

TE PUAWAI

The Blossoming



The Professional Update for Registered Nurses

NOVEMBER 2009

TE PUAWAI

The Blossoming

Whakatauki

Kia tiaho kia puawai te maramatanga

*“The illumination and blossoming
of enlightenment”*

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

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College of Nurses Aotearoa

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Professor Jenny Carryer

RN, PhD, FCNA(NZ), MNZM

Executive Director

Recently I had the opportunity to attend the Cartwright Comes of Age seminar in Auckland. The seminar was held to mark the 21st anniversary of the release of the Cartwright report and was a forum for critical and consumer perspectives on the major themes and recommendations from the Cartwright enquiry.

One theme raised during the day was the realization that there will be a number of people working in health services now for whom the words Cartwright Enquiry may hold little meaning. Accordingly let me just bring any such readers up to speed. The Cartwright enquiry was convened in 1988 to investigate the management of women with abnormal cervical smears at National Women's hospital in New Zealand during the 1970s and 1980s. During this period Dr Herbert Green tested his theory that carcinoma in situ (CIS) was not always a precursor of invasive disease by constantly reviewing women rather than actually treating the disease. Most importantly women were unaware that they were essentially part of an experiment and many important issues such as informed consent

remained unaddressed. Some women died and many women were subjected to prolonged investigation and review.

Justice Sylvia Cartwright presided over the enquiry and produced a report, which was strongly critical of the care the women had received. The report recommendations have subsequently been responsible for our processes around ethical approval of research, the requirements for informed consent and the establishment of the Health and Disability Commissioner role and the Code of Rights. In addition recommendations stressed the need for care to become patient rather than provider centered and it was this theme that I was asked to address at the workshop and would like to share in this editorial

It has been said that to be sick or to be a patient is a situation of immense vulnerability. Whilst that is undoubtedly true and important twenty-one years later we might want to expand the notion of patient centeredness to consumer or people centered care but the principles or concerns remain the same.

In 1976 my experiences as charge nurse of an oncology ward made me very aware of the value of patient centered care. I was a very new charge nurse and the notion of oncology wards was previously rare. I established a number of processes which involved making it possible for families to be constantly present in the ward by providing food, spare camp stretchers or lazy boy chairs and making family members feel welcome and included. It was extremely gratifying to see the difference in patients who were thus supported.

Doing these things put the patient at the centre by meeting their needs regardless of institutional rules and strictures. My mother (as a registered nurse from the 1950s) found such practices quite unbelievable but went on to acknowledge the value and still speaks of her own unresolved anguish about the treatment of hospitalized children in her era. Parents were required to drop their very young child at the door and to return only when called to collect the child after a week or ten days or however long the admission was.

History has not had the patient at the centre and it is salutary to wonder how such cruelty could have been approved ostensibly on the basis of minimizing disruption to institutions and to health professionals

themselves. Patient centeredness is, as much as anything, a state of mind and our historical state of mind has been slow to reach that point.

In 1847 the first official Act of the American Medical Association was to adopt a code of ethics. The contents of that code which can be found on line were revealing. In the section on patient obligations it stated that

- 1) A patient should never weary his physician with a tedious detail of events or matters not appertaining to his disease.
- 2) The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them.
- 3) Never do anything about your own health care without consulting your physician

As per its time or era this Code of ethics captured a particular world- view. It also rendered women invisible. It is easy to see how such a world-view combined with the relative positioning of women in the world created a legacy whereby women especially could be treated in particular ways as they were at National Women's hospital. But we have now moved to a position post Cartwright and through the Code of Health and Disability Consumer rights where patient centeredness is central to our discourse meaning that at least we talk and write about it constantly.

There is now growing evidence to show that putting the patient at the centre of our thoughts and actions makes a difference to outcomes especially in long-term conditions and patient centeredness is now seen as central to the quality agenda. There is much talk about the expert patient and about shared decision making. The key principles are now largely accepted and they include the responsibility of health professionals to provide full information at all times and to involve people in decision- making in a transparent manner. Protection of dignity is of paramount importance and there is continual discussion about the need for and value of continuity of care

Sadly I am not sure we have moved very far beyond the rhetoric of "patient" centered care. Several

issues give me concern. Central to patient centered care and notions of the expert patient is the idea of patient's responsibilities. This is all very well but allows for potential tension arising between patient responsibilities and the possibility of patient (or victim) blaming. There is potential for this to be exacerbated by the resource-constrained environment, which is the current and future situation in health service delivery

Just recently we have seen the demise of the Primary Health Care Advisory Council seemingly triggered at least, by GP concern with a new service models package which the multi disciplinary Primary Health Care Advisory Council had spent 18 months discussing, consulting, writing and approving. General Practitioner concern expressed by NZMA and RNZCGP members of the Council noted that in the new service model described there was insufficient importance attributed to the role of the GP in first contact care .

There is little notion of patient-centeredness in this decision and from my personal perspective it shows a strongly provider centric basis for decision-making. The service models package was very focused on patient centered care, on issues of access and of planning for a current and future context where GP availability is very scarce in many areas.

On a different note (but equally importantly) much research over the last 20 years shows that nurses who have long been educated in a patient or rather person-centered framework have absorbed and adopted the dominant provider centric ethos within months of commencing practice; largely as a survival mechanism. It is interesting to see how much they regain that focus when they work in certain environments such as a hospice, which are by their very nature people, centered.

Patient centered care is both an attitude and a practice focus and it is hard to say which one comes first?? Currently I think our structures and funding and leadership models continue to favour a medical model of care and leadership rather than a patient centered model. There is a self-fulfilling circuitous process in place in which attitudes and beliefs shape our infrastructure and our infrastructure shapes our attitudes and practice. There is a huge amount of work to be done before the rhetoric of people or patient centered care becomes our reality.

College Board Member Election

Debbie Penlington has recently resigned at the end of a long term as a College Board member and as co-chair person of the College. We are very sorry to lose her wise and gentle counsel, her attention to detail and her superb ability in chairing meetings. Recently there have been considerable demands on her personal time and combined with a demanding job at MIT she has made the decision to resign from College leadership. We extend a sincere thank you to Debbie from the Board of the College and on behalf of the membership .

Debbie's role as co chair has been taken up by Board member Judy Yarwood but her resignation leaves a vacancy in the Non- Maori caucus of the College Board. Accordingly we have called for nominations and now request that members vote for one of the two nominees listed here.



Angela Bates
RNRMRHV BA (Hons) MA, Msc

I qualified as a registered general nurse in the UK in 1980. After qualifying I worked for 12 months as a staff nurse on a medical ward at a large general hospital in the North West of England before undertaking midwifery training. I spent the next five years working as a midwife but I felt too constrained in the hospital environment and decided to move into primary health care.

In 1988 I qualified as a health visitor (specialist community public health nurse) and for the next 7 years I worked in some of the most deprived areas of England. During this time I was struck by how resourceful people can be when faced with adversity, I saw the effects poverty has on individuals, families and communities. This ignited my passion for addressing disparities. My work as a health visitor involved working with children and families to

address child protection issues so when a position became available as a senior designated nurse for child protection, it seemed an appropriate career move to make. The role involved supporting and working with health professionals, investigation of child deaths, developing child protection training packages and policies.

In 1998 I completed an MA in child care law and practice at Keele University UK. That same year I moved with my family to Scotland where I spent 2 years working with homeless people delivering nurse led primary care services.

In 2000 I moved back to England and was instrumental in developing the health services for the homeless people in Chester. The following year I received the Queen's Nursing Innovative and Creative Practice Award which included a 12 month personal development workshop. Much to my delight the award ceremony was held at the prestigious Café Royal in London. I obtained a Master's in clinical nursing at Liverpool University in 2004.

My work with vulnerable homeless people led to a career in prison health, which at the time was going through great change and transition. I worked at the largest training and rehabilitation, category C, prison in the UK for 3 years before emigrating with my family to New Zealand in early 2006.

I have had several roles since coming to New Zealand and I am currently employed in Wellington as a Primary health care nurse specialist working in a variety of settings. I truly believe that every individual has a right to high quality care regardless of their situation or where they live. I remain passionate about reducing inequalities in health and improving access to health care for vulnerable populations. I am committed to the development of nursing and raising the profile of nurses, as we are in the privileged position to make a difference to the lives of the people we serve.

I have recently taken on the role of Primary Health care Coordinator within the College and would see a board membership as bringing Primary Health care issues to the centre of College Attention.



Dr Jill Clendon
RN MPhil (Hons) PhD
(Nursing)

I am an academic staff member at Nelson Marlborough Institute of Technology teaching in the Bachelor of Nursing programme. My teaching and research focus is primary health care. Examples of my research include examining child health outcomes in nurse-led clinics, qualitative evaluation, community needs analysis, the history of the Well Child/Tamariki Ora health book, and enhancing the preparation of undergraduate nursing students to take up positions in older adult care. I have a clinical background

in paediatrics and primary health care working most recently for the Nelson Marlborough District Health Board during the recent influenza pandemic.

I am actively involved in primary health care in the Nelson region, being a member of the regional primary health care nurse advisory group and the Nelson Bays Primary Health Organisation Clinical Governance Group.

I am passionate about primary health care and the provision of effective nursing care to individuals and families in the context of their communities. Nursing has the potential to positively impact on health outcomes in a variety of ways and it is imperative that we continue to work toward effective upskilling of nurses to take on the challenge of achieving this goal. This will be through effective education, leadership, and mentorship. The College of Nurses has a key role to play in meeting this challenge both through their contribution and voice in governmental policy development and by providing effective leadership and mentorship for nurses at all levels.

I would like to see the College improve its profile among nurses in all sectors as a voice of advocacy on professional nursing issues. As a group of individuals we need to use our voices to speak with our colleagues and clearly articulate the role of the College in New Zealand and how our colleagues can be involved.

I have been a member of the college for over 10 years and am proud to be involved in an organisation that actively canvasses all its members to become involved in those issues that directly impact on our practice as nurses – it is this role that makes the College unique and something we must build on as we seek to widen our membership base. It would be an honour to be a member of the Board as the College works toward reinvigorating its role in New Zealand nursing into 2010 and beyond.

Vote in the College Board Election.

Vote online - Log onto www.nurse.values-exchange.org.nz

First time users of the College Values Exchange, Sign in using your email address (the one you receive college emails on) and use the password 'values'. Voting in the College election via Values Exchange is completely anonymous and only available to registered College Members. If you have any questions about voting online please contact the College office on (06) 358 6000 office hours are 9.30-3.00.

Vote by Post - If you are unable to vote online please vote for your preferred new College Board member here. Post by 15th Dec 2009 to the College office - PO Box 1258, Palmerston North 4440

Angela Bates

Jill Clendon

“Depo-Provera, Is this an ideal contraceptive for young people, but what about depression”?

Depot-medroxyprogesterone acetate (Depo, or depo-provera), was thought to cause changes in mood among women using it for contraception. The purpose of this short article is to consider the current research about the effect of Depo on mood and if this contraceptive choice can be used with young women with a past or current history of depression. The paper critically reviews past research articles concerning the use of depo.



Nurse Practitioner, Louise Roebuck in her Waves consulting room.

Working with young people in school settings, at Family Planning Clinics and at Youth One Stop Shops, some of the issues presenting are to do with contraceptive and sexual health. I am often faced with vulnerable at risk youth who have become sexually active at a young age. Many of these young women have chaotic lives, have come from a neglected and abusive past and taking the oral contraceptive has found them facing unplanned pregnancies as they find it difficult to take a pill every day. Others choose depo as it is convenient, just four injections a year, it suits their life style at this time in their lives. Many of these young women have also had past and present depressive episodes, are self harming and also dealing with sexual abuse,

neglect and trauma from their past lives. Mental health practitioners have been concerned that depo may be associated with changes in mood or even an increase in their depressive symptoms. The purpose of this paper is to look at research and best practice so we can offer young woman with a choice that suits them, without the need for concern that this will cause further increases in their depressive symptoms.

Depression and depo-provera, fact or fiction?

In the 1970's early clinical trials of depo suggested from some data a small percentage of women reported negative mood changes (Cromer, 2000). These studies have shown that they all shared a

crucial flaw, they failed to collect baseline data on mood prior to depo starting, so this was not accurate in estimating the increased incidence of depression. Cromer (2000), concludes that if investigators do not collect noticeable information before initiating hormonal treatment, they cannot be certain that adverse effects are not attributable to the treatment, rather than representing symptoms that the woman had prior to commencing on depo.

82% of pregnancies in the 15-19 age group in the United States are unintended, nearly 100% in young women under 15. As the failure rate of depo is 0.3% this method is the top tier of contraceptive efficacy (Whitaker & Gilliam, 2008).

Westoff (2003), states that depo-provera is a highly effective contraception option that many woman prefer to use. This clinical trial was held over one year and included young women in a Primary Health Care practice, an adolescent clinic, a Family Planning Clinic and a psychiatric hospital. Of the 3857 women in the study less than 2% report depression. Westoff (2003), concluded that depo does not cause depressive symptoms; these young women would present with depression regardless of the hormonal injectable contraceptive they were on.

In 1992 the World Health Organisation published the results of a nine year study of women using depo. The overall data showed no increase in depressive symptoms; the study included women who had more depressive symptoms at study entry. For all women there was no increase in symptoms over the course of the study.

Gupta, O'Brien and Jacobsen (2001), did a 12 month prospective study in adolescents, this similarly showed that there was no emergence of depressive symptoms or significant change in negative or positive affect. A prospective study set in a United States urban clinic amongst young, poor Hispanic inner city women compared adolescents on depo to controls. These young women were known to have a higher prevalence of depression. They used the Beck Depression Inventory (BDI) and the Multiple Affects Adjective Checklist, Revised. (MAACL-R). This study found that there was no statistically significant differences in depressive symptoms when using depo as a contraceptive over a period of one year and there was no significant changes in negative or positive affect (Haider & Darney, 2007),

DEPO PROVERA USE AND YOUTH...

Poem written by Lou Roebuck

June 2009

*You're about to hear about depo and youth
Listen to me as I hear the truth
They often have issues and feel real bad
However this was happening years before the JAB*

*Lives of abuse, neglect and dysfunction
Terrible things happening, always something
Some people think depo is real risky
But we all know young people can be frisky*

*How the hell can some take the pill
Every day, not an option, when at the pub and the mill
Drinking and fighting, look at what's real
Get over ourselves, reach out and feel*

*Let's look at the research, depo can be the right thing
To stop the pain from an overnight fling
They come to us horny, maybe smoking a bong
Preventing youth having depo, may be very wrong*

*Look at the options and way them up
Trust us at Family Planning and youth one stop shops
Ask the right people, get the right advice
Depo is ok, is safe and is alright*

*Depo is not the cause of mood swings
This is caused by many other things
At times it is needed to keep the kids safe
Depo certainly has its place*

*Look at the lives way before they had sex
We all know this has had a negative effect
Depo provera is an option at times
To help our young women in their lives*

*Listen again to the research, keep up to date
Our youth rely on us, to be safe with their mates
We need to advise, assist and let them know
The safe way to have sex, have fun and give life a go*

*As health professionals supporting youth
They need to hear all, including the truth
Depo is not a bad thing for them to have anyway
It can provide safety and protection today*

*No matter what we teach, say and do
We always need to stay very true
Depo is an option, can be the right one
As we all know youth want to have fun*

A study by Boroditsky (1999), considered fatigue and depression alongside depo provera use in adolescents. His study highlights the difficulty in reporting of these symptoms and subjective reporting can be markedly increased just by the type of and frequency of questioning. There are so many other variables to consider including recent onset of sexual activity, interpersonal and intrapersonal issues which can have a major effect on young women whether on depo or not. Boroditsky, a Canadian gynaecologist, advises that many young, single women often change relationships, and he has seen many practitioners choose depo as an ideal contraceptive as first line therapy for young women with significant psychosocial problems, communication difficulties, language barriers, developmental challenges and other medical conditions that would contraindicate the use of other methods e.g. deep vein thrombosis and epilepsy. These young women were often reporting disrupted life styles, living on the streets or couch hopping and wandering through life with no fixed routine. Depo is often a better option for this group as an unplanned pregnancy will cause a lot more stress and bring up other issues such as teen pregnancies and terminations.

Cromer (2000), looked at a large group of young people that were on depo and those that were not on any hormonal contraception. 397 women were enrolled in the study. Adolescent depression prevalence has been reported to range in a western population from .4%-8%. This study has demonstrated that the use of depo for contraception does not result in depressive symptoms or worsening of a pre-existing depressive state. If the young woman had a pre existing depressive state depo does not worsen their mood and may be associated with an improvement in affect over a period of one year.

Civic et al, (2000), also researched depo-provera use and depression. They found that practitioners have often reported depression and young users of depo, although this has not been found in research and clinical trials. This study further looked at women who had stressful or chaotic lives that were more likely to be depressed, and due to this were more likely to choose depo as a contraceptive that is reliable and long acting. They concluded it was likely depression was more linked to situational causes rather than biological ones. Edinburgh &

Saewyc, (2009), have shown that when working with runaway, sexually exploited girls in the United States, depo is often the best method of contraception and also they had seen no increase in depressive symptoms amongst this group of young women.

Westoff et al (1998), followed 497 women over a one year period and found no increase in depressive symptoms. The women who scored higher in depressive symptoms before starting depo, experienced a decrease in depressive scores during the study. The results from this study suggest that use of depo provera should not exacerbate symptoms with pre-existing depression. Although these findings do not rule out the occurrence of mood changes using depo, they do not support withholding this injectable contraceptive due to concerns regarding possible mood changes. The concluding comments from all studies have found women should be advised that mood changes can occur for all women both positive and negative using depo provera, as in other women on no hormonal contraception or using another method of contraception.

As a Nurse Practitioner working with young people in Taranaki I am often faced with supporting young people in making the right choice for their contraceptive method which is the best option for them at this time in their lives. In all studies researched there has been no evidence to suggest an emergence of depressive symptoms on depo, nor was there any evidence to show significant changes in negative or positive affect. Many of the young people I see have come from a dysfunctional background, have histories of abuse and neglect and have become sexually active at an early age. They are also engaging in other high risk activities including the mis-use of drugs and alcohol. For me these young people do very well on depo provera. Many have a trial of the combined oral contraceptive and have reporting losing it, forgetting to take it or just can't be bothered. Many don't want their caregiver/whanu/parent to know they are sexually active and prefer an injection as no one is about to find their pill in a bedroom drawer. All these factors need to be taken into consideration when supporting a young person with a form of contraception. These studies have shown that a diagnosis of depression should not prevent a young person from having depo provera offered

to them as a contraceptive option. Many mental health practitioners are advising young women with a past history of depression to use Yasmin a combined oral contraceptive. For many this is not an option as the cost is around \$120 for 6 months and also means remembering to take a pill every day. Other low cost combined oral contraceptives may be just as effective.

Guillebaud a Professor of Family Planning and Reproduction, London does not see depo provera as a problem to use with women who have had a history of depression. He states that 'any past severe endogenous depression requires above average support'(2004,p.338). This is not a contraindication to use but as with anyone who has depression, additional support should be in place to monitor their moods.

Conclusion

Depressive symptoms are often high in young women, but all studies reviewed have found no increase in depressive symptoms after one year of depo provera use. Concerns that depo may cause mood changes or worsen pre existing depressive symptoms are unfounded and may exclude a large population of adolescents who may potentially benefit from the use of this contraceptive agent. Contraceptive and reproductive health experts advocate the use of depo provera in women regardless of their depressive symptoms. As in any clinical cases, all factors need to be taken into consideration. There is no evidence to suggest an increase in depression when using depo provera. We should not be denying young women of depo provera when this may be a very acceptable and affordable means of contraception for them. It is a discrete, convenient and low maintenance method, ideal for adolescents with or without depression.

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The Therapeutic Uses of Ache

Glenn Colquhoun is a doctor, poet and children's writer. His first poetry collection, *The Art of Walking Upright*, won Best First Book of Poetry at the 2000 Montana New Zealand Book Awards. In 2003 he won the Poetry Category and also became the first poet to be awarded the coveted Montana Readers' Choice Award. He has written several children's books and has been the convener of the New Zealand Post Book Awards. In 2004, Dr Colquhoun was the recipient of the Prize in Modern Letters.

Glenn gave this deeply moving oration at the recent Royal NZ College of GPs conference. We are delighted to have been given permission by Glen himself and the GP Pulse magazine (where it was originally published) to share this oration with you.



Dr Glen Colquhoun, RNZCGP Conference

The Wolffian ducts are embryonic structures in mammals. Under the influence of testosterone they form the internal genitalia of the male: the epididymis, the vas deferens and the seminal vesicles. They also have a role in the development of the kidney as well as the Mullerian duct, a precursor of the female reproductive tract. Disturbances of testosterone metabolism give rise to a number of disorders affecting this system including complete androgen insensitivity syndrome, 17 β hydroxysteroid dehydrogenase deficiency, LH receptor mutations and 5 α reductase deficiency. I learnt this in medical school. I don't know why I remember it now. More useful information has long since disappeared but the Wolffian ducts remain a magnificent testimony to the fact that I once knew something, a great pyramid perhaps, hinting at a previous civilization. I regret few people with

disorders of their Wolffian ducts have ever been patients of mine. In fact, apart from a few of the old favourites, I don't often see much of what I learnt about in medical school at all. The things no one told me about take up too much time: WINZ forms, ACC forms, insurance forms, medical certificates - disorders of paperwork completely ignored by the syllabus. Nevertheless I am beguiled, most of my day I sit and listen to people talk. Of all the conditions I do see that no one ever taught me about in medical school, ache is by far and away the most common. Many times in my practice I have been forced to leave the tar-seal of the textbook to help a consultation proceed over its terrain. In those moments I have returned to what I have learnt from life by living it, mainly from making a hash of it. It is the most reliable source of ache I know.

Before I go any further I should try to explain what I mean by ache but that won't be easy. I can't quantify it or measure it and most of my life I have called it other things: God, sin, failure, pain, joy, and that-voice-inside-that-won't-be-quiet. It is most commonly located in that small groove between my stomach and my chest - retrosternally, I suppose, although it can climb into the back of my eyes and it can equally descend. It does not make me feel happy or sad but is usually a mixture of both, at times a loneliness, at others an exhilaration; sometimes it is a dog barking at the approach of danger. It seems to exist on a ledge, a place I come to at the edge of myself and from which I am capable of connecting to what is beyond me. If I was to have a tow bar this would be a good place to put it.

The more I am aware of it in me the more I see it in others. At first I thought I was projecting my inner life onto them but the longer I work in medicine the more consistently I bump into it. It may be in the specific demand a patient makes but it is usually more subtle than that, submerged, looking at me with crocodile eyes from the swamp of whatever else is going on saying, 'It's me. I'm here. I'm hungry.' Sometimes people point at it and roar saying, 'Fix that - it must be a disease.' Usually people are only aware of a vague disturbance instead, dressing it up in a number of other complaints. I'm not even sure it is a disease, more some sort of pregnancy. Nonetheless it requires a careful midwifery. Having said all of that I suspect the best way for me to explain ache to you is for me to show you what it feels like.

Most Sundays, as a child, I lay on the lounge room floor with my father and watched television. There was usually a Western on at midday and I would be equally engrossed in the actions of the seventh cavalry and my father beside me. In summer he would wear only a pair of shorts and his large brown body would loom over me like the USS Enterprise docked beside my tug. Sometimes I would lie on his back and survey his moles, wondering at his smell and architecture. It has always seemed an apt memory. He was my landscape.

I grew up a man's son. My father was a builder off the farm at Ardmore, south of Auckland, all muscle and meat. His hands were twice the width of mine, even as an adult. Hard work was a way for him to make sense of the world as well as an answer to arguments. Despite my aversion to hard

work I like to think I am a chip off the old block. He took me with him to work from the time I was a child. At first I nailed pieces of wood together then graduated in time to digging drains, painting the soffit, mixing concrete, framing up, putting on the roof and hanging doors. He taught me how to be with men and to talk like them at the same time, looking down at me sitting on a nail-box. 'You drink a mean milkshake, old king,' he would say in a way that made me want to have this achievement alone chiselled into my tombstone.

When he was thirty-eight he was diagnosed with Parkinson's disease. I was thirteen and over the next thirty years he was dismantled plank by plank. I watched him fall into irrelevancy then ruin then idiocy. It seemed an irony that the illness attacked what he was best at, being in his body. In his later, most disabled, years I remember spending nights with him at times, placing his urodome, getting up to his calls in the middle of the night to find him in a ball of sweat, helplessly trying to get the blanket off his feet, or wedged under the bed where he had been trying to stand up for the last hour.

There is a desperate beauty in the failing body. Being afforded the view is one of the great privileges of medicine. Breasts fall, bellies sag, the skin fills with subtle arcs and whorls as though it was sketched. Bones become more prominent. Eyes wetten, yellow and seem to protrude as though we are weathered back to something older and more eternal and more humble. Immortality can be hard to live with. Flesh seems relieved in the end to be rid of the responsibility. This is the beauty of the tide gone out over the tight lap of the sea against its belt. Sometimes people seem to make an appearance in their own skin for the first time as though they were stepping out from behind a curtain to take a bow. When the body you are watching fail is a parent all this seems even more poignant, as though the sky and sea itself are melting. Hot on the heels of this realization comes the next: that we are somehow expected to take their place. In that case there can be no parents at all - only children whose old ones have gone on. We are all uncertain.

My father was seven stone when he died - all Alps and no plain. Looking down on him in the end with everything said and all else withered away only what was necessary remained: a sure knowledge of our helplessness and love to ballast that, an awareness that



Dr Glen Colquhoun and Dr Jonathon Fox at the RNZCGP Conference

this is all we are and that this is all we are. He was powerless in the long-run, fighting a rear-guard action nonetheless, the wagons drawn up in a circle and the ammunition running down. He kept hammering away at the bolt while we slipped away one by one. I still see him patched up at the Alamo, giving me a wink now and then, taking a break from the gun battle to drink a mean milkshake, Mexicans everywhere crawling over the roof. Perhaps ache has something to do with this.

My ex-wife is blue-eyed and Australian, qualities alone for which a man should marry. There is still much I do not know about her and much that I cannot say but her life had been very different to mine. Somewhere in the making of her sense of self had been sown a great pain and she grew around it to survive and because she had no other choice. It made her extraordinarily watchful and extraordinarily imaginative. In the worlds she created for herself she existed untroubled. She was continually troubled when asked to live in the one most of us think is the only alternative. I have never met anyone so real in all my life and suspect I never will again. She took me into the dark and I stayed long enough for my eyes to adjust and see that it was full. The problem was everyone expected her to live in the light. We are righteous about that.

For ten years we were a team. I intervened at every border between her and the world of the everyday and

she inducted me into the ten heavens and hells of the mind. The irony is she knew my world better than me, like a tourist who has seen more of our country than we have. She could not live here however. She loved people and when she allowed herself to be with them they would feel her searchlight eyes bore into them to find their hidden joys and sorrows, pressing a finger to her lips to reassure them that she would keep them secret. But the energy to do this exhausted her and she would have to withdraw and rest to repeat the exercise on a daily basis. For her being social was not a thing to be taken for granted. She was not scared of us. She was scared of all of us.

In lots of ways I am more proud of the man I was then than any I have been before or since. I walked between our worlds and smoothed her transition, held her hand, made up excuses, beckoned, defended and listened. Painstakingly, I made her believe in a life outside her head and when she had come to trust me fully I failed her spectacularly. Eaten from the inside out I did not recognise how wrung out I had become or indeed that one could become so exhausted. I left her when she was safest. People will say that I fell in love with somebody else which is true but the other truth is that I was more tired than I have ever been in my life. Destroying in such a way the trust I had begged for so long has bestowed an exquisite pain. It was a terrible loss of innocence.

In many ways love itself is all ache. When it is destroyed the mushroom cloud can leave our skies red for an unreasonably long time. Its loss is also a very public and personal humiliation, a failure of what is expected of us by those watching and by ourselves. And failure, of course, is one of the great furnaces of ache - almost a precondition. This may be because we usually have to be stopped in our tracks in order to notice what is right in front of our eyes and failure is a useful sledgehammer, or it may be that something has to be just out of reach for ache to be fully realised and failure opens up that gap. Over time our sorrows accumulate. Ache becomes part of our shape - a weird anatomy. It can be felt, seen, perceived and mapped by those who know its language. We wear those we have loved in the same way. Sometimes they protrude and bump into people on their way past. Sometimes we bend around their invisibility and others only notice that we walk funny. If nothing else the hopeless in love are good company, sensing the rot in each other and making everyone else feel good about themselves by comparison. Getting better is much more dangerous. Perhaps all ache at the end of the day is a reaching.

For the first two years of her life I sung my daughter to sleep. The old numbers were my favourites:

*I'm calling to tell you it's over,
yes darling, you're now free to go.
You're saying you're sorry you hurt me
but you hurt me much more than you know.*

It seemed to work more often than not and made me feel that I was a loving father. The truth in retrospect was that in the solitude of that dimly lit room I could unleash the talent that had never been recognised by my sisters on a defenceless child. I had watched for her milestones carefully and ticked them off with pleasure when they arrived: smiling, sitting, crawling, walking and then her first word. As soon as one was reached I would be restless for the next. I dearly awaited her first three word sentence. A three word sentence would contain a subject, object and predicate and seemed unreasonably important considering I would do just about anything to limit her sentences to three words now. Not long before she turned two I remember holding her in my arms one night beside her cot. She was snug in her pyjamas with her large brown eyes almost shut. I had just finished the chorus, eyes half shut myself, lost in the honey-dew of my voice:

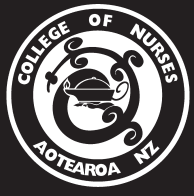
*I'm just on the blue side of lonesome,
right next to the Heartbreak hotel,*

*in a tavern that's known as Three teardrops,
on a bar-stool not doing so well.*

When I looked down my daughter was staring up at me wide-eyed. She opened her mouth slowly and with a purpose I had not seen before. I knew something profound was about to happen. 'Don't sing daddy,' she begged, shattering the ambiance I had created. I was parent enough to appreciate her first subject, object and predicate but am still wounded somehow that for eighteen months she had been desperately searching for the language to tell me to shut up.

When she was two I took her to the swimming pools. It was her favourite place and I became used to concealing my body in the deep end of the children's pool like some old hippopotamus. The braver she became in the water the further she would roam from me and the more delighted she would grow in that independence and the feel of the water on her body. She began to ripple out from me in ever increasing circles. One day I watched her splash with joy in the water like some demented bird, her arms flapping and her body shaking at the feel of the water on her naked skin. She was delighted and oblivious and had moved far enough away from me that I saw her for the first time and knew in that moment I would lose her. Her fundamental relationship was with the world. Her job was to grow and taste and experience and mine was to be fed on for long enough to allow her to do that well. She would never love me in quite the same way that I would love her. Hot on the heels of this insight was the realization that I had consumed my parents in exactly the same way. For a period of time I seemed to be exquisitely skewered, blind to my parents for forty years and unseen by my daughter in return. I also knew that this is how life is supposed to work. We love our children and pay back our parents at the same time. The debt of one generation is repaid in the next. We are pip then apple then apple core. It was just as well I was in a swimming pool because I wanted to cry.

What I wanted to cry about was all the knowing and not knowing I seemed to hold at that moment but could not discharge. Dramatic irony is that bit in a movie where we see what is going to happen next but the character in the story doesn't. We want to reach out into the celluloid, tap them on the shoulder and tell them there is an axe murderer in the shower. Being a parent is like that. Often ache drives us to speak, to place some meaning in its gaps but there are times when nothing can be said and we come to a hard edge



The Therapeutic uses of Ache cont.

of the world. The throb is palpable from here but the view can be bleak or spectacular depending on how we look at it. When we love our children we bring so much inside knowledge that they cannot and should not be aware of. It can be overwhelming. My daughter is the only person I am happy to be ignored by for the rest of my life.

It seems to me that there are two fundamental ways of approaching the nature of ache. The first way is to say that ache is about our limitation as human beings. It occurs when something rises beyond us and we are not able to reach out to it in the usual ways. That is why it is found in the face of death, love, failure and the unsaid. It arrives when we are forced to consider the irreducible gap in human existence. As human beings we do not know where we came from, or why we are here, or where we are going but despite this we still make small islands of meaning to stand on. We could not function otherwise. Ache is the knowledge that something fundamental to our existence will always be just out of our knowing. It is inherent in the act itself of creating a place to stand and binds us together in the midst of our isolation.

The second way of approaching ache is to say that it is solid and reliable and all we are doing when we sense it is responding to a physics we cannot otherwise describe. It is a response to our connection with all things and exists most reliably at our edges. If physics and biology teach us anything at all it is that our edges are fluid. We are highly coiled - little different from the universe beyond that seems so separate. We may be elaborate knots but we unravel. Perhaps ache is a tug on our loose threads. Maybe that is why it feels so tangible. Perhaps it is the memory of energy for itself, a recognition of a fundamental kinship in others and in landscape and in the great throb of existence. Perhaps, as I said before, it is gravity, a response to unseen shape that dents space-time and draws us together.

But what has any of this got to do with medicine? Despite the fact that ache is part of the human condition the truth is it hurts. Even at the best of times it bites. Sometimes it hurts because the separation is too sharp and the connection is too far away for consolation. And sometimes it hurts because we ignore it, pretending it does not exist or worse still, that it is a doubt or enemy to be squashed and bent out of shape. Then it gnaws, filling us with subterranean roar, manifest in all sorts of non-apparent ways.

It is also anatomical, an organ system specific to

the individual. Many times it tells us what is really going on with someone when we cannot find out otherwise. More importantly it is often the point from which a person can begin to get better again. The art of medicine it seems to me is in part the art of the encounter. It requires the ability to come alongside another human being and then provide space for magic to result. When all else fails ache can guide us to where that space is. Perhaps it is a tool of instinct. It can be an attitude, a position from which to regard the world and then it can be diagnostic. Maybe it is a radar of sorts.

But ache used wisely in the consultation is also therapeutic. When someone has lost someone they love, when they are facing their own death, when they are failing at their job or the past is continually making a hash of the present then being able to see what really ails and sitting in the ache with them for a time is about all that we can do. Ache builds and rages like the weather. When we wait with people in its path we are saying that some things are inescapable and transforming but we survive them. I am not saying that we should relive our grief with patients but at times we may need to admit we are in the abyss with them so that they recognize they are not alone. When all else fails then simply the process of being in the same space and sharing the fire is important. People can figure it out from there. This is not doing nothing, ache recognizes ache.

But perhaps the most pressing reason that ache is an issue in medicine is the fact that people keep coming to see us with it. I have learnt to be terrified when patients begin their consultation by saying, 'This won't take a minute.' Ten minutes later too many are sobbing. It seems ache in one form or another takes up half my day. Maybe that is a product of where I work. Maybe it is my father and ex-wife and daughter and every other stray ache in me telling me to ask one more question. Ache is important in medicine because it is pounding on the door.

Maybe all I am saying is that spirituality is hugely important in medicine and seems at times to be forgotten. At the end of the day I think ache is that point beyond which human beings need faith to function. Faith and doubt may be more important in our practice than we think. It seems a deep irony to me that my adult life has been spent in long retreat from organized religion and my shattered childhood dreams of the ministry and yet I find myself now in a profession where each day I sit and listen to people

love, cry, praise, confess and ache - desperately hoping that one of them will have a sore ear or at the very least a disorder of their Wolffian ducts. But I shouldn't be surprised. Biology comes and goes and we do what we can as health professionals but spirituality is at the core of being well because it can alter our story and give us the emotional ability to make sense of whatever befalls us. It also reassures us that whatever shape we end up in we are not just human beings. At the heart of medicine is compassion, not science, not politics nor policy, not commerce but the assorted wreckage of human beings, their frailty and the long slow unwinding of our bodies. It is a profession of skin and ache and spiritual by its very nature. The consultation is its holy place, a source of communion and a science lab for the physics we have not yet described that occurs between people.

Every community requires an Auntie Huia. At eighty, her garden is still the best in Te Tii, where I once lived. The front yard is crammed with fruit trees and the backyard teems with kumara, silver-beet, cabbages, riwai, pumpkin and corn depending on the season. I can never remember what crop should be planted in which season but am always grumpily reminded that I should if I expect people to think I am a doctor. It is no use discussing medical school curricula with her. She is deliberately unreasonable. The sea barks like a dog beyond this down a short embankment where her aluminium dingy waits tied to an old eucalypt which reminds me of her except for the colour. Up until a couple of years ago her great joy was to row out into the inlet in this vessel to check her mullet net, a pleasure she blames me for curtailing every time I see her after I told her she shouldn't go out alone following a series of TIA's. The mullet at least are grateful. The inside of her whare is always neat apart from the flax work poking out of half finished piupiu or kete. Sometimes a dribble of wool drools from whatever article of clothing she is knitting for whoever she decides needs it.

I have been told off my Auntie Huia more than anybody else in my life. Everyone who has lived at Te Tii has for that matter. She is the last keeper of the old ways and has high standards. No one would have it any other way. Even the seventy year olds are frightened of her and still sit up straight if she raises an eyebrow. I know we will lose her one day. The ghosts are nibbling her edges but they will be sorry. The feeling tightens in me like a fist at times because we will be bereft, lonely and rudderless, doing anything to annoy her one more time. At times she leaves the impression that she has

half left anyway and is only hanging around because she is the last and who else is going to clean up our mess. Her eyes look meaningfully at the distance, her ears aware of better conversations than we can give her now - mind you, any underestimation of her location in this world would be swiftly dealt with.

Recently I drove back to Northland for a few days. Auntie Huia had been in a car accident three weeks earlier and was not well. Her leg was sore and she had a headache. In hospital I pull up a chair beside her bed and we talk. First she growls me for coming. It is a waste of time and of petrol and who on earth is looking after my daughter. She makes a point of starting the conversation in Maori so she can switch to English with a sigh as I lag behind. There is nothing wrong with her ... why can't she be left alone? After this she is silent and I tell her I love her, that everybody loves her and that she is important to us. 'Oh come on, man! ... Gee ... I don't know.' She turns her head and looks away for a while. We sit and say nothing. Noise will come later: the diagnosis of her sub-dural haemorrhages, her fear of incapacity, the worry she will not be able to finish the knitting she has promised to a charity in Romania, the explanations to her family. But for the time being we have to sit. She stares out the window at workmen demolishing an old nursing home next door, its timbers akimbo. It is the same attitude my wife took looking through the blinds at St George St the last time I backed out of the driveway. Olive wants to stay with her mum and doesn't want a bath and I brush too hard against her knots. Dad kicks open the saloon doors and fires off a few rounds, cursing Mexicans without knowing it is not appropriate anymore and I kneel beside my bed as a ten year old boy for hours to feel God like I am supposed to. Everything that happens next flows from here. And that is how I would like to finish, beside this wise and brave and cranky old woman clinging on, our ache beautiful, damned, incandescent and unspoken - heard in ways we do not yet understand; an exquisite skewering reminding us that one day we will change shape and with luck remember. In the meantime we talk about the nursing home beyond and its rot and the pity of it all and for a time the conversation is so extraordinarily brave I am left undone.

College of Nurses Symposium

Nursing and the Health of Older People: Practice, Policy and Partnership

16th and 17th October 2009, Wellington

The Wellington Regional Group of the College of Nurses are to be congratulated for providing a stimulating two day programme with informative speakers from a wide variety of areas concerned with services for older people. The 140 delegates in attendance enjoyed the inspiring presentations, informative sponsors, lively debate and professional networking opportunities at this Symposium.

The symposium format allowed delegates to hear all sessions and to engage fully with presenters on a wide range of topics; here we include just a small selection of papers and topics presented.



Rae Lamb presented "The View from the HDC on Aged Care Nursing."

Keynote Speaker

Professor Marilyn Waring (College Patron)
Gender, social justice and poverty: what a nation looks like when the Executive bans these words.

Marilyn provided an excellent and challenging opening paper in which she noted the key connections between economic recession, poverty and the suffering of vulnerable members of society. She went on to say that at community/local levels income loss will be concentrated in already vulnerable groups compounding their social and economic disparities.

She noted that in any financial crisis women prop up the family in a balance of paid (mainly part time) and unpaid work. Often this work includes the care of older people. Globally for women the recession intensifies their hardship as they work in vulnerable employment also overseas unemployment means some additional family members may return home and increase demands on housing and income. Societies with greater inequalities are far more prone to poor health, increased crime, xenophobia, poor housing, the list goes on and the recession magnifies these.

She also drew delegate's attention to the close connection between the investment in the health and welfare of vulnerable people and the ultimate



Sam Jackson (left), College Board and Wellington Committee members participate in the opening of the Symposium.

health and well being of a nation. Withdrawing welfare support and preventative care in tough economic times is a certain recipe for increased suffering and longer term problems.

Keynote Speaker

Rae Lamb (Deputy Health and Disability Commissioner)

Aged Care Nursing - The view from the Health and Disability Commission

Rae discussed several case studies of complaints to the Health and Disability Commissioner related to residential care settings. She suggested that in these settings communication and relationships were extremely important. It was valuable for symposium delegates to have the opportunity to reflect on the complaints process and the learning and growth, which occur when complaints are well handled and findings are implemented. Rae noted the importance of responding promptly and proactively to concerns and the need to really listen when faced with a complaint.

Nurse Practitioners: A key role in providing high quality care to older people across primary, secondary and tertiary settings.

Presenters: Mary Daly (NP, OPRS, HVDHB), Liz Langer (NP, Psychogeriatric, ODHB), Helen Bowen (Gerontology NP Intern, WDHB), Janet Parker (Gerontology Nurse Consultant, WDHB).

Here nurse practitioners or nurse practitioner interns shared evidence of their roles in providing services to older people in a range of settings. In particular Helen Bowen and Janet Parker shared exciting evidence of the development of NP services across the continuum of care at Waitemata DHB. They already have excellent evidence of improved patient outcomes, and reduction in admissions. They offered a developing model of care of interest and relevance to all District health Board areas

Research and Innovation: Foundations for Practice

Presenters: Dr Michal Boyd (NP), Mary Jane Gilmer (NP, AUT University), Dr Stephen Neville (Massey University)

Dr Stephen Neville reported on his research that analysed social isolation and loneliness in 700 adults aged 65 years and older. He concluded that specific predictors of loneliness included economic living standards and age; emotional loneliness; poor self rated health and depression. Mary Jane Gilmer spoke of her work providing primary health care services to homeless people in association with the Auckland University of Technology and Dr Michal Boyd spoke of her practice as an NP and research she has led investigating the changing patterns of need in residential care settings.



Left: Professor Marilyn Waring delivers her keynote address Right: Community Perspectives in Nursing Panel.

Ethics: Care of Older People and Ethical Decision Making

Presenters: Amanda Lees (Lecturer National Centre of Health, Law and Ethics, AUT), Dr Rosemary Godbold (Senior Lecturer in Health Care Ethics at the National Centre for Health, Law and Ethics).

Dr Rosemary Godbold spoke about the ethical issues in elder care; the role of values in ethical care and the link between ethics and nurses current / future practice.

Amanda discussed the concept of dignity. She also spoke about ethics and New Zealand specific values which included the challenge where several different value systems compete. She suggested that ethics helps to provide a common starting point for moving forward in thinking about delivering

optimally ethical care for older people. They both discussed the concept of the Values Exchange www.nurse.values-exchange.org.nz as a tool for open exchange of differing values and ethical standpoints and how this can be used to open up transparent discussion.

Power point presentations from many of the Speakers sessions are available via the link on the College website www.nurse.org.nz

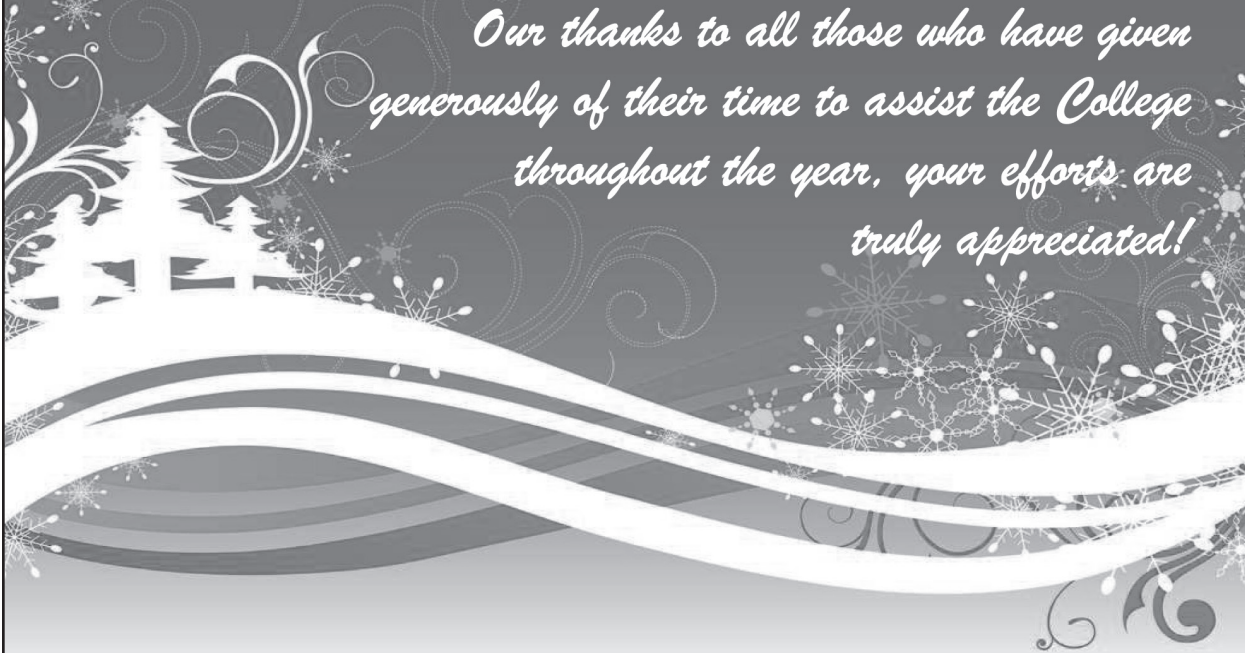
This was, as it set out to be, a stimulating, challenging and enjoyable event, we would like to thank all the speakers for giving of their time to present at this Symposium. We would like to thank our major sponsors Massey University and Moving on Training (Australia) for their valuable support as well as our other sponsors who all helped make this a very worthwhile event.



Left: Dr Annette Huntington -Welcome Address Right: Delegates participating in open discussions with the panel.

The Executive Director, Board and staff of the College of Nurses wish all our members a very happy and peaceful Christmas and a safe and rewarding New Year.

Our thanks to all those who have given generously of their time to assist the College throughout the year, your efforts are truly appreciated!



College Office Holiday Closure

The College of Nurses Office will be closed over the Christmas and New Year Period from 23rd December 2009 to 23rd January 2010. Emails and phone messages will be checked on a regular basis during this time.

If you require urgent assistance with any Indemnity Insurance matters please call the College office phone (06) 358 6000, a contact person and number for Indemnity Insurance matters will be provided on the answer phone message.

Nurses when you're with a patient ... there's often an elephant in the room

Smoking is too big to ignore

- 45% of adult Māori smoke
- 31% of adult Pacific smoke
- 21% of all adults smoke
- 60% of smokers want to quit
- 80% wouldn't smoke if they had their time again

You can help



It's as simple as **ABC**...

Ask whether a patient smokes

Give **B**rief advice to quit

Offer evidence-based **C**essation support

For more information about the role of nurses in smoking cessation go to: www.moh.govt.nz/
There's an e-learning tool for health care professionals at: www.smokingcessationabc.org.nz
It provides • practical information about **ABC** and **NRT** • Printable certificate for professional development • Takes about 20–40 minutes to complete

NURSES' ROLE IN SMOKING CESSATION

PROVISION OF NRT TO PATIENTS AND THEIR WHĀNAU



Introduction

Nurses come across the health burden that tobacco use has on our community, in their daily work. Throughout the various work settings, from infant care through to palliative care, nurses witness the impact of exposure to tobacco smoke on people's health. Therefore nurses are in an ideal position to make a difference in smoking cessation and to improve the health of their patients.

Most people who smoke want to quit¹ and many can be helped with advice and support from health care professionals. Nurses are the largest health care workforce and are involved in nearly all levels of health care. A meta-analysis of clinical trials has found that advice and support from nursing staff can increase people's success in quitting smoking, especially in a hospital setting².

The challenge is to incorporate smoking behaviour monitoring and smoking cessation interventions as part of standard nursing practice so that all patients are asked about their tobacco use and those who smoke are given advice to quit along with reinforcement and follow-up.

Registered nurses provide "...interventions that require substantial scientific and professional knowledge and skills. This occurs in a range of settings in partnership with individuals, families, whānau and communities."³

The New Zealand Smoking Cessation Guidelines (2007) refer to the 'ABC' – an aidé memoire for evidence-based clinical practice. 'A' is for asking all people if they smoke; 'B' is for giving brief advice to stop smoking; and 'C' is for cessation support, which should be offered to all people who smoke.

The role of nurses in the 'ABC'

Nursing practice should incorporate the 'A' in all patient contacts and follow up with the 'B' and 'C', or referral to 'C', for all patients who smoke.

The chance of someone quitting smoking roughly doubles⁴ with the use of nicotine replacement therapy. Other pharmacotherapies (eg, varenicline, bupropion and nortriptyline) and behavioural support are also effective in helping someone to quit.

Although nurses may not be in the position to provide ongoing behavioural support for patients making a quit attempt, the provision of nicotine replacement therapy through the quit card scheme and referral for ongoing support sits easily within practice.

¹ 2008 New Zealand Tobacco Use Survey Quitting Results . Wellington: Ministry of Health.

² Rice VH, Stead LF. Nursing interventions for smoking cessation. *Cochrane Database of Systematic Reviews* 2007, Issue 4. Art. No.: CD001188. DOI: 10.1002/14651858.CD001188.pub3

³ Nursing Council of New Zealand [Competencies for registered nurses December 2008_p4](http://www.nursingcouncil.org.nz) Wellington www.nursingcouncil.org.nz

⁴ Stead LF, Perera R, Bullen C, Mant D, Lancaster T. Nicotine replacement therapy for smoking cessation. *Cochrane Database Syst Rev* 2008(1):CD000146.

Providing people with access to fully subsidised NRT

Nurses are able to provide people who smoke access to fully subsidised NRT (currently nicotine patches, gum and lozenge). The Government funded Quit Card Scheme provides registered Health Care Practitioners (HCP) without prescribing rights with the ability to offer subsidised NRT to anyone who smokes. The Quit Card is essentially a voucher provided by a HCP who is registered as a Quit Card Provider. The Quit Card is redeemed, for a co-payment of \$3, at a pharmacy. The pharmacist shares the responsibility for supplying the NRT.

The easiest way to register as a Quit Card provider is to complete the online e-learning tool - Smoking Cessation ABC, <https://smokingcessationabc.org.nz/> which provides the basics of ABC, and on completion, HCPs can register on-line to become Quit Card providers. The tool takes between 30 and 40 minutes to complete. DHB Smokefree Teams are also delivering ABC training across their health care workforces and are able to include Quit Card training for their registered HCPs into training sessions.

Nurses who are Quit Card providers are able to provide access to NRT not only to their individual patients, but also to others who smoke including parents, caregivers, and whānau. Nurses have a duty of care to encourage and support whānau to be smokefree.

Māori experience a greater health burden from tobacco exposure than the rest of the population. The Whānau Ora approach recognises the central role whānau have in achieving maximum health and wellbeing. Nurses can increase effectiveness of practice and optimise patient outcomes by including whānau in the process. This can be practically demonstrated through the provision of NRT through the use of the Quit Card scheme.

Children exposed to tobacco smoke are at risk, both in terms of the health consequences of tobacco smoke such as respiratory tract conditions as well as the modelling and normalisation of smoking tobacco. Parental smoking is a key risk factor for children and young people initiating smoking⁵. Supporting parents to be smokefree through the provision of Quit Cards and referring them to cessation support are key actions nurses can do to protect a child from tobacco harm and promote a healthier lifestyle within the family.

Patients / clients and their family / whānau need encouragement and support to make positive changes towards becoming smokefree. Nurses play a pivotal role in making this happen.

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⁵ National Year 10 ASH Snapshot Survey 2008

2009 Trailblazer Award Report

Being a recipient of a 2009 Trailblazer Award allowed College member Jill Tresize to attend the Northern Queensland Practice Nurses Conference in Cairns on 20th-22nd August. Jill reports on this 'refreshing' conference and shares with us some photographs of local attractions.



Jill Tresize snorkelling on the Great Barrier reef. (She thought this suited the dehydration topic!)

Jill Tresize

RN, PG Cert, MCNA.

I recently attended a conference in the sunny tropics of Northern Queensland. The weather was in stark contrast to gloomy wet Auckland. As always conferences are great networking opportunities and this one was no exception. There were several NZ nurses who were working in various fields of Primary Healthcare. One nurse was involved in sexual health, one was a practice nurse and one was working as a renal nurse on one of the remote islands.

There were two streams or themes; one was children and the other was chronic care. All topics hold interest for primary care nurses as their role is primarily generalist in most cases of primary care nurses working within a practice/ clinic setting.

One of two standouts for myself was the presentation on the "medicare claiming numbers" simply because practice (primary care nurse concept is foreign to them) nurses placed so much emphasis on their ability to talk and walk the numbers. I fear to the detriment of patient-centred nursing. The other was a presentation on rehydration for the elderly and very young. Both populations being frequent attenders in primary care settings.

Dehydration in the elderly and very young.

As a primary care nurse we often triage phone-calls involving sick children or take calls from the spouse of an elderly patient. I thought these key points may be applicable to many of your own work situations. Although it is basic education it is helpful to be reminded of what to watch for as summer approaches and poor food storage practices promote gastroenteritis.

Key points for Dehydration.

- Fluid held in muscle (40%). Therefore the elderly and the very young who have less muscle mass are more susceptible to dehydration.
- Dehydration has significance when >3% (NZ guidelines for rehydration fluids state 4%) of body weight is lost. (Always a good idea to have a recent baseline weight in this population when presenting to the clinic).
- Children can remain infectious with a pathogen for up to 3 weeks but it is more likely to be only 1 week in most adults.
- An easy tip to tell an adult to look for in a child is a depressed fontanelle and less wet nappies.
- There is no evidence to support antiemetic, antimotility or antidiarrhoeal medication use in children.
- Rehydration solutions are mandatory. In NZ these are Gastrolyte, Pedialyte most common, and Plasmalyte and Sustalyte.
- Observations should be made to assess the severity of the dehydration. This can usually be done over the phone.
- There are the standard ABC, alertness and arousal, Breathing, & Circulation with the addition of Fluids in and Fluids out.

Fluids In

Degree of Dehydration

Very Mild (3%)
 Mild (5%)
 Moderate (7-8%)
 Severe (>10%)

Symptoms

Reduced urine output.
 Dry mucus membrane,
 Lethargy, tachycardia: Reduced skin turgor
 All of the above

Signs

Thirst no clinical sign
 Mild tachycardia
 Sunken fontanelle & pallor
 Poor perfusion

Fluids out

Diarrhoea- How long: How much: Describe it.
 Vomiting – How long: How much: Describe it
 Urine Output- reduced, excessive, concentrated.



Rita Walker presenting dehydration in the elderly and very young.



This the local pool, 24hr security, 12hr life guards, 1m deep and a superb example of townspeople protecting what is precious, never any vandalism. The pool is surrounded by a large ablution block meticulously clean with toilets and showers. Unfortunately the beach is unfit for swimming hence the local pool solution.

Electrolyte solutions are preferred because

- Water doesn't restore electrolyte imbalance and can lead to further electrolyte loss.
- Ingestion of fruit juices, soft drinks, sports drinks and cordials can paradoxically worsen the dehydration because of their high sugar content and imbalance of electrolytes.

The bells were ringing for me when the speaker presented a case study of an elderly woman, on a number of medications, with impaired functional status, some confusion which may or may not have been long term, and a plethora of chronic conditions, diabetes, COPD, hypertension and a touch of CHF.

The most common causes of dehydration in the elderly are Gastroenteritis, Heat, febrile illness: UTI, pneumonia, Chronic lack of food, dementia, depression and travel.

In nursing homes clinical studies (no references given) have shown that 98% of residents consumed less than the daily recommended intake (1500-2000mls). Of all elderly patients admitted to Australian hospitals, 34% were diagnosed with dehydration (Joanna Briggs Institute, Best Practice

2001). Those of us having worked in hospitals can all recall the case of the locker fluids being placed out of reach of the patient or on the side affected by a stroke.

REHYDRATION FORMULA

An easy way to work out a formula to rehydrate an older person is to calculate 100mls/kg for her 1st 10kgs, 50mls/kg for the next 10kgs and 15mls/kg for each kg after 20kgs. So if she weighs 56kgs, it is 1000mls for her 1st 10kgs, 500mls for her next 10kgs and 15x36 for the remaining 36kgs = 540. Therefore daily intake needs to be 2040 for the next 24 hrs. When you consider an elderly spouse needing to provide assistance to obtain this level of oral intake it is no surprise that so many end up in hospital. Frequent small amounts are the key.

This presentation had a good fit with the other chronic disease presentations, setting up nurse led clinics; motivational interviewing ; promoting self management through prevention and patient education and chronic kidney disease. I did have a sense of déjà-vu during most of the chronic disease presentations. When you start seeing the same jokes and the same stats the level of concentration wavers. This was especially so in the diabetes

presentation. Surprisingly no-one had really heard of the “Flinders Model” and no-one had undertaken motivational interviewing training. The emphasis for chronic disease was still very much along the prescribed templates of obtaining clinical data.

Although general practice has had a longstanding role in chronic disease management, workforce models and government funding have historically impaired service delivery.

Having worked within several different PHOs in

New Zealand, I can state with confidence that even allowing for the Australian Dollar conversion NZ reimbursements for nurses performing chronic disease monitoring are a little more realistic. I got the impression that collaborative practice was alive and well in NZ but was really just “jargon” over in Australia.

In summary the conference gave me insights into similar care provision for chronic diseases but the importance of the method of funding as always, underpins effective service delivery.



A group of aboriginal children playing on the main street beach.

College of Nurses, Aotearoa

Regional Co-ordinator Vacancies

Manawatu, Hawkes Bay

The Regional Coordinators role is the face of the College in your area, if you have a little time and could possibly organise 2-3 meetings a year it would greatly benefit the members in your area.

If you would like to know more about this role please contact Kelly in the College office for more details (06)358 6000 or admin@nurse.org.nz

New Primary Health Care Coordinator for College

It is our pleasure to introduce Angela Bates as the new PHC Coordinator for the College.

Angela has recently taken over the role of co-ordinator and facilitator for the primary health network from Julia Ebbett. We would like to thank Julia for all her past efforts in this role and are delighted once again to welcome a highly experienced and well-qualified clinician in this role.

Angela is currently employed in Wellington as a Primary health care nurse specialist working in a variety of settings. She believes that every individual has a right to high quality care regardless of their situation or where they live.

Angela is passionate about reducing inequalities in health and improving access to health care for vulnerable populations. For Angela's full profile, please see page 4 - (Board Election).

New Regional Coordinator for Canterbury

As Judy Yarwood previous Regional Coordinator from Canterbury steps up to take on the Role of Co-Chair of the College we would like to introduce the new Regional Coordinator for Canterbury, Dr Mary Jo Gagan.



Dr Mary Jo Gagan
PhD, PHCNP, FAANP

Dr Mary Jo Gagan received her baccalaureate degree at the University of Wisconsin, Eau Claire (1982), her Masters of Science in Nursing from Michigan State University (1987) and her doctorate from the University of Iowa (1996) all in the USA. Across her career she has worked in a paediatric intensive care unit and a dialysis unit as a RN, in a family planning clinic, urgent care clinic, several primary health care clinics in rural areas,

a university health service, and a geriatric service as a nurse practitioner. She has held a variety of positions within the University of Arizona, provided consultation to CPIT and OPIT on NP programs and currently is employed by the University of Otago Centre for Postgraduate Nursing Studies as a Senior Lecturer and coordinator for the clinical master's program and by the Kingdom Clinic in Woolston where she is a primary care nurse practitioner.

Mary Jo is a fellow in the American Academy of Nurse Practitioners (2004) and is well known as a nurse practitioner, an educator, and an advocate for nursing and nurse practitioners in the USA. She is well published and has presented at conferences around the world on a variety of topics related to nursing and nurse practitioners.

Mary Jo enjoys a variety of outdoor activities and this is part of what brought her to New Zealand first in 1988 then again in 2004 and finally to stay in 2007. The other draw to NZ relates to the growing presence of Nurse Practitioners in NZ. Doctor Gagan was registered as a primary care nurse practitioner in NZ in May 2009 intends to invest her energies in advancing the role and the educational preparation of Nurse Practitioners and all nurse in NZ.

We wish her well in her new role as Regional Coordinator for Canterbury.

New Regional Coordinator for Marlborough

The College of Nurses welcomes Robyn Kemp from Blenheim into the role of Regional Coordinator for Marlborough. Robyn shares with us her journey in nursing and goals of attaining NP prescribing status.



Robyn Kemp
RN, BA, MN, MCNA(NZ)

Born in Rangiora North Canterbury I moved to Blenheim to attend Marlborough Girls College. I then trained as an RN locally at Wairau Hospital in the last few years of Hospital Based training. Working initially mainly in the medical service I have also worked locally in a number of more community based roles over the years. These have included Polytechnic Health Nurse and working as a smear-taker and promoter for the Cervical Screening Program.

Currently my main role is working for Family Planning in a clinic based near the town centre. These rooms are also utilized by the Sexual Health clinic once a week where I am employed by NMDHB as the local coordinator and Specialist Nurse for this service. The area of sexual and reproductive health has grown over the past 26 years since I first started working for Family Planning. The opportunities for nurses to increase their knowledge, expertise and involvement in this field, have been huge. This has encouraged me to increase my own knowledge and ability to provide care for a vast range of clientele, and foster my strong interest in Women's Health Issues.

In the 1990s whilst struggling to maintain my sanity parenting 3 young children alone, I took up extramural study through Massey and successfully

graduated with a BA in 2000. My interest in study was fostered and three years later when the Primary Health Care Scholarships became available I found myself again drawn towards further study. After successfully achieving some funding to help cover costs (particularly travel and accommodation) I embarked on a Master of Nursing. My ultimate goal was to complete my MN with appropriate qualifications allowing application to Nursing Council for Nurse Practitioner status with Prescribing.

After numerous trips to Palmerston North, Wellington and Auckland campuses dependant on where papers of that semester were being offered, many late nights or early mornings I successfully graduated with my MN in April 2008. It was an incredibly lonely journey, and very challenging at times with numerous obstacles, but also very rewarding and fulfilling.

Circumstances delayed my original intentions of pursuing NP status after completing study. Sometimes it can be so easy to forget what you've achieved, and the vision that you originally had, because you're so caught up in just doing your job. But currently with support from Family Planning and a prescribing mentor that is now getting back on track. My intention now is to complete the goal I originally had when I commenced my MN as I feel that in the area I work within an NP has significant opportunity to offer improved timely services and treatment to clients. Large numbers of migrant and seasonal workers coming into Blenheim provide another challenge dealing with clientele from differing cultures, ethnic groups with minimal English and often ineligible for NZ funded healthcare.

Relaxation for me is leisurely reading or enjoying time down the beautiful Marlborough Sounds with my partner fishing, or doing a puzzle with no phone or email access. Between us, my partner and I have 5 adult sons, (I'm totally outnumbered by males) and one adorable 17 mth old bundle of energy grandson.

Having recently joined College of Nurses and in taking on the Regional Coordinators role for Marlborough, I look forward to meeting current and potential new members.

2009 Scholarship Recipient Reports

Recipient of the Irihapeti Ramsden Scholarship for 2009

David Healee



David Healee

**RGN, MA (Applied Nursing), ADN, ONC,
MCNA(NZ), Doctoral candidate, Auckland
University of Technology.**

I was pleased to receive the Irihapeti Ramsden Scholarship and wish to convey my thanks to the College for this award. I am working towards a Doctor of Health Science (DHSc) using a grounded theory methodology to examine how older adult's recover from hip fracture, and I am currently interviewing participants.

This research project has arisen from thirty plus year's clinical practice in orthopaedic nursing and a constant desire to expand my knowledge. This project aligns with the current emphasis in healthcare to improve the outcomes for older adults. Examples of current strategies this project aligns with, are the 'Older Person's Health (2002) and ACC Falls Prevention (2005) strategies. Understanding the older adult's recovery processes and perspective following hip fracture should enable a quality-focused approach to delivery of care, policy formation and strategic planning relative to this injury. With the current ageing population and an expectation of an increased potential for hip fracture rates, knowledge gained from this research may inform future nursing practice.

The scholarship grant has assisted in meeting the costs of transcribing interviews and travel costs for participants. Listening to the participants talk about their recovery denotes a level of courage we often fail to recognise in our everyday practice. I look forward to hearing more participant perspectives as I continue to interview.

While working full time as a nursing lecturer at Auckland University of Technology, and entering the field to interview participants, I am continuing to discover that the relationship between practice and whom we nurse is often only strengthened by the knowledge we gain from listening to the recipients of that care. I will continue to enjoy listening to how older adults recover from hip fracture.

CHANGED YOUR PHONE, ADDRESS or EMAIL?

If your contact details are changing please let us know.
e-mail - admin@nurse.org.nz phone - (06)358 6000

Disclaimer

The College of Nurses Aotearoa (NZ) provides *Te Puawai* as a forum for its members to express professional viewpoints, offer ideas and stimulate new ways of looking at professional practice and issues. However, the viewpoints offered are those of the contributors and the College of Nurses does not take responsibility for the viewpoints and ideas offered. Readers are encouraged to be both critical and discerning with regard to what is presented.

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