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The Dissector

Journal of the Perioperative Nurses College of the New Zealand Nurses Organisation

June 2022, Volume 50, Number 1

RECRUITMENT & RETENTION

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Editor: BRON TAYLOR
Email: dissector.editor@gmail.com

Publisher: MICHAEL ESDAILE
Advantage Publishing Ltd
michael@advantagepublishing.co.nz
Tel: 09 416 5309 / 027 495 4510

Editorial Committee:
CATHERINE FREEBAIRN
OLIVIA BRADSHAW
REBECCA PORTON-WHITWORTH
SHONA MATTHEWS

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CORRESPONDENCE
The Editorial Committee welcomes all correspondence intended for publication. Correspondence should be addressed to the Editor, Bronwyn Taylor:
dissector.editor@gmail.com
Or call: 027 323 2857
Please ensure the author's name, address and telephone number appears on the title page of any article or letter intended for publication.

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Recruitment and retention . . .

Tēnā koutou katoa. In this issue we explore the topic of recruitment and retention. It is not the first time *The Dissector* has had this theme; the June 2016 issue had this same focus. In that issue, Sarah Elley predicted the nursing workforce shortfall would be a 'significant reality' within 10 to 20 years (Elley, 2016, p. 25).

Unfortunately, in part due to the pandemic, the 'reality' has come sooner than expected. This year the nurse staffing crisis has hit headlines. Nurses have been put in untenable and unsafe situations, working overtime and picking up extra shifts to cover staffing shortfalls (Smith, 2022).

Our country has an estimated 4000 nursing vacancies currently (Longmore, 2022), with no quick fix on the horizon. It is clear that recruitment and retention of our precious nursing workforce needs to be a priority for everyone.

At an event on International Nurses Day (May 12), the New Zealand Nurses Organisation's (NZNO) 'five fixes' for the nursing shortage were announced. These are: actualising te Tiriti — making their aspirations real for Māori and Māori nurses, more nurses across the health sector, pay and conditions that meet nurses' value and expectations, more people training to be nurses and more Māori and Pasifika nurses (Longmore, 2022).

It will be interesting to see these actualised. However, only time will tell whether they are sufficient to resolve the current crisis.

Sustaining and developing our workforce

This issue has two opinion pieces with this focus.

Dr Isabel Jamieson outlines historical and current issues around the recruitment and retention of nurses in Aotearoa New Zealand. Isabel highlights some of the concerns that must be addressed if we are to retain the new generation of nurses.

Former Perioperative Nurses College Chair Leigh Anderson provides us with her third and final article on the ngawari kaimahi | flexible workforce project at Te Toka Tumai (Auckland DHB).

Leigh challenges us on our assumptions and asks us to reflect on our thinking, including how we staff our perioperative departments. She argues that we must investigate new and innovative ways of working if we want to ensure we continue to provide quality care.

Cultural safety

NZNO Kaiwhakahaere (executive/leader) Kerri Nuku has said that actualising te Tiriti across the health system is critical to ensuring both authentic engagement with Māori and provision of culturally safe practice (Longmore, 2022).

Rangi Blackmoore-Tufi has written a reflection on some of the challenges she has faced being the sole Māori nurse in her department. Rangi's experiences show us it's important we have knowledge of Te Tiriti and Tikanga to ensure provision of a culturally safe environment for our Māori colleagues as well as our Māori patients. In a companion piece, Rangi and I have collaborated on an article about culturally safe care in the perioperative environment. The idea for this came from Rangi sharing her experiences, sparking a recognition that more education around Te Tiriti and Tikanga was needed for tauiwi (people who are not Māori) staff.

Research report

In our final article associated with recruitment and retention, Grace Wu has provided a report on her Masters research into the features of an effective orientation programme for new graduate and novice operating room (OR) nurses. Grace argues that retention after orientation can hinge on orientee satisfaction of training components, adding that competency and confidence are outcomes tied to a culture of support from peers, educators, preceptors, managers and OR teams.

Perioperative anaphylaxis

This issue's clinical article from Amanda Lindsay is about the physiological impact of perioperative anaphylaxis. Amanda highlights the need for nurses working within the perioperative environment to understand normal and abnormal physiology and its impact on patient care. She argues that understanding immune system responses can allow us to adapt our care and be an active member during an emergency.

I do hope you can come to the Perioperative Nurses National College national conference in Christchurch. It's been a long time since we have been able to gather together and I look

Continued on page 6.

The Dissector

INDEX TO ADVERTISERS

Touching Base

AUTHOR GUIDELINES

The Editorial Committee of *The Dissector* welcomes articles, reports, book reviews, letters to the editor, exemplars, case study experiences, research papers/projects, theatre regional news etc. Please send your ideas to: dissector.editor@gmail.com

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College develops educational webinars

Dear friends and colleagues, welcome to Table Talk. Since I last spoke to you all, your national and regional committees have been working hard to develop educational content for our members. This has resulted in the delivery of three Webinars since April.

Each region is taking turns to host a Webinar. The focus is on sharing nursing expertise throughout the perioperative continuum.

Please see below the content and link to our Webinars:

Link: https://myhealthhub.co.nz/pnc/

Recorded Webinar #1:

Part 1, Working outside your normal areas of practice during the pandemic – Suzanne Rolls;

Part 2, Management of adults with diabetes undergoing surgeries and procedures – Amber Cox.

Recorded Webinar #2:

Part 1, The Below 10,000 patient safety initiative – Jill Wilson and Ash Kirk;

Part 2, Scrub vs Rub Surgical Handwashing – Aimee Keogh.

Recorded Webinar #3:

Part 1, Scrubbing, Gowning and Gloving – Nadine Harrison-Smith;

Part 2, Specimen Management – Robyn Guy.

These webinars are accessible to all members of the Perioperative Nurses College of the New Zealand Nurses Organisation (PNC, NZNO). Please make sure that you answer the questions at the end to qualify for your CNE certificate. We also very much value your feedback on any sessions as we would like to make sure that we are meeting your educational needs.

Annual conference

Planning for our annual conference, in Christchurch from September 29 – October 1, is finalised. For more information go to the website: https://tinyurl.com/y4x5s5vb to review the excellent programme that has been put together by the conference organising committee made up of members from the recently amalgamated Nelson/Marlborough-Canterbury West Coast Region.

As always, this is an opportunity for us all to come together to learn, network and re-establish professional links that have been lost due to the pandemic.

I am very much looking forward to seeing you in Christchurch on September 29.

Kindest wishes

— Juliet Asbery, Chair, Perioperative Nurses College of the New Zealand Nurses Organisation

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Editorial, continued from page 3.

forward to seeing you there.

We are still looking for additional Editorial Committee members to join *The Dissector*. If you are interested in joining us, please consider submitting a letter expressing your interest with a copy of your CV to the PNC secretary on pnc.sec@xtra.co.nz and include the Dissector Chief Editor on dissector.editor@gmail.com. For further information on the role and responsibilities of the editorial committee please contact the Chief Editor.

Noho ora mai.

— Bron Taylor, Chief Editor

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Olivia Bradshaw joins Editorial Committee

The Dissector Editorial Committee warmly welcomes our newest member, Olivia Bradshaw. Olivia has had two articles published in *The Dissector*. Last year she won the MEDSPEC Best Article by a Novice Writer Award for her article titled *Local Anaesthesia and Pain Management Post Thoracotomy*, published in the March 2021 (Vol. 49, No.2) issue.

We are very excited to have her join us and look forward to working with her.

Olivia Bradshaw (nee Talayancich) (RN, BN, PG Cert)

Olivia Bradshaw has lived in Christchurch for most of her life and completed her Bachelor of Nursing Degree there in 2016. She has worked as a Registered Nurse in Christchurch Public Hospital Operating Theatre Department for six years. She is currently working in the cardiothoracic speciality. Prior to this she worked in both vascular and general surgery. She has experience working in both elective and acute obstetrics, as well as acute plastics, gynaecology and paediatrics.

Olivia is extremely passionate about perioperative nursing, which led her to complete a Postgraduate Certificate in Perioperative Specialty Nursing through Whitireia Community Polytechnic in 2020. She says her overall goal and passion is to continue to further develop her clinical skills and education by achieving a Master's Degree in Health Science.

Olivia is recently married and lives with her husband on a dairy farm in North Canterbury. When she is not at work, she enjoys spending time on the farm. Other interests include makeup artistry, exercise and spending time with friends and family.

Olivia says she is "very excited to be joining the editorial committee" and is looking forward to this new experience and learning opportunity.

Devika Cook steps down

Unfortunately, due to personal reasons, Devika Cook has stepped down from the Editorial Committee. Dev has been a valued member of the team since December 2018. We thank her for contributions and we wish her all the best. Devika's PACU knowledge, wit and dry humor will be much missed by the team.

With the team currently at five members, we are actively looking for more members to join. The terms of the establishment of the Editorial Committee call for PNC NZNO to appoint an Editorial Committee with a minimum of five and a maximum of seven members, including the Editor. Current members are: Bron Taylor (Editor), Shona Matthews, Catherine Freebairn, Rebecca Porton-Whitworth and Olivia Bradshaw.

Christchurch ready for PNC Conference

Christchurch is ready to host the 2022 Perioperative Nurses Conference, running under the theme From Strength to Strength. The conference will be held at St Margaret's College from Thursday, September 29 - Saturday, October 1, 2022.

Registrations are open and a comprehensive line-up of speakers has been organised by the 10-strong organising committee.

Organising committee

The Canterbury/West Coast-Nelson/Marlborough PNC Region's Organising Committee for 2022 comprises: Vanessa Baccaltos (Convenor); Gill Cowlishaw; Sarah Elley; Marilyn Casey; Meg Agnew; Robyn Strachan; Robyn Guy; Sue Claridge; Nadine Harrison-Smith and Cass Raj.

"As nurses, we know how valuable education can be especially during these busy times," says Vanessa. "We can't wait till we can gather together again to learn, develop our practice and socialise with our colleagues. The conference committee has been well prepared and despite cancelled attempts to host, this is our chance to celebrate our nursing specialty!

"Our theme From Strength to Strength draws from our resilience, hard work and dedication that we have given to our nursing profession during these challenging times. See you all at conference!"

Exhibitors

The conference's Gold Sponsor is REM Systems Paragon Care New Zealand.

REM Systems has been a regular supporter of the annual PNC Conference. REM was the Platinum Sponsor in 2013, 2018 and 2019 and a Gold Sponsor in 2016 and 2017.

The Silver Sponsors for 2022 are Essity, Medtronic and Stryker.

For the full list of Exhibitors go to: https://perioperative conference2022.co.nz/category/sponsors/

For further conference information contact **Joanne Reddock, The Conference Team; tel: 03 359 2600 | Mobile: 027 303 8703 | email:**joanne@conferenceteam.co.nz

IFPN elects new president

The International Federation of Perioperative Nurses (IFPN) has elected Patrick Voight RN, MSA, BSN, CNOR of the USA as its new president. He replaces the retiring Mona Guckian-Fisher.

Mr Voight will serve a three year term (until 2024).

His involvement in IFPN started when he elected to the board in 2009 representing the United States. He has continued to serve in various roles including Ambassador (strategic planning and membership) and two terms as Treasurer.

In taking over as president, Voight thanked outgoing president Mona Guckian-Fisher "for her leadership in advancing the mission of IFPN, especially with the International Council of Nursing (ICN) and the World Health Organization (WHO).

"The last three years has seen a significant increase in our influence internationally and membership growth to the point that we now

Continued on page 10.

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represent over 500,000 perioperative nurses globally.

"As we enter the end of year two of the pandemic, Perioperative Nurses have been challenged in many ways we could never have imagined. Some of the challenges we have experienced globally include:

1. Stopping and starting our elective surgical cases;
2. Long wait list and access to the theatre schedule;
3. Converting our Operating Theatres and Recovery Rooms into COVID Units;
4. Working in areas outside of our clinical competency;
5. Supporting hospital staff with management, and use of PPE.

Toll of pandemic

"As a result, we have seen the emotional and physical toll the pandemic has had on our fellow nurses, resulting in turnover of staff and nurses leaving the profession. The International Council of Nursing reported that prior to the pandemic there would be a shortfall of six million nurses by 2030. Since the pandemic they have adjusted their projections to now be a 28 million gap globally. This will have serious implications on providing access to all individuals in need of surgical intervention and our ability to meet this demand globally."

President Voight says that individually none of us have all the answers how to address these challenges "but as a global board of directors representing the Pacific Islands, Asia, South East Asia, Europe, Middle East and the Americas, we will come together with solutions and a way forward for Perioperative Nursing and our patients."

From the nurses' station to GM

Southern Cross Healthcare has appointed three former nurses to General Manager's positions at three hospitals across its network: Rotorua, New Plymouth and Invercargill.

Stephanie Thomson's appointment as GM at Southern Cross Rotorua Hospital comes 35 years after she completed her nursing training at Waikato Polytechnic. Her eventual progression to the GM role within Southern Cross Healthcare has been a natural one, having worked as a nurse practitioner, Nurse Manager, and Acting GM at Rotorua Hospital.

In New Plymouth, Lee McManus also brings a wealth of medical and managerial expertise to her new role as GM at Southern Cross New Plymouth Hospital, with a nursing career that stretches back to the 1980s and a management career that began in the mid-1990s. Most recently she was the Hospital Manager Acute and Planned Care at Taranaki District Health Board.

Meanwhile, Jo McLeod has taken over the reins at Southern Cross Invercargill Hospital after beginning her healthcare career as a nurse in 1995. She switched her focus to more senior leadership roles in 2011 and most recently held the acting GM role at Southland Hospital.

Southern Cross Healthcare Interim CEO Chris White says the new appointments are about more than just their impressive clinical expertise.

"Our new GMs have a deep understanding of hospital operations and the role our hospitals play within the wider health sector and see the opportunity for us to evolve the ways we work to further support the health and wellbeing of New Zealanders," he said.

Stephanie Thomson, the new GM at Southern Cross Rotorua Hospital.

"They have the right blend of skills and experience we need to push transformational change across our network and deliver a private healthcare model that is more innovative and offers superior value care.

"Their experience from across many facets of the health sector will be important in delivering excellent patient care and tackling the challenges often faced by the health sector."

These key appointments come as Southern Cross Healthcare continues to broaden the services it provides as New Zealand's leading independent healthcare provider, which now includes wholly owned and joint-venture hospitals, specialist centres, physiotherapy and rehabilitation clinics, and workplace-based mental health and wellness services.

Aged Care Commissioner is a former nurse

A nurse who recently headed the Bupa rest home and retirement village business has been appointed New Zealand's inaugural Aged Care Commissioner.

Carolyn Cooper has been tasked by the Government with "leading much-needed systematic change in the sector".

Carolyn Cooper completed hospital-based training in the Wairarapa and began her health career as a registered general and obstetrics nurse. She has had a more than 40-year career in all parts of the health service, mostly in the public hospital system, including governance, executive and clinical leadership roles.

Prior to joining Bupa, Carolyn worked as Executive Director, Clinical Operations for the Illawarra Shoalhaven Local Health District based in Wollongong, New South Wales. She also worked as a General Manager for Canterbury DHB, has been the Chief Operating Officer at Wairarapa and Hutt Valley DHBs, and worked as the Executive Director of People and Culture for the Wairarapa, Hutt, and Capital and Coast DHBs.

"I have a very broad health experience background. I understand the way DHBs work, I understand how other parts of the sector work. And I am there for older people, that is my main thing — to make sure of their rights, protection and access to healthcare.

"I have lived experience in the area - my mum is in aged care - so I understand what it's like to be a family member. There's lots to me other than my experience with Bupa."

The aged care sector is short about 1000 registered nurses, which has forced the closure of some rest homes and the loss of 500 aged care beds since November 2021. More than 36,000 New Zealanders live in aged residential care, while a further 75,000 receive home-based care. Demand for aged residential care was forecast to increase by an estimated 15,000 beds by 2030.

The Dissector online

Perioperative Nurses undertaking research will be interested to know that back issues of *The Dissector* are available online via the following international databases:

- Gale: Academic OneFile – 2011 onwards
- Gale: Nursing Resource Center – 2011 onwards
- Gale: Nursing and Allied Health Collection – 2011 onwards
- Gale: Health Reference Center Academic – 2011 onwards
- Ebsco: CINAHL Complete – 2012 onwards
- Proquest: Nursing and Allied Health – 2013 onwards

It is a measure of the journal's standing within the international Perioperative Nursing field that these international sites sought out *The Dissector* for content.

NZNO members can also access *The Dissector* electronically in the Academic OneFile database via the NZNO website.

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Sustaining the Nursing Workforce

Abstract The historical and current issues around the recruitment and retention of nurses in New Zealand are outlined in an opinion piece by Dr. Isabel Jamieson, RN, BN, MNurse(Melb), CertAT
Keywords: nursing recruitment, nursing retention, safe staffing, fair pay, COVID 19 pandemic

Recruiting, retaining, and sustaining the nursing workforce has always been a concern to the profession. As I write this opinion piece, the need to retain our nursing workforce seems to be as hot a topic as it ever will be; the profession is in crisis.

Prior to the COVID-19 pandemic, the global shortage of nurses was estimated to be 5.9 million and worryingly "if only an additional 4 per cent of the global nursing workforce were to leave as a result of the pandemic impact, this would push the global nurse shortage estimate up to seven million" (Buchan et al., 2022, p.4).

Nursing Shortfalls

The recent *Sunday* current affairs programme on TV1 (Skinner, 2022) brought the issue into sharp relief, reporting that the New Zealand nursing shortfall is currently 4000.

"DHBs and communities in Aotearoa New Zealand are beyond crisis when it comes to having enough appropriately trained and experienced nurses to do the job well."

Anne Daniels, the president of the New Zealand Nurses Organisation notes "DHBs and communities in Aotearoa New Zealand are beyond crisis when it comes to having enough appropriately trained and experienced nurses to do the job well" (Daniels, 2022).

Why?

New Zealand has an aging nursing population so many are starting to retire. Others are burnt out due to decades of understaffing and under-resourcing, coupled with the lack of national workforce planning and the unprecedented demands of the COVID-19 pandemic.

Closed borders, part of the pandemic management strategy, only added to the problem by delaying the arrival of internationally qualified nurses (IQNs). Schools of nursing are unable to increase student numbers because they cannot access enough clinical places. Furthermore, attracting nurse educators to tertiary nursing education is another challenge for the profession, which also has an aging educator population and arguably burnt-out faculty staff.

Reviews and Research

The Nursing Advisory Group (2022) safe staffing review revealed nursing has been struggling for an unbelievable 20 years to ensure the nursing workforce matches the care needs of New Zealanders. The Chair of NAG stated, "we have not achieved safe staffing or healthy workplaces in our hospitals, and we have some way to go" (NAG, 2022, p.5).

This rhetoric is concerning for a profession that at its heart seeks to care for others but how can we when we are not supported to do so?

My recent research, which sought the views of early-career Generation Z New Zealand registered nurses (RNs) about nursing, exposed some troubling findings. One question asked about their experiences, professionally and personally, during the COVID-19 pandemic. While some did express their gratitude for a workplace that supported them, the majority described a beleaguered workplace that exposed them to relentless change. Moreover, the impact of the pandemic on their personal lives became intrusive due to their families and friend's concerns about 'catching the disease'; this was not what they had signed up for. Overall, the Generation Z RNs were happy that they had chosen to be nurses. However, they did express concern about their salaries, their safety at work, access to resources and poor nurse-patient ratios. These findings contribute to concerns about the retention of our workforce.

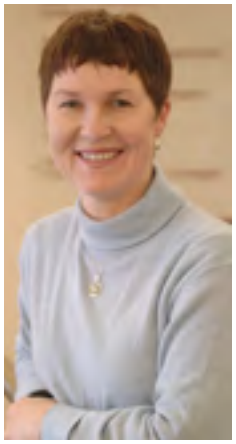
What is the answer?

The recommendations from Buchan et al. (2022) are worth considering. They suggested a multi-pronged approach to ensure the retention of nurses. Locally, employers need to address nurse burnout by providing a supportive workplace in conjunction with on-going and wide-ranging nationwide nursing workforce recruitment and retention planning. Strategies could include the assurance of safe staffing levels, fair pay, structured career pathways, regular workforce impact assessments, increasing the number of pre-registration students, and a review of the

overreliance on internationally qualified nurses.

The current nursing shortage was predicted more than 10 years ago (NAG, 2022). Now is the time to expedite a national plan for the recruitment and retention of nurses to ensure the workforce can always meet the care needs of our population.

About the author: *Dr Isabel Jamieson has more than 40 years of nursing experience. Since completing her hospital-based training she has worked as a theatre nurse, a Registered Nurse as First Assistant, an infection control nurse and was the original nurse manager with the mobile surgical bus. She has been a lecturer at Christchurch Polytechnic Institute of Technology (CPIT) and became a Doctor of Philosophy (Health Sciences) in February 2012. Isabel is a long-standing member of the Perioperative Nurses College of the New Zealand Nurses Organisation, has served on the Editorial Committee of The Dissector and was very active on the Professional and Education Committee of the College. She is now a Life Member of the College and is Senior Lecturer (nursing), University of Canterbury (UC). Her role is to coordinate the newly established Doctor of Health Sciences programme as well as offering doctorial supervision. She is also a principal lecturer at the Ara Institute of Canterbury (Ara) overseeing the joint UC/Ara graduate entry nursing programme and supporting master's thesis students.*



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The Nursing Advisory Group (2022) safe staffing review revealed nursing has been struggling for an unbelievable 20 years to ensure the nursing workforce matches the care needs of New Zealanders.

Ngawari kaimahi Flexible Workforce

"No problem can be solved from the same level of consciousness that created it" — Einstein

In the first article in the series on the Ngawari kaimahi / Flexible Workforce, published in the March 2020 issue of The Dissector, LEIGH ANDERSON gave an overview and background on the new 'flexible' way of working at Te Toka Tumai (Auckland DHB), focussing on why there is a need for nurses to return to providing assistance to the anaesthetist as an anaesthetic nurse. The second article, published in the December 2020 issue, described the steps taken to socialise the concept of a more flexible perioperative workforce at Te Toka Tumai. That article clarified the importance of open discussion and mapped out the beginning of the flexible workforce plan. In this third and final article, Leigh provides an update on the flexible workforce project and challenges us on our assumptions about perioperative staffing.

Current state

Traditionally and currently, perioperative departments at Te Toka Tumai (Auckland DHB) have been coordinated and staffed by registered nurses and anaesthetic technicians. Our standards and models of care are based upon national and international literature. This literature purports the safe and efficient running of operating rooms is dependent upon appropriately skilled nurses who are essential to safe and efficient care in the perioperative environment (ACORN, 2014). However, healthcare is a team sport; teams take care of patients, the responsibility does not only fall to nursing staff, but instead is a collaboration between nurses, anaesthetic technicians, surgeons and anaesthetists.

It is well documented that we have a national and international shortage of nurses, with Te Toka Tumai alone being short of 420 nurses, with a national shortage of 4,000 nurses (Longmore, 2022) and internationally a whopping 5.9 million shortfall (International Council of Nurses, n.d.). There is no simple or elegant solution on the horizon to end this shortage, so to enable us to continue to provide perioperative care at the level required we need to investigate new and innovative ways of working, including staffing models for the perioperative departments. Working within a flexible model goes some way to address this shortage.

Throughout the last 18 months, the philosophy of developing a flexible workforce at Te Toka Tumai perioperative departments has gained traction and acceptance. The first cohort of nurses began the RNAA programme in June 2021. We have since had others join the programme and suitably trained anaesthetic technicians may now work in the post-operative care units (PACU) alongside registered nurses. Currently these are anaesthetic technicians who have had their education in the United Kingdom, with recent PACU experience (within the last five years).

Implementing this has taken much more work than just a change of philosophy; this new way of working has prompted us to revisit all of our PACU orientation and competency workbooks. Fresh eyes highlighted that we made a number of assumptions regarding the skill-set of the staff who commence work within our departments. Our perioperative education team has done a stellar job of working with our PACU senior staff to create a very comprehensive familiarisation and competency package for staff at all levels without any assumption of previous knowledge or skill. Plans are in place to provide PACU training for New Zealand educated anaesthetic technicians in the near future.

The benefits of a flexible workforce with the ability of team members moving across roles to provide care where needed are already evident, sometimes at short notice. Those taking part are relishing the opportunity to learn new skills and contribute to patient care in a different way.

Attracting nurses?

Often when talking to nurses about alternate models of care in the operating room, I am asked about what is happening nationally regarding attracting people into nursing as a profession. There is significant national work being done in this regard. The Nursing Pre-Registration Pipeline Group was established in late 2019 to collectively progress improvements to the nursing pre-registration pipeline in New Zealand and to support the nursing workforce's ability to meet current and future challenges. The Nursing Pre-registration Pipeline Working Group is a district health board (DHB) Director of Nursing led programme of work in partnership with the Ministry of Health, New Zealand Nurses Organisation, Nursing Council of New Zealand, education providers, aged residential care and nursing leaders from across the sector. The aim is to get a shared understanding of the pre-registration pipeline and to work with training providers to ensure the supply and demographics of nurses matches demand and meets the needs of the populations we serve. There is also a focus on supporting new nurses and keeping nurses within the profession (Central Region Technical Advisory Services, 2022). Further Information about this programme of work can be found on the TAS website: https://tas.health.nz/employment-and-capability-building/workforce-information-and-projects/nursing-workforce-resources/

Big assumptions that shape our thinking

We each need to reflect on our thinking about how perioperative staffing should (or could) look. Working within a flexible workforce is just one initiative and we really need to do more than just this one thing. As

we do this it's useful to keep in mind that we each have big assumptions about how things 'should look'. These assumptions are reflected in how we shape our thoughts and our picture of how we believe things should be.

I am an avid supporter of nurses and the nursing profession. I have always said, and taught that, in the perioperative environment, it is the registered nurse's role to advocate for the patient in their care. They are their voice, and are to speak up on behalf of the patient whenever the situation requires it. In challenging my own thinking, I suggest that this is an example of a 'big assumption' – and one that is closely guarded, valued and spoken at any given opportunity. Is it true? Other professions in the operating room are also there with the patients' needs at the centre of what they do. This debate potentially brings us full circle to remember why we are in the profession we are in; to serve our community and care for them when they are unwell so they can be as healthy as they possibly can.

We perhaps need to really challenge our assumptions and our thinking to unearth opportunity. For example, do we need to turn our mind to considering the contribution that an unregulated workforce can contribute in the perioperative environment? What are the other solutions you have implemented or that you are considering within your department or hospital?

To conclude (for now)

Returning to comments from my first article; a flexible workforce is one that is integrated and flexible across perioperative roles, respecting the skills and knowledge of each professional group. This workforce is educated and supported to enable the highest quality, safe care to the community that we serve. It is the responsibility of perioperative leadership to enable a fully capable workforce who can provide care within a changing environment. The notion of a flexible workforce in the wider sense, forces us into an uncomfortable position where we rethink the value of nurses within the perioperative workspace.

We can no longer afford to continue working in the same ways that we have; the current nursing shortage is forcing us to rethink how we can best provide safe patient care in the perioperative environment.

About the Author *Leigh Anderson RN, MN (Hons) is the Pou Whakahaere Nahi (Nurse Director) for Āhua Tohu Pōkangia (Perioperative Services) at Te Toka Tumai (Auckland DHB). Leigh is a past Chair of Perioperative Nurses College of NZNO (2008 to 2013) and Board member of the International Federation of Perioperative Nurses.*

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Effective Orientati
New Graduate and Novice

By Grace Wu RN, PGDipHSc, MNurs (First Class Hons)

Abstract A structured New to Operating Rooms (NTOR) orientation programme for nurse orientees to train as perioperative nurses was established in 2003 by Te Toka Tumai/ Auckland District Health Board (Nova, 2015). This article describes results from a study of the features of an effective orientation programme for new graduate and novice operating room (OR) nurses while training at Te Toka Tumai. Identification of effective features is necessary given retention after orientation can hinge on orientee satisfaction with training components.
Key words: Operating Room, New Graduate, Novice OR nurse, Orientation Programme

Introduction

A qualitative descriptive study was undertaken in a perioperative setting in one district health board (DHB) in New Zealand within a tertiary care hospital environment. This study aimed to explore and identify the features of an effective orientation programme for new graduate and novice operating room (OR) nurses. Findings from international studies have relevance for the New Zealand graduate nursing workforce and factors that influence the structure of programmes offered during the first year of nursing practice, such as orientation programmes (Scott, Huntington, Baker, & Dickinson, 2011).

However, there is a paucity of information and little is known from studies that include or touch upon the features of perioperative orientation and training programmes in New Zealand. It was anticipated that findings from this study would identify features impacting the effectiveness of structures that underpin orientation and training programmes, nursing practice and research.

Background

New Zealand, like other countries, has experienced a nursing shortage impacting all areas of hospitals. A 2011 article confirmed about 10 per cent of nurses under 30 were contemplating departure from their nursing career (Clendon & Walker, 2011). A review of the literature revealed an absence of research investigating the features of effective OR nurse orientation programmes in New Zealand. Data collected by perioperative services at Te Toka Tumai revealed that 297 nurses completed the NTOR programme between 2014 and 2018 (Te Toka Tumai, 2018) with a retention rate of 60 per cent by 2018. The need for an effective orientation programme to train and, following completion, retain new graduate and novice OR nurses is a key goal for DHBs in New Zealand.

Orientation programmes for newly employed OR nurses have been established both informally and formally for many years, both in New Zealand and in overseas hospitals (Adlam, Dotchin, & Hayward, 2009; Haggerty, Holloway, & Wilson, 2013). These programmes include Nurse Entry to Practice (NETP) (MOH, 2004) and New to OR (NTOR) programmes. Te Toka Tumai's NTOR programme is offered to both new graduates and experienced new to OR nurses.

Literature Review

Review of the literature revealed an absence of research on this subject in New Zealand. Sixteen international articles were reviewed that pertained to the features of effective orientation and training programmes for new graduate and novice operating room (OR) nurses. Three overarching themes were identified as relevant: OR orientation programmes and nurse orientee retention; the importance of nurse preceptors; and the impact of mentorship programmes on new graduate and novice OR nurses.

Methods

A qualitative descriptive research method (Polit & Beck, 2004; Sandelowski, 2000) was used for this study. Research design collected data from three focus groups each composed of five OR nurse participants and a fourth session with one OR nurse interviewee who identified as Māori. Inclusion criteria and purposive sampling identified qualified participants. Comments were transcribed, coded, and thematically analysed. Three main themes and nine sub themes

Author Grace Wu (third from left) with fellow nurse educator Jia Jen Chang and the January 2021 NTOR nurses.

on Programme for e Operating Room Nurses

emerged. Triangulation enhanced study credibility and optimized study rigour, for example ethical considerations and responses to Maori. Qualitative processes: transferability, dependability, confirmability and reflexivity underpinned research trustworthiness (Moule, Aveyard & Goodman., 2016).

Findings

A total of 16 OR nurse participants provided data for this study. The study cohort included 15 OR nurses who were focus group participants and one OR nurse interviewee. All study participants were female and employed full-time with experience ranging from one to six years in perioperative units. Three main themes and multiple sub-themes emerged from the data analysis (see table 1): meaningful learning activities, support in preceptorship and constructive feedback to assist in successful learning. Orientee motivation, competence and confidence were tied to satisfying experiences. Effective orientation features included support for preceptors from management, structured programmes and rostering that provided consistent access to preceptors for OR training. Post-NTOR training mentorships were also viewed as supportive by orientees.

Table 1: Main themes and sub-themes

Main themes	Sub-themes
Meaningful learning activities	Training in theory: Classroom learning
	Hands-on practice in OR simulation
	Confidence in OR nursing practice
Support in preceptorship	Culture of support
	Preceptor teaching expertise
	Continuing support: Mentors
Constructive feedback to assist in successful learning	Motivation and learning
	OR competency and feedback
	Safe learning environment

Meaningful learning activities

Meaningful learning activities further reinforced orientee confidence from the feedback they received via formative assessment and competency audits of OR skills. For example, scrub role assessment and urethral catheterisation. Participants stated that classroom theoretical study combined with simulation, OR hands-on and role play activities were viewed as both enjoyable and informative.

Nurses in the New to Operating Rooms (NTOR) 2021 training undergo a briefing.

Support in preceptorship

Participants identified three main elements which supported preceptorship: a culture of support, teaching expertise of the preceptor and continuing support from mentors. They stated that a culture of support from peers, preceptors, senior teams, management and surgical teams is key to creating a safe learning environment.

Constructive feedback to assist in successful learning

Participants identified that three elements of feedback affected their NTOR training: motivation and learning; OR competency and feedback; and safe learning environment. Participants felt that receiving constructive feedback was a key feature for effective orientation programmes. Nurses were also motivated to improve their performance based on feedback from audits of their perioperative skills. The participants discussed how completion of OR competency provided an opportunity to receive feedback that enhanced their confidence.

Meaningful learning activities, support in preceptorship and constructive feedback to assist successful learning were supported by subthemes. Constructive feedback from preceptors developed competence and confidence for new graduate and novice OR nurses. Motivation, competency and confidence can be achieved when training occurs in a safe learning environment that involves hands-on practice.

A operating room simulator session in 2021.

Didactic classroom learning and hands-on practice in simulations were found to be connected to a safe learning environment. This connection combines meaningful learning activities and constructive feedback to assist successful learning as an important nexus of support.

Findings highlighted the benefits of on-going support from OR management for preceptors who in turn provide support for OR nurse orientees. A link was revealed between standardised teaching consistently delivered by preceptors combined with consistent access to preceptors for orientees. Participants viewed these features as effective components of NTOR training. Nursing managements' access to pools of qualified preceptors, so as to arrange matching with orientees for OR teaching encounters, was one limiting factor to providing support.

Discussion

The three main findings of the study were meaningful learning activities, support in preceptorship and constructive feedback to assist successful learning.

Meaningful learning is an active process that can develop learner cognition and an ability to learn effectively by transforming knowledge into meaning (Christie, Carey, Robertson, & Grainger, 2015; Jamison & Lis, 2014). Study participants revealed that meaningful learning activities provided opportunities for them to acquire knowledge of their specialty. They acknowledged that the structure of the NTOR programme had developed their competency and confidence through meaningful learning activities that allowed practice of new skills in a safe learning environment. Nurses unfamiliar with perioperative settings were initially exposed to didactic education and then gradually acclimatized to perioperative culture, structure and policies.

Study participants affirmed that hands-on training and support were features of NTOR programmes that illustrated orientation effectiveness. These features are consistent with research literature that connects OR nurse competency and confidence to orientation training (Allanson & Fulbrook, 2010; Mollohan & Morales, 2016; Wilson, 2012).

The NTOR programme includes structured didactic group teaching, simulated OR role play and preceptor guided OR immersion (Mollohan & Morales, 2016; Trice, Brandvold, & Bruno, 2016).

Effective learning is facilitated through enjoyable experiences and constructive feedback during OR training (Sherman, 2015). Study data confirmed that OR nurse participants viewed structured and consistent didactic, simulated and real-world OR learning experiences as satisfying if supportive relationships underpinned their training. These features of NTOR training are consistent with Sherman's (2015) belief that younger OR nurses seek enjoyable, interesting and meaningful work. This study's findings affirmed that meaningful learning activities structured and consistently taught can optimise new graduate and novice OR nurse experiences.

Jamison and Lis (2014) discussed how learner-centered instruction which constructively aligns with orientee learning styles are important for building knowledge and transformation of that knowledge into competencies. Structured and consistent teaching during learning activities was viewed by participants as another key feature of a successful NTOR orientation programme (Adlam et al., 2009; Haggerty et al., 2013). Different preceptors who teach the same task to orientees and follow a standardised step-by-step sequence were perceived by study participants as adding consistency to NTOR training that was valued by orientees.

In contrast, study data revealed that different preceptors who did not teach the same protocol sequence created confusion amongst

orientees. For example, if the correct step-by-step sequence to catheterise a sedated patient is not taught consistently by different preceptors, or by the same preceptor in different sessions, this inconsistent training could increase mental effort such as cognitive load, thus causing confusion (Sorensen & Yankech, 2008; Young, Van Merrienboer, Durning, & Ten Cate, 2014).

In this study constructive feedback emerged as a main theme to support successful learning. Study data revealed that participants were motivated as orientees after receiving constructive feedback from their preceptors and peers. In contrast, study data revealed that participants viewed negative and critical feedback as frustrating or discouraging.

Groves et al. (2015) explain that in clinical encounters "the most effective feedback is constructive feedback" (p.1737). Constructive feedback can identify the strengths and weaknesses of nurses in training (Mollohan & Morales, 2016; Wilson, 2012; Zinn et al., 2012). Data collected in this study also identified how constructive feedback was perceived by orientees as optimising a nurse's sense of competency in the OR.

Implications/Recommendations

Competency in OR nursing skills and confidence are outcomes tied to a culture of support from peers, educators, preceptors, managers and OR teams. Rostering consistent access for orientees to preceptors during OR training and standardized precepted teaching were effective features. Support from management, preceptors, peers and OR teams and preceptor training in reflective feedback with OR nurses were also seen as effective. Retention after NTOR orientation can pivot on satisfaction with training features. Formal mentorships to bridge NTOR to first year OR nursing practice can further optimise retention.

Conclusion

A successful orientation programme also offers consistent preceptorship for newly employed OR nurses. Exploring the experience of new graduate, novice and senior OR nurses identified effective support mechanisms such as preceptor guidance, support that increases confidence underpinned by competence and a diverse 'culture of support' for orientees during their NTOR orientation programme.

This study identified gaps in knowledge and practice that could impact the culture of support. Orientees perceived dependable and ongoing access to preceptors during OR training and consistent training by different preceptors who utilised standardised procedures as desirable features of training in an NTOR orientation programme. Informal supportive mentorship after completion of NTOR training was also viewed as desirable.

Viewed through the eyes of study participants, three overarching features emerged as being effective for developing competency and confidence. These features were consistent instruction by preceptors for orientees, consistent access to preceptors by orientees and post-NTOR relationships such as informal mentorships to extend support and improve competence and confidence.

About the Author: *Grace Wu, Perioperative Nurse Consultant RN, PGDipHSc, MNurs (First Class Hons), has more than 30 years of perioperative nursing experience within New Zealand and overseas. She has formerly held roles as cardiothoracic and transplant OR nurse, OR Nurse Educator, and Nurse Educator Programme Coordinator of New to OR and New to PACU programmes within the Perioperative Directorate at Te Toka Tumai. Currently, she is a Nurse Consultant for Āhua Tohu Pōkangia perioperative at Te Toka Tumai. She was conferred a Masters of Nursing Degree (research based) from the University of Auckland in 2020.*

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Physiological Impact of Perioperative Anaphylaxis

By Amanda Lindsay

Abstract Nurses working within the perioperative environment need to understand normal and abnormal physiology and its impact on the patient during an acute intervention. Understanding how our immune system responds and abnormal responses can allow us to change and adapt our care of the patient and be an active member during an emergency.

Keywords Physiology, neuro-muscular blocking agents, immune system, external, innate and adaptive responses, mast cells, anaphylaxis, emergency response anaphylaxis immediate management card.

Introduction

Caring for a patient in the perioperative environment requires knowledge of both normal and abnormal physiology. Physiology is described as a branch of the study of biology that focuses on normal functions of living organisms; it is the process of using science to explain these functions (Lemoine & Pradeu, 2018).

Critically analysing how a patient's physiology is impacted by acute intervention provided by healthcare professionals grants us a higher understanding of how, and why we do what we do for our patient's wellbeing.

The immune system is always active and working to defend us from tissue damage and disease. This system can be impacted on and directly stimulated by the acute intervention of the administration of anaesthetic agents. One such agent is neuro-muscular blocking agents (NMBA) such as Rocuronium. Reddy et al. (2015) state that Rocuronium has a one in 2499 incidence of anaphylactic event rate. When this occurs, the patients' normal physiology is altered and health practitioners, including registered nurses, must treat the changing physiology accordingly.

Immune System Response – Externally, Innate and Adaptive

John and Brady (2020) explain how the immune system is often separated into categories. Firstly, external barriers, then innate immunity, and finally adaptive immunity.

External barriers qualify as those that are physical and mechanical such as skin and epithelial linings. This category also includes biochemical barriers such as normal flora, saliva, and stomach acids to name a few. The categories presented by Jones (2016) differ slightly including external barriers within innate immunity.

Innate immunity is the second category that destroys pathogens that enter the body (John & Brady, 2020). Hirayama, Iida, and Nakase (2018) explain how epithelial and innate immune cells have receptors that are activated when specific microbial products come into direct contact with them. This starts a cascade which results in an inflammatory response. This early inflammatory response attracts white cells such as neutrophils which ingest the pathogen. The resulting product is pus at the site of infection (John & Brady, 2020). The next step in innate immunity is when monocytes arrive at the site of infection and become macrophages where they dispose of the foreign materials. There may also be involvement from eosinophils in this process. However, they are more prominently known for regulating heparin released by mast cells.

The final category is adaptive immunity. Adaptive immunity is described by John and Brady (2020) as the process of recognition within the body of foreign pathogens. Jones (2016) explains that this process is specific to each individual pathogen, with the response becoming more efficient with multiple exposures due to memory cells (Jones, 2016). The body recognises the foreign antigen through T and B cells. The T cells activate and divide to create cytotoxic T cells and memory T cells (Jones, 2016). B cells create immunoglobulins, antibodies to the pathogen as well as memory B cells (John & Brody, 2020; Moini, 2019).

Mast cells, which are part of adaptive immunity, are found throughout the body. These cells are in most connective tissues such as adipose tissues, ligaments, and particularly adjacent to blood vessels (Higgins Roche, 2019; Jones, 2016). They are often found alongside macrophages and microphages (Moini, 2019).

In everyday life the mast cell's purpose is to react to pathogens, allergens, and form part of the immune response as well as to help with inflammation caused by tissue injury. Moini (2019) explains how the immunoglobulin IgE binds with the mast cell, and then antigens bind to the receptor to activate the cell. This activation, described as the triggering of the cell response (Donald Venes, 2013), prompts the mast cell to release histamine and it may also release heparin and serotonin. Higgins Roche (2018) expands on this, explaining that the mast cells also release leukotrienes, cytokines, and prostaglandins. Mast cells have a counterpart called basophils in the blood which also release histamines by binding with IgE. The released chemicals respond directly to bacterial pathogens, whilst beginning to mediate inflammatory and allergic responses such as asthma and hay fever (Moini, 2019; Roche, 2018). These cells can also be activated without the presence of IgE within an inflammatory response (Omman & Kini, 2020).

Acute Intervention – Administration of Rocuronium

During an acute procedure requiring the patient to be anaesthetised, an acute intervention administered was an intravenous anaesthetic with an endotracheal tube (ETT) airway. The neuromuscular blocking agent (NMDA) administered was Rocuronium, which results in total paralysis, including respiratory muscles (Dewa et al., 2019).

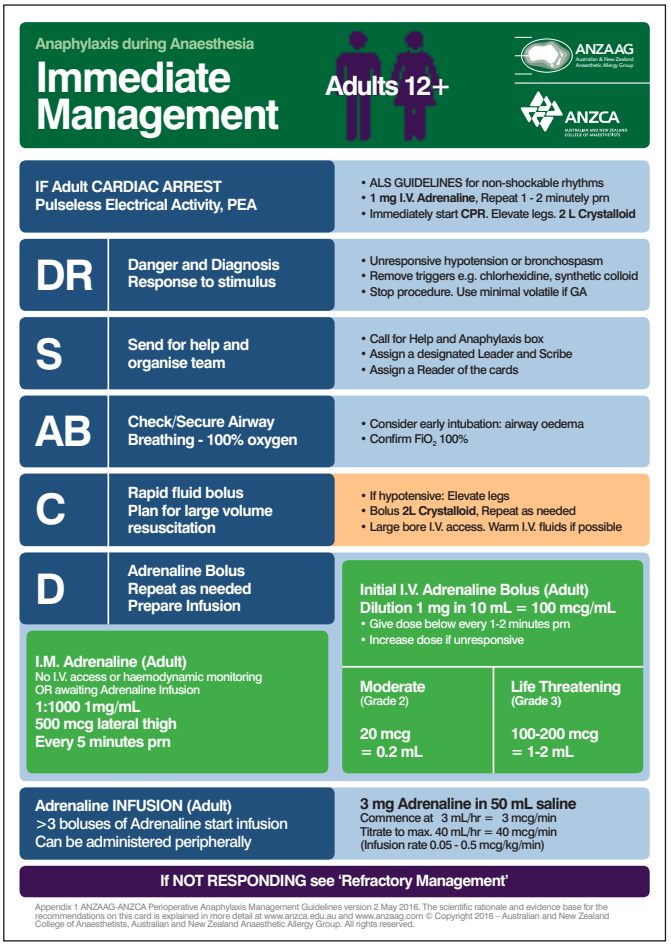
Rocuronium was indicated as this was a rapid sequence induction (RSI) (Reddy et al., 2015). Post induction, the patient began to show signs of deterioration. The physiological response was deemed to be anaphylaxis grade three (Ring & Messmer, 1977) which Harper et al. (2018) define as a systemic reaction that is both life-threatening and severe.

If a normally non-harmful substance introduced to the body, such as Rocuronium, results in an immune response, it is considered an

allergic response (Moini, 2019). The difference between physiology and pathophysiology regarding immune responses and mast cell activation is that normal responses do not cause tissue damage, unlike allergic responses.

Volcheck and Hepner (2019) explain that 60 per cent of intraoperative anaphylactic events are linked to IgE-mediated mast cell and basophil activation. However, they also note that mast cells can be activated outside of this pathway via direct non-specific mediators. This is named non-IgE mediated hypersensitivity. NMBAs attribute between 50 to 70 per cent of perioperative anaphylactic events in multiple listed countries, including New Zealand, via both pathways concurrently (Volcheck & Hepner, 2019).

Mass mast cell activation can result in a range of clinical manifestations. This manifestation is classified against a scale by Ring and Messmer (1977) which puts the reaction into one of four grades. Grade one results in changes to skin. Grade two results in mild system involvement which is deemed non-life-threatening. Grade three is life-threatening system involvement. Grade four is cardiac and/or respiratory arrest.



DR S AB C D IF Adult CARDIAC ARREST Pulseless Electrical Activity, PEA Danger and Diagnosis Response to stimulus Send for help and organise team Check/Secure Airway. Source: Australian and New Zealand Anaesthetic Allergy Group (2016). Retrieved from http://www.anzaag.com/Docs/PDF/Management%20Guidelines/Adult_Immediate_Management_Card_2016.pdf

With this event graded at three, the patient was showing severe multi-system involvement with decreased tissue perfusion (Graham, 2022). The patient had respiratory manifestations of increased airway pressures and a severe drop in oxygen saturations, as well as cardiac manifestations of tachycardia and hypotension.

Graham (2022) and Ebo et al. (2019) discuss the body's experience of constriction of smooth muscle, peripheral vasodilation, and increased capillary permeability. The resulting vasodilation, loss of intravascular volume into the interstitial space, redistribution of blood between vascular compartments, and therefore loss of preload and afterload, produce hypotension and tachycardia. With venous return decreased, stroke volume decreases which will decrease tissue perfusion resulting in hypoxia. Associated bronchospasm is often a feature in patients with airway related co-morbidities but can also occur spontaneously and be related to mechanical factors (Dewachter & Savic, 2019).

Emergency Response – Nursing Intervention

An emergency response pack specifically for this event and the corresponding emergency flow chart was brought into the operating room.

The Anaphylaxis during Anaesthesia Immediate Management for Adults 12 plus card was devised by the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) and Australian and New Zealand College of Anaesthetists (ANZCA). The card has clear and concise steps to take in an anaphylactic event following the adage of danger/diagnosis, response, send for help, airway, breathing, and circulation (DRSABC) which is also the foundation for cardiopulmonary resuscitation guidelines (ANZAAG, 2016a). This document also has a pediatric card and a refractory management card which are included within adverse reaction packs and anaphylaxis boxes throughout New Zealand's district health boards.

The nursing implications within the perioperative environment are guided by this card and by direction from the Anaesthetist. Firstly, the Anaesthetist stopped the infusion of intravenous agents and gasses that may have been causing the reaction to remove triggers as the flowchart dictates (ANZAAG, 2016a). Volcheck and Hepner (2019) agree that withdrawal of the offending drug should be the first action taken if deemed anaphylaxis. The next step is to send for help. This is specified as anaesthetic help by Seifert (2017) and to designate roles of leader which in this case was the Anaesthetist, scribe, and card reader (ANZAAG,2016b).

Due to the procedure occurring during after-hours, staffing was reduced so some roles were managed by the same person or people were changed as required. I was asked to call for help. This involved ringing the Duty Anaesthetist and Theatre Coordinator to increase both medical and nursing presence in the room. Following this, I was designated as the card reader, myself and the other nurse in the room were also designated to draw up medications as required and scribe these whilst the Anaesthetist and Anaesthetic technician were completing tasks.

One of these tasks was the next step on the card related to airway and breathing. In this reaction, the ETT airway was secure. However, airway pressures were still increasing and oxygen saturations were dropping. The ventilator's oxygen supply was increased to 100 per cent to help compensate for increased consumption, confirmed by Kunzel et al. (2020) as the recommended course of action. Salbutamol was given via the ETT. Bronchodilators are often used when bronchospasm appears to be occurring during an anaphylactic event (Volcheck & Hepner, 2019).

Hypotension is the primary focus of the circulatory section of the card. A crystalloid fluid bolus is recommended to compensate for peripheral vasodilation (Volcheck & Hepner, 2019). Ebo et al. (2019) say that this volume replacement is essential and resuscitation will not be possible if the replacement is inadequate. Another component was patient positioning and large-bore intravenous (IV) access (ANZAAG, 2016a). The nursing implications for the patient were for us to position the patient in Trendelenburg. We then manually lifted the patient's legs so they were elevated to increase peripheral resistance and aid venous return as much as possible (Angus, 2020). The technician inserted a large-bore IV cannula with help from the nursing team who positioned the patient's limb for access and handled opening the equipment necessary for the task. This included running the fluid through the giving set and attaching

this to the IV line once this was secured. In preparation for potential large-scale fluid resuscitation, another bag was also primed to be hung following completion of the first infusion.

Adrenaline is a critical medication used in the treatment of anaphylaxis as it interrupts the effects of mediators and prevents the release of further mediators (Volcheck & Hepner, 2019). Adrenaline also promotes vasoconstriction, increases cardiac output, and causes bronchodilation, helping to mitigate critical consequences (Graham, 2022).

The card gives instructions on how much adrenaline to administer as a bolus immediately and follows on with dosages for the adrenaline infusion post bolus. Savic and Garvey (2020) reinforce that this is critical. It was requested by the Anaesthetist that I draw up an adrenaline bolus in accordance with the card. The card dictates a dosage of 100 to 200mcg for grade three reactions. The card specifies to use the 1mg in 10ml ampules, giving a total injectable amount of one or two mls. The Anaesthetist confirmed to draw up 200mcgs or two mls. This bolus can be administered as required every one to two minutes (ANZAAG, 2016a). It is advised within the ANZAAG (2016b) guidelines that other members of the healthcare team outside of anaesthetics should be enlisted as required for these tasks.

Further nursing implications for this patient was the need for ICU monitoring overnight. Graham (2022) states that it is imperative for nurses in critical care to continue to monitor for reoccurring reactions and complications from the initial reaction. This may include continuing fluid management, adrenaline infusions, and ventilation. Graham (2022) also suggests that nurses provide comfort and support to the patient and family as required following the event.

Literature Review

When analysing the literature surrounding perioperative anaphylaxis, it is clear that the adverse reaction packs or anaphylaxis boxes we have that guide practice align with current literature. ANZAAG's literature, such as their management cards, are quoted within the National Auditing Project on Perioperative Anaphylaxis sixth edition (NAP6) as credible anaphylaxis algorithms. NAP6 is the Royal College of Anaesthetists (2018) latest resource regarding perioperative anaphylaxis and is used to guide practice throughout the United Kingdom. Interestingly, I was unable to source a nationwide guideline recommendation for the United States of America to provide a comparison. One criticism in regard to the situation described in this article was the need for a singular person to complete more than one designated role. This was unavoidable due to staff availability at the time. However it is clearly specified that these should be delegated to individual people. This was reflected upon by the healthcare team following the event.

Conclusion

The normal physiology of the immune system can be greatly impacted upon by the administration of anaesthetic agents. These agents such as NMBAs can result in anaphylactic events. Perioperative anaphylaxis is a complex, changing, and challenging situation. Critically analysing current literature regarding the impact interventions in the perioperative environment have on our patient's normal physiology, helps us to prepare for these. Resources such as ANZAAG's (2016a) anaphylaxis immediate management card provide invaluable pathways for management. By analysing the nursing implications in life-threatening situations, such as perioperative anaphylaxis, ensures we have the knowledge to provide the patient with the best possible outcome.

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A safe environment for Māori patients starts with a safe environment for Māori nurses

In this article RANGI BLACKMOORE-TUFI reflects on some of the challenges she has faced being the sole Māori nurse in her perioperative department. Changes made following a frustrating and stressful day have made the department a safer place for Māori staff and patients. The idea for the companion article in this issue 'Culturally Safe Care in the Aotearoa Perioperative Environment' came from the restorative hui, when it was recognised that more education around Te Tiriti and Tikanga was needed for tauiwi (people who are not Māori) perioperative staff.

I have worked in the perioperative department for around five years as a nurse. Coming from a very kaupapa Māori (a Māori way) based upbringing and being surrounded with inspirational Māori leaders throughout my studies to become a registered nurse, I had always envisioned from early on in my journey this is who I wanted to be. A Māori nurse, not just a nurse who happens to be Māori by ethnicity.

There have been many challenges I have faced being the only Māori nurse in my perioperative department. Some nurses are fabulous in explaining the reasoning behind why Te Tiriti is such an important document, others have told me it is a government document but cannot understand why it is so important. At one point I was faced with racial discrimination, which opened my eyes to the lack of cultural safety knowledge and understanding by nurses.

One morning I arrived at a shift where an in-service was about to take place. When I heard the teaching was about tūpāpaku (deceased) patient processes, something that heavily incorporates Tikanga (customs and traditional values), I became worried as this was a very tapu (forbidden; taboo) subject and this was the first time I had heard about this teaching happening. I would have expected to have had some discussion around this in-service as I had been putting together the Tikanga resource folder for the department. Twice I spoke to my leaders about my concerns as I was aware that Tikanga was not proficiently understood in our department. On both occasions my concerns were not acknowledged and I was made to feel more of an annoyance.

As the presentation commenced, the first Māori word was not pronounced properly. I thought "that is okay, she gave it a go and I know neither English nor Māori is her first language", so acknowledged that. As the teaching went on, I noticed all Tikanga had been stripped from the presentation. There was no aroha (love/affection/empathy) incorporated in the deliverance of such a tapu important process. Te Reo words that were incorporated in the policy had been removed from the slides and changed to English words. Kaupapa Māori services were

replaced with English services. At the end of this in-service, I asked the question, "why was Tikanga not incorporated in your presentation?" I was immediately interrupted by the presenter and told that "Tikanga has nothing to do with the presentation". As I tried to explain that the policy for this subject incorporates Tikanga, I was talked over and consistently cut off in front of the department staff members present. I felt there was no point trying to explain myself as nobody could understand why this is impacting me and why I was so offended.

Following the presentation, other nurses made comments like "it's not all about Māori" and "are you mad because you're not on the presentation?" This was never the case nor was it the reasoning behind my questioning. I felt a duty to ensure the deliverance of this presentation was Tika (correct). I had to stand there and watch a teaching session that I knew was not Tika. I witnessed a sacred process getting the mana and mauri stripped from it, while also being belittled, which was the reason I was offended. I became frustrated because I had voiced my values and beliefs and was then made to look like it was just myself who had the problem.

Around two hours after this incident I was approached by my charge nurse, who urgently needed me out of theatre. I handed over what I was doing and went to her. She explained "there is a Māori patient in pre-op who needs to have a caesarean section. There has been an incident involving the patient's partner and a staff member. The partner, who has left the hospital, and is not allowed back and the patient is now not talking to anybody. I need you to come and talk to her because we need to get her into theatre".

I immediately went to this young Hapū Māmā (pregnant women). I went into the bed space and asked everybody to leave, then sat with her. I immediately sympathised with her, held her hand, gave her a hug, and had a brief korero, instantly building rapport. Within five minutes she was ready to be taken into theatre.

I became her support person and I sat with her through the whole operation into recovery until she went to the ward, even though this went through my lunch break.

Her continuity of care while she was in the perioperative department was my only focus. As anaesthetists were preparing for their procedure, the allocated midwife interrupted and asked the patient "what's your partner's name and how is it spelt?" I said to the midwife "not right now, that is not our focus". She continued to speak to the patient, stating that her partner will not be allowed to enter onto the hospital ground and security needed his name. The patient started to become frustrated, as did I. I had just spent time calming this Māmā down, refocusing her mind on her baby that was about to enter this world and the midwife was compromising the progress we had just made. I stood up and asked the midwife to leave it and go away and then I sat with this Māmā, held her hand and spoke to her like 'this is my sister'. I opened my heart to this Māmā and cared for her and connected with her as I would my own whanaunga (blood relatives).

I went home extremely frustrated. I surrounded myself with my whanau where I felt supported, and I began to reflect. I quickly went from being frustrated and angry to mamae (hurt). I felt devalued, isolated, unheard and embarrassed. I felt embarrassed to be part of a workforce that did not appreciate what I bring to the department culturally. I became doubtful in my own practice and began to wonder if nursing was even for me. I have a passion for this specialised area of nursing and I know I love the mahi (work) we do, but my wairua (spirituality), hinengaro (mental health) and mana was being affected. My very own personal Te Whare Tapa Whā had been compromised.

I started reflecting on everything that had happened to me culturally since starting in this department.

Tikanga in my area meant 'blue pillows' and 'do not touch a Māori patient's head', but they did not understand the reasoning behind this. On another occasion, a patient asked to have a Karakia (prayer) in theatre prior to the procedure (a surgical termination of pregnancy). The nurses in theatre declined, saying "since when do we do that? They do that in pre op, not in theatre."

I was shocked at this statement as these same nurses were using this Karakia process in their professional development portfolios to advance in their careers, yet did not apply it to practice. This was not implementing the Tikanga we have in our policy. I had to break it right down to them and then organise someone from the Māori health support team to come and do a Karakia in my break as I was allocated to another floor that afternoon.

Another example I was present for was when nurses had mistaken an elderly lady for having mental health problems as she was not communicating with them in pre op. It transpired that this Kuia (elderly Māori woman) only spoke fluent Te Reo Māori and she had an involuntary tongue movement. This was only found out when I was asked to bring the patient into theatre. She noticed I had a Māori name when I introduced myself and she proceeded to speak fluent Te Reo Māori to me.

A restorative hui was called around the series of events that took place. I was supported by strong Māori colleagues and leaders that I felt safe with and that uplifted and supported me. I was able to say how I felt and the impact that the series of events had on my hinengaro and my mana. I remember being scared, scared to speak up and tell the truth out of fear that I would break the relationships I had with my colleagues or superiors in my department. I was scared that my superiors would be angry at me for drawing attention to the department and I was scared that I was going to be forced to be a nurse who just happens to be Māori.

The outcome from the hui was very different from what I anticipated and expected; I was heard at this hui. Changes have been made to prevent this from happening throughout my department. Karakia has been implemented, this is said in Te Reo and English at the beginning of each day. Tikanga sessions have been scheduled in the in-service calendar and my Māori resource folder is almost complete for staff to use and refer to when needed. We are not there yet, however our department has made a positive start.

From my experience, we are a fast-growing population of international nurses with a high ratio of Māori patients. It has been extremely difficult to be just one Māori nurse, one Māori voice and one Māori advocate in my department. Cultural safety and Te Tiriti are heavily incorporated in the nursing degree in Aotearoa. I have found that Aotearoa trained nurses understand the importance of cultural safety and know how to incorporate this in everyday practice. International trained nurses need more assistance in understanding these prior to practicing in Aotearoa to gain a better perspective of the implications this can have on our Māori nurses and the departments they work in. A safe environment for Māori patients starts with a safe environment for Māori nurses.

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Culturally Safe Care in the Aotearoa Perioperative Environment

By Rangi Blackmoore-Tufi & Bron Taylor

Abstract Perioperative nurses must provide safe patient care. An important aspect of safe care is culturally safe practice. This article discusses nurses' responsibilities for reducing inequities and providing culturally safe care in the operating rooms in Aotearoa New Zealand.

Keywords: Cultural Safety, Equity, Ti Tiriti o Waitangi, Tikanga

Introduction

Equity is the absence of avoidable or remediable differences among groups of people (World Health Organisation, n.d.). Healthcare providers, institutions, professional organisations, patient representatives, and all stakeholders must collaborate to ensure equity in all aspects of care for all patients (Association of periOperative Registered Nurses, 2022). Addressing and eliminating health inequities requires health professionals and health organisations address the determinants of health inequities, including institutionalised racism, to ensure a healthcare system that delivers appropriate and equitable care (Curtis et al., 2019).

Healthcare professionals must examine themselves and consider the potential impact of their own culture on healthcare delivery, including their own biases, attitudes, assumptions and stereotypes to enable provision of culturally safe care (Curtis et al., 2019). In order to provide culturally safe nursing care in Aotearoa, nurses must also have an increased awareness of cultural beliefs and practices important to Māori, incorporating them into day-to-day nursing practice (Hamlin & Anderson, 2011).

Cultural Safety

Cultural safety is defined by the Nursing Council of New Zealand (NCNZ) as the effective nursing practice of a person or family/whānau from another culture, determined by that person or family/whānau (NCNZ, 2011). Cultural safety in healthcare relates to the experience of the recipient of nursing services, extending beyond cultural awareness and cultural sensitivity (NCNZ, 2011). Unsafe cultural practice is defined as any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual (NCNZ, 2011).

NCNZ expects that all nurses undertake a process of reflection on their own cultural identity and recognise the impact that their personal culture has on their professional practice. Nurses must incorporate the articles of Te Tiriti O Waitangi in their practice (PNC, 2016). This is acknowledged within the professional development and recognition programme (PDRP) domain of professional responsibility (NCNZ, 2007).

Cultural safety requires healthcare professionals to influence healthcare to reduce bias and achieve equity within the workforce and working environment (Curtis et al., 2019).

Te Tiriti o Waitangi

Aotearoa's original founding document was He Whakaputanga o te Rangatiratanga o Nu Tirene: the Declaration of Independence of the United Tribes of New Zealand, signed in 1831 by 13 Ngāpuhi chiefs (Ministry for Culture and Heritage, 2022).

In 1840 more than 500 Māori chiefs and representatives of the British Crown agreed to Te Tiriti o Waitangi. Most of the Māori chiefs signed a copy in the Māori language, agreeing to give the British queen (Queen Victoria) te kawanatanga katoa (governance or government over the land) whilst retaining te tino rangatiratanga (the exercise of chieftainship over their lands, villages and taonga katoa – all treasured things). In return, the Crown gave an assurance that Māori would have the queen's protection and all rights accorded British subjects (Orange, 2012).

As Healthcare professionals in Aotearoa we must recognise and respect Te Tiriti o Waitangi (Treaty of Waitangi). Te Tiriti provides the health sector with a framework for Māori development, health and wellbeing (NCNZ, 2020).

NCNZ defines four principles of Te Tiriti that form the basis of interactions between nurses and Māori health consumers. The first principle enables Māori self-determination over health, recognises the right to manage Māori interests, and affirms the right to development. The second principle involves nurses working together with Māori with the mutual aim of improving Māori health outcomes. The third principle indicates that nurses must recognise that health is taonga and act to protect it. The fourth principle requires that the nursing workforce recognise the citizen rights of Māori and the rights to equitable access and participation in health services and delivery at all levels (NCNZ, 2011).

The historical "three P's" — partnership, participation and protection, which came out of the Royal Commission on Social Policy in 1986 — are now outdated and said to reflect a reductionist view of Te Tiriti (Beri, 2019). NCNZ have recently described five enhanced principles, premised on the Waitangi Tribunal Claim — Wai 2575: the Health Services and Outcomes Inquiry. These are Tino Rangatiratanga (self-determination), Pātuitanga (partnership), Mana Taurite (equity), Whakamarumarutia (active protection), and Kōwhiringa (options) (NCNZ, 2020).

Tikanga

Tikanga can be described as patterns of appropriate behaviour including

customs and rites (Ministry of Health, 2014). The concept is derived from the Māori word 'tika' which means 'right' or 'correct'. In Māori terms, to act in accordance with tikanga is to behave in a way that is culturally proper or appropriate.

The basic principles underpinning tikanga are common throughout Aotearoa; however, different iwi (tribes), hapū (sub tribes) and marae (Māori community meeting places) may have their own variations (Victoria University of Wellington, n.d.). Tikanga encompasses, amongst other things, karakia tapū (incantation or prayers), rahui (a temporary ritual prohibition), rangatiratanga (self-determination), kotahitanga (unity/oneness), wairuatanga (spirituality), manaakitanga (showing respect/kindness) (MOH, 2014). Values include the importance of te reo (language), whenua (land) and in particular whānau (extended family) (Auckland DHB, 2013).

Tikanga best practice is focussed on Māori as it reflects Māori values and concepts. However, policies and delivery of care is relevant regardless of ethnicity as they reflect best practice standards of care and processes, assisting in provision of quality care for everyone (Auckland DHB, 2013). Tikanga best practice reflects the intent of tapu (restricted) and noa (free from restriction). For example, food is considered noa and kept separate from bodily functions, which are tapu, therefore anything that comes into contact with the body or substances must be kept separate from food (Auckland DHB, 2013).

Māori health is a complex interaction with multiple dimensions, extending beyond the physical being and medical diagnoses. Māori identity, beliefs, values and practices are considered significant factors that contribute to holistic wellbeing (NCNZ, 2011). Te Whare Tapa Whā (the four cornerstones/sides of health) model of health developed by Tā Mason Durie represents a Māori view of health and wellness in four dimensions. These are identified as taha wairua (spiritual health), taha hinengaro (mental health), taha tinana (physical health) and taha whānau (family health) (Purdy, 2020).

Holistic, culturally safe care of Māori patients considers all four of these dimensions. For example, karakia (blessings/prayer) is essential in protecting and maintaining wairua, hinengaro and tinana aspects of a tāngata whaiora (Māori consumers/clients/patients).

Examples of Tikanga in Practice

All staff must introduce themselves and explain their role and service to the tāngata whaiora (Māori consumers/clients/patients) and whānau during all encounters. Where appropriate, an interpreter should be offered (Auckland DHB, 2013).

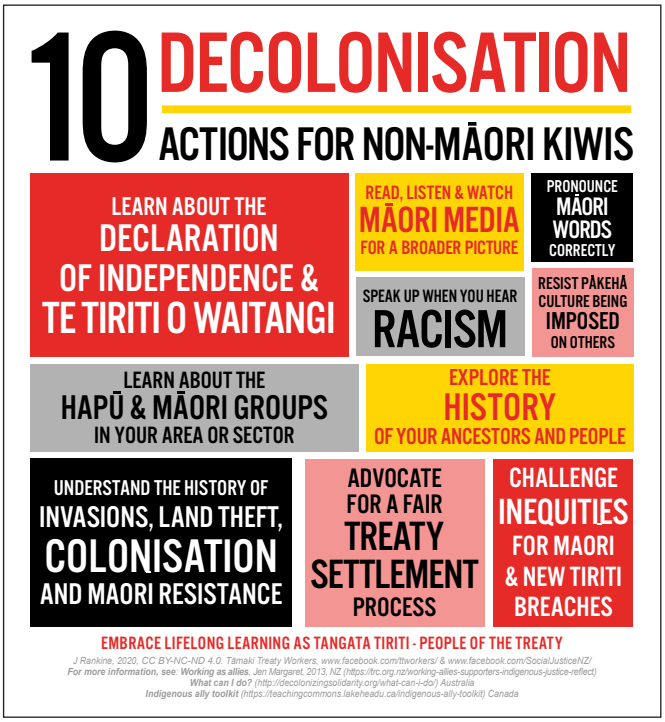
Tāngata whaiora and whānau should be actively encouraged, included and supported by staff to be involved in all aspects of care and decision making. At all times, tāngata whaiora and whānau should be offered the opportunity for karakia, unless physical care of tāngata whaiora is compromised. If karakia cannot occur, staff must sensitively explain the reasons and discuss options.

Taonga (valuables/heirlooms) should only be removed if leaving them on will place tāngata whaiora at risk. Consent is required from tāngata whaiora or whānau before removing taonga and they must be given the option of removing taonga themselves. Wherever possible, taonga should be taped to the tāngata whaiora. Whānau should have the option of caring for removed taonga, or it should be stored in an identified valuables safe (Auckland DHB, 2013.)

One example of tikanga particularly important in the perioperative environment includes the removal of body parts, which is considered tapu, regardless of how minor the part/tissue or substance is perceived to be by staff. The patient and whānau must be consulted with prior to removal and return of body parts, tissues and fluids. In the case where body parts are to be returned to the patient and whānau, these should be returned in a manner that reflects the appropriate tikanga practices that are set in place and should be checked by appropriate Māori staff before returning it back to members of the patient's whānau (Elias, 2018).

Staff should give clear verbal explanations of procedures with tāngata whaiora and whānau as early as possible. This is important when the removal or retention of a body part is involved, especially amputations. The procedure needs to be explained, and both verbal and written consent required. Time should be allowed for consultation between the tāngata whaiora and their whānau, unless their physical well-being is at risk. This allows tāngata whaiora to uphold the tikanga of whanaungatanga (sense of family connection) so that they can feel comfortable and more confident with their decision (Elias, 2018).

Consent for the retention of all body parts and tissues is required and these must be stored and labelled correctly in case they are requested to



be returned. An example of this is during childbirth many Māori request that the placenta is returned to the whānau. This is because the placenta is translated into whenua (placenta/land) and many people choose to bury the placenta and plant a tree over it sustaining new life and making a connection back to the whenua. This is an important tikanga as it enforces tāngata whenua (association with the land, home), just like the umbilical connections between an unborn child and its mother as well as the belief that Māori come from Papatūānuku (Earth Mother) as though they were born from the land itself (Elias, 2018).

Culturally safe care of tūpāpaku (deceased) patients is also highly important in the perioperative environment. Care should be taken to ensure the safety and non-violation of mana (integrity/prestige) and tapu (sacredness of the tūpāpaku at all times. Staff must ensure care of tūpāpaku is performed with compassion, reducing distress to the whānau as much as possible. Any death can be extremely difficult for the whānau to cope with and it is important that an appropriate Maori health service is made available to provide support (Auckland DHB, 2021).

The whānau will require time with the tūpāpaku as part of the grieving process and should be given as much time as they require whenever possible. Another area should be found for the tūpāpaku and whānau if the OR is required. The whānau may wish to stay with the tūpāpaku and wherever possible they should be supported to do so. If this is not possible, for example if the coroner specifies, a full explanation should be given. The whānau should be asked if they want to participate or assist with cleaning and laying out the body and any cultural practices or requests adhered to. Care must be taken with taonga, which may be released to whānau (Auckland DHB, 2021).

Services should have a predetermined pathway for movement of tūpāpaku. Pathways must avoid public areas and pathways where food or dirty linen is present wherever possible. Whānau should be allowed to accompany the tūpāpaku when being moved. Tūpāpaku should be moved feet first, however the wishes of the whānau should always be respected as to how tūpāpaku are moved (Auckland DHB, 2021).

Māori nurses

Evidence suggests that a culturally diverse workforce can improve cultural competence of both health systems and health professionals, in turn creating improvements in patient outcomes (AORN, 2022). Māori nurses comprise eight per cent of the Aotearoa nursing workforce (NCNZ, 2019). The Māori nursing workforce is crucial to the delivery of high-quality, culturally responsive healthcare services and for Māori and their family/whānau to feel culturally safe (Wilson, 2018).

Nurses who identify with Māori ethnicity are critical to enabling achievement of Māori health equity (Wilson, 2018). The Aotearoa Ministry of Health standard for achieving equity is that the proportion of Māori nurses matches the proportion of Māori in the population (New Zealand Ministry of Health, 2018), which is 17 per cent (Statistics NZ, 2019). This indicates that Māori are currently underrepresented in the Aotearoa nursing workforce, and thereby likely to be under-represented in the perioperative nursing workforce. It is crucial that healthcare organisations actively work towards recruiting Māori nurses as part of our Te Tiriti responsibilities.

Local Research

A recent Aotearoa study on nurse staffing practices in the OR found that ensuring patients had their cultural needs met during their perioperative experience was an essential element of safe patient care (Taylor, 2021). Findings support the need for nurses to understand and practice tikanga best practice.

The study identified that part of culturally safe patient care included accepting the patient as an individual with specific cultural needs. Findings indicated that culturally safe care includes ensuring that the patient's cultural and religious beliefs are respected and supported,

with family/whānau considered as part of the patient's holistic care. Having family/whānau surrounding them was seen to be particularly important to Māori and Pacific patients. An example of this was making allowances for the family/whānau to come to the pre-operative area with the patient, so they could be with them right up to the time they go for surgery (Taylor, 2021).

Findings also indicated that to support provision of culturally safe care training should be provided. This training should include tikanga best practice, considered essential to ensuring culturally safe care for Māori patients, to ensure responsibilities under Te Tiriti o Waitangi are fulfilled (Taylor, 2021).

An identified limitation of the study was the lack of Māori nurse participants. One of the study's recommendations was for further research to ascertain what culturally safe perioperative nursing care looks like from Māori nurse perspectives, as well as Māori patient and family/whānau perspectives (Taylor, 2021).

Conclusion

To ensure provision of culturally safe care, all nurses working in Aotearoa should have an in-depth understanding of the revised principles of Te Tiriti o Waitangi. It is not enough to be able to cite the outdated 'three 3's'. As a health system it is imperative that we ensure access to appropriate cultural safety training and education alongside monitoring actively for all new and senior nurses from Aotearoa and those who are internationally qualified nurses. Perioperative nurses must have knowledge of Te Tiriti and an understanding of Tikanga principles, including the Te Whare Tapa Whā model of health. More research is required on what more can be done to provide culturally safe care within the perioperative environment.

About the Authors

Tēnā koutou katoa. Ko wai au?

Ko Maungataniwha te maunga. Ko Tāpapa te awa. Ko Ngātokimatawhauroa te waka. Ko Mangamuka Marae te marae. Ko Ngāpuhi te iwi. Ko Rangi Blackmoore - Tufi tōku ingoa.

Rangi Blackmoore-Tufi *completed her nursing degree in Te Matau a Māui (Hawkes Bay) at Te Aho a Māui (Eastern Institution of Technology). She moved to Tāmaki Makaurau (Auckland) to start her nursing career which began in rehab/stroke under the NETP programme. She decided she wanted to become more specialised, this is where she began her career in the perioperative department. Rangi works part time in the community for an outreach team providing services to Māori and Pacific Island whanau. She is one of two proxies for the Tāmaki Makaurau region for Te Rūnanga o Aotearoa.*

Bron Taylor, *R Comp N, MN (First Class Hons) is the Whakahaere Nāhi |Associate Nurse Director – Workforce Development, Education and Training for Āhua Tohu Pōkangia | Perioperative Services at Te Toka Tumai | Auckland DHB. She completed a Masters of Nursing through the School of Nursing at the University of Auckland last year. Her research explored OR nurse staffing in an Aotearoa | NZ context. She is the current Chief Editor of The Dissector.*

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