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Reflection / Huritau

Answering the call: Academic nurse educators returning to practice on the eve of COVID-19

Jenna Blunden[1,2], MAdvPrac(Crit Care), CTLT, RN, Clinical Lecturer

Michelle Poulsen[1], MHealSc, RN, Clinical Lecturer

[1]*Department of Health Practice, Ara Institute of Canterbury Ltd, Christchurch, Aotearoa New Zealand*
[2]Corresponding Author: jenna.blunden@ara.ac.nz

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Abstract

Prior to Aotearoa New Zealand's first COVID-19 related death there was an urgent regional need for frontline prepared registered nurses with highly specialised skills. In these exceptional circumstances nursing academics can provide a workforce reservoir to meet this exigent need. In the early stages of pandemic response planning, a district health board sought support from a local provider of nurse education, asking for nurse academics who were willing to return to practice. Learnings highlighted the value of academic staff having clinical currency allowing them to meet moral and professional responsibilities. Furthermore, it is evident that a collaborative relationship between education and healthcare providers can allow access to frontline prepared, highly skilled registered nurses to be called upon in a time of need.

Keywords: COVID-19, lecturer-practitioner, nursing, return to practice

Introduction

The call to return to clinical practice came during the first week of the 2020 nation-wide lockdown, where several registered nurses were placed in isolation after potential exposure to COVID-19. Our personal experiences as academic nurse educators returning to specialised clinical practice under extraordinary circumstances provided an opportunity for reflection.

Reflection is a meaningful tool used in nursing to actively engage in a process of analysis and evaluation to inform change for future practice (Bulman & Schutz, 2013). Borton's model of reflection uses three questions *What? So What? and Now What?* to assist in the systematic deconstruction of experiences (Borton, 1970; Williams et al., 2012). The first question *What?* allows practitioners to consider what has happened during the experience. The second question *So What?* gives meaning to the experience through evaluation as part of the transformative stage of learning. The final, and arguably most important, question *Now What?* provides an opportunity to use insights and understanding gained through the process to inform future practice (Skinner & Mitchell, 2016). Borton's (1970) framework has been selected as a guide to reflect on the personal, professional, and institutional response to an unexpected staffing crisis on the eve of COVID-19 in Aotearoa New Zealand.

What?

In March 2020, prior to Aotearoa New Zealand's first COVID-19 related death, there was an urgent regional need to identify frontline prepared registered nurses with specialty skills. In the early stages of pandemic response planning, a district health board sought support from a local provider of nursing education, asking for full-time nurse academics who were willing to return to practice if, or when, required. Nursing management of invasive mechanical ventilation was high priority in the event of rising COVID-19 cases (Gilroy, 2020). Co-location of a DHB and nursing educational institute allowed for greater visibility, and ease of access for the DHB to identify clinically competent registered nurses with critical care experience. The call to return to practice for both of us, as nursing lecturers, came earlier than

anticipated. It was sudden and time critical due to staff in a regional hospital being required to isolate, following potential exposure to an active COVID-19 case (West Coast District Health Board (DHB), 2020). This left the hospital significantly understaffed and in need of urgent clinical support. Less than 48 hours after receiving the call, lesson plans were swapped for stethoscopes and scrubs.

So What?

The decision to 'answer the call' was borne out of a commitment to nursing that necessitates registered nurses act as moral agents in their provision of care (Water et al., 2017). Such a commitment was considered by us to be applicable irrespective of an educational or clinical setting. A principle concern was one of personal safety and the potential impact on whānau (family). At this time the reality of COVID-19 in the healthcare setting had only been portrayed through international media reports (BBC, 2020; Regencia et al., 2020). Documented deaths included not only those of patients, but also that of frontline healthcare staff worldwide (Kavanagh et al., 2020; Keles et al., 2021).

While personal confidence in clinical capability and healthcare infrastructure in Aotearoa New Zealand was high, apprehension about an unfamiliar work environment existed. The greatest concern stemmed from the impact on personal life and the length of separation from family and dependents. Whānau were worried about potential exposure to the virus and subsequent transmission into the family home. This appeared to be consistent with experiences reported internationally from frontline nurses caring for patients affected by COVID-19 (Catania et al., 2021; Galehdar et al., 2020; Shen et al., 2020). It was important to acknowledge such anxiety and fear, and fortunately there was an understanding of the moral and professional responsibility required to assist in a time of crisis.

The relationship that existed between the DHB and education provider ensured that this professional obligation to the wider community could be fulfilled (Carbery, 2019). Due to the pressing circumstances, an immediate decision was made by the chief executive and acting head of department to facilitate our release into practice. The logistics of redeployment from an educational to a clinical setting were only realised en route to the regional hospital. There were no existing systems in place to facilitate a reassignment of this nature. In this extraordinary time the usual employment processes were bypassed in favour of an arrangement that reflected a loan of us, as lecturers, to the DHB. Subsequently, it was agreed that a salary would continue to be paid by the educational institute and remuneration would be sought from the DHB at a later date. Trust in the existing relationship between the educational and clinical providers permitted a seamless transition to practice and allowed the focus to be on the job at hand.

Arrival at the hospital was met with a sense of profound gratitude from staff for the willingness to respond to clinical need which included working in the critical care unit that same evening. There was recognition and celebration of solidarity, unification in a time of crisis and teamwork, which embodies the key values of nursing pioneered by Florence Nightingale (Phillips & Catrambone, 2020). Nursing Council of New Zealand (2012) states that a fundamental requirement of professional nursing relationships and ethical conduct is collegial respect. This was upheld by a willingness to fill the roster gaps and provide a level of flexibility that facilitated existing staff their rostered time off.

Now What?

It is our opinion that in exceptional circumstances nursing academics can provide a workforce reservoir to support existing clinical staff. Reflection on the experience suggests that a collaborative relationship between education and healthcare providers can allow access to frontline prepared, highly skilled registered nurses in a time of need. Learnings from this experience emphasise the value of academic staff having clinical currency, allowing them to meet moral and professional responsibilities in a pandemic or disaster response (Jackson et al., 2020). The implications extend further still. Recognition on the part of the educational institute to facilitate academics in retaining their clinical competence is not only beneficial for the credibility of the educational provider, but for the nursing profession and its many stakeholders (van Oostveen et al., 2017). We believe there to be considerable value in joint appointments between academia and clinical nursing. Yet the lack of institutional support to promote dual clinical and academic nursing roles would appear to be counterintuitive to upholding evidence-based practice (Gibson, 2019). It is our view

that the two roles are not mutually exclusive and given careful consideration could positively influence the quality of nursing education, healthcare delivery, and job satisfaction.

The opportunity to participate in Aotearoa New Zealand's COVID-19 nursing response allowed for a meaningful contribution to frontline nursing in unprecedented times. A moral premise of caring, and the trust that nurses have a commitment to do only good, underpins the foundation of nursing (International Council of Nurses, 2012; Water et al., 2017; New Zealand Nurses Organisation, 2019). Leaving family behind to step into the unknown on the eve of COVID-19 was motivated by the pull to clinical nursing and the urgent request for a highly specified skill set. The redeployment was, however, not entirely altruistic. A sense of value and pride was evoked in being able to practice the specialty skills that had been developed over many years of nursing in a critical care setting. The experience proved both exciting and daunting and was driven by the overriding feeling of being compelled to 'answer the call'.

Whaea taku toa I te toa takatahi taku toa takitini taki mano e

It's not by my own self but by that of the many

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