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He Mihi

Kei ngā kaihoe, kei ngā mangainga nō tō Hinepiripiri waka e kōriparipa
ana i ngā whenewhene, e tōngakingaki ana kia wawe atu ai te ūnga ki te wāhi e noho nei a tūroro,
a oke kia piki te ora, kia piki te kaha, kāore i ārikarika ngā mihi ki a koutou.
Tēnā, takoto atu! Takoto atu! Nikā ngā pānga o Te Kura Matatini o Whitireia
e whakamānawa atu nei ki a koutou.

Nau mai, piki mai ki te ao tapuhi mahaki, arā,
ko te mahaki te hunga kua pāngia e te mate, ā, he tangata kua ngoikore, kua hauā rānei i tētahi mate,
i tētahi aituā, tērā pea e riro ana mā tētahi atu e tiaki. Ka riro mā te tapuhi ia e tiaki.
Tomo mai ki tōna ao tapuhi.

Ko tā te hautaka-ā-tau mahi nei he momo putanga whakaaro hei
whakatewhatewha i ngā piki me ngā heke o te ao hauora e hāngai pū ana ki te tapuhi mahaki.
Hei momo wānanga tēnei hautaka, hei kupu whakamiha atu hoki ki te hunga i waho o Whitireia,
nā rātou nei te kaupapa tapuhi, otirā tōna ao hauora i tuarā.

Ka riro mā ngā ika-ā-Whiro o te ao tapuhi o te ao hauora,
mā ngā tore kai huruhuru anō hoki ētahi whakaaro e whakatakoto hei whakaaroaro
mā te tangata tautōhito, mā te mea mātau, mā te tau.

Nā reira, hoea tonutia tō Hinepiripiri waka.
Tēnā tiaia! He tia! He tia!

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Dean's View

DR KATHY HOLLOWAY RN DN FCNA(NZ)

THE OCTOBER 2013 Australasian Nurse Educators conference, with its theme of Purposeful Partnerships for Practice, reaffirmed the place of Whitireia as a leading provider and thought leader for nursing and health workforce education in this part of the world (and perhaps beyond). Globally there is much written about the stormy nexus of the approaching 'silver tsunami' of healthcare need and the receding shore of the ageing nursing workforce – it is clear that service partnerships with nursing and health workforce education has to be part of the solution.

'With awareness comes choice' is one of my favourite aphorisms. This is tempered by an acknowledgement that while awareness does not guarantee choice, ignorance certainly limits it. This 2014 issue of the *Whitireia Nursing and Health Journal* provides an opportunity to become aware of some specific recent disruptive innovations (as described by Professor Darbyshire in his editorial), such as nurse entrepreneurialism, cultural safety and interprofessional education. While these ideas are not necessarily unique, the potential they offer to consider things differently is timely.

Nationally, nursing leaders are calling for an evidenced-based lens to workforce planning strategy (National Nursing Organisations, 2014). This reflects a need for nursing educators to 'do things differently'. Whitireia has a long history of providing innovation and disruption on the margins, which we will continue to offer to our communities. Our challenge is to balance the tension between incubating innovation and ensuring the diffusion of our learning to the wider healthcare community – this journal remains an important part of that process.

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Editorial
An Idea Whose Time Has Come: Nursing Entrepreneurialism

PROFESSOR PHILIP DARBYSHIRE

ENTREPRENEURIALISM in nursing and in nursing education is an idea whose time has assuredly come. The concept of the 'nurse entrepreneur' is not, of course, new. In addition to Florence Nightingale herself, nursing has a tradition of great 'social entrepreneurs' who had a positive impact on health and society. For example, Lillian Wald was a public health innovator who founded the famous Henry Street Settlement, Clara Barton established the American Red Cross, and Florence Wald established the American Hospice Movement (Gilliss, 2011).

Numerous researchers and leaders have urged healthcare professionals to adopt more creative, innovative and entrepreneurial approaches to address emerging and potentially intractable 'wicked problems' (Burns, Hyde, & Killett, 2013; Bore & Wright, 2009; Stoppelenburg & Vermaak, 2008) of healthcare and service delivery are to be addressed. This call has been echoed in key international nursing reports and enquiries (Cook, 2008; Drennan et al., 2007; Lipley, 2006; Thompson, 2007; Reed & Skinner, 2007; Roberts, Bridgwood, & Jester, 2009; McDonald, 2011). Calls for entrepreneurial approaches across business, health, education and nursing have also come from management leaders such as Peter Drucker and Clayton Christensen, through Christensen's 'disruptive innovation' (Christensen, 2012) ideas. For example, what healthcare analogies would be comparable to the disruptive innovation that saw computing move from a gigantic, ultra-expensive, ultra-complex, exclusive mainframe to today's ubiquitous mobile device and smartphone? Wilson (2012) says that:

> The time to act is now. There is tremendous movement on the entrepreneurship front in countries around the world. As evidenced by the numerous recent reports and initiatives focused on entrepreneurship education, there is also sufficient buy-in for action. … With the current momentum, now is the time to take these efforts to the next level – to move from words to action as well as to address entrepreneurship education. (p. 2)

The major 'The Future of Nursing' report in the United States noted that: 'Nursing education programs and nursing associations should provide entrepreneurial professional development that will enable nurses to initiate programs and businesses that will contribute to improved health and health care' (Institute of Medicine, 2010).

In the United Kingdom, a similar top-level report into nursing, 'Front Line Care' recommended: 'Development of the entrepreneurial skills that nurses and midwives need to lead and respond to changing demands and innovative models of care must be included in pre- and post-registration education and training' (Prime

Minister's Commision, 2010, p. 103).

In South Australia where I am based, academic and public policy leader Geoff Mulgan reinforced these ideas in his vision for the state's future: 'South Australia should investigate the scope for more systematic innovation around long-term conditions through funding to allow GPs, nurses and other social entrepreneurs to demonstrate new models, with assessment to determine the impact on other parts of the system, including savings to the acute sector' (Mulgan, 2008, p. 34).

The worlds of health and education as we once knew them are shifting sands under our feet. The time for insipid or tokenistic attempts at collaboration or partnerships has long passed. A myriad of influential voices have placed calls for strong entrepreneurial approaches and initiatives in healthcare that take notions of partnership to a different level.

Despite growing calls in literature for a stronger entrepreneurial approach and ethos in nursing (Boore & Porter, 2011; McSherry, Pearce, Grimwood, & McSherry, 2012; Melnyk & Davidson, 2009; Rai, 2007; Wilson, Whitaker, & Whitford, 2012; Wilson, Averis, & Walsh, 2003), as well as a burgeoning interest in evolving the 'entrepreneurial university' (Barcan, 2011; Gibb, Haskins, & Robertson, 2009; Rae, Moon & Gee, 2010), there have been little or no innovative responses from the health or university nursing sectors worldwide. There are no 'Professor of Nursing Entrepreneurship' or 'Director of Nursing Entrepreneurialism' positions currently offered anywhere in the world, although some US universities have centres with an entrepreneurial remit. One Professor of Nursing Entrepreneurship role was created at Rochester, New York, in 2007, but as an Emeritus role. An extensive online search suggests that the role is no longer current. For many health and higher education bureaucracies and their staff, entrepreneurialism is a dirty word that is on a par with profiteering. As a result, life in healthcare continues to be inertia as usual or redisorganisation disguised as change (Oxman, Sackett, Chalmers & Prescott, 2005).

THE IMPETUS FOR ENTREPRENEURIAL APPROACHES IN NURSING

A plethora of social, economic, political, managerial, demographic, professional, educational and technological drivers spur the need for greater entrepreneurialism in nursing. Health funding is in an almost perpetual crisis. Technology is moving too fast for many of our systems to adapt to it. The managerial decades have largely failed to deliver greater health outcomes. In many ways people have lost faith or trust in their health services and even in their health professionals. I do not know any serious thinkers in healthcare who think that 'more of the same' is going to help.

Gibb & Hannon's (2006) conceptualisation of entrepreneurialism from over a decade ago remains salient (see Figure 1).

It is clear that we require new approaches to thinking, creativity and problem-solving in nursing, nurse education and healthcare. Last decade's approach to the role, scope and potential of nursing will not address today's and tomorrow's health challenges.

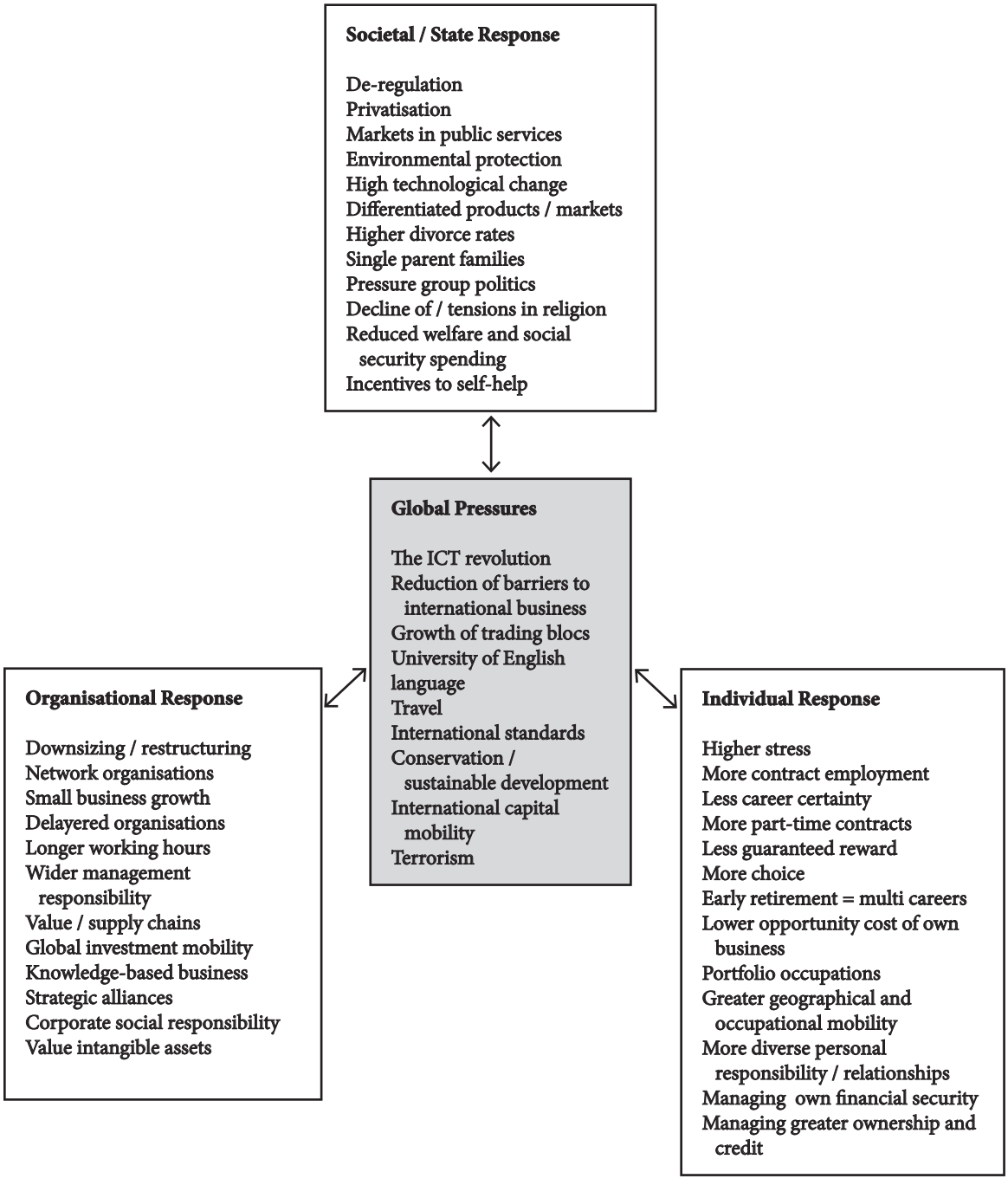
THE BENEFITS OF ENTREPRENEURIALISM

As Gibb, Haskins & Robertson (2009) note, the concept of 'the entrepreneurial university' has moved beyond the '… narrow focus upon commercialisation of intellectual property and the fears of "prostitution" of the "idea" of a university that results from this … Entrepreneurship has been located as an individual and organisational behavioural and development response to uncertainty and complexity broadly relevant to citizens and organisations of all kinds, private, public and autonomous (p. 27).

WHERE IS OUR ENTREPRENEURIAL LEADERSHIP?

Any university or health service that prides itself on being innovative or entrepreneurial must ask itself what plans it has to create the first chair or director of nursing entrepreneurship. The creation of such an entrepreneurial leadership opportunity would help address Gibb et al.'s 'key challenge' to 'create entrepreneurial role models within departments and gradually to build a cul-

Figure 1. Pressure Moulding the 'Entrepreneurial Society'



Reproduced from Exhibit 1, Gibb, A., & Hannon, P. (2006). *Towards the Entrepreneurial University. International Journal of Entrepreneurship Education*, 4(1), 73–110. Retrieved from http://irandanesh.febpco.com/FileEssay/karafarin-c-1386-10-30-m21.pdf

ture of rewarding innovation' (2009, p. 23). This initiative would also demonstrate international leadership in nursing and health entrepreneurialism.

Such a person and position would:

- Influence and lead the development and growth of entrepreneurialism in nursing both nationally and internationally.
- Support and inspire nursing entrepreneurialism and its more public sector-associated 'intra-preneurialism' (Brandriet, 1992; Curran, 1993) within all health sectors.
- Attract the most dynamic, creative and passionate staff, students and faculty with entrepreneurial flair and talent, who are committed to creating new approaches to nursing and healthcare's many challenges.
- Develop a focal or 'magnet' point for nurses who are keen to explore social entrepreneurship approaches (Danna, 2008; Danna & Porche, 2008; Dawes, 2008; Tedmanson & Guerin, 2011) to nursing, health and community problems. Also support efforts to bring these ideas to fruition and to market.
- Encourage and support specific ideas with commercial potential via business links.
- Promote and disseminate the 'academic enterprise' and 'entrepreneurial academic culture' identified by Crow (2008, p. 1) as being so crucial to the 'creativity and innovation with intellectual capital' that are the 'primary asset of every college and university' (p. 1).
- Develop future teaching, research, collaboration, publishing and funding strategies as well as service innovations and other opportunities specifically linked to nursing and healthcare entrepreneurialism (Asoh, Rivers, McCleary, & Sarvela, 2005; Darbyshire, Downes, Collins, & Dyer, 2005).

Such a role would combine academic and service-development sensibilities with entrepreneurial flair. It would do so across nursing, healthcare and the commercial, non-government organisation and social enterprise sectors.

As an emphatically non-traditional role, and one with an entrepreneurship remit, flexibility would be key (Gibb et al., 2009; Luke, Verreynne, & Kearins, 2010) to every aspect of the role's creation, operation and development.

The challenge for the health or education sectors is: 'Are you up to this?' Sadly, even recent history suggests that this will be an uphill struggle. Many health services, hospitals, universities and schools continue to be run as lumbering behemoths and glacially unresponsive bureaucracies that are, in the memorable phrase of the Keogh report (2013), 'trapped in mediocrity' Keogh, p. 3).

This simply cannot continue and an engaged entrepreneurialism from nurses and their education and service leaders is needed. Healthcare and education are businesses: live with it. These are multibillion-dollar enterprises that have been hamstrung for decades by the mindset that everything necessary will be done by governments that will continually draw on a bottomless bucket of funding. There can be few who believe this any more. I do not want to hear another generation of nurses and health professionals describe how their ideas for change, inspired suggestions and enthusiasm for 'new ways' of doing things are so relentlessly beaten out of them by that thing called 'the system'. We can create a different and better system.

As I write this, I am watching one of the world's prominent business gurus – Gary Hamel – at the World Business Federation in Sydney describing how we are no longer in the 'knowledge economy' but in the 'creative economy'. I wonder if anyone has told healthcare? He throws out the challenge that every employee should be a 'business innovator', that every employee should have ready access to *all* of the information needed to create improvement and success. If it takes longer than a week for an employee with a potentially good idea to 'line up the permissions needed' to run a small experiment or 'trial' of the idea, then 'you are not serious about innovation' (Hamel, 2013).

The time to get serious about entrepreneurial thinking, practice and possibilities in nursing is *now*.

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Identity, Ethics and Cultural Safety: Strategies for Change

DAWN DOUTRICH, LIDA DEKKER, JANET SPUCK & RENEE HOEKSEL

Cultural safety within nursing is a vital concept gaining global influence. It demonstrates ways in which culture and the sense of self are connected to safe and ethical care for patients. It is argued that transcultural nursing and cultural competence preparation have tended to depict the 'diverse' patient as the 'other', while reaffirming the hegemony of the dominant culture. When caregiver interactions lack critical reflection, unequal treatment and poor patient outcomes are often the result. Engaging in personal and professional reflection can help healthcare workers understand their culture's own relative power and privilege. It is suggested that intercultural interactions need attitudes and skill sets that support cultural needs instead of reaffirming the dominant influence of one culture. It is also noted that faculty practice and strategies have changed, aiming to improve critical reflections among faculty and students.

KEYWORDS: cultural safety; nursing ethics; nursing education; identity; reflection

CULTURAL SAFETY GREW out of indigenous experience in nursing education in Aotearoa New Zealand and has philosophical roots in critical theory. Explicit values include social justice and equity. The cultural-safety framework demands the healthcare provider engage in a process of personal and professional reflection, particularly about power and privilege. The Nursing Council of New Zealand introduced cultural safety into nursing in 1990 (Nursing Council of New Zealand, 2011).

Stemming from anthropology and nursing, the first transcultural nursing course was taught in the US by Leininger in 1966. The purpose of transcultural nursing is to provide care that is culturally congruent. Leininger (1999) stated: 'Culturally congruent care means to provide care that is meaningful and fits with cultural beliefs and lifeways' (p. 9). In 1995 the American Academy of Nursing's panel on promoting cultural competence in nursing education developed a position paper on 'academic programs and issues related to preparing students for culturally competent practice'. The panel defined cultural competence as 'a complex integration of knowledge, attitudes and skills that enhances cross-cultural communication and appropriate / effective interventions with others' (American Academy of Nursing, 1995).

Nursing research in Japan, Aotearoa New Zealand and other countries has informed our faculty practice and resulted in a series of changes in nursing programs at our college in the US. The changes are founded on the understanding that differing definitions of self exist, from those tending to be individualistic and 'I' oriented to those who are more communally defined. The changes to our programmes were also

informed by research themes from a previously published study. This paper, which is informed by Ramsden's seminal work (2002, p. 116), describes strategies, including attitudes and skill sets, which support the ability to interact with colleagues, students and patients respectfully and with appreciation for the complexities of each intercultural encounter.

IDENTITY, ETHICS, AND CULTURAL SAFETY: STRATEGIES FOR CHANGE

Nursing research in Japan, Aotearoa New Zealand and other countries has informed our faculty practice and resulted in a series of changes in nursing programmes at our college in the US. The purpose of this paper is to introduce ideas from the research that elucidate ways in which culture and the sense of self is intertwined in safe and ethical care for patients. Further, the purpose is to describe changes in faculty practice and strategies geared to improve critical reflections among faculty and students to improve patient outcomes.

IDENTITY AND ETHICS: AUTONOMY AND THE SELF

In the US, bioethics discourse has been dominated by principle- or rule-based ethics (Beauchamp & Childress 2009; Volbrecht, 2002). Four primary rules or principles are generally identified, including respect for autonomy, justice, non-maleficence and beneficence. In the typical discourse, ethical conduct derives from these principles and includes such behaviours as telling the truth and protecting confidentiality. An autonomous patient self is the starting point, a foundation for the ethical conversation. Yet the patient may not be the autonomous individual that clinicians presuppose. In a study of Japanese nursing scholars who obtained master's or doctoral degrees in the US, Doutrich (2000) documented the study participants' changing sense of self. This change was from a person described as interrelated and connected to a more individualistic and autonomous but sometimes 'less kind' self (Doutrich, p. 155). The participants talked of 'changes at the core' and 'changes in my self' (p. 155). They said, 'I got tough. It is the Japanese way to be soft to the other person …' (p. 155). They talked about differences in the sense of self and said, 'The way we [the Japanese] think is always thinking of the other person's feelings and thinking. If I cannot predict what you think, what you feel, I am lost completely … But Japanese, because we have less ego boundaries, we don't have "I" or "you" or that kind of thing' (p. 146).

Minami (1985) discussed this different sense of self in her influential work on Japanese nursing ethics, 'East Meets West: Some Ethical Considerations.' Much of the nursing literature in the English language describing values and ethical concerns of Japanese nurses relates their discomfort with the autonomy principle (Wros, Doutrich & Izumi, 2004). Japanese nurses are not alone in this. Though this example is from nurses, not Japanese patients, it is possible to extrapolate – the sense of self and self-identity for the Japanese general population is profoundly different from the autonomous 'I'.

When culture is broadly defined and cultural identity includes such constructs as race, ethnicity, age, sexual orientation, religious affiliation, gender identity, class and socio-economic status, an individual's identity can be said to be made up of a mosaic of cultures (Geertz, 1973; Nursing Council of New Zealand, 2011). This allows for a fluid sense of self, based in part on experience, context and interpreted meaning.

Fagan (2004) and others (Sherwin, 1992; Ho, 2006) have challenged the autonomy principle with particular attention to the multicultural client and to people from oppressed groups. What clearly emerges from these critiques is that one size does not fit all in terms of the autonomous self. The history, situation and socio-political context, and the individual's mosaic of identities, need to be taken into consideration in the bioethics conversation. This has significant implications for ethically and culturally safe patient care.

CULTURAL COMPETENCE

Cultural competence, a term used to signify culturally and linguistically appropriate care, has been expected of health professionals for decades

and is required by multiple regulatory bodies and for institutional accreditation in the US. Purnell and Campinha-Bacote are both transcultural nurses. Purnell (2002) defines cultural competence as 'the adaptation of care in a manner that is consistent with the culture of the client' (p. 193). Campinha-Bacote (1999) describes it as 'the process in which the healthcare professional continually strives to achieve the ability and to effectively work within the cultural context of a client (family, individual or community)' (p. 203). Other transcultural nurses (e.g. Giger; Andrews; Boyle) have also published extensively on transcultural nursing and cultural competence (Murphy, 2006).

Beyond the US, cultural competence is considered significant and it has global applications in healthcare. Like principle ethics, cultural competence has been criticised for a lack of historical and socio-political attention (Gray & Thomas, 2005). Stemming from anthropology, cultural competence has tended to depict a patient from a non-dominant culture as the 'exotic other', while reaffirming the hegemony of the dominant culture (Seaton, 2010). For example, in an effort to be culturally competent, most acute care facilities in the US ask patients the question 'Is there anything about your culture that will help us provide you with better care?' before admitting them. What the patient considers the cultural norm may be quite difficult to express. Like a fish in water, the patient swims in his or her cultural norms and takes them for granted. Despite well-intended culturally 'competent' caregiver interactions, the lack of critical reflection has resulted in an institutionalised continuation of unequal treatment (Institute of Medicine, 2003) and poor patient outcomes. In fact, asking this question of patients reasserts an unequal power relationship and implies that the patient will be able to articulate and define cultural needs in ways the healthcare community can understand.

CULTURAL SAFETY

Cultural safety grew out of the neocolonial experiences of Māori nurses and nursing students in Aotearoa New Zealand during a time of global resistance and socio-political change (Richardson, 2010; Ramsden, 2002). Cultural safety has roots in critical theory, so deep exploration of power and privilege are a starting place for deconstructing institutionalised and professional power and discovering the way these shape healthcare outcomes of people using or accessing healthcare. Central to cultural safety is the ability for the health professional to establish, maintain and sustain a trusting relationship in which the recipient of care is more likely to have a safe care experience (Ramsden).

As faculty in a college of nursing we found that some of the students in our courses, who are all registered nurses, initially responded to our requests to describe their cultures as, 'I don't really have a culture. I'm just normal.' Significantly, students from the non-dominant culture could often describe their history for several generations. Additionally, registered nurses came to our courses ascribing individual patient illness as a result of 'poor choices'. They had little understanding that the notion of 'choice' is not an equal opportunity. They lacked knowledge of connections between historical trauma, generational stress, social determinants of health and biological / genomic results of oppression, expressed as disease or lack of health. These and the reasons identified earlier fuelled interest in methods of teaching and learning about culture in healthcare that were not based on cultural competence. We wanted to find frameworks that would help students (and faculty) explore the structural violence and institutionalised oppression we saw resulting in health disparities and inequities for our patients. We had heard about cultural safety and understood it to be defined in part as 'the effective nursing practice of a person or family from another culture' that 'is determined by that person or family' (Nursing Council of New Zealand, 2011, p. 7).

> The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal

> culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual. (Nursing Council of New Zealand, 2011, p. 7)

To study cultural safety, we went to Aotearoa New Zealand and interviewed nurses about their clinical and teaching practices with regard to cultural safety. The study is described in more detail and with elaboration on the findings in a previously published article (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012). Primary themes of the study include the following:

1. Reflection is key.
2. Know who you are and where you come from. This includes your history and the mosaic of cultures that define your way of being in the world.
3. Walk alongside. Establish participatory relationships with patients, students and colleagues, rather than maintaining hierarchical power or subservience.
4. Inspire desire for getting it right.
5. Assure that cultural safety continues to evolve over time.

The third theme, 'walk alongside', includes the notion of establishing collaborations and participatory relationships with patients. This is the heart of patient- and family-centred care. The fifth theme, the idea that cultural safety must continue to evolve, addresses the concern that if it were to become fixed and rigid, it would become the new orthodoxy, an anathema to the spirit of cultural safety. Richardson (2010) brings Southwick's (2001) critique of cultural safety and transcultural nursing into her discussion of the problems inherent in the hegemony of the nursing profession. Richardson states that Southwick challenges the profession to stop reproducing the conditions of oppression through unexamined assumptions and ethnocentricity. We posit that examining previously unexamined assumptions could help solve the problems we've identified with principle ethics and the not-so-autonomous patient self. Problems arise when well-meaning providers assume that their clients, like them, have individualist values and are autonomous selves who prefer to make decisions independently. Solutions begin with the provider understanding his or her own origin and actively participating in an ongoing process of reflection, including a robust examination of their own ethnocentric assumptions.

We want to make clear that we do not dismiss cultural competence but instead make a distinction between cultural competence and culturally safe care. Like Duke, Connor and McEldowney (2009), we identify the skill sets from both cultural safety and cultural competency as critical to patient care and outcomes. Cultural competence offers understanding of the cultural lifeways of patients. The practice of cultural safety requires ongoing personal and professional reflection and an exploration of power relationships in healthcare and education. Both cultural competence and cultural safety affect patients' trust, patient care and patient outcomes. They may also both contribute to healthcare providers' motivation for addressing oppression and inequity; cultural safety practice demands this.

LOOKING FORWARD TOGETHER: STRATEGIES FOR CHANGE IN ETHICAL DISCOURSE AND CULTURAL UNDERSTANDING

The research undertaken in Aotearoa New Zealand affirmed that reflection is key to the process of cultural safety. Participants of this study suggested that it is crucial to make a safe environment for the health student and provider to reflect, especially on 'who they are and where they come from'. This includes 'looking to your own broken treaties' and 'knowing your own genocidal history' (Doutrich et al, 2012). We understand from our US context that this refers to exploring the historical trauma and structural violence that has been practised in the US, including, but not limited to, slavery. It suggested to us that we look to our own neocolonial (Ramsden, 2002) history and the number

of broken treaties that have been considered the norm with the First People / Native Americans / Native Alaskans in the US. The theme, 'reflection is key', suggests that through self-awareness providers and students can learn about their own values and prejudices (Gadamer, 1975). This provides the opportunity for faculty and students to articulate values and discuss where they come from with relatives, sometimes for the first time. This can also highlight the notion that not everyone has the same values. Reflection on self and on practice invites providers and students to link what they already know and to connect the known with new insights, particularly about how power shapes healthcare relationships.

'Looking to our own broken treaties' requires that we open ourselves to information on the links between power, politics, economics, historical oppression and health, and that we understand this information in a data-rich yet personal way. Through understanding historical trauma and our relative positions as both perpetrators and injured, we may stop judging our patients and ourselves, and come to the relationship with an authentic stance, new knowledge and compassion.

'Cultural moments' is a label for a technique we've used to de-shame cultural mistakes in various settings, including acute care and academic. These cultural misunderstandings or mix-ups are the times when we've had our cultural assumptions 'emerge' to shock or surprise us. To dissect a 'cultural moment' allows the teller of the narrative to share an assumption that has been unhelpful in practice or education. A cultural moment is a situation that brings new understanding to light. It involves reflection and requires being open to learning. It honours our cultural teachers, often patients or students. We started including a 'cultural moment' for a few minutes in each of our faculty meetings. Faculty members take turns sharing cultural-moment situations they have experienced. These have helped us be more self-aware and, in the education setting, to model that with our students.

One cultural moment we discussed took place in a short-stay surgery, where a patient was supposed to come in for a procedure and be released the same day. He was a person who was Hispanic and when he arrived the interpreter asked if he'd had anything to eat or drink. He responded that he hadn't had anything to drink since the night before, but he'd had a good breakfast. This meant no surgery that day. The surgery schedule had to be changed. The patient was inconvenienced. And the mix-up caused a cost increase for engaging the interpreter a second time. The staff questioned how this could have happened: the man had been told not to eat or drink. In reflecting on this situation, the teller of the story said, 'the most common delusion connected with communication is that it has occurred'. She went on to describe how, when the family was asked what they heard when told about how to be ready for the day surgery they responded with, 'you said not to drink anything so we made sure he didn't'. They didn't hear the part about not eating too. This was an expensive learning experience for the hospital and a time-consuming inconvenience for the patient and his family. The hospital staff did not blame the family or patient and rescheduled his procedure with better instructions. Because the staff were able to reflect on the communication breakdown and identify where it happened, they were able to systematise a preventative intervention. They now ask future patients what they understand or what they heard about preparing for surgery. The staff could laugh about the idea that 'communication' has occurred because the provider said something – an unexamined and ethnocentric assumption. There is now a plan in place to have patients 'teach back' and for all providers to systematically use an intervention to gauge the patient's understanding of health information.

Not only does the practice of sharing cultural moments allow us to learn from mistakes and reflect on how it might have been different, it also allows for the institutionalisation of reflective practice and provides an opportunity for system change.

CONCLUSIONS

Uncovering fluidity in patients' sense of self and health workers' lack of deep context (including privilege, power and historical oppression for some people's mosaic of cultures) calls into question the assumption of the autonomous self as a foundation of principle ethics and shakes up the ethical discourse. Likewise, exploring assumptions of cultural competence invites alternative viewpoints that include uncovering power and exploring context. Safe, effective nursing care is connected with providers' ongoing self-awareness and reflection on self and practice. This kind of care is associated with cultural safety, patient safety, patient- and family-centred care and ethical practice.

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Interprofessional Education: How Can it Enhance Learning?

ARI NEOCLEOUS

Interprofessional Education (IPE) has been promoted as an approach to enhance the collaboration, communication and professional practice of health professionals. IPE has potential benefits for patient care and service delivery as it builds relationships and the sharing of knowledge between differing professional groups. For IPE to be effectively implemented institutional and professional barriers need to be overcome. Overcoming prejudices towards other professions is also a challenge that needs addressing. Establishing IPE affects the role of the lecturer and also that of the students. Lecturers need to consider curriculum implications, including the teaching and learning activities and the resources needed, as the professional preparation of students is seen as a vital component of clinical teaching and practice.

KEYWORDS: IPE; collaborative partnership practice; Bloom's taxonomy; communication; teamwork

INTERPROFESSIONAL EDUCATION (IPE) has been promoted as a strategy that enhances the collaboration, communication and professional practice of pre- and post-registration students and health professionals. IPE develops skills, knowledge and attitudes that promote teamwork and facilitate learning between different professions (Henderson, O'Keefe & Alexander, 2010; National League for Nursing (NLN), 2012) such as nursing and paramedicine. IPE between professions can result in a higher quality of patient care as health professionals learn more about each other's roles and work in partnership to promote the most favourable health outcome (Poore, Cullen & Schaar, 2014).

The need for IPE was first discussed in the Colwell report in 1974 and this is further supported by the report from the Victoria Climbié Inquiry chaired by Lord Laming in 2003 (Barr, 2002). Laming's report emphasised the lack of communication between disciplines and concluded that nothing had moved on since 1974. In New Zealand, the report into the death of James Whakaruru blamed poor communication by all parties and highlighted the need for interprofessional collaboration, which was a catalyst for change (New Zealand Children's Commissioner, 2000). This change needs to take place in tertiary settings so that students can graduate with a better understanding of collaborative practice and teamwork that will make them ready to work in their chosen profession and alongside professionals from other disciplines (Stone, 2010).

BENEFITS OF IPE

IPE has benefits for patient care and service delivery. It builds relationships and the sharing of knowledge between different professional groups. The World Health Organization (WHO, 2010) has promoted IPE as 'a necessary step in preparing a "collaborative practice-ready" health workforce that is better prepared to respond to local health needs' (p. 7). By working together, professionals from different vocations can ensure that the patients and their families receive the best possible care while they in turn gain insight

into each other's roles. In the workplace IPE can improve professional practice as it not only aids understanding of differing roles, but also aids assessment and decision-making (Barrett, Greenwood, & Ross, 2003; Patsios & Carpenter, 2010). This collaboration can also help to prevent duplication of roles, which can result in better patient compliance as patients do not have to continually repeat information to the various professions (Bennett et al., 2011; Freeth, 2007). By collaborating and working in partnership with the family and other professionals, health professionals can recognise problems as they arise and respond accordingly to ensure early intervention by the appropriate professional. The benefit to the patients and their families is that they have easy access to professionals and the care they receive will be 'seamless' (Mann et al., 2009).

INSTITUTIONAL BARRIERS

Various institutional barriers need to be overcome for IPE to be effectively implemented in training courses. Time is one problem, as academic programmes have their own curricula and timetables to meet, and allocating a time to get all professionals together can be difficult, usually due to workload (Buring et al., 2009). Implementing IPE gradually can allow time constraints to be addressed (Buring et al.).

In undergraduate education, another barrier is the need for room space that can accommodate the large number of students (Buring et al., 2009). To resolve this, faculty teams (also cross faculties) should collaborate and find a solution (Street et al., 2007). Being housed in one building or area can address the need for space.

Underlying the problems of time and space, the budget is usually a driving factor for institutional leaders. Highlighting that IPE could lead to a more efficient use of resources and also improve student outcomes increases the chances of it being comprehensively implemented (Bennett et al., 2011). IPE could also benefit institutions as they can build stronger relationships with stakeholders by producing graduates who have better communication skills and are able to work collaboratively with other healthcare providers. This can increase productivity, which will in turn benefit stakeholders and reduce healthcare costs (Poore et al., 2014).

PROFESSIONAL BARRIERS

Another challenge of IPE is overcoming prejudices towards other professions that have arisen from previous experience or, as Horder (2004) suggests, 'tribalism'. Different professions can fail to appreciate each other's roles – a challenge that needs addressing. The introduction of IPE is hindered by professional stereotyping, which can lead to resistance to change (Barnes, Carpenter & Dickinson, 2000; Cragg, Jelley, Burrows & Dyer, 2013; Hind et al., 2003). In undergraduate education this resistance is reflected in a lack of commitment from educational leaders and from practice and placement settings (Street et al., 2007; Cragg et al.).

Ignorance about other professions can be prevented by better communication. One solution is to incorporate learning experiences where educators from specialist professions run sessions in which they share their knowledge that will benefit all involved with students of different professions.

Even if the above were overcome there is still the challenge of gaining acceptance from the regulating bodies such as the Nursing Council of New Zealand and individual tertiary educational institutions, which offer different regulations and course content. To review curricula for compatibility and alignment regarding the inclusion of IPE will take time and commitment from all professions.

The introduction of IPE could also have implications for the requirements of professional bodies (Barr, 2002; Barr, Helme & D'Avray, 2014). Commitment from registration boards is necessary along with a curricula change if IPE is to be implemented in education (Bennett et al., 2011). Introducing different professions, such as nursing and paramedicine, to IPE early in their professional education can address issues of stereotyping and understanding of roles. It also highlights to students that all professions need

to work together for the benefit of the patient (Street et al., 2007). Collaborative practice will enhance the students' knowledge and skill base while promoting respect and equality between professions (Street et al.; Bennett et al.). IPE will also enable students to demonstrate good communication, teamwork and problem-solving skills.

OPPORTUNITIES FOR INITIATING IPE

Allport's 1979 contact hypothesis provides a theoretical basis for the development of IPE (Hean & Dickinson, 2005; Mohaupt et al., 2012). This hypothesis suggests that contact between different groups can help develop understanding of any negative attitudes and stereotyping, which, once acknowledged can be addressed (Hean & Dickinson; Mohaupt et al.). Allport's contact hypothesis theory identifies the following areas: institutional support, a level playing field regarding status within the group, awareness of differences and similarities between participating groups, and that all participants enter into the process expecting the outcome to be positive (Hean & Dickinson; Mohaupt et al.).

COMMUNITY OF PRACTICE

To enable IPE to take place there needs to be commitment from teaching faculty to engage together on topics that they have a passion and drive for (Endsley, Kirkegaard & Linares, 2005). These interactions form communities of practice, where a group of people with a shared enthusiasm for a topic share their knowledge and experiences on a regular basis (Endsley et al.). Quite often it is down to the individual to seek out other professionals and form such a team that can work together with the aim of ensuring the best outcome for the student / patient. A community of practice has been described as a professional forum where the professionals come together for mutual engagement, joint enterprise and shared repertoire (Wenger as cited in Davis, 2006). To enable IPE to work, lecturers from different disciplines must agree on a common goal and make the time in their workload to meet. Effective team working requires all members to be equally committed. As Patsios and Carpenter (2010) highlight, 'there is a difference between attending and doing' (p. 7). This is an opportunity to share knowledge, develop ideas and discuss sharing of resources, such as teaching across programmes (Endsley et al.).

TEACHING AND STUDENT ROLES

Establishing IPE affects the role of the lecturer and also that of the students. The lecturer organises processes that aid students' learning, and manages and maintains a supportive environment that ensures the student group will work effectively (Brimble, 2008; Race & Pickford, 2007; Macauley & Billings, 2011). By engaging with the students, the lecturers can identify conflicts, resolve problems and move forward. By participating in conversation with the students and using active listening skills, lecturers will be able to help the students think how they could work through problems and develop their cognitive thinking skills. This engagement with the student groups also allows the lecturers to facilitate teamwork and shared learning (Burns & Sinfield, 2004; Edmunds & Brown, 2011; Lindqvist & Reeves, 2007).

Lecturers will need to consider the teaching and learning activities and the resources needed so that the students can meet the intended learning outcomes of the IPE sessions. Bloom's taxonomy has been in use for many years and has appeared in many differing formulas over this time (Materna, 2007). Frameworks such as Bloom's taxonomy can help lecturers develop intended learning outcomes.

It has been updated by Anderson and Krathwohl (as cited in Materna, 2007) with a two-dimensional table. Bloom's taxonomy offers a recognised framework for learning able to cross boundaries. The six main themes of Bloom's taxonomy are still present but now under the heading of 'Cognitive process dimension' along the horizontal axis of the table (Anderson & Krathwohl as cited in Materna). These themes are joined by four new themes on the vertical axis: factual, conceptual, procedural and metacognitive. The vertical axis begins with

'factual' at the bottom, where the student needs to understand the basics of a subject to be able to solve problems in it. Therefore the students will need to understand the importance of IPE and how the intended learning outcomes work towards meeting this objective. The next row up is 'conceptual', and this is where the student understands how the basic elements interact within a larger structure allowing them to work together. This row is followed by 'procedural', where the student knows how to proceed and use inquiry to decide how to use the skills gained. The final row of the vertical column is 'metacognitive', where the student can demonstrate a general understanding of the subject and is also aware of their own understanding (Materna). This enables the student to demonstrate insight into their own learning (Materna). This new format for Bloom's taxonomy allows educational objectives to be addressed from both dimensions, which promotes a positive outcome for both the facilitator and student (Vickery & Lake, 2005).

A vital component of clinical teaching is the preparation of students as it helps to ensure they are ready to apply both theory and practical techniques (Tanner, 2002; Tang, Chou, & Chiang, 2005). This preparation is especially important where students from different health professions are involved, as it is likely that students are being taught different ways of observing and noticing in their respective courses and may perceive things differently (D'eon, 2004; Gilbert et al., 2000; Street et al., 2007). The inclusion of scenarios will give the students the chance to participate in problem-based learning, which offers deep learning, improved critical thinking and improved interpersonal team working and collaborative skills (Payler, Meyer & Humphries, 2008; Solomon, 2010). The importance of learning through experience by undertaking set tasks with peers will enable students to develop their communication skills. Communication skills are very important skills for all healthcare workers to acquire, and more so when two or more professions are involved (Kolb, 1984; Arnold & Underman Boggs, 2011). Students who collaborate and work together will be able to learn from their peers while improving their knowledge, skills and understanding of differing roles (Beckman, 2004; Hoffman, Rosenfield, Gilbert & Oandasan, 2008). The development of students should take place in a supportive environment that is familiar to all participants, using effective feedback methods. This model is good practice for the students to follow (Archer, 2010, Draper, 2007, Hays et al., 2002; Garrett, MacPhee, & Jackson, 2010).

The development of self-awareness for students is an essential part of any faculty's curriculum as it allows the students to identify their own learning needs (Teunissen, Stapel, van der Vleuten, Scherpbier, Boor & Scheele, 2009; Yoo, Yoo & Lee, 2010). Encouraging students to review their learning experience and synthesise this knowledge will promote self-awareness and help them learn how to learn by identifying their strengths and weaknesses (Rolfe, 2002; Whitireia Community Polytechnic, 2011; Poore et al., 2014). IPE promotes self-awareness through reflection. Students can identify areas where collaboration and cooperation have taken place to enhance their learning and their understanding of how different professions can work together to provide a better quality of care for patients (Plack & Greenberg, 2005; Poore et al.; Stein-Parbury, 2009).

CONCLUSION

IPE has the potential to improve healthcare service delivery for patients. By collaborating and working in partnership with professionals from a range of occupations, stakeholders and students will benefit. They will be exposed to a variety of roles involved in healthcare delivery that will enhance their knowledge and therefore their practice with patients. However, implementing IPE in a tertiary education setting raises many issues. Gaining a commitment from the educational institution is the first challenge that needs to be overcome. IPE has been promoted in national health strategies, but tertiary institutions offering health education and professional bodies need to actively support its implementation to make it a reality.

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Recognising Cultural Safety Issues for Indigenous Students in a Baccalaureate Nursing Programme: Two Unique Programmes

HAZELL PENN

Indigenous students need support to succeed when meeting the demands of a baccalaureate nursing programme. What does support look like? In a study tour to New Zealand in 2013 a nurse educator from Canada compares two nursing programmes a world apart. These programmes are at Camosun College, Victoria, British Columbia, Canada, and at the Faculty of Health, Whitireia Community Polytechnic, Porirua, New Zealand. At Whitireia the individualised programmes and specific course content allowed for an indigenous perspective. Further research is needed to look at reasons why people in diverse cultures become marginalised. Faculty development is required to promote deeper insight into the hegemonic values guiding the programme and improve the attrition rates at Camosun College.

KEYWORDS: aboriginal nursing students; indigenous nursing students; nursing programme; cultural safety

GUIDED BY CAMOSUN COLLEGE'S educational and strategic plan, the Canadian Department of Health and Human Services undertook an initiative to foster the success of aboriginal nursing students enrolled in the Bachelor of Nursing Science (BSN) programme, to realise aboriginal students' goals of becoming registered nurses. Representatives from the aboriginal community within Camosun College, aboriginal elders, aboriginal healthcare community leaders, and nurse coaches from Camosun College and faculty from University of Victoria came together to develop the pilot project. Using the Co-active Coaching Model (CTI) a new mentorship / coaching group was initiated (H. Kimsey House, Kimsey House, Sandahl, & Whitworth, 2011). The CTI model promotes the 'coachee' or client of the coaching. It aligns well with mentorship but further recognises the inherent strengths of the client.

In New Zealand I discovered a unique and inspiring nursing programme offered at Whitireia. The Bachelor of Nursing Pacific (BN Pacific) runs alongside the Bachelor of Nursing Māori (BN Māori) and a concurrent Bachelor of Nursing. This paper will share the lessons I learned from reflecting on different approaches to foster success in the BN Pacific in New Zealand and the BSN degree in Canada. I will focus on what I saw as an outsider looking in. The paper offers my reflections from a study tour to New Zealand in 2013 where I considered the hegemonic values in nursing education and how they prejudice indigenous nursing students' success. The central

question asks: How do programme structures choose to support and educate indigenous nursing students?

It is obvious but maybe too simplistic to list similarities of these two Commonwealth countries colonised by Europeans over approximately the same historical period. This shared history offers a foundation to understand the indigenous students' journey when entering a nursing baccalaureate programme while still affected by recent colonial history.

Historically, both nursing schools have experienced high attrition rates in the indigenous cohort, but Whitireia embarked on some remarkable new programming in 2002. At Camosun College in Victoria, Canada, five per cent of the annual intake of approximately 192 nursing students is reserved for aboriginal nursing students from British Columbia. Approximately nine students receive funded placements each year. Camosun College Nursing Faculty recognised that cultural safety practices needed to be in place to support the aboriginal students (Ramsden, 1990). However, judging by statistical success, these practices are not well understood and therefore still lacking. Attrition rates among aboriginal students continued to be too high year after year. It was a revolving conundrum. The institutional hierarchal framework and stereotypical white Western medical model is still intact at Camosun College, and obviously not inherently supportive for students from indigenous colonised backgrounds.

Although there are many commonalities between the two nursing programmes and many of the same challenges in both communities, Whitireia embarked on a new path not contemplated in western Canada.

In 2008, US nurse researchers visited Whitireia to inform US nursing education and practice. This research was discussed in 'Cultural Safety in New Zealand and the United States: Looking at a way forward together' (Doutrich, Arcus, Dekker, Spuck & Pollock-Robinson, 2012). Cultural safety considers the perspective of the patient as the norm in contrast to the culture of healthcare (Doutrich et al.). Perhaps it is time to consider further the perspective of cultural safety for nursing students in nursing education programmes. I suggest this work be expanded to inform educators of the experience of indigenous nursing students in programmes in Canadian nursing schools.

The nursing literature indicated that the work on cultural safety issues in nursing from New Zealand was more comprehensive than research generated in Canada. The Nursing Council of New Zealand defines cultural safety as 'the effective nursing practice of a person or family from another culture, and is determined by that person or family' (Nursing Council of New Zealand, 2005, p. 4). In New Zealand this concept has been integrated into nursing education for two decades. Alongside this, educators began to question whether nursing schools could ensure the same for their nursing students. My attention centred on the nursing programmes at Whitireia, which appeared to be dramatically different, offering two additional culturally specific nursing education streams, the Bachelor of Nursing Pacific and the Bachelor of Nursing Māori, alongside the conventional nursing programme. My focus was on the Pacific nursing qualification, and I considered what could be transferable to my own institution.

Although there are many commonalities between the nursing programmes and many of the same challenges in both nursing communities, Whitireia took on a unique approach spurred on by the doctoral writing of Dr Margaret Southwick, former Faculty of Health dean at Whitireia, and strongly supported by the present dean, Dr Kathy Holloway. In her doctoral work, Southwick (2001) contested the mainstream view of nursing education for indigenous nursing students. According to Southwick it was necessary to question the status quo. She suggested that despite the rhetoric surrounding the profession, it was obvious from her research that although it was the espoused goal of nursing to offer culturally safe nursing care, 'the unexamined and often unintentional consequences of hidden hegemonic values is that the

discipline of nursing itself becomes an agency of oppression' (Southwick, p. 14). This description raises questions that are difficult for nursing to respond to.

This concept also raises the question of whether nursing education is able to recognise the cultural domination of one group by another and its own hegemonic ways. Can nursing adequately critique this internal situation? Some would argue that educating aboriginal student nurses is about skills acquisition plus academic calibre for the new generation of nurses. Others recognise that the deep-seated colonial oppression and distinct cultural heritage issues need to be acknowledged and aboriginal student nurses strongly supported as they integrate their cultural heritage while forming a professional identity.

In 2012 Camosun College Faculty Association (CCFA) supported me to pursue a Co-active Coaching Certification (CPCC). At the same time, I was able to use some Federal funding from Aboriginal Health and Healing Research Initiative (AHHRI) earmarked to support the new cohort of aboriginal nursing students. I implemented the Coaches Training Institute (CTI) co-active coaching model and mentorship models and arranged various social and cultural opportunities with the intention of supporting indigenous students in the Camosun programme.

In June 2012, I contacted the dean at the Whitireia Faculty of Health to request an opportunity to visit for an experiential view of the nursing programmes offered there. An invitation was extended and the timing was a perfect fit with my work at Camosun. I received study development leave from Camosun College and arrived in Porirua on Waitangi Day, 6 February 2013.

So what did I see and experience? I learned that Whitireia nursing courses have approximately 140 entrants a year. Making up this number are three cohorts of which the BN Pacific enrols 30–40 students and the BN Māori 30. This compared to 192 students at Camosun College. Probably the key point of the programme at Whitireia is the shared overview that emanates from the nursing leadership. The nursing leadership acknowledges the big picture, the history of colonisation and its ramifications and the impact this can have on student success.

Whitireia recognised the need to provide structures for indigenous students to incorporate their culture and heritage into their programme of study. This prompted me to question some of the institutional concepts still held by nursing educational bodies in Canada. The temptation to place the problem with the individual students still lingers. At Camosun College the CTI coaching model provided a different approach and starts from the premise that the client is naturally creative, resourceful and whole. This is a challenge to enact in an established nursing programme. Faculty members, bound by many responsibilities in their day-to-day work and the need to orchestrate a nursing degree, are not always aware of the complex issues that the indigenous students face and students' cultural strengths are often masked by the dominance of the hegemonic culture of nursing. Southwick (2001) identified that little research had been undertaken to elicit information from indigenous nursing students themselves, asking about their experience of being in a predominantly white middle-class cohort or their experience of being together in a cohort comprised of diverse indigenous heritages. Southwick cautioned the reader to move beyond mere description because that creates the prospect of locating the 'problem' with the participants (2001). In the process of undertaking her research project, Southwick herself admitted to being constantly challenged by the complexities of the issues involved.

The complexities are the very issue. Nursing programmes may not 'stop' and make time to investigate how these issues present for students. The oppression experienced by indigenous students on entering a conventional programme may perpetuate the history and marginalisation further. Southwick (2001) questioned whether nursing can capitalise on diversity as opposed to being the centrifugal force that becomes a 'self-serving strategy to protect the interests of nurs-

ing' rather than pursuing a duty of care (2001, p. 52). Thus, not only does nursing mask its own privileged voice, it is proposed that nursing will appropriate the needs of the marginalised in order to preserve its own privilege. Does nursing reach out to serve the health needs of a marginalised and vulnerable population?

My experience with the aboriginal students at Camosun College has taught me that the taken-for-granted dominance of the white Anglo / European culture in nursing and the cultural safety debate have paradoxically legitimised the dominant culture (Southwick, 2001, p. 54). My experience at Whitireia has taught me that it does not have to continue this way. So how can nursing in Canada respond to the needs of indigenous nursing students and the contradictory forces of cultural diversity, while acknowledging that the dominant culture still has the power to dictate the nursing curriculum? Meleis (1996) suggests that nursing practice would be better served by research that looked at the reasons why people in diverse cultures become marginalised rather than trying to describe their cultures from an outsider or visitor perspective.

At Whitireia the individualised programmes allowed for an indigenous perspective. Teachers with their own experience of being an indigenous person taught the students. I witnessed the students embarking on their baccalaureate nursing programme being acknowledged into a community of indigenous teachers and learners and embarking on specific course content about indigenous peoples' issues and ways of being. They were given opportunities to find their own stories and, I would also suggest, an opportunity to unlearn another story. As Southwick (2001) states:

> While other students may enter the programme with some anxiety about whether or not they have the ability to 'make it', that anxiety seldom prevails. Measuring themselves against their peers, their talk is often along the lines that if others have made it, then they can make it as well. This is generally not the experience for Pacific Islands students, particularly those who have been educated within the New Zealand context. These students have been scripted through their previous experiences to accept academic failure as the norm. (p. 79)

At Whitireia this was appreciated as a crucial element of educating indigenous nurses. They would be able to recognise and change the systems that affect them and their indigenous culture and community, their health and well-being.

Our challenge now is exploring how our nursing programme at Camosun College can incorporate the core elements of this unique programme in a different setting. For our nursing department today, we need to draw on the broader Camosun College community. Many of the student issues, fully appreciated and incorporated at Whitireia, *are* also recognised and supported by the Aboriginal Education Department at Camosun College and some informal evaluation has begun. During this evaluation students indicated that they valued being brought together as a group and felt they found a stronger voice that way. It is hoped that this will support their successful study towards becoming registered nurses.

To progress at Camosun College, I suggest the following strategies:

- a deliberate application of an evaluative process to understand the aboriginal students' perspective;
- plans to celebrate the aboriginal students entering the programme;
- mentoring by second-, third- and fourth-year aboriginal nursing students (who would be eligible for leadership credit); and
- hiring aboriginal staff.

These would be valuable first steps to improving the attrition rates at Camosun College. Faculty development to promote deeper insight into the hegemonic values guiding the programme would also be beneficial. Could a Canadian aboriginal nursing degree programme follow?

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My Years at Napier Hospital: December 1924 – May 1931

MARY EAMES NÉE WELLOCK

The first part of Mary Eames' memoir of her time as a nurse at Napier Hospital was published in the 2013 edition of the *Whitireia Nursing and Health Journal*. There Mary recounted her memories of the 1931 Napier earthquake and how she narrowly escaped death when the Nurses' Home collapsed. In this, the second part of her memoir, she describes the daily life of a nurse – the hardships and the rewards – from her first day when she was put to work on a ward with no orientation but was helped and encouraged by a woman with arthritis who had been in hospital for nine years until the time she left to get married. Mary didn't have a day off in her first five months, but also recounts her interesting education, common diseases and treatments of the time as well as social events and the fun they had.

STUDENT TO STAFF NURSE

Having been on a waiting list for six months, I at last received notice to report at Napier Hospital on the 19th December 1924. Feeling very elated that I was about to begin my career as a nurse, I caught the train from Wellington on the appointed day. All was well until a short time after leaving Dannevirke, when the train suddenly came to a halt. We were all very puzzled by this as there was no station in sight. Very soon the guard came through to say that there had been a washout on the line and that we would have to wait for a relief train to come from Napier. He said that we were somewhere near Matamau. We had a long wait. We pitied the mothers with tired and restless children and hungry babies. Presumably to relieve the monotony some youths came through the carriage saying 'move forward to the relief train'. We all collected our belongings and moved forward to find it to be a hoax. This happened twice. Eventually the guard came through with a lantern as it was then dark and told us to go slowly as we would have to walk across the sleepers and there was still water rushing across below. With the aid of lanterns and fellow passengers we managed it without anyone falling.

It was after midnight when we arrived at Napier. The *Tangaroa*, a small coastal steamer which in those days carried passengers from Napier to Wairoa, had awaited our arrival to collect those bound for Wairoa so consequently they had priority for taxis. Napier passengers without private transport had to wait in the taxi office till the cars returned. It was after 1 a.m. when I arrived at Napier Hospital, very tired and hungry and uncertain about my next move. The driver was very helpful, he asked the telephone operator to ring the Night Sister saying, 'Sister Mitchell will look after you.' On arrival, Sister Mitchell gave me a warm welcome and took me to Margaret Ward where Nurse Smith gave me coffee and toast, which was a real lifesaver. Nurse Smith told Sister that there was a spare bed in her room as her room-mate was away on annual leave. With Sister I crept into the Nurses' Home, found the room and I was soon in bed, but had little sleep.

In those days we had a probationary period of three months, for which we had to provide our

own uniforms comprising of two navy pinstripe uniforms with belts, twelve aprons, two pairs of black stockings and shoes. Cuffs and caps were provided; they were very stiffly starched and were fastened with studs. Nurse Smith came off duty at 6 a.m., after having breakfast she came up to her room and she was extremely kind. She supplied me with cuffs, collar and studs, and also made up a cap for me. She then showed me where the dining room was and told me to go in when I heard the breakfast bell. I entered and was welcomed by a very surprised Home Sister who had not been informed of my arrival. I was taken to the 'Pros' [probationers] table and I was told that being the most junior member of the staff, I must give precedence to all senior members when entering or leaving a room, also to put my hands behind my back when speaking to seniors.

The hours of duty were:

Morning duty	6 a.m. to 2 p.m.
Afternoon duty	2 p.m. to 10 p.m.
Night duty	10 p.m. to 6 a.m.

In later years there was also an extra duty, a divided time 6 a.m. to 11 a.m. returning at 2 p.m. until 5 p.m.

Sisters came on duty at 6.30 a.m. and remained till 2.30 p.m., they relieved the senior afternoon nurse for her meal, also for lectures and when test papers were being written.

As a result of my eventful arrival I was somewhat apprehensive of my first day on duty. It proved to be 9–5 in Jellicoe Ward, which was the Women's Medical Ward. At the time there was no Preliminary School, nor instruction of any kind before our first day on duty, so it was a bewildering experience. The ward was very busy, there being forty patients, of this number fourteen were on the verandah. I was to be responsible for bed making, polishing the lockers, mopping the floor, and getting up patients who were well enough. The first patient was an elderly arthritic unable to dress herself, she also had conjunctivitis and her eye had to be irrigated. I was shown how to do this and told that I would have to do it from then, each morning. The second patient was also arthritic, her legs were quite rigid and she had very little movement in her arms. She had to be helped to a wheelchair. She had been in hospital for nine years. She knew just how everything should be done. I do not know how I should have survived those first few weeks without her encouragement and advice.

There were two 6 a.m.–2 p.m. nurses on duty, the senior morning nurse often started at 5.30 a.m. in order to do [patients'] urine tests before starting washing patients and making beds. The junior [nurse] helped with this. When the patients' breakfasts arrived Sister and the senior nurse served it and the junior morning nurse carried it out on large trays and fed helpless patients. Tea was made and carried around by both [nurses]. Then the dishes were collected and stacked ready for the ward's maid to wash. [Bed-]panning was done by the junior nurse and medicine given by the senior before going to their own breakfast. Sister returned to the ward and visited all patients. When the '9–5' [nurse] had attended to all verandah patients she gave out the patients' soup or tea, collected dishes and prepared staff morning tea.

We had not heard of stainless steel in those days and all bowls, kidney trays etc. were enamel and the [probationer] had to scrub them all with sand soap every morning before they were sterilised. She also had to keep the tub room tidy and rinse out all soiled linen, bandages all had to be washed and hung out to dry. By this time the patients' midday meal arrived. Sister and the senior nurse served the meal and it was carried out on large trays by the junior who afterwards collected and stacked dishes. The juniors did panning before going to their meal. The senior gave out prescribed mixtures and later went to her meal.

Antibiotics had not yet been discovered – patients in medical wards were very ill for much longer periods and required intensive treatment. Pneumonia patients ran very high temperatures for seven to nine days when it usually subsided. Until then they required four-hourly sponges, also had mouth and pressure points treated. Oc-

casionally empyema would develop necessitating the insertion of a drainage tube. This required frequent dressing. There were a number of suppurating wounds, boils, osteomyelitis, etc. These were treated with two- or four-hourly foments or eusol compresses. Rheumatic fever cases were very ill. We rubbed painful joints with oil of Wintergreen. Abortion [miscarriage] cases had four-hourly douches. With all these four-hourly treatments having to be done twice on each duty, except at night when treatments were done only once, there was no spare time for anyone.

In the afternoon there was one senior nurse plus the [junior] till 5 p.m., if she was able to finish her work by then. We first cut all the bread and butter for the patients' tea. Patients were washed, beds made and quilts changed. All treatments had to be done once before patients had their tea. The [junior nurse] often cooked eggs and fish for patients in the ward kitchen. She collected and stacked dishes and did panning before going off duty. The senior nurse gave out mixtures and took temperatures before going to tea. Latterly when divided duty was introduced temperatures were done by this nurse. The afternoon 'extra' [nurse] previously did this in the busiest wards.

Night duty was also busy, there being only one nurse in each ward. The night 'extra' would help for a while in the busiest wards. After going around her patients the night nurse would cut the bread and butter for the patients' breakfast, iron and roll all bandages, in surgical wards she often had to pad splints. She also had to boil all bed pans, and in the men's wards, the urinals as well. Enemas had to be given to operation cases who were being operated on that day and an early cup of tea given. New operation cases were sponged and beds made for the first five days. All linen had to be taken away in the morning. Treatments were done, temperatures taken and the report written. Early morning tea was given and dishes washed.

In surgical wards, the same routine duties [were required]. The senior morning nurse did the final skin preparation for cases to be done that day and gave preoperative injections etc. There was no recovery room and patients returned to the ward anaesthetised. The anaesthetics used in those days caused vomiting during recovery and constant supervision was required. The vomiting was painful for patients with abdominal wounds.

Theatre training was done first as a junior and later when more senior. Weekends were very busy for, as well as the usual cleaning of walls, trolleys etc., we sterilised all theatre gowns, caps, guards, swabs, dressings etc. for the theatre use. In addition to this, we sterilised about two drums for each ward. The night nurse in each ward made swabs, rolled gauze and made perineal pads for the women's wards. They packed the drums ready to be collected every Saturday morning and taken to the theatre.

Tuberculosis (TB) in its various forms was rife in those days. Milk was not pasteurised and children were admitted with bovine TB of joints, spine and glands. TB spines occurred in adults too. We also had adults with phthysis abscesses. Phthysis was common and special shelters were built to accommodate these patients. As sunshine and fresh flowing air was an essential part of their treatment, these rooms were built facing the sun and windows and doors were often wide open day and night. A nutritious diet and cod liver oil was given, also complete rest. If caught in the early stages many recovered, but many could not be helped as they were in an advanced stage when admitted.

Infectious diseases were treated in two separate isolation wards. While nursing these we lived quite separately in a cottage adjoining the wards with the Sister-in-Charge. With us in the cottage we had a cook and assistant cook who also did some housework. The Isolation Porter had his separate sleeping quarters and had his meals in the kitchen.

In those days children were not immunised against measles, whooping cough and diphtheria as they are today. Measles made young children very ill. They needed a lot of nursing care, they ran very high temperatures, the rash was irritat-

ing and needed frequent sponging. Their eyes had to be protected from the light, otitis media and broncho-pneumonia were common complications and several babies died.

Whooping cough was distressing for young children. When they felt the onset of a paroxysm they became frightened and would cry, this made them vomit. Small amounts of food were given at intervals as they often lost a lot of their meals.

We had a few very bad cases of diphtheria requiring tracheotomy. These cases had to be 'specialled' day and night until three consecutive negative swabs were obtained and the tube removed. We had occasional outbreaks of scarlet fever, which was a painful and serious infection. Because of its effect on the heart, pericarditis occurred in many cases. When nursing scarlet fever we were not permitted to go into crowds for fear of spreading infection. For this reason I was unable to see the famous ballerina Pavlova and I have always been sorry about this.

During my term on duty at Isolation, I think that it may have been 1928 or early 1929, we had a typhoid epidemic with as many as twenty-nine cases in the ward at one time. Without the aid of antibiotics and modern drugs it was a long and serious illness with high temperatures over a long period requiring careful nursing. Patients required frequent sponging, mouth [care] and pressure points carefully attended to with as little movement as possible. Enemas were given every second day unless diarrhoea was present and a fluid diet for three weeks or more according to their condition. Many patients were delirious and bed linen needed frequent changing. One young Maori boy was delirious for three weeks and had to be specialled day and night. Another had a perforated bowel and required immediate surgery. The outbreak was due to the consumption of contaminated shell-fish taken from an area near the sewage flow at Port Ahuriri.

All typhoid linen had to be soaked in 1–60 carbolic. We afterwards washed out any soiled sheets or blankets and wrung them out by hand before they were sent to the laundry. They also had to be sorted and counted. This was an exhausting procedure.

Both wards were very busy, there were several different infections. This meant frequent changing of gowns and scrubbing and disinfecting of hands. We were all very tired. Towards the end of my term of duty at Isolation I developed typhoid and became very ill. In the early hours of one morning I developed severe abdominal pain. Dr Berry was informed, he thought that perforation might occur so ordered me to be transferred to Robjohns Ward, then the Women's surgical. I was put on to the outdoor trolley, which had wooden wheels with iron rims, and we clattered up the road to Robjohns. Very soon Dr Berry and two House Surgeons, Drs FitzGerald and Clark, arrived. After examining me, a consultation was held. They decided not to operate. I was told afterwards that the theatre had been set up in readiness, fortunately I did not need it. I stayed on in Robjohns for the duration of my illness. I was then given sick leave. I was off duty for a total of eleven weeks and as a result I was unable to sit my final examination with my own group and had to wait six months for the next examination.

The reason for the outdoor trolley was because most of the wards had been built separately and they were not joined by corridors as they are today. Patients going to the operating theatre, X-ray or Physiotherapy had to be taken quite long distances in the open, wet or dry. In wet weather a canvas was strapped over the patient and the accompanying nurse protected her head with an umbrella.

I mentioned earlier that we had a probationary period of three months. At the end of this time, if Matron considered us suitable, we were summoned to her office and we signed on for three years and agreed to 'abide by all rules and regulations'. We were then given an order to the head of the sewing room authorising her to supply us with two pink uniforms. These we wore until the end of our second year, when we were given two 'grey' uniforms. These were really of a blue and white pin striped material, which looked grey from a distance.

We were given a change of duty every two

months – not necessarily in a different ward but different hours. In some ways this was a good thing, for we were able to follow a patient's treatment and progress from the onset till discharge. This was helpful for exams.

We were allowed one day off duty per month. This was not always possible if nurses were sick. Matron often had no nurses to spare for relieving duties. I had to wait five months for my first day off and then was at a loss to know what to do with it. We all lived together in the Nurses' Home while training, in fact throughout the time we spent there. As part of the 'Rules and Regulations' we were obliged to be in at night by the following times:

First year	9 p.m.
Second year	9.30 p.m.
Third year	10 p.m.
Sisters	11 p.m.

One 'Picture Pass' till 11 p.m. per month for nurses.

A book was kept in the hall that we signed when going out and on our return. The Home was locked at 10 p.m. Nurses having late passes had to report to the Night Sister who checked and recorded time of return and let them into the Home. We had all our meals in the Home, midday dinner was very formal as Matron was present. Meals were cooked in the Home kitchen and served by domestic staff, there were two sittings for each meal.

Our salary by today's standards was a mere pittance.

First year's salary was £2 10s 0d per month
Second year's salary was £3 5s 0d per month
Third year's salary was £4 10s 0d per month
When registered £5 10s 0d per month
During midwifery training £5 10s 0d for eight months
As a second year Sister I received £9 5s 0d per month

Strangely this did not worry us. On the whole we were very happy. Living together we shared our joys and sorrows and made lasting friendships.

There being no Preliminary School at that time, we had lectures from Matron on various nursing techniques and sat an exam at the end of the course. We also attended lectures on anatomy and physiology from Dr Berry and House Surgeons. Dr Berry set a test paper at the end of every month, which he marked very stiffly. Mistakes in answers had to be corrected and rewritten, spelling mistakes had to be written out fifty times! At the end of our first year, papers in anatomy and physiology were set by Honorary Doctors. If we passed, we then attended medical and surgical lectures given by Drs Berry, Francis and House Surgeons. The monthly test papers continued, these were very good for us. We were careful in taking down our notes and they spurred us on to rewrite them in our lecture books when off duty. We bought our own textbooks.

All lectures were held in the evening. When off duty we had to get into uniform to attend and if on duty Sister relieved us and we caught up with our work when we returned to the ward. In our second year we attended a course on invalid cookery, which was held at the Technical College. We sat both practical and theoretical examinations at the end of the course.

As a result of the excellent lectures we received, and our monthly test papers, we were well equipped for our exams, both Hospital and State finals. The results were good, many passing with Honours. I was very surprised to find that I had topped New Zealand in my Midwifery.

After passing our state final it was usual if asked to stay to do six months' charge duty, either relieving Sisters for annual leave or having a charge of ward. On completing this it was usual to go to McHardy Home, which was then a first-class training school and to train for six months as a maternity nurse or for eight months doing 20 deliveries for a midwifery certificate. At the time I trained, Sisters Ethel Smith and Bull were in charge. They gave us a good training both theoretical and practical. We also had lectures from Drs Berry and Francis. At this time Hastings

Maternity Annex at the Memorial Hospital was opened but not fully staffed. Sisters Owen and Bruce were in charge. We went in groups of four, I think, from McHardy Home for a month until permanent staff were appointed. The general part of the hospital was not opened until later.

We had no Graduation Ceremony in those days, we sent away for our certificate and medal. The medal usually arrived in a 2 oz tobacco tin. We then went in search of our favourite Sister who would pin it on for us.

A number of Napier graduates became leaders in their profession both in New Zealand and abroad. The most notable of these being Miss E. C. MacKay who became Matron-in-Chief of the New Zealand Nursing Service during World War II. For service to her country and her profession she was awarded the OBE, RRC, MID. After the war Miss Mackay held an important position with the Immigration Department in London for three years. She interviewed nurses and other women wishing to work in New Zealand. This at times took her to Germany, Holland and Belfast.

Miss F. Burdett became Matron of Alexandra Maternity Home in Wellington, a position she held for a number of years. For her service in this field she was awarded the OBE.

Sister Joyce Lloyd was for some years Matron of McCarthy Home for elderly women. She suffered with arthritis for many years and was a 'guinea pig' for cortisone treatment. Sister Ruth Connelly enrolled in the first class and gained the Post-Graduate Diploma of Nursing returning to establish the first Preliminary School at Napier and becoming the first Tutor Sister. Sisters Ethel Smith and Bull were jointly in charge of McHardy Home when it was a training school.

Sister Chris Thomasen was appointed Submatron of Napier Hospital. Sister I. Russell was Matron of the Hastings Memorial Hospital for a number of years. For her service she was awarded the OBE. The above mentioned all graduated during the years Dr Berry was Medical Superintendent. He was an excellent teacher. I feel that it was largely due to his effort and keen interest in our training that the results were so good.

Members of the nursing and medical staff that I remembered from 1924–1931 are:

Miss Rose Macdonald – Matron. I have always been sorry that within the Hospital there is no memorial or public recognition of Matron MacDonald and her service to the Hospital Board. She served from 1912–1929. Sister E. Roy was Sub-Matron and was appointed Matron in 1929 when Miss MacDonald retired. Miss Roy retired in 1931. Miss Letty Croft was then appointed as Matron.

Sisters I remember from December 1924–1931 were: Sisters Hilditch, Wells, Thompson (2), Cole, Cullwick, Canavan, Campbell, Cooper, Everett, Sellars, Haden, Haultain, Spencer (2), Smith (2), Owen, Wood, Stewart, Smallbone, Thomasen, Mitchell, Russell, Read, Robb, Burdett, Bull, McKenzie, MacKay, Lowe, Spensley, Boshier, Anderson, Connelly.

Medical Superintendents were: Dr J. Allen Berry till 1930, Dr A. C. B. Biggs

Assistant Medical Superintendent: Dr R. S. R. Francis

House Surgeons I remember were: Drs W. Hamilton, Stowe, Shaw, Stoddart, Isaacs, Costello (2), Abernethy, Vautier, Pennington, Ritchie, Wood, Purvis, Hunter, Sheppard. J. J. Foley who later became Medical Superintendent when Dr Biggs retired.

Honorary Surgeons: Drs P. Leahy, Cashmore, W. W. Moore, H. Wilson, T. Gilray, A. G. Clark, A. Costello, G. E. Waterworth.

Dr J. A. Berry also operated and long before its time introduced early ambulation following surgery. It was routine treatment for his cases to walk around their bed on the first day if their condition was satisfactory. This was in 1924.

Honorary Physicians: Drs FitzGerald, Will, Barnett, Waterworth*, Bathgate, Ballentyne, Comrie, Culton, E. H. J. Berry.

*Dr Waterworth who was later surgeon.

Ear nose and throat specialist: Dr Stuart Scoular.

Radiologist: Dr Harvey.

Bacteriologist: Mr Hicks followed by Dr Muriel Bell.

Dental Surgeons: Mr Forde followed by Mr M. Maloney. B. Colvin.

Pharmacists: Miss Craig followed by Miss Mulholland.

Physiotherapists: Miss Lynch, Miss Dean and Miss Fillery.

Other people I remember were Mr Sandes who was the engineer in charge of the boiler room and ensured the operation of steam sterilisers, cooking appliances and radiators for heating the wards. Bert Single, his assistant, was the one who 'fixed' anything that went wrong in this field.

One of the social events we looked forward to was the opening of the tennis season. There was an asphalt court quite close to the old Nurses' Home. Matron usually invited the members of the Hospital Board, the local MP, House Surgeons and friends of the nurses. This was always a happy occasion. Each half year after the final examinations the semi-finals organised a party for the finals. These were hilarious events often in fancy dress. A group of local professional and business men organised a Nurses' Ball each year. It was usually held in the RSA hall. Sometimes it was held in a new ward before it was occupied. This event was a great success and always looked forward to. The last two years of the time I spent at Napier Hospital the same group of men organised two picnics in the summer. The first two were held at Waipatiki beach, the following year at Waimarama. Having two separate days enabled nurses to change duties so that all could attend. Transport was supplied by the organisers.

These are just a few memories of my years at Napier Hospital. I left the hospital in May 1931 and was married on the following first of June. Since then there have been many changes – new buildings, new techniques, many new and effective drugs, antibiotics and sophisticated diagnostic aids. With all this, the patient is still in need of sympathy and understanding.

Te Ao Māori, Te Ao Hauora: A Student Nurse's Reflection

RANGIMARIE TAUREREWA

Te Whare Tapa Whā is a Māori health model used to encompass a patient's mental, physical, spiritual and family well-being. Connections have been made between social relationships and well-being; social relationships are vital to successful communication. The setting of an aged-care facility provides opportunities for reflection on the taonga provided to Hauora Māori and shows the privilege nurses are granted in their profession. Te Whare Tapa Whā is a blueprint for professionals to understand and work with all patients, regardless of ethnicity or race. It does not only refer to a patient's well-being but also the benefits that nurses can gain from implementing the four pou in their everyday nursing practice. Healthcare professionals must gain an understanding of their responsibility to act in a manner deemed professionally, ethically and culturally appropriate.

KEYWORDS: reflection; well-being; te whare tapa whā

MIHI

Kaua e rangiruatia te hāpai o te hoe; e kore tō tātou waka e ū ki uta.

Don't paddle out of unison; our canoe will never reach the shore.

This whakataukī (Māori proverb) symbolises the work of the nursing profession. Working in partnership with one another and with patients will ensure optimal health and well-being for all patients and whānau in our care.

I selected this whakataukī in the hope that this article can inspire and encourage future nursing students from all ages, cultures and ethnicities to work together, in partnership with colleagues, throughout their training as students and careers as registered nurses.

Ko Ruapehu me Taupiri ōku maunga
Ko Whanganui me Waikato ōku awa
Ko Aotea me Tainui ōku waka
Nō Raetihi me Rangiriri ōku whānau
Ko Te Puke me Horahora ōku marae
Ko Te Māhokihoki rāua ko Tāwhiao ōku rangatira
Ko Ngāti Tūwharetoa me Tainui ōku iwi
Tihei mauri ora.

Taloha ni na matua ma na tamana Tokelau. E hiki te fakafetai ki te tupu i te lagi ona ko tona aloha mai kia teki tatou.

Malo ni, ko tōku ingoa ko Rangimarie Lisa Taurerewa. Talosia ke kavea te matakupu tenei ke malama lahi ki ei na teine ma na tama tauhi tauale.

Fakafetai lahi lele.

INTRODUCTION

This article aims to convey the learning and understanding I gained from reflecting on a clinical placement at an aged-care facility as a year one student nurse, in the Bachelor of Nursing Māori programme at Whitireia New Zealand. Our first clinical experience was much anticipated.

Part of my clinical experience involved reflection on learning that was gained in the clinical setting of aged care. As a class we had learnt the importance of reflection in nursing practice and discussed the reflection frameworks that assist with this process (Durie, 1994; Gibbs, 1988). To preserve the confidentiality of clients, their families and the clinical setting I was working in, I use pseudonyms. The client in this article is referred to as Mr R. According to the Nursing Council of New Zealand's (NCNZ) *Competencies for Registered Nurses* (2012), the registered nurse is to 'Ensure documentation is accurate and maintains confidentiality of information' (p. 16).

Reflection can provide evidence of achieving this competency. Competency 3.3 states that the registered nurse is to ensure she or he 'Communicates effectively with clients and members of the healthcare team' (NCNZ, 2012, p. 27). I will discuss professional comportment and my understanding of this along with a description of the differences between therapeutic and social relationships.

TE WHARE TAPA WHĀ

The Māori health model Te Whare Tapa Whā (Durie, 1994) provides a tool for reflection. I discuss here the four pou of this model and the value they hold in nursing practice in relation to my clinical experience. Through it I gained a deeper knowledge and appreciation of this highly treasured Māori health strategy.

Taha Wairua

Taha wairua is a patient's spiritual being, the essence of their faith, morals and belief systems. It is important to understand this when incorporating Te Whare Tapa Whā into nursing practice. Brooks et al. (2005) state, 'Spirituality is a broader concept that encompasses an individual's relationships with self, others and a higher power' (p. 24). With this in mind, it was important to ensure Mr R felt comfortable with the presence of a student nurse in what he considered his 'home'. Although Mr R said he had no religious beliefs, it was important for me to understand that this was his choice. I felt no obligation from the client to practise religious rituals when performing cares, feeding and other nurse duties. For example, the client had no desire to perform a karakia (prayer) before meals, but this was a ritual that I had practised from a young age. I found it difficult to refrain from enforcing my beliefs as a Māori onto Mr R, but I came to understand quickly that this clinical experience was client-centred and my own needs had no place.

Taha Whānau

Taha whānau relates to the social relationships a person has established with family, friends and colleagues. This is vital to understand, particularly when working with Māori patients. The concept of whānau or family is important in Māori culture. When one person in the whānau unit is unwell or experiencing moments of sickness, the whole family as a collective is affected. It was important for me to remember to work in partnership with patients as well as their whānau during this clinical experience. Whānau relationships are important in any clinical setting, but in an aged-care facility it is extremely important to be cautious of the language used and how one behaves when caring for a client and obtaining personal information (San Miguel & Rogan, 2012).

For example, when caring for Mr R, I felt it was crucial to understand his whānau relationships. This would allow me to understand his background and where he stood in his whānau unit. I would be able to use this understanding to work with Mr R and his family to achieve the optimal level of well-being. The knowledge gained from Mr R allowed me to appreciate his family history and who he considered family, while remembering to respect his privacy and unwillingness to disclose some information. This process was difficult because Mr R was entering the first

stage of dementia; however, it was exciting to finally meet Mr R's brother, Mr T. It was great to 'put a face to the name'. After speaking with Mr T, I saw the love and friendship the two brothers shared. He told me about their childhood and things began to make sense, and I developed a deeper understanding and appreciation for Mr R.

Taha Tinana

Taha tinana represents a patient's physical well-being, an understanding of medications that affect the body and the various medical conditions that can occur in the human body. I found the strain of physical work involved in nursing extensive. Aching back, sore feet and dry hands are not understood by members of the population who are not nurses (Robinson, Abbey, Abbey, Toye, & Barnes, 2009). I was extremely exhausted by the end of my first shift and looked forward to the drive home. I began to realise my thinking was selfish; I was afraid that my enthusiasm to leave at the end of the day had not gone unnoticed. I made it a goal to overcome this and to be physically prepared for my next shift. From this experience I have developed a deeper respect for the physical activity that is involved with working in aged-care facilities.

Taha Hinengaro

Taha hinengaro is the emotional or mental state of an individual. Assessing a patient's emotional well-being is important when providing nursing care and interventions. Arieli (2013) states that the 'clinical placements are experienced as emotionally challenging and stressful' (p. 193).

After analysing the spiritual, social and physical aspects of this placement, nothing was more difficult to control than my emotions. I found myself having to build a tougher skin. I had to remember my purpose for being on this placement and the appropriate setting in which to allow myself to be emotional. I was showering Mr R and discovered scars on his back; they resembled scars my pet dog had. The animal abuse my pet dog had suffered was similar to what Mr R had experienced in his life. I felt hurt when I realised Mr R had been treated the same as my dog had at one point in his life; it was heartbreaking and difficult to see. I learnt to manage and control my emotions.

I felt that Mr R and I shared a special connection, especially when it came to my final day at the facility. I was nervous, sad and upset that this experience was coming to an end. When the shift ended, my colleagues and I visited our clients and said our final goodbyes. We ended our relationship with a waiata (song) as this was a custom of our culture and a gift of thanks for all we had learned while at this aged-care facility. This was our way of coping with leaving this placement and closing the relationship in a respectful manner (Bland, 2007).

EFFECTIVE COMMUNICATION

Competency 3.3 requires the nurse to use 'a variety of effective communication techniques' and to ensure she or he 'employs appropriate language to context' (NCNZ, 2012, p. 17).

While on my clinical placement I was able to engage with the doctor, the registered nurses, the residents and the many healthcare assistants. I had to adjust my use of language and remember that certain terminology and language was not familiar for Mr R. I had to communicate in a more effective way, and consider the meaning and impact certain terms might have on him. After reading Mr R's patient files, I identified his ethnic background, and was able to vary my use of language and tailor our communication to ensure he would understand.

I had difficulty communicating with the doctor. I felt very intimidated, and reluctant to initiate conversation with him, so I avoided this. Before the long-anticipated encounter with the doctor on duty, I researched the medications Mr R was on and made sure I knew Mr R's medical history from his notes. When I finished talking to the doctor I walked away realising my preconception of the doctor was false. Although this doctor is a health professional, he is human too.

PROFESSIONAL COMPORTMENT

It was important that I could understand and recognise the appropriate time to remain profes-

sional. On reflection, I could have been better prepared emotionally for the end of the clinical placement. Saying farewell is something I do not handle well, especially if I have built a close connection with someone. Learning to do this has been a difficult process, but this placement helped me to deal with these emotions. It has taught me the importance of my job and that the emotions that come along with it are acceptable. It has grown my understanding of professional comportment.

Griffith (2012) defines professional comportment as 'critical in determining a nurse's effectiveness in relating, communicating, and collaborating with colleagues and members of the healthcare team' (p. 902). Reflecting on this has shown me the level of professionalism required from nurses and the importance of using appropriate language in the clinical setting. At this point in my nursing education I view professional comportment as a skill to continue developing. I value the skills I have learned, such as the ability to acknowledge differences in verbal and nonverbal communication in social and therapeutic relationships.

According to McKlindon & Barnsteiner (1999), 'The therapeutic relationship standard has two clearly defined outcomes: (a) empowerment of both families and staff, and (b) the management of interpersonal boundaries' (p. 238). A therapeutic relationship is one in which a health professional uses effective communication to engage with, and effect change in, a patient. It is a relationship initiated by the nurse and hopefully well received by the patient. Many things can affect the success of the therapeutic relationship, such as time, culture, skin colour, age or gender (Papps & Ramsden, 1996). It is important for the patient too to acknowledge this therapeutic relationship if the nurse has any hope of working in partnership with them.

Research has consistently found a positive relationship between social relationships and various aspects of well-being (Street, Burge, Quadagno, & Barrett, 2007). The relationships nurses build in social settings are not only with the client, they can be with the whānau and friends who may visit the client. Although the care that nurses provide maintains a client focus, it is essential that whānau also support the client throughout the treatment and recovery. (Ministry of Health, 2010).

CONCLUSION

In this article I have reflected on my clinical learning in an aged-care setting. I used Te Whare Tapa Whā to explore my experiences, revealing how my taha wairua, taha whānau, taha tinana and taha hinengaro have been affected by my nursing practice. I have aligned this knowledge with the Nursing Council of New Zealand competencies for registered nurses, which has provided further reflection on my emotional state during this placement. I highlighted the importance of preparing for my emotional well-being, applied this to competency 3.3 and discussed my understanding of professional comportment. Finally, I briefly described the difference between therapeutic and social relationships to demonstrate the importance of the two. Although different, both are essential to the health and well-being of any client in any setting.

Mā te atua e manaaki, e tiaki hoki.

Nāku noa. Tofa ni.

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Using Reflection to Improve Person-Centred Care as a New Graduate Registered Nurse

LUCIE IRWIN-WHITNEY

Tanner's reflection model can be used to examine nursing practice and to help nurses understand where they have gone wrong with their person-centred interactions. The model is applied to a new graduate nurse's interactions with a dementia patient in an aged-care facility. Noticing, interpreting and responding are reflection tools that can allow health practitioners to recall the situation, acknowledge what went wrong and evaluate the best approach to use in the future. The nurse had to decide which approach to use with the distressed patient, selecting a person-centred approach rather than the task-focused one that she was more familiar with. The case demonstrates the importance of person-centred care, which allows nurses to offer personal and sensitive care to patients.

KEYWORDS: reflection; dementia; person-centred care

NURSES USE REFLECTION as a tool to investigate the causes and consequences of their actions in order to improve their practice and prevent 'compassion fatigue' (Bloniasz, 2011, p. 12).

Using Tanner's clinical judgment model (Tanner, 2006), I was able to reflect on a situation that arose on the ward I work on, and explore how this experience has influenced my developing nursing practice. In sharing this experience, I hope to encourage student nurses and registered nurses to look for opportunities in their working lives to reflect on and develop their skills.

USING A FRAMEWORK FOR REFLECTION

Tanner's clinical judgment model (Nielsen, Stragnell, & Jester, 2007) is often used to guide the health professional's reflective process. This model appealed to me in this situation as it allowed me to explore in-depth what happened and why I left the interaction feeling uncomfortable with the nursing care I had provided. It also gave me the opportunity to consider alternative actions I might have taken.

In comparison to another popular reflective cycle by Gibbs (1988), Tanner's model delved more deeply into what happened for me in the moment and guided me more thoroughly through it. The Gibbs cycle provides two broad areas of explanation: what happened and how it made the nurse feel (Taylor, 2004). Tanner, on the other hand, guides the reflector through four areas of the situation: background, noticing, interpreting and responding. Nielsen et al. (2007) explain that Tanner's model is a 'sensible way' of uncovering the ongoing factors and processes that influence nursing actions (p. 514). Tanner's model is also particularly suitable for student nurses, as students can progress incrementally through the four stages of reflection over the course of their studies.

Reflection helped me to analyse the reasons

behind my interactions and to consider how I could adapt my practice in future to suit the individuals in my care.

CRITICAL REFLECTION USING TANNER'S FRAMEWORK

My description of this reflective process is intended to step through the different stages that I went through during this reflective exercise. I have changed the names to protect the client's confidentiality.

I had just begun my first job as a registered nurse at a mental health ward for older adults. It was 2.20 p.m. and the afternoon nurses were about to arrive on the ward. An older woman, Joy, was sitting at a table crying and seemed distressed. When I sat down with her, she explained that she needed to 'get clean for mummy' and wanted to have a shower.

Background

This was my third shift as a nurse on the ward, and Joy was not one of my assigned clients. I had, however, sat with her several times previously and helped her with tasks such as walking to and from the dining room. She had expressed gratitude in these interactions and seemed to recognise me. My experience of Joy's needs was limited, and I had not cared for someone with her particular symptoms before. Joy is affected by dementia, so the communication and nursing skills I used when interacting with her were based on my experiences with older people I had met as a student on medical wards. I expected that empathy, as well as distraction and diversion techniques, would have a good effect. I knew that Joy had showered that morning and often had a shower before bed. I was also aware of the fact that I needed to hand over to the afternoon nurses soon.

Noticing

I noticed initially that Joy was tearful and restless. She spoke of being 'dirty' and needing to 'get clean for mummy', even though she was well dressed and presented. Joy was sitting alone, and the other nurses and healthcare assistants were busy with other clients. I noticed about myself that I was feeling stressed as I prepared for handover, and a bit worried about how I was going to help Joy.

Interpreting

I interpreted the situation as Joy not being orientated to time, person or place. She did not remember showering that morning and did not realise that her mother was not alive. She seemed to believe that she was a child still, and felt distressed that she was not ready for her mother's visit. By using a person-centred approach, I interpreted Joy's belief of being a child as indicating that Joy was feeling lost or afraid. I believed that she wanted a shower, but that this was unnecessary as she had showered that morning. I thought that if I combined comfort and distraction, she would move on from her preoccupation with showering. I recognised that in my role as a nurse I had a duty to help Joy and to work through her distress.

Response

In response to Joy's distress, I attempted to distract her by providing a cup of tea, playing a game and actively listening to her. We went for a walk together around the ward. She continued to express distress over being 'dirty' and asked me to help her shower. I was aware that my methods of working with Joy's distress were not working, which was stressful and disappointing for me. As a new nurse in this area I felt pressure to be able to help calm Joy, but began to feel I lacked the ability to do so.

Reflection-in-action

When an afternoon nurse arrived, Joy told her about wanting to have a shower, and I replied that she'd already had a shower that morning. The other nurse responded by telling Joy that she would help her have a shower as soon as handover was finished. Joy was relieved and sat down to wait while we had hand-over. I was surprised by this response, and realised immediately that perhaps I had been thinking about the situation

in the wrong way. I had been so accustomed to attitudes of a task-focused medical ward that I hadn't stopped to think about the most simple response to Joy's distress. I felt slightly embarrassed that I hadn't just helped Joy with a shower when she had asked for one, as I had thought that this would have been frowned upon, given that it was technically unnecessary (although not unnecessary in Joy's mind). This is probably due to my previous experience in physical health wards. Here, due to time constraints and the nature of the nursing, clients were required to fit into a time and task schedule, not the other way around.

Although I had begun to doubt my ability as a mental health nurse while trying to help Joy, I realised that helping a person shower is within my abilities, but that my preconceived notions of nursing and previous experience of wards with a less person-centred focus meant that I had not considered this to be an option.

Reflection-in-action and Clinical Learning

This experience with Joy has highlighted the need for a shift in my nursing practice. I have realised that the ward I am currently working at has a very person-centred approach to nursing care. Therefore, activities such as showering more than once a day are not deemed unnecessary if it helps the client by improving their mood and their quality of life. This practice is supported by research suggesting it is an effective way of working with people with dementia, and no doubt many other people too (McCarthy, 2011; Pringle Specht, Taylor, & Bossen, 2009).

In the future I will reflect more regularly and use reflection-in-action to decide whether my actions are incorporating this new knowledge. This experience preceded a major shift in my nursing practice, and my learning from this has been applied to many situations since.

Brooker (2004) claims that person-centred care (in relation to working with people with dementia) must encompass four main elements. One of these elements is the ability to view the world through the perspective of the person with dementia, acknowledge that this is their reality and use this insight to guide care and interactions. By acknowledging that from Joy's perspective she was dirty and needed to shower before her mother arrived, it is easy to see that one of the most effective ways to relieve her distress was to help her shower. In doing so, one could also use the opportunity to create a more positive social environment for Joy and value her as an individual, two of the other main elements of person-centred care (Brooker). It could be proposed that the popularity of this model in the area of dementia stems from the desire to prevent the erasure of people with dementia's 'social citizenship', as has unfortunately been prevalent in the past (Brannelly, 2011). By incorporating person-centred care a nurse facilitates the maintenance of social regard and the involvement of people in their own lives.

It could also be seen that although showering may have eased Joy's distress, its effectiveness may have been short-lived. If a client continued to feel the need to shower, having already showered several times, this would no longer be practical for the nurses and other staff. In this case, a progression from person-centred care to relational-centred care may be useful. Relational-centred care recognises and addresses the significance of the context of one's relationships (Morhardt & Spira, 2013). For example, in Joy's case, this could involve talking to her family and friends to explore her childhood history, especially her relationship with her mother. From this information I could develop different ways of interpreting and responding to her preoccupation with being clean for her mother. Following this particular incident, I found that involving Joy in a discussion about her mother and what she was like was a very effective and calming distraction technique.

CONCLUSION

Tanner's model has been useful for my reflection on what happened during this interaction with Joy, and what it means for my future practice. To more effectively nurse clients, I will take into

account the lessons of this reflection when I am faced with similar situations. For example, when faced with a distressed person, I will be more prepared to try to look at the situation from their perspective and acknowledge that this is their reality. By doing this, potential nursing responses that are person-centred become apparent, and I can help a person work through their distress in a manner that is suitable for them. If I was faced with a similar situation in the future, I would not be so quick to rule out the option of showering, but would also look at the individual's relational context in order to find different ways to address their concerns.

The reflection process has helped me to recognise, in-depth, what was going on for both Joy and me in this interaction and to analyse my response to it. Despite initially appearing as a minor occurance, this situation has highlighted areas for development in my practice. It also demonstrates that many of the interactions nurses have with their clients have the potential to be reflected upon and to become learning opportunities.

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Nurse Be with Me

TIFAIMOANA IOSEFO

Hear my silence
And you will see me
I am at peace

Hear my faith
And you will comfort me
I have no fear

Hear my culture
And you will know me
I am accepted

Be with me

Hear my words
And you will serve me
I am real

Hear my pain
And you will feel me
I am courage

Hear my joy
And you will dance with me
I am life

Nurse be with me

TIFAIMOANA IOSEFO *is a second-year nursing student in the Bachelor of Nursing Pacific at Whitireia New Zealand. She was inspired to write this poem following her experience working with older adults in aged residential care and also through helping to care for her grandmother.*

Tifaimoana has thought a lot about the relationships between nurses and aged people in residential care. She believes it is essential for nurses to listen carefully to what older people need, and that this is especially important when the person cannot express this for themselves. Nurses cannot take the patient's needs for granted; they instead should watch and hear the 'voice' of the person in care.

The purpose of this poem, which is written from the perspective of a nurse, is to stimulate thinking about working with older adults and strive to highlight the importance of paying attention to 'voice'.

Author Guidelines

AIMS AND SCOPE

The *Whitireia Nursing and Health Journal* annually publishes articles that reflect the interests of the Faculty of Health. Manuscripts are invited from undergraduate and postgraduate students, staff and professional affiliates.

Articles include: research articles, scholarly articles, conference presentations, reflections, editorials and student work including poems and art work.

MANUSCRIPT PREPARATION

Suitable Articles

- Clinically focused health research that is sound in methods and ethics
- Articles that incorporate multidisciplinary collaboration
- Reports about enhanced practice and evaluation e.g. quality assurance or health disciplines.
- Theoretical discussions or review articles e.g. research
- Teaching and learning developments
- Special reports, e.g. analyses of political or social dialogues, conference debates
- Speeches, poems, artworks
- Assignments edited for publication
- Other works will be considered

Format and Style

The *Whitireia Nursing and Health Journal* has a plain English policy. This policy aims to ensure the journal is accessible to the nursing community, including nursing students, and promotes an idea fundamental to nursing and health: clear communication.

Articles submitted to the journal should be written in clear, professional language. Please spell out the first occurrence of abbreviations and acronyms and explain all specialist terms.

If your article is accepted for publication, the publishers will help edit and shape the language to plain English guidelines.

Abstract

Please provide an abstract of less than 150 words on a separate page.

Keywords

Please suggest three to five keywords that link to themes in the article.

Tables

Submit diagrams and tables on a separate page and number each plate consecutively with Arabic numerals. Cite the numerals in the text.

Referencing

The *Whitireia Nursing and Health Journal* follows the conventions of the American Psychological Association (APA).

Authors are responsible for the use of correct references and citations. Please include in the reference list only those papers, books and other resources referred to in your article. APA guidelines are available at: http://www.whitireia.ac.nz/resources/Pages/APAReferencing.aspx

Author Information

On a separate page provide your details including name, qualifications, professional role if relevant and the context of the article.

MANUSCRIPT SUBMISSION

Manuscripts should be double-spaced, with margins of not less than 2cm on every side, and with pages numbered consecutively.

Manuscripts meeting the above requirements should be submitted electronically in Microsoft Word to health@whitireia.ac.nz with 'Attention: Coordinating Editor, *Whitireia Nursing and Health Journal*' in the subject line.

ACCEPTANCE PROCEDURE

Copyright Disclaimer

The responsibility for originality belongs to the individual author. Articles should be submitted with the knowledge that the work has not been published previously nor submitted for publication elsewhere.

Manuscripts are electronically submitted to Turnitin (plagiarism prevention tool) as part of the review process.

Acceptance

Each manuscript is submitted to the *Whitireia Nursing and Health Journal* Editorial Committee for blind peer review by two reviewers.

Manuscripts are accepted outright, accepted with amendments, or declined for publication. Authors are notified of the decision via email.

Mentors

A mentor may be offered to assist the author with amendments.

Proofs

Prior to publication, the publisher provides a proof of the article with editing suggestions to the author by email for sign off and return.

Whitireia
NEW ZEALAND

FACULTY OF HEALTH
FACT SHEET

Providing professional education to prepare graduates for the global environment of health and social care

The Faculty of Health at Whitireia is a national leader in professional and vocational education for the health industry and foundational studies. For over 26 years, Whitireia has committed to providing opportunities for equitable access to success for diverse communities of learners in partnership with industry. The Faculty of Health has been part of that legacy and is committed to advancing the health and wellbeing of individuals and populations through the education of health professionals to provide health care across a multitude of settings and disciplines. Faculty staff and students are dedicated to providing a positive and innovative force in the evolution of the health professions and in the changing health care system, and are the leaders for health care's future.

QUICK FACTS

- Leader in preparation of diverse health workforce for New Zealand
- Strong partnerships with regional district health boards and industry
- One of only two providers of paramedic education nationally
- Paramedic programme is accredited by the Australasian Council of Ambulance Authorities
- One of only two tertiary providers contracted by Te Pou for graduate mental health nursing postgraduate education
- Second largest provider of postgraduate nursing education nationally
- Only national provider of education for Royal New Zealand Plunket Society
- National leader in simulation for nursing and paramedicine – recognised by Laerdal as a demonstration site
- Consistently highly commended in regulatory audits by Nursing Council and Social Work Registration Board for partnerships with industry and student support
- Finalist in Wellington Gold Awards for support to the region

ACADEMIC PROGRAMMES

Certificate

- Certificate in Work Skills (Health & Social Sciences) (Level 2)
- Certificate in Foundation Education – Health Science (Level 4)
- Certificate in Foundation Education – Social Science (Level 4)
- Certificate in Preparation for Tertiary Stucy (Level 3)
- National Certificate in Mental Health and Addiction Support (Level 4)
- National Certificate in Tamariki Ora:/Well Child Services (Level 4)
- Certificate in Health Professional Practice Development (Level 7)*

Diploma

- Diploma in Enrolled Nursing (Level 5)

Degrees

- Bachelor of Health Science (Paramedic)
- Bachelor of Nursing
- Bachelor of Nursing Māori
- Bachelor of Nursing Pacific
- Bachelor of Social Work

Postgraduate

- Postgraduate Certificate in Hospice Palliative Care *Multidisciplinary*
- Postgraduate Certificate in Specialty Care* *Multidisciplinary*
- Postgraduate Certificate in Nursing
- Postgraduate Certificate in Perioperative Specialty Nursing
- Postgraduate Certificate in Primary Health Care Specialty Nursing

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PORIRUA
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WELLINGTON
AUCKLAND

FACULTY OF HEALTH
FACT SHEET

Whitireia
NEW ZEALAND

STUDENTS

- 1201 equivalent full-time students (EFTS) in 2014: Certificates and diplomas – 315; Bachelors – 655; Postgraduate – 206
- 16% of enrolments identify as Pacific students
- 9.5% of enrolments identify as Māori students
- 42.5% of enrolments are under 25
- Low student/faculty ratio in simulation and clinical learning placements
- National provider of only Bachelor of Nursing Māori programme
- First national provider of Bachelor of Nursing Pacific programme
- Average programme success rates across faculty programmes were 89.8% in 2013

FACULTY

- Full-time – 46; part time – 16. Māori/Pacific – 30%
- National leadership in Nursing Education: Dean is Chair of NETS, STTI Nurse Leader, member of Nursing Education Advisory team advising Health Workforce New Zealand and National Nursing Organisations (NNO) group. Associate Dean is Chair of Education sub-committee of College of Mental Health Nurses
- National leadership in nursing workforce development: Dean is a member of nursing leaders advisory group to the Ministry of Health
- New Zealand Qualifications Authority appointed monitors for Manakau Institute of Technology and Nelson Marlborough Institute of Technology nursing programmes
- Panel members for programme accreditation with NZQA and NCNZ

RESEARCH

- 69 research outputs in 2013 ranging from completed master theses, authored books and chapters, peer reviewed journal publications and international conference presentations
- Targeted research areas in diverse health workforce development; clinical curriculum development and mental health care
- Research Contract with Ako Aotearoa – Pacific pedagogies for success
- International research partnerships with Oregon Science University, USA and University of Technology Sydney, Australia
- International research team member for e-cohort study with Massey University, University of Auckland, Auckland University of Technology, University of Queensland and associated Uni8 group
- Visiting scholar from Canada with a focus on nursing curriculum for diverse populations
- National Research team in simulation learning outcomes for nursing

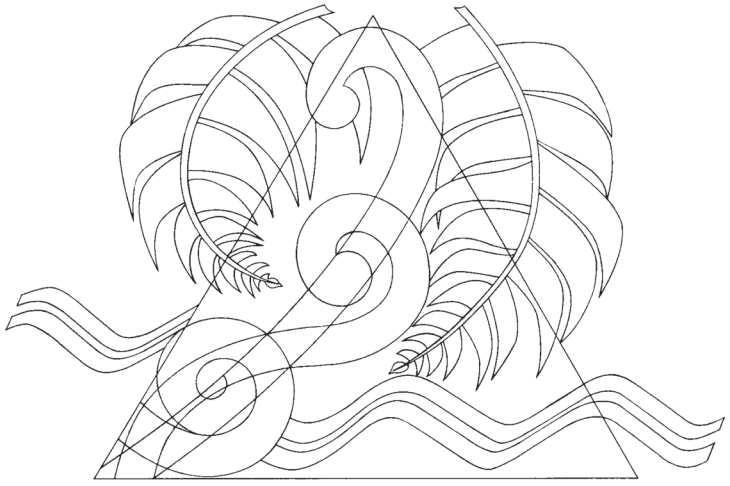
INITIATIVES AND OUTREACH

- Three year contract from Department of Corrections to deliver mental health education to nursing workforce
- Demonstration site for Laerdal New Zealand as part of simulation curriculum development
- Co-hosts of 2013 Australasian Nurse Educators conference with Capital Coast DHB and Massey University
- New Zealand Qualifications Authority appointed monitors for Manukau Institute of Technology and Nelson Marlborough Institute of Technology
- Collaborative initiatives with institutions in Switzerland, Australia and USA create potential for faculty and student exchanges and reciprocal knowledge transfers

July 2014

WHITIREIA NEW ZEALAND FACULTY OF HEALTH

www.whitireia.ac.nz/about/Pages/FacultyofHealth



This design symbolises the framework of the Nursing and Health Studies' philosophy. The triangular form acknowledges the three articles of the Treaty of Waitangi, Habermas's three ways of knowing and the nurse–client–empowerment model. The unfolding koru represent the growth of the school while the fronds represent maturity. The location of the school at Whitireia and its identity as part of this community are represented by the sea.