another way to move forward. It provides New Zealand with the opportunity to gain insight as to how other countries handle the issue of preventing pressure injuries. New Zealand can learn from these initiatives and other countries can learn from what is done in New Zealand. Good international example of programs that measure pressure injury indicators at structure, process and outcome are the CALNOC study in the US (Stotts, Brown, Donaldson, Aydin, & Fridman, 2013) and the LPZ study of the University of Maastricht in the Netherlands, both programs have existed for over 15 years and have a wealth of data (Halfens et al., 2013). The School of Nursing at Massey University is currently running this program in New Zealand. Another great example of international collaboration is the participation of the New Zealand Wound Care Society in establishing the new International Pressure Injury Guidelines (Haesler (Ed.), 2014).

In conclusion, the problem of pressure injuries has been around for some time. Over the last 75 years considerable attention has been given to get a better aetiological understanding of the problem. Despite a better understanding it has become evident that most pressure injuries are caused due to a failure of continuity of care. As such, preventing them requires a system based approach. Currently New Zealand can only estimate the burden of pressure injuries due to inconsistencies and underreporting. Measuring progress using Donabedian's quality model (structure process and outcomes) provides an adequate strategy for preventing pressure injuries in New Zealand. The nursing profession should lead this important work and connect with existing international programs to build partnerships and accelerate learning.

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# The Nurse Practitioner Intern Supervisor/Mentor Project

Article by Liz Manning RN BN MPhil FCNA(NZ)



Over the last few years the collective drive towards development of Nurse Practitioners (NP) in New Zealand has focused strongly on the academic and clinical preparation for advanced clinical practice and great steps forward have been made. There has however been no targeted focus on the skills required to be a supervisor/mentor to these highly skilled nurses. A project is now underway which shifts the focus onto health practitioners who are supporting, supervising and mentoring our NP interns.

*Liz Manning RN BN MPhil FCNA(NZ), Project Manager*

*'Setting out to become a nurse practitioner is a bold move and no easy task; anyone doing so needs all the help they can get. We also know the people providing support often welcome assistance too. The NP support and mentor project will provide an easily accessible quick online reference guide for anyone who has taken on board the important task of helping our interns become the best of the best.'*

*Dr Mark Jones, Project Lead.*

In late 2015 the executive of the College of Nurses (NZ) and Nurse Practitioners NZ discussed the need for resources which could quickly, concisely and effectively inform practitioners who are approached to be supervisors or mentors of NP interns. The College committed to undertake a project to develop these resources.

The aim of the project is to establish a suite of online tools, accessible to the public, which will concisely deliver some important messages about becoming an NP supervisor or mentor, including;

- The NP intern supervisory process and how to best observe and facilitate reflective practice.
- NP scope, domains and competencies- reviewing the scope and the requirements of advanced practice.
- NP application process- evidential requirements, portfolio development, writing a reference.
- Prescribing practice- reviewing practice against domain four and auditing.
- Employing an NP intern- contractual requirements and job descriptions.



A small project team has come together, sponsored by the College Executive Director Professor Jenny Carryer, with Dr Mark Jones as the project lead. The project team has representatives from the Nursing Council, NPs, post graduate academic staff, a General Practitioner and College administrator. Alongside the project team are some key sector experts who will bring different sets of skills and knowledge to the project.

The resources will be multimedia, a mix of short video clips, web links, key documents, guidelines and audio presentations. The project team has been very fortunate to secure the assistance of Tanya McQueen, Director of [Global spirit films](#), who will film and edit the video clips.

The project is in its early stages but aims to have resources up and running on the College website by mid-2016.

# 2015 National Nursing Informatics Conference

Report by Liz Manning RN BN MPhil FCNA(NZ)

The National Nursing Informatics Conference was held at the Air Force Museum in Christchurch on 19th October 2015. A large turnout of delegates and some excellent speakers saw an inspiring and thought provoking day linked together with great networking. HiNZ also developed a conference 'App' to link delegates, circulate information, presentations and competitions for the Nursing conference and the following 2 day Health Informatics conference.

Hector Matthews, Executive Director of Maori Health at Canterbury DHB opened the day and warmly welcomed delegates and speakers to the conference while thanking organisers and sponsors. The opening address was delivered by Denise Kivell in her role as chairperson of Nurse Executives NZ.

Keynote speakers:

**Kim Mundell**, HiNZ CEO delivered an excellent session challenging nurses to take a lead in the informatics world. Kim, originally a registered nurse stated that health informatics underpins the nation's ability to deliver flexible cost effective health care. HiNZ, a neutral professional body supports the entire field of health informatics and in her role as CEO Kim meets with a broad range of influencers and leaders in the field, but asked 'where are the nurses?' She named a small number of nurses who are highly regarded in informatics however, there is a need for nurses to be taking a lead across the sector in delivery of projects. Other clinicians are approached and asked for opinions and advice, but nursing is still a quiet voice. Kim challenged nursing to grow confidence in the language of informatics and to challenge processes that don't fit with nursing needs and to articulate what will work for patients and nursing.

**Gabe Rijpma**, Sr Director Health and Social Services, Microsoft Asia, delivered a thought provoking session on the role of technology in changing healthcare delivery. He talked about 'care without walls' and utilisation of patient sensors, monitoring devices, telemetry and virtual care consultation. He challenged the delegates to consider 'how positive is a hospital visit?' and 'what outpatient work can be done virtually?' Focus was on keeping well and use of predictive care management as well as integration of workflows from service to service and between health professionals using an 'intelligent cloud'.

A well-received innovation was the developing work to remove the need for passwords by using facial recognition. He went on to state that technology isn't the barrier, so much is now possible, commitment and capital investment in technology is now the barrier to changing the way we manage health.

**Associate Professor Karen Monsen** from the University of Minnesota School of Nursing, discussed how data from the electronic health record can bring the voice of nursing practice into policy and research. She used highly effective visual ideas of 'bling and donuts' to demonstrate how 'big data' can show the impact of nursing interventions. Dr Monsen challenged evidence based practice as being rigid, inflexible guidelines, promoting the more flexible practice based evidence and reported that it is possible to use large datasets of structured and unstructured information with different approaches to analysis to find out if intervention practices relate to patient outcome. She encouraged New Zealand nurses to let the data speak and suggested that unlike the massively complex, non-collaborative health insurer system in the United States, we have a distinct advantage in collecting data as we have a small country with public health and NHI systems.

The day continued with more excellent presentations on nursing documentation and electronic health records, use of apps and websites in health, tele-consultation, nursing observations, midwifery data systems and nurses leading IT innovation.

Sheree East and Kim Mundell together with their teams really did a great job and were pleased to announce another conference at Auckland's Sky City on 3 November 2016.

## ***Moving House or Changing Job***

**Please remember to update your contact details with the College office.**

**Email: [admin@nurse.org.nz](mailto:admin@nurse.org.nz)**

# Method or Madness?: The Dominance Of The Systematic Review In Nursing Scholarship

**Article by: Annemarie Jutel**

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**Aporia The Nursing Journal** can be viewed here: <http://www.oa.uottawa.ca/journals/aporia/>

In 1972, Irving Zola published his seminal piece, “Medicine as an institution of social control,” in the journal *Sociological Review*. This eloquently written article defines medicalisation and develops an explanatory theory for medicine’s expanding jurisdiction and social authority in contemporary society. This piece stood in contrast to his earlier empirical social science research, interviewing attendees at the Ear Nose and Throat clinic about their presenting complaints. [1] He could not have known at the time, any more than could have his publishers, the impact that his reflections on medicalisation would have on the field. Presented differently, reflecting different methodological perspectives, both publications nonetheless contributed to furthering of the sociology of health and illness.

As the example of Zola underlines, there are many ways to advance knowledge, and scholarship takes many forms. A discipline which is generous in determining what it values as scholarship and how it can be presented is poised to embrace the novel, the exceptional and the transformative. Who would have thought, for example, that comedy might contribute to academic discussions of medicine? The benefit of hindsight shows us the importance of Leonard Stein’s 1968 “Doctor-Nurse Game”. [2] This text was included in a tome entitled “classic texts in health care” [3], and is cited prolifically in nursing, medical and interdisciplinary journals which explore inter-professional relationships in health. Remarkably however, this article was presented as humour, complete with cartoon caricatures of swan-necked, white-capped sisters, and eyebrow-raised, stethoscoped medical specialists throwing darts at a professional wheel of fortune. It is not alone in its genre. Richard Smith’s [4] light-hearted “In search of non-disease” made important points about the social framing of disease which have been well-exploited by numerous academic writers since its rather recent publication.

Like humour, simple stories also deliver important truths. Arthur Frank’s *At the Will of the Body*, an account of his personal experience of serious illness is a poignant example of scholarship through narrative. His stories and others like it now buttress a wide range of disciplinary discussions in nursing, social science and medicine. I take particular inspiration in my own work from Suzanne Fleischmann [5] and Mildred Blaxter’s [6] respective (and poignant) accounts of the diagnostic trajectory in illnesses which were ultimately to prove fatal to both. They “speak” eloquently to me as nurse, as I identify with the authors’ suffering, but they also highlight important critical principles like the transformative nature of the diagnostic label, and the silencing impact of diagnostic technology.

Medical journals acknowledge the importance of such stories in health care practice: Annals of Internal Medicine includes a regular doctor-as-patient stories, just as the British Medical Journal invites authors to submit stories about memorable patients, mistakes, and anything else that conveys “instruction, pathos, or humour.”

Despite the example set by medicine and sociology, nursing is restricting, rather than expanding, what it allows authors to present. This is a situation which requires rapid redress. In the paragraphs to come, I will describe how the journals which stand for the mouthpiece of nursing have become overly concerned with presenting its scholarship and talking about its discipline in a standardised and exclusionary manner. This reflects a positivistic, audit-oriented belief in knowledge generation that is stymieing our profession and its scholars. This approach emerges from a devotion to evidence-based practice, and persists to the detriment of the field. An overreliance on systematic review trivialises nursing’s intellectual autonomy, instead, instilling method and design into a hierarchically unjustified supreme position.

The idea of combining the results of more than one study of a similar phenomenon in order to increase their impact is at the heart of the systematic review. Early attempts at this approach were undertaken by Karl Pearson[7,8] and Ernest Jones, whose work was only “discovered” in 2003[9] by an Anglocentric field, ignorant of Jones’ publication (written in French) which reviewed material published predominantly in French and German. Ronald Fisher presented statistical techniques for using the results of independent studies to predict probabilities in 1932.[10]

But the practice did not become prevalent until the second half of the 20th century. In the late 1970s, a number of summarizing research papers were published, including Hall’s[11] “Gender Effects in Decoding Nonverbal Cues,” Smith and Glass’[12] “Meta-analysis of Psychotherapy Outcome Studies,” and Rosenthal and Rubin’s[13] summary of 345 experiments studying the tendency of researchers to obtain results they expect because of their influence in shaping responses. This study did not attempt to assess the quality of the individual experiments, rather to encompass the results of all existing studies. Their paper, they suggested, could serve as a methodological template for summarizing other entire areas of research.

Evidence based practice enhanced the prominence of this method, as both rely upon the same premises. Archie Cochrane’s 1972 diatribe on Effectiveness and Efficiency is at the base of the contemporary evidence based practice movement. There, he lamented the absence of measurement of effectiveness of medical interventions and described the randomised controlled trial as a tool for “open[ing] up the new world of evaluation and control” and perhaps saving the national health service.[14]

The systematic review is “the application of scientific strategies that limit bias to the systematic assembly, critical appraisal, and synthesis of all relevant studies on a specific topic”.[15, p167] This definition emerged from the Potsdam Consultation: a consortium organised to assess and address the production of high quality meta-analysis and review of randomised controlled trials. The Potsdam Consultation developed a list of guiding principles and a methodological overview covering protocol development, search strategy, study selection, quality assessment, analysis, evaluation of heterogeneity, subgroup analyses, sensitivity analyses, presentation, interpretation, and dissemination.[15]

The over-arching theme in definitions of the systematic review is the notion that the review is a form of research itself. Webb and Roe refer to the systematic review as “Pieces of research, which aim to identify, appraise and summarise studies of relevance to a particular topic”.<sup>[16]</sup> Straus and colleagues describe it as “A summary of the medical literature that uses explicit methods to systematically, search, critically appraise, and synthesize the world literature on a specific issue”.<sup>[17]</sup>

In any case, the prominence of the systematic review is buttressed by the similar prominence of evidence-based practice in clinical practice and decision-making. Yet, Goodman<sup>[7]</sup> has pointed out that there is an important tension between between efforts to make medicine more scientific and remain true to “clinical judgement,” a tension which is present in nursing discussions of EBP. Many have railed against the prominence that the tenets of evidence based practice have assumed in nursing. Gary Rolfe, for one, has maintained that EBP is open to many of the criticisms that it directs at other forms of knowledge generation. It lacks the “hard” evidence to support claims of its validity that it requires of other forms of practice. Evidence based practice fails to meet its own standards, “it is no more based on evidence than the forms of practice it seeks to replace” he writes .<sup>[18 p85]</sup>

Others have pointed out that evidence-based practice is the fascist imposition of a empirical project—a dominant ideology excluding alternative forms of knowledge.<sup>[19]</sup> The dominant hierarchy privileges certain kinds of research, and particular positions. Morse<sup>[20]</sup> positions EBP as a politics of ignorance—myopic and exclusionary—which uses Cochrane standards for evaluating funding for all forms of research. It is a fine sieve which ends up funding drug trials by the powerful, and relegating qualitative researchers unable to access funds, credibility, and importantly, power.

Many authors, including myself, have argued that EBP is a significant means for advancing nursing knowledge, but not one which should be used to the exclusion of all others. I have used the example of ‘overweight’ as a heuristic for understanding the limitation of EBP. Whilst EBP may be useful for describing epidemiological trends in BMI, the effectiveness of interventions for reducing weight, or the correlation between overweight and other pathologies, its preferred forms of evidence can neither capture nor explain the depth and breadth of the weight loss question. It fails to demonstrate the use of weight as an unreliable proxy measure for lifestyle practices; the ethnic insensitivity of BMI and its contribution to the marginalisation of underprivileged populations; the range of commercial interests are served by the promotion of overweight-as-disease; the role of aesthetics in clinical assessment; the cultural and historical frames in which the discourse of weight is a reflection of inner character, and so forth.<sup>[21]</sup>

Despite the fact that there isn’t full agreement about the place that evidence based practice should hold in nursing, it has an iron grip. And, we’re not working hard enough to loosen it. This is a shame; rather than increasing nursing knowledge, EBP is replacing it, substituting its episteme for ours.

I’ll return to the review article, which is EBP par excellence, and what’s more, is a perfect heuristic for recognising how we’ve sold out. Reviews have a constitutive role for a field.

They juxtapose, explain and analyse an assembly of related concepts which both author and publisher believe worthy of dissemination to the discipline. They are used as research resources, teaching tools, and in the digital age, means by which journals and authors achieve notoriety.

Because of their function as broad-brush summary of a topic, and subsequent utility as pedagogical aid, they result in high citation counts, which in turn result in high bibliometric ranking: a measure of status in contemporary academe. Unabashedly, most nursing journals recruit the review, knowing full-well its ability to influence the field, and reap benefits for the journal.

The review article is a criterion by which nursing defines itself and its priorities: those subjects worthy of review. In a Bourdieuan framework, the review is part of the cultural field or the “series of institutions, rules, rituals, conventions, categories, designations, appointments and titles which constitute an objective hierarchy, and which produce and authorise certain discourses and activities”. [22, p21]

When one looks at the discursive construction of the review article, in any of a number of contemporary nursing journals, one is confronted by the dominant and unwavering presence of evidence based practice. Instructions to authors include the mandatory use of sub-titles such as “design,” “methods,” “quality appraisal,” “data abstraction,” “synthesis” and “results.” Links to useful resources point authors exclusively to QUORUM statements, Cochrane Collaborations, EPPI, NICE and other EBP-based assessment tools. There is a salient absence of references to the academic traditions of reading and writing, promoting the systematic review as the standard to which nursing authors should aspire.

The language used these journals is the kind that MacLure [23] describes as a mix of scientific positivism and audit culture rhetoric, reifying the way in which texts must be approached. As MacLure so aptly represents, what is left unspoken in the discursive representation of the systematic review are the important themes of analysis and interpretation. The lexicon privileges audit over textuality, reproducibility over illumination. She describes the, ...fantasy of a text-free knowledge economy, where nuggets of evidence can be extracted from the rhetorical contaminations of persuasion, argument, justification, context and partiality that are inherent in all texts ... an ancient and persistent delusion. [23 p399]

Journal content in our discipline reflects either the supreme position of the systematic review within the profession, or more likely, the impact that journal policies have in shaping that which the profession judges worthy of publication. Journals have significant power to mould what they contain, even more so now in the day of manuscript management software which includes required form fields that an author cannot skip: an abstract must be structured, a method identified, an article category designated. But beyond the mechanics of manuscript control, the more powerful the journal, the more powerful its ability to influence the presentation and even the epistemologies of nursing knowledge. And, the power of the journal is also based in the review article.

With research evaluation exercises, and performance-based research funding, the impact factor of a journal (already a positivistic/problematic bibliometric category) constitutes its cultural capital. The more the journal’s content is cited, the higher its impact factor. The higher its impact factor, the more submissions it is likely to receive, and the higher the quality of the resultant publication.

Nursing researchers become compliant docile subjects as they conform to journal standards which “other” traditional ways of treating the synthesis of research material. Reporting methodology--including tables to organise “evidence,” and presenting a range of justifications of trustworthiness, from methodological algorithms to quality assessment tables, and detailed search criteria--confirms inflexible bonds within which nursing is compelling its academics to reflect.

One could argue that there's room for a traditional review within these discursive constraints. A savvy author could arrange a benign expression that would fit into the various sub-sections of the methodology and quality analysis description. This is a "narrative" review; quality appraisal can consist of "evaluating whether the material presented a cogent, supported argument for the themes it presents;" the discursive post-methods discussion can tolerate the header "results."

However, there are two reasons to reject this conformity. Firstly, there isn't room, amongst these headings, to express the things that matter. I present as an example, a review I have written for a prominent journal of sociology a few years ago.[25] I drew together therein many threads from a range of theoretical and historical perspectives to describe a nascent sub-discipline of medical sociology. I presented both a history and a platform: including classical texts, and mad ones. Mad they might have been, but the latter garnered significant popular interest, and despite (or perhaps because of) their heretics, played an important role in shaping discussions, as other scholars scuttled to respond, and set the story right. These little bits of sociological lunacy wouldn't pass quality analysis, yet explain the direction the discussion

has ended up taking. It's simultaneously the heterogeneity and the similarities of the articles I bring together that create the base for my argument. When dialectic is the method, a "summary table" will capture neither content nor direction.

Secondly, conforming to the structured abstract kowtows to an unjustified technology of control. As Avis wrote "New academic identities are being created in which values such as academic independence, intellectual curiosity and expert judgement are being replaced by industriousness, rulefollowing, compliance and self-imposed endorsement of 'the hegemonic position of managers'".[23, p297]

That reviews are systematic is perhaps but one symptom in a more generalised attempt of the nursing journal to be submissive itself to what it sees as the scientific, or more precisely, the professional imperative. It is by producing and using research, wrote Fawcett, that "nursing will be able to declare its independence".[26 p39]b

But there's also that dogged need in the nurses' search for professionalization for them to withdraw from the Doctor Nurse game, that game where "nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time ... appear[ing] passive ... so as to make her recommendations appear to be initiated by the physician".[2] The professionalization of nursing has compelled nursing to consider how professional knowledge is constructed, and in the profession from whose grip they wish to escape, this is via EBP. Bonnell[27] has argued that nursing will be marginalized if it rejects the empirical, quantitative research, regardless of the legitimacy of their counter-argument.

For nursing to establish itself as a credible field it must have the means and techniques to imagine itself into existence, and then to represent, manifest and valorise itself in a consistent manner to its own members and to other fields. If EBP is our only tool, we have at stake here the survival of the field. We are at a place where we establish the credibility of our thoughts on the basis of our method, rather than of our arguments.

We would do well to seek inspiration from the publications of our medical counterparts. The Lancet devotes a sub-section to "Articles that advance or illuminate," encouraging debate and opinion via

such fora as Viewpoint, Essay, Reportage, and the Departments of Medical History, Ethics, Medicine and Art, and Literature and Medicine.

As Goodman's has written: "...weighty burdens are borne by leaders and soldiers of the evidence-based movement, who, at great scientific and moral peril, might presume closure in complex domains, terminating debate and chilling research in cases where more debate and research are precisely what is wanted".[7, p49]

## Notes

a. Impact factor is calculated as the number of citations in the current year to items published in the previous two years for a give journal, divided by the number of substantive articles and reviews published in the same two years in that journal.

b. It must be said that Fawcett also argued in this article for, in addition to research compliance, for "NOT [caps mine] relying on others for the knowledge which shapes our practice" : a position which should be seen to support other ways of knowing, of researching...and of undertaking reviews!

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# College of Nurses ePortfolio

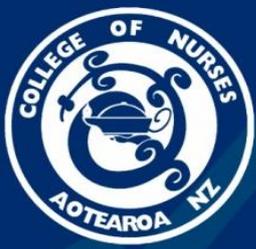
Liz Manning, College ePortfolio Administrator

Membership of the College of Nurses Aotearoa offers a number of advantages and opportunities. One of these is free access to the award winning nursing [ePortfolio](#) site.



ePortfolio is a tailored electronic storage platform for holding your evidence of competence in nursing practice. You can use it to present basic competence for a Nursing Council random recertification audit, store your nursing documents or use it to present your Professional Development and Recognition Programme (PDRP) documents.

The ePortfolio development started in 2012 led by [Nga Manukura o Āpōpō](#) (NMoĀ). As the Māori nursing and midwifery workforce development programme, NMoĀ wanted to focus on increasing the uptake of portfolio development by Māori Registered Nurses. A project team of key stakeholders including the Nursing Council NZ, nursing portfolio and e-learning experts transformed the existing Mahara education portfolio platform into a system tailored for nursing regulation requirements. The Nursing Council has since approved the site for use in submission of random recertification audit evidence and a link is included on the front page.



Dashboard **Content** Portfolio Groups Administration

### Kia ora! Welcome to your ePortfolio

ePortfolio is a fully featured electronic portfolio system with social networking features to help you collate your nursing portfolio evidence. Make sure you click through the links below to set up your ePortfolio properly. With ePortfolio you can;



- Create your own portfolio
- Share with managers, assessors, and colleagues
- Ensure that you comply with the **Nursing Council NZ Audit Requirements**.
- Refer to the **Checklist** of things every RN must have in an ePortfolio.
- Ensure that you adhere to the **NCNZ Code of Conduct** for nurses.
- Professionally present your work, add a link to any Smart device, or submit evidence in new ways, such as video uploads, podcasts or photos. Make sure that you **NEVER** video or photograph patients or colleagues.
- Check out **FAQS for Users** and **FAQS for Assessors** for more information.



There are FAQs sections, user guides, groups and forums on the site so you can link with colleagues who are also registered. Ask them to give you feedback on your comments, do your peer review, undertake your appraisal or even assess your portfolio.

#### RN (policy) Competency 3.1

Establishes and maintains effective interpersonal relationships with others, including utilising effective interviewing and counselling skills and establishing rapport and trust

#### Self Assessment

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- Place feedback
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ePortfolio offers users new ways of presenting evidence including audio, podcasts, photos and scans.

Evidence of professional development hours and practice hours requires verification from employers, nurse leaders or managers. Nurses and assessors both sign declarations to ensure the ePortfolio and the assessment are valid and current.

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# Professional Supervision-Fostering Critical Reflection For Advanced Nursing Practice

**Report by Liz Manning RN BN MPhil FCNA(NZ)**

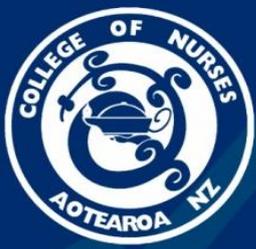
Enthused, excited, motivated, refreshed.... some of the words used by attendees at the professional supervision workshop / short course facilitated by Dr. Catherine Cook on the 12<sup>th</sup> and 13<sup>th</sup> October 2015 at Massey University Albany Campus.

The course focused on critical reflection, cultural considerations, frameworks, function and limitations of supervision in nursing practice. This was skillfully delivered by Dr. Cook in a welcoming environment using a mix of short presentations and thought provoking exercises which encouraged attendees to consider not only the role of the supervisor but the viewpoint and position of the supervisee.

A diverse group of nurses attended the course, with varying levels of experience in supervision. Pre reading provided introduced areas to be considered during the course. Attendees aimed to either develop new skills or augment and refine existing supervision skills and practice. The course was delivered in a way which effectively brought the group together to ensure all voices were heard and valued.

This proved to be a very well received course and is highly recommended for anyone interested in nursing supervision.

The course equates to 22 hours of professional development.



Nurse Practitioners  
New Zealand



# Nurse Practitioner Development Day



Presented By  
Dr Michal Boyd &  
Bernadette Paus



Wanting to become a Nurse Practitioner or develop a Nurse Practitioner role in your service?  
Are you unsure of where you are in the process?  
Or just unsure of the process and what is expected altogether?  
Or thought about it but been put off by the process?  
Or are you just totally confused???

Join us to dispel the myths and gain a clear understanding of the Nurse Practitioner role

Date	Time	Location	Venue
22 August 2016	9.00 am to 1.30 pm	Auckland	Building 730 Room 220 Tamaki Campus The University of Auckland

College of Nurses Member Registration Fee \$175.00  
Non College of Nurses Member Registration Fee \$195.00  
**Earlybird Discounted Fee \$175.00 if paid by 25 July 2016**

## AGENDA FOR THE DAY

9.00 am to 11.30 am

**Bernadette Paus: *Portfolio Development Using the Latest NCNZ Guidelines***

11.30 am to 12 noon

Light Lunch

12 noon to 1.30 pm

**Dr Michal Boyd: *NP Panel Interview and Position Development***

Certificates for professional development hours will be issued to attendees at the end of the day

REGISTER ONLINE - [www.nurse.org.nz/event-registration-form](http://www.nurse.org.nz/event-registration-form)

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**NPZ – Nurse Practitioners New Zealand**

is a division of the

**College of Nurses Aotearoa (NZ) Inc**

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The College of Nurses reserves the right to cancel/postpone a workshop. A refund of the registration fee or transfer of registration to a future workshop will be offered. Please see [www.nurse.org.nz](http://www.nurse.org.nz) for our full cancellation policy.



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Kim Carter RN FCNA(NZ) NZCPHCN (NZNO)

Taima Campbell RN, MHSc (Nsg) PG Dip Bus (Māori Dev)  
Dr Mark Jones FCNA(NZ) FACN

Location	Date/Venue	Time	Earlybird Discounted Fee If Paid By
Hamilton	8 & 9 August 2016	9.00am – 4.30pm	12 July 2016
Dunedin	14 & 15 November 2016	9.00am – 4.30pm	18 October 2016

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## PRIMARY HEALTH CARE 2 DAY LEADERSHIP WORKSHOP

### Feedback Received from 2015 Workshops

*“Excellent and highly appropriate and relevant topics. Most highly qualified and educated lecturers – thank you! Feel very motivated in my leadership pathway, you have planted seed in my mind and heart.”*

*“At first I felt this workshop was not what I had expected but by the end of the 2 days I really felt I benefited from the total approach. I was impressed by the quality of all the speakers.”*

*“Presentations were all clearly given by good, confident leaders and role models. Very empowering couple of days – Thank you.”*

*“All speakers were clear and concise in their delivery and extremely knowledgeable. Good that there was plenty of time for discussion with the nurses attending the workshop which produced some interesting and informative debate. Plenty to think about to take nursing forward.”*

*“What a fantastic array of speakers, so interesting, knowledgeable and inspirational. Hugely relevant content to working in the current primary health care environment.”*

*“Inspiring – my horizon has been widened – candle has been lit - and now actions will be taken.”*

*“Excellent presentation. Inspiring speakers. Plenty of opportunity for interaction and positive learning. Thank you. Would happily recommend this workshop to colleagues.”*



# PROFESSIONAL BOUNDARIES & RELATIONSHIPS WORKSHOP

## FOR REGISTERED NURSES & NURSE MANAGERS



Presented by-  
**Patricia McClunie-Trust PhD MA BSocSci RN**  
 Principal Academic Staff Member  
**Centre for Health and Social Practice**  
*Te Tari Hauora me Te Tari Tikanga-ā-Hapori*  
 Waikato Institute of Technology

This workshop is designed to help nurses to define and explore professional relationships within the clinical, cultural and social communities in which they work and live. Being involved in caring and advocating for other people can involve complex and challenging personal and professional situations. This workshop will assist participants to explore issues that they have experienced in their professional lives and examine practical and effective ways to manage challenging situations.

Attendees will gain an in-depth understanding and knowledge of the current Nursing Council Professional Boundaries, Code of Conduct and the Code of Ethics guidelines. Beneficial for all registered nurses and highly recommended for Nurse Managers especially those supervising nursing staff. Certificates are issued to attendees for professional development hours.

Location	Date/Venue	Time	Earlybird Discounted Fee Applicable If Paid by
Hamilton	24 June 2016	9.45am – 4.00pm	27 May 2016
Christchurch	15 July 2016	9.45am – 4.00pm	10 June 2016

Register now - [www.nurse.org.nz/workshops](http://www.nurse.org.nz/workshops)

College of Nurses Member Registration Fee \$175.00  
 Non College of Nurses Member Registration Fee \$195.00  
**Earlybird Discounted Fee \$175.00 (see dates above)**

Morning tea (available on arrival from 9.45am), lunch and afternoon tea are included.  
 Certificates for professional development hours are issued to attendees at the end of the day.

[www.nurse.org.nz](http://www.nurse.org.nz)

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# College of Nurses Aotearoa (NZ) Inc

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<i>Name</i>	<i>Date Awarded</i>
<i>Judy Yarwood</i>	<i>October 2014</i>
<i>Dr Stephen Neville</i>	<i>October 2015</i>
<i>Taïma Campbell</i>	<i>October 2015</i>

