CONTENTS

Professor Jenny Carryer

RN, PhD, FCNA(NZ), MNZM
Executive Director

Recently I spent 10 days in Vancouver, Canada specifically to look at the development of the nurse practitioner role there. It was a fascinating week made even more delightful by the fact that it was of course very warm and sunny with daylight until about 9.30pm. Given our current winter conditions it was a real break!

The health system in British Columbia Canada is reasonably similar to that of New Zealand with regard to the funding and structure of primary health care (PHC) services but they have much more recently implemented a PHC strategy; about 2006 as opposed to 2001 in NZ. Large sectors of the population in British Columbia are unable to access a General Practitioner and can only attend casual walk in clinics staffed by general practitioners providing brief attention to the presenting problem. Just as in NZ the demographic data shows that the level of the General Practitioner workforce is unlikely be sustained even at present low numbers.

The duration of implementation of the nurse practitioner role is comparable (last 6-8 years) but British Columbia has proportionately more NPs in positions than we do in NZ. I visited with faculty from the University of British Columbia, which has had a nurse practitioner program for several years. The curriculum for nurse practitioner preparation is (as it is in NZ) a 2 year masters degree with relatively similar content. Differences however are of interest and include:

- a much stronger focus on links to the clinical environment with active preceptoring in formal clinical placements of long duration. In addition there is a stronger focus on procedural competence in course and clinical work. They are far more focused on teaching and supervising skill as well as knowledge development.

- there are only three scopes of NP practice in BC; family, adult and child. The vast majority of candidates enroll in the family practice scope and all candidates are strongly prepared for a primary health care service delivery. I did observe though that some candidates who had prepared in the family practice scope had effortlessly transferred to quite different roles; one in chronic pain care and one caring for a population of people recovering from severe trauma.

- the requirement that the students are enrolled full time for the 2 years thus supporting the arrangement of clinical placements to align with course work. Students bear the cost of fees and unemployment for 2 years. Most students are comparable to NZ students in that they are predominantly women who have been in the workforce for some years. As in NZ they have significant uncertainty of employment once authorized so I found it quite amazing that so many students were prepared to make this level of sacrifice.

While I was there the OSCE (Objective Structured Clinical Examination) testing was being conducted. In British Columbia the nurse practitioner candidate is authorized

(following successful completion of the masters degree) through OSCE testing conducted in two batches a year. The Nurse Regulatory Board oversees the examination and examiners are currently US licensed NPs although the intention would be to utilise Canadian NPs when there are sufficient with experience. What is interesting about the OSCE is its highly objective nature and the fact that it focuses intensely on clinical skill and knowledge and does not privilege those who are able to write and speak with greater ease. Having said that however NPs that I spoke to felt that while it was a safe and very effective model, there was further work to be done in translating what has essentially been a medical model of testing into a more nurse friendly process. No-one wanted anything removed but they felt some additions could capture nurse specific characteristics of care.

During my visit I met with Barbara Mildon (Director of Nursing: Fraser Health) and talked with Linda Sawchenko (Director of Nursing: The Interior). Both have been responsible for NP position creation in BC and both have battled with funding structures, which directly challenge NP employment as they do in NZ Both directors have however been allocated significant one off funding to construct the roles which do exist and which are directly responsible for the employment of 165 NPs in Vancouver and beyond in wider BC. There are currently no suggestions to extend this process and no real attention to sorting the main stream funding processes which could facilitate greater use of NPs (sounds familiar!).

I met with 10 NPs and visited 6 of them in their practice environments. Without exception I was deeply impressed by their vision, expertise and the nature of the service they had crafted for specific populations. Amongst the NPs I met an NP who is employed specifically to be the sole primary health care provider for about 600 Farsi speaking refugees who are largely young adults or children and have a very high incidence of post traumatic stress disorder. Their only other option for service is the walk in clinics, which have 5 minute doctor appointments and that is the only option for the remaining 1000 of this population who she cannot enroll due to lack of staff and resource. This NP had hired Farsi speaking interpreters and a social worker. She had formed a relationship with a local pharmacy that was compounding products, which her population trusted for pregnancy, birthing and other problems. In partnership with local community members she was conducting health education sessions. With an NP student from UBC and a child health RN she was seeing these people with very complex needs for all presenting medical and health problems including antenatal care. Of interest is the BC system that antenatal care is provided by GPs or NPs until 24-28 weeks when the woman is handed over to specific maternity providers.

I met an NP who is employed to provide full primary health care services to a large Punjabi Indian population with mental health and addiction problems and very high levels of diabetes and cardiovascular disease. She too had instigated a huge range of community partnered health education endeavours and provided a weekly radio show and newspaper column which were accessed by the Punjabi population from all over Canada. Again this was in addition to providing the full range of what we would call general practitioner services to this population.

In contrast I met an NP working in a private general practice taking enrolled patients from a diverse population. Of particular interest was her energetic collection of outcome data and as an example she was able to demonstrate outstanding drops in HAB1c levels for people with diabetes. Her GP colleagues made a special point of meeting with me to express their huge support for the model of care she provided and also expressed how much more satisfactory their own work experience was now that they could afford to spend more quality time on more complex medical problems. This is of huge interest given the current drive by the RNZCGP (see recent NZ Doctor July 1st) to protect the need for GPs in NZ to have a primary contact and relationship with all presenting patients.

At the Maxine Wright centre for women living with violence and with addiction problems I

met a wonderful NP providing full primary health care services and antenatal care to these young women and their babies and children. Of note was the environment of the clinic, which included the daily serving of a free healthy lunch and a huge amount of parenting and child rearing education. In addition cupboards of clothes and child resources were made freely available through relationships established with other community providers.

Meeting these NPs and observing their practice was extremely confirming of the model of NP practice as a transformative form of health service delivery. The addition of previously designated medical skills to a nursing approach to primary health care resulted in services, which provided improved access, excellent outcomes and very community centered care. In addition the simplicity of areas of practice was quite compelling given our current debates in NZ.

Of the 35 or so NP candidates sitting the OSCE while I was there only 1 had guaranteed employment despite the vast areas of unmet need in Vancouver alone.

It is an irony that just as in NZ, those supporting the development of NPs are having to battle medical resistance (although there were pockets of very strong support where doctors had actually worked with an NP) and the persistence of tedious bureaucratic, legislative and funding barriers to full utilisation of this valuable health workforce. Imagine if one could actively measure the downstream consequences and costs of providing walk in clinic care to the 1000 refugees with complex health needs as opposed to providing NP led primary health care for them. This trip has certainly refocused my energy in striving to have the NP role fully established in New Zealand.

Prof Jenny Carryer
Executive Director

NOTICE OF ANNUAL GENERAL MEETING

The Annual General Meeting of the College of Nurses Aotearoa (NZ) Inc will be held in Wellington on

Friday 16th October 2009

Venue: **Lecture Theatre 10A02**
Museum Building
Massey University
Buckle Street
Wellington

Time: **5.30pm**

Remits: Individuals or regional groups may submit remits for consideration at the Annual General Meeting. Remits must be in writing and received at the College office no later than **Friday, 4th September 2009.**

Quality improvement in Plunket: A Six Year Journey.

Florence Trout MPhil (Massey) FCNA (NZ)
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Introduction

The Te Puawai Journal of December 2003 published The Superiority of Action in Quality Improvement, an article I wrote to signal the Royal New Plunket Society Inc (Plunket) decision to start the journey with the Te Wana Quality Program, and its merits. This article updates readers with the progress made since then - a six year journey that for me has been a highlight in my career. It is encouraging to acknowledge all fourteen Plunket business units (National Office, PlunketLine, and thirteen Plunket Areas throughout New Zealand) for achieving accreditation, a milestone for Plunket and those who are engaged in the program today.

Quality improvement in Plunket is implemented as a cycle of review and planned action in all its managed divisions. The program of choice has similarities to participatory action research methodology. Plunket provides family health promotion programs delivered by paid staff and volunteers, now in its 102nd year. The universal, quality reviewed, no fee, health promotion program accessible to families at home or near where they live, remains a priority to population health gain.

A thumbnail sketch of Plunket in 2009;

1. The universal Well Child Health/Tamariki Ora program is a cornerstone service
2. Plunket aims to reduce disparity in child health outcomes
3. Focus is to identify the highest need families so that their needs are met in an appropriate and timely way
4. Visits are made to about 50,000 families with new babies each year
5. Plunket still believes communities should be enabled to help themselves
6. Services delivered are worth $100m, funded from various agencies and including volunteer labor (estimated as $15 hour)
7. Volunteers are organized in incorporated area society entities and are governors
8. Plunket employs over 1000 specially trained staff (95% of whom are women)
9. Plunket is a registered Private Training Establishment with New Zealand Qualifications Authority for education programs
10. Every Plunket team shares in the accreditation status that recognizes the attainment of sector service standards.

Action in the Te Wana Quality Program is a systematic approach to continual quality improvement. The program is designed to increase the capacity of a community agency's ability to attain true primary health care standards. Ultimately, better health outcomes can be expected for defined populations through better links with other community groups. The emphasis is on coordinated engagement and continuing improvement at national and area levels.

Why did Plunket choose Te Wana?

Plunket sought a systematic and future oriented quality improvement program to fit its future values. The Te Wana Quality Program was the

program of choice in 2002 and remains the program of choice in 2009. The standards and review processes promote action to 'challenge ourselves to achieve things and to challenge our organizations to achieve the standards of highest quality' (Health Care Aotearoa Kaumatua Kaunihera, 1999). Te Wana values are compatible with Plunket values and include: Te Tiriti o Waitangi, social justice, health promotion, community participation and team work. There are three good reasons why Te Wana works well for Plunket. First, the program is recognized by external stakeholders like the Ministry of Health and Primary Health Care Organizations. Furthermore, it suits the Plunket context as a community-owned, national organization, fitting well with Plunket business plans and core values, and social policy.

Benefits for Plunket

There are several ways that Plunket benefits from involvement in the Te Wana Quality Improvement Program. First of all, it results in increased confidence and capability to deliver a universal service in today's world. The bottom-up approach encourages professional growth and development for nurses and others as a holistic team. It provides opportunities for the development of self assessment of standards and reviewer skills. It establishes a three year cycle for planned and systematic improvement and is an effective connector with other organizations also using the Te Wana Quality Program. Finally, and most significantly, the Australian Quality Improvement Council through La Trobe University can award accreditation on the recommendation of Te Wana, the sole NZ license holder affiliated with Health Care Aoetaroa Inc.

Action in health care quality improvement

The four principles suggested by the National Health Committee (2002) for action in health care quality in New Zealand are; greater responsiveness to Maori, stronger leadership, greater consumer involvement, and better coordination. The Te Wana Quality Program has potential to enhance all four principles because of the values and focus on four separate types of activities; an exploratory process to gain understanding of the current situation, a plan made for intervention, action after people involved agree to the intervention process, and reflection or revision to evaluate the intervention (Health Care Aotearoa, 2001).

Earl-Slater (2002) identifies four actions in his description of action research; iterative where knowing is added to and built on in order to do better with tightly fitting resources, pragmatic in relying on logical information, participative by owners of change, and reflective with careful thought given to what is happening in reality. These four characteristics can also be identified and compared with systematic quality improvement programs (MoH, 2002, p4). Literature tends to support greater feelings of ownership from action through people involvement, greater insight into processes and constraints, and possibilities for formulating actions based on evidence and analysis (Bennett, 2008; Gunter & Alligood 2002; Rowe, 2002)). This implies that action in quality improvement programs is strongly aligned to action in research.

Anne Rowe, research and development facilitator at the University of Sheffield (UK), describes a 'whole systems' approach to change service delivery (2002). Rowe describes five program principles in achieving real change to systems over a period of two years (p92). The similarities between Rowe's suggestions and the Te Wana Quality Program are remarkable. The Te Wana program states that sustainable quality improvement occurs through systematic reflection, interaction, learning and collective ownership (HCA & QIC, 2007, p9). Table one compares Rowe's principles and features with the Te Wana Quality Program principles.

Table one: Comparison of Program Principles, Features and Te Wana.

Five program principles (Rowe)	Seven key features of the program (Rowe)	Te Wana Quality Program (QIC & HCA)
Practitioner inclusiveness	Clarification of expected changes	Practitioners lead the self-assessment process through use of standard journals
Stopping as well as starting	Development of public health links	Two modules for Core standards and delivery of Primary Health Care
Accountability framework	Building competence /confidence in practitioners	Engagement of nurses and learning is incorporated into the program process and its resources.
Managed program at each site	Health needs assessment and determination of priorities	Nurses manage geographic teams in a 3 year cycle of improving health needs assessment in communities.

Public health practice includes
- Health inequalities
- Community involvement
- Interagency partnerships Muilti-agency/stakeholder work Explicit values reflected in the standards and in the process includes focus on networks and relationships with other agencies and stakeholders to work collaboratively.

Organization change and structures for staff Standards can be used in planning service delivery improvements by each team over time.

Community involvement Links with community groups, clients and agencies are made explicit in the program, and at the time of the external review.

The compatible principles and features described by Rowe and the characteristics of implementing Te Wana in Plunket suggest that this quality program has potential for whole system improvement with active staff engagement. This seems to me to match well with action research. Kelly (2005) offers practical suggestions for community interventions using participatory action research, referring to bridging the theory-implementation gaps in community based research activities. Community members and professionals can work together to take action, and evaluate outcomes. .

The Primary Health Care Strategy (MoH, 2001, p 24) states that quality processes are most effective when they are integral to and an ongoing part of the way systems operate. Further, high quality organizations as health providers will be those that have a culture of continual development. While this may be stated clearly, it may not be clear to everyone.

Several authors, including Rains and Ray (2007), and Sang (1999), comment that a shift is called for to move from tokenism to meaningful partnerships with citizens. Four emerging strands suggested by Sang are; recognition of overt identification of rights and responsibilities in relation to health and well-being, need to value learning at every level in the healthcare process, learning to manage one's own lifestyle and health journey, and working in partnership through mutual discovery and informed consent. These thoughts seem to strengthen the notion of involving staff in quality improvement in a particular way. Process and systems have become extremely important, and as Bennett (2008) states, achieving excellence in community services now and into the future requires clinical engagement and leadership.

Discussion

In New Zealand more emphasis is being placed on primary health care, a priority for local and central governments, and health authorities. However, there are questions yet to be answered as primary health care nurses struggle to allocate time to develop an essential nursing competency - quality improvement in a population health context.

Most community organizations realize that rationed resources means that there is never enough to meet all needs, and, there are many interpretations of what justifies "need" for health care intervention. The Te Wana Quality Program represents a process that is true to its name, supporting accountability and tracking improvements, for families who need care the most. It is a hands-on program which involves Plunket nurses and other staff in new ways, fostering increased enthusiasm for quality improvement. It also involves volunteers and stakeholders in ways previously under utilized.

Millar and Beardall (2001) suggest five common purposes in achieving better health care:
1. providing better access to cost effective primary health care services
2. providing better coordination, integration, continuity and comprehensiveness of care
3. providing more focus on the patient and improving the experience of care
4. providing better working conditions for health care providers, and
5. improving health and reducing inequities in heath status.

All of these themes are inherent in the Te Wana Quality Program. Plunket now has a repeating cycle for reflection using a set of appropriate standards, giving nurses more opportunity to enhance effective responses to child health promotion in populations. Practical ways to meet obligations in the Treaty of Waitangi are also helpful.

Most primary health care nurses struggle to deliver a meaningful service to diverse families based on assessing health determinants, a population concept. Many different measures are needed, and the word quality is used in a variety of ways by various groups of nurses. Griffiths (1995) suggests

that measures of structure and process should be validated by their relationship to outcomes, and will remain the best quality indicators as outcome data are often more difficult to find. The first priority may be to develop a deeper understanding of structure and process in order to improve the strength of subsequent investigation of population outcomes (Griffiths, 1995, p1098). It is interesting to acknowledge the Ministry of Health project in 2006, jointly funded with the Pediatric Society to develop a monitoring framework for child and youth health. Craig, Jackson, and Han (2007) report recommendations for additional measures or indicators to achieve maximal child health gains for New Zealand, useful elements in outcome evaluations.

The decision made by the Royal New Zealand Plunket Society Inc to implement the Te Wana Quality Program has developed the understanding for a cycle of continual quality improvement in the organization as a whole. While the standards give structure and explicit values to assessment activities, the potential to strengthen better primary health care outcomes for better child health remains future clinical and funding challenges.

Conclusion

Nurses and others have opportunities to fully participate in improving quality over time in a range of ways. Experience has shown that Te Wana is true to its name – "to challenge ourselves to achieve things, and to challenge our organizations to achieve the standards of the highest quality" (Kaumatua Kaunihera, Te Wana Quality Program 2007, p2), and implementing the program is a journey without end. Improvement means that scarce resources for health care must include allocating resources to sustain quality improvement. All staff need to know they do a good job and can improve on relevant standards. Leaders need to support continuous quality improvement in ongoing cycles. Quality improvement in PHC is recognized for complexity arising from many community agencies involved with the same families. And finally, continuous improvement of services must lead to better population health outcomes, specifically for Maori families.

These sentiments are compatible with those expressed by a number of authors, suggesting that staff engagement needs to be a holistic process rather than a particular isolated event. Each geographical Plunket area is responsible for their own journey in improving quality of child populations, to the same sector standards. Establishing defined and relevant quality improvement goals will eventually lead to better primary health care measured by population specific methods, and, more satisfaction for staff. This journey provides nurses with challenges, opportunities and connections with other community focused agencies, the beginning to learning how to impact on child health gains for populations..

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For information about Te Wana - www. hca.org.nz
For information about the Plunket Society – www.plunket.org.nz

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Supported by speakers from consumer groups, nurse practitioners and researchers in aged care.

Earlybird Registration before Aug 31st - $245.00
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For symposium programme, speakers and other information go to the Symposium website **www.cnasymposium.wordpress.com**
or the link on the College website **www.nurse.org.nz**

College of Nurses Symposium 2009

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

Health care for older people is customarily provided by a combination of public and charitably funded organisations whose philosophies and objectives vary, and which have tended to address the health needs of older people in ways that have been distinct from the mainstream. A number of services and strategies have been developed over the years to address some of the health issues older people deal with. It is increasingly acknowledged, however, that challenges and changing conditions of health care for older people cannot be viewed in isolation, since many of them are relevant to the wider health care sector. The health of older people is a concern not just of older people and those health professionals working with them, but of the community and health care professionals as a whole.

The idea of a Symposium arose from a growing sense among health professionals and others that a variety of salient issues relating to the health care of older people needs to be addressed and resolved. These include provision of suitable care and services to an increasingly large part of the population, the need for a well-conceived work strategy, and in general questions concerned with the increasing acuity and complexity of health care in this sector. The Symposium may not be able to address every one of these issues, but those organising it expect it to provide a creative forum for the discussion of some of the most pressing of them.

A two-day Symposium, organised by the Wellington branch of the College of Nurses, Aotearoa, is for health professionals contributing to the health care of older people. There will be stimulating speakers, papers, discussions and debate. This is an excellent opportunity to meet and debate a broad spectrum of issues relating to the health care of older people with a range of people active in the field. Among those contributing to the Symposium will be leading figures from organisations working with older people including consumer organisations, ministry advisors, nurse practitioners, researchers and policy makers. Speakers will address the issues from strategic, research-related and clinical points of view, and will include Professor Marilyn Waring, Rae Lamb, Dr Jean Gilmour (RN), Dr Mark Jones (RN), Roz Sorenson, Dr. Michal Boyd (NP) and Professor David Seedhouse.

Health care for older people entails more than just chronic care management. The health care needs of older people relate to a range of physical and psycho-social issues, with varying degrees of severity. The effect of these long-standing issues can eventually be compounded by acute illness superimposed on other longer-term physical and mental changes. Vulnerability and ill health among older people also requires additional health care. Nurses play a key role in supporting older people in the management of their long-term health concerns. They and other health professionals can be the champions of appropriate care and services for older people. Good health care for older people is underpinned by practices that value older people, maximize their potential, and ensure that they receive quality holistic care in partnership with those providing it. Policy-makers work closely with health professionals and older people to ensure that supportive frameworks are in place. Policy-makers, health professionals and older people can form alliances in partnership using an interdisciplinary person-centred approach, supporting older people with good practice and effective strategies.

The Symposium will bring consumers, strategy makers, researchers and clinical health care professionals together to inform and debate these and other issues to do with health care for older people. It will offer thoughts on positive change, locally and nationally, designed to improve health care for older people, and will be a catalyst for wider debate to ensure that in future health care for older people is both efficient and effective.

The Symposium will be a great opportunity for interested health care professionals to gain valuable professional development hours (14 hrs), network with others and contribute to a blueprint for the future of health care.

Please see over page for Symposium Speakers and programme information. For further programme information and registration details please go to the Symposium website www.cnasymposium.wordpress.com or via the link at www.nurse.org.nz or contact the symposium administrator by email -admin@nurse.org.nz or phone (06) 358 6000.

Sylvia Meijer and Vicky Noble
for the Wellington Organising Committee

We are pleased to announce the following keynote speakers for the Symposium:.

Prof Marilyn Waring (College Patron) *PhD (Waikato). Professor of Public Policy, AUT University. Gender and governance adviser to the RAMSI mission in the Solomon Islands. Treasurer of the Association for Women's Rights in Development (AWID) and one of two international members of the Board of the Canadian Index for Well Being.*
Marilyn was elected to New Zealand Parliament at 23 and served 3 terms. Author of "Counting for Nothing: what men value and what women are worth" it was the subject of a best selling documentary made by the NFB Canada "Who's Counting: Marilyn Waring on sex, lies and global economic".

Ms Rae Lamb, *Deputy Health & Disability Commissioner*
Rae manages the teams responsible for the whole complaints resolution process, including the triage and assessment of complaints, referrals to advocacy, providers or other agencies, and investigations. Rae also has permanent delegated responsibility for some investigations including rest homes, nursing, pharmacy and dentistry. Prior to this, Rae was a journalist working primarily as a political reporter and then covering health for eight years as Radio New Zealand's health correspondent.

Prof David Seedhouse, *Professor of Health and Social Ethics at Auckland University of Technology and Professsor of Values Transparency at Staffordshire University, UK. CEO of VIDe Ltd – creators of the Values Exchange.*
Professor Seedhouse is best known for his writing on health and ethics, yet his work straddles many areas of social, philosophical and political concern. His primary interest now lies in the development of Values Exchange, designed to enable transparent decision-making in health care, local democracy and other social settings.

The Symposium Programme also includes speakers and panel discussions on the following themes:

- **Community Partnerships**
- **Policy**
- **Practice - Nurse Practitioners in care of older People.**
- **Issues and Innovations**
- **Blueprint for Future Directions: The future of service provision.**
- **Older People and Ethical Decision Making: An interactive workshop.**

Drinks and music on the Friday night will be followed by the AGM at 5.30pm

Symposium Registration Information

College of Nurses Aotearoa Members	**$245.00**
Non CNA Members Earlybird *	**$245.00**
Non CNA Members (Registration after Aug 31st)	**$260.00**

*** Earlybird registration must be received by Aug 31st** to qualify for the reduced rate.

Registration fee includes attendance at all presentations both days; lunches, morning/afternoon teas, drinks on Friday evening and a conference pack containing materials relevant to the symposium.

Register now - Download the registration form from **www.cnasymposium.wordpress.com** where you will also find accommodation options and full terms and conditions of registration and a full programme or you can find the Symposium link at the College website **www.nurse.org.nz**
Any questions, please phone (06) 358 6000 or email admin@nurse.org.nz

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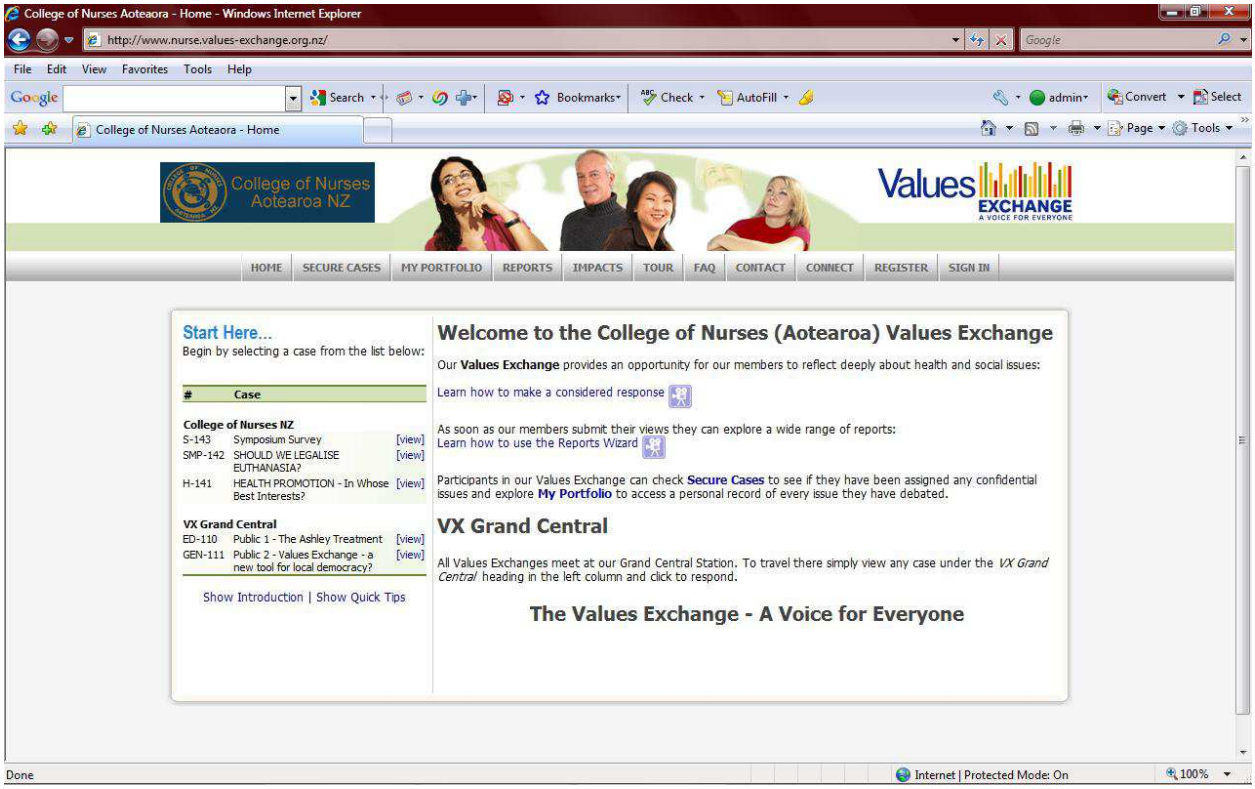
Values Exchange - a new College Initiative for 2009

The Board of the College is pleased to announce that we have purchased a Values Exchange on behalf of the College. We will be working closely with Professor David Seedhouse to make the Values Exchange a key part of College operations both internally and externally.



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Professor Seedhouse is best known for his writing on health and ethics, yet his work straddles many areas of social, philosophical and political concern. His primary interest now lies in the development of Values Exchange, designed to enable transparent decision-making in health care, local democracy and other social settings.

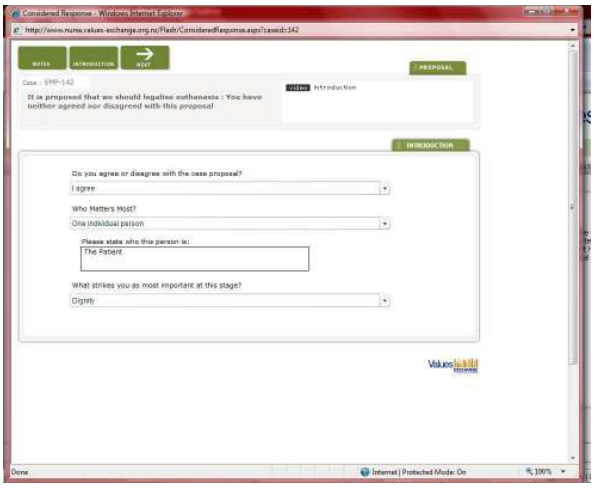
The values exchange is a web-based tool to which College members will soon have password-protected access. It has several possible uses both internal to the College or as a basis for workshops for health professionals. The possible ways of using the exchange include as:

A Unique Communication Tool

The Values Exchange is a unique tool, designed to help people who happen to be in different cultures and sub-cultures understand each other better. Currently, people enter into disputes and conflict because they cluster in 'tribes', each thinking its own group has 'the best' information and insight. By using the same framework of meanings and choices different cultures learn to appreciate why other cultures think and decide as they do; they realise that everyone has something important to contribute to each decision, and tolerance and respect grows quickly. We think there are major possibilities for having different groups of health professionals better understanding each other's view points.

A way to manage groups

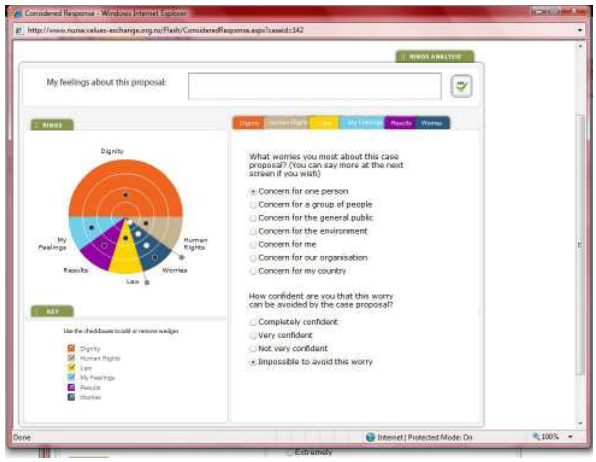
• Thousands of people can be quickly bulk-loaded onto the Values Exchange – or anyone can self-register
• People can be arranged into any imaginable combination of groups. Our reporting tools enable instant comparisons of any variable or variables in our database. For example, if you (or any respondent) want just the results from a particular ethnic group, or postcode, or age range then this is derived with a mere one or two clicks.



Creating Reports or submissions

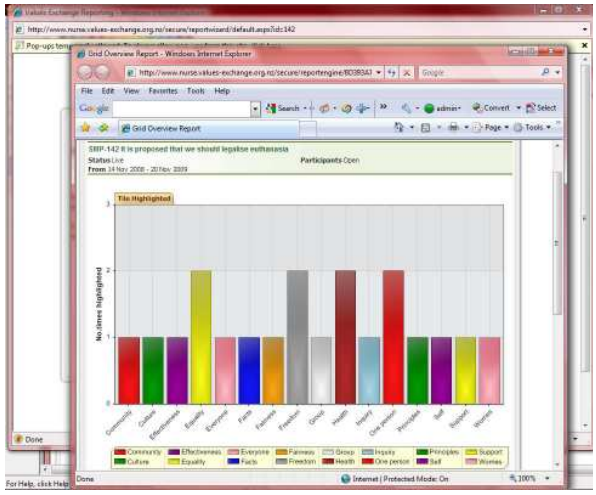
As people respond to each case their views and values are arranged in a powerful database.
This enables them to explore what everyone thinks about single cases; it also compiles their values over multiple cases, so they can:
• See their personal values trends – why do I keep making these decisions?
• See other people's values trends - why do other people think differently from me?
• Compare themselves with other individuals
• Compare themselves with other groups
• Compare group values trends with other group values trends collectively.
As soon as he or she submits her decision on any case each person is able to see what everyone else thinks. Every report is automatic, instantly available and fully transparent to every participant: nothing is hidden.

The Values Exchange www.nurse.values-exchange.co.nz is also a Powerful Survey Tool.



Surveys

• Simple one-off 'snap polls' - set up in five minutes with full, automatically analysed results instantly
A simple poll result
• In-depth surveys – set up within an hour with full, automatically analysed results instantly
• In-depth surveys over time – develop consensus ideas and solutions using a sequence of surveys – include everyone in collective, transparent decision-making
• Surveys can be open to all, or made secure and private to smaller groups.
• Instantly create themes in free text with 'theme builder' – find out what really matters



Once we become familiar and comfortable with internal College utilisation of the Values Exchange we will explore opportunities for increasing on line professional development opportunities for nurses and workshops designed to increase the opportunity for health professional groups to increase their communication and mutual understanding.

College members registered for Member Mailouts will receive an email in early August confirming their automatic registration to Values Exchange, please refer to the email to log onto Values Exchange. If you have not received this email, register via the registration link on the College Values Exchange home page.

"Oh, You're One of Those Nurses"

Angela Bouwers
Registered Nurse/BsN
Canada

The concept of relational practice in nursing is one of the founding principles that our profession has been known for. Oftentimes, however, the psychomotor tasks that a nurse is expected to complete take precedence in the busy hospital setting. As nurse researcher G.A. Hartrick states "Nurses have the opportunity to make a profound difference in peoples' health and healing experiences. However, our emphasis and reliance on mechanistic models of relating often results in our failure to realize this opportunity (2008)". This insight from Hartrick is very congruent to my own experience as a newly graduated Registered Nurse working in a small community hospital. I found to retain a balance between relational practice and completing the psychomotor tasks set before me, I had to be very self aware and intentional in my practice. I feel a competent, caring nurse is one that can use equally and in balance both a knowledge of the psychomotor skills and a relational focus within his/her nursing practice.

I received my Bachelor of Science in Nursing through the local college, North Island College, which is known for its focus on relational practice. While the psychomotor skills I learned within the curriculum provided a strong basis for my nursing practice, they did not take centre stage as to what was most important in patient care. Safe, competent practice was well-established by my nursing instructors with a reminder to practice ethically in remembering the person and fighting the temptation to allow the focus to be drawn to the skills that needed to be performed. The support from fellow students and instructors to take time to relate with a patient and really see them as a person with a context and journey, felt congruent to what I feel is the core of nursing. To be a caring nurse means to be able to see deeper than the monitoring of vital signs, the administration of medication, the laboratory values, the bandaging and casting, the IV fluids, and ECG monitoring. A caring nurse is able to see, really see, the person. It is to look into your patients eyes and see a reflection of your sister, your brother, your friend, your mother, your father, your grandmother, your grandfather…..yourself. If that relational, person-to-person connection can happen the psychomotor skills needed to support that persons healing become complementary.

However, once I graduated and entered the work force as a casual Registered Nurse in a small remote hospital, I came up against a huge pressure to place more emphasis on psychomotor skills than relational practice. The older and more experienced nurses would ask me where I did my nursing education and when they heard North Island College they would say "Oh you're one of those nurses". It appeared that nurses who graduated from a more technical and skill-focused institution were more highly valued than those institutions that have more of relational focus. I struggled to remember why relational practice was important in the face of the huge learning curve I was trudging through.

One day, I had an interaction with a patient in the emergency department who taught me yet again that while having the psychomotor skills to act competently and safely is incredibly important, a nursing practice that is relationally based is the first step to establishing a therapeutic and trusting relationship with the patient. I was on my first day orientation at small community hospital on the northern-most tip of Vancouver Island. The nurse (call her BA) I was partnered with felt the best way for me to be oriented to the hospital would be by placing me in the 5 bed emergency room and coming to check on me every once in a while. I was managing quite

well through the day when the police brought in a severely intoxicated woman who had fallen and hit her head on the concrete bed in the police cells. Realizing the need for more support (as the other 4 emergency beds were also occupied), I asked my orientation nurse to come and help me. The Dr had asked us to start the woman on IV fluids so BA asked me if I could start the IV which I said I could do after I had talked with the woman and introduced myself. Not seeing the need for this step in the process, BA suggested that I hold the woman's arm down while she started the IV. I felt a lot of tension internally at this point as I knew ethically I had to stand on my belief that relational practice is just as important as the psychomotor skills that needed to be completed in this scenario. Respectfully, I asked BA if I could have a minute with the patient before we started the IV. Shaking her head but remaining agreeable to this plan, BA went to collect the IV supplies. Meanwhile my patient was mumbling incoherently and trying to get out of the bed. Squatting down so that she could see my face, I told her my name, and asked her what her own name was. After this connection was made I asked the patient if she knew where she was. In her comprised mental state the patient replied "I think I am in the police cells and I think someone is trying to do something horrible to me!" Stunned by the implications of this patient's perception about her whereabouts and safety, I gently put my hand on her shoulder and told her of the situation she was in and where she was. Understanding flickered in her eyes as I told her we would need to put an IV in her hand and asked her if this was ok. With a more peaceful look in her eyes the patient agreed and stayed still through the whole process. Afterwards, I thanked BA for giving me time to have that moment with the patient before she started the IV and after this encounter I noticed a more accepting attitude from this nurse.

I think students and new graduates in the nursing profession are presented with many challenges the minute they step onto the ward. One of these challenges is the decision that appears to need to be made to either be the clinically, medically minded nurse who is proficient at every psychomotor skill or it's to be the relational, health and wellness, holistic nurse who can demonstrate the person to person caring aspect of nursing. As one very salient research article found it is difficult for many nursing students to see value in their practice because they become preoccupied with their perceived lack of knowledge and technical skills. Nurses and nurse educators should be aware of how this brands new graduates and informs their sense of developing professional identity (Beckett, Gilberson, & Greenwood, 2007). With the current state of a nursing shortage, it is easy for new graduates and students to decide to become more proficient in the skills aspect of nursing and consequently sacrifice the relational parts that are just as important to nursing as a caring profession. I have seen new nurses, under the pressure of high patient loads, increased acuity, and staffing shortages prioritize the relational piece of nurse-patient interaction to when there is time…. of which there rarely is. I myself often felt the push towards skill development even at the cost of losing the relational development part of my practice. Yet, I found, as Beckett, Gilberson, & Greenwood (2007-Jan) research shows that despite their feelings of deficit in terms of skills and knowledge, it is clear that many nursing students are, in fact, effectively negotiating relational ethics." To have this experience in emergency further enforced the importance to have a nursing practice that balances both the psychomotor skills and the relational practice. I hope that by sharing this experience nursing instructors, students, new nursing graduates and nurses will remember the importance of having a caring therapeutic nursing practice that takes time for the relational aspects of care in balance with psychomotor skill development.

Works Cited

Hartrick G.A. (28 June 2008). Relational capacity: the foundation for interpersonal nursing practice. Journal of Advanced Nursing, 26 (3), 523-538.

Beckett, A, Gilbertson, S, & Greenwood, S. (2007, January). Doing the right thing: nursing students, relational practice, and moral agency. Journal of Nursing Education, 46 (1), 28-32. http://www.ncbi.nlm.nih.gov/pubmed/17302097 website accessed June 03/09.

Trailblazing towards a Smokefree world in Mumbai

Trailblazer Award 2008 Recipient Grace Wong (left) from Nurses for a Smokefree Aotearoa, reflects on her recent trip to Mumbai, India to attend the 14th World Conference on Tobacco or Health.

Grace Wong (left) and global nurse tobacco control leaders Professor Linda Sarna, Dr Stella Bialous and Professor Sophia Chan"

Mumbai was extraordinary. I was immersed in a hot wet atmosphere smelling of traffic emissions, sewage, flowers or cooking wherever I walked outside. Beautiful children followed me, plucking my elbow and mutely putting their empty hands to their mouths – up and down, up and down. Every time I walked down my hotel street I passed a homeless family who lived their whole lives on the footpath. There were a babe in arms, a toddler and a pre-schooler. When I went out at 6.30 am they were asleep on thin mats on the concrete. The parents slept on the outside of the pavement but there was no shelter. Every aspect of this family's lives was public. Sleeping; eating; begging; talking. Sometimes they sent the pre-schooler after us with a flower to sell. The human beings in this family belonged to the eight million who are homeless or live in slums in Mumbai.

I am glad that as nurses we respect and help others and advocate for equity. Smoking and nicotine addiction impose an involuntary burden on families and individuals and I am glad I am one of the many nurses in New Zealand who work to help smokers quit. I was one of nearly 2,000 delegates at the 14th World Conference on Tobacco or Health in Mumbai, India in March. The conference participants came from 129 countries. Sixty percent were from developing countries. Tobacco companies aggressively promote tobacco product sales and tobacco production in these countries. The effect on health and the environment is devastating. It was encouraging to participate

Dancers having dinner at the networking event, 14th World Conference on Tobacco or Health

in concerted international efforts to address these problems.

The conference networking night was stunning. An Indian village was created at the local cricket club. It had street food stalls from all over India. The entertainment included henna tattoos on hands, massage, dance performances and an astrologer. I lost my colleagues – only to see them Indian dancing on the stage! It was an alcohol, tobacco and meat free outdoor event. Everyone enjoyed themselves, ate a lot of tasty Indian food and talked tobacco control with new friends from round the world.

There was a pre-conference workshop for nurses as well as a conference session dedicated to nursing research. The pre-conference workshop was attended by 43 nurses from 19 countries. It aimed to increase nurse involvement in smoking cessation education and interventions and tobacco control advocacy worldwide. The Global Network for Nurses and Tobacco Control was launched. It is based on a scoping document commissioned by WHO and authored by Jennifer Percival the tobacco control officer for the Royal College of Nurses. I was fortunate to meet Jennifer, Dr Ruth Malone, a nurse activist and academic who is the new editor of the prestigious international journal, Tobacco Control, and other distinguished nurse academics such as Professor Linda Sarna, Dr Stella Bialous and Dr Sophia Chan. All the workshop participants actively promoted nurse participation in smoking cessation interventions in their respective countries. They supported their work with rigorous research – a model we follow here in New Zealand.

Over 50 people attended the conference session dedicated to nursing research. A range of scientific papers was presented. One interesting paper advanced knowledge about barriers to the

provision of smoking cessation intervention by nurses by using structural modeling. The study found that role attitude, perceived resource availability, perceived co-worker's activities in addressing patients' tobacco use and perceived ability were important influencers affecting practice variation. My own paper reporting the development of Nurses for a Smokefree Aotearoa/New Zealand and the results of the needs assessment and national survey of nurses and smoking was well received.

My trip to India put New Zealand on the map with nurses from other countries supporting smokefree. My time in Mumbai and the short tour I went on after the conference gave me insights into Indian culture and society. These will be invaluable for my PhD research with Asian New Zealanders.

Grace Wong RCpN, MPH FCNA(NZ)
Director, Nurses for a Smokefree Aotearoa/ New Zealand

To join: email grace.wong@aut.ac.nz

Indian nurse delegates, 14th World Conference on Tobacco or Health

Trailblazer Awards 2009

We wish to announce that the Trailblazer Awards Recipients for 2009 are:

International Trailblazer Award $1500
Award to be shared by Gillian Alcorn and Rebecca Zonneveld

Trailblaxer Award $750
Awarded to Jill Tresize

The College Scholarship Committee has awarded a shared International Trailblazer Award to two applicants to enable both to attend the National Nursing Centres Consortium 8th Annual Conference on Nurse Managed Health Centres: Disruptive Innovations for Comprehensive Care in Philadelphia in November 2009.

Rebecca Zonneveld and Gill Alcorn are both trailblazers in Nursing in NZ through their achievement of Nurse Practitioner status in the area of youth health. This area of practice is increasingly recognized as a specialty scope of practice because of the specific knowledge and expertise required to work effectively with this group providing a solid foundation for health and wellbeing in later years, also the impact that nursing can have on reducing existing inequalities in this target group.

Rebecca and Gill will be giving a joint presentation on the model of care underpinning their respective community based health services, “Vibe” and “Evolve”, at the conference. The gathering will provide an opportunity to enhance the already active connection with the National Nurse Centres Consortium in the United States, and explore international developments in their chosen field.

Gill Alcorn has contributed significantly to the developing Nurse Practitioner network in New Zealand, providing leadership and mentoring to others on the pathway. Both Gill and Rebecca are role models for other advanced nurses through their establishment of new models of care for young people and their commitment to best practice. Both will be wonderful ambassadors for Nursing in New Zealand.

Jill Tresize is the successful applicant for the second Trailblazer award of $750 as a contribution to expenses to attend a practice nurse conference in Cairns in August this year. Jill’s experience is in chronic care management in primary health care, in particular improving seamless integration across various providers, and her interest in this conference is in relation to establishing nurse led clinics. Jill is keen to build on her experience in Counties Manukau DHB, where she has been involved in clinical practice and teaching chronic care management.

2009 Scholarship Recipient Reports

Recipient of the Puti Puti O'Brien Scholarship for 2009, Julia Ebbett reports on her masters research on patients' perceptions of the nursing contribution through the CarePlus programme.

Julia Ebbett RGON RSCN (UK) BN PGDip HSM, MCNA(NZ).

"What are patients' perceptions of the nursing contribution through the Ministry of Health funded semi-structured programme currently known as CarePlus?"

I have worked as the CarePlus Coordinator for HBPHO since July 2004. The question of how and what difference the nursing contribution in CarePlus makes has emerged from my practice work. Having completed papers in the Department of General Practice and Primary Health Care, Otago University in long term condition management, and primary health care as well as health research papers it seemed only natural to progress onto Master in Primary Health Care by thesis and explore these emerging concerns.

With ninety two percent enrolments, (equivalent to 5792 patients enrolled) in the CarePlus programme in Hawkes Bay PHO, the research is timely. My research commenced in early 2008 following approval from Central Region Ethics Committee with the intention of completing in March 2010.

The aims of this study are:

- To determine patient perceptions of the overall nursing contribution through the CarePlus programme
- To ascertain from patients elements of the overall nursing contribution they find helpful and why (these elements may include but not be limited to education, self management, care plans, skills teaching)

My research project seeks to understand the patient perception of the nursing contribution, specifically to the Ministry of Health funded semi structured programme currently known as CarePlus. As the largest primary health care workforce, nurses have the potential to effectively support patients in navigating health and treatment as well as supporting patients to utilise self management strategies. Such nursing roles are pivotal in the delivery of the CarePlus programme which focuses on setting health goals and fostering patient self management. Patient self management is critical, given that the burden of chronic disease is predicted to increase in future years (WHO, 2002). Indeed, patients who manage their chronic disease well are less likely to have acute episodes of care requiring hospitalization. This study will provide preliminary findings to assist in understanding the nursing contribution in CarePlus. This project will build on research already undertaken during which patients reported that the additional care provided by CarePlus funding was beneficial (MoH, 2006). Elements of patient perceived 'additional care' resulting from the nursing contribution will be identified.

College of Nurses awarded me the Putiputi O'Brien scholarship which will be used for ongoing associated costs of receiving supervision from Wellington. I am grateful for this assistance, without which, this research would not be able to progress. Thank you to all those who continue to provide support on a day to day basis through the ups and downs associated with combining research, study, work and young family commitments.

Recipient of the Marilyn Waring Scholarship for 2009, Collette Blockley reports on her studies on the experiences of survivors of poor prognosis cancer.

Collette Blockley

The experiences of survivors of a poor prognosis cancer: From first symptoms to five years plus, cancer free. What are their perceptions of why they survived?

I was delighted to receive the 2009 Marilyn Waring Scholarship and I wish to thank the College for supporting nurse researchers. This study commenced officially early 2006 (the idea was conceived a long time before this). I work full time as a nursing lecturer and study half time which is not something I would recommend, however it is the reality of many New Zealand nurses. I will share why I became interested in survivorship and at what stage the study is currently at.

I have often observed in my nursing practice the situation where two people similar in age, physical characteristics and social/cultural background are diagnosed with the same type of cancer. One patient dies very shortly after diagnosis and the other patient outlives their life expectancy by many years. A diagnosis of cancer can be a life changing experience for everyone, whatever their background. Faced with the knowledge that one's life is threatened demands internal and external resources that prior to diagnosis may not be obvious. A cancer diagnosis threatens to diminish or end a person's life, so why is it that some people not only survive and recover, but go on to thrive and lead an even richer and more fulfilling existence than before the diagnosis? This is one of the unexplained phenomena in cancer nursing.

Given that people are living longer after a diagnosis of cancer because of earlier diagnoses and more effective and aggressive treatments, survival is more likely than ever before. However cancer is the most common cause of death of New Zealanders (Ministry of Health 2007), and twice as many Maori die from cancer than non-Maori. Many factors contribute to survival and the quality of life of survivors. The purpose of this study is to explore a sample of New Zealanders' cancer survival experiences and perceived reasons for surviving a poor prognosis cancer. A grounded theory study based on the work of Glaser and Strauss (1967) is in the process of being developed to explore the research questions. In-depth, semi-structured interviews with twenty participants who have survived longer than five years following diagnosis of a poor prognosis cancer have been completed, with a further seventeen participants available to confirm or refute the data. Currently in-depth analysis including the development of core categories is well underway. These core categories are in the process of being selectively and systematically coded by a process of constant comparative analysis, to develop a core category which integrates all other categories. This multiple analyses procedure ensures rigour in arriving at a theoretical explanation for the experiences and reasons for surviving from the research participants' perspectives.

The two main concepts identified to date are a) possessing or harnessing an inner fight or strength and b) having sufficient levels of

family and community support. The idea of possessing inner strength may be explained by the phenomenon of resilience, which itself may be a factor of coping ability and positive adjustment to illness that is life threatening. The level of family/community support one receives when seriously ill may also contribute to developing inner strength, when such support is appraised as action-oriented and problem-focused.

The development of this theory may assist newly diagnosed patients with cancer to position themselves in the best possible place for survival and assist health professionals to provide the appropriate support for them. Since nurses are often in the position to care for persons with a poor prognosis cancer, it is important to progress our understanding of the experiences of people who have or are surviving cancer and the factors that people themselves believe contribute to their survival. This knowledge will not only prepare nurses better for their patient support role, it will potentially assist the persons diagnosed with cancer.

Thank you
Colette Blockley

New Regional Coordinators for Otago

We are pleased to announce that Jean Ross and Rachel Parmee will be sharing the position of Regional Co ordinator for Otago.

They are looking forward to hosting a Portfolio Presentation workshop around September / October.
This one day workshop with instructor Stephen Neville will quickly and easily aid you in completing your own Professionally presented protfolio .
Stephen has instructed at many of these workshops and with feedback from participants like " many RN's have found today to be highly beneficial and with the cost at only $150 for the day was well worthwhile" and "Stephen really is a fantastic presenter, I put off doing my porfolio thinking that it would be too difficult, but it is now a simple managable task."
All attendees will receive a portfoilo and full set of notes as well as a certificate for 6 hrs of professional development hrs.

A regional group meeting will also be held with Stephen as guest speaker, discussing the clinical of Aged care. This will be followed by supper and all RN's are invited to attend, so bring along a friend. To register your interest please email Jean -jeanr@tekotago.ac.nz or Rachel - rachel.parmee@kinect.co.nz

Calling all Canterbury Members, Old and New

Meeting Monday 24th August 4.30 - 6pm in N603 on the 6th floor of the Nursing department, CPIT
We would like to catch up with everyone, bring people up to date with the Colleges activities think about regional activities for the future and look at installing a new College Regional Co-ordinator/s.
All very welcome Any inquires to Judy Yarwood at yarwoodj@cpit.ac.nz

College of Nurses, Aotearoa

Regional Co-ordinator Vacancies

Manawatu, Hawkes Bay, Marlborough

Please contact the College office for more details.
(06)358 6000 or admin@nurse.org.nz

Conferences & Events

Save The Date

26th & 27th August 2009 Christchurch
Leading in Care - Soaring in Practice
College of Emergency Nurses and Flight Nurses Annual Conference
For more information go to - www.conference2009.co.nz

16th October Wellington
College of Nurses Aotearoa Inc. Annual General Meeting
(See page 5 for details)

16 & 17th October 2009 Wellington
Symposium- Nursing and the Health of Older People: Practice, Policy and Partnerships.
College of Nurses Annual Conference -
(see page 10 for more details)

13th & 14th November 2009 Wellington
Palliative Care Nurses New Zealand Society Inc Biannual Conference
"United We Stand – Strengthening The Links"
(see page 15 for more details)

If you know of an event that you would like to see in this section of our next issue in August, please send details to admin@nurse.org.nz

Community based nursing - a job to be proud of.

Jill Trezise, College member, shares her story on how the influences of her early life led her to a position as an independent community nurse, proud of the differnce she is making in her community.

Jill Tresize

I wanted to be a nurse for as long as I can remember, my dolls had nursing uniforms and my baby dolls regularly had all manner of invasive procedures conducted upon their poor plastic bodies.
Early life experiences form the basis of perceptions and ways of knowing. From my early years my perceptions around health were of wellness, very healthy lifestyles, among a predominantly elderly community within a very tight coastal beach environment . Socialisation occurred at church every Sunday and inviting new members to share a Sunday roast with new friends from church was a pre-requisite to belonging to the local community.
So.....how has this early life experience influenced my nusing practice?
Moral imperative forms the basis of my caring attitude which is characteristic of my hospital trained peers (1975-1978). Social injustice raises my ire which I believe has roots in the classless and endearing traits of a community that formed very many protective layers upon it's members through "thick and thin". On reflection it is the formative early years that consolidated my own personal nursing philosophy.

Learning experiences and resiliency are increased through adverse conditions. Many of my generation will be familiar with hard work, low incomes, lack of child care and a the male chauvinistic attitudes of the males, suiting the menial and subservient nature of nursing in that time. I have learnt much, gained strength and become very resilient following lifes' bitter sweet blows.
Secondary healthcare was the foundation of my nursing experience but from the aforementioned strength I have assumed collective responsibility for those less fortunate than myself. I believe the moral imperative attiditudes of my local community influenced my compelling need to offer something back to those women. I can still taste the hot chocolate served up after school by elderly spinsters, I can smell the violets that we picked together from the retired missionary's front garden, I can feel the fur coat that we were given by the high society widow to play dress ups in, and I can remember the sorrow of our neighbour as she sat by the fire getting warmth on the evening that her blind husband died. These wonderful elderly folk nutured me through childhood, so it is natural that I would feel a strong sense of déjà vue in visiting other old folk within any community. Growing old has a commonality that crosses all cultures and classes. Hence my sojourn into primary care after 15 years in secondary care.
The knowledge gained from working many years in a small hospital, in various roles such as; after hours supervising, A&E work , CCU, ICU and Neonatal work have given me a broad set of skills to consolidate into chronic- care long term conditions. It also raised my awareness of the need to stem the burgeoning health crisis in diabetes and cardiovascular disease among disparate populations such as Pacific , Maori and the elderly.
This is my new found passion, well after 4 years I still feel a novice. My experience is now firmly integrated within the patient's own experience and sense of being within their own health continuum. My personal professional health development centres along the needs of my patients. Therefore if I need to integrate with Non Government, allied health, secondary care specialist and my peers I can.

In order to become more effective within this wider scope of nursing I became independent. No I am not academic, in fact I am dyslexic . I am reassured that the most innovative and creative New Zealanders such as Richard Taylor and the Mad Butcher are also dyslexic, this notion sustains me.

Independent nursing autonomy gives me political freedom and allows me to chair an interdisciplinary cell group of all my peers working in South Auckland. As I struggle through post graduate education I am cheered at a group of nurses that voluntarily give up their precious time. These nurses meet occasionally in order to share experiences, network and learn from others in an evidence based informal learning environment.

This freedom also means that if I develop a relationship with a client that exceeds the prescribed hourly commitment I can see them when I want. My friends never ever abuse this privilege and try to ensure that I don't either. In this capacity I have witnessed elder abuse, gastro intestinal haemorrhage at home, legalities of relations accessing power of attorney, unsafe and unhealthy living conditions within the governments housing schemes, and poverty and starvation on a scale that no New Zealander should have to experience. Hence I try to build personal strength, subsequent family/whanau strength and build protective community layers to prevent this happening.

Nursing practice within primary care settings is becoming increasingly complex. My own set of personal professional development this year has involved immunisations, long term conditions (another post graduate paper), respiratory (CNE) continuing nurse education , diabetes update , community health worker teaching sessions, depression modules, sexual health standing orders, smear update, and CVD. My next paper next semester was to be rural health as I felt this paper content most reflected my professional development needs working within an outreach setting. However sadly this paper has been postponed due to lack of applicants. I am now resigned to either education or leadership papers.

My community outreach work is where I feel truly valued. My relationships with people in this setting are one of trusted friend which itself brings a sense of mutual respect, kinship, caring and loving. There is a strong sense of advocacy in these roles but most important is the respect shown to me by family members. With their permission I can then co-ordinate various agencies to address their own social determinants of health.

Case management needs to be recognised within the primary health care sector. District health boards (DHBs) can lead innovative pathways into integration with other allied health professionals. These multidisciplinary teams such as physiotherapists, dieticians, speech therapists, pharmacists. GPs, administrators, housing and income support workers, diabetes nurse specialists, respiratory nurse specialists and cardiovascular nurse specialists can make a difference.

Unfortunately there is still no agency (that I know of) within primary health care that pulls it all together.

Primary healthcare generalist nurses are the way of the future. They have the level of knowledge and networking required to co-ordinate the plethora of services involved in order to make a difference.

I have held the hands of three dying patients recently. Their co-morbidities comprised principally of congestive heart failure, diabetes, lung cancer , COPD and liver failure. These presentations included end stage lung cancer, haematemesis and maleana, and septic shock.

These experiences continue to inspire me. Two out of three of these patients died but those two both died knowing that someone cared. The other has recovered, is surrounded by loving family and is committed to living life with an improved quality.

I am proud to be a nurse, my mother was also proud and my daughter is also proud to be a nurse. I look forward to an exciting time within nursing of innovation, value, respect and above all being recognised by all as an integral part of people's communities, and assisting those same communities in meeting their personal and collective community health needs.

Jill Trezise

Nurse to anyone and everyone that I meet including the dogs!

Membership Update Form

Over the past year we have completely upgraded our database and accounting system and would like to thank all our members for their patience while we have been working through the occasional hiccups in this process.
It is vitally important that we have a complete set of contact details for all our members, these are required for Indemnity Insurance purposes but also because something as simple as a change of employment or address can leave us with no way of contacting you. Some of our records have not been updated in many years and although you may not have moved house we do require an update of email addresses, phone numbers, employment and expertise information.

Please fill in the form below and post or email to the College office ASAP, address below.

Please write clearly in block letters.

Date .....

Preferred Name.....

Title ..... First Name..... Surname.....

Postal Address .....

City ..... Postcode.....

Ph No. Hm (.....)..... Bus Hrs (.....).....

Cell .....

Email Address ..... (Preferred email for College emails)

Alternate Email Address .....

Qualifications ..... (Professional and Acedemic)

Employer.....

Profession .....

I **do** / **do not** wish to receive Member Email Updates.

I **do** / **do not** wish to be included in Discussion Group Emails

Clinical Experience / Expertise (please specify).....

.....

Research Interests.....

.....

Please tick.

- ❍ Workforce Development
- ❍ Leadership / Management
- ❍ Policy Development / Review
- ❍ Education
- ❍ Curriculum Development
- ❍ Portfolio Development
- ❍ Career Development
- ❍ Legal Issues
- ❍ Working with the Media
- ❍ Preparation of Submissions
- ❍ Research
- ❍ Nursing / Health Informatics
- ❍ Report Writing
- ❍ Community Involvement

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Email - admin@nurse.org.nz