Te Puawai

The Blossoming

The Professional Update for Registered Nurses

August 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

Professor Jenny Carryer
RN, PhD, FCNA(NZ) MNZM
Executive Director

Lately there has been a noticeable rise in telephone enquiries from organisations who have suddenly decided that a Nurse Practitioner would be the answer to their immediate problem of maintaining service provision. At the same time advertisements for Nurse Practitioner positions are appearing around the country. I have seen a couple of irritable comments associated with blogs on the NZ Doctor web site asking "so where **are** all these NPs, we have been trying for weeks to find one for our practice."

This is such an irony when one considers how long and how assiduously we have been developing, promoting and providing evidence about the role. Our advice many years ago was that workforce demographics suggested that the need for both nursing role development and the establishment of Nurse Practitioners would be a vital part of ensuring safe service development.

Recently two particular announcements have caught my attention.

1) Dr Malloy says in this week's GP Pulse it is estimated 81 per cent of GPs are aged over 45, 45 per cent are aged over 55 and 40 per cent of GPs want to retire in the next decade (NZ Doctor, May 21 2014).

2) Senior doctors warn public waiting lists will lengthen and hospitals could become unsafe if a chronic shortage of specialists is not urgently addressed. The Association of Salaried Medical Specialists says the shortage will swell to 670 full-time positions in the next seven years.

In a report released on Monday, the association says nearly a fifth of senior doctors are due to retire in the next five years, further compounding the shortage. Executive director Ian Powell said nearly half of specialists in the workforce at present are recruited from overseas, and the high turnover rate makes the health system vulnerable. He said a plan was agreed with DHBs in 2010 to employ 260 more doctors each year, but that hasn't happened, and the Government should act immediately.

http://www.radionz.co.nz/news/national/251839/warning-of-looming-specialist-shortage

Both of these announcements reveal the ongoing challenge for NZ as a small country with limited resources to sustain the kind of health service we all expect. They also affirm our long-standing assertion in nursing that nurses and NPs need to be utilised much more wisely and to their fullest potential.

In the case of Nurse Practitioners it is so sad that the role was not more warmly understood and embraced much earlier on. It is very frustrating to consider the many (maybe at least a 1000) nurses who have completed a clinical masters degree but not taken the next steps towards NP authorisation because they cannot see any obvious job prospects. It is not surprising that there are very few ready and waiting NPs simply sitting in the wings waiting to be summoned to a position. There will now inevitably be an unnecessary time lag between advertising and hiring needed Nurse Practitioners.

This leads me to reflect back on the period when we launched the NP role in New Zealand. I was part of a Ministry of Health road show (in 2002) travelling around the country to provide information and raise awareness of the role as a workforce strategy. I noticed in every DHB that despite Ministry invitations going to all key players in the organisation it was almost universal that the CEO, the COO, the GM, the Funding and Planning Manager all apologised and said the DON would be attending (along with other senior nurses in the organisation). The overall message was that this was nursing business and therefore not important to them. One can absolutely guarantee that had this been a Ministry road show about medical workforce development every single one of them would have attended.

The outcome of their non-attendance was of course a level of ignorance about exactly what a Nurse Practitioner was, what they could do, and where they could meet population need as a component of strategic workforce development. In my view such ignorance, whilst now diminished to some extent, is still far too widespread. I see weekly evidence of its persistence through enquiries made about the most basic facts of NP capabilities and employment potential.

I am also reminded of a comment I heard frequently through the last decade in response to the recovery process nursing undertook following the widespread destabilising and general chaos which occurred in the 1990s. That comment or some variant inevitably described nursing as empire building. Requests for the establishment of leadership positions, increases in nurse specialist positions, establishment of primary health care nursing infrastructure were often viewed as nurses building an empire. It always seemed to me that whereas our agenda was the safety and quality of service delivery it was frequently interpreted as a drive to feather our own nests or fulfil our own self-interest.

I am not sure to this day that I understand why there should be such a reaction to anything that can possibly be construed as “the advancement of nursing’. Why is it not perceived as the advancement of service delivery. The accusation of self- interest is much less likely to be directed at medicine and that is undoubtedly a great irony.

For the health sector to maintain service delivery against the workforce challenges clearly looming then it will take a multi-sector response. It is no longer acceptable to ignore the actual and potential developments in nursing or to expect piecemeal and ad hoc responses when gaps such as colonoscopy services are revealed. Taking nursing seriously with an enormous potential contribution is something the whole sector, including politicians, policy makers, senior managers and other key decision makers, must own in partnership with nursing leadership.

Obituary
Janet Maloney-Moni

E te tuāhine, haere, haere, haere
Haere ki te kainga tuturu mo tatou katoa o te tangata
Haere ki o matua ki o tipuna
Moe mai ki roto i te Ariki

Janet Maloney-Moni was endorsed as the first Māori Nurse Practitioner in New Zealand in 2003. She made her application for Nurse Practitioner to the Nursing Council of New Zealand after she had developed and delivered a successful rural mobile DSM (Disease State Management) nursing service to North Waikato.

Over the years Janet has been hugely influential in Māori development for both education and health sectors as a registered nurse, nursing tutor, training provider, clinical supervisor, mental health services manager and author. When asked what it was that attracted her to becoming a Nurse Practitioner, Janet said it was "*the opportunity to work more autonomously in the community delivering health care that motivates the people to take care of themselves. Working independently allows me to control how much time I am able to spend with people. Understanding their diagnosed chronic conditions and how to self manage as well as preventing other whānau from developing these conditions takes time and that is what I am able to give. It was also to prove our credibility and how significant our contribution to health care within communities can be.*"

She established her own business in her hometown of Opōtiki; Moni Nursing Services and was contracted to provide community based nursing service in Opōtiki and surrounding districts.

In 2006 Janet published Kia Mana: A Synergy of Wellbeing, capturing her journey of reflection and inquiry seeking to understand, explain and validate her practice as a Maori nurse working with Maori clients. The journey reveals a clearly identifiable intertwined cultural and clinical approach that characterised her practice as the first Maori Nurse Practitioner in Aotearoa, NZ.

After a short illness and courageous battle Janet passed away peacefully with her whanau in Opotiki aged 62 years. She is survived by her son Leon, twin daughters Nadine and Renay and beautiful moko (grandchildren).

Janet was known for her tenacity, strong sense of direction, passion for nursing and making a difference for Maori. Her passing has left a huge gap for Maori nurses in Aotearoa. We thank her whanau for sharing her with us and reassure them that the legacy that Janet has left for us all will not be forgotten. Moe mai, moe mai, moe mai ra.

Provided on behalf of the College Board by Taima Campbell

The Right To Say No To Research Trials

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

It has become clear over the past few months that patients cannot rely on the Code of Consumers' Rights to protect them from being enrolled in clinical trials or other research studies without their consent having been obtained first. It is proving difficult to find out exactly when patients lost that right, and even more problematic to know how to rectify the current unsatisfactory situation.

What hasn't changed is the fact that many patients/consumers are willing to consider the offer of becoming a research participant – provided they are first given the opportunity to read the patient information sheet about the research trial and to have their questions answered.

Some history

The AWHC was established in 1988 and held its first meeting in July that year, a month before the release of the Cartwright report of the Inquiry into the treatment of cervical cancer at National Women's Hospital. In the wake of the report's publication ethics committees were completely trans-formed into committees with both lay people and health professionals whose primary role was to protect the rights of patients and ensure that no-one was enrolled in any kind of research without giving their informed consent to be involved.

The office of the Health & Disability Commissioner was set up in late 1994 and consultation on a proposed Code of Consumers' Rights began the following year.

On 1 July 1996 a legislated Code of Consumers' Rights came into effect.

Right 6, the right to be fully informed, states that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -

1(d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and

1(e) Any other information required by legal, professional, ethical, and other relevant standards.

Right 7, the right to make an informed choice and the right to give informed consent, states that:

4(c) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where –

(a) It is in the best interests of the consumer.

For some unknown reason the debate about ethics committees approving research involving participants who lack the capacity to consent to participate has focused almost solely on Right 7(4) of the Code, not Right 6(1) d and e. Even the Health & Disability Commissioner's response to the letter the AWHC wrote about the practice of enrolling

people in research trials without their informed consent, focused on Right 7(4). Anthony Hill stated in his letter "as you know there are two passionately held and opposing schools of thought on Right 7(4)."

Actually, the AWHC did not know that. Having been involved in the two consultation processes during the development of the Code of Consumers' Rights, the Council believed that the mere thought of enrolling people in research trials without their consent was illegal, utterly abhorrent and against the Declaration of Helsinki, and the NZ Code of Rights, being enshrined in legislation, protected patients from such practices. After all, this issue was at the very heart of the Cartwright Inquiry. Once the recommendations in the Cartwright Report were implemented patients would never have to worry about being enrolled in research trials without their consent ever again. Right? Apparently not.

Anthony Hill stated in his letter that "this is not a matter about which HDC has received complaints, nor is it one that prompted many submissions in the recent Act and Code review, soon to be completed."

The AWHC did not include the issue in our submission because we did not know that in New Zealand thousands of unconscious patients in intensive care units around the country are being enrolled in clinical trials without their consent. The Council was also blissfully unaware that there was any debate going on about whether this practice was legal or not.

The Ministry of Health's chief legal advisor, in a letter to the Ministry's ethics committee chairs and members, dated 7 April 2014 but not posted on the ethics committee website until months later stated:

"Research involving participants who do not have the capacity to consent (and where no-one legally authorised to give consent on behalf of the participant does so) is not lawful unless it satisfies Right 7(4) of the Code of Health and Disability Services Consumers' Rights (the Code). Committees do not have the authority to give consent on behalf of participants." (1)

It also says: "Investigators must satisfy the committee that proposed research is lawful before the committee approves an application. Committees are not required or able to give legal advice to investigators; it is the responsibility of the investigator to ensure that the research is lawful."

This is not at all reassuring. There is big money involved in clinical trials and both the investigators and the DHBs have a huge conflict of interest in deciding what research is lawful and what is not.

The letter from the MOH's chief legal advisor has not been enough to stop ethics committees' approving research involving participants who lack the capacity to consent.

The HDC, the consumer watchdog, is sitting on his hands, has refused to undertake an investigation, and is waiting to receive a complaint from someone other than the AWHC, although the Council hasn't given up and has written to him again.

The AWHC has also written to Minister of Health Tony Ryall. As he was the Minister who pushed through the changes that ensured the focus of ethics committees would now be on approving research proposals – not protecting the rights of research participants – it is extremely unlikely that Mr Ryall is going to come to the rescue of the unconscious patients in the country's ICUs any time soon.

References

1. http://ethics.health.govt.nz/

College Board Update

College Board member Nicola Russell has secured a doctoral scholarship to commence her PhD studies at Massey University very shortly. Accordingly she has made the decision that in order to complete a PhD in 3 years she needs to resign from the College Board. The Board has decided to ask Dr Mark Jones who was the next polling candidate in the most recent Board elections to join the Board as her immediate replacement. In addition Judy Yarwood is completing a long period of service to the Board as Co-Chairperson and will stand down in October. This Board vacancy will be advertised in the normal manner. See call for nominations in this issue of Te Puawai.

Margareth Broodkorn is also completing her 4 year term in October. She was to have been replaced by Janet Maloney-Moni who has passed away just this last week. The Maori Caucus will also be calling for nominations.

NOTICE OF

ANNUAL GENERAL MEETING

for

College of Nurses Aotearoa (NZ) Inc

Thursday 16th October 2014
6.30pm
at the
Holiday Inn Auckland Airport
Auckland

followed by guest speaker –

Allison Lanham

Individual Giving Manager for

Variety – The Children's Charity

7.30 to 8.30pm

Drinks will be available to be purchased with nibbles provided from 6.00pm

College of Nurses members please RSVP to the College office -

email - member@nurse.org.nz

AGM Remits: Individuals or regional groups may submit remits for consideration at the Annual General Meeting. Remits must be in writing and received at the College office no later than **8th September 2014.**

A copy of the College rules is available on the website

www.nurse.org.nz

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06 358 6000

AGM Guest Speaker

Allison Lanham
Individual Giving Manager
Variety – The Children's Charity

"Allison Lanham recently started as the Individual Giving Manager at Variety – The Children's Charity. Her main responsibility is to grow the Kiwi Kid Sponsorship Programme that connects donors with specific Kiwi children in need. Prior to Variety, Allison worked in Charlotte, North Carolina (USA) as the Director of Development at Girl Scouts, Hornets' Nest Council and Annual Giving & Constituent Relations Manager at Discovery Place, Inc. – a collection of science museums. During her time at the museum and Girl Scouts, she increased the number of individual donors and donations as well as planned multiple large-scale events. She has a Bachelor of Science degree from James Madison University in communication studies focusing on marketing and non-profit studies."

Moving House or Changing Job

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

Email: admin@nurse.org.nz

Global Advanced Practice Nursing Learning Symposium - July 2014 Philadelphia USA

Report by Dr Kathy Holloway

I was privileged to be invited, as a nurse researcher around advancing nursing practice within the registered nurse scope from New Zealand, to a recent Global Advanced Practice Nursing Learning Symposium in Philadelphia. Nurses needing to practice to the full extent of their education and expertise to meet health care need are one key message from the 2011 Institute of Medicine (IOM) report – The Future of Nursing: Leading Change, Advancing Health[1]. Advanced practice nursing (APN) is understood as a key policy platform to achieve this goal. The growth of APN roles internationally comes with great variation of definition and operationalization of the call to action. In response a global group of advanced practice nursing health policy makers, practitioners and thought leaders came together for a two-day invitation-only symposium in the USA.

The goals of the Symposium were to learn how countries have or are developing and utilizing APN's to improve access to care for their populations and to share best practices around access, cost and quality. The expected outcome (now under development post symposium) will be a white paper report to inform a planned Future of Global Nursing report for the Robert Wood Johnson Foundation (RWJF) building on from the original work. The problems of lack of access to primary health care and provider shortages are universal, and the development of APN-based solutions to these challenges has the potential to positively impact the health of both developing and developed countries.

The symposium was attended by 14 invited international nursing leaders from Australia, South America, France, Spain, Hong Kong, South Africa, Peru, Brazil, Canada and of course New Zealand including Dr David Benton (CEO of ICN). Additionally, 15 colleagues from across the USA were invited - many involved in the call to action programme from the IOM report through the RWJF.

Having the opportunity to discuss the shared concerns and enablers for releasing the potential of nursing to contribute to advancing the health of our communities was a great privilege. There are some differences between countries related in part to the ratio of doctors to nurses i.e. where there are fewer doctors there is usually more developed roles for advanced practice nurses. As an example in Greece there is less than one nurse per doctor, advanced roles for nurses have not developed. Whereas the reverse ratio is true in the UK, Canada and the USA where advanced nursing roles are more developed.

The definition of advanced nursing practice was an area of much debate with a broad consensus that the understanding of the APN as exclusively the Nurse Practitioner role is not supported. Advanced practice can and does occur within the scope of the registered nurse and the group were very interested in the work that the NNO group had done through the 2011 glossary. The NNO definitions of specialty and specialist were also shared and provoked interesting discussion.

Prescriptive authority was recognised as a key element in supporting access to healthcare for underserved populations. New Zealand was held up as an example of good practice with many other countries including the USA (the first to grant prescriptive authority to NPs) struggling with inconsistent approaches. Canada (represented by Dr Denise Bryant-Lukosis) has done some interesting work in the delineation of clinical nurse specialist and nurse practitioners and the place of expanded practice.

Overall the key challenges to the contribution of the APN were summarised as the lack of a defined role; unstable funding; inconsistent or unnecessary regulation; opposition from other health providers; nurse migration and inconsistent education and training standards. There is resonance for us in New Zealand in all of those facets I would argue.

The symposium was an exciting opportunity to share policy and practice and overall reinforced that there is more that is the same than is different when you focus on advancing health as the touchstone for why nursing needs to respond.

Dr Kathy Holloway

Board Vacancy

Nominations are called from the

College Membership to fill a non-Maori Caucus vacancy on the

College Board which will arise

following the conclusion of Judy Yarwood's term.

Nominations will also be called to fill a Maori Caucus position.

Nomination forms will be e-mailed to College Members

Short Update On Plans To Have Nurses Conduct Endoscopy Screening In NZ

Provided by Professor Jenny Carryer

Following on from the Bowel Screening Programme, Health Workforce New Zealand and the Ministry of Health's Cancer Team have convened an Advisory Group to develop and implement the role of nurses performing endoscopy. The advisory group is comprised of nursing and medical representatives and supported by HWNZ and Ministry of Health staff. Prof Jenny Carryer is a member of the advisory group.

Development of the nurse role in performing gastrointestinal procedures will be considered in the wider context of developing advanced nurse roles that contribute to the career pathway for nurses. Nurses working in gastroenterology and most specifically, endoscopy are expected to have a direct/indirect increase in service delivery which releases medical staff to undertake more complex procedures.

Training of nurses to perform endoscopies is to complement the training currently available for gastroenterology and general surgery registrars. The nurse role in performing endoscopy is not proposed as a substitute for the role of gastroenterologists and general surgeons. Development of the nurse role in performing endoscopy and associated training as well as an increase in the number of registrars training in gastroenterology and general surgery are together critical for the delivery of bowel screening in New Zealand.

It is expected that endoscopy training for nurses, gastroenterologists, and general surgeons will be subject to identical standards and, expectations and that there will be common governance of the training available to all three professions.

Currently the advisory group is working through a process of determining an agreed education and training program for experienced nurses who are keen to expand their practice in this area. Some consultation has begun with the education sector but no firm decisions have yet been made.

Workshops and Events 2014

Professional Boundaries and Relationships Workshop

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

Hamilton

12 September 2014

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

Nurses in Business Seminar

Auckland

13 November 2014

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

www.nurse.org.nz

Low Uptake on HPV Vaccine

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

The results of a cost-effectiveness study undertaken by the University of Otago Wellington and released in April 2014 has revealed that the vaccine coverage rate for girls and young women was only 47% at the time of the analysis of the available data. While coverage is currently estimated to be around 56% it is still low, especially when compared to vaccination coverage rates in Australia. In marked contrast to other NZ vaccine coverage statistics, coverage rates for Maori and Pacific are higher than for European.

The HPV vaccine Gardasil which protects against two of the HPV (human papilloma viruses) that can cause cervical cancer and two that can result in genital warts, was introduced into NZ in 2008. Despite protests from women's health groups about the lack of sufficient evidence that it would provide protection against the development of cervical cancer, it was introduced as the cervical cancer vaccine.

In May 2008 then Prime Minister Helen Clark announced that the government would provide $177 million in funding over five years for the 3-dose vaccine. From September 2008 the vaccine was offered free to 300,000 teenage girls between 12 – 18 years of age. The government said the cervical cancer vaccine was expected to save around 30 lives each year.

Since 2011 Gardasil has been routinely offered to 12-year-old girls (Year 8) in schools, who also have the option of having the vaccine at their GP a few years later.

University of Otago Wellington researcher Professor Tony Blakely says the reason for the low coverage rates may be that parents are given too many options. In a press release dated 15 April 2014 he said: "Having the option to either have the vaccination at school, or delay a few years and get it from a GP is likely causing a lot of parents to delay. One possible way to achieve higher coverage might therefore be to have only a free school-based programme, as in Australia, with the requirement to pay the full market price in other settings." (1)

Since the very beginning of the roll out of the HPV vaccine programme some parents have been concerned with the idea of their 11- and 12-year-old daughters being given a 3-dose HPV vaccine at such a young age, and many parents have opted to wait a few years.

Six years after the introduction of the HPV vaccination programme clinics around the country (sexual health, family planning and student and youth health clinics) have reported a declining number of first presentations for genital warts, with the steepest reductions occurring in young women aged 15 – 19 years.

The study found that the greatest health gain was from the prevention of genital warts, with smaller gains from reduced rates of cervical cancer. As it takes around 15 years for cervical cancer to develop following infection with one of the cancer-causing HPV types, and over 90% of HPVs are cleared by the immune system within 3 years, it is not clear what the claim about the reduced rates of cervical cancer is based upon.

Reference

www.otago.ac.nz/wellington/otago069004.pdf

Mass Treatment

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

"Mass prescription for modest individual benefit is new. Truly informed choice will require more than good intentions. We will need better data, from bigger trials, and better risk communication than for conventional medical treatment," Ben Goldacre, doctor, author of "*Bad Science*" and "*Bad Pharma*" and a research fellow in epidemiology, says in an editorial in 23 July 2014 issue of the *British Medical Journal*. (1)

"When we offer a preventive drug to large numbers of healthy people, we are a long way from the doctor treating a sick patient. In some respects, we are less like doctors and more like a life insurance sales team: offering occasional, possibly life-changing benefits, many years from now, in exchange for small ongoing inconvenience and cost. This represents a new kind of medicine, and delivering informed choice that reflects differing patient preferences will require wholesale structural improvements in how we gather and communicate research evidence."

While Ben Goldacre is writing about mass treatment with statins his observations are applicable to a wide range of preventative drugs that are now being prescribed to large populations in order to lower the risk of a particular patient experiencing a particular adverse event such as a stroke, a heart attack or a hip fracture.

"This persisting uncertainty about the precise risks and benefits of statins is a serious barrier to informed patient choice: after two decades of wide-spread statin prescription, it also shows that we have so far failed to implement the core principles of evidence based medicine," he says.

In an era of informed choice and increasingly personalised medicine, one size does not fit all. While some people are prepared to put up with considerable side effects in the hope that it will increase their chances of avoiding a heart attack, others are not willing to put up with even quite mild side effects of drugs that they have to remember to take on a daily basis and which they experience as reducing their quality of life.

Informed choice and informed consent mean that healthy people must be given good evidence before they agree to mass prescription. Ben Goldacre believes that before doctors are able to provide this, an information revolution is necessary. Without bigger and better research trials and new information tools, doctors "can say only that statins are – broadly speaking – likely to do more good than harm. This is not good enough," he concludes.

Reference

1. Ben Goldacre & Liam Smeeth. "Mass treatment with statins." Editorial *British Medical Journal*. 23 July 2014

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 the 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, MoH, Medicines Control 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 within the New Zealand health system.

These conference events are open to all those with an interest in future non-medical prescribing. Attendance at the Prescribing workshop will be a favourable professional development component for NP audit process.

Register Online:
www.nurse.org.nz/event-registration-form

Nurse Practitioners New Zealand

A division of the College of Nurses Aotearoa (NZ) Inc

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

www.nurse.org.nz