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Our obsessive restructuring

In a recent Listener (March 20-26) Jane Clifton talks about the R-word... most often known as restructuring but sometimes referred to euphemistically as reorganisation, reprioritisation, realignment and even, more recently, re balancing. In true Jane Clifton fashion she concludes her introduction by saying "in other words, cuts".

This week (beginning March 15th) the Ministry of Health released internal, consultation documents on planned restructuring subsequent to the formation of the National Health Board (a giant high-level restructure) and undoubtedly as a result of the political changes under a new Government. At the same time many DHBs are yet again engaged in various degrees of restructuring in an attempt to manage budgets better.

Anyone who has been in health for any length of time will be aware that restructuring is a constant fact of life and a quick review of the literature about restructuring suggests that it is a largely pointless process which seldom achieves the desired goals, seldom improves outcomes and has many unintended and largely negative consequences.
A number of researchers point out that there are no randomised trials or longitudinal studies of restructuring and little scientifically acceptable cross-sectional work.

One review I found on line (Braithwaite et al, 2005) outlines the evidence challenging the restructuring phenomenon which showed that there were considerable negative effects such as "setbacks of at least 18 months in progress, problems in fusing different organisational cultures, no better recruitment and retention of clinical staff and savings below those forecast."

Braithwaite et al (academics at the UK Centre for Clinical Governance Research) also note that:

"The tectonic plates of organisational structures always seem to be moved around in healthcare but does this change the way clinicians practice or services get delivered? The evidence on balance suggests not. So it's a puzzle why ministers and senior departmental staff keep restructuring. Perhaps it's just an exercise of power more than anything else."

In the same source it is noted that
"Restructuring is so pervasive, in fact, that observers could be forgiven for thinking it is the only change tool available. In the health sectors of Britain, New Zealand, Canada, the USA and Australia the activity seems virtually continuous. Primarily it consists of regular mergers, altering the responsibilities between central and peripheral bodies, setting up new agencies that trigger domino-like changes to the official responsibilities of other agencies, constantly tweaking organizational charts and re-orienting who reports to whom."

Further the authors note that
"In truth, there are no randomized trials, no longitudinal studies of multiple restructuring events or time series designs and little scientifically acceptable cross-sectional work. There are local case-study examples in the grey literature, of course, but hypothesis-testing research is virtually non-existent. Where there are studies, they challenge rather than support restructuring"
There is a stunning similarity in the critical reports of the restructuring phenomena and most of it will be deeply familiar to those of us who have lived through or observed many restructurings. Again drawing on Braithwaite et al who say it so much better than I can:

"New organizational charts are released displaying new boxes with novel titles and some trimming of old positions, not a lot changes in terms of their own work or responsibilities. Sure, the title of their clinical directorate may alter because someone fuses two or more together—or the name of a new national body is publicized with fanfare, with a mandate to enhance quality or safety or compliance with regulations—but the professional arrangements that deliver direct, local care to patients seem untouched."

For many organizations restructuring has become a recurrent and continuous process. It is rarely acknowledged that restructuring puts the physical and psycho-social health of all organizational members at risk. Just reflect from your own experiences how much time is devoted to distressed conversations, planning and writing the inevitable submissions, feeling distracted by possible personal implications for what is proposed and the inevitable guilt when some lose and some gain from the changes implemented.

It is to me a deep irony that after so many years and such pressure to improve our ability to deliver health services within budget we still revert to the tried but empirically untested processes of restructuring; not just here in NZ but across the Western world. Is it because the real changes needed are just too hard and too protected by vested interests?

Just moments ago, I had an interesting discussion with a doctoral student who is caught up in planned restructuring and planned divestment of services at one DHB. She made the simple but profound observation that no matter how a service is restructured and no matter what service is discontinued the clients will still be there and their needs will still present at some other port of entry. Just possibly they will also present more acutely or with more complex needs and through a more expensive service.

There are always casualties of restructuring and all too frequently nursing bears considerable brunt. Many of us watched with horror as nurse leadership was dismantled in the 90s, substitution of nurses with care assistants occurred and the foundational structures, which allowed nursing to manage nursing, were dismantled. Much of that has been rebuilt in the last decade but is it safe or secure and were the lessons truly learned?

The Ministry restructuring documents bear the usual words about consultation and people being listened too. They have the requisite coloured boxes and altered reporting lines. Buried in the document is the repositioning of the Chief Nurse position at level 4 in the management tier whilst the Chief Medical Officer reports directly to the Director General of Health, sits on the Executive Leadership team, with stated recognition as to the significant 'strategic leadership' responsibility of the role. The Chief Nurse position is buried within the workforce division suggesting some extraordinary assumptions as to what that position is about. From that position how will the person in the role be effective?. How will they ensure that all policy decisions and especially those concerned with safety and quality and with primary health care services are subjected to critically important nursing oversight? The previous incumbent had also made a determined effort to position the Chief Nurse role as a 'professional anchor' within the Ministry, in an attempt to give all nurses a sense they could influence policy and in turn that policy reflected the support the profession needed in order to provide the best possible care. Within the new structure there is a very real risk that such connectedness will be lost, or at least severely compromised.

Such a move suggests that the Ministry of Health continues to understand health and health services from a medicalised perspective and ironically has not truly grasped the directives of the primary health strategy. The strategy aimed to move the focus from a reactive and medicalised model of first contact care to a model of community partnership and community embedded ownership of health and health services with a focus on proactive and integrated services. How could medical advice possibly be so much more pertinent to that agenda than nursing advice?

It always amuses me in a kind of painful way that we have had a medically led health care system for about 100 years and we now have an epidemic of long term conditions and severe challenges in funding the services to which we have become accustomed. Is this alone not an indication that a change of focus and changing the advice on which we depend is long overdue? Instead, yet again, we are embarking on another round of what some have called "rearranging the chairs on the deck of the Titanic". Seems pointless and curious really in a system that speaks constantly of the importance of evidence.

Braithwaite, J Westbrook, J., Iedema, R (2005) Restructuring as gratification J R Soc Med. 2005 December; 98(12): 542–544.

Pilot of Physician assistant role proposed for New Zealand

Recently the College received briefing documents reporting the intended trial of physician assistant roles in New Zealand.

The briefing document stated that:
Over the past few months, the Auckland DHBs and the University of Auckland Faculty of Medical and Health Sciences have been undertaking preliminary investigations into a possible pilot of the medical model Physician Assistant role in the region. This work has coincided with the establishment of the Ministry of Health's Health Workforce New Zealand (HWNZ – previously the Clinical Training Agency Board) which, through its workforce innovations unit, has been liaising with the DHBs in relation to pilots of different models of care and/or different scopes of practice for health workers.

As a result of discussions between HWNZ and the Northern Region DHBs, it has been decided that, as a first step, the region should plan for a pilot of the medical model Physician Assistant role in surgery (including elective surgery). This pilot is to be undertaken by Counties Manakau DHB on behalf of all the Northern Region DHBs. The University of Auckland Faculty of Medical and Health Sciences is partnering the DHBs in the pilot.

The pilot is the first step of a wider pilot of the Physician Assistant role in the region and is a joint initiative between HWNZ, the DHBs and the University of Auckland. At this stage, HWNZ has approved funding to enable the pilot to be developed. Once the CMDHB pilot is underway, pilots in other DHBs and specialties in the region will be considered.

Purpose

The purpose of the first pilot at CMDHB is to determine whether Physician Assistants trained under the USA medical

model and working under the delegation of a vocationally registered medical practitioner have a role to play in the future of surgery in NZ.

- We also hope that the pilot will provide information that may assist with:
- determining the issues associated with undertaking a pilot of this nature (this first CMDHB pilot is seen as a "pilot of the pilot")
- determining whether Physician Assistants may have a wider role to play in other medical specialities
- determining future regulatory requirements, if the Physician Assistant role is to be established in NZ
- decisions regarding the potential development of a NZ based education programme for Physician Assistants

Proposal

The proposal is to bring two USA trained Physician Assistants to NZ to work at CMDHB for a period of 12 months. The Physician Assistants will work in a midlevel role under the delegated authority and supervision of a Senior Medical Officer (SMO) and within the SMO's scope of practice. The pilot will be independently evaluated.

The Physician Assistant role does not currently exist in the NZ health workforce but it is well established in the USA and is being developed in the UK. A pilot similar to what is proposed for the Northern Region is currently underway in South Australia and Queensland. The pilot at CMDHB will be modeled on the Australian pilot and will draw heavily on the knowledge and experience of those involved with this pilot.

The College has been aware for a long time that moves were afoot to consider implementing this role in New Zealand. In 2006 we commissioned a literature review on physician assistants which was complex due to the enormous amount of international literature available. In summary this review noted that:

It would appear that Physician Assistants are well established and fully accepted as health providers in both primary and secondary care within the US. Evaluations of the quality, cost and accessibility of care they provide are positive. While there is some overlap with the Nurse Practitioner role, there is sufficient evidence to suggest that their medical-based training and required supervision enables them to occupy a different and potentially complementary niche within the healthcare team. Physician Assistants are clearly a cheaper option to most physicians, but are receiving higher salaries than Nurse Practitioners and in some cases higher salaries than new medical graduates. The role is gradually being introduced into the UK, with some opposition, and there is also interest from the Australian health system (Brooks & Ellis, 2006).

One other finding from the literature review was that physician assistant candidates tended to come from existing health professional groups and especially from nursing, which has worrying implications for the provision of nursing services. Varying opinions are currently being expressed about "whose" work the physician assistants would actually be doing but there is general consensus that there is more than enough work for all and that existing health professionals of all categories are stretched to their limits.

The College was invited to provide feedback to those overseeing the physician assistant pilot and after some deliberation responded as follows:

The College, NPNZ and NPAC-NZ recognise the immense challenges facing the health sector and we are respectful and committed to innovation and new ways of delivering services. In all decision-making, the ability to service the needs of patients and communities should be the overarching framework for decision making.

Accordingly we do not offer or suggest any formal resistance to exploring the role of physician assistant in New Zealand. However we offer a number of caveats to that view.

We note your comment that "The DHBs see making greater use of mid level practitioners like Physician Assistants as one possible strategy for meeting growing health service demands." We are aware that this terminology (mid level practitioners) is used in the highly medicalised health system of the United States and we note the relatively poorer outcomes for investment in that country. It is an unfortunate term implying a hierarchy of value with full medical training as the pinnacle of that hierarchy. In some instances some categories of health professionals are even referred to as non- physician providers - a terminology which speaks volumes.

Not surprisingly nurses and nursing organizations view health and health service as a much more complex entity with medicine and medical training as important but also as a single component of that entity. There are many other forms of knowledge and skill other than medicine offering high level care and services.

One major challenge to news ways of working in health is to break down the silos of primary, secondary and tertiary care and move beyond structured contracts for services to an approach which follows people across the continuum of care. When the nurse practitioner role was launched in NZ in 2001 it was based on a substantial evidence base showing excellent health comes and safety derived from a practitioner with the capacity to provide high level nursing services plus including additional skills historically delivered by doctors.

The journey to establish that strongly evidence based role in NZ has been long and hard and fraught by ignorance and obstruction. At this point in time almost all of the legislative barriers identified in 2002 remain in place meaning that the 70 pioneering nurse practitioners work with frustration and lost potential to fully meet the health care needs of the people to whom they provide high-level services. There are no guaranteed clinical programs associated with the nurse practitioner academic pathway to ensure structured and supported development as is experienced by medical registrars.

You will understand that it is hard for us to feel especially enthusiastic about a physician assistant pilot attracting immediate high-level support, which will undoubtedly be sustained. We also note the salary range being mentioned [reported anecdotally as $90-120k per annum] and wonder why it is higher than that which is offered to nurse practitioners given the relative educational and clinical preparation, and the level and complexity of service independently and autonomously delivered by nurse practitioners.

Our final caution; a careful review of the literature shows that, inexplicably, nurses are frequently attracted to the physician assistant role and the salary level offered in this country will no doubt increase that drift. Certainly some nurse practitioner candidates who have endured the frustration and unemployment uncertainty may well consider that pathway. Such a development may support the current model of service delivery but will do nothing to support innovation and new ways of working. It will also waste the particular skill, knowledge and attributes of nurses, especially senior nurses which should be used far more imaginatively."

We copied this feedback to health minister Hon. Tony Ryall and to Professor Des Gorman as Chair of Health Workforce New Zealand. This was in order to use this pilot to draw attention to the scandalous waste of time and energy, which occurs through the ongoing failure to seriously address the persisting funding barriers to Nurse Practitioner employment. Equally wasteful is the continued existence of nearly 60 legislative barriers, which create daily obstacles to NP practice and waste time and money and reduce the quality of care and access for patients. Sixty-three barriers were identified in 2002 and it is a testimony to bureaucratic dithering that almost all of them of them still exist in 2010.

SYMPOSIUM
HEALTH – The Wealth of the Nation"

24th - 25th November 2010
AUT North Shore Campus,
Akoranga Drive, Auckland

Day 1: 7:30am – 5:00pm,
Evening event: 6:30pm – 10:30pm
Day 2: 9:00am – 3:00pm

Key Speakers: Gareth Morgan, Glenn Gardener, Chris Clarke, Jenny Carryer

During this 2 day Symposium, key speakers will present their perspectives and research on the current practices in respective health systems. Panel forums and small group meetings will provide an opportunity for participants to explore further the information presented throughout the day.

The Event Objective is open dialogue between delegates as to how this issue may be approached and to provide a vehicle for health professionals to lobby progressive policy change and systematic development.

The symposium will be useful to anyone working within the health sector interested in innovative models to serving community ongoing health needs.

For information or to register your interest contact: Helena Mill, email: hmill@aut.ac.nz

PROFESSIONAL PORTFOLIOS

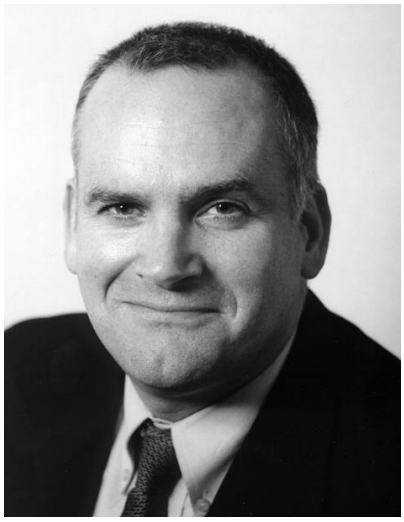
College of Nurses Professional Portfolio's are available for purchase from the College office. This includes a full set of instructions for completing your own professional portfolio to comply with Nursing Council regulations)

$30 for members, $35 for non-members. (Inc postage & GST)

To purchase a portfolio, please forward payment and postal address details to the College office - PO Box 1258, Palmerston North 4440 or call (06) 358 6000 for more information.

Nurse, Care for thyself.

On February 19th 2010, an historic meeting occurred in the history of New Zealand nursing. I dare say that we could look back to others of equal import, and there are no doubt more to come, but, on this day, the collective leadership of our profession came to a consensus that will form the basis for the ongoing development of the Registered Nurse role and scope.



Dr. Mark Jones

The meeting concerned came about following the consultation exercise undertaken by the Nursing Council toward the end of last year in which they sought opinions as to the future regulation of the RN scope of practice. Council set about this task as it was faced with an ever-increasing range of demands for guidance as new roles and functions for the RN were being determined, not only by our own profession, but also by policy makers and employers. Notable was the debate around surgical first assistant roles (whereby nurses undertake de facto surgical activity) the provision of colposcopy services by nurses, and the Ministry of Health consideration, albeit behind closed doors, of the potential for nurse endoscopists to assist with the delivery of the yet to be finalised national bowel screening programme. These are just a few example of the so called 'expanding role' of the RN, and in my role as Chief Nurse I was almost daily being asked for an opinion as to whether nurses could excise moles, inject into eyeballs, laser spider veins, and many other possibilities.

An obvious starting point to address these issues is the agreed and gazetted RN scope of practice. Yet, many were questioning whether the scope statement gave sufficient guidance, with some looking for rather more of an endorsement of their plans, and indeed current practice, and others seeking limits to be placed on what they could reasonably be asked or expected to do as a registered nurse. At this point the Nursing Council did a brave thing; they turned to our profession for guidance.

We need to just stop off for a moment here and consider the position of our regulator, the Nursing Council of New Zealand. The Council is charged under the terms of the Health Practitioners Competence Assurance Act (HPCA) to ensure the public receive quality nursing care and are protected from errant practitioners. Whilst the Minister of Health appoints some of its members, Council undertakes this role independently from government, and anyone else for that matter. This status does irk policy makers from time to time, as well as representatives of the profession in our various nursing organisations, yet the right to self-regulation is a prize to be cherished. Council could, therefore, have made a pronouncement as to the extent of the RN scope of practice and nipped any potential role creep in the bud, yet they were wise enough to realise this issue was truly significant for the profession and the public in general. Balancing public safety with the need to innovate and determine the future nature of nursing required a decent consultation process with all concerned.

So, Council duly consulted, and the nursing profession responded. Unfortunately the responses received, not just from nursing, were supposedly a jumbled mess. Some wanted the Council to exercise due authority and regulate every aspect of the potential expansion of the RN scope, others envisaged a more liberal hands off approach with nurses determining their own competence within the existing scope statement, some wanted this combined with oversight from employers, different opinions were expressed from professional organisations and trades unions. In essence, and pardon me, the Council got a 'bum steer'. For my part, I was exasperated that NZ Nursing couldn't get its act together and give our Council a clear direction, and I went out of my way to express that opinion. The realisation that we had missed a golden opportunity to provide our colleagues, and representatives of the public interest sitting on Council, with a clear message and reassurance that they could take us forward through re-modelling the scope statement or

leaving it as it is, with some published guidance, was a serious blow. Surely our profession had the wit to sort out its own agenda?

Once the Council had posted the summary of responses to the consultation on its web site various interest groups began to soul search. Directors of Nursing of DHBs all suggested they had given the Council a unified opinion, nurse executives of private providers similarly agreed, and it seemed that the professional organisations hadn't deviated so much in their view. So why was Council saying the consultation was diffident? Faced with this question and the obvious realisation that our profession needed to get a grip on the situation and give Council a clearer view next time it asked (it had indicated the intent to do so early this year), the umbrella group for our national leadership; Nurse Executives of New Zealand (NENZ), invited just about everyone who had an interest in our profession to a consensus conference. We were to address the RN scope issue once and for all!

Looking around the room on February 19th, the seriousness of the situation was evident. Everyone was there. Nurse educators, professional organisations, pretty much all of the NENZ membership, state sector Directors of Nursing, their private sector counterparts, the military, Chief Nurse, and representatives of Council themselves. Gary Lees, Chair of NENZ and Director of Nursing for Lakes DHB opened up with an outline of the task at hand; other speakers followed highlighting the need to get this right. Yet it was the frank approach taken by the Nursing Council representative that was to break the deadlock. We were given an insider view of the consultation results, and whilst one would have hoped that all parties had been straightforward in their comment, the reality was somewhat different. It transpired that a significant non-nursing profession that wields some clout in our health care system had been expressing unease at the potential for an expanded RN scope of practice, the limits thereof being determined, heaven forbid, by nurses themselves. This disquiet had not been made known directly to the Council, rather it had been suggested to the office of the Health and Disability Commissioner that patient safety was indeed at stake. This siren call will be familiar to anyone who has watched reactions to nursing seeking to acquire more extensive practice rights, such as the ability to prescribe. Running for the moral high ground of societal risk is an easy way of unsettling those charged with ensuring safe practice and quality service provision. Sneaky though. Once this manoeuvring was clear, things got going rather quite easily.

I would have to say that Council's PR in this respect could have been rather better. The general sense that nursing "did not get its act together," and that it was this that had wrong-footed these decision makers, had played into the hands of the naysayers determined not to see our profession widen its scope of practice other than through the most rigorous of regulatory processes. Indeed, I had found myself being critical of a seemingly disjointed approach, when in reality the skulduggery of others was at hand.

Nevertheless, freed from the burden of potential self-deprecation at not having given Council a consistent view, we were able to once again determine an agreed position there and then. We would need to do a little more work on definitions of expanded, extended and advanced practice and highlight the importance of being adequately prepared for new types of roles with their associated responsibilities. The profession would reassure the Council that it had the means to determine what is and what is not the practice of an RN. A decision making flow chart on RN scope challenges has been developed an will be tested. The use of the flow chart, supporting criteria and the Ministry of Health's credentialing framework for health professionals, soon to be released, will provide the reassurance Council requires.

The process to do this would be supported by nursing organisations. In addition, a formally mandated consortium of nursing organisations, for now recognised as the NZNO, The College of Nurses, The National Council of Mäori Nurses, and College of Mental Health Nursing has been established to provide endorsement of practice standards and specialty knowldge and skills frameworks. The consortium may use a range of contemporary practice experts working to an agreed decision making framework to ensure that practice standards are supported by formalised standards, education, professional development, credentialing, and appropriate clinical supervision. All of this would be underpinned by a robust competency based PDRP system.

There you have it. February 19th saw a definite consensus and within a matter of days, Jocelyn Peach, secretary to NENZ, pulled together our deliberations and duly forwarded notice to Council that we have the ability to determine what is and what is not nursing practice, and to advise them as appropriate. Work still needs to be done around some definitions, PDRPs tweaked, and a decision-making framework agreed upon, but it will be relatively straightforward to draw from existing expertise here and off-shore. We are getting there, and at least so far as the RN scope of practice is concerned, have been able to demonstrate that our profession can indeed care for itself.

Welcome to new College Board Member

The College of Nurses is delighted to welcome Angela Bates to the College Board. Angela is currently employed in Wellington as a primary health care nurse specialist and believes that every individual has a right to high quality care regardless of their situation or where they live. She is passionate about reducing inequalities in health and improving access to health care for vulnerable populations.Angela is committed to the development of nursing and raising the profile of nurses.

Angela last year took on the role of Primary Health Care Coordinator within the College and welcomes the opportunity of bringing primary health care issues to the centre of College attention.

Apply Now

TRAILBLAZER TRAVEL AWARD 2010

The Trailblazer Travel Awards honour the pioneers who entered the initial Comprehensive Nursing (Polytechnic) programmes, 1972-1977 at ATI (AUT), Christchurch Polytechnic (CPI), and Nelson Technical Institute (NIT) and Wellington Polytechnic (Massey University).

Trailblazer Travel Award – Value $750
to attend or present at a NZ or International conference.

Trailblazer Travel Awards applications closing date is 30 June 2010

Application forms available on the College website www.nurse.org.nz
or contact the College Office Phone/Fax: 06 358 7000
Email: admin@nurse.org.nz

NURSING 100

The Auckland Region of the College of Nurses Aotearoa (NZ) invites all NZ nurses to join them in a national event to celebrate 2010 as the International Year of the Nurse along with the centennial year of the death of Florence Nightingale (1820 – 1910).

are gifting 100 minutes of their time to promote nursing as a fantastic career or to deliver a nursing related service. This event will start on 12 May (Nurses Day). We encourage all Nurses to take part in this significant event to promote New Zealand nursing.

How will you gift your time either as an individual or as groups/organisations

Activities may include but are not limited to:

- Promoting nursing as a career choice eg in the media, schools, expo's, clubs, organisations
- Promoting nursing as a caring profession eg spending time with patients in age care disability services, health promotion
- Nurses currently in practice (direct patient care) could reaffirm their commitment by giving 100 minutes towards the provision of quality patient care
- Registered nurses in practice who do not provide direct patient care eg nurses involved in management, researchers, education and policy could identify initiatives that will allow them to spend 100 minutes promoting the future of nursing or nursing related activities (could span the environment from individual home help or care delivery to strategic communication at Government level)
- Nurses who do not practice nursing (and do not have an APC) e.g retirees, those who work in other business endeavours, could gift 100 minutes volunteering to assist someone in general need or share their story in some way to promote nursing as a fantastic vocation.

How to do it?

The website www.nursing100.org.nz to be launched in April will allow you to to register your gift of 100 minutes You can enter your name and a summary of your gift. In return, a certificate can be provided for you to include in your personal PDRP portfolio. This website will also be linked to the College of Nurses website www.nurse.org.nz

Nurses wishing to take part in this event are asked to ensure that their activities are within their scope of practice and that they are competent to do so. They are also asked to check with providers or consumers about issues related to confidentiality and indemnity, if applicable.
The event is open to any registered nurse who is willing to gift 100 minutes irrespective of membership or affiliation with the College.

The College of Nurses journals, website and other publications may publicise examples of what nurses did in their 100 minutes which we are sure will make fascinating and inspiring reading.

Register at **www.nursing100.org.nz**
For more information contact the Auckland Regional Coordinator, Willem Fourie at wifourie@manukau.ac.nz or your regional coordinator.

COLLEGE OF NURSES AOTEAROA NZ

Please remove or copy and post on your noticeboard.

Antenatal and Newborn Screening in New Zealand

Pregnant women in New Zealand currently have access to three antenatal and newborn screening programmes and one quality improvement initiative. It is a woman's choice whether to participate in screening or not, but it is recommended that discussions about screening take place early in pregnancy.

The first screening test should be discussed beforehand and offered with, the first antenatal blood tests. This is a test for human immunodeficiency virus (HIV). If a woman does have HIV, she can pass the virus on to others, including her unborn baby. This test is important as it can reduce the risk of the virus being passed from mother to baby from as much as 32 percent to less than 1 percent.

The sooner a woman knows she has HIV, the sooner she can get treatment and support for herself, her partner and family or whānau and minimise the risk of passing the virus to her baby.

During the first trimester you should discuss first trimester screening for Down syndrome and other conditions. From 8 February 2010 two new screening options are available. The intention of these tests is to provide a safe and reliable screening, consistent with screening offered in other countries for those women who choose to participate.

The two screening options available to New Zealand women are:

First Trimester Combined Screening, which should be offered in the first three months of pregnancy. It includes a first trimester maternal serum screening test, (blood test) taken between 9 weeks and 13 weeks and 6 days of pregnancy, and a nuchal translucency scan (NT scan), carried out between 11 weeks and 13 weeks and 6 days of pregnancy. One combined result which indicates the chance of the woman having a baby being affected by Down syndrome or some other conditions.

The maternal serum screening blood test is fully publicly funded, however generally a surcharge applies for NT scans.

Second Trimester Maternal Serum Screening, which should be offered after 14 weeks of pregnancy have passed, or before 20 weeks of pregnancy, or were not able to get a nuchal translucency scan. This test is fully funded.

The next screening programmes should be discussed before baby is born and are done just after baby is born.

Newborn metabolic screening is available to all New Zealand babies and is done at 48 hours of birth or as soon as possible after that. The baby's blood is tested for rare but life-threatening disorders. This test used to be called the Guthrie test.

If the mother agrees to have the test done, a few drops of blood are taken from the baby's heel. The drops of blood are placed on a blood spot card and sent to the National Testing Centre at Auckland City Hospital for testing.

For the few who are diagnosed through the screening programme, the benefits of screening are enormous. Because the disorder is picked up early, it can often be treated before the baby becomes sick.

Within one month of the baby's birth a screening test to check the baby's hearing will be offered. Most babies are screened before they come home from hospital. In New Zealand up to 120 babies are born each year with a moderate to severe hearing loss. Over half of babies found to have a hearing loss have no family history or any other reason to think they are at risk. Without screening it is difficult to detect hearing loss in babies until speech and language development becomes delayed.

Most babies pass their newborn hearing screening. For the few babies who need follow-up after screening, an audiology assessment is carried out. This should occur before baby is three months old. Babies found to have a moderate to severe hearing loss are able to have early interventions, such as hearing aids and special education, which can help them reach their potential. These should be started by the time baby is six months old.

Even if a baby passed newborn hearing screening, they could still develop a hearing loss later.

For more information on the screening programmes and quality initiative described in this article please go to www.nsu.govt.nz

Your Antenatal and Newborn Screening Timeline

National Screening Unit

Before pregnancy

Days

+1 +2 +3 +4 +5 +6

Get information about screening for you and your baby

During your pregnancy

Weeks

1 4 8 12 16 20 24 28 32 36 40

Discuss HIV screening and screening for Down Syndrome and other conditions along with other first antenatal blood tests with your midwife, GP or obstetrician (8-12 weeks)

First trimester combined screening for Down Syndrome and other conditions. (Blood test 9-13 weeks and 6 days) (Nuchal translucency scan 11-13 weeks and 6 days)

Second trimester maternal serum screening for Down Syndrome and other conditions (Blood test 14-20 weeks)

Discuss Newborn Metabolic and Newborn Hearing Screening with your Lead Maternity Carer (28-36 weeks)

After baby is born

Days

+1 +2 +3 +4 +5 +6

The heel prick is due 2 days after baby is born

The hearing screening tests should be carried out within 1 month after baby is born

All women must be given information to help them make choices about screening.
For more information please contact your midwife, GP or obstetrician or you can visit www.nsu.govt.nz

MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

Rural General Practice Network Conference

Report by Judy Yarwood FCNA(NZ) Co-Chair, College of Nurses Aotearoa (NZ) Inc

11-14 March 2010, Christchurch.

The Rural General Practice Network Conference theme for 2010 'Rural health – No 8 wired' resonated throughout three autumnal days in Christchurch recently. 'Skinny wires' - using acupuncture to ring fence pain, 'Taking it to the wire' – exploring the technique of noninvasive ventilation to buy time, 'Wired Wild West Coast DHB' – discussing the geographical, meteorological and medical challenges of rural healthcare delivery , 'Trip wired' - a foray into not only the physical and geographical factors, but also the accompanying social and emotional factors of transporting people from rural locations and hospitals to base hospitals, and 'Wired for the future' - medical students experiences of learning about rural practice were some of the great key note and concurrent sessions presented by nurses, doctors and other health professionals, all with a passion for things rural!

Photo courtesy of Udo von Mullert- Palmerston North

Notwithstanding there were some interesting presentations given by our medical colleagues I will focus on nursing presentations in this brief overview of the conference.

Having said that, I want to start with a few words about the Minister of Health, Tony Ryall's address, responsible as he is for health care policy and delivery, thus strongly influencing our ability to do what it is we do best! Tony Ryall, was of course 'Politically wired'! He immediately identified what for him and therefore for us, was the most acute challenge in health care – the health workforce. Not having heard the minister in the flesh so to speak. I was impressed with his ability to be on the podium for over an hour taking a wide range of questions from the floor. Two rural areas, Dannevirke and Dargaville joined the minister's session via the internet, showing the way of future rural networking. Although the staff, mostly nurses from what I could see, looked a tad uncomfortable appearing on the big screen, this technology enabled them to be a part of this session and to also put questions to the Minister. Delegates on site queued at microphones with questions, many of which, not surprisingly, revolved around funding; Nevertheless all were listened and responded to by the Minister, who on more than one occasion asked the questioner for their solution, some of which were forthcoming. His key message to one and all was 'Better, sooner, more convenient primary health care' will take centre stage with emphasis on patient centred, collaborative and clinically led health services, not forgetting Integrated family health centres. Rhetoric we've heard before, nonetheless when the minister acknowledges low income families with young children must have warm dry houses it suggests politicians are beginning to grasp the relevance of social determinants in determining health outcomes.

Sharon Hansen, NP gave the opening key note address, a coup I thought for a gathering that has historically taken a medical focus. About two years ago Sharon, with her wide experience in Primary Health Care (PHC) joined a general practice in the South island town of Temuka, located just 15 minutes

north of Timaru. To make her case for the rural nature of Temuka Sharon showed pastoral scenes, that interestingly included snaps of rather large milk tankers zipping by, showing the social impact Fonterra's nearby processing plant at Clandeboye is having on New Zealand's rural landscape. Temuka Health Care, owned and operated by a general practitioner (GP), has a team of four registered nurses (RN) all of whom work in collaboration with a variety of other health and social professionals. In the address Sharon, the GP, and one of the RNs spoke about the benefits and challenges the practice team faced as they came to grips with the having a NP in their midst! Introducing new practitioners into a settled practice team such as Temuka has caused everyone involved, including the community to re-evaluate and adapt their thinking about the delivery of health care services. This appears to be the norm as the development of the NP role becomes an accepted role in service delivery, particularly in PHC. Exactly how this development is playing out in rural areas was revealed in a recent survey, the topic of a concurrent session.

Professors Jenny Carryer, Julie Boddy and Dr Claire Budge conducted a survey last year with the aim of exploring the transition from rural health nurse to NP in New Zealand and found the process for many was somewhat ad hoc. Surveying all rural nurses who have been recipients of rural nurse scholarships they found of the 21 nurses aiming for NP status only 1 had achieved NP status, one had unsuccessfully applied to Nursing Council, one was waiting to hear from Nursing Council about the success or otherwise of her application, and the remaining 17 were yet to get the process underway. Findings from the survey revealed four key themes; Uncertainty, resistance and obstruction, process issues and NP competencies challenging rural nurses.

While many factors influenced these outcomes, what nurses mostly wanted to make this process successful was support. Supportive mentors, supportive colleagues both nursing and medical, and one could argue a supportive profession. Author, social activist and feminist bellhooke's sentiments are worth remembering at such boundary spanning times 'A degree of pain is involved in giving up old ways of thinking and knowing and learning new approaches'

Someone who knows first hand what bellhookes is talking about is Jean Ross, one of the early leaders in rural health nursing. Jean is currently working in academia where she is completing a PhD 'Understanding practice in place'. Jean's passion for all things rural flows through to her doctoral study, which looks at the construction and performance of nurses professional identity and practice associated with rural place. Through various discourses in rural nursing associated with the concept of place Jean talked about how she identified three key themes in relation to the rural nurse, locality, locale, and a sense of place. What struck me was the way these themes resonated for rural nurses present, some of whom spoke with gratitude about what it meant for them to hear their reality being acknowledged and valued. Hearing practice recognize theoretical constructs in this way, not only highlights the complexity of rural practice, but must also make many years of study worthwhile.

'Professional issues in nursing', a panel discussion lead by well known names in the world of nursing be it in rural or urban locations, Susanne Trim, Dr Jane O'Malley and Jean Ross were ably chaired by Great Barrier Island's rural nurse Leonie Howie. Issues confronting rural nurses in 2010 range from emerging new scopes of practice, models of nursing care, and legislative and regulatory frameworks influencing rural nurses practice. Despite an increasing need for nursing expertise in rural areas, it appears there is still a way to go before we have clarity about rural nursing practice roles. Jane O'Malley spoke of the progress made at the West Coast DHB following the expansion of Rural Nurse workforce strategy, including the ongoing development of Rural NPs, and the ways in which rural nurse specialist roles are supported and extended. Extending any nursing role is reliant on access to education, and for some rural nurses this can throw up multiple challenges. Travelling to and from educational institutions can be disruptive, not only to work places, people and communities but also to family life. Burgeoning internet technology is fast changing the way some educational programmes are delivered, making these more accessible and acceptable for those in remote, often rural locations. Jean's contribution offered insights into some new and innovative educational courses that are reducing what have been considerable professional barriers for rural nurses.

One of the joys of stepping out of everyday life and connecting with colleagues at conferences is networking, and this must be even more so for rural practitioners, be they nurses or doctors. Practicing, as so many do, in relative isolation, the chance to hear about other colleagues activities, innovations and experiences is always rewarding, and this conference was no exception.

Consumer alliances align with the College of Nurses vision

by Judy Yarwood FCNA(NZ) Co-Chair, College of Nurses Aotearoa (NZ) Inc

This paper is based on a presentation given at the New Zealand Rural General Practice Network conference held in Christchurch in March 2010.
As many of you know the College of Nurses Aotearoa (NZ) (The College) is a professional body of nurses committed to providing a forum for critical inquiry into professional, educational and research issues relating to nursing and health care, and to achieving equitable health outcomes for all New Zealanders.

The College vision '100% access – Zero disparities' is about professional excellence in nursing practice as from that comes the best possible health care for everyone. From this vision comes the three directions of the 2009-2012 Strategic plan. Firstly, aligning nursing workforce development with community need. Secondly, influencing policy and health leadership, and finally developing a sustainable future. All of which we do through being responsive to the dynamic health environment in which we find ourselves.

As a way of achieving this vision we've been exploring innovative ways of forging new relationships with consumer communities, to fulfill nursing's social mandate which Smith (2007) identifies as listening to what it is people want from nurses, what it is they see we can provide for their communities. The first consumer alliance the College forged was with Grey Power resulting in effective relationships and making older person's concerns more visible, through joint media releases highlighting health related issues such as Ageism concerns, and the quality of care for the elderly.

What was key in developing this first alliance was to grasp the importance of the ways in which the broader socio-economic and political factors influence the health of older people, such adequate housing, good nutrition and social networks, rather than a preoccupation with physical health (Neville, 2006).

These thoughts were in mind when I first approached RWNZ about 3 years ago. Formerly known as the Women's Division of Federated farmers (a sign of times long gone!) this organization has been in existence for over 80 years and caters for rural women of all ages and walks of life. Started by women dedicated to improving social and economic conditions of rural people, their fundamental aim of strengthening rural communities remains pivotal to the organization today.

With overt values of forward thinking, focused, flexible, professional and enabling, RWNZ is aiming to be identified as the group policy makers consult when developing future policy affecting rural communities. In the process of developing this alliance one of the first lessons I learned was patience! The pace was theirs to set and still is! My desire to get the deal done and dusted was not helpful! We are aware of the significant role RWNZ plays as an active consumer voice – one that successfully advocates on behalf of rural women and communities and one that is regularly consulted for their views about rural life. Following initial conversations with senior personal a meeting was held with the RWNZ Council.

At that time I talked about what we saw as the generic benefits to the organization –

- Of the College being able to contribute to the wider health and wellbeing of rural

communities – through joint media releases, supporting parliamentary submissions, providing information about relevant health issues

- Opportunities for RWNZ to inform the College of their key issues
- RWNZ would be informed of key nursing initiatives such as the developing NPs roles, changing scopes of nursing practice , future research and development projects
- Opportunities would be had to comment of key issues supported by the College and vice versa keeping in mind the power in numbers! With both organizations having effective communication strategies, various support groups and resources, our combined capabilities could guarantee voices would be heard.
- Mechanisms to disseminate information – for example through the College journal Te Pui Wai, Nursing review, the College website and electronic discussion groups. A recent example has been dissemination through the College all members electronic discussion group about the RWNZ's concerns over proposed ACC changes.
- Many of their questions at that time related to the availability of Nurse Practitioners (NP) in rural locations, as they saw this role as critical to relieving some of the pressures being experienced related to the lack of health services and staff in acute situations. People living in rural areas have the right to a good quality responsive and appropriate service, one that recognizes rural families may have different needs to urban dwellers, but needs all the same, needs they can expect to be met. If we believe as Helman (2007) does, that family is the real site of PHC then the more we can support families be they rural or urban the better off we will all be.
- Following this meeting, and ongoing conversations a Memorandum of Understanding was struck between the two organizations ' to facilitate and promote co-operation and collaboration and the mutual benefits of the College and RWNZ'. Just as the success of the Grey Power alliance was based on an understanding of health in a much broader socio-economic and political context, so too is it with this alliance. This was apparent as we learned more about the contemporary issues facing RWNZ, such as
- Distance and costs being a barrier to health services
- The need for adequate housing for amongst others itinerant dairy workers
- Transport issues for many groups including school aged children and the elderly
- Social isolation, and loneliness, with evidence of dwindling social capital.
- Since signing the Memorandum of understanding the College has been asked to comment on and provide support for a number of issues influencing rural health – such as changes in Maternity and ACC services. The latter surfaced last year when ACC changed their contracts with home based providers to eliminate reimbursing payment for the first 20 kms of travel for support workers. For the rural sector this was a serious erosion of services (that has yet to be remedied despite serious lobbying). Developing this alliance with RWNZ is one step for the College in aligning our nursing work force with community need. It's early days yet – we've much to learn, more risks to take, however I'm convinced that the health challenges of our diverse, complex and uncertain world will only be addressed through creative collaborative relationships and by us listening to and heeding the needs of families and communities.

References

Helman, C. G. (2007). Culture, health and illness. England: Hodder Arnold.

Neville, S. (2006, March). Consumer alliances. Nursing Review, 6(11), 17.

Smith, G. R. (2007). Health disparities: What can nursing do? Policy, Politics & Nursing Practice, 8(4), 285-291.

The importance of a nursing strategy for residential aged care

by Noeline Whitehead RN MN (doctoral candidate)

Introduction

By the late 2030's one quarter of New Zealanders will be 65+ (Boston & Davey, 2006). Our future older people will have different expectations as they age. What care will they want and need? Who will care for this burgeoning population of older people especially those who will need residential care? How will New Zealanders ensure that they receive the quality of care they are entitled to expect?

The government has stated that "People in the New Zealand health and disability system receive people centred, safe and high-quality services that continually improve and that are culturally competent". (Minister of Health, 2003)

Position Statement

The overarching goal in developing a strategy will be to ensure that the importance and value of the role of the registered nurse (RN) in residential aged care (RAC) in New Zealand is recognised and that there is a skilled RN workforce to meet the needs of the residents. 'Nursing' needs to take ownership now so that nurses in the future can meet the needs of the ageing population and in particular of those older people who need residential care. Nurses need to influence decision making on staffing levels, skill mix, the nursing model of care and nursing leadership in RAC.

Nurses need to be supported to provide outstanding resident care in a safe, high quality environment. This requires the development, dissemination, and a culture of exceptional nursing practices and strategies; a supportive, innovative workplace that empowers nurses to achieve clinical outcomes that out older people have an entitlement to. Nursing needs exceptional leaders to achieve this.

Residential aged care is a complex clinical speciality and the facilities in which it is provided are complex environments (Bland, 2007). Today's RAC facilities are places of high dependency (Boyd et al., 2008). Dependency and acuity is set to increase further as 'ageing in place' enables older people to remain at home much longer and the number of people over 85 years rapidly increases. The challenge is to prepare enough nurses to provide the best care to achieve the best outcomes for the residents. Having the resources needed to deliver evidence-based care and being empowered to deliver that care, is paramount to achieving the best resident outcomes. Other health professionals are needed as part of the team to complement the work of nurses. In

addition, based on the current model of care, there will need to be increasing numbers of frontline workers, second level nurses and an unregulated workforce, to support the registered nurses in their endeavours. This will require the registered nurses working in this industry to be skilled in the human resource practices necessary to delegate care to and direct this workforce. The shortage of medical practitioners is already placing additional stress on the RNs working in RAC (Carryer, Hansen, & Blakey, 2010). The role of nurses with post graduate education and nurse practitioners will become increasingly vital to achieving the best outcomes for residents. With our population becoming increasingly multicultural, along with issues already mentioned, improved models of care are needed.

Current concerns

The Health and Disability Commissioner reported that the second largest group of health care related complaints in New Zealand stem from rest homes (Patterson, 2004). The level of complaints has increased from 10 percent to 15 percent of the total number of complaints in 2008 and 2009. This and the resulting media interest in the sector have provided a negative image of the care provided. With the level of complaints increasing so is the exposure to risk for nurses who work in the sector. The New Zealand Nurses Organisation continues to express concern about staffing levels, skill mix and the quality of care.

Demographic changes in the RAC population

The need for skilled and knowledgeable gerontological nursing staff has never been greater. The political reform of aged care services has resulted in the complexity and scope of nursing practice in the residential aged care (RAC) setting increasing. Over the last 20 years in Auckland there has been a minimal increase in the number of RAC bed of three percent. However, the mix of beds has changed with a thirteen percent shift from rest home level care to hospital level care. The ratio of beds to 1000 persons over 65 has declined from 74 to 53. The percentage of the population over the age of 85 years who live in RAC had reduced from 40 percent to 27 percent over a 20 year period. This reflects the success in shifting care to community settings. as a result the people living in RAC are on average older and more dependent with the proportion of residents with high dependency increasing from 16 percent in 1988 to 35 percent in 2008 (Boyd et al., 2008).

Registered nurse staffing

With this level of increasing dependency it is difficult to understand the rationale for the reduction in the minimum registered nurse staffing requirements in RAC. Prior to the introduction of certification in 2002 the registered nurse requirement for hospital level care (high dependency) was one full time registered nurse to every five hospital beds. Therefore, if a hospital had 45 beds it was required to have nine full time registered nurses or the equivalent of 360 hours per week of registered nurse hours or 1.14 hours per resident per day. With the introduction of certification, facilities have been able to develop their own staffing rationale provided that they meet the requirements in the "Aged Related Residential Care Service Provider Agreement" of a registered nurse on duty at all times, 168 hours per week or 0.5 hours per resident per day for the same 45 bed high dependency facility.

Following concerns by a number of staff and consumer organisations the Ministry of Health published staffing recommendations in the SNZ 8163:2005; The New Zealand Handbook; indicators for safe aged-care and dementia-care for consumers, developed by experts in the field of RAC. It recommends a registered nurse on duty at all times and a minimum of 1.14 hours per resident per day increasing to 2 hours per resident per day when levels of acuity amongst residents is high (Standards New Zealand, 2005).

Registered nurse hours and quality of care

There is a large volume of research that indicates the importance of registered nurses in providing quality care to residents (Maas, Specht, Buckwalter, Gittler, & Bechen, 2008a). The levels of registered nurse hours recommended in the 'Handbook" are well supported by empirical evidence that indicates that adverse events decrease as registered nurse hours increase. A study conducted in Auckland New Zealand reported an association between increasing registered nurse hours and deceasing (Whitehead, Parsons, & Dixon, 2007). The positive relationship between nurse staffing levels and the quality of nursing home care has been widely demonstrated to such a level that it is difficult to ignore the evidence (Bostick, Rantz, Flesner, & Riggs, 2006; Dellefield, 2000; Horn, Buerhaus, Bergstrom, & Smout, 2005; Kim, Harrington, & Greene, 2009; Kramer & Fish, 2001; Maas et al., 2008a; Schnelle et al., 2004; Zhang, Unruh, Liu, & Wan, 2006).

There is evidence to support that having reasonable levels of registered nurse hours can improve

efficiency and effectiveness in RAC. Empirical evidence demonstrates that higher quality not only improves the quality of life of residents but also can result in better financial returns for the owners. Nursing homes had a trend of total higher costs of $US13.58 per resident per day in a poor quality outcome group compared with a good quality outcome group. When such adverse events as pressure ulcers were reduced so were input costs reduced (Rantz et al., 2004). These findings are supported by other studies where a higher prevalence of pressure ulcers was associated with higher cost and the higher prevalence of use of depressants and hypnotics increased inefficiency (J Bostick, 2004; Laine, Finne-Soveri, Bjorkgren, Linna, & Noro, 2005). Other quality issues linked to registered nurse hours include; weight loss; incontinence, pain, hydration, and activities of daily living changes (Whitehead et al., 2007).

Neglect and abuse

When staff do not or cannot fulfil their duty to residents, such as missing providing care, it is neglect. Abuse is well defined and may include failure to provide adequate staffing; the falsification of clinical records, physical abuse, unauthorised restraint, force feeding, depriving residents of food and sexual abuse, Psychological or emotional abuse includes berating, ignoring, ridiculing, cursing, threatening punishment or deprivation, depriving residents of control over decisions and choices that affect their lives, and misappropriation of property and money. The extent to which residents experience neglect and abuse in New Zealand Aged care facilities has not been quantified.

Staff stability, staff turnover, career pathways and professional development

Evidence abounds that staff characteristics such as turnover, staffing levels of other direct care staff, worker stability, and use of agency staff need to be considered (Castle & Engberg, 2007; Collier & Harrington, 2008). RNs working in RAC do not access post graduate education to the same extent as their colleagues working in the public sector. The reasons for this include; feeling supported; family / work life balance, and cost. There is very limited opportunity for career progression (Carryer et al., 2010). Stability of nursing leadership is pivotal to quality outcome for residents (Maas, Specht, Buckwalter, Gittler, & Bechen, 2008b; Rantz et al., 2003). Carryer (2010) points out to a lack of nurse-focussed leadership. Since the implementation of certification, there has been a move away from nursing leadership to non nurse site managers. Practical experience indicates that the turnover in nurse managers or senior clinical nurse is high, and maybe reaching 40 percent over the last 2 years.

Accountability

In a New Zealand study RNs reported that being accountable for caregivers posed numerous challenges for them. While they expressed great admiration for the caregivers the RNs recognised that some caregivers are unsuitable for the work required of them. Further, RNs express their concerns about their lack of ability to influence the hiring and termination of staff for whom they were accountable. Time pressures meant that they were hard pressed to supervise the caregivers and this led to a significant level of stress (Carryer et al., 2010). Access to nurses with advanced clinical expertise is variable. Further, timely medical intervention has been highlighted as an issue by registered nurses working in RAC (Carryer et al., 2010).

The impact of health reforms on registered nurses working residential aged care

Many senior nurses working in RAC express the view that with the introduction of certification the time spent on minimum compliance by registered nurse has substantially increased. While there was turbulence in the health care environment and the challenges facing managers prior to the introduction of certification, long-term care managers were coping well (Madas & North, 2000). Registered nurse job satisfaction in Auckland in 2005 was revealed to be acceptable to the nurses (Bogert-Johnson, 2005). However, later research indicates that RNs report that they find it a struggle to deliver quality care in the current environment and consequently report low confidence levels (Carryer et al., 2010).

The need for a nursing strategy

Relevant international research reinforces the need for RNs in RAC. The key themes need to be indentified and assessed for their relevance to New Zealand. A list of relevant research articles for consideration has been developed. While it is extensive it is not reflective of all research that may be relevant. For New Zealand nurses to be enabled to work in RAC with job satisfaction, pride and to be safe and quality of life for each nursing home resident and their family is optimised a nursing model needs to be developed by nurses. Areas that

need to be examined in the New Zealand context are; (1) the education and preparation and ongoing development of nurses in gerontological nursing, (2) RNs with leadership and gerontological nursing expertise delegate and direct the care of the residents, (3) staff development, and competitive compensation, (4) strengthen nursing leadership with post graduate education that prepares nurses well for leadership role within the sector, (5) each RN is accountable for quality of care and is assigned a specific group of residents and is accountable for their quality of care, (6) each RN is accountable for developing evidence-based nursing care plans and for ensuring that the care is provided to residents as prescribed, (7) evidenced based RNs staffing levels that provided for adequate time for nurses to provide outstanding resident care in a safe, high quality environment, (8) recruitment and retention of registered nurses in RAC, (9) development of advanced nursing practice and in particular the Nurse Practitioner roles in RAC and (10) clinical outcomes measurement that reassures the public that the industry is meeting prescribed expectations. This should be clearly linked to staffing and skill mix.

The strategy considerations

- What is that ARRC does?
- Identify what it is that RNs do in RAC?
- The complexity of the role of a registered nurse working in RAC.
- Level of risk for nurses working in RAC.
- Education and preparation for RNs working in RAC.
- Specific competencies required.
- Nursing leadership including education and preparation.
- What will make it an attractive sector to work in?
- What are the barriers?
- Role of the second level nurse and the unregulated workforce.
- Further models of care -- Nurse Practitioners, multidisciplinary teams and medical services?
- Hours needed to maintain resident safety and nurses' safety?
- How to ensure there is a nursing workforce for the sector?
- How many nurses will be needed – ageing population and predictions of bed numbers required?
- Finally support further research that centres on residents wellbeing and safety in New Zealand RAC will inform decision making.

The key possible work streams for consideration:

- Accessing and reviewing research papers
- Workforce development
- Quality of care
- Staffing and skill mix
- Nursing leadership
- Education requirements
- Models of nursing

Relevant New Zealand documents

The key documents that we will need to consider (and there will be others);

The New Zealand Health Strategy (Ministry of Health, 2000)

Health Practitioners Competence Assurance Act ("Health Practitioners Competence Assurance Act, ," 2003)

Health and Disability Commissioner Act 1994 and Code of Rights ("Health and Disability Commissioner Act 1994 (as at 01 November 2008)," 1994)

Positive ageing strategy (Ministry of Social Development, 2001)

Health and disability sector standards (Standards New Zealand, 2008)

Health of Older People Strategy (Ministry of Health, 2001)

Age related residential care service provider agreement 2009/2010 (District Health Boards New Zealand, 2009)

Nursing Council nursing competencies (Nursing Council of New Zealand, 2007)

Nursing Council nursing, nursing delegation and direction of care DHBNZ workforce strategy

SNZ 8163:2005 The New Zealand Handbook; indicators for safe aged-care and dementia-care for consumers (Standards New Zealand, 2005)

Key research papers identified to date

A list of papers identified to date is available but not included in the article.

References

A full list of references is available on request, please contact the College of Nurses office admin@nurse.org.nz

The College of Nurses is pleased to present

RN Professional Portfolio Presentation Workshops

for 2010 presented by Dr Stephen Neville.

These workshops are an enjoyable and invaluable day providing you with all the skills and information required to complete and maintain your own Professional Portfolio with ease as required under the HPCA(2004). You also receive a certificate of attendance adding 6 hours towards your required professional development hours. Registration is open to all Registered Nurses.

Book Now for -

Location	Date	Venue	Workshop Registration Non CNA(NZ)	CNA(NZ)* Members Registration	
Auckland	29th April 2010	MIT - Manukau Institute of Technology A- Block Room A406South Campus, Otara	$ 175.00	$ 155.00	Includes morning tea & lunch
Christchurch	20th May 2010	CPIT- Christchurch Polytechnic A134 - Imagitech Lecture Theatre Madras Street, Christchurch	$ 175.00	$ 155.00	2 Cafés very close by.
Dunedin	21st May 2010	Otago Polytechnic Room - H311 3rd floor of H Block Cnr Forth and Union Streets Dunedin	$ 195.00	$ 175.00	Includes morning tea & lunch

* College of Nurses Aotearoa (NZ) Members discounted rate. Membership enquiries contact the College office, details below.

Register your interest now for the following locations -

Wellington – Date to be advised
Hawkes Bay – Date to be advised
Nelson / Marlborough - Date to be advised

Workshops are run for 6 hours (Usually from 10am – 4pm)
(Prices vary depending on location, venue and catering.)

Numbers are limited for each workshop, if you or any of your colleagues are interested in attending one of these workshops please register your interest ASAP by emailing admin@nurse.org.nz directly. We require your Name, Phone Bus Hrs, Postal Address and Email Address in the body of the email please. If your Invoice should be made out to your employer, please include this info as well.

If you are interested in hosting a Portfolio Workshop in your area for your own group/employer, please contact the College office for details.

Please feel free to circulate this to anyone who may be interested or post onto notice boards.
See below for more detailed explanation of the workshop.

Contact the College office –
Phone (06)358 6000 Email admin@nurse.org.nz or Post to PO Box 1258, Palmerston North 4440

Portfolio Presentation Workshops – more information

Background
With the introduction of the Health Practitioners Competence Assurance Act (2003) there is a now a requirement for nurses to formally demonstrate ongoing competency. The development of portfolios is considered to be an appropriate way to not only fulfil these legislative requirements but also professionally develop nurses in practice. While many nurses who work within DHB provider arms are familiar with the development of portfolios as part of various professional development and recognition programs, there are a significant number or nurses who have not had this exposure. These nurses practice in a wide range of settings, e.g. aged care facilities, NGOs, the smaller private surgical facilities and primary health practices, often with little professional support and advice. The College of Nurses would like to assist this group and they would benefit from being able to access practical professional support in portfolio development in order to meet their professional and legal obligations.

Purpose of workshops
For all attendees to develop the skills required to confidently complete their professional portfolio to meet Nursing Council requirements and in which the individual nurse can take pride.

To provide an understanding of legislative and professional requirements in relation to competency review as part of the HPCA Act(2003) to those nurses who currently have little or no access to professional advice and support.

Please note –This is a day for Registered Nurses who are not on a PDRP Programme and want to develop a Professional Portfolio where they can clearly demonstrate competencies to meet the RN Scope of Practice.
This is <u>not</u> a Nurse Practitioner Portfolio Development course.

Who can attend?
All nurses who believe they need support and advice in development of their professional portfolio, particularly those who do not currently belong to DHB based PDRPs nor have access to professional advice and support e.g. nurses who practice in the aged care facilities, NGOs, smaller private surgical hospitals and primary health care settings.

Workshop Outline
The workshop will be interactive and practice based with each person completing some work on their own portfolio. Participants will work both in groups and as individuals and use the group and the facilitators to assist and support them with their work.

Areas covered will include:

- Understanding the Nursing Council competencies
- Becoming familiar with the portfolio format and terminology e.g. exemplars, peer review, case review, performance appraisals, professional development
- Understanding the different forms and ways of presenting evidence
- Practice in completing aspects within their own portfolio
- Ongoing support and services offered by the College of Nurses

Workshops will take a full day from 10am-4pm and networking and collegial support will be an important part of the day.

What others have said about this workshop-

"Stephen was fantastic and as it was the first time all the nurses had met together ever, the day had a good vibe."

"I personally got a lot out of it and it has given me some great ideas for my role also."

"We really appreciated the fact that Stephen was able to give us a day for this and all feel that it was so very worthwhile attending. It has broken down what was a major daunting job into easily explained and achievable tasks."

"Great day, great presenter and at the end of it a complete understanding of what is required in my portfolio. Highly Recommended!"

New Regional Coordinators for Otago

We, Jean and Rachel, are pleased to take on the position as regional coordinators for Otago. We are open to suggestions on how best we can facilitate the needs and requirements of members. We bring to the position different but complementary skills, and at the same time we have a number of life events which connect us. We look forward to sharing our skills, experience and connections over time as we get to know existing and new members with in the region. To begin the process we have provided the following biographies:

Jean Ross MA (NURSING), BN, RGON, FCNA(NZ) Principal Lecturer at the School of Nursing, Otago Polytechnic in Dunedin

I have worked, lived and assimilated with the rural context for the majority of my life both in Wales, UK and in New Zealand. I believe my personal experience of life in a rural community and professional expertise, both clinically and academically, offers a well-rounded grounding for the delivery of rural health services in New Zealand.

I was joint co-director of the National Centre for Rural Health (1994-2003), which was the first of its kind in New Zealand. The Centre has been instrumental in promoting the need to ensure that rural health is recognised as a speciality while acknowledging the fundamental issues of potential recruitment support, development and diversity of rural practitioners. The Centres' philosophy focused its direction and energy into undertaking a number of core rural national research projects from 1996 through to 2003 which I was in a position to lead. These projects included; the role, evolution and career development of rural nursing; dimensions of successful rural teamwork and development of an educational teambuilding resource tool; and implementing the national rural health care strategy (2002).

I have continued my interest and commitment to the promotion of rural activates, through research and attending/presenting at many national and international conferences, and have published, promoting rural nursing and rural teamwork. I was the founder and coordinator (1995/6-2003) of the Rural Nurse National Network and convened the Inaugural Rural Nurse National Network Conference held in Christchurch, New Zealand 2001. The conference stimulated both national and international interest and offered rural nurses the medium to put forward their vision for future direction and funding by the Ministry of Health. I was also instrumental in developing and convening the first interdisciplinary postgraduate Diploma/Certificate of Primary Rural Health Care (while funding was available) from 1998 through to early 2003, run out the University of Otago.

Early on in 2003 there was a change to the national funding for rural health support and education, this

change, prompted me to reconsider my contribution to the sector. To continue on with my vision for the delivery of successful rural health care and development of rural nursing in New Zealand led me to take up a position within the School of Nursing through Otago Polytechnic, with the opportunity to develop a postgraduate educational nurse practitioner programme specifically for rural nurses. More recently I have established an educational rural thread throughout Otago Polytechnic, School of Nursing's three year BN degree programme which will commence 2010.

I was successful in 2007/08 to receive Rural Innovative Funding from the Ministry of Health for the development and publication of the first rural text book. This edited book is the first rural health-related book to be published in New Zealand. Based on the work of 17 New Zealand rural nurse contributors, the book provides a broad overview of topics relating to rural nursing. Topics range from theory development, to describing and adapting practice for the contemporary rural landscape, as well as research relating to clinical practice. I have been a Fellow of the College of Nurses Aotearoa since 1999, and a mentor to rural nurses supporting them in their application to Nurse Practitioner through The Nurse Practitioner Advisory Committee of New Zealand.

In 2008 I was nominated by colleagues and received the Rural General Practice Network Peter Snow Memorial award for my contribution to rural health care in New Zealand.

I am currently a PhD candidate (in my 5th year part time) through Department Geography, University of Otago my focus is on the identity or subject position/s of nurses who practice in a rural context.

Rachel Parmee MA,BA, DIP ED, DIP SOC SCI. DIP TEACHING, RGON, FCNA (NZ) Senior Lecturer at the School of Nursing,Otago Polytechnic in Dunedin

My background is in education and practice. I began as a secondary teacher in Christchurch, having completed a BA in History at Canterbury University and Diploma in Teaching at Christchurch College of Education, before becoming an "older" student at Christchurch Hospital School of Nursing in 1982. During this time I completed a Diploma in Education through Massey University. After working for a year as a staff nurse in Haematology I undertook a full time year at Massey University and completed a Dip Soc Sci (Nursing). I then worked for four years as Charge Nurse of the ENT ward at Christchurch Hospital before moving to Dunedin in 1991 to take up a role as lecturer in the new Bachelor of Nursing programme at Otago Polytechnic.

Since then I have held numerous roles in the School of Nursing with several periods working in clinical practice and administration.

Roles within the School of Nursing include development and teaching in the Practice, Professional Nursing and Complementary Therapy courses in the Bachelor of Nursing, development and co-ordination of the Bachelor of Nursing for Registered Nurses, and development, teaching and management of the Postgraduate programme. I have had the privilege of supervising and marking several theses and dissertations during this time. I have marked assignments for Massey nursing students and was part of the Praxis editorial committee when it was based in Dunedin.

My own post graduate education continued as I completed a Masters degree at Victoria University undertaking a action research to study living and working with asthma.

My practice experience during my time in Dunedin has included care of the older adult, Service Leader of the Paediatric Unit at Dunedin Hospital, Practice Nursing and co-ordination of Practice Nurse, GP and Practice Manager education for South Link Health.

During the past year I have been responsible for facilitating a successful review of the Bachelor of Nursing curriculum at Otago Polytechnic. I look forward to working with the implementation of the new curriculum.

My research interests include the experience and management of chronic illness. I plan to continue this work with a new project involving nurses and clients in the community. I also plan to work with colleagues on an action research project around the implementation of the new curriculum.

During my time with various roles in Dunedin I have built up important networks and friendships with nurses in the education, secondary care and community spheres of practice. I look forward to renewing these links as I undertake this exciting role within the College of Nursing Aotearoa.

I am particularly interested in supporting Registered Nurses to recognise and expand on their strengths through education and practice. I see this role as an opportunity to continue this work.

New Regional Coordinators for Taranaki

The College of Nurses is pleased to welcome new Taranaki Regional Coordinators Lou Roebuck. Lou has been heavily involved with College activities over the years and is currently the Chair of NPNZ (Nurse Practitioners New Zealand)

Lou Roebuck pictured with College Fellow, Simon Browes.

Lou Roebuck RN, NP, MCNA(NZ)

Lou graduated in 1980 from Greenlane Hospital. She worked in ED, ICU medical and surgical, ENT then travelled to Perth and worked through the three main hospitals as an agency nurse.
Moving to the Primary Health Care sector happened after a move to New Plymouth in 2000, where the hours were more flexible with a family of 6 children. This change highlighted the difference in a wellness model of health, rather than looking at sick people and a more medical model of diagnosis and treatment that she was used to in the hospital system. Lou completed her Masters of Nursing via Massey University in 2006 and became a NP in Primary Health Care, youth health in 2007.

Lou says "I am excited about working alongside Simon and bringing together the Primary and Secondary sectors. A priority for me is to raise the profile of the College and inform nurses about the added advantage of belonging to a professional body. For me throughout my postgraduate study it was essential and I felt very supported. Jenny Carryer (the College Executive Director) especially for me is a great advocate for nursing and was very approachable and happy to share her knowledge and wisdom."

College of Nurses, Aotearoa

Regional Co-ordinator Vacancies

Manawatu, Hawkes Bay, Tarawhiti, Whangarei

The Regional Coordinators role is the face of the College in your area, if you could 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

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Report - Expert Nursing Advisory Group on Smoking Cessation

SNANZ

SMOKEFREE NURSES
AOTEAROA / NEW ZEALAND

In December 2009, the organisation Nurses for a Smokefree Aotearoa brought together nominated members of eleven national nursing organisations of to convene "An Expert Nursing Advisory Group on Smoking Cessation".
The College of Nurses Aotearoa was represented by Nancy Allen (Smoking Cessation Co ordinator Capital and Coast DHB), and Carol Ford (Project Nurse for Tairawhiti DHB in relation to smoking cessation in Primary Care.) Both Carol and Nancy have provided this report on the first meeting.

The group has 2 purposes

1. To provide expert advice to the Ministry of Health
2. To work towards achieving the objectives of Nurses for a Smokefree Aotearoa within the represented organisations.

The objectives of Nurses for a Smokefree Aotearoa are as follows:-
- to increase quit rates and decrease initiation and relapse among nursing clients and the public
- to increase quit rates and decrease initiation and relapse among nurses and student nurses.

Key messages for College of Nurses Aotearoa membership

- Smoking related diseases are the single leading cause of PREVENTABLE DEATHS in New Zealand. They are 12 times the annual road toll.
- Evidence underpinning the NZ Smoking Cessation Guidelines (MOH 2007) underlines the key role that nurses play in influencing smokers to quit. It is a duty of care and a fundamental of good clinical practice to assess clients for nicotine addiction, to recommend cessation, to offer nicotine replacement and to refer for support.
- Online training is readily available – www.smokingcessationabc.org.nz It takes 30 – 40 minutes to complete, after which you receive a certificate of professional development completion. You can then register to become a Quitcard Provider. In the current climate, these can be regarded as core competencies for nurses in clinical practice.
- 13% of nurses currently smoke – and 4% of doctors. We are well positioned to encourage and support all colleagues to become smokefree.
- Most of the people who are easy to encourage to stop smoking have already been successful. Our work now and in the future is with the seriously addicted – and it is difficult! Success requires determination, commitment and collegial support.
- New Zealand has reached a tipping point with regard to smoking cessation – SMOKEFREE is now the norm in this land and smoking rates WILL CONTINUE TO REDUCE.
- The implementation of the Smoking Cessation Guidelines is summarised in the ABC approach.
  At every encounter, a smoker is Advised to stop smoking,
  offered **B**rief advice and referral to Cessation support.
  Cessation support includes NRT(which is heavily, and in some cases fully, subsidized) and access to follow-up support.(Free support services include Quitline, Aukati Kai Paipa and some Pacific Island provider services)
- The MOH targets for DHBs and PHOs are designed to transform clinician behaviour in support of the guidelines implementation – so prepare to be transformed!
- The rest of the world is watching with keen interest.

Report prepared by Carol Ford and Nancy Allen.