Health Impact Assessment of the Cultural and Clinical Nursing Support and Training Programme

Final Report
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Executive Summary

This Whānau Ora HIA (a health impact assessment which focuses on Māori populations and strengthening Māori whānau wellbeing) assessed a proposal to establish a cultural and clinical nursing training and support programme which aims to assist the exchange of skills and expertise between specialist practitioner nurses from the DHB provider arm and specialist practitioner nurses working in the community. The WOHIA was carried out at the request of the Hawke’s Bay District Health Board (DHB) and was undertaken by Quigley and Watts Ltd and Katoa Ltd.

Long-term conditions consume approximately 70 percent of the healthcare spend and 80 percent of deaths are attributable to such conditions. Māori are over-represented in negative long term conditions statistics. Very often Maori with long term conditions have complex medical needs and live in challenging social and economic conditions. The Hawke’s Bay DHB believes there is a need to improve access to health services in the community for people with long term conditions to fully implement the ‘chronic care model’ which recommends care in the community, the health care system and the health-provider organisation - hospital, clinics, or a loose network of physician or community practices.

In order to fully implement the chronic care model for Māori patients nurses require specialist skills. The skill sets of Māori provider nurses and hospital based specialty nurses are complementary however the Hawke’s Bay DHB believes there are currently inadequate opportunities for these nurses to share such skills with each other. Establishing a programme to facilitate this sharing of skills was explored in this Whānau Ora HIA.

For this Whānau Ora HIA several sources of evidence were used to assist in undertaking the appraisal of the programme. These were:

1. Literature review
2. Scan of relevant long-term conditions policy documents and practices
3. Interviews and workshops with community and key stakeholder groups

Analysis of the information gathered identified a number of possible positive and negative consequences.

Potential positive pathways for staff and patients

1. Potential to maintain and develop relationships

Nurse-to-nurse, organisation-to-organisation and nurse(s)-to-patient/whānau. Nurses will meet and learn from each other and develop mutual respect. which will in turn assist organisational level relationships.

The training programme has the potential to lead to a better team approach and better networks and connections.

2. Potential for knowledge transfer

Between nurses, from nurses to patient/whānau, from patient/whānau to nurses

To support a better understanding and embed a new model of practice and a team approach to long term conditions

To encourage complementary learning through; case study or peer review of medical notes by clinical nursing specialists, creating academic pathways for the nurses, cultural competency training and other learning types to support Māori nurse workforce development.

Increased awareness of a determinants-of-health approach.
Improved knowledge of community and hospital services.

3. Potential to improve patient and whānau outcomes

Access to a complete model of care which addresses planned management and acute issues for long-term conditions in the community.

Fewer emergency department hospital visits.

A better hospital experience.

Potential negative pathways on staff and patients

1. Potential to disrupt relationships

Nurse to nurse – the risk of ‘culture clash and antagonism’

Organisation to organisation -if employers do not see the value, do not release staff, do not agree to be part of the programme or have a bad experience from the programme

Patient/whānau to nurse – if whanau did not wish to see another nurse and/or the trust between patient/whānau and nurse is broken

Inappropriate use of Māori workforce development funds

2. Potential to decrease patient and whānau outcomes

If patients/whānau are uncomfortable in mainstream healthcare and this is replicated with Māori providers and patients are left with no where to go for care.

3. Potential to hamper knowledge transfer

Nurses not having the time, support or resources to prepare adequately

Undermining of patients/whānau confidence in Whānau Ora nurses

Facilitators and barriers (factors that may support or negate potential pathways)

1. Preparation is important to facilitate positive outcomes

Preparation to maintain and develop relationships

A suitable timeframe; trusting nurses to select who they wish to work with; including existing staff in the preparation; engaging key players early

Preparation to assist knowledge transfer

Initial training is important; whānau knowing what to expect; using trusted models to transfer knowledge; a clear model of care for long term conditions that everyone understands

Preparation to assist patient and whānau outcomes

A clear model of care is developed and described, understood and agreed by the patient/whānau; an understanding of how the model of care involves all stakeholders.

2. Process and approach is important to facilitate positive outcomes

Processes and approaches to maintain and develop relationships

Ethics – Whānau and Nursing practice; in-home visits.
Processes and approaches to assist knowledge transfer
Joint clinic work; back-fill nurses; shared ‘kete’ of knowledge; sustainability

Processes and approaches to assist patient and whānau outcomes
Understanding of Māori treatments; clear and consistent messages about the long term model of care and the roles of all players consistently applied throughout the approach.

3. Systems can support the pathways

Systems that maintain and develop relationships
Memorandum of understanding; senior management engagement is required to maintain long-lasting organisational relationships.

Systems that assist knowledge transfer
Access to medical notes; agree performance measures across organisations; include measurable outcomes such as fewer emergency department presentations.

Systems that assist patient and whānau outcomes
All systems developed should have an eye on how they will assist patient and whānau outcomes to ensure that bureaucratic systems are not implemented.

Recommendations

Preparation required for the training programme
A clear description of the proposed training programme is outlined.

Be clear the money for this training programme is to support Māori workforce development, and that other funds will be needed to support the other resources /development sought for long term conditions.

Preparation required in other areas to support the training programme
A clear description of the long term conditions model of care describing the team approach, roles and settings of patient/whānau, primary care workers hospital based staff and community workers is developed. This description should discuss the difference between planned management, assessment and acute care and how they relate to this training programme.

A ‘contact details resource’ allowing training programme workers to contact each other and key service providers in the community and hospital.

Develop clear and consistent messages (plus any necessary resources) for use by nurses regarding planned management, assessment and acute care of long term conditions.

Processes and approaches within the training programme
Allow complementary learning to occur, including academic learning, cultural competency, and other learning processes that would complement the training programme.

Use key concepts that underpin the training programmes processes and approaches – such as Mason Durie’s Powhiri model for engaging whānau, a determinants of health approach, a holistic Whānau Ora centered approach, a positive approach about whānau life.
Have a staged approach to developing trust and relationships, that recognises that one size will not fit all and that each provider organisation should develop its own protocols which might include:

- The development of a memorandum of understanding between organisations
- Ways for nurses to get to know each other and discuss ways of working together and who/how to make it happen, e.g. include hospital kaitakawaenga or no; models of care chosen to underpin their work. Allow relationships to develop and to reach agreement to work together.
- Consideration of starting with patient note reviews and case reviews (patient not present)
- Building towards clinic-based shared learning – with roles clearly delineated and full approval of patient/whānau. Good transport access to the clinic is required.
- A final stage objective which may be in-home shared learning. Consider full day clinics with the second half of the day as case review to share learning.

Prepare for ethical issues regarding the consent of patients/whānau to participate in the training programme, and any potential issues around health professional responsibilities while in the home.

Use an action research approach where each provider sets the tone for what occurs and how (within the framework), with built-in review and evaluation on a regular basis.

**Systems**

Begin the training programme with Māori providers who are interested in being involved from the outset, offering it wider as the process becomes more developed. Allow Māori providers to self-select their involvement and ‘go where the energy is’ in the first instance. Maintain the buy-in of these key decision makers and develop a memorandum of understanding between the organisation and the District Health Board.

Back-filling of nurses is critical to the success of the programme so nurses have adequate time to set aside for preparation, ongoing processes and review/updating.

Write the training programme into the District Annual Plan and secure sustainable funding.

**Future**

Development of discharge planning is required so that a patient is handed from hospital to Māori providers (and not just a hand over to the general practitioner). For example, make discharge planning a nursing responsibility not a medical responsibility. Data is already collected as the discharge forms have Māori Provider as a ‘box’.

Information technology developments are required so that patient notes can be shared between Māori providers, hospital and other key primary care agencies.

At some point, expansion into primary care will be needed as many patients with long-term conditions are not managed well in primary care – but first get it right for Whānau Ora nurses.

Use the Whānau Ora nurses in a training capacity within the DHB ‘cultural training programme’ that is already ongoing. Brings the Māori patient journey into an already good training programme.

Consider adding respiratory nurses as soon as possible as there is a perceived unmet need in this area.
## Content

Acknowledgements................................................................................................................ 2

Executive Summary............................................................................................................... 3

Content.................................................................................................................................. 8

1. Context............................................................................................................................ 10
   1.1 Who has undertaken the Whānau Ora HIA................................................................. 10
   1.2 History of engagement................................................................................................. 10
   1.3 Purpose of report........................................................................................................... 10
   1.4 What is Whānau Ora HIA............................................................................................... 10
   1.5 Programme context ....................................................................................................... 10
   1.6 Draft Programme ........................................................................................................... 12

2. Whānau Ora HIA Process Undertaken ............................................................................ 15
   2.1 Screening ...................................................................................................................... 15
   2.2 Scoping/setting the priorities of the HIA ......................................................................... 15
   2.3 Appraisal........................................................................................................................ 16
   2.4 Evaluation...................................................................................................................... 17
   2.5 Potential stakeholders.................................................................................................... 17

Appraisal Findings ............................................................................................................... 18

3. 1 Appraisal Findings: Summary of literature review .......................................................... 18
   3.1.1 Models of care for people with long term conditions.................................................... 18
   3.1.2 Shared care and appropriate training important .......................................................... 18
   3.1.3 Nurse to nurse learning and the development of expertise ......................................... 19
   3.1.4 The provision of whānau appropriate services and health outcomes .......................... 20
   3.2.1 Local context - Long-term conditions nursing services in Hawke’s Bay DHB.......... 21

4. Appraisal Findings: Workshops and interviews ............................................................... 24
   4.1 Current context relevant to the draft programme............................................................ 24

5. Appraisal Findings: Causal pathways .............................................................................. 31
   5.1 Potential positive pathways on staff and patients ........................................................... 31
   5.2 Potential negative pathways on staff and patients.......................................................... 34
   5.3 Facilitators and barriers (factors that may support or negate potential pathways) ......... 35
6. Discussion ........................................................................................................................................... 40

7. Recommendations ............................................................................................................................... 43
   7.1 Preparation required for the training programme ........................................................................... 43
   7.2 Preparation required in other areas to support the training programme ........................................ 43
   7.3 Processes and approaches within the training programme ............................................................. 43
   7.4 Systems ....................................................................................................................................... 44
   7.5 Future ......................................................................................................................................... 44

Appendices .............................................................................................................................................. 45
   Appendix A: Participants in the Whānau Ora HIA ............................................................................ 45
   Appendix B: Revised draft programme ............................................................................................... 47
   Appendix C: Literature review ............................................................................................................ 51
   Appendix D: Work Programme, DHB activities to support Māori providers, 2009/10 ............... 84
1. Context

1.1 Who has undertaken the Whānau Ora HIA

This Whānau Ora HIA (health impact assessment) was undertaken by Quigley and Watts Ltd and Katoa Ltd at the request of the Hawke’s Bay District Health Board (DHB). The Whānau Ora HIA was carried out on a proposal to establish a cultural and clinical nursing training and support programme which aimed to help the exchange of skills and expertise between specialist practitioner nurses from the DHB provider arm and specialist practitioner nurses working in the community.

1.2 History of engagement

The authors and the Hawke’s Bay DHB had worked together previously on several successful HIAs. The Hawke’s Bay DHB was considering a new programme to provide cultural and clinical nursing training and support, and recognised a Whānau Ora HIA would be a useful approach to assist the engagement of stakeholders and to help ensure the best possible programme was developed.

1.3 Purpose of report

The purpose of this report is to introduce the concept of Whānau Ora HIA, describe the method, findings and recommendations of the Whānau Ora HIA.

1.4 What is Whānau Ora HIA

The focus of Whānau Ora HIA is on Māori populations and strengthening Māori whānau wellbeing. It looks at Whānau Ora as an aim and emphasises determinants of health known to have a particular impact on Māori health and wellness. The starting points are Māori models of health (e.g. Te Pae Mahutonga, Te Whare Tapa Wha) rather than generic models of health. Whānau Ora HIA provides a clear Māori voice into decision making processes. Whānau Ora HIA is a multidisciplinary approach that investigates the potential health and wellbeing implications of a proposed policy or programme. Its aim is to deliver evidence based recommendations that inform the decision-making process, in order to maximise gains in Whānau Ora and to reduce or remove negative impacts or inequalities. Whānau Ora has many potential definitions, one of which by the Ministry of Health is ‘Māori families supported to achieve their maximum health and wellbeing’ (Ministry of Health, 2007). Flexible methods are used in the WOHIA process to ensure the approach best fits with the proposal in question, the resources available, and the local populations affected.

1.5 Programme context

1.5.1 The broader issue

Long term conditions are a high priority area – they consume approximately 70 percent of the healthcare spend and 80 percent of deaths are attributable to such conditions. It is unjust that Māori are over-represented in negative long term conditions statistics.

It is common for Māori patients with long term chronic diseases in Hawke’s Bay to arrive at the hospital Accident and Emergency Department seriously ill and in need of admission to hospital for specialist care. While in hospital the patients are seen by hospital specialty nurses who have one particular disease as their area of expertise. Many of these patients have many long term conditions, including either diabetes, and/or cardiovascular, and/or renal and/or respiratory disease. It is common for the patients to be treated by a series of
different clinical specialty practitioners (nursing, medical and other). As a consequence of this approach, the patient may see a number of different specialists, each with a slightly different set of treatments and care instructions.

Discharge planning is not ideal for many patients or their whānau, as discharges at the hospital are often done under great pressure and the planning does not occur. There are instances where patients who have entered the hospital via Accident or Emergency, or via their general practitioner, return back to their communities without other primary care providers or community nurses knowing they’ve recently returned from hospital. This is primarily because the notes from the hospital only return to the patient’s general practitioner and not to other primary care workers.

Very often these patients have complex medical needs and live in challenging social and economic conditions. These conditions are critical in determining Whānau Ora. As one approach to addressing this, the Hawke’s Bay DHB believes there is a need to improve access to health services in the community for people with long term conditions.

1.5.2 Current thinking on management of long term conditions

The goal of long term conditions management is to shift the orientation and design of practice in order to promote a systematic, planned approach to care for those with ongoing health problems through productive planned interactions between informed, activated clients (and families) and prepared, proactive practice teams (Wagner, 1998).

The ‘chronic care model’ that has been widely adopted in New Zealand, and is used as the basis for work within the Hawke’s Bay DHB is described as having three settings (Wagner, 1998, p.2-4):

- the entire community, with its resources, and public and private policies;
- the health care system; and
- the health-provider organisation, whether a hospital, a small clinic, or a loose network of physician or community practices.

Wagner’s (1998) model identifies six essential elements:

- community resources and policies – linkages between health-provider organisations and community based resources such as exercise programmes, home care agencies, community case managers, etc;
- health care organisation – where long term conditions are prioritised by all health providers;
- self-management support – patients [and their whānau] become the principal caregivers;
- delivery system design – creation of practice teams, where acute care is separated from the planned management of long term conditions and routine tasks are prioritised;
- decision support – integration of evidence-based clinical practice into daily practice via reminders, and specialist expertise a phone call away; and
- clinical information – computers to provide reminder systems for primary care teams, to help provide feedback to doctors, and registries for tracking and planning patient care.

1.5.3 Specific issue under consideration of this Whānau Ora HIA

The skill sets of Māori provider nurses and hospital based specialty nurses are complementary. However the Hawke’s Bay DHB believes there are currently inadequate
opportunities for these nurses to share such skills with each other. This sharing of skills is the main focus of this Whānau Ora HIA.

The current Māori Provider contracts within Hawke’s Bay DHB are listed in Appendix D.

1.6 Draft Programme

Throughout the course of the Whānau Ora HIA the draft programme moved from a concept/idea discussed by the two authors with District Health Board colleagues, to a powerpoint presentation at the Whānau Ora HIA scoping meeting, to a first draft written document that was able to be provided to the Whānau Ora HIA participants for discussion during the appraisal stage. This version was acknowledged at the time to be ‘less than perfect’, and a starting point for discussion. In many ways a role of the Whānau Ora HIA was to test both the concepts and language used with stakeholders.

The draft programme sits within the context of many initiatives the Hawke’s Bay DHB is developing in an attempt to reorient services more efficiently towards the management of long term conditions. The original draft programme, ‘issues and all’ is presented here as a record of the starting point for the Whānau Ora HIA

The draft programme – August 2009

In partial response to improve the management and treatment journey of Māori patients with long term conditions, the Hawke’s Bay DHB developed a draft programme to establish a cultural and clinical nursing training and support programme. The programme aimed to help exchange skills and expertise between specialist practitioner nurses from the DHB provider arm and nurses working in the community, and help achieve broad aims such as:

- improve the Māori patient journey
- improve health outcomes
- reduce inequalities

These will be achieved by a formal structured reciprocal programme to promote the exchange of expertise in order to:

- support nurses to enhance Whānau Ora skills
- support nurses to enhance specialty practice expertise
- facilitate the incorporation of new knowledge and methodologies into the management of long term conditions.

The draft programme acknowledged the New Zealand Health Care Strategy, the Primary Health Care Strategy, He Korowai Oranga and the Ottawa charter as influences on the programme, and the Treaty of Waitangi as a founding document.

Turuki funding was set aside to improve access to health services in the community, particularly for long term conditions and funding is available for a support and training programme. There is existing support and capacity for undertaking cultural and clinical nursing support and training programme within diabetes, renal and cardiovascular care¹. The overall aim of the draft support and training programme is to improve the patient journey for Māori patients with long term conditions to improve health outcomes and reduce inequalities.

¹ It is noted that ideally respiratory disease would be included in the initiative but at this stage the Provider Arm of the DHB does not have the resources to offer expertise in this area. Cancer will not be included as part of this initiative as the pathways of care are substantially different.
Current working suggests specialist hospital-based nurses have shared clients, access to clinical knowledge and skills, access to an inter-disciplinary team, and have been able to amass knowledge and clinical skills over a prolonged period of time. In comparison the nurses working with Māori providers have a unique knowledge of the community in which they work, have cultural knowledge, are engaged with the determinants of health on a daily basis and are often younger and less clinically experienced than their hospital based counterparts.

Figure 1 below describes how the training programme is proposed to support both hospital specialty nurses and Māori Provider Whānau Ora nurses.

**Figure 1. Cultural and clinical support and training model**

![Cultural and Clinical Support And Training](image)

Source: Tūruki Hawke’s Bay District Health Board Maori Workforce Development Plan 2008-2011

Those directly affected by the draft proposal:

Nurses within DHB Provider Arm hospital-based services – there is existing support/capacity within diabetes, renal, cardiac nurse specialties:

- Configure services so that *hospital specialty nurses* are able to work across the sectors
- Support nurses in developing their cultural competency.
- Nurses within Māori Provider community-based health Services
- Resources provided to support *nurses within Whānau Ora as an area of nursing practice* to enhance clinical practice development in long term conditions
- Sharing Whānau Ora knowledge and skills.

All nurses

- Support nurses in developing new care delivery approaches in relation to long term conditions
- Using intensive experiential learning

The draft support and training programme would include disease specific knowledge in diabetes, renal and cardiac care (in the first instance), and may cover:

- Care delivery approaches
- Health literacy
• Motivational interviewing -
• Supported self management
• Goal setting
• Lifestyle coaching
• It may also include:
  • Clinical and cultural supervision (from whatever source, though non-DHB sources may be more expensive)
  • Shared clinics/home visits
  • Clinical practice exchanges
  • Back fill to allow clinical practice development
  • Shoulder to shoulder experiential learning
  • Shared clinical tools and methodologies e.g. IT
  • Case review
  • Best practice exemplars
  • Traditional healing, rongoa

The proposed initiative will be funded through Tu Mai.

It is hoped that the draft support and training programme may also lead to life-long learning outcomes for the nurses involved and assist with their ongoing career progression, as shown in Figure 2.

**Figure 2. The learning continuum from novice to expert**
2. Whānau Ora HIA Process Undertaken

The Whānau Ora HIA process followed the methodology as described in the document Whānau Ora Health Impact Assessment (Ministry of Health, 2007). The stages undertaken in this Whānau Ora HIA were:

2.1 Screening

Screening is the initial selection process to assess whether a Whānau Ora HIA should be undertaken or not. This stage was carried out informally by a small team within the Hawke’s Bay DHB, and it was agreed a HIA would be a useful approach to carry out on this draft programme.

2.2 Scoping/setting the priorities of the HIA

Scoping typically highlights the key issues that need to be considered and sets out what will be done in the HIA. The scoping meeting was held with a group of key people (listed in the acknowledgements) at the Te Aranga Marae on the 17th July 2008 and was facilitated by Robert Quigley and Fiona Cram. A full copy of the scoping report is available from the authors.

The scoping meeting was the first opportunity for the two authors of the ‘draft programme’ to enter into discussions with others about the draft programme. This created a lot of discussion at the scoping meeting, not only on what the Whānau Ora HIA should focus on, but also on ways to clarify the first draft of the programme prior to presentation to wider stakeholders.

From the scoping meeting the group made the following recommendations about the Whānau Ora HIA and its scope.

The WOHIA process would seek to ensure a clear understanding of the:

- draft proposal – via discussions with the DHB;
- populations affected – national and international literature; regional documents; interviews with key stakeholders as required; and
- evidence about how models of nursing may affect Whānau Ora and/or health outcomes and whether/how support and training programmes are effective – national and international literature; interviews with health sector stakeholders; whānau.

By considering Māori models of health the Whānau Ora HIA would:

- bring a Whānau Ora understanding to the draft programme;
- be responsive to the Ottawa Charter and inclusive of the determinants of health; and
- contribute to the reduction of health inequalities and Māori aspirations for Whānau Ora.

2.2.1 Objectives of the Whānau Ora HIA

- To engage key stakeholders in a discussion of the draft programme.
- To develop a clear understanding of the draft proposal and the Māori populations affected.
- To document the potential positive and negative impacts on Māori from the draft proposal.
• To assess the implications for equity and inequalities that may arise from the draft proposal.

• To inform the development and implementation of the draft proposal by providing timely and practical recommendations to the decision makers. Make recommendations of ways to enhance potential positive impacts and mitigate potential negative impacts on Whānau Ora.

• To develop a framework for undertaking Whānau Ora HIA that may be used when undertaking future Whānau Ora HIA.

2.2.2 Components of the programme to be addressed

All parts of the draft programme were discussed and addressed in the Whānau Ora HIA.

2.2.3 Determinants of health

The determinants of health that were the focus of discussions during the Whānau Ora HIA were:

• Factors that limit access to appropriate whānau care by Māori patients with long term conditions, such as:
  o inappropriate care models where patients are unable to access clinically- and culturally-appropriate care
  o barriers to accessing appropriate care

• Nurses clinical and cultural competency:
  o care that meets patients and whānau social, cultural needs
  o care that meets patients and whānau complex clinical needs

2.2.4 Populations affected

The group identified the following groups that could be potentially affected most in terms of health and wellbeing:

• Māori patients with long terms conditions in the Hawke’s Bay District Health Board area.

• Whānau of the patients

• the communities the patients and their whānau live in

• nurses working within a Whānau Ora model and their organisations

• clinical specialty nurses and others they work with

2.3 Appraisal

The aim of this stage of a Whānau Ora HIA is to collect information to inform whether the draft programme has the potential to affect Whānau Ora (either positively or negatively) if the strategy is implemented as proposed. This stage also determines what practical changes can be made to the policy to protect and promote Whānau Ora.

For this Whānau Ora HIA several sources of evidence were used to assist in undertaking the appraisal. These were:

• Literature review (undertaken by Quigley and Watts)
Scan of relevant long term conditions policy documents and practices
Interviews and workshops with community and key stakeholder groups

2.4 Evaluation

Typically assessment of how the HIA process was undertaken (process evaluation) and the extent to which the recommendations were taken up by the policy makers (impact evaluation) is carried out. Unfortunately an approach by the Hawke’s Bay DHB for funding for an independent evaluation of the Whānau Ora HIA was unsuccessful so no evaluation has been done. However, future evaluation of the outcomes of the final programme is warranted.

2.5 Potential stakeholders

The scoping group brainstormed which stakeholders they saw as important to involve in the WOHIA. The full listing of those included at one point or another in the WOHIA is in the acknowledgements.
Appraisal Findings

3. Appraisal Findings: Summary of literature review

Two-thirds of New Zealand adults have been diagnosed with a long-term condition. These long conditions account for more than 80 percent of deaths. Long-term conditions disproportionately affect Māori, Pacific peoples and people of low socioeconomic status. These groups have higher rates of mortality and morbidity from long-term conditions than other groups in society and many people have more than one long-term condition. (The full literature review is available in Appendix C).

3.1.1 Models of care for people with long term conditions

There is a substantial body of literature which discusses the care of patients with long term conditions and which describes optimal models of care for these patients. The Chronic Care Model which describes the care for patients with long term conditions recognises the importance of a team approach, good clinical management at the primary care level, patient self-care and family and whānau being participants in care. This, and other similar models, help patients and family better cope with the challenges of living with, and treating, long term conditions by establishing effective self-management.

High quality care for patients with long term illnesses is associated with health professionals having a fuller understanding of the patient’s life and preferences and the importance of family care givers and nurses. Successful care takes account of the complexities patients face on a daily basis and coordinated care in the context of family and community is important.

Coordination of care across clinicians and treatment/care sites is of critical importance for persons with long term illness. Consumers place great value on having a clinician and/or team who are familiar with the “whole” patient and family and who are able to coordinate and communicate medical activities across caregivers and settings; in some settings such a system is associated with better outcomes.

Shared care between primary care and specialists, ie that which fosters interdisciplinary collaboration and communication, promotes continuity of care for the patient and is considered to produce the best outcomes. Efficient involvement of specialists with primary care teams is likely to offer the optimal combination of knowledge and skills people with long term illnesses need.

3.1.2 Shared care and appropriate training important

A number of commentators have highlighted the need for improved clinical training for staff, especially nurses, working within the models for patients with long term conditions and suggested nurses need to be well prepared to provide chronic illness care and to influence change in an evolving health care system. The literature recommends nurses education and training must include clinical practice in patient-focused and outcomes oriented settings.

Others have suggested optimal care for patients with long term conditions involves some kind of "shared care" arrangement between generalists and specialists as part of an ongoing relationship among the patient, GP, and specialist.

Some of the literature stressed the importance of establishing good teamwork from different service providers with the need for good links between general practice, community, allied
health services and secondary care. This teamwork requires relationships based on shared principles and goals and effective two-way communication, ideally including paper-based communication. It was noted that regular interpersonal contact between the professionals helps to build professional trust and understanding of each other’s roles. It is recommended models be developed where providers who are not necessarily co-located can work as a team.

NZ primary care nurses also recommended a multi-disciplinary team approach for the care of patients with long-term conditions and described a system where a cardiac nurse specialist, respiratory nurse specialist, and a gerontology nurse specialist, along with a diettian, pharmacist, physiotherapist, and social worker could be available for consultation, promotion of the guidelines and to increase evidence-based practice. The nurses suggested these professionals could also be available for joint visits with the practice nurse when support and guidance were required. They suggested this could also be a way to incorporate secondary care specialist expertise into the primary care setting.

A British system in which community nurses developed relationships with acute hospital staff especially those in urgent care services, admissions, wards, and the hospital discharge liaison team was found to help breakdown traditional boundaries and enabled the community nurses to follow the patient’s pathway through the hospital and ensure smoother admissions and timely discharge. This programme has shown that working jointly with health visitors (community health workers) the community nurses have been highly effective in addressing the needs of vulnerable families. Each professional has different skills and the teamwork and the sharing of skills and information in the clinical care management is effective for people living with long-term conditions.

A number of researchers stressed the need for nurses in community roles who deal with these particular patients to have good clinical skills in assessment, education, planning and delivery of patient care.

3.1.3 Nurse to nurse learning and the development of expertise

Much of the literature on learning for nurses related to student nurse training and it was difficult to find reference material that related to the one on one “shoulder to shoulder” mentoring/learning described in the proposed programme. No articles were found which directly reflected the proposed model however the literature contained useful discussion which identified some of the factors which might lead to the success or failure of the process of adult teaching and learning.

Discussion in the literature identified mentoring as a means of up-skilling nurses. However it was recommended both the ‘teacher’ and the ‘student’ be adequately prepared for the role. The need for the ‘teachers’ to be appropriately skilled was stressed. It was noted that just being experienced is not sufficient qualification for being a good teacher or mentor and that a number of personal attributes and conditions are necessary to facilitate successful learning. It was also noted that just getting ‘students’ to work with qualified staff in practice environments does not guarantee learning. One researcher described a “critical companion” as a person who can help the nurse to understand what they want or need to change and how they can manage that change. The “critical companion” requires personal characteristics such as supportiveness, approachability, empathy and the ability to think laterally and non-judgmentally and be able to work across role and structural boundaries in the service. The ‘absolute requirements’ for successful mentoring which were identified included mutual attraction, mutual respect and time and energy.

The attitude of both the ‘student’ and the ‘clinician’ and the relationship between them was noted as having a vital influence on learning.
A number of commentators noted the importance of support by employers and colleagues noting that both parties need preparation for their roles and support from the healthcare organisation. The learning situation must also be acknowledged and facilitated by the employer by allowing the necessary time to develop the new skills. There should also be recognition of the need for support for mentors especially of the time commitment and resources required to allow them to do create a relationship which is supportive and beneficial to both people.

It was also recommended learners and other colleagues are clear about their expectations so each understands the value of the planned learning outcomes and can see long term benefits from it. There also needs to be a sharing of focus and purpose between the learner and the more skilled partner.

A number of commentators stressed the value of the learning taking place in the environment where it would be used. The application of learning in real-life situations is likely to be more salient for both the learners and the teachers since the cultural and social interactions are an important part of the learning process. Adult learning theory argues that learning is most effective when the learner is able to make sense of new knowledge in the context of their immediate life experience.

Mentors themselves can benefit from the mentoring role especially when mentoring is formally recognised and contributes to the mentors own professional development. Mentors can also find the process to be a useful learning exercise themselves as they were required to model exemplary clinical care, behaviour and attitudes which can of result is an improvement in the mentors own practice.

In some studies mentees noted that willing mentors where more likely to be successful than those forced into the role and poor mentorship can bring lasting consequences for those being mentored. Poor relationships inhibit learning and positive relationships enhanced it.

3.1.4 The provision of whānau appropriate services and health outcomes

There is a large body of literature commenting on health inequalities in the Māori population which identifies a lack of access to culturally acceptable health care services as one of the barriers to health. Although there does not appear to yet be research which measures the health outcomes of services which are considered to be culturally appropriate researchers say it is clear health service provision with little Māori participation results in poor Māori outcomes. Anecdotal evidence suggests Māori are more responsive to care provided ‘by Māori for Māori ’ and there is evidence that mainstream services fail to meet Māori health needs because they fail to take account of Māori health beliefs and practices and perhaps more importantly treat the patient and the illness individually without consideration of the “whole” person and their wellbeing in the context of the whānau.

The barriers to accessing care among Māori include:

- the attitudes of health workers toward Māori
- unsatisfactory encounters with professionals
- nursing practice focuses on illness rather than health, on the individual rather than the whānau
- practice that is strongly based on the biomedical model rather than an holistic approach
- experiences of disempowerment and discrimination
Researchers suggest engagement with Māori must be with the whānau when dealing with health issues, and that failing to do so will not result in better health outcomes. The success and importance of Māori models of health come from the fact that they operate within the cultural context of the whānau and not just illness as is often the case in mainstream health services.

Commentators note that Kaupapa Māori programs that provide an environment based on Māori cultural values, processes and beliefs and a blend of contemporary and traditional practice improve Māori health outcomes. They also comment that holistic healthcare delivered to Māori in a respectful and collaborative manner can impact positively on the health of Māori and that successful nursing methods were described as a ‘synergy of clinical nursing skills and intimacy with tikanga Māori’.

One commentator noted “Positive health experiences stem from meaningful partnerships established between nurses and clients, and influence the efficacy of healthcare providers. In such partnerships nurses bring health and illness expertise while Māori women bring the knowledge about their health beliefs and practices and life circumstances.”

Engagement with whānau is seen as a priority for Māori and it was noted;

- the health system should engage with whānau, rather individuals – to focus on the family’s potential, rather than individual’s problems.
- that health and wellness cannot be separated from each other or from the all the issues that confront whānau.
- the health system recognise that for Māori it is not possible separate wellness from whakapapa, reo, tikanga as all these things create and sustain identity.
- that sharing information and education all the whānau together is more effective than education the patients alone.

Other success factors in nursing of Māori included;

- collaboration and information sharing with other health professionals especially in coordinating care for patients within the hospital system and around discharge planning and care; and
- being able to bridge communications gaps between Māori, community and hospital services and expert clinical skills.

3.2.1 Local context - Long-term conditions nursing services in Hawke’s Bay DHB

There are a large number of different nursing services offered within Hawke’s Bay. This section is not designed to be a full stocktake of services as that is beyond the scope of this project. It is designed to give a feel for the type of services offered and by whom. The nursing-related contracts provided by Māori health providers include:

- Whānau Ora mobile nursing services and disease state management (MAOR0121) - hospital specialty nurses managing diabetes, cancer obesity etc in the community
- Whānau Ora Māori community services – whānau support services (MAOR0117) - working with whānau to develop health plans for everyone in the whānau, particularly to refer people on into the health system. These services take a wider determinants/health promotion approach. There may be some clinical components if
a nurse is delivering this service, but clinical components are generally not part of Whānau Ora contracts.

- Kahungunu Hikoi Whenua Health Promotion Programme (MAOR0114)
- Dental health educator (D01011)
- School based nursing (CO1014) – services offered to 5-12 year olds or 5-18 year olds on-site in schools
- Disability support services (MAOR0113)
- Support mothers and pepi (MAOR0104) - working with single young mothers of Māori descent to help them access services
- Tamariki ora Well Child 0-5 years. Whānau family care (CO1010) – helping the family into community services
- Free contraception (MAOR115)
- Asthma management (COOC0036) (MAOR0105)
- Outreach immunization (COCH0013)
- Nursing Service (MAOR0110)
- Healthy families early prevention. Capacity and capability (MAOR0112)

Some of these services are provided by nurses, and some by non-clinical team members (e.g. kaiaiwhina, community social workers). The main nurses providing care for people with long term conditions are Māori Mobile Nursing Services and Whanau Ora nurses.

There are approximately 15 Whānau Ora nurses across four providers (Te Kupenga Hauora Ahuriri; Kahungunu Health Services - Choices; Te Taiwhenua o Heretaunga Trust; Central Health (formerly Te Whatuiapiti Trust)). Note that not all Māori providers have nurses, those that do mostly have registered nurses, and one has an enrolled nurse. Also, not all nurses working for Māori providers are Māori.

The above contracts are spread across 10 Māori providers, with the five largest providers listed first:

- Te Kupenga Hauora Ahuriri
- Kahungunu Health Services Trust (Choices)
- Te Roopu Huihuinga Hauora Trust
- Te Taiwhenua O Heretaunga Trust
- Central Health (formerly Te Whatuiapiti Trust)
- Ha o te Ora o Wharekauri Trust
- Kahungunu Executive Ki Te Wairoa Charitable Trust
- Nga Kaitiaki Hauora o Waikaremoana Trust
- Ngati Pahauwera Inc
- Te Whānau o Rongomaiwanine Trust
Other relevant context includes Whānau Ora contracts which are currently being strengthened to deliver healthy eating, physical activity and smoking, as a function of the Hawke’s Bay Health Promotion Strategy: Kahungunu Hikoi Whenua. Māori health provider contracts are being rolled over to 30th April 2010, when there will be a reconfiguration of agreements to align the contracts across the different providers and remove any duplication. The aim of this is to increase clarity about services being contracted and delivered. The DHB is also working on a capacity and capability programme of work for workforce development, and this must tie into any recommendations from the Whānau Ora HIA to promote alignment between the two.

Within the hospital there are three clinical nurse specialists available to participate in the draft programme. They cover diabetes, renal and cardiac. There is also a clinical navigator position being appointed at the hospital to help the Māori patient journey within the hospital.
4. Appraisal Findings: Workshops and interviews

Workshop and interview findings have been grouped into themes to assist with analysis. These themes are not mutually exclusive and some comment within the themes, and between themes, is at times contradictory. The findings represent the views of the participants and are therefore important to consider in any approach or recommendations.

4.1 Current context relevant to the draft programme

4.1.1 Nursing Practice

There were tensions evident between the primary health care environment Māori health providers operate within and the secondary health care environment of the hospital. Participants commented on their perceptions of both contexts and how these impact upon nursing practice and the relationships between health provider sectors.

a. Hospital Nursing Practice

Several participants commented that the hospital provides secondary care and is seen to be highly ‘medicalised’. A participant added that the hospital was also seen as ‘public’ whereas primary care was seen as ‘business’ and this added another layer to the barriers between primary and secondary care.

Secondary care nurses were described as not being focused on, or aware of, the causes of health issues. Many participants were of the view that hospital-based nurses had little idea of what goes on in the community and/or that their perceptions are ‘rosy’. There was a perception that many nurses had gone directly to hospital work after graduation, without spending any time in community nursing. Participants from one provider talked about the mis-perceptions they had noticed among student nurses on placement with them about what community nursing is, and what community nurses do. These participants suspected this misperception was a result of their nursing training, and that many hospital-based nurses had experienced the same training without any ‘reality check’. Another participant argued ‘technical experts’ who do not have community knowledge need to acknowledge their need to learn about the communities they work with (also see below, ‘c. Relationships’).

b. Community Nursing Practice

Although primary care in the community has a health promotion and prevention approach as a key focus, it also has a clinical role. Whānau Ora nurses were described as having a clear understanding of clinical care and coordinating it within the community. They were seen as providing a link between all the different specialties patients with multiple health conditions and their whānau need to engage with. Whānau Ora nurses are also still up-skilling even though they are not in secondary care, so it would be a mistake to think that they do not have good clinical skills. Many were participating in peer and case review organised by their provider organisation. They have an understanding of Māori health, determinants of health, and the use of strength-based approaches with patients and whānau.

Many participants disagreed with the assertion in the draft proposal that community-based nurses were inexperienced. Many of the community-based nurses attending the hui had worked in the hospital context and were experienced in both hospital and community-based work. At the same time, providers were committed to the professional development of nursing staff so were able to see and comment on if, and how, the draft proposal might ‘fit’ in

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2 Rather than describing the community nurses as lacking in clinical skills, they were described in the proposal as young in their clinical trajectory which can result in a lack of clinical depth in provider services.
with the professional development needs of their nursing staff (also see below, 'Workforce Development').

Participants also talked about the way Whānau Ora nurses worked with whānau and the importance of engaging with whānau in a non-judgmental way. For example, focusing on the patient and not looking around at their environment/home; using layman’s terms to explain things; being culturally responsive (e.g., karakia, manaaki); and being flexible and responsive (and not treating everyone the same). It was also acknowledged Whānau Ora nurses often provide care for the whānau rather than just the patient - even when the intent of the visit was clearly to treat the one patient.

c. Relationships

Some participants described positive relationships that already existed between the community-based and hospital nurses, where providers felt they could call upon the skills and expertise of the hospital nurses. The proposed initiative was therefore seen as a way of continuing and improving existing relationships, as well as building new relationships.

A number of participants talked about the importance of ‘attitude’ for the success of the proposed initiative. For example, one participant described how the shift from a hospital into a community setting requires health professionals to become ‘listeners’ rather than ‘tellers’. It was therefore important the hospital nurses were prepared to take this step. Another participant commented that the attitude of non-Māori nurses who worked in Māori health provider services was very important. These nurses needed knowledge, and an appreciation, of the Māori and other worldviews. This would enable them to be responsive to people from other cultures. Another participant predicted problems if a hospital nurse specialist was officious and unable to build rapport.

Some participants were concerned that if the hospital nurses had bad experiences working within this initiative that it might have repercussions for the care of patients when they were in the hospital. One participant also expressed concern that hospital nurses learning more about the determinants of health for Māori would not necessarily result in better outcomes for patients. This participant’s experience was that this knowledge does not always prevent the imposition of pre-conceived ideas about patients and their whānau. Nurses need the right ‘attitude’ to learning about the ‘reality’ of life for whānau if it is to lead to a change in the nursing practice of speciality nurses.

Participants talked about the need for hospital nurses to develop a deep understanding of, and an ability to build rapport with, Māori. They stressed that this requires much more than learning ‘rules’ or a recipe they could apply when working with Māori patients and their whānau. It was emphasised by some participants that the hospital nurses need to ‘go on a journey’ with the Māori providers into the community, and into whānau as knowledge about whānau and Whānau Ora was not something that they could learn quickly. The issue of mutual respect was seen as important and also as something which takes time to develop; it cannot be rushed and the time needed has to be resourced.

The draft initiative proposed here was seen as similar to other initiatives. For example, one participant talked about nurses from Specialist Care Baby Unit and community nurses working together, with the Baby Unit nurses spending a week or two working alongside providers. The Baby Unit nurses benefited from visiting the homes of the babies and their whānau and seeing the realities of their lives.
4.1.2 Workforce development

a. Who should be included?

There was some discussion among participants of which part of workforce was going to benefit: many Māori health providers have non-Māori nurses working for them; and there are many Māori community-based nurses who do not work for Māori providers. If the aim of the initiative is Whānau Ora and the reduction of disparities then Māori and non-Māori community-based nurses who are responsible for Whānau Ora need to be part of workforce development. On the other hand, if the money for the initiative comes from a Māori workforce source then it makes sense to involve/include all Māori community-based nurses regardless of who their employer is.

Providers also talked about if, and how, the programme could be extended beyond nursing staff as many of their other staff have close contact with whānau with long-term conditions and would benefit from the professional development, education/support. They were also reluctant to single out nursing staff, especially when other staff were now very interested in finding out about better care management. For these providers the proposed initiative would include: practice nurses, enrolled nurses and community support workers. Community support workers are often the first point of contact for whānau in the community when they seek primary health care so involving and up-skilling these staff was seen as very important. This would also signal that the medical model of health care is not the only answer to health issues faced by whānau.

There was discussion about whether the initiative would be useful for Tamariki Ora nurses with some participants indicating they would probably be interested if there was a paediatric nurse specialist involved from the hospital. Tamariki Ora nurses were also considered to be on their own ‘journey’, and getting professional development already.

A question was raised by a provider about whether District Nurses would be involved as they also have a lot of contact with whānau, and are often the point of follow-up contact with whānau once a patient comes out of hospital.

b. Academic credit

Regardless of which staff were involved participants discussed the possibility for some academic acknowledgement of the new learning nurses (and possibly other staff) would be engaged in. If nurses were able to get academic credit the programme would contribute to their ongoing education and eventually a pay increase. Participants stated Whānau Ora nurses should be encouraged, rather than expected, to go on to gain more academic qualifications.

c. Working shoulder-to-shoulder

A provider commented that there was always a need for staff to have skilled people alongside them, to refresh their skills and support them. The best person to do this for nursing staff, in their view, was another clinical person. They were, therefore, positive about any initiative that would involve a clinic in which hospital and community nurses could work alongside one another. Another participant stated that while working ‘shoulder-to-shoulder’ may build networks and collegiality, it does not necessarily mean people pick up skills and knowledge. Nor does it guarantee reciprocity. This person felt it was essential to break down the barriers, and facilitate communication, between primary and secondary care in order to facilitate sharing and learning. Learning could also be ensured through a structured learning environment (e.g., peer reviews, case reviews), and is subject to evaluation by a skilled practitioner.
An example of a successful clinic initiative was provided by a participant. The half-day clinics (plus half-day review sessions) were the result of a collaboration between a respiratory nurse and a Māori provider and were run at no cost of the provider. The clinics increased understanding of whānau circumstances; meant that whānau did not have to travel to the base hospital for treatment; and reduced the number of ‘frequent flyer’ admissions to hospital.

Following on from the discussion of this model, many participants agreed there was a need for training support for respiratory nurses, as ‘everyone seems to be supporting children and diabetes/renal, but little is done for respiratory’ and this was considered to be a big issue for whānau.

Other participants felt hospital nurses needed to come into the community and get a sense of what it is to be Māori. Their view was that the hospital nurses needed to pass on their knowledge to the community nurses who would then use the knowledge in their work with whānau.

Providers talked about related initiatives which they had benefited from in the past. For example, the providers meeting in Wairoa used to have regular meetings with a diabetes specialist and a heart nurse. Other initiatives in Hastings (e.g., the nurse-to-nurse café) were too difficult for those in Wairoa to get to. This discussion highlighted the importance of any initiative needing to be offered locally.

d. Cultural Learning

There was feedback from some participants that the initiative should not be seen as an opportunity to enhance the cultural knowledge of hospital nurses. (Although, one participant argued Hauora providers were well-placed to offer this training for hospital nurses.) The DHB has a basic cultural knowledge training programme and this complements the proposed initiative. There were also kaitakawaenga in the hospital who could support hospital nurses in this, rather than them attempting to learn to do it themselves. It was also considered important that the kaitakawaenga be involved in some way so nurses have this support when they are back in the hospital. There was also the suggestion that Māori nurses in the hospital be involved in some way.

4.1.3 Nursing practice for long-term conditions

Many patients with long-term conditions have, or are at risk of getting, more than one condition and end up with very complex medical needs. According to a participant the challenge of long-term conditions for nursing is the need for advanced assessment skills, better pathophysiology and either specialty acute care or disease management skills. Others stressed the need for patient-centred, bottom-up care.

Participants commented that a good time to engage with whānau of patients with long term conditions would be at first diagnosis, and/or at first admission to hospital for that condition. The ideal was for a Whānau Ora nurse to be connected with the patient at this stage.

Whānau ora nurses tend to be mobile and visit patients at home. Seeing patients at home has the advantage of whānau involvement. Nurses can also develop an understanding of patients’ home conditions, especially the barriers to care that patients and their whānau deal with on a day-to-day basis. Commentary on the Chronic Care Model in the literature stresses the importance of healthcare teams understanding the realities of patients every day lives (Bodenheimer et al., 2002; Wagner et al., 2003). Participants also stressed the importance of sharing the positive aspects of whānau life, as an emphasis only on the negative may be too confronting for nurses and therefore not helpful.
Clinics may be more efficient and may work well for some patients, but participants believed clinics may not suit all patients. Clinics also have the advantage of fostering a team approach which is important with long-term conditions. A team approach also builds networks and connections, including team members’ knowledge of services that can be accessed in the hospital and in the community. As one participant stated, ‘Nurses need to work together for the benefit of their clients; they need to respect each others’ knowledge and skills’.

Other work has shown it is not easy (or desirable) to select out the person with the long-term illness and ignore the care of the rest of the whānau on a visit. This ‘leaking over of cases’ must be prepared for and expected. In a clinic or home setting it was seen as important that any nurse involved in patient care be able to offer ‘real whānau care’.

Participants advised that tangata whaiora with long-term conditions may be whakamā and not want anyone to know about their condition. A providers’ role was to work with them to help them to understand and accept their condition, and the treatment they received for it. This might involve arranging travel for them to get to clinics and/or sitting in with them during doctors visits.

4.1.4 System

Many participants talked about Māori having bad experiences in Hastings hospital. The patient journey they were concerned about was not just the transfer of patients between the community and the hospital, and vice versa; it was also about Māori patients’ hospital stays and the treatment whānau received.

The importance of communication and agreement at a systems level was seen as pivotal to the success of any attempt to coordinate activities and initiatives between the hospital and Māori providers. So, for example, at the nurse level cooperation and relationships might be good but this will be hindered if there is not agreement and communication at a management level. Participants therefore saw the need for any MoU to be a ‘living document’ and something managers must buy in to, and that everyone knows about.

If there is systems-level cooperation this would facilitate, for example, the sharing of patient notes; consistent communications with patients and their whānau; and clearer processes and shared goals. It would also impact on better discharge planning (see below). According to participants this interface between the primary and secondary care environments needs support, resources and understanding.

Providers also talked about the willingness of the hospital to invite community-based nurses to case reviews and in-service training. Participants noted that if this occurred it would go a long way to building relationships and sharing skills between primary and secondary care. It would also mean patients would hear the same language from the all health providers they are in contact with (i.e., consistency of communications).

There are workforce development initiatives for Whānau Ora nurses being implemented through Tu Mai and it was recommended the DHB make sure the different programmes complement, rather than overlap with, each other. Dianne Keip (DHB) has 3 pilot programmes in the planning phase. This work will be useful to inform the new initiative. Eldred Gilbert has an example of a successful programme that worked with 25 high risk families – such information could be part of any training programme, even if the programme is no longer operational.

4.1.5 Discharge planning

While outside the scope of this Whānau Ora HIA, discharge planning was discussed by many participants as a critical and particularly problematic area for patients with long term
conditions. Typically there is little or no assessment of patients’ home situations so advice given to patients and their whānau may not be appropriate. As a result patients often require readmission at a later date.

Current access to the wards by Māori Provider nurses is poor. Participants described how even after attending a meeting and agreeing with key hospital staff about the need for Whānau Ora nurses to meet people prior to discharge, Whānau Ora nurses were blocked from going on to the ward by the receptionist.

Another example given was of discharge notes being sent only to the patient’s GP, and not to the Māori provider. Providers were looking for some way to ensure they were contacted as a matter-of-course when one of their patients is discharged from hospital (as provider information is already being collected in the patient files). Ideally the patient’s Whānau Ora nurse would be included in case meetings and discharge planning.

It was acknowledged discharge planning issues were linked to understaffing in the hospital and the late-night requirement for beds. Participants suggested the situation could be eased if discharge planning was made a nursing responsibility, rather than a medical responsibility. Improved discharge planning was also seen as a potential outcome of the proposed initiative.

Participants described a special programme for ‘frequent flyers’ that Tauranga Hospital uses, where a special flag in the patient notes means a case manager is assigned to look after the patient journey. A similar programme is to be launched in Hawke’s Bay soon. Much of the necessary data is already collected on the hospital forms (Māori Provider etc), but at this stage it is not used. The new scheme may help avoid a situation familiar to several participants where a single child was admitted into the hospital more than 50 times, before the Māori provider was contacted.

4.1.6 Patients and Whānau

Participants commented about the preparedness of patients and whānau to be involved in any initiative that would involve introducing them to another health care provider; namely, a hospital-based, non-Māori clinical care specialist nurse. There was concern about how patients and their whānau might react to the introduction of a new person to their care routine, especially if care was currently being primarily provided at home. A participant talked about the risk to the relationship between the Māori health provider and the patient if things went badly with the additional health professional. There is a risk the patient might disengage from the health provider.

There was some tension about whether or not the hospital nurses should be invited to accompany the community nurses into patients’ homes. Tangata whaiora, for example, might find the presence of another person very disruptive and threatening. It was noted that it would be important the patient’s permission was sought before additional person was introduced into their care. While a few participants had concerns about whether this could be done in a way that truly gave patients a choice, other participants were certain patients would feel they could refuse without thinking their care might be compromised. Some participants also felt only certain homes would be suitable for such visits.

A participant also described how Māori can have entrenched attitudes about what is culturally appropriate health care. This participant also emphasised the importance of discussion and explanation along with permissions being sought, as people want the best for themselves and their whānau and will appreciate the need for examinations and practices that they might initially consider culturally offensive. The importance of three-way discussion between: hauora nurses, hospital nurses and community was stressed.
Participants raised the issue of which patients would be able to participate in this initiative. There was a concern only Māori patients would be involved and it was noted that if non-Māori patients were enrolled with a Māori provider they should also be included (if, for example, a clinic was to be offered). Other participants raised the issue of Māori patients with long-term conditions who were linked into other, non-Māori, primary care services. The proposed initiative would not address the skill level of the nurses providing care to these patients and their whānau. Others felt it important to ‘get it right’ for Whānau Ora nurses first before any thought of expansion to other primary care nurses. Hawke’s Bay PHO already has a cultural practice training programme for all its staff and extends the training to staff from other PHOs.

A participant stressed the importance of ensuring that, if a clinic was offered, it was accessible in terms of transport, child-friendliness, waiting times and opening hours. For another participant it was important clinics be close to whānau. Such a clinic would provide whānau with an opportunity to ‘opt in’ to receiving care from someone they know who is working alongside a clinical specialist. Only those patients happy to be involved in this would be selected.

Finally there was an acknowledgement that sometimes things ‘fall over’ because whānau are not doing their bit, and that this is not the fault of either nursing service.
5. Appraisal Findings: Causal pathways

Whānau Ora health impact assessment seeks to identify potential positive and negative pathways on Whānau Ora from the proposed training programme. Once identified recommendations can be made to support and enhance potential positive pathways and reduce or eliminate negative pathways. All of the following pathways are components of Whānau Ora. The positive pathways fall into three categories:

- Potential to maintain and develop relationships
- Potential for knowledge transfer
- Potential to improve patient and whānau outcomes
- Similarly, the potential negative outcomes fall into three categories:
  - Potential to disrupt relationships
  - Potential to hamper knowledge transfer
  - Potential to decrease patient and whānau outcomes

These are described in more detail below, followed by a discussion of the facilitators of, and barriers to, the pathways.

5.1 Potential positive pathways on staff and patients

5.1.1 Potential to maintain and develop relationships

**Building relationships**

There is potential to build relationships between three groups:

- Nurse-to-nurse
- Organisation-to-organisation
- Nurse(s)-to-patient/whānau

Many participants discussed these outcomes, as nurses will get to meet each other and learn from each other and develop mutual respect. This will assist at an organisational level as relationships and trust will build between hospital and Māori Providers, and at an individual level as the nurses' relationships develop. The relationships between nurses and whānau also have the opportunity to be further developed as a team approach to care of long term conditions is implemented.

In the literature Harris et al. (2007) noted that ‘Regular interpersonal contact helps to build professional trust and understanding of each others roles… we need to develop models where providers who are not necessarily co-located can work as a team.’

The need for clinicians to recognise the realities of patients’ lives was discussed by a number of the authors commenting on the Chronic Care Model for people with long term conditions. Wilkes et al. (2008), for example, noted that high quality care is associated with health professionals having a fuller understanding of the patient's life and preferences, the importance of family care givers and nurses, rather than doctors, because of “their education and role.” They stressed that successful care takes account of the complexities patients face on a daily basis.
**Team approach**

The training programme has the potential to lead to a better team approach, better networks and connections. Using a team approach each nurse would work to their skill set, where planned management (and assessment of long term conditions and routine tasks) are prioritised by the Whānau Ora nurse and acute management by the hospital specialist nurse. The programme can also support team linkages at the hospital via good communication with kaitakawaenga.

A number of commentators in the literature support the building of relationships between health professionals as a positive step in the management of patients with long term conditions (e.g., Abbott et al., 2007; Harris et al., 2007; Saxe et al., 2007). Boyd (2006) also reported the need for the full range of health professional – including dietitians, pharmacists, physiotherapists and social workers to be an integral part of any successful multi-disciplinary team in the treatment of patients with long term conditions.

**5.1.2 Potential for knowledge transfer**

**Knowledge transfer is three way:**

- Between nurses
- From nurses to patient/whānau
- From patient/whānau to nurses

The programme has the potential to support knowledge transfer by all who participate. For hospital nurse specialists to better understand the life circumstances of patients/whānau, and of the planned management and assessment approach of the Whānau Ora nurses, and the wider determinants of health approaches. Wilson (2008) also stated that “Positive health experiences stem from meaningful partnerships established between nurses and clients, and influence the efficacy of healthcare providers. In such partnerships nurses bring health and illness expertise while Māori women bring the knowledge about their health beliefs and practices and life circumstances.”

For Whānau Ora nurses the transfer of knowledge is around ‘sharp end acute clinical skills’ and how these can be blended into a Whānau Ora approach by the hospital nurse specialist in the team. Each nurse will have their current understanding reinforced and deepened by sharing their knowledge with others. In the literature Nettleton and Bray (2008) identified professional mentorship, both formal and informal, as important in fostering professional growth in knowledge, skills, attributes and practice. They noted that the mentors themselves can benefit from the mentoring role especially when mentoring is formally recognised and contributes to the mentors’ own professional development.

There is also potential for patients and their whānau to understand the importance of planned management of long term conditions and of acute care.

**To embed a new model of practice for long term conditions**

The training programme has the potential to support a greater level of understanding about a team approach and roles of each health worker regarding long term conditions. For example, the planned management and assessment role of Whānau Ora nurses, the acute clinical management role by hospital specialty nurses and the linkages to other providers such as kaitakawaenga, general practitioners and other community support groups.

**To encourage complementary learning**
The programme can support those providers who have case study or peer review of medical notes by clinical nursing specialists; of academic pathways where appropriate for the nurse, cultural competency training and of other learning types that support the Māori nurses in their workforce development.

Boyd (2006) reported that primary care nurses working with patients with long-term conditions using the Care Plus scheme considered there to be a need for workforce development. Boyd reported there is poor workforce development for nurses providing chronic illness care and many nurses do not have the time or financial resources to attend formal post graduate study in part due to the small business model in primary health care and the lack of education funding available. The proposed programme has the potential to address these barriers to learning.

**Awareness of a determinants-of-health approach**

Hospital nurse specialists could take their community knowledge, Whānau Ora, public health and determinants of health approach back into the hospital setting. This may have a flow-on effect to other secondary care colleagues.

**Knowledge of community services and hospital services**

Better knowledge by clinical nurse specialists of services that can be accessed in the community; better knowledge for some Whānau Ora nurses of services that can be accessed in hospital.

The Chronic Care Model describes the use and knowledge of community-based resources, policies and linkages as important in supporting patients with long term conditions to manage their conditions (Bodenheimer et al., 2002; Wagner et al., 2003).

**5.1.3 Potential to improve patient and whānau outcomes**

**Access to a complete model of care within the community**

The training programme has the potential to lead to a model of care that addresses both planned management and acute issues for long term conditions, in a community setting.

Malony-Moni (2006) argued that engagement with Māori must be with the whānau, and that failing to do so will not result in better health outcomes. She identified the accessibility, affordability and appropriateness of health services as being of vitally importance of Māori health outcomes and described nursing in a kaupapa Māori framework as: being non-judgmental, caring, whānau-oriented, whare- and marae-based, empowering clients in managing their health and working with kaumatua and kuia in developing co-ordinated and collaborative care. Malony-Moni noted the success of seeing patients in their own environment particularly noting that there is often more than one person in the family with the same problem/illness and that sharing information and education all the whānau together is more effective than education the patients alone. She found in this environment patients frequently shared information with others in the community and marae.

**Reduced risk**

Provision of consistent messages and appropriate advice around planned management and acute care as required has the potential to reduce risk to the nurses and organisations, and a safer service for patients/whānau. Better handover between primary and secondary care was also considered to be a potential outcome. Participants commented that one wrong decision can follow a nurse (and a service) for many months/years and reducing that risk is important. Another participant said it would “help to ensure that I’m practicing safe, and that my colleagues are practicing safely.” She went on to describe how nurses in the community may
not have teams to talk to, and have to make decisions ‘now’ about treatment and commented that any support for nurses in this environment would be beneficial.

**Fewer emergency department hospital visits**

Participants commented that running side by side community clinics also meant the patient would not have to travel to the base hospital for an appointment and it was perceived this would reduce the number of ‘frequent flyers’ back into the hospital via the emergency department.

**Better hospital experience**

The patient would know at least one person (the hospital nurse specialist) in the hospital system, and this may assist them when admitted.

In the literature Bowler (2006) described a British nursing programme in which community nurses developed relationships with acute hospital staff especially those in urgent care services, admissions, wards and the hospital discharge liaison team was found to help breakdown traditional boundaries and which enabled the community nurses to follow the patient’s pathway through the hospital and ensure smoother admissions and timely discharge.

Wilson (2008) also noted that ‘Culturally appropriate services are fundamental for improving the access and use of services by Māori women.’ and commented that Māori are not a homogenous group and that there is a great diversity of views and practices.

### 5.2 Potential negative pathways on staff and patients

#### 5.2.1 Potential to disrupt relationships

**Nurse to nurse**

Several participants thought there may be a risk of ‘culture clash and antagonism’ if the exchange is ‘jumped into straight away’ and noted both sets of nurses are unlikely to be prepared for what is expected of them, or the situations they may find themselves in. For example hospital specialty nurses may have less of an understanding of what goes on in the community or have a ‘rosy’ perception; and Whānau Ora nurses may have an unfair picture of their nurse specialist colleagues.

**Organisation to organisation**

If employers do not see the value, do not release staff, do not agree to be part of the programme, or have a bad experience from the programme then the scheme may not succeed and relationships will have experienced another blow.

**Patient/whānau to nurse**

Nearly every participant raised the issue about whether whānau would want another person participating in their care especially at home. Participants commented there was a potential risk to the relationship between the whānau and the provider, and of whānau disengaging, if;

- things had gone badly with the additional health professional
- the bond of trust already established was broken.

**Inappropriate use of Māori workforce development funds**

There is little funding available for Māori workforce development and it needs to be used for development of that workforce, not development of long term condition models or resources.
5.2.2 Potential to decrease patient and whānau outcomes

The potential for the bond between patients and provider breaking down makes ongoing treatment difficult and potentially prevents the patient/whānau from receiving appropriate care. Some patients/whānau are already uncomfortable in mainstream healthcare due to past poor experiences, if this is replicated with Māori providers there are few options for care remaining and patients may opt out of care completely.

5.2.3. Potential to hamper knowledge transfer

*Nurses not having the time, support or resources to prepare adequately*

This has the potential for little or no knowledge transfer; where ‘we’ve tried working together and it didn’t work’. Getting it right first time is important.

Several commentators in the literature cite the need for both teachers and learners to be supported and given the time and opportunity to learn and particularly note the need for support from management and colleagues for learning situations to be effective. (Harris et al., 2007; McCormack et al., 1999; Vallant and Neville, 2006).

*Undermining of confidence in Whānau Ora nurse*

Some patients/whānau might get the impression the Whānau Ora nurse is ‘not good enough’ as there’s now a pakeha nurse in the room. The patient/whānau in the future may want the pakeha nurse ‘all the time’ as he/she helped me with an acute condition.

5.3 Facilitators and barriers (factors that may support or negate potential pathways)

The items below are actions that may affect whether the positive and negative outcomes occur. These factors typically have a dual action, where if the action is done well, the positive pathway is more likely to occur, whereas if done poorly the negative pathway is more likely. Respondents reported both potential positive and negative outcomes, whereas we have listed the positive aspect of each factor to prevent duplication.

5.3.1 Preparation is important to facilitate positive outcomes

*Preparation to maintain and develop relationships*

- A suitable timeframe

Preparation time is required to allow nurses to work out the best ways to work together. Developing a trusted bond and mutual respect cannot be rushed. Nurses need to be familiar with, and at ease with, each other before they ‘work together with patients’. This will allow them to be ready for difficult situations that might come up and know how they will work together to deal with them. If they are comfortable and working as a team it will help to put patients at ease and more accepting of a different kind of care. Team building/bonding with nurses is an important first step.

A number of commentators in the literature strongly recommend the need for preparation of both the teacher and the learner and especially note that there must be a positive attitude and mutual respect between the mentor and mentee (Andrews and Wallis, 1999; Duchscher, 2001; Flanagan et al., 2000).

- Trust nurses to select who to work with

In preparation for the training programme nurses could self-select their ‘buddy’, so natural rather than forced relationships develop. Individual practitioners and their attitudes really matter. If either is officious or difficult building rapport will be a problem.
McCormack et al. (1999) describe the notion of a ‘critical companion’. This person supports the learner and requires personal characteristics such as supportiveness, approachability, empathy and the ability to think laterally and non-judgmentally and be able to work across role and structural boundaries in the service. Others note the need for mutual respect and the right attitude as being important in the teacher/learner relationship (Andrews and Wallis, 1999; Vallant and Neville, 2006).

- Existing staff should be included in the preparation

Kaitakawaenga, for example, may be a source of information and stories about moving between the two worlds of hospital and community. Integrating their experience into the training programme should be explored. They are also an important navigator for patients’ journeys between the hospital and community and know the skill required to achieve successful transition for patients.

- Engage key players early

Preparation with key decision makers is important. Engage these stakeholders early in the process to ensure buy-in.

**Preparation to assist knowledge transfer**

- Initial training is important

Initial training of both sets of nurses before they go out into the field will be needed to ensure maximum knowledge transfer occurs. Sharing knowledge is not straightforward (despite some taking it for granted), and skills to do it well need to be learned. The shift into sharing knowledge often requires professionals to change from being a ‘teller’ to a ‘listener/supporter’ and this is a hard shift for some people.

A number of commentators in the literature also noted learning did not automatically result from people working together. Flanagan et al. (2000) noted there are distinct conditions which must accompany participative learning in the workplace. These are that the learner must have a desire to learn, that it must be within the learners’ capabilities and that the work environment must be prepared to support work-based learning. Duchscher (2001) observed that some commentators noted that just being experienced is not sufficient qualification for being a good teacher or mentor and that a number of personal attributes and conditions are necessary to facilitate successful learning.

McCormack et al. (1999) noted that while “experience is a valuable source of knowledge in order for it to become learning there must be a systematic approach to assist nurses reflect on practice experience and synthesise the learning.” They also noted that adult learning theory argues that learning is most effective when the learner is able to make sense of new knowledge in the context of their immediate life experience. It is also noted that it is easy underestimate how much support nurses need to meet those challenges.

Flanagan et al. (2000) also noted the need for both learners and teachers to be prepared for their role. “The fact that nurses have long been involved in providing learning opportunities in clinical settings does not mean that those who support learners in undertaking work-based learning will automatically have the necessary skills.” They stressed the need for the ‘teachers’ to be appropriately skilled. They also recommended ensuring there is clarity about expectations not only of the learners but also those of their colleagues so they understand the value of the planned learning outcomes and can see long benefits from it.

- Whānau knowing what to expect
Engaging whānau early in the process is a key component of the long term conditions model (for good care) and is equally important for this training programme. If whānau know what the plan is before it happens, understand what is happening and why is important, they will be more likely to cooperate, agree and participate fully. It is essential there is a two-way knowledge transfer between the patient/whānau and the nurses.

- Use trusted models to transfer knowledge

Mason Durie’s powhiri model of engaging with whānau might be a useful model to pursue in orienting hospital specialty nurses about how to engage with people in a community setting.

- A clear model of care for long term conditions that everyone understands

This training programme will create new roles for practitioners. Protocols will need to be put in place about how care is negotiated and possibly changed because of the involvement of the clinical nurse specialist eg prescribing (there will be a need to involve the prescribing general practitioner). The relationships need to be established so these changes can happen if need be (professionals must not get into care disputes in front of a client/whānau.) There needs to be a good communication system in place between all those involved in the health care of the whānau, and possibly even other non-health agencies that have responsibilities with the whānau.

The New Zealand literature strongly supported the need for holistic whānau care (Malony-Moni, 2006; Simon, 2006; Wilson, 2006).

**Preparation to assist patient and whānau outcomes**

- A clear model of care that is described, understood and agreed to by the patient/whānau about planned management of long term conditions, and the importance of that alongside acute care.
- An understanding of how the model of care moves between whānau, community, primary and secondary care, and agreement of the roles of patient/whānau, health and non-health workers involved in the management of patient/whānau long term conditions.

**5.3.2 Process and approach are important to facilitate positive outcomes**

**Processes and approaches to maintain and develop relationships**

- Ethics – Whānau

The power dynamic is important when seeking permission for a home visit with whānau. For example, who should seek permission so the client does not feel their care will be compromised should they refuse. Care is required to prevent unintentional inference of coercion, and to ensure relationships are maintained. Seeking permission is probably best managed by the Māori provider.

- Ethics – Nursing practice

There are ethical issues around the reporting of unlawful activities a health professional may see within a home (Health Practitioners Competency Act). Processes must be clear on legal responsibilities and liabilities. This can then feed back into the informed consent process.

- In-home visits

Nurses need to share in the positive aspects of whānau life, to take the edge off the harsh realities of some whānau’s lives and to help maintain the positive relationship that exists.
Without this sharing it might be too confronting and unhelpful for both nurses and/or patient/whānau.

**Processes and approaches to assist knowledge transfer**

- **Joint clinic work**

Clinics are acceptable for patients/whānau, as long as access to the clinics by whānau is not a problem. Maniapoto and Gribben (2003) in an evaluation of a primary care clinic set up to deliver accessible, culturally acceptable care to Māori living in a high-need area noted its success as being attributable to cultural acceptance because it met their diverse needs, was easy for people without transport to get to it and its affordability.

The literature also touches on the value of the environment in which learning takes place. McCormack et al. (1999) noted that a number of commentators stressed the value of the learning taking place in the environment where it would be used. The application of learning in real-life situations is likely to be more salient for both the learners and the teachers since the cultural and social interactions are an important part of the learning process.

Field (2004) also noted many researchers identify the difficulty of transferring knowledge learned in one situation to other slightly different situations and quoted research which noted the value of learning that takes place within real life contexts where learners were allowed to participate legitimately as “learners”. She also added that learning is a process that takes place within a framework of social participation.

- **Back-fill nurses**

The use of back-fill nurses at Choices (a Maori provider) appears to be an approach that is working well to allow nurses to participate in other learning opportunities.

- **Shared ‘kete’ of knowledge**

The concept that knowledge is not owned by any one group/person and must able to be shared by nurses and patients must be understood by all participants.

In the literature review Wilson (2008) supported this noting that one of the underlying premises of cultural safety is the recognition that diversity exists not only between cultural groups but also within them. So nurses learning about specific beliefs and practices are unlikely to learn enough to achieve culturally safe nursing practice. Wilson stated that “the establishment of relationships with clients to elicit the cultural beliefs and practices that need to be respected and integrated into their health experience is essential. Consequently, it is the recipient of nursing care who determines whether a nurse’s practice is safe not nurses.”

- **Regular and transparent review and evaluation processes**

The training programme can link into existing review and evaluation processes, and develop new systems as required and allow the programme to be adapted as required. This will help manage risks and problems as they arise.

- **Sustainability**

Sustainable relationships require documentation at a strategic level, such as in the District Annual Plan. Sustainable funding would reduce any reluctance by organisations to take part, as it would be seen as an ongoing initiative and not just a pilot.

**Processes and approaches to assist patient and whānau outcomes**

- **Understanding of Māori treatments**
Hospital nurse specialists will need to be open to rongoa treatments and have an understanding of these prior to meeting patients/whānau. This is an important component of the complete model of care.

- Clear and consistent messages about the long term model of care and the roles of all players consistently applied throughout the approach.

5.3.3 Systems can support the pathways

**Systems that maintain and develop relationships**
- Memorandum of understanding

An MOU can make the relationship concrete from the start. By ensuring that everyone knows about the MOU, and having appropriate expectations about what each agency (hospital and Māori providers) think they are putting into, and getting out of, the relationship is important. Relationships will be strengthened if each health professional knows and understands what expected roles and responsibilities are.

- Senior management engagement is required to maintain long-lasting organisational relationships.

**Systems that assist knowledge transfer**
- Access to medical notes

Everyone needs access to the same information to assist with knowledge transfer. Information technology developments that allow better access to patient notes for both primary and secondary care, to facilitate a seamless flow of information, are required.

- Agree performance measures across organisations

Include measurable outcomes such as fewer emergency department presentations.

The Chronic Care Model lists shared clinical information systems and the use of evidence-based guidelines to provide standards for optimal care as important components in the successful care (Wagner et al., 2001).

**Systems that assist patient and whānau outcomes**
- All systems developed should have an eye on how they will assist patient and whānau outcomes to ensure that bureaucratic systems are not implemented.
6. Discussion

When taking a Whānau Ora approach to decision making it is important to acknowledge that many of the determinants of Whānau Ora are outside of the control of the health and disability sector. The health and disability sector however have a valuable role in ensuring that its programmes support Whānau Ora as much as possible. Hence the role of this Whānau ora HIA was to take a draft programme developed by the Hawke’s Bay District Health Board out to key stakeholders to ask them whether the draft programme “looked like a good idea or not and if it could work for them?”. And if it seemed workable, then how the draft programme could be structured to support Whānau Ora?

The District Health Board acknowledged the draft programme taken out to key stakeholders was ‘not perfect’, and the HIA gave key stakeholders the opportunity to comment freely and frankly on the programme at an early stage of its development. Stakeholders were generous with their time and ideas, particularly as to how the draft programme might work for them, and what the benefits might be for them and patients/whānau.

Key themes emerged from the findings, grouped around:

- maintaining and developing relationships
- knowledge transfer
- patient and whānau outcomes

The themes could either be positive or negative, and that largely depended on whether or not key facilitators or barriers might exist. If participants believed the barriers were more likely to occur, then they believed negative outcomes would more likely follow. Conversely, if participants believed the facilitators were more likely to occur, they believed positive outcomes were more likely to occur.

The potential positive and negative impacts, with their preceding facilitators or barriers are represented within Diagram 1 and 2 below. These barriers and facilitators make clear where potential recommendations can (and have) been made to prevent the potential negative pathways from occurring and to promote the potential positive pathways. Diagram 1 shows that the potential positive pathways arising from the clinical and cultural nurse training programme are dependent on three facilitators being met – systems in place; good preparation; and excellent process and approach. If these facilitators are achieved the potential positive outcomes include maintaining and developing relationships; knowledge transfer; and improvements in patient and whānau outcomes. All of which are likely to improve Whānau Ora outcomes.
Diagram 1. Potential positive pathways.
Diagram 2 shows that the potential negative pathways arising from the clinical and cultural nurse training programme are dependent on three barriers occurring – systems not set up; insufficient preparation; and processes and approach lacking; poor preparation; and poor process and approach. If these barriers occur then the potential negative outcomes include disruption to relationships; hampering of knowledge transfer; and potential to decrease patient and whānau outcomes. All of which are likely to reduce Whānau Ora outcomes.

Diagram 2. Potential negative pathways.
7. Recommendations

7.1 Preparation required for the training programme

A clear description of the proposed training programme is outlined. We have drafted a second proposal (Appendix B) outlining:

- Aims and objectives
- The health and community workers included/excluded from the training programme
- Background on long term conditions
- Potential ways to work together
- Be clear the money for this training programme is to support Māori workforce development, and that other funds will be needed to support the other resources/development sought for long term conditions.

7.2 Preparation required in other areas to support the training programme

- A clear description of the model of care for long term conditions describing the team approach, roles and settings of patient/whānau, primary care workers hospital based staff and community workers is developed. This description should discuss the difference between planned management, assessment and acute care and how they relate to this training programme.
- A ‘contact details resource’ allowing training programme workers to contact each other and key service providers in the community and hospital.
- Develop clear and consistent messages (plus any necessary resources) for use by nurses regarding planned management, assessment and acute care of long term conditions.

7.3 Processes and approaches within the training programme

- Allow complementary learning to occur, including academic learning, cultural competency, and other learning processes that would complement the training programme.
- Use key concepts that underpin the training programmes processes and approaches – such as Mason Durie’s Powhiri model for engaging whānau, a determinants of health approach, a holistic Whānau Ora centered approach, a positive approach about whānau life.
- Have a staged approach to developing trust and relationships that recognises one size will not fit all and that each provider organisation should develop its own protocols which might include:
  - The development of a memorandum of understanding between organisations
  - Ways for nurses get to know each other and discuss ways of working together and who/how to make it happen, e.g. include hospital kaitakawaenga or no; models of care chosen to underpin their work. Allow relationships to develop and to reach agreement to work together.
Consideration of starting with patient note reviews and case reviews (patient not present)

Building towards clinic-based shared learning – with roles clearly delineated and full approval of patient/whānau. Good transport access to the clinic is required.

A final stage objective which may be in-home shared learning. Consider full day clinics with the second half of the day as case review to share learning.

Prepare for ethical issues regarding the consent of patients/whānau to participate in the training programme, and any potential issues around health professional responsibilities while in the home.

Use an action research approach where each provider sets the tone for what occurs and how (within the framework), with built-in review and evaluation on a regular basis.

### 7.4 Systems

Begin the training programme with Māori providers who are interested in being involved from the outset, offering it wider as the process becomes more developed. Allow Māori providers to self-select their involvement and ‘go where the energy is’ in the first instance. Maintain the buy-in of these key decision makers and develop a memorandum of understanding between the organisation and the District Health Board.

Back-filling of nurses is critical to the success of the programme so nurses have adequate time to set aside for preparation, ongoing processes and review/updating.

Write the training programme into the District Annual Plan and secure sustainable funding.

### 7.5 Future

Development of discharge planning is required so that a patient is handed from hospital to Māori providers (and not just a hand over to the general practitioner). For example, make discharge planning a nursing responsibility not a medical responsibility. Data is already collected as the discharge forms have Māori Provider as a ‘box’.

Information technology developments are required so that patient notes can be shared between Māori providers, hospital and other key primary care agencies.

At some point, expansion into primary care will be needed as many patients with long-term conditions are not managed well in primary care – but first get it right for Whānau Ora nurses.

Use the Whānau Ora nurses in a training capacity within the DHB ‘cultural training programme’ that is already ongoing. Brings the Māori patient journey into an already good training programme.

Consider adding respiratory nurses as soon as possible as there is a perceived unmet need in this area.
Appendices

Appendix A: Participants in the Whānau Ora HIA

Ana Apatu (Hawke’s Bay District Health Board) -
Tuakana August (Hawke’s Bay District Health Board) -
Potace Bennett (Māori/Pacific health Co-ordinator, Hastings Health Centre) -
Kataraina Clarke (Te Taiwhenua o Heretaunga) -
Fiona Cram (Katoa Ltd) -
Lois Dawson-Mikaere (Public Health Nurse Flaxmere) -
Maria Elstone (Practice Manager, Choices) -
Makareta Epblett (Mobile Primary Care Nurse Specialist, Community Hauora Services Te Taiwhenua o Heretaunga) -
Rob Ewers (Service Manager, Central Health) -
Donna Foxall (EIT Nursing Lecturer) -
Eldred Gilbert (Hawke’s Bay District Health Board) -
Leigh Hikawai (Māori Health Co-ordinator, Hawkes Bay PHO) -
Susan Jacobs (Dean, Faculty of Health and Sport Science, EIT) -
Lisa Jones (Hawke’s Bay DHB Population Health Intelligence Manager) -
Dianne Keip (Planning and Funding Chronic Disease management, Hawke’s Bay DHB) -
Ann McCleland (Nursing Lecturer, EIT) -
Robyn McCormack (3rd Year Student Nurse EIT) -
Chris McKenna (Hawke’s Bay District Health Board) -
Tracy McMillan (Health Promotion, Hawke’s Bay DHB) -
Roger Maaka (Dean, Māori Studies, EIT) -
Tracey Morgan (RN, Choices and Hawke’s Bay Rep of the NZ Nurses Organisation) -
Celia Murphy (Quigley and Watts Ltd) -
Joan Plowman (Public Health, Hawke’s Bay DHB) -
Rob Quigley (Quigley and Watts Ltd) -
Maree Rohleider (Hawke’s Bay District Health Board) -
Sharon Rye (Te Kupenga Hauora Ahuriri) -
Rose Smith (Hawke’s Bay District Health Board) -
Victoria Spiers (Clinical Nurse Educator Hawke’s Bay DHB) -
Nancy Taane (Te Kupenga Hauora Ahuriri) -
Jean Te Huia (CEO, Choices) -
Tracee TeHuia (Director of Māori Health, Hawke’s Bay District Health Board) -
Marion Terry (Wairoa PHO practice nurse) -
Jeremy Tumoana (Contracts manager, Hawke’s Bay District Health Board) -
Dianne Wepa (Māori Health Team, Hawke’s Bay DHB) -
Katherine Archer (Impact Health NZ Ltd) -
(Kahungunu Executive Ki Te Wairoa Charitable Trust) -
(Manaaki House) -
(Ngati Pahauwera Iwi Society – Hauora) -
(Te Korowai Hauora ki Ahuriri) -
Amber Riley (interviewed with Tracee Te Huia) -
Appendix B: Revised draft programme

Suggested based on findings of Whānau Ora HIA

Through the course of the Whānau Ora HIA the draft programme moved from a concept/idea that was discussed by the two authors with District Health Board colleagues, to a powerpoint presentation at the Whānau Ora scoping meeting, to a first draft written document that was able to be provided to the Whānau Ora participants for discussion during the appraisal stage. The ‘first draft’ version (highlighted in grey within the full document) was acknowledged at the time to be ‘less than perfect’, but recognised as a starting point for discussion. In many ways a role of the Whānau Ora HIA was to test both the concepts and language used with stakeholders.

This revised draft of the programme is based on the findings of the Whānau Ora HIA.

THE REVISED DRAFT PROGRAMME – NOVEMBER 2009

The Hawke’s Bay DHB has developed a draft programme to establish a cultural and clinical nursing training and support programme. The programme aims to develop the Māori workforce by sharing skills and expertise between hospital specialist nurses from the DHB provider arm and Māori Provider nurses working in the community on the management of long term conditions3. The programme will be a formal structured reciprocal training programme that aims to:

Promote Māori workforce development
- Maintain and develop partnerships
- Transfer knowledge
- Improve patient and whānau outcomes

The draft programme acknowledges the New Zealand Health Care Strategy, the Primary Health Care Strategy, He korowai Oranga and the Ottawa charter as influences on the programme, and the Treaty of Waitangi as a founding document.

Key concepts that will underpin the training programme include Mason Durie’s Powhiri model of engaging with whānau, a determinants of health approach, a holistic Whānau Ora centered approach, and a positive approach about whānau life.

Tu Mai funding for Māori Workforce development has been set aside to support and training programme, and those working with long term conditions were considered a priority area. There is existing support and capacity for undertaking cultural and clinical nursing support and training programme within diabetes, renal and cardiovascular care4. The overall aim of the draft support and training programme is to improve the patient journey for Māori patients5 with long term conditions to improve health outcomes and reduce inequalities.

Background on long term conditions

The goal of long term conditions management is to shift the orientation and design of practice in order to promote a systematic, planned approach to care for those with ongoing health problems through productive planned interactions between informed, activated clients (and families) and prepared, proactive practice teams (Wagner, 1998).

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3 A co-benefit will also be the development of hospital specialty nurses skills and knowledge. -
4 It is noted that ideally respiratory disease would be included in the initiative but at this stage the Provider Arm of - the DHB does not have the resources to offer expertise in this area. Cancer will not be included as part of this - initiative as the pathways of care are substantially different. -
5 And pakeha clients of the Māori providers -
The ‘chronic care model’ (Wagner, 1998) that has been widely adopted in New Zealand, and is used as the basis for work within the Hawke’s Bay DHB is described as having three settings:

- the entire community, with its resources, and public and private policies;
- the health care system; and
- the health-provider organisation, whether a hospital, a small clinic, or a loose network of physician or community practices.

Wagner’s (1998) model identifies 6 essential elements:

- community resources and policies – linkages between health-provider organisations and community based resources such as exercise programmes, home care agencies, community case managers, etc;
- health care organisation – where long term conditions are prioritised by all health providers;
- self-management support – patients [and their whānau] become a key provider in the planned management of long term conditions;
- delivery system design – creation of practice teams, where acute care is separated from the planned management of long term conditions and routine tasks are prioritised;
- decision support - integrate evidence-based clinical practice into daily practice via reminders, and having specialist expertise a phone call away;
- clinical information – computers to provide reminder systems for primary care teams, help provide feedback to doctors, as registries for tracking and planning patient care.

A critical component of this model relevant to the training programme is that planned management and assessment of long term conditions remains a role of Māori Provider services, and that acute clinical care remains a role of the hospital specialty nurse. Neither is attempting to take over the other’s role but to each clearly understand the value each role and know when and how to work together for the best patient/whānau outcome. It also supports the practice of both components, at the same time, in a community setting. The role of patient/whānau is also clearly spelled out, so they are aware of the benefits of each nurse type and the importance of the each role, the patient/whānau’s important role in the management of the long term condition, and how the patient/whānau will be supported as they move within the health and community sectors.

**Who is the Tu Mai funding for?**

The Tu Mai money is for direct use in Māori workforce development, and so funding is proposed to be used to carry out the training programme for the Māori workforce.

- Māori Registered Nurses working in Māori Provider community-based health services dealing with clients who have long term conditions (diabetes, renal, CVD).
- Māori community workers working in Māori Provider community-based health services dealing with clients who have long term conditions (diabetes, renal, CVD).
- Non-Māori Registered Nurses and community workers working in Māori Provider community-based health services dealing with clients who have long term conditions (diabetes, renal, CVD).  

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6 Māori providers have advised that due to the holistic nature of their service they wanted their non-Māori workforce to be included.
Who else will be directly involved as a component of the draft programme?

Nurses within DHB Provider Arm hospital-based services – there is existing support/capacity within diabetes, renal, cardiac nurse specialties to work side by side with Māori providers.

Potential ways to work together

We propose the training programme begin with Māori providers who are interested in being involved from the outset, offering it wider as the process becomes more developed. We propose Māori providers self-select their involvement in the first instance. We hope to maintain the buy-in of these key ‘early adopters’ and develop an memorandum of understanding between the organisation and the District Health Board.

We propose an action research approach be used where each Māori provider sets the tone for what occurs and how, with built-in review and evaluation on a regular basis. For example it may be appropriate to have a staged approach to developing trust and relationships, such as:

- The development of a memorandum of understanding between organisations
- Ways for nurses get to know each other and discuss ways of working together and who/how to make it happen, e.g. include hospital kaitakawaenga or no; models of care chosen to underpin their work. Allow relationships to develop and to reach agreement to work together.
- Consideration of starting with patient note reviews and case reviews (patient not present) -
- Building towards clinic-based shared learning – with roles clearly delineated and full approval of patient/whānau. Good transport access to the clinic is required.

A final stage objective which may be in-home shared learning. Consider full day clinics with the second half of the day as case review to share learning.

The Māori workforce can also be funded to undertake complementary learning on relevant courses, be they academic or non-academic, as requested by the Māori worker.

We note given the level of work already covered by Māori Providers that ‘back-filling’ of nurses is critical to the success of the programme, so that nurses have adequate time to set aside for preparation, ongoing processes and review/updating; while ongoing delivery to patients/whānau continue apace.

The draft training programme may include disease specific knowledge in diabetes, renal and cardiac care (in the first instance), and may also cover:

- Care delivery approaches
- Health literacy
- Motivational interviewing
- Supported self management
- Goal setting
- Lifestyle coaching
- It may also include:
- Clinical and cultural supervision (from whatever source, though non-DHB sources may be more expensive)
• Shared clinics/home visits
• Clinical practice exchanges
• Back fill to allow clinical practice development
• Shoulder to shoulder experiential learning
• Shared clinical tools and methodologies e.g. IT
• Case review
• Best practice exemplars
• Traditional healing, rongoa

What other supports are being investigated to make this training programme work?

Participants will need to prepare for ethical issues regarding the consent of patients/whānau to participate in the training programme, and any potential issues around health professional responsibilities while in the home.

A ‘contact details resource’ so that all people participating in the training programme can contact each other, and the necessary community and hospital providers.

Resources about planned management, assessment and acute care of long term conditions – providing clear and consistent messages that can be used by all service providers.
Appendix C: Literature review

Literature Review for the Whānau Ora Health Impact Assessment of Hawke’s Bay DHB Draft Nursing Initiative for Patients with Long-term Conditions

Prepared by Quigley and Watts, for Hawke’s Bay District Health Board, October 2009

Executive Summary

Models of care for patients with long-term conditions

An increase in the incidence of long-term diseases is making new demands on healthcare systems and internationally new models of care are being developed to ensure patients with long-term conditions receive the most appropriate care. These new models of care recognise the importance of a team approach, good clinical management at primary care level, patient self-care and family/whānau being participants in care.

The importance of good systems - information sharing systems, training for staff, good clinical skills, team work, good communication continuous relationships with the care team, individualisation of care according to patient’s needs, services based on evidence and cooperation among clinicians are all.

Shared care with specialists and primary care working together as a team is promoted as an important way of helping patients with long-term conditions achieve better care and improved self-care. This combination enables clinical expertise to be matched with the knowledge that primary care providers have about the day to day realities facing patients at home in the context of their family/whānau.

Patient-centred care which includes family/whānau is stressed as important both in the models of care for patients with long-term conditions and in Māori models of care. The literature clearly iterates the need for the provision of care which is able to reach the whole family and which ensures the realities of the patient’s life situation are realised and considered. Health consumers place great value on having a clinician and/or team who are familiar with the “whole” patient and family and who are able to coordinate and communicate medical activities across caregivers and settings. In some settings the literature suggests this kind of care is associated with better outcomes.

While advanced clinical knowledge and skills are emphasized as being essential for ideal care of patients with long-term conditions the literature provides examples traditional primary care team members, such as nurses and medical assistants, can be trained to perform aspects of clinical case management.

Studies of community nurse care models which care for patients at home have concluded that nurses in community roles need good clinical skills in assessment, education, planning and delivery of patient care. Mentoring is recommended as a way of fostering the development of clinical capacity for community nurses.

The proposed nursing model would facilitate the sharing and passing on of different skills. The specialist nurses can share clinical skills and the and the Whānau Ora nurses share the understanding of the individual and their living environments. This sharing of knowledge and skills and the development of relationships between the two nursing disciplines would
facilitate a shared care opportunity which should encourage collaboration, improved communication and improved follow up of patients.

The model would also facilitate coordination, communication and establish networks across treatment sites which the literature cites as an important factor in the successful care of patients with long-term conditions. The efficient involvement of specialists with primary care teams may offer the optimal combination of knowledge and skills that chronically ill people need.

Nurses to nurse learning

Much of the literature on learning for nurses related to student nurse training and it was difficult to find reference material that related to the one on one “shoulder to shoulder”. No articles were found which directly reflected the proposed model. However many of the observations are applicable to adult learning and mentoring.

A number of the papers noted the need for both the teacher and the student to be adequately prepared for the role they take on, for mentors to be adequately trained and prepared for the role and “students” to be supported and given the time and space to learn.

The notion that learning is likely to be successful if it is acquired in the situation where it will be used was endorsed by a number of commentators. Evidence has shown the acquisition of clinical skills is context dependent and the ability to apply knowledge and perform competently is dependent on familiarity with the specific clinical context.

The social and cultural nature of knowledge and especially the role that activity and experience play in learning practical skills means that practice-based learning has advantages. This means that learning in the clinical environment is likely to be successful.

The application of learning in real-life situations is likely to be more salient for both the learners and the teachers since the cultural and social interactions are an important part of the learning process. However it was also noted that just getting students to work with qualified staff in practice environments does not guarantee learning. The mentors must be prepared, there must be a good relationship between the mentor and mentee and the mentors supported in terms of recognition of the time commitment and resources required to allow them to do create a relationship which is supportive and beneficial to both people.

Several commentators noted that learning is likely to be bilateral so mentors may also learn from their students and benefit from the mentoring role especially when mentoring is formally recognised and contributes to the mentors own professional development. However poor mentorship can bring lasting consequences for those being mentored. The need for

Research has also stressed the importance of contextual learning, the significance of guided participation in activities and the sharing of focus and purpose between the learner and the more skilled partner.

Whānau ora care

There is a large body of literature which comments on health inequalities in the Māori population which identifies a lack of access to culturally acceptable health care services as one of the barriers to health. However there does not appear to yet be research which measures the health outcomes of services which are considered to be culturally appropriate.

Anecdotal evidence suggests Māori are more responsive to care provided ‘by Māori for Māori ‘ and there is evidence that mainstream services fail to meet Māori health needs because they fail to take account of Māori health beliefs and practices and, perhaps more importantly,
treat the patient and the illness individually without consideration of the “whole” person and their wellbeing in the context of the whānau.

However several commentators noted the importance of the recognition that diversity exists, not only between cultural groups but also within them. So, nurses learning about specific beliefs and practices are unlikely to learn enough to achieve culturally safe nursing practice. Good cultural practice relies on “the establishment of relationships with clients to elicit the cultural beliefs and practices that need to be respected and integrated into their health experience”.

Failure to identify key cultural beliefs and practices, or the worldview of health, well being and illness risks providing healthcare that lacks relevance and compromises its efficacy for Māori.

Successful care of Māori has been described as ‘a synergy of clinical nursing skills and intimacy with tikanga Māori’. Commentators describe a health system that:

- can engage with whānau, rather individuals – to focus on the family’s potential, rather than individual’s problems;
- that acknowledges that health and wellness cannot be separated from each other or from the all the issues that confront whānau;
- recognises that for Māori it is not possible separate wellness from whakapapa, reo and tikanga as all these things create and sustain identity.

Nursing in a kaupapa Māori framework has been described as being non-judgmental, caring, whānau-oriented, whare and mare–based, empowering clients in managing their health and working with kaumatua and kuia in developing co-ordinated and collaborative care.

The success of seeing patients in their own environment, especially since there is often more than one person in the family with the same problem /illness, and sharing information and education all the whānau together is more effective than education of the patient alone.

Other factors described as essential in the nursing of Māori included; collaboration and information sharing with other health professionals, especially in coordinating care for patients within the hospital system and around discharge planning and care; being able to bridge communications gaps between Māori, community and hospital services and expert clinical skills.
Introduction

The Hawke’s Bay District Health Board, Quigley and Watts Ltd and Fiona Cram are undertaking a Whānau ora Health Impact Assessment (HIA) on a proposal to establish a cultural and clinical nursing training and support programme which will facilitate an exchange of skills and expertise between specialist practitioner nurses from the DHB provider arm and nurses working in the community. There is a need to improve access to health services in the community for people with long term conditions. The intent of the proposed programme is to allow clinical specialist nurses from the hospital and nurses with a Whānau Ora scope of practice to mutually assist each other to increase their skills to care for Māori patients with long-term conditions.

Project context

The draft proposal acknowledges the NZ health care strategy, the primary health care strategy, He Korowai Oranga, the Ottawa charter and the Treaty of Waitangi as founding documents.

Long term conditions are a high priority area – they consume approximately 70% of the healthcare spend and 80% of deaths are attributable to such conditions. It is unfair and unjust that Māori are over-represented in negative long term conditions statistics.

The goal of chronic conditions management is to shift the orientation and design of practice in order to promote a systematic, planned approach to care for those with ongoing health problems through productive planned interactions between informed, activated clients (and families) and prepared, proactive practice teams (Wagner 1998).

The issue

It is common for Māori patients with long term chronic diseases in Hawke’s Bay to arrive at the hospital Accident and Emergency Department seriously ill and in need of admission to hospital for specialist care. While in hospital the patients are seen by hospital specialty nurses who have one particular disease as their area of expertise. Many of these patients have several long term conditions, including either diabetes, and/or cardiovascular, and/or renal and/or respiratory disease. It is common for the patients to be treated by a series of different clinical specialty practitioners (nursing and medical) – each nurse specific to just one of the diseases the patient has. As a consequence of this approach, the patient may see a number of different specialists each with a slightly different set of treatments and care instructions.

Once discharged these patients return to the care of the primary care providers in the community and many into the care of community nurses with a Whānau Ora scope of practice.

Very often these patients have complex medical and social problems which contribute to their ill health. The specialist nurses have shared clients, access to clinical knowledge and skills, access to an inter-disciplinary team, and have been able to acquire knowledge and clinical skills over a prolonged period of time. The nurses working with Māori providers have a unique knowledge of the community in which they work, have cultural knowledge, are engaged with the determinants of health on a daily basis and are often younger and less clinically experienced than their Provider Arm counterparts.
Draft Proposal

Tu Mai funding was set aside to improve access to health services in the community, particularly for long term conditions and funding is available for a support and training programme. There is existing support and capacity for undertaking cultural and clinical nursing support and training programme within diabetes, renal and cardiovascular care. The overall aim of the draft support and training programme is to improve the patient journey for Māori patients with long term conditions to improve health outcomes and reduce inequalities.

It will be achieved by a formal structured reciprocal programme to promote the exchange of expertise that:

- supports nurses to enhance Whānau Ora skills
- supports nurses to enhance specialty practice expertise
- incorporate new knowledge and methodologies in the management of long term conditions.

Figure 1. Cultural and clinical support and training model.

This proposal is cognisant of the work of the Government Whānau Ora Taskforce (Whānau Ora Taskforce, 2009) and sits along side the Hawke’ s Bay DHB Te Turuki Workforce Development Plan 2008-2011. (See Appendix D.)

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7 It is noted that ideally respiratory disease would be included in the initiative but at this stage the Provider Arm of the DHB does not have the resources to offer expertise in this area. Cancer will not be included as part of this initiative as the pathways of care are substantially different.
Literature Review Research Questions

This literature scan explores:

- nursing models for long term conditions
- nurse to nurse learning and the development of expertise
- the provision of whānau appropriate services and health outcomes

Methods

A search of the Medline and CINAHL databases from 1996 to the present was carried out through the Wellington School of Medicine library with additional searching on Google and Google Scholar. Abstracts were scanned and relevant papers retrieved. Full papers were read and data recorded.

Search terms used were: nursing models, models of care, nursing practice, nursing care, nurse learning models, chronic care models, chronic conditions/disease, long term conditions, cardiovascular, renal/kidney failure, effective, success factors, clinical competence, continuing education, nurse to nurse learning, on the job training/learning, nursing professional development, mentoring, training, Whānau Ora effectiveness, Māori health providers.

Limitations of the review

This was a rapid review, covering three very broad topic areas within a short timeframe. While efforts have been made to search as widely and select as systematically as possible, this review only provides a ‘broad brush’ sketch of key findings in the literature, and should not be considered a comprehensive or in-depth review. Additional detail within many papers was not possible to capture in this report due to pragmatic limitations. Where the evidence is sparse, findings must be treated with caution.

A limitation of the review is that much of the literature on nursing models for long-term conditions, nurse education and mentoring is from overseas.
Models for the Care of People with Long-term Conditions

Long-term and/or chronic conditions

Long-term conditions defined as are any on-going, long-term or recurring conditions that can have a significant impact on a person’s life. (National Health Committee, 2006)

They are sometimes known as ‘chronic conditions’, ‘chronic diseases’, or ‘chronic illnesses’. They include conditions such as cardiovascular disease, cancer, diabetes, respiratory disorders, arthritis, chronic pain, depression, Parkinson’s Disease, epilepsy, Alzheimer’s Disease, HIV/AIDS, bipolar disorder, alcohol and drug dependency and many other conditions.

There are many different definitions of long-term conditions used around the world. Some of these relate to the time period of the condition (eg, conditions that are of ‘more than 3/6/12 months duration’), others are about the course of conditions (eg, ‘progressive, with fluctuating symptoms’), while others focus on the impact of the condition on patients and families.

Māori, Pacific people, people with low incomes, older adults, and people with disabilities have been identified as populations facing particular disadvantages with long-term conditions. (MOH a)

Long –term conditions in New Zealand

The Ministry of Health (2009a) states long-term conditions are now the major challenge for the New Zealand health system. Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The predominance of modifiable risk factors such as physical inactivity, obesity and tobacco consumption have continued to fuel the rise of long-term conditions. Along with the detrimental health outcomes from long-term conditions the individual, their family/whānau, the community and the health sector experience considerable financial and social costs. The major risk factors also place a significant economic burden on New Zealand society and consume huge resources both in terms of direct health care and the indirect costs on society as a whole. (MOH 2009)

Two-thirds of New Zealand adults have been diagnosed with a long-term condition (Ministry of Health 2008b), and they account for more than 80 percent of deaths (National Health Committee 2007). Long-term conditions are not randomly distributed across society, with several disadvantaged groups tending to have greater exposure to health risks, lower access to health services, and consequently poorer health as a result of long-term conditions. In New Zealand, long-term conditions disproportionately affect Māori, Pacific peoples and people of low socioeconomic status (Ministry of Health and Otago University 2006). These groups have higher rates of mortality and morbidity from long-term conditions than other groups in society. Many people have more than one long-term condition.

The prevalence of long-term conditions has risen in recent years and current predictions expect the burden of long-term conditions to continue to rise.

Other countries indicate similar incidence of long-term or chronic conditions. Bodenheimer et al. (2002) noted in the US half of those with chronic disease have more than one illness, 88% of those 65 plus have one or more chronic diseases and chronic diseases account for 75% of national health care expenditure.
This increase in the incidence of long-term diseases is making new demands on healthcare systems and internationally new models of care are being developed to ensure patients will long-term conditions receive the most appropriate care. These new models of care recognise the importance of a team approach, good clinical management at primary care level, patient self-care and family and whānau being participants in care.

**International Models of Care for long-term conditions**

**Chronic Care Model**

Bodenheimer et al. (2002) and Wagner et al. (2003) both commented that a healthcare system designed for acute rather than chronic care means the urgent, acute problems are managed but that these patients are not adequately taught self-management of the chronic condition. They assert successful care of patients with chronic (long-term) conditions requires:

- community resources and policies – linkages with community-based resources eg - exercise programmes, senior centres etc to support patients and families -
- health-care organisations which view chronic care as a priority
- self-management support - a range of healthcare disciplines working collaboratively to help patients and their families/whānau acquire the skills and confidence to manage their condition and routinely assess problems and accomplishments
- delivery system design – non-physician and primary care staff trained to support patient self-management and ensure appropriate follow-up care
- evidence –based practice guidelines to provide standards for optimal care and integrated into every-day practice and guidelines reinforced by clinical "champions" - leading educational sessions for practice teams -
- clinical information systems

Wagner et al. (2001) made similar assertions and noted there are increasing numbers of people living with major chronic illnesses who face obstacles in coping with their condition which relate to medical care that does not meet their needs for effective clinical management, psychological support and information.

Wagner et al. (2001) also quoted an Institute of Medicine report which stressed the need for continuous relationships with the care team, the individualisation of care according to each patient’s needs, services based on evidence and cooperation among clinicians.

Wagner et al. (2001) identified quality care as that characterized by productive interactions between the practice team and patients that consistently provides the assessments, support for self-management, optimisation of therapy and follow-up associated with good outcomes.

The authors discussed the Chronic Care Model (as described above by Bodenheimer et al) noting that the model helps patients and family better cope with the challenges of living with, and treating, chronic illness by establishing effective self-management.

Rothman et al. (2003) discussed the important role of primary care for people with major clinical illnesses and stress the need for coordinated care in the context of family and community. The authors quoted the Institute of Medicine (USA) “... the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal care needs, developing a sustained partnership with patients and practicing within the context of family and community.”
Rothmans et al. (2003) suggest the defining features of primary care are continuity, comprehensiveness and coordination but note the complexity of chronic illness requires frequent involvement of more than one caregiver and institution and note that this makes coordination the cornerstone of high-quality medical care.

Saxe et al. (2007) noted the importance of consistent, guideline-based, high quality care to improve clinical status and outcomes for patients with long-term conditions. Support to encourage self-care should come from the health care team and community resources via a delivery system at practice and institutional levels that is redesigned for easy access to planned clinic visits so the chronic disease can be controlled before exacerbations occur. When all aspects of the new system for chronic illness care are addressed, prepared health care teams and knowledgeable patients are supported to work together to manage illness and protect health.

Rationale for the Chronic Care Model

Rothman et al. (2003) said the clinical epidemiology of major chronic disease suggests a central role for primary care for four reasons;

- most patients are at lower end of severity
- treatments for the most prevalent diseases use limited and widely used, non-toxic treatments
- many patients with chronic disease have more than one illness so there is increased need for care coordination
- expertise in behavioural change and self-management care is central to successful care and primary care clinicians are generally better able to facilitate this.

Rothman et al. (2003) promote the Chronic Care Model (as described by Wagner et al. (2001) and Bodenheimer et al. (2001) as a model which provides effective self-management support and links to patient-oriented services in the community which can help patients and families cope.

Saxe et al. (2007) and Wagner et al. (2001) noted that leading health care experts in the United States have stated the greatest primary care challenge today is meeting the complex needs of patients with chronic illness or impairment.

Saxe et al. (2007) quoted other researchers who concluded that among the measures to help address the complex needs of patients with long term conditions is the need to actively help patients and families to participate in their care through behavioral interventions and support from community resources.

Wilkes et al. (2008) also discussed the Wagner Chronic Care Model particularly noting that high quality care is associated with health professionals having a fuller understanding of the patient’s life and preferences, the importance of family care givers and nurses, rather than doctors, because of “their education and role.” They stressed that successful care takes account of the complexities patients face on a daily basis.

Effectiveness of the Chronic Care Model

Both Bodenhiemer et al. (2002 and Wagner et al. (2003) suggested these measures would ensure informed, activated patients who can interact with a prepared, proactive practice team and result in improved outcomes.

Both sets of authors say case studies have shown this kind of care has resulted in improved management of people with chronic diseases.
Wagner et al. (2001) quoted work done by a Cochrane Collaboration which reviewed diabetes treatments and found that the more comprehensive the intervention the more likely it was to be successful.

Rothman et al. (2003) assert that coordination of care across clinicians and treatment/care sites is of critical importance for persons with chronic disease. Consumers place great value on having a clinician and/or team who are familiar with the “whole” patient and family and who are able to coordinate and communicate medical activities across caregivers and settings; in some settings such a system is associated with better outcomes.

Rothman et al. (2003) noted other commentators have also suggested shared care between primary care and specialist care may produce the best outcomes. They noted the efficient involvement of specialists with primary care teams may offer the optimal combination of knowledge and skills that chronically ill people need.

Rothmans et al. (2003) identified effective chronic illness care as a primary care team that organises and coordinates patient care through a series of interactions during which they elicit and review data concerning patient perspectives and other critical information about the course and management of the condition or conditions, help patients set goals and solve problems for improved self management, adjust therapy to optimise disease control and patient well-being and ensure follow-up.

Saxe et al. (2007) noted that Chronic Care Model interventions have demonstrated a more positive effect on processes and/or outcomes of care compared to usual care interventions (standard community-based primary care services or provider education) The authors stated that clinical initiatives have demonstrated that these interventions lead to improved health care outcomes, enhanced access to care, positive impact on self care management skills, decreased hospitalisations and emergency department visits, and/or enhanced satisfaction with health care for individuals with prevalent chronic illnesses Additionally, this care framework fosters interdisciplinary collaboration and communication that promotes continuity of care for the patient.

**Importance of non-medical staff and training for primary care workers in Chronic Care Model**

Rothman et al. (2003) quoted several studies which have shown that non-physician professionals such as nurses or pharmacists who are skilled in modern self-management support and adjustment of therapy by protocol may be critical components of effective chronic care management. They noted that these clinical managers are unavailable to most primary care practices but traditional team members such as nurse and medical assistants can be trained to perform aspects of clinical case management. They also assert that primary care can play an important role in chronic care but system support and improvement are critical to its success.

Saxe et al. (2007) highlighted the need for improved clinical training for staff, especially nurses, working within the Chronic Care Model. “To ensure that advanced practice nurses are well prepared to provide chronic illness care and influence change in an evolving health care system, their education and training must include clinical practice in patient-focused, outcomes oriented settings that employ state-of-the-art information technology.” The competencies required include:
- patient centered care
- partnering
- quality improvement
- information & communication technology
- a public health perspective founded upon Chronic Care Model concepts.

Saxe et al. (2007) stressed the need to include the appropriate skills for nurses during training.

Harris et al. (2007) suggested optimal care for patients with long term conditions involves some kind of "shared care" arrangement between generalists and specialists as part of an ongoing relationship among the patient, GP, and specialist.

Wilkes et al. (2008) who studied community nurse care of patients at home concluded that nurses in community roles need good clinical skills in assessment, education, planning and delivery of patient care and recommended mentorship as a way of fostering the development of clinical capacity for community nurses.

**Community Matrons need advanced clinical skills**

A British programme described by Bowler (2006) described an approach to managing the care of patients with long-term conditions with the use of 'community matrons' – senior registered nurses who worked in the community and visited patients at home. The competence framework (from the British National Health Service Modernisation Agency) recognised that these community nurses must be registered nurses with advanced clinical skills, extended prescribing and decision-making skills, experience with long-term conditions and chronic disease management and have effective leadership skills.

In describing the role of these community nurses Bowler (2008) noted that the nurses carried out a comprehensive clinical, psychological and social assessment of the patient and developed a personalised care plan with the patient and carers or family members. The aim of the plan was to promote early detection of exacerbations of the illness and provide education and support to control and minimize the effects of illness and reduce complications.

These community nurses took clinical responsibility for patients care and coordinated the contribution from a range of different healthcare professionals.

One of the successes of the community nurse programme was the relationships they developed with acute hospital staff especially those in urgent care services, admissions, wards and the hospital discharge liaison team. These relationships helped breakdown traditional boundaries and enabled the community nurses to follow the patient's pathway through the hospital and ensure smoother admissions and timely discharge.

**Importance of shared care and team work**

Harris et al. (2007) noted that most patients with chronic diseases have more than one chronic condition and suggested patients attending specialist services are less likely than patients in primary care to receive preventive care for conditions unrelated to the specialty. They also noted that general practice also offers continuity of care, which patients with chronic disease seek as their needs become more complex. The authors also assert that with appropriate support, (direct funding, training and infrastructure support) there is scope for practice nurses to take a greater role in supporting patients to develop self-management skills.
However Harris et al. (2007) stressed the importance of establishing good teamwork from different service providers. “The links between general practice and private or state-employed community and allied health services are poorly developed. The current team care arrangements rarely involve more than paper-based communication. At the very least, teamwork requires a relationship based on shared principles and goals and effective two-way communication. Regular interpersonal contact helps to build professional trust and understanding of each others roles… we need to develop models where providers who are not necessarily co-located can work as a team.’

**Value of care in the community**

Wilkes et al. (2008) identified the importance of continuity of care and the difficulties that occur when a range of different nurses are involved in providing care. They cited work in the UK where care by community nurses was found to be flexible and responsive to patient’s needs. Specialist nurses were perceived as having more advanced knowledge. They also cited a Canadian study of chemotherapy patients which found community clinics helped improve patient quality of life for a number of different reasons but noted the importance of specialist input. They noted that communication with cancer care specialists helped to engender a sense of security and provide continuity of care.

Wilkes et al. (2008) looked at patient perceptions of the service they received from community nurses who visited patients at home mostly to deal with ulcers. Patients noted the importance of relationships and being able to build a rapport with the nurse, seeing the same nurse regularly, having time to talk things over (several noted that hospital nurses were too busy to do this), continuity of care, the need for competent and experienced nurses and their ability to recognise when expert care was required. The importance of the patient-nurse relationships was identified as being a major factor in keeping these people out of hospital.

Bowler (2006) noted that typically patients with long-term conditions receive ad hoc intermittent care in response to crises, with little preventive intervention between these episodes. Inevitably during acute exacerbations patients often used hospitalisation as the only option. Bowler described an initiative Britain in 2004 where the Sunderland Teaching Primary Care Trust developed a partnership with City Hospitals Sunderland National Health Service Foundation Trust to offer nurse-led care to patients in the community and support them in their own homes as alternative to hospital admission into secondary care. The nurse-led team demonstrated a significant reduction in hospital admissions.

**New Zealand Response to Patients with Long-term Conditions - Care Plus**

One New Zealand response to dealing with patients with long-term conditions has been the introduction of the Care Plus scheme into primary care.

Care Plus is part of the Primary Health Care Strategy. It provides additional funding for primary health organisations (PHOs) to give more care to people who use high levels of care or have high needs because of chronic conditions or terminal illness. With Care Plus, patients receive expanded, better-coordinated, lower-cost services from a range of health professionals.

Care Plus aims are:

- improved management of chronic conditions
- reduced inequalities
- improved teamwork within PHOs
lower-cost services for high-need primary health users.

Eligible patients are high-health users or have chronic conditions that need ‘intensive clinical management’. These patients are usually managed in the practice by a team of health professionals.

All PHOs will offer Care Plus services once they have completed a preparatory phase and their detailed business plans have been approved by the DHB.

Care Plus patients receive:

- low or reduced cost access to nurse and/or doctor expertise and time
- continuity of care that includes a Care Plan jointly developed with the patient and - ongoing support through pre-planned regular reviews -
- advice on improving health outcomes through better self management, with support to identify and meet realistic personal health goals

Care Plus provides additional capitation funding (approx 10 percent) to target about five percent of the enrolled population – those patients with the highest needs in each PHO. (MOH 2004)

Boyd (2006) recorded the discussion at a national workshop held on October 27, 2006 in Palmerston North which was a forum for primary health care nurses to discuss their experiences of providing chronic illness care. Notes from the meeting included the following points:

Positive Benefits of Nurses Providing Care Plus and Chronic Conditions Care

Increased opportunity for Client Centred Care with individualised goal setting and personal empowerment

Improved health outcomes that resulted from greater client self management. Nurses particularly noted that an holistic approach is required that goes beyond the medical aspects of the disease

Care Plus funding allows for greater flexibility in how care is delivered with more time to counsel people with chronic conditions and the ability to incorporate a person’s unique circumstances into care which greatly improved the effectiveness of the intervention.

Appropriate use of nursing expertise and an opportunity for team building within the practice and increased collaboration with GP colleagues. Care Plus was considered a way to raise the capability of the practice nurse workforce.

An increase in the nurse care coordination role for people with complex circumstances. which allows the nurse to provide information about community resources and appropriate referral processes.

Barriers to Providing Care Plus and Self Management for People with Chronic Conditions

Lack of nationally consistent tools and resources - there are currently no nationally consistent resources, such as assessment and goal setting tools, care protocols, patient education resources and coordinated information systems and a lack of information sharing in primary care which has meant that considerable time and resources have been expended to reinvent Care Plus from the ground up.
No consistent outcome measures which has made it impossible to compare the health gains of Care Plus nationally. A dearth of analysis and dissemination of outcome data was perceived as a barrier to implementing best practices for chronic illness care.

Difficulties in sharing of patient medical information across health care settings and with other team members involved in the person's care particularly for health care providers working with patients in NGO's and in secondary care services. The inaccessibility of medical records across primary and secondary care resulted in coordination gaps and duplication of patient information gathering and testing.

Chronic illness care funding silos eg Diabetes Get Checked, Care Plus, Falls Programmes, Green Prescription have separate funding schemes, and for people with several co-morbidities, there is an overlap in programme requirements that has created a documentation burden.

Suggestions for Enhancing the Delivery of Care for Lifelong Conditions
A directory of community resources for nurses delivering chronic illness care to facilitate better integration with other local community agencies and resources, particularly NGO's and secondary services.

Multi-disciplinary team approach eg a cardiac nurse specialist, respiratory nurse specialist and a gerontology nurse specialist, along with a dietician, pharmacist, physiotherapist and social worker could be available for consultation, promotion of the guidelines and to increase evidence-base practice. These professionals could also be available for joint visits with the practice nurse when support and guidance were required. This could also be a way to incorporate secondary care specialist expertise into the primary care setting.

Outcome measures and continued development of care models which promote self management of long term conditions, integration of nursing and the multi-disciplinary team across all health care settings, including primary, secondary and NGO providers.

New Zealand Response to Patients with Long-term Conditions – Te Toi Hauora Nui
The report Te Toi Hauora Nui - Achieving excellence through innovative Māori health service delivery (Ministry of Health, 2009b) described that chronic conditions contributed the major share of the disparity in life expectancy between Māori and non-Māori. There are significant disparities between Māori and non-Māori in disease rates and outcomes for CVD and Type 2 diabetes. The report also went on to say that Māori health providers offered a range of services in response to the growing chronic disease burden. Primary care GP services aimed at empowering patients and their whānau to take greater control of their health and wellbeing featured prominently. A strengths-based approach was taken to the report, describing the features of typical Maori providers. However the report noted that ‘A concern from this study is the lack of available supporting clinical data and evidence to assess the effectiveness of interventions for improving cardiovascular and diabetes amongst Māori. This area requires immediate attention.’ The report concluded that Maori providers were critical current and future players for addressing chronic diseases in New Zealand (Ministry of Health, 2009b).
Nurse to nurse learning and the development of expertise

Much of the literature on learning for nurses related to student nurse training and it was difficult to find reference material that related to the one on one “shoulder to shoulder” mentoring/learning described in the proposed programme. No articles were found which directly reflected the proposed model. Even articles which discussed mentoring and peer-learning described teacher/learner scenarios that did not directly relate to information exchange between two professionals in a practice environment. Most models included more formal learning structures – seminars and lectures, project work, tutorial groups, the involvement of professional tutors, the learning of multiple skills and/or the acquisition of additional qualifications and assessment of the learner.

While there is little nurse education literature which directly relates to the proposed model some of the literature contained useful discussion which identifies some of the factors which might lead to the success or failure of the process of adult teaching and learning.

Preparation needed for teaching and learning

A number of the papers noted the need for both the teacher and the student to be adequately prepared for the role they take on.

Flanagan et al. (2000) in discussing workplace learning for nurses noted there are distinct conditions which must accompany participative learning in the workplace. These are that the learner must have a desire to learn, that it must be within the learners’ capabilities and that the work environment must be prepared to support work-based learning.

Students must be motivated to learn from the experiences they engage with in the workplace, they must have the confidence to take responsibility for their own learning and be able to balance it with the demands of other work commitments. The learning situation must also be acknowledged and facilitated by the employer by allowing the necessary time to develop the new skills.

Flanagan et al. (2000) also noted the need for both learners and teachers to be prepared for their role. “The fact that nurses have long been involved in providing learning opportunities in clinical settings does not mean that those who support learners in undertaking work-based learning will automatically have the necessary skills.” They stressed the need for the ‘teachers’ to be appropriately skilled. They also recommended ensuring there is clarity about expectations not only of the learners but also those of their colleagues so they understand the value of the planned learning outcomes and can see long benefits from it.

Andrews and Wallis (1999) made the same point highlighting the need for mentors to be adequately trained and prepared for the role. They also suggested students must be able to direct the sessions to ensure their needs are met and they are acquiring new knowledge and skills.

Duchscher (2001) identified the peer group as a powerful means for student nurses to learn clinical skills but noted the need for mentors to be well prepared for the role.

Duchscher (2001) observed that some commentators noted that just being experienced is not sufficient qualification for being a good teacher or mentor and that a number of personal attributes and conditions are necessary to facilitate successful learning.

Focus groups of a small number of graduate nurses in New Zealand carried out by Vallant and Neville (2006) found the attitude of both the student nurse and the nurse clinician had a vital influence on the relationships formed between the two parties and that this relationship
in turn influenced learning. They suggested both parties need preparation for their roles and that support from the healthcare organisation is also important.

The environment is important for clinical learning

Andrews and Wallis (1999) carried out a literature review on the use of mentorship in the training of student nurses and described the process as practice-based learning i.e. the reliance on clinical staff to support, supervise and teach students in practice-based settings. They commented that this type of practice-based learning does have some problems. They noted that just getting students to work with qualified staff in practice environments does not guarantee learning.

McCormack et al. (1999) noted that other commentators stressed the value of the learning taking place in the environment where it would be used. The application of learning in real-life situations is likely to be more salient for both the learners and the teachers since the cultural and social interactions are an important part of the learning process.

Field (2004) notes many researchers identify the difficulty of transferring knowledge learned in one situation to other slightly different situations. This difficulty of “transfer” is likely to be one of the causes of the so called ‘theory-practice’ gap. She noted for optimal learning consideration needs to be given to both theoretical and practical approaches and, given that learning is both culturally situated and individually constructed, that it should come from a variety of different sources.

Field (2004) said a growing body of educational thought has emphasized the socially and culturally situated nature of knowledge and especially the role that activity and experience play in learning practical skills.

Field (2004) quoted research which noted the value of learning that takes place within real life contexts where learners were allowed to participate legitimately as “learners”. She also added that learning is a process that takes place within a framework of social participation.

She commented that socially transmitted learning is likely to be bilateral so mentors within practice areas may also learn from their students.

Field (2004) also quoted research that stressed the importance of contextual learning, the significance of guided participation in activities and the sharing of focus and purpose between the learner and the more skilled partner.

Edmond (2001) also endorsed the notion that learning is likely to be successful if it is acquired in the situation where it will be used. Evidence shows the acquisition of clinical skills is context dependent and the ability to apply knowledge and perform competently is dependent on familiarity with the specific clinical context. Edmond also said evidence suggests learning occurs in physical interaction and social participation and noted the value of “real world” experience in learning. “The evidence is that the different kinds of knowledge and intuitive nuances of professional practice can only be apprehended, comprehended and internalised through well-guided immersion in the reality of practice itself.”

Dracup and Bryan-Brown (2004) also discussed the value of learning in the clinical setting. “Preceptors (nursing term used for mentor) help new nurses deal with the uncertainties in the clinical setting that is inherent to gaining proficiency. … nursing is taught through an apprenticeship system and the role of “guide at the side” is critical to moving from novice to expert”

Vallant and Neville (2006) explored the relationship between student nurses and nurse clinicians on whom the students rely to gain clinical knowledge and experience in New Zealand. They carried out a literature review and held focus groups with a small number of
graduate nursing students to find out about their experience of relationships with nurse clinicians during clinical placements during their training.

Quoting their (international) literature review Vallant and Neville (2006) noted that clinical learning cannot be separated from the context in which it occurs. Findings from their literature review indicated the quality of the learning environment hinges on many factors including nature, type and perceived relevance of the clinical setting, opportunities for learning and the relationships with other participants in the practice area.

**Support for learners**

The need for support for the learners was also raised.

In a article discussing practice development McCormack et al. (1999) in which practice development is defined as ‘a continuous process of improvement towards increased effectiveness in person-centred care through the enabling of nurses and healthcare teams to transform the culture and context of care’ stressed the need for a focus on changing the culture and context of the practice and not just a particular intervention. The authors also note that person-centred care requires greater emphasis on clinical effectiveness, patient outcomes and evidenced-based practice.

McCormack et al. (1999) also noted the importance of the nurses gaining ownership of any change process. Nurses must be aware of the need for change and be encouraged to question their own attitudes, beliefs and values and to begin to challenge clinical practice. Implementing cultural and structural change also needs to be agreed by the multidisciplinary team, supported by research evidence to achieve the introduction of new norms of clinical practice and leadership.

McCormack et al. (1999) noted that while “experience is a valuable source of knowledge in order for it to become learning there must be a systematic approach to assist nurses reflect on practice experience and synthesise the learning. They also noted that adult learning theory argues that learning is most effective when the learner is able to make sense of new knowledge in the context of their immediate life experience. It is also noted that it is easy underestimate how much support nurses need to meet those challenges. It was suggested this need can be recognised by a “critical companion” who can help the nurse to understand what they want or need to change and how they can manage that change. The “critical companion” requires personal characteristics such as supportiveness, approachability, empathy and the ability to think laterally and non-judgmentally and be able to work across role and structural boundaries in the service.

**Mentoring**

Mills et al. (2005) identified mentoring as a strategy to improve the recruitment and retention of remote rural nurses and clarified the different roles of mentoring, clinical supervision and preceptoring
Mills et al. (2005) noted mentoring, clinical supervision and preceptoring are extremely important concepts for the development and support of rural nurses.

Mills et al. (2005) suggested mentoring, with its broader focus, has the potential to develop a professionally stronger and more rounded work force, with the fostering of scholarship and research, as well as clinical expertise, through the development of relationships between wise and experienced rural nurses and those who are beginning their careers as rural nurses.

Nettleton and Bray (2008) identified professional mentorship, both formal and informal, as important in fostering professional growth in knowledge, skills, attributes and practice. They noted that the mentors themselves can benefit from the mentoring role especially when mentoring is formally recognised and contributes to the mentors own professional development. However poor mentorship can bring lasting consequences for those being mentored.

Nettleton and Bray (2008) carried out a survey to assess the value of mentoring for new nurses when a new model of nursing education "Making a Difference" was introduced in the UK. The model was introduced in response to recognition that newly qualified nurses didn’t have the practice skills expected of them by employers. The model used a mentor for student nurses in practice situations.

Mentors noted inconsistencies can exist within a mentoring system and local practices can vary.

<table>
<thead>
<tr>
<th>Element</th>
<th>Mentoring</th>
<th>Clinical supervision</th>
<th>Preceptoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>Outside the immediate work setting</td>
<td>Within the work setting, but away from the immediate work area</td>
<td>Within the work setting</td>
</tr>
<tr>
<td>Time</td>
<td>Long time-frame with a progression of relation phase</td>
<td>Long time-frame with a progression of relationship phases</td>
<td>Short period, usually 2–12 weeks</td>
</tr>
<tr>
<td>Relationship</td>
<td>Confidential discussions; minimal reporting on relationship status in a formal setting</td>
<td>Confidential discussions; minimal reporting on relationship status in a formal setting</td>
<td>Formal reporting on the progress of the preceptor</td>
</tr>
<tr>
<td>Level of commitment</td>
<td>High level of commitment; may require a time commitment outside of the work setting</td>
<td>High level of commitment; hopefully conducted within working hours, but away from the work setting; may require a time commitment outside of the work setting</td>
<td>Lower level of commitment; conducted solely in the work setting</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Broader outcomes that can encompass improved clinical practice, career progression, scholarly endeavour, personal achievement</td>
<td>Improved clinical practice</td>
<td>Clinical skill development</td>
</tr>
</tbody>
</table>

Mills et al. (2005) noted mentoring, clinical supervision and preceptoring are extremely important concepts for the development and support of rural nurses.
Mentors noted a perceived benefit for themselves but also noted time pressure associated with it.

Mentees noted that willing mentors where more likely to be successful than those forced into the role.

Nettleton and Bray (2008) noted the importance of support for the mentors and recognition of the time commitment and resources required to allow them to do create a relationship which is supportive and beneficial to both people.

The attributes of a good mentor

Andrews and Wallis (1999) highlighted the importance of the personal characteristics and interpersonal skills of the mentor and noted that effective mentorship hinges on the relationship between the mentor and the mentee. They noted that different commentators have described the mentor/mentee relationship with the common theme ie the significance of the personal characteristics of the mentor. Important characteristics of a good mentor include approachability, effective interpersonal skills, adopting a positive teaching role, paying appropriate attention to learning, providing supervisory support and professional development ability. "The literature illustrates a comprehensive catalogue of personal attributes and skills required for effective mentoring. Absolute requirements for successful mentoring listed are mutual attraction, mutual respect and time and energy."

Andrews and Wallis (1999) also noted that some authors highlight a lack of time and poor planning as significant barriers to effective mentoring.

In conclusion the authors noted “Perhaps in reality no one person has all the attributes of a good mentor and students would be better served by a mentoring team.”

Dracup and Bryan –Brown (2004) noted the need for mentors to understand what it is like to be a novice and for them to be able to guide new nurses with skill and empathy. They also noted that length of experience does not necessarily make someone a good mentor and that those without the necessary knowledge and skills could “scare off the next generation” if they are not able to set a positive and constructive tone and be committed to facilitating growth and career opportunities.

Dracup and Bryan –Brown (2004) noted potential difficulties in the relationship between mentor and mentee and stressed that imparting knowledge gained by years of experience can be difficult and frustrating for both the mentor and student. Dracup and Bryan –Brown (2004) noted five competencies of a good mentor: self knowledge, strategic vision, risk-taking and creativity, interpersonal and communication effectiveness, inspiration.

Vallent and Neville (2006) noted that studies have identified the interpersonal characteristics of mentors that enhance student learning as role modeling skills, patience, respect, consistency, genuineness, understanding, sympathy, being approachable and having a memory of being student themselves. Current knowledge and experience, effective management skills and a willingness to teach are other characteristics of nurse clinicians identified as enhancing student learning. Vallant and Neville (2006) also said the literature suggested both negative attitudes and a negative atmosphere created in the clinical learning environment can cause feelings of vulnerability and inadequacy in student nurses.

Good practice essential for mentors

Field (2004) who reviewed education literature and related it to nursing also noted that simply working with experienced clinicians may not be sufficient for novices to progress toward becoming an expert. The author commented that in Benner’s novice to expert model the development of “knowledge embedded in expertise” might better be defined as “clinical
acumen”. To begin to acquire the levels of nursing practice learning described by Benner (1984) the student requires good practice placement, and stimulating dialogue with an excellent mentor who has a good basis of theoretical knowledge and who in turn requires senior support.

Field (2004) suggested the key to progressing from novice to expert is excellent mentor support, and asserts that the nursing student can get it wrong and make defective assumptions if exposed poor practice example.

Outcomes of mentoring

In a student nurse training situation Duchscher (2001) used student nurse peers in mentoring roles and noted that the participating students found the method to be mutually supportive, cooperative and collaborative. The students appreciated the value placed on their knowledge and experience, liked the opportunity to work in partnership with other students and enjoyed the reciprocity and mutuality of the experience. The students found being the mentor a useful learning exercise as they were required to model exemplary clinical care, behaviour and attitudes.

This suggests one of the benefits of mentoring is an improvement in the mentors practice.

Field (2004) noted there was little research on the impact of the mentor on student learning.

Vallant and Neville (2006) explored the relationship between student nurses and nurse clinicians on whom the students rely to gain clinical knowledge and experience in New Zealand. Their findings from the student focus groups indicated poor relationships with the clinical nurses inhibited learning and positive relationships with the clinical nurses inhibited learning and positive relationships enhanced it.

Formal learning structures

King et al. (2007) reported on an initiative in which Aboriginal health workers (AHW) were funded to undertake a postgraduate diabetes course. AHW were offered training because they are the “first point of contact with all clients and other health professionals (especially in remote areas), are responsible for the initial diagnosis and for referring the client to other healthcare providers. AHW were offered training in diabetes to attempt to improve the quality of life of Aboriginal people with diabetes. Courses (at Flinders University) were developed for registered nurses and allied health professionals. Though some of the AHW found the course difficult it helped them become more confident and competent as health professionals. They acquired a clearer understanding of diabetes and improved empathy for patients; a realisation that they had a responsibility and expertise to care for patients; increased personal satisfaction especially in being able to empower Aboriginal to diabetes self care.

Primary Care of Patients with Long Term conditions – Staff learning needs

The special training needs of staff working to care for patients with long-term conditions in primary care and in the community were discussed by a number of commentators.

New Zealand Literature

Carreyer (2004), commented on the importance of primary health care as a process because of its potential as a linking mechanism for families and individuals who are at risk of ill health. She noted that “Nursing believes that we need to move more into intersectoral partnerships with community development and participation the development of the community.’
She also commented “The development of nurse practitioners acknowledges nursing acceptance not just of primary health care responsibilities but also the need to develop seamless services which follow patients and populations groups across the primary/secondary interface.

Carreyer went on to note that systems at that time had resulted in significant levels of nursing expertise and service being located outside the general practice setting with many in the secondary sector. Carreyer considered the secondary sector had maintained some investment in nursing education in the specialist nursing caring for people with long term conditions but that this remained a barrier to developing an integrated health service being delivered in primary care.

Boyd (2006) reported that primary care nurses working with patients with long-term conditions using the Care Plus scheme considered there to be a need for workforce development. Boyd reported that there is poor workforce development for nurses providing chronic illness care and that many nurses do not have the time or financial resources to attend formal post graduate study in part due to the small business model in primary health care and the lack of education funding available. The nurses said very few practice nurses have had specific education in chronic illness care, self management skills, motivational interviewing and effective goal setting concepts.

These primary care nurses suggested education be coordinated, in module form and provided via distance learning mechanisms such as on-line learning, by DVD and other different education delivery methods (modularised education and internet based education that can be delivered by distance learning). They also recommended the development of centres of excellence which could act as core training centres.

International Literature

Learning to work in teams

Humphris et al. (2007) discussed the need for inter-professional learning for collaboration in primary care. They noted the growing complexity and demand which new frameworks for chronic conditions put on primary care services.

Humphris et al. (2007) said given the often complex needs of individuals with chronic diseases a team based approach to care delivery is seen as the most appropriate approach. This has implications for the way in which health care professionals are provided with opportunities to learn about working in an inter-professional team in the context of a shift from the traditional model of acute hospital inpatient care to a more community based self-care management model of care. In order to be able achieve these models healthcare professionals must develop a capability to work in teams and collaborate.

‘Inter-professional learning’ describes occasions when two or more professionals come together to learn with and from each other with the intention of promoting a collaborative practice. Central to this is the intention to build relations between professionals to enhance the quality and responsiveness of the services they deliver.

Humphris et al. (2007) quoted a study carried out within the National Health Service (NHS) in Britain which showed that effective inter-professional team working can improve communication, cost-effectiveness and efficiency of care and outcomes for people showing that a team makes collaborative work more powerful than working separately. (cited Borrill C, West M, Shapiro D, Rees A (2000) Team working and effectiveness in healthcare, British Journal of Health Care Management 6:364-371)
Humphris et al. commented that the significant challenge is how to create, within the existing and future workforce, the capability to work in multi-professional teams capable of effective collaboration. The development of such capability necessitates changes in how that workforce is prepared. As the demands for services increase so the workforce needs to continue to evolve, new forms of practitioner and new forms of delivery of care are inevitable. Developing capability for multi-professional working is only one means to deliver the end which remains a flexible and responsible workforce.

**Community matrons – an example of community clinical nurse experts for patients with long-term conditions**

The development of a ‘Community Matron’ service in the UK has been one of the ways used to develop new methods of care for patients with long term conditions in the community.

Some of the lessons learned in this programme may be useful in the development of the Hawkes Bay model.

Harrison and Lydon (2008) noted that new and effective health services increasingly focus on primary care and extend the support available to the growing and increasingly complex population of clients with long term conditions and chronic ill health. The most at risk patients are the disadvantaged patient groups with poorly controlled long-term conditions and poor access to existing health and social care services, particularly preventive services.

Warrington (UK) developed a ‘community matron’ service within existing health visiting health visitor and district nursing services. These specialist nursing roles deal with people with long-term conditions. The primary clinical role of the nurses is the care and coordination and case-management of the most complex clients in the vulnerable populations. The role involves close team working with both primary and secondary care colleagues and social care provider agencies to ensure that packages of care are realistic, flexible and meet a patient’s overall needs. Health visitors who understand of family dynamics and the impact on the wider health of the family are important partners for the community nurses (who have the clinical skills). Joint working with community nurses and health visitors has been highly effective in addressing the needs of vulnerable families as each has different skills.

Harrison and Lydon (2008) noted a need for both clinical and community skills to achieve self care for patients with long-term conditions. Community nurses have the clinical skills but the strengths of the health visitors lie in their ability to follow-up and engage hard –to-reach clients and use every opportunity to promote health and support self-care.

Harrison and Lydon (2008) also noted that these skills are the foundation of supporting people with long term illnesses and suggested the new community nurses who did not have a background in community nursing would benefit from spending time with the health visiting colleagues, observing the subtle, highly-skilled assessments and client interactions.

Harrison and Lydon (2008) commented ‘At the root of reactive clinical care management lies better anticipatory care for clients… an area where health visiting skills are particularly useful.” However they also stressed the importance of good clinical care.

“’The community matron role is not about hierarchy or the transformation of nurses into pseudo-medics, it is a timely and realistic response to very real patient needs, particularly in vulnerable communities. A background in health visiting has greatly influenced professional practice and encouraged joint learning experiences with colleagues from other disciplines. It is only with teamwork and the sharing of skills and information that clinical care management will be an effective measure for people living with long-term conditions.’
Drennan et al. (2005) have also commented on the development of the role of community nurses noting that many National Health Service hospital trusts and primary care organisations employed hospital nurses, experienced in the care of people with long term conditions, for case management and community nurse roles.

The Drennan et al. (2005) study aimed to identify the key knowledge and support that hospital based nurses, experienced in caring for patients with long term conditions, require working in primary care contexts as community nurses. A key message from the study was that nurses who move from the hospital environment to the community, irrespective of level of clinical expertise, become novice practitioners again. There are four main reasons:

a. **The patient is in control of all decisions** affecting their health and well being, including their home environment. Assessments, treatment, care and advice giving are continually negotiated acts between the nurse, the patient and their family carers/informal network of support. Achieving positive patient outcomes are therefore reliant on the nurse’s ability to establish and maintain a relationship with the patient. This is unlike a hospital where the decision-making is led by professionals, including everything from the ward environment to the timing of treatments.

b. **The patients and their carers undertake most of their own health maintenance, treatment and care activities**. The nursing contribution is a small part of the overall patient’s daily experience. This is in contrast to the hospital environment.

c. **The multiple systems and infrastructures** that support the delivery of health and social care vary between local areas. This is unlike a hospital with a single system and infrastructure.

d. **The nurse has to make clinical and professional decisions, sometimes rapidly in less than ideal circumstances, at a physical distance from professional colleagues**.

The study findings suggested two elements were necessary for the successful transition for the nurses and safe and effective services for their patients/clients:

- Ensure there is a range of **mechanisms for supported learning** for nurses to progress from novice to an expert practitioner working in primary care without compromising the patient, the care network or the nurse.

- Ensure that there is **overt support and recognition from stakeholders** within the organisation and across the local network of health and social care for both the new role and the new to primary care nurse.

The authors also recommended the nurses:

- work with role models and practice educators
- have access to expert mentors with different skills and knowledge and possibly an expert resource group
- use clinical supervision activities with mentors
- have a ‘buddy’ or peer to have daily de-briefing
- have the opportunity for case review and discussion with an experienced mentor with a high level of frequency in the early stages

Bowler (2006) noted the long-term conditions team and specialist nurses provided the training and clinical supervision for community nurses.
Whānau Ora Appropriate Care and Health Outcomes for Māori

There is a large body of literature which comments on health inequalities in the Māori population which identifies a lack of access to culturally acceptable health care services as one of the barriers to health. However there does not appear to yet be research which measures the health outcomes of services which are considered to be culturally appropriate. Ellison-Loschmann and Pearce (2006) commented that while it is too soon to assess the effects Māori provider organisations have on the health status of Māori it is clear that health service provision with little Māori participation results in poor Māori outcomes.

CBG Research (2009) in an evaluation of the Māori Provider Development Scheme noted that there was not a method in place to measure the outcomes of the services provided. Presently only changes in capacity and capability are measured. Janssen (2008) also noted there is little research on Māori health provider outcomes. Wilson (2008) researched Māori women’s perceptions of health and their interactions with mainstream health care noting that there was a paucity of research in this area.

However anecdotal evidence suggests Māori are more responsive to care provided ‘by Māori for Māori ’ and there is evidence that mainstream services fail to meet Māori health needs because they fail to take account of Māori health beliefs and practices and perhaps more importantly treat the patient and the illness individually without consideration of the “whole” person and their wellbeing in the context of the whānau.

Meeting the needs of Māori patients

Maniapoto and Gribben (2003) in an evaluation of a primary care clinic set up to deliver accessible, culturally acceptable care to Māori living in a high-need area commented. ‘One strategy to ensure health services for Māori become more effective is to provide services that are more responsive to the needs and expectations of all Māori, and acknowledge traditional Māori models of health. Implicit in these traditional models of healthcare is the traditional practice of ‘Tikanga’ (Māori customs), which are acceptable to many Māori consumers of Māori health services. Whilst Māori and non- Māori live side by side, they do not always share the same environments or the same narratives, nor do they subscribe to identical values or aspirations.’

The researchers said their qualitative research confirmed the reason for the rapid growth and acceptance of the service by Māori was a large degree of cultural acceptance by Māori of a service that met their diverse needs. In addition the location of the facility was critical for Māori, as it was easy for people without transport to get to. They identified the main reasons for people accessing this facility were affordability, cultural acceptability and close proximity to where patients’ lived.

Maniapoto and Gribben (2003) concluded that ‘The added value that ‘by Māori for Māori’ strategies offer the provision of culturally appropriate models of healthcare delivery. This can be summarised in the following points:

- Tikanga Mo Nga Iwi Me Nga Hapu – appropriate engagement of Māori
- Tino Rangatiratanga – Māori control over healthcare
- Taha Whānau – involving the whānau (family) in healthcare
- Taha Tinana – maintaining physical wellbeing
- Taha Wairua – maintaining spiritual wellbeing
Taha Hinengaro – maintaining emotional and mental wellbeing

The evaluation found clients of the service reported very high levels of satisfaction with the service in a comprehensive sense and that although the fee levels were important, the overall patient focus of the service was also a major driver of patient satisfaction.

Janssen (2008) carried out a study to explore the effectiveness of a culturally appropriate nurse-led diabetes and heart disease programme for Māori clients. Janssen noted little prior research had looked in-depth into the functioning of small Māori health providers.

Janssen (2008) reported the programme was culturally appropriate, supportive and beneficial to the health objectives. The atmosphere, wellness approach and whanaungatanga in particular, were appreciated by all participants and that the sense of community, which is strongly influenced by Māori values and staff attributes, such as the use of self-deprecating humour were appreciated by the patients. Being part of a community allowed clients to feel safe, to reveal their inadequacies yet remain engaged and supported so they could work on lifestyle change when they felt ready.

Janssen commented that as the study progressed the complexity of clients’ health status became apparent. One key revelation was that for several participants diabetes proved to be the least of their problems as the impact of their other co-morbidities became apparent. The study reinforced the importance of continuing with Māori service provision. It affirmed the objectives of rangatiratanga in allowing Māori to determine what services are most appropriate for their people. The study demonstrated the effectiveness and commitment of Māori nurse-led health services and underlined the importance of continuing Māori health workforce development, because Māori clients do have a unique understanding and rapport with Māori health staff.

Barriers to care for Māori

Ellison-Loschmann and Pearce (2006) discussed the disparities in health between Māori and non-Māori and identified a number of complex factors which contribute to this. One of these factors is “access to” and “access through” healthcare. The “access through” concept takes account the quality of the service offered. The barriers to accessing care among Māori included the attitudes of health workers toward Māori, unsatisfactory encounters with professionals and experiences of dispowerment and discrimination. They also commented on evidence which shows that doctors are less likely to advocate for Māori and Māori are less likely to be referred on for secondary treatments.

Rumball-Smith (2009) reviewed the evidence for disparities in the quality of public hospital care for Māori and non-Māori. She noted that though there was very limited evidence, the evidence that was available indicated that Māori received poorer treatment than non-Māori according to standards and clinical need. She noted the need for the development and validation of Māori-specific quality indicators.

Wilson (2008) found Māori women consistently encountered health services and health care providers that were problem focused, who compartmentalised their health issues or problems. This resulted in the women’s needs not being recognised and planned interventions being inappropriate. The research reinforced the need for culturally appropriate and acceptable interventions and health care providers are vital to improve access and ongoing care for Māori.

Wilson (2008) observed that when interventions “go wrong” or outcomes are not achieved it is not unusual for patients to be blamed and labeled ‘non-compliant’ but anecdotally it is the service itself which is failing because it is culturally inappropriate and unacceptable to Māori.
Barton and Wilson (2008) asserted that contemporary nursing practice focuses on illness rather than health, on the individual rather than the whānau and is strongly based on the biomedical model rather than an holistic approach and does not fit with the Māori worldview.

Malony-Moni (2006) commented that engagement must be with the whānau in dealing with health issues, and that failing to do so will not result in better health outcomes.

Māori nursing practice

Simon (2006) in a paper which discussed a programme for training Māori nurses identified five characteristics of Māori nursing practice:

- the promotion of cultural affirmation including cultural awareness and identity
- the support of, and access to, Māori networks
- the adoption of Māori models of health
- the enabling of visibility and pro-activity as Māori nurses
- the validation of Māori nurses as effective health professionals

Simon (2006) recommended for all nursing staff to be alert to:

- the impact of western scientific models on Māori healthcare
- the (often passive) non-acceptance of Māori within mainstream institutions
- the benefits of valuing indigenous nursing programmes

Simon (2006) noted that it is difficult to identify what might constitute Māori nursing practice and to identify Māori nurses and nurse practitioners as 'Māori' refers to an increasingly diverse category of people. She also noted how little nursing literature exists on Māori nursing practice. In part this may be because traditionally Māori practice has been passing information on orally and passing knowledge from one generation to the next. Māori knowledge and practice has remained largely with Māori and is validated within Māori understandings of that knowledge.

With reference to the training of Māori nurses Simon noted that Māori society is diverse and not all Māori have the cultural background or experiences and that it is misleading to presume all Māori will benefit to the same degree from similar cultural input. However with regard to Māori nursing she highlights the importance of Māori models of health because they operate within the cultural context of the whānau and not just illness as is often the case in mainstream health services.

Simon (2006) stressed the need for Kaupapa Māori programs that provide an environment based on Māori cultural values, processes and beliefs to improve Māori health outcomes but notes that the future practice for Māori is not about returning to traditional practice only, rather it is about a blend of contemporary and traditional practice. She also noted that her research among nurses trained through a special Māori nursing programme showed the importance of being able to identify as Māori as well as the use of Māori practices and Māori models of care.

Culturally Specific Nursing Care

McMurray and Param (2008) discussed whether or not, and to what extent, culture-specific care can redress health inequities. They noted that a primary healthcare approach has the ideal framework to focus on equity, access, empowerment and intersectoral partnerships and provide the essential elements for maintaining health. The authors note that many
indigenous people are disadvantaged by the Australian health system and discuss the need for culture-specific care. Their conclusions noted the need for a focus on the breaking down of the power relations which pervade clinical interactions and the need for a partnership approach to providing health care. The partnership approach means that health providers are not always the dominant group and requires decision making to be with rather than for another group. A partnership approach would help ensure the diagnosis and plan for treatment includes culturally embedded input and decision-making in relation to how people maintain their health in the context of relationships with the social and natural environment and the social order. So, health care professionals do not provide culture-specific care rather, through partnerships health professionals work with indigenous people to plan culturally appropriate care which encompasses needs which determine health such as infrastructure, housing, family support within cultural, family and community groups.

Wilson (2008) quoted a number of researchers who have shown nursing is linked to the quality of patient outcomes and that culture and health is a concept established in nursing. She also noted that one of the underlying premises of cultural safety is the recognition that diversity exists not only between cultural groups but also within them. So nurses learning about specific beliefs and practices are unlikely to learn enough to achieve culturally safe nursing practice. She said “the establishment of relationships with clients to elicit the cultural beliefs and practices that need to be respected and integrated into their health experience is essential. Consequently, it is the recipient of nursing care who determines whether a nurse’s practice is safe not nurses.”

Wilson also noted “Failure to identify key cultural beliefs and practices, or the worldview of health, well being and illness risks providing healthcare that lacks relevance and compromises its efficacy.’ She went to say ‘Culturally appropriate services are fundamental for improving the access and use of services by Māori women.’ However Māori are not a homogenous groups and there is a great diversity of views and practices.

Wilson expressed concern that despite nurses being taught cultural safety they still failed to ascertain the cultural beliefs and practices of the Māori women in the study.

Wilson said “Positive health experiences stem from meaningful partnerships established between nurses and clients, and influence the efficacy of healthcare providers. In such partnerships nurses bring health and illness expertise while Māori women bring the knowledge about their health beliefs and practices and life circumstances.”

Achieving Cultural Safety for Nurses

Mixer (2008) in a review of literature on teaching cultural care and ethnonursing asserted that despite many years of research of transcultural nursing knowledge development there remains a lack of formal, integrated culture education in nursing. She said that ‘cultural competence’ development has been described as a journey rather than a destination and suggests that one does not become culturally competent but constantly works towards ‘cultural competence’ throughout a professional nursing career. She also noted that simply belonging to a minority group does not make one culturally competent and suggested nursing education research has found that cultural immersion helped personal growth, increased sensitivity to the needs of others and a general expansion of one’s worldview and assisted nurses to address a more holistic perspective and cultivate cultural sensitivity and awareness.

Mixer also reported the results of a pilot study which looked at how culture care was taught to student nurses. One of her findings was the importance of mentoring as a means of learning

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8 In New Zealand the term cultural safety is used in preference to cultural competence.
how to “care”. Caring was taught to students through mentoring and role modelling: listening, “being approachable” “checking in”. Mixer also noted that the care was reciprocal and mutual and multidimensional.

Campinha-Bacote (2008) commented that there is generally agreement in the literature that teaching cultural competency should focus on attitudes, skills and knowledge but that “cultural desire” – the motivation of the nurse to want to engage in the process of becoming culturally competent is also necessary. The author asserts that this desire is more likely to be “caught " rather than “taught" and that there is no consensus on how to teach it but suggests that caring, love, sacrifice, social justice, humility, compassion and sacred encounters are important components of wanting to be culturally sensitive.

Whānau and Patient Centred Nursing Models of Care

Lyford and Cook (2005) described a Kaupapa nursing service at Tauranga Hospital which uses a Whanaungatanga Model of Care to guide nursing practice. The authors noted that Māori are poor users of primary health services, over represented in secondary services and carry a high burden of disease. The authors quoted Durie noting “Health for indigenous people is a multidimensional, temporal way of being and is not necessarily the absence of disease. In the development of health initiatives designed to impact positively on Māori health statistics, this philosophy of wellness and wellbeing must be considered." The service developed, Te Puna Hauora Kaupapa Māori, offered a range of health services and offered Māori the choice of the Kaupapa service or the mainstream service.

The model is whānau based and it is recognised that whānau involvement is essential in the restoration of health for Māori. Traditional healing methods are offered as a choice and tikanga is used in practice in the unit.

Lyford and Cook (2006) described how two specialist educator positions acknowledge whakapapa and establish links before attempting to commence any education noting that sometimes the first session may be purely introduction and listening. The Kaupapa nurse educators acknowledge how treatment regimes will affect life of the person and not just their condition and education is personalised to the individual’s social context and whānau. Although non-Māori staff are employed the emphasis is on Māori directorship and Whānau centred care. The authors commented on the compartmentalisation of care by different diseases and noted that this results in the fragmentation of care and fails to provide cohesive clinical management.

Lyford and Cook(2006) say the service offers a culturally safe alternative for Māori requiring secondary health care and makes a difference to the health experience of tangata whaiora. The success and strength of the service lies in, among other things, the kinship connections with whānau, hapu, iwi and local Hauora.

Barton and Wilson (2008) noted that Māori centred practice models are not well articulated in the literature but that such a model constructed within the cultural context of a Māori world can provide guidance for working with Māori clients. Te Kapunga Putohe uses the hands to depict a partnership between nursing practice and Māori practices.

Barton and Wilson (2008) cited a number of papers which have identified that Māori experiences of non-Māori doctors have not been positive and have created fear about health services. These have also suggested that holistic healthcare delivered to Māori in a respectful and collaborative manner can impact positively on the health of Māori.

Te Kapunga is an approach to guide nursing practice to focus on developing meaningful relationships with Māori and can aid nurses to keep Māori central to their practice by being guided by Māori values, beliefs and Māori clients and whānau.
In her book Malony-Moni (2006) described her practice as a Māori community nurse and gave many examples of how knowing and observing Māori tikanga achieved positive health outcomes for the individuals and whānau she was treating. She put her success down to the fact that she was Māori, cared about her patients, knew what she was talking about, and that her patients understood what she was saying. She explained her success and nursing method as a synergy of clinical nursing skills and intimacy with tikanga Māori.

She stressed the principles of He Korowai Oranga and noted that the health system should; engage with whānau, rather individuals – to focus on the family’s potential, rather than individual’s problems; that health and wellness cannot be separated from each other or from the all the issues that confront whānau; recognise that for Māori it is not possible separate wellness from whakapapa, reo, tikanga as all these things create and sustain identity.

Malony-Moni (2006) commented that engagement must be with the whānau in dealing with all these issues, and that failing to do so will not result in better health outcomes. She believes families need to acknowledge their own potential to do things for themselves. She identified the accessibility, affordability and appropriateness of health services as being of vitally importance of Māori health outcomes.

Malony-Moni (2006) described nursing in a kaupapa Māori framework as: being non-judgmental, caring, whānau-oriented, whare and mare –based, empowering clients in managing their health and working with kaumatua and kuia in developing co-ordinated and collaborative care.

Malony-Moni (2006) noted the success of seeing patients in their own environment particularly noting that there is often more than one person in the family with the same problem /illness and that sharing information and education all the whānau together is more effective than education the patients alone. She found in this environment patients frequently shared information with other in the community and marae.

Other success factors in her nursing of Māori included; collaboration and information sharing with other health professionals especially in coordinating care for patients within the hospital system and around discharge planning and care; being able to bridge communications gaps between Māori, community and hospital services and expert clinical skills.

Abbott et al. (2007) described the experience of Aboriginal health workers and general practitioners working together using patient-centred care for chronic disease self-management in an Aboriginal medical service. Aboriginal health workers were trained to work with general practitioners using patient-centred care for chronic disease self-management in an Aboriginal medical service.

Abbott et al. (2007) found that people gave more honest disclosure of their problems with an Aboriginal peer than a doctor and noted that in the trial many patients disclosed valuable information to the Aboriginal Health Workers that they had not previously disclosed to their GPs.

Abbott et al. (2007) Found patient-centred health measures were useful in the clinical setting. The major benefits were in facilitating communication and patient-centred health goals which motivated both workers and patients. The authors noted that much of the literature notes that patient-centred measures are useful for program evaluation and research but clinically their greatest advantage is in improving communication between health care providers and patients. They noted that this is potentially even more valuable when Aboriginal Health Workers administer the measures.

Abbott et al. (2007) found patient-centred measures can be empowering giving patients an opportunity to express their feelings about their healthcare and take the consultation beyond
the model of symptoms and treatments. Multiple, seemingly overwhelming, social and medical problems can paralyse both patients and health workers and make it unclear where to start. Patient-centred care was useful in developing plans based on the patients own priorities. The Aboriginal health workers reported the tools gave a better understanding of the patient problems and barriers to self-care. They also strengthened relationships between Aboriginal health workers, patients and doctors and improved teamwork. The experience was motivating and encouraging for Aboriginal health workers who often provided extensive support, both emotional and practical to patients with high burdens of chronic disease and self-management difficulties.


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### Appendix D: Work Programme, DHB activities to support Māori providers, 2009/10

www.moh.govt.nz/moh.nsf/pagesmh/9650/$File/dhb-activities.doc

**HAWKES BAY DHB**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Activity</th>
<th>Specific Action</th>
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<tr>
<td>Funding / Contracting</td>
<td>Contracts</td>
<td>Whānau Ora contracts – Hawkes Bay DHB will work with Māori providers to support delivery of effective health promotion activities. Hawkes Bay DHB will offer health promotion courses through local EIT and through working more collaboratively with Hawkes Bay DHB health promotion advisors.</td>
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<td>Tamariki Ora contracts - Hawkes Bay DHB will transition Tamariki Ora to National wellchild framework including support for Māori providers for workforce development and better IT systems reporting.</td>
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<td>Hawkes Bay DHB will realign and support more resources to existing Māori provider contracts for greater capacity and delivery of effective ante- and post-natal programmes.</td>
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<td>Workforce</td>
<td>Implementation of Te Turuki, the Hawkes Bay DHB Māori Workforce Development Plan 2008-11</td>
<td>Hawkes Bay DHB will assist NGOs and Māori providers to develop their own Māori health workforce plans.</td>
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<td>As part of retention strategy, Hawkes Bay DHB will identify potential secondment opportunities between NGOs, Māori providers, PHOs and the DHB.</td>
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<td>Hawkes Bay DHB will establish an ongoing funding pool to assist Māori provider staff to gain formal qualifications.</td>
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<td>Hawkes Bay DHB will support Māori provider training development.</td>
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<td>Hawkes Bay DHB will encourage Māori health workers to attend development initiatives already in place.</td>
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<td>Mentoring Māori providers to deliver effective population health programmes</td>
<td>Hawkes Bay DHB will support a population health project (HEHA) Kahungunu Hikoi Whenua.</td>
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<td>Other Themes: Specific Health Areas</td>
<td>Reproductive Health</td>
<td>Hawkes Bay DHB will support workforce development with family planning services – providing contraception under standing orders.</td>
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<td></td>
<td>Ante and Post-Natal Programmes</td>
<td>Hawkes Bay DHB will realign and support more resources to existing Māori provider contracts to support greater capacity and delivery of effective ante natal and post natal programmes.</td>
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