Te Puawai

The Blossoming

The Professional Update for Registered Nurses

April 2014

TE PUAWAI

The Blossoming

Whakatauki

Kia tiaho kia puawai te maramatanga

"The illumination and blossoming

of enlightenment"

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

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College of Nurses Aotearoa (NZ) Inc

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Editorial

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Executive Director

Thanks to College members who have made substantial contributions to this edition of Te Puawai. This editorial will be a general update on a number of key issues.

Firstly I want to draw your attention to Dr Jill Wilkinson's excellent update on the increasingly complex issue of prescribing. Thanks to Jill for her conscientious work in pulling this together; it is an extremely valuable resource. Underlying this article is the very solid work being done by Pam Doole on behalf of Nursing Council as they negotiate the minefield of legislation, policy, PHARMAC and custom and practice issues as we work towards expanding nursing services for clients and patients in the context of prescribing.

Thanks also to Diane Williams for being prepared to represent the College on the Rural Health Alliance. Diane attended the conference on our behalf, joined the executive of RHANZ and has written a comprehensive report for this edition of Te Puawai.

Dr Kathy Holloway has joined the Board and brings a rich dimension of expertise in the area of defining specialist practice and relevant standards development. I am delighted to note that she will become our representative on the National Nursing Consortium, which is an excellent use of her skills. She will be replacing our just departed Board member Angela Bates NP who is returning to the UK. Later this year we will also be welcoming Nurse Practitioner Janet Maloney-Moni to the Board as a member of the Maori caucus.

The world never stands still in nursing or health. This week I attended an interesting symposium on the growing challenge of providing colonoscopy to the numbers of people requiring either surveillance or diagnosis following a positive faecal occult blood test or suspicious symptoms. If a national bowel-screening project is rolled out this pressure will expand acutely. The issue is not just one of who will actually perform the endoscopy but how will sufficient rooms,

equipment and support staff be made available and how will this be funded.

Nurses present on the day were clear that the RN scope of practice supports this kind of role expansion but nursing is not interested in simply passing endless colonoscopes in a technician role. Rather we would incorporate the task as part of a continuum of care for people requiring such intervention. We would also see it as being essentially backed by postgrad education in patho-physiology, pharmacology and assessment and clinical decision making as a minimum. The actual process of teaching colonoscopy procedure was well described by an Australian nurse who is involved in such a program in Australia. It was unclear on the day as to exactly what procedures medicine currently uses for teaching such procedures but there was agreement that the standards and processes should be identical for any person regardless of disciplinary background.

An article reprinted from the Women's Health Action network in this edition, raises issues about the ethical and practical concerns of a national bowel-screening program. This is an opinion piece, and as such does not represent the views of the College but it is thought provoking and important nonetheless. Reviewing literature about any screening program immediately reveals just how difficult it is to make decisions about the cost, risk, harm and benefit ratio of screening programs. Prostate screening via PSA testing has been a source of debate for many years with the advice now erring strongly away from PSA testing. There is now growing disquiet about the over treatment resulting from mammography. For nurses at the front line of health education and primary health care these are challenging issues which must be confronted if we are to provide people with appropriate support and guidance.

Moving House or Changing Job

Please remember to update your contact details with the College office.

Email:

admin@nurse.org.nz

Patient Portals Widen Nurses' Role

Article from National Health IT Board

2014 is the year of the portal. By the end of the year, the National Health IT Board aims to have half of all general practices in New Zealand offering a patient portal.

Portals offer patients online secure access to their own medical records and a range of time-saving services, at any time of the day or night. These services include:

- making appointments with a GP or nurse
- ordering repeat prescriptions
- viewing test results
- viewing their medical history, medication lists and immunisations
- a summary view of GPs' notes.

There is also an option of two-way messaging between patients and general practices.

As well as empowering patients to take greater ownership of their healthcare, portals offer many benefits for practice nurses. They are the next step in the move away from paper-based health information to electronic systems, cutting down on administration and freeing up more time for patient care.

Island Bay Medical Centre in Wellington has had a patient portal for two years, and primary healthcare nurse Jo Sutton has been using it for the past six months. The practice has several hundred patients registered to use the portal, and is hoping to increase the number.

Jo believes portals will widen the scope of nurses' role. "Using a portal is much less time consuming than phoning, texting and sending letters," she says.

"With recalls, for example, we can post a message on the portal to let people know when they're due for a tetanus booster or an immunisation, and then they can book an appointment online."

Island Bay Medical Centre uses a portal system from ManageMyHealth, one of four vendors offering portals. Patients can sign up for a portal at reception, and the practice's website has a link to ManageMyHealth.

Nurses who have signed up for the patient portal have their name entered in the system.

To use the portal, Jo logs into Medtech and goes to the provider inbox of ManageMyHealth. The portal has its own tab on the Medtech site, so there's no need for a separate log-in.

Jo checks the portal several times a day, usually between appointments. New messages to her from patients appear in bold. She says it takes her only a couple of minutes to answer most questions.

At present, most of the requests sent to Jo are about appointments, recalls or smear tests.

"I don't think patients realise yet that they could ask me a much wider range of questions. The portal is perfect for asking non-urgent questions – advice on travel immunisations, for example, or questions from long-term condition patients who are managing an injury or a fall," says Jo.

"There have been times when patients have asked too many questions, but most of them take little steps and gradually increase their use of the portal. They're more likely to worry

about bothering a GP than they are to over-use the portal.

“It’s important to educate patients about what portals should and shouldn’t be used for. We tell them it’s about tracking health goals, booking appointments, ordering repeats and seeing results. We make it clear that it isn’t for emergencies, and point out that some doctors use it and some don’t.”

Jo says patients are very positive about portals and appreciate the convenience of being able to contact the practice 24/7 from anywhere with internet access. Older patients have been particularly enthusiastic about portals, especially if they frequently order repeat prescriptions or have questions about their medication.

“Patients say they find portals straightforward, clear and easy to use, and I think nurses would say the same if they gave it a try. Portals are a great tool and they have lots of potential for nurses.”

Kay Brittenden, practice manager at Bush Road Medical Centre in Kamo, Whangarei, has spent the past three months setting up a ManageMyHealth patient portal. The practice plans to start trialling the system with a few patients in early April, and will continue adding small groups of patients to the trial before going live.

“Patients know portals are coming and some of them have been ringing to find out when they can register. We have a patient who is deaf and is very keen to be involved, so we’ll probably use him in our trial group,” says Kay.

“I can see all kinds of benefits for patients but I want to take it slowly so we can get it right before we launch.”

Bush Road Medical Centre plans to document its set-up procedures and share them with other practices considering setting up a portal, as there had been many issues to resolve. It is still deciding whether to buy an email address for each nurse, so they could all log on to the portal.

Patients will initially be able to request repeat prescriptions, make appointments and view consultation notes. Kay plans to set the system up for patients to be able to send messages to doctors, and will open the portal up for patients to be able to contact nurses at a later stage.

A message board allows nurses to send notices to patients, such as flu jab reminders.

Although the set-up process has been time-consuming, Kay is looking forward to the launch of the portal and is sure it will be a useful tool for nurses.

“One of the main benefits to nurses will be giving them another tool to reach patients. Hopefully we’ll have less phone tag,” she says.

“The patient portal concept is great – we shouldn’t be afraid of it.”

The Medicines Amendment Act 2013: Changes for NP and RN Prescribing

Article by: Dr Jill Wilkinson, RN PhD

Nurse practitioner prescribing

On 1 July 2014 the Medicines Amendment Act 2013 will amend the prescribing framework to name nurse practitioners as *authorised prescribers*. The regulations that currently permit NPs to prescribe are the Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005 and the Misuse of Drugs Amendment Regulations 2005. Under these regulations NPs are authorised to independently prescribe medicines in the class of '*designated nurse prescriber*', but they may only prescribe from the list of 1379 approved prescription medicines on the Schedule[1] in the Regulations. The prescription of controlled drugs is limited to three days' supply, only in an emergency, and from a list of 42 controlled drugs. The Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005 will no longer apply from 1 July.

The move to the authorised class is important because NPs, like general practitioners, midwives and optometrists, will be able to prescribe all medicines that are relevant to their area of practice and not just those listed on the Schedule. For example, if a NP's area of practice is wound care, s/he will not be prescribing cardiology medicines. The restriction to area of practice applied also as designated prescribers, but the restriction to the Schedule impeded best practice as the list became outdated.

Although the Medicines Amendment Act 2013 will name NPs as authorised prescribers, a consequential amendment to the Misuse of Drugs Regulations 1977 is still required to ensure NPs retain the ability to prescribe controlled drugs. Rather than carry over the current restrictions into new regulations, in April 2014 the Ministry consulted on a proposal to allow NPs to prescribe controlled drugs within their area of practice for up to one month supply for Class A or B, and up to three months supply for Class C. Feedback from the consultation will inform final advice to Ministers on the amendments. It is anticipated these will be approved by Cabinet by 1 July.

The Medicines Amendment Act also amends the definition of Standing Order in the Medicines Act to include NPs as health practitioners authorised to issue Standing Orders. This amendment does <u>not</u> in itself enable NPs to issue standing orders. Amendment to the Medicines (Standing Order) Regulations 2002 is also required. The amendment to the definition of standing order in the Act does, however, allow such a regulation change to be made in the future. An amendment to the Medicines (Standing Order) Regulations would require Ministerial support

[1] 'Schedule' in this context refers to an annex or appendix to a statute (in this case the Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005. This Schedule, or list of approved medicines for NPs, should not be confused with the Pharmaceutical Schedule which lists all prescription medicines and therapeutic products subsidised by the Government. The pharmaceutical management agency Pharmac publishes this list.

and approval from Cabinet. Until the Standing Order Regulations are amended, doctors and dentists are the only health practitioners who can issue standing orders.

Furthermore, until such time as regulations for specialist nurse prescribing (discussed below) supersede the Medicines (Designated Prescriber—Registered Nurses Practising in Diabetes Health) Regulations 2011, NPs will not be able to supervise RNs prescribing in diabetes health. Unlike NPs who prescribe(d) independently in the designated class, nurses prescribing in diabetes health must be supervised by an authorised prescriber (S.5, 1). The reason NPs cannot be supervisors when they become authorised prescribers is because the Medicines (Designated Prescriber—Registered Nurses Practising in Diabetes Health) Regulations 2011 were made under the Medicines Act 1981 (S.105B), and that Act defines a practitioner as a doctor or dentist.

Commensurate with the changes to the Medicines Amendment Act 2013, the Nursing Council has determined that the NP scope of practice is a prescribing scope and will cease registering NPs without prescribing rights from June 2014. Nurse practitioners registered prior to this date without prescribing will have a condition put on their practice indicating they may not prescribe.[2]

Registered nurse prescribing

In 2013 the Nursing Council was invited by the Minister to apply to the Board of Health Workforce New Zealand (HWNZ) for an extension of the prescribing framework to registered nurses (RNs). A consultation document proposed two levels of RN prescribing within the designated class: community nurse prescribing and specialist nurse prescribing.[3] Responses to the proposals have been largely positive[4] and the Council is proceeding in the first instance with an application for specialist nurse prescribing. This level of prescribing is intended for nurses with advanced skills and knowledge who work in specialty services or general practice teams with particular patient groups. An example would be a respiratory clinical nurse specialist, remembering that the Nursing Council does not regulate role titles conferred by employers. Feedback on the consultation document supported the addition of wording to the RN scope of practice indicating a nurse may be authorised to prescribe, rather than establishing a new and separate scope of practice for RNs who are authorised as designated nurse prescribers.

The Nursing Council's application is for specialist nurse prescribing in the designated class of prescriber (note that the title of 'specialist nurse prescribing' is not yet confirmed). A list of approved prescription medicines is therefore required. There is extensive work involved in preparing and consulting with the Ministry, HWNZ and Pharmac on the list of medicines, including controlled drugs, and the conditions that can be applied to particular medicines. For example, a medicine might be considered suitable for the list as a topical application, but not the oral preparation of the same medicine. The classification of various medicines is another consideration, with some falling off the list if the appropriate formulation deemed

[2] Nursing Council of New Zealand. (2014). *Nurse practitioner: Future changes to scope of practice*. Retrieved from http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Nurse-practitioner

[3] Nursing Council of New Zealand. (2013, February). *Consultation on two proposals for registered nurse prescribing: Community nurse prescribing and specialist nurse prescribing [Consultation document].* Wellington: Author.

[4] Nursing Council of New Zealand. (2013, October). *Analysis of submissions. Consultation on two proposals for registered nurse prescribing: Community nurse prescribing and specialist nurse prescribing.* Retrieved from http://www.nursingcouncil.org.nz/Publications/Consultation-documents/Analysis-of-submissions-concerning-registered-nurse-prescribing

for specialist nurse prescribers is, for example, a general sale item.

A change brought about by the Medicines Amendment Act 2013 is that the approved list of medicines can be published in the *New Zealand Gazette*, rather than listed as a schedule in the Regulations. Updates to the Gazetted list will be approved by the Director General of Health.

When there is general agreement on the list of medicines, the application for specialist nurse prescribing will be made to the Board of HWNZ who will then provide advice about the application to the Minister. Regulations will be drafted, consulted on, amended, and finally approved by Parliament. The Pharmac Board will approve the medicines list and subsidies, then the Nursing Council will publish a notice in the *New Zealand Gazette* with the list of approved medicines and the qualifications nurses would need. A post graduate diploma that includes pathophysiology, clinical assessment skills, pharmacology and a prescribing practicum was recommended in the evaluation of the diabetes nurse specialist prescribing project,[5] and is expected to be the standard for other groups of specialist nurse prescribers. Once the new regulations eventuate, the 2011 regulations for nurses prescribing in diabetes health will be revoked and this group encompassed in the specialist nurse prescriber regulations. In the meantime the PHARMAC consultation and decision on the extension of subsidies has been completed. The Nursing Council will therefore start accepting applications for prescribing authorisation from nurses working in diabetes health from 1 May 2014.[6]

Medicines legislation is a complex area, and this update is intended to outline the key issues rather than provide a detailed analysis of all the factors that are related to the topic. Regulatory change is contingent on the cooperation of numerous stakeholders who willingly engage in a shared vision for safe and timely access to appropriate medicines. Flexible models of care are needed if we are to meet the future health needs of New Zealanders. The changes that the Medicines Amendment Act 2013 will bring about are a step towards this vision through better use of a skilled and knowledgeable nursing workforce. As this update points out, however, there are many steps yet to be taken for this vision to be realised.

Workshops and Events 2014

Professional Portfolio Workshops for RN's

(Check the website for dates & venues scheduled soon)

Professional Boundaries and Relationships Workshop

Covering the requirements for Nursing Council's Code of Conduct training for 2014

Palmerston North 16 May 2014

Schedule of dates for further workshops will be available on the website soon.

Nurses in Business Seminar 2014

(Scheduled date and venue will be available on the website soon)

All events are advertised & registration can be made online via the College website

www.nurse.org.nz

[5] Wilkinson, J. A., Carryer, J., & Adams, J. (2013). Evaluation of a diabetes nurse specialist prescribing project. *Journal of Clinical Nursing.* doi:10.1111/jocn.12517

[6] Nursing Council of New Zealand. (2014). *Registered nurse prescribing in diabetes health services.* Retrieved from http://nursingcouncil.org.nz/Nurses/Authorisation

The Problem With The Bowel Screening Pilot

Reprinted with the kind permission of the Auckland Women's Health Group Newsletter

What is it about general elections and screening programmes?

The promise to establish a national cervical screening programme was announced during the lead up to the 1990 election, following the release of the report of the Cartwright Inquiry into the treatment of cervical cancer at National Women's Hospital in August 1988. The breast cancer screening programme was launched in a hell of hurry in December 1998 in the lead up to the 1999 election.

This year being another election year, pressure is mounting on the government to prematurely roll out a national bowel screening programme. (1) (2) (3)

This would be a big mistake because the 4-year bowel cancer screening pilot currently underway in the Waitemata DHB is having problems, and any attempt to launch a national bowel screening programme without rectifying the issues causing major concerns would result in utter chaos and simply confirm that those in charge of our health system are unwilling to learn from the lessons of the past.

Currently all people aged between 50 and 74 years of age who live in the Waitemata DHB area and are eligible for publicly funded health care are being offered a free bowel screen. The pilot began in October 2011 and is due to be completed in 2015, by which time most of those who have taken part will have been screened twice.

It would be incredibly foolish and unethical to rush in to establishing yet another screening programme before we know precisely what resources are needed to screen, examine, diagnose and treat the healthy people that are being encouraged to undertake the screening test. The pilot bowel screening programme in Waitemata DHB has revealed some unexpected problems that must be thoroughly assessed and rectified before any other DHB inflicts bowel screening on its population. More about these later.

The FOBT

The Faecal Occult Blood Test (FOBT) involves sending in a faecal sample which is tested for any traces of blood.

While a positive result means that blood is detected in the faecal sample, it does not mean the person has bowel cancer. It simply means that a further test is needed to find what is causing the blood to be there.

It is important that those who choose to be screened understand that the FOBT is not 100% accurate. In fact it is not known what the false positive rate and the false negative rate of this screening test is. This is not good news as it means a lot of people are going to become very anxious and may remain anxious even when a further test, a colonoscopy, does not find anything wrong.

Colonoscopy

If the first test result is positive for the presence of blood an appointment will be made for a colonoscopy which is an examination that looks at the lining of the bowel to check for the presence of polyps. A polyp is a benign growth on a stalk. Around 80% of bowel cancers begin life as an adenomatous or benign polyp. Polyps develop very slowly and usually take many years to turn into a cancer.

It is considered best practice to remove all polyps found during the colonoscopy which are then sent to the laboratory for testing. The Waitemata DHB pilot has revealed that those being referred for a colonoscopy have large numbers of polyps and it is taking a lot more time than was anticipated to remove them.

As Waitemata DHB is struggling to meet the unexpected demand on its colonoscopy services due to the time each colonoscopy takes, people are waiting many weeks for their colonoscopy after learning that the result of the FOBT indicates they need one. For many it is a nerve-wracking wait.

The emotional impact

However, the anxiety experienced while waiting for the colonoscopy appointment is just the start. There is no relief in sight even after the lab results arrive. Even if the polyps are found to be benign people are being advised to come back in six months and have another examination.

This is completely unnecessary and does nothing to reduce anxiety levels. It can result in people remaining in a constant state of stress and fear, which in itself can be harmful for their physical and emotional health and wellbeing.

Of course, the media has been silent about the downsides of the bowel cancer screening pilot, preferring instead to run stories about those who had their polyps removed and found evidence of cancer or of pre-cancer – the success stories don't differentiate between the two.

Ministry of Health

The Ministry of Health isn't exactly being honest about the bowel screening pilot either. Their website says the pilot is looking at the safety and effectiveness of bowel screening. (3) But it isn't. The pilot is actually a cohort study which will not provide evidence of safety and effectiveness the way a randomised controlled trial (RCT) would do. The pilot is simply an implementation feasibility study which seems to be ignoring the very real potential for harm including the risks of overdiagnosis and overtreatment.

It is also not clear whether it is measuring the effect on the wait time to investigation on people presenting with symptomatic bowel cancer. This is surprising and of concern in a feasibility/implementation study, as it is an important population safety aspect.

The MOH website also features a statement that says "international evidence shows that bowel cancer screening programmes can save lives through early diagnosis and treatment." (4) There is no reference to what international evidence they are referring to. As no effect has been demonstrated on all-cause mortality this is simply not true. (5)(6)

It is totally unacceptable that the Ministry of Health is not providing balanced information about both the bowel cancer screening pilot and screening programmes in general.

Part of the problem is the composition of the working groups that the MOH/NSU chooses to establish and oversee screening programmes.

Accurate data

Before any decision is made to establish a national bowel screening programme it is vitally important that such a decision is based on accurate data. Waitemata DHB is working on this and is very aware of the need to make sure that both the Ministry and the Minister of Health do not make a decision based on data that subsequently proves to be incorrect.

The Auckland DHB is very clear that it does not have the capacity to provide the services required. At its Hospital Advisory Committee meeting on 19 February a discussion revealed that the increased colonoscopy requirements will "place an additional strain on the anatomical pathology service and highlights the need for trained nurses to assist." All three Auckland DHBs have the same issues in regard to these wait lists. The minutes of the meeting record that while the government has no nat-ional or regional programme it does have a 4-year pilot in place at Waitemata DHB. "At the end of the pilot the government will consider the results and costs with a view to determining how to proceed nationally." Note it is "*how*" not "*whether*."

Evaluating the pilot

An evaluation of sorts has been built into the bowel screening pilot, but as already noted it is not measuring the potential for harm in terms of over-diagnosis and overtreatment.

There is also the very real possibility that a national bowel screening pro-gramme would not be cost effective. Even if the Waitemata DHB pilot does indicate that the resources required indicate it should not go ahead, all the DHBs know that the government is going to roll it out nationwide regardless of the cost to the health system or the harm it can cause to healthy people.

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Diet Drinks Linked To Heart Problems In Older Women

Reprinted with the kind permission of the Auckland Women's Health Group Newsletter

Postmenopausal women who drink two or more diet drinks a day are more likely to experience cardio-vascular problems such as a heart attack or stroke, as well as diabetes, high blood pressure and a higher BMI (Body Mass Index) according to research presented at the American College of Cardiology's 63rd Annual Scientific Session.

The Women's Health Initiative Study, a long-running observational study of cardiovascular health trends among postmenopausal women, looked at nearly 60,000 women with an average age of 62.8 years and found a relationship between diet drink consumption and cardiac events and death, making it the largest study to look at diet drink consumption and cardiovascular problems. (1)

Older women who consume two or more diet sodas per day are 30% more likely to suffer a cardiovascular event and 50% more likely to die from a related disease than women who rarely consume the drinks.

"Our findings are in line with and extend data from previous studies showing an association between diet drinks and metabolic syndrome," said Andur Vyus from the University of Iowa Hospitals and Clinics, and the lead investigator of the study. "We were interested in this research because there was a relative lack of data about diet drinks and cardio-vascular outcomes and mortality."

The association persisted even after researchers adjusted the data to account for demographic characteristics and other cardiovascular risk factors and co-morbidities, including BMI, smoking, hormone therapy use, physical activity, energy intake, salt intake, diabetes, hypertension, high cholesterol and sugar-sweetened beverage intake.

Other studies have also suggested soft drinks can be harmful for older women. One study showed colas, both diet and regular, are associated with lower bone density – an issue for older women who may be at risk for osteoporosis.

Metabolic syndrome

Sweetened drinks have also been found to be associated with weight gain in adults and teens, and seem to increase the risk of metabolic syndrome, which makes both diabetes and heart disease more likely.

Further research needed

While it's important to keep causation and correlation separate, the findings definitely warrant further inquiry, Vyas said. "It's too soon to tell people to change their behavior based on this study; however, based on these and other findings we have a responsibility to do more research to see what is going on and further define the relationship, if one truly exists," he explained. "This could have major public health implications."

The good news

While carbonated beverage sales have been falling for years in the US, the steep decline in diet drinks is a fairly recent phenomenon. According to *Beverage Digest*, carbonated soft drink volumes in 2013 were down for a ninth straight year, and the rate of decline is increasing. Last year volumes fell 3% which brought the industry back to levels last seen in 1995. (2)

Fizz

In New Zealand sugar-sweetened soft drinks have increasingly come under fire in recent years as rates of obesity continue to rise followed by the increase in type-2 diabetes. Even the soft drink industry is prepared to acknowledge that New Zealand, like many countries, has an obesity problem and that its products play a role. (3)

Fizz (Fighting Sugar in Soft Drinks), a new advocacy group of public health doctors and researchers headed by Dr Gerhard Sundborn, a researcher at Auckland University, is campaign-ing to make New Zealand free of sugar-sweetened drinks by 2025. (4) The University of Auckland and the University of Otago hosted a symposium in Auckland in February 2014 – *"Sugary Drink Free Pacific by 2030?"* (5)

However, new evidence suggests that diet drinks are not the way to go either, and are probably best avoided.

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New College Board Members

The College of Nurses is pleased to welcome two new members to the Board – Dr Kathy Holloway (non Maori Caucus) and Janet Maloney-Moni (Maori Caucus).

Dr Kathy Holloway, RN, DN, FCNA(NZ)

Kathy is Dean of Faculty, Whitireia New Zealand, Chair of Nurse Education in the Tertiary Sector (NETS) and author of regular online Webscope column in New Zealand Nursing Review.

Kathy is a New Zealand educated registered nurse and completed her doctorate in the development of a Specialist Nursing Framework for New Zealand which has been used nationally by a number of specialty nursing groups and informs the Specialty standards credentialing process developed by the National Nursing Consortium.

Janet Maloney-Moni, NP, FCNA(NZ)

Janet Maloney-Moni was the first Maori Nurse Practitioner in New Zealand. She was registered as a Nurse Practitioner in 2003 and works in her home town of Opotiki in the Bay of Plenty amongst her own Whakatohea people.

Janet spent the first 8 years providing health care to people in the eastern bay with the contracts she had with the BOPDHB under her company Moni Nursing Services. As part of her business she also provides health assessments for CYF youth justice system.

Janet published her Masters thesis (2004) on the advice of professional colleagues and this book; *Kia Mana A Synergy of Wellbeing*, is a recommended text for nursing students.

Janet decided she wanted to take time out from working in her home town and spent a period of time in 2012 working as a remote nurse in a small Aboriginal community in South Australia called Oodnadatta and in the opal town of Coober Pedy. She found this to be an invaluable experience. During 2013 Janet took on the challenge of a locum Nurse Practitioner working at Puhi Kaiti Medical Centre in Gisborne. She has now returned to Opotiki and works at the Whakatahoea Health Centre for her Iwi based Trust Board.

Janet looks forward to continuing to grow her practice as a Nurse Practitioner with prescribing and is always willing to support registered nurses who wish to take the journey towards this registration. Janet is a Fellow of the College of Nurses, an expert advisor to the Health and Disability Commissioner and a contracted panel member NCNZ for NP assessment and registration in Primary Health, Whanau Ora and Chronic Care.

Most importantly of all she is a nanny to her 5 mokopuna.

RHAANZ AGM & Conference Day

March 2014

Article by: Diane Williams, NP

As a founding member of the newly formed Rural Health Alliance Aotearoa New Zealand (RHAANZ), the College of Nurses, represented by Diane Williams, NP, attended RHAANZ's 2014 Annual General Meeting (AGM) and conference and provided the following report – Judy Yarwood

It was with much curiosity and enthusiasm that I attended the Rural Health Alliance Aotearoa New Zealand RHAANZ's AGM, and associated conference in Wellington in March representing the College of Nurses. Rural New Zealand is the heart of our country; it is important to our economy, our national identity, our leisure and our welfare. Therefore it is in the interests of the nation that all rural communities throughout New Zealand experience optimal health and wellbeing, through access to safe, effective and acceptable health services.

Let me explain what RHAANZ is ....and what it is not. It is not a branch of the District Health Board (DHB) Service Alliance Teams, the network that is funded by and filled with DHB/Primary Health Organisation (PHO) appointments and directed by the Ministry of Health's (MOH) current strategy for health care. RHAANZ, established in March 2013, grew from the Rural General Practice Network (RGPNZ) and brings together health, social and political agencies with a rural focus to provide a unified voice, advocacy and resources to influence policy affecting the health and wellbeing of rural communities. Health representatives, include nursing, medicine, pharmacy and allied health groups, are all part of 22 organisations aligned to RHAANZ. The newly elected chair is Dr Jo Scott-Jones a rural general practitioner (GP) and the newly elected RHAANZ Council is made up of 12 members, including myself as the College of Nurses representative for the term 2014 to 2015.

AGM

The concept of rural is any area which is not a main urban area as defined by Statistics NZ; and health is more than the absence of illness. It is a process of engaging social, mental, spiritual and physical well-being. Health is seen as a fundamental resource to the individual, community and to society as a whole and is a basic human right. Within this context time was spent considering the strategic plan, which is to be distributed to the member organisations for consideration and comment.

RHAANZ Conference

Several key speakers, not health professionals, nor did they even work in the health industry, spoke throughout the day long conference. Their addresses were very informative and covered a wide range of topics as described and discussed below. The major take home message was there needs to be a greater degree of information sharing and networking between national

organisations and government departments if a co-ordinated rural voice is to become a reality.

Ian Proudfoot, (Head of Agribusiness, KPMG) discussed the complex state of rural economics and the rural people that hold it all together in "Global Agribusiness Outlook and the importance of having healthy people with the right capabilities". Primary Agriculture earns NZ$36 Billion/yr = 70% of all NZ's exports. Food security is the No.1 priority worldwide and the rapid increase in food investment/assets/market developments, evolving higher quality protein demand worldwide. China is NZ's largest market. Dairy farming is booming, while meat, wool, fresh produce and timber continue to be export earners.

The call was for sound data analysis tools and reporting to influence governance and improve capacity. Some solutions are found in faster broadband, improved customer relationships and marketing, production systems requiring people with great capabilities and resilience. Recognition of the importance of the primary sector in schools, an increase in core science subjects, and investment in people training to meet the changing face of rural NZ is urgent. We also need to recognise the impact of the declining talent base of farmers 'sunset years', the maximisation of Maori and female rural workforce and leadership within the primary sector, the promotion of great positive rural stories to influence urban beliefs, because it is the people, the people, the people... sound familiar?

The inconsistency of natural environments, water availability and usage ('water footprints' are the new carbon footprints), the flow on effects of Christchurch earthquakes, economics, the rural/urban divide, the urbanisation of our country, regional council policies that don't work for farmers, and promotion of softer study options for NZ youth are just some of the barriers faced.

Some positive moves were revealed by Craig Young, Head of Industry Relations, Chorus. He identified 50% improvement to Digital Subscriber Line (DSL) NZ wide, 360 schools are connected to fast broadband, Vodaphone erecting 154 new towers to service location and 1200 new cabinets to give 20,000 more users access for DSL. Good news for hospitals and x10 IFCHs in major centres. 226 Rural health clinics are meant to have improved access to Serial peripheral Interface (SPI) networks. However, 23% of business is carried out rurally and 13% of rural locations don't have broadband and what about the 70 odd rural hospitals? It is expected rural will continue to have very different capabilities and disparities to their urban counterparts.

Telehealth initiative on the West Coast - Dr Martin London, Rural GP South Westland, gave great examples of how telehealth is working on the remote West Coast, from specialists holding Interdisciplinary team meetings across the Southern Alps and in various West Coast locations, to virtual daily Paediatric ward rounds to individual one on one links with a patient, their mother, and GP to provide timely care (reducing extensive travel, time off work and school and real time access for the GP to the specialist), to Continuing nursing and medical education sessions for staff which are open to non DHB practitioners as well. There is even the very likely possibility the very first transportable MRI scanner for limb investigations will be trialled in Haast.

"The importance of keeping rural communities well from a Government Policy perspective".

Malcolm Alexander's, (CE, Local Government NZ.) thinking towards local government issues 15-20yrs from now was not an attractive vision. An assets rich/income poor demographic is projected for many rural populations in NZ and the world at large. So how will people cover their rates and other related costs with little ready cash? How will councils fund the much needed infrastructure? For example, road maintenance; local councils fund 90% of local roading and most local roads provide transport of agricultural produce in NZ to export ports. We are encouraged to flow the "Buy Local" campaign, to keep regions economically viable. Of equal concern is the out of sight, underground aging water and sewerage networks forecast to cost billions of dollars to replace by struggling local governments who are losing rate payers to urban areas.

Local Government New Zealand (LGNZ) are calling for policy now, not in 20 years' time, in an effort to keep rural communities strong, well, productive and working together. Earth quake strengthening is now Government policy and extremely expensive, but declining rural commercial markets with little recuperation of investment means properties will be left to decay. In response, LGNZ are asking for a balance of life risk with cost, i.e. a targeted application to reinforce street front verandas and balustrades as they create 90% of damage risk and affordable rather than a blanket everything approach. The call to integrate health services/Justice/police/ welfare services to provide seamless care and self-management, keep services as close to home and safe as possible, and strengthen the workforces is a big call. Change can be achieved with a shift in attitude, sharing of data and removal of silos of funding and information.

Tane Cassidy, General Manager Communications and Capacity, Health Promotion Agency, spoke to the need to incorporate different learning styles, address health literacy, new education programs, public health awareness and linking.

Transforming a Rural Community - how three small rural communities intend to transform their communities (Ohakune, Waiouru and Raetihi) Che Wilson, Pou Arahi, Ngati Rangi Office and Don Cameron, Mayor, Ruapehu District Council gave a fresh look at how a small region with 53 health care delivery contracts to service 4000 people actually turned thinking on its head to improve the opportunities for employment, housing and healthcare (costed out at $3,000 a A&E visit , v's $300 for GP care for a similar episode of care). They combined to provide a careers expo day where each presenter offered real jobs to the community and 33 people came away with employment.

Dr Sue Peoples, Social Scientist Agricultural Research, brought home statistics and the very real stories of the little spoken perils of 'farmer stress', the context of living /working in the same place/space, long hours, financial strain/stresses, relationship issues, increased depression and suicide rates when the farmer is not coping... it is everyone's problem, not just his wife's. Farming behaviours in response to peak season workloads and stress lead to gradient changes in decision making which are irrational, which in turn lends itself to poor health and injury. Of note,

were the long term sequelae of Leptospirosis and its devastating effects on famers and their families. Sue promoted laughter as the best medicine and preparedness for times of drought etc.

Federated Farmers are providing online support for depression in an effort to encourage farmers and their families to call for help before things reach crisis point. **Rural Women** are promoting a rurally targeted "It's Not OK" and letterbox sticker campaign to enable rural women to speak up and ask for help in an effort to address rural domestic violence **Free Ph 0800 456450**

Neil Bateup, Chairman Waikato-Hauraki-Coromandel Rural Support Trust - There are now 14 Rural Trusts in NZ to supply 24/7 x 365 days a year assistance accessible by phoning "0800ruralhelp" for farmers in a crisis situation e.g. flood/drought. It is supplied farmer to farmer, by well experienced farmers who facilitate practical steps to work plan a way through the issues.

Suicide and Depression in Rural Areas - Keith Hawke, Independent Documentary Maker, Hawke Films Ltd, shared a behind the scenes look at a DVD he is producing, with a run of 500 copies to be made. However, despite its very relevant title it has very little chance of airing on TV due to the subject matter.

Suicide prevention model in Raglan - Dr Fiona Bolden, Rural GP, Raglan. After a significant increase in rates in 2012, two Raglan professionals triggered a several pronged approach to reduce the risk in their community and bring their community back together. These included a wallet card of help contact numbers, newspaper ads to increase awareness, Mental health '101', attended by 50 people, and a Meridian sponsored Mental Health Awareness program that attracted another 122 people. An informal Te Mauri Tau for men over 40yrs saw a decline in alcohol use within the men's group and an 'Evening of Light' candle ceremony celebrated increased awareness and the choice of life. No locals have committed suicide since.

Farmers Wellness Strategy and Action Plan - Gerard Vaughan, Consultant Mental Health Foundation and Lynda Clark, Dairy Women's Network, discussed personal sustainability as researched by Dairy NZ, marrying evidence to needs targeted at rural people through their website, which links to Movember and Mental Health Foundation to promote knowledge and skills for farmers. Gerard and Lynda hope to track feedback for long term research.

Lesley Barclay, Deputy Chair, National Rural Health Alliance (RHA) Australia, spoke of resources going to what is funded not what is necessarily needed, and research undertaken that revealed an under spend of A$16million in rural indigenous health alone. Those funds have been reclaimed to provide much needed services and further research to improve rural health care in Australia in a life course pipeline approach. Lesley's extensive work, including an article about "Why rurality is killing Australians" and Fact sheets on a range of topics can be accessed on www.ruralhealth.org.au. Lesley rated the use of defensive submissions to agencies to keep services as a poor second to submissions with good data and dynamic solutions. Lesley also laid the challenge to make the most of social media in a positive way to effectively retell good stories and encourage new blood into health workforces. There is moderate success in the push to create rural clinical

placements. A$23-24 million is set aside for education with simulation models and high level training is creating regeneration with health becoming the largest employer in some localities.

Of concern in NZ (as in Australia), is the sustainability of rural centres. Reflected by the continuing drop in rural school roles, centralisation of services, rural health practices relying on supervision from afar, the depleting numbers or lack of experienced hands to provide on call support, both professional and volunteers (Ambulance/Fire Brigade/First Response). Distance should be considered on the deprivation scale

Lastly, what did the College of nurses contribute to this forum?

- For the utilisation of nursing expertise to its full potential, recognition of advanced nursing roles, new models and ways of working in the community. For 100% access and to reduce disparity in health care an approach is needed that forges genuine partnerships placing patient and community need ahead of the challenge to professional power and traditional patterns of privilege.
- Nurse Practitioners (NP) are a proven safe and highly cost effective workforce for rural areas. With employment encouragement there are many rural nurses ready to step up and take on this role.
- The lack of rural streaming in undergraduate nursing education programmes to support the rural sector needs as well as the early identification of those students wishing to enter the rural workforce to proactively recruit and retain them in rural positions. Concerns regarding relatively few NETP placements in rural PHC.
- Address the mismatch of numbers of newly registered graduates to the numbers of jobs available in NZ to avoid forcing nurses out of their communities to gain work. Supply of roles where the health need is greatest.

Whilst at the RHAANZ and Rural General Practice conference that immediately followed, it was pointed out by student nurses from several regions that there is next to no rural placement/career options promoted in their tertiary institutions, unlike their medical student counterparts who have substantial programs dedicated to guiding, educating, nurturing and placing them into well managed rural practice experiences.

Now there is a challenge for College of Nurses to pursue!

Diane Williams NP

Unravelling why geography is Australia's biggest silent killer

Author: **Lesley Barclay**
Professor of Rural Health at University of Sydney

Acknowledgement: THE CONVERSATION http://theconversation.com

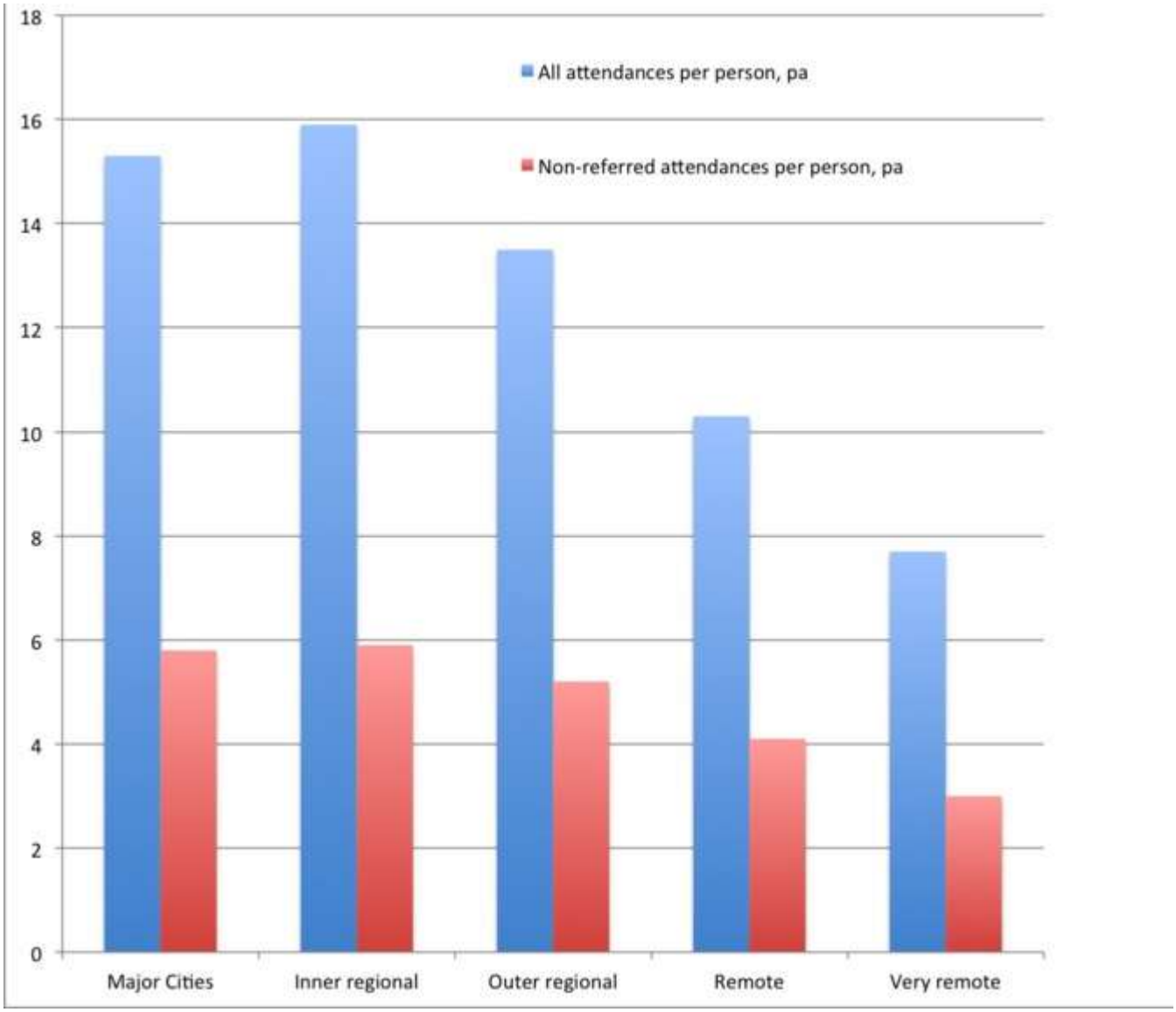
Many people think the poorer health and lower life expectancy of people living in rural or remote Australia are attributable to the under-supply of health services in those areas. But this is only one contributing factor.

Far more important is the distribution of health risk factors and how they interact with the nature of rural and remote places, which results in people dying younger. **Data from the National Health Performance Authority** shows life expectancy at birth ranges from 83.6 years in metro areas to 81.5 in regional hubs and 78.2 in rural places.

The picture is even grimmer when we **look at avoidable deaths**. From a population of 100,000, there are 115 avoidable deaths in metro areas compared to 171 in regional hubs and 244 in rural places. Clearly, there's more than one factor at play here..

Compared with those living in major cities, the people of rural and remote Australia have fewer years of completed education and lower incomes. And a greater proportion of them have a disability, smoke, and drink to risky degrees. They also have poorer access to the internet and mobile phones.

And then there's access to health professionals, including doctors, which is notoriously poor in rural areas. Compared with the rate at which city people access Medicare, people in rural and remote areas are at a massive disadvantage – there's a so-called "Medicare deficit" of around $1 billion a year.

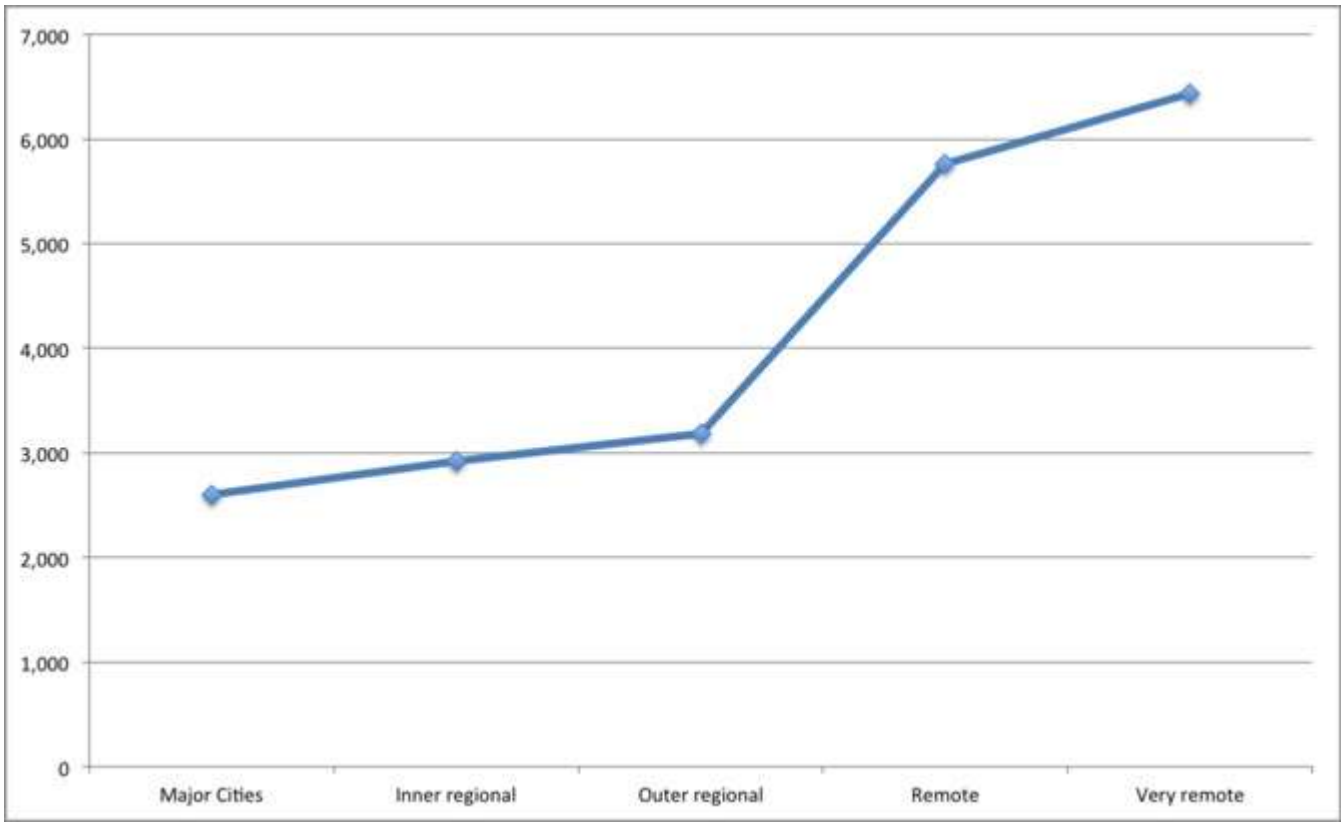


A graph showing Medicare attendance by location. Attendances derived by NRHA using Medicare attendance data and ABS 2012 population data. The rest of the figures are directly from Medistats. Medistats

In 2012-13, for instance, there were 5.8 **GP services per head funded by Medicare**, compared to 5.9 in inner regional areas, 5.2 in outer regional areas, 4.1 in remote areas and 3 in very remote areas. In country areas, there's also less access to private hospitals, even for those who are privately insured.

And apart from these well-known deficiencies in access to health services, people in rural and remote areas also have less access to health-promoting infrastructure, such as targeted smoking cessation activities, organised physical activities and the information contained in health promotion campaigns.

All in all, there's a slanting line across key health measures such as potentially avoidable death, potentially avoidable hospitalisation and life expectancy from major cities through to very remote areas. Cancer survival rates show the same pattern.



Potentially preventable hospitalisations by location (per 100,000 pop. 2010-11) COAG Reform Council

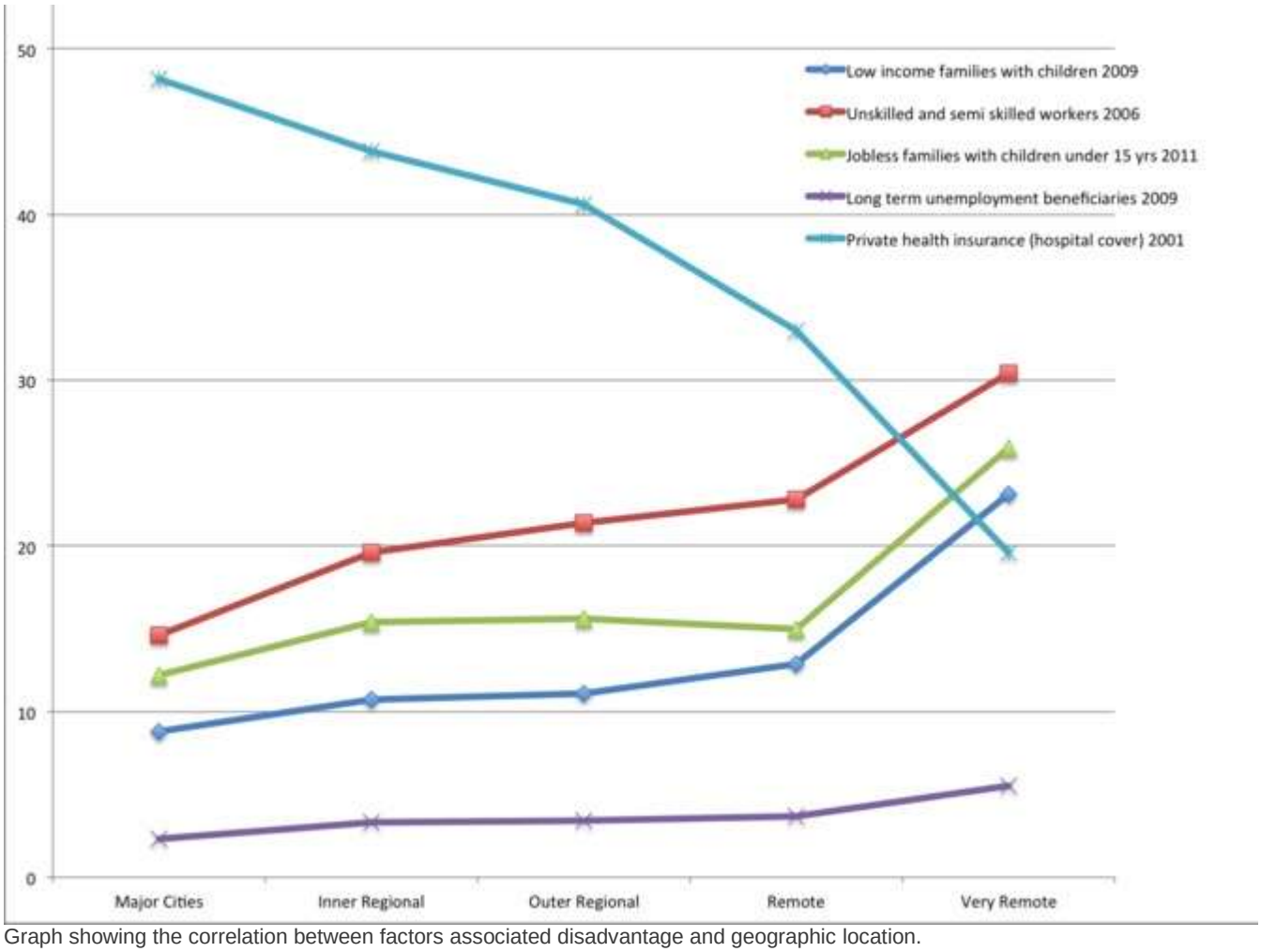
Social factors that impact health, such as income, completed years of education, disability, smoking and risky drinking, show the same gradient. All of these result in a higher incidence among the people of rural remote areas of various disadvantages relating to work, income, education and children (think of the proportion of families with young children in poverty).

If we are to address these disadvantages, we need to unpick the relationship between socioeconomic status and geography. From an equity standpoint, the important issues are why levels of employment are low, why in a particular place there are few professionals and many labourers, why internet access is low, and why are there fewer people with education above year 11 – and what can be done about these things.

It seems safe to assume that the causes of health deficits include “rurality” – a combination of remoteness and town size because it’s obvious that town size, not just remoteness, will strongly influence variables, such as income, educational attainment, work skills and housing costs.

But our current measures are so crude that Urana, a town of 800 people in the Riverina region of New South Wales, Townsville, with around 195,000 people, and Darwin, with around 130,000 people are in the same category.

Another data set collects measures socioeconomic status. Variables used to calculate this index typically include income, internet connection, the percentage of people schooled to year 11 only, the proportion in the labour force who are unemployed, long-term health conditions or disability, and people paying less than $166 rent per week.



Graph showing the correlation between factors associated disadvantage and geographic location.

All of these are almost certain to be influenced by two characteristics of place: its distance from a capital city or other large centre, and the size of the town. The remoteness and the size of a particular community influences its access to schools, jobs and high-paid employment. Other issues, such as the nature of the main local industries, or economic drivers, such as weather, are also influential.

We can keep doing new analyses to expand our understanding of how various factors interact to cause the clear health disadvantage in rural and remote areas. These might even suggest the causes for the different but they will be misleading without a solid understanding of underlying variables.

While the role of income and education on health status are universal and universally accepted, it's too early to dismiss place – especially "rurality" – as a determinant of health status.

It seems likely that place is a primary determining factor in the worse health of rural and remote Australians, with socioeconomic status being an intermediary. In other words, low income might be the toxin, with place being what allows it to harm people.

We know socioeconomic status is a major determinant of health, but understanding how the characteristics of a particular place impact health is critically important if we are to understand how to improve health and longevity in rural and remote Australia.

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Nurse Practitioners New Zealand
Conference Cluster 2014

Massey University

Wellington

NP Portfolio Development Day - 4th September 2014
Prescribing Workshop - 5th September 2014
NPNZ Professional Issues Conference - 6th September 2014

Considering a prescribing pathway? This conference cluster is not to be missed.

With the recent legislation changes from designated prescribing to authorised prescribing for Nurse Practitioners, introduction of Diabetes Nurse Prescribers and vision of RN prescribing on the horizon, it is exciting times for non-medical prescribing in New Zealand.

This conference cluster will be of interest to all nurses and other non-medical prescribers who are considering aligning a prescribing component to their practice.

Presenters from Nursing Council, Chief Nurses Office, College of Nurses Aotearoa (NZ) Inc, Pharmac, Medsafe and NZNO have been confirmed. Along with these speakers there will be clinical and research presentations from Nurse Prescribers with established prescribing pathways across a range of areas of practice with in the New Zealand health system.

Register your interest now to receive updates on these events,
email - admin@nurse.org.nz with 'NPNZ Events' in the subject line.

Nurse Practitioners New Zealand

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Registration, programme & speakers information available as it is released on the website, go to -

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