Te Puawai

The Blossoming

The Professional Update for Registered Nurses

August 2016

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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Contents

Editorial

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

Professor Jenny Carryer

Lately I have been reflecting on the now very long time I have been involved in nursing leadership. Some things have changed markedly and one of the most profound changes is around the availability of nurse leaders. I find it helpful to think of there being two types of leadership within nursing; organisational leadership (heading an organisation) and disciplinary leadership (i.e. leading the discipline of nursing in political, policy and strategic settings). Both types of leadership are vitally and equally important.

Organisational leaders are the Directors of Nursing (or similar) in DHBs, PHOs, Aged Care settings and many many other diverse places. Their role is to lead, guide, direct and oversee the provision of safe nursing services in the respective setting. Their roles are often difficult and demanding especially where they have full accountability for nursing services but reduced control over budgetary and other important resourcing issues. They are often extremely busy and of necessity fully occupied with their role obligations.

Disciplinary leaders are those people who step into the public sphere and become a face and voice for nursing. They compile submissions, appear before select committees, chair or join Ministry working groups, speak to or write for the media, and so forth.

Other nurses move into non traditional roles and provide vital service but do they or can they easily retain their identity and allegiance to their own discipline? As CEO's of DHBs, leaders in health quality and safety issues, heads of multidisciplinary organisations outside the immediate health sector they cannot be seen to be too heavily engaged with any particular discipline and thus are in effect lost to direct professional engagement with nursing.

Sometimes organisational and disciplinary leaders are one and the same people. And this is where the change has occurred most noticeably as more often these days they are not the same people. Being an organisational leader of nursing services is demanding and has become more so as resources tighten, demand increases and workforce challenges grow. It is clear that requests for assistance with the work of a professional organisation are much more likely to remain unanswered these days. Many of us are noticing a dearth of volunteers to represent nursing in a range of ways following requests for such help or contributions. It is increasingly difficult for nurse leaders to have the head space to stay on top of the demands of their own organisation and simultaneously abreast of the vast array of professional and political issues for nursing as a discipline.

And so what used to be an active and energetic national community of nurse leaders (functioning outside the confines of any one organisation) has become a much quieter and increasingly lonely space. This is a problem as the need for active, powerful and highly strategic disciplinary leadership has never been greater. I don't see any easy or immediate solutions. There is a certain level of confidence and courage required to step into the public arena; some might say it requires a thick skin. Are we providing younger emerging nurse leaders with enough mentorship and opportunity to step up?

I am glad the College will be relaunching its mentorship and supervision scheme under the leadership of Liz Manning; it's a small but important start. But I welcome members' suggestions as to how to tempt or support people to step into the leadership domain. There is plenty of room!!!

New Zealand Health Strategy: Future Direction

In April 2016, following an extensive consultation by the Ministry of Health, the government published a "refreshed New Zealand Health Strategy." Minister of Health Jonathan Coleman stated in the foreword that "the Strategy sets the framework for the health system to address the pressures and significant demands on its services and on the health budget." (1) It is the first review of the health strategy undertaken since 2000. The 39-page document sets the direction for development during the next 10 years and features the words "All New Zealanders live well, stay well, get well" on the front cover.

The Health Strategy refers to the opportunities and challenges faced by the health system, outlines the future we want, and then describes the five strategic themes –

- People-powered
- Closer to home
- Value and high performance
- One team
- Smart system

Significantly, the word 'poverty' is not mentioned anywhere in either this document, or in the second part – "Roadmap of Actions 2016." It is hard to believe that poverty wasn't mentioned in numerous submissions on the revision of the strategy, especially in connection with child health.

The word 'investment' appears frequently throughout the document, as in "investing in health and wellbeing early in life and focusing on children, young people, families and whanau" – described as setting the foundation for lifelong health – which is one of four goals listed under the "Closer to home" theme.

For children and young people who are struggling with health and/or social problems, the document

states that “it will be important to take a social investment approach and co- ordinate activities across agencies.”

Each of the sections on the five strategic themes ends with a vision of what the health system could look like in 2026. Note the use of the word “could” rather than “should.” So no pressure, even though the second part of the Strategy, the Roadmap of Actions, sets out concrete action areas to focus on over the next five years, and states that the roadmap will be updated annually.

Parts of the vision for “Closer to home” include statements such as:

- People are safe, well and healthy in their own homes, schools, workplaces and communities.
- We have well-designed and integrated pathways for the common journeys people take through our health and disability system (e.g. cancer, maternity, diabetes), starting and finishing in homes.

The government’s vision for “Value and high performance” includes:

- The health system provides high- quality, accessible health services that help people live well, stay well, get well, at the lowest cost it can and within the resources available.
- The health system minimises harm to people, by openly tracking harm when it occurs, and learning from mistakes, so that the system as a whole can improve.

Given the current government’s emphasis on delivering “more extensive services within the resources available,” while expecting the whole health sector to do more for less money, it is impossible not to feel somewhat cynical while reading the “refreshed” Health Strategy.

It is also impossible to ignore actions such as the Minister’s expectations that DHBs will meet the health targets set by the government despite evidence that some come with unintended consequences (e.g. over- treatment), the government’s withdrawal of funding from NGOs such as the Problem Gambling Foundation, ASH, LifeLine, and women’s health groups, as well as the Ministry’s refusal to take action when confronted with evidence of the huge amount of harm done to patients by medical devices such as breast implants, metal-on-metal hip joint replacements, the mesh, and pregnancy test kits.

Add to this the Ministry’s refusal to support or fund life-saving devices such as pepi-pods which have been credited with producing the first drop in Maori infant mortality rates in a decade (see article on page 4). When the statement about “the need for a fair and responsive health system that improves health outcomes for key groups, including Maori…who are not currently gaining the same benefits from the health system as other New Zealanders” (1) is placed alongside the refusal to fund pepi- pods it doesn’t count for much.

Reference

1. http://www.health.govt.nz/publication/ new-zealand-health-strategy-2016

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Exploring Innovations Of Aged Care

Article by: Professor Jenny Carryer

Having an ageing population is not just a New Zealand problem, but a global problem, and we need to look to other countries successes and challenges.

I have recently returned from a five-day study tour in the Netherlands, exploring the innovations in the care of older people living there.

While the Netherlands are trying to reduce the number of older people in residential settings, New Zealand too are trying to manage access to this expensive type of care, which does not necessarily enhance people's functional ability and quality of life. The Netherlands have made considerable advances in making their services much more person-centred and are certainly leading in this area. On the other hand we considered that New Zealand was well ahead in its goal of integrating services across the continuum of people's needs, rather than allowing services to moperate as siloes,"

Dr Andy Towers from Massey's School of Public Health, Ms Carmela Petagna from the Health Quality and Safety Commission, Dr Jan Weststrate, Hon Research Fellow Massey University, Ms Tracey Siebele, Whanganui District Health Board, Anja Jonkers, Chief Inspector Aged Care, Ms Pakize Sari, General Manager of Wellingtons Te Hopai Elderly Care, Ms Andrea Bunn, Whanganui District Health Board, Prof Jenny Carryer

We visited De Hogweyk, a village structure for the care of people with dementia. This was the most extraordinary experience of the trip. Founded 23 years ago the village is resourced in the same manner and to the same level as all residential facilities in The Netherlands and receives people with severe dementia for permanent long term care until death. However, the person-centred approach to dementia care considerably sets this facility apart from other facilities in dementia care both in the Netherlands and worldwide. The village uses the notion of back stage (all mechanisms for the care and safety of the residents) and front stage (their life, home, entertainment and autonomy). The back stage is kept entirely invisible and residents live in houses of 6-7 which function independently for food and laundry, gardening (etc) with resident engagement. One to two caregivers are stationed in each house between 6am and 10pm and manage the care of the residents alongside the cooking and laundry assisted by any residents that choose to do so. The character of each house is based

on the previous lifestyle of the residents who are assessed prior to entry. This influences the choice of art on the walls and the music playing and whether beer or wine is served at 5pm!!

Despite the similar funding and the same level of dementia there is no comparison between this facility and more conventional facilities. Residents respond to the normality of the environment with complete reduction in the supposedly normal distressing characteristics of dementia. In another unit we visited which was of high quality in terms of usual care, some residents paced, shouted, destroyed furniture, were restrained and confined especially at night and there were many mechanisms for preventing one resident from disturbing another. In absolute contrast the residents of De Hogweyk wandered freely, socialised, some recognised that we spoke English and responded in kind, slept in normal beds and had a busy social life including club membership etc. The village contained a supermarket, pub, restaurant, a full theatre for musical shows etc.

During our pre visit briefing with the founder in the village restaurant a resident wandered in and joined us. She was served a drink by the staff as we were and listened attentively to our meeting. This sounds small but it captures the essential philosophy of the village. People with severe dementia respond to a normal environment and normal social conventions.

I was struck by the impeccable grooming of the residents and the general air of purpose for all of those who were mobile.

Hogweyk Village

“One of the aspects the group found most interesting, is the development work from a societal perspective that the Netherlands is undertaking to support their families and communities to care for their elders. The model of care demonstrated in the dementia village, Hogeweyk, is now being modelled in Rotorua. To see people with severe dementia living in a community environment and undertaking ordinary activities of daily living was truly inspiring. The idea of nursing and support being ‘invisible or normalised’ also provides food for thought as we develop models here.”

One of the surprise benefits of the study tour, was through the diversity of the interests of the New Zealand study group, members not only learnt from the Netherlands but from each other. “We all established relationships that will foster future opportunities for collaboration and working in partnership. We believe there are opportunities for our emerging clinical leaders to partner across countries to learn from each other. This study tour has presented us with a unique opportunity to influence older people’s health particularly for dementia care and ongoing quality developments in New Zealand,”

Massey University’s School of Nursing has a Memorandum of Understanding with Maastricht University to conduct a New Zealand arm of a long standing multi-country study that has been running for 15 years. The study matches process issues with specific patient outcomes including pressure injuries, falls and malnutrition. The group met the founders of the research project and were able to learn a great deal more about the process by which the study engages PhD and masters students and has contributed to a decline in prevalence of a number of negative care outcomes across the 6 countries involved in the project.

The study group visited residential care facilities and met with the Chief Nurse, Professor Marike Schurmanns and the Chief Health Inspector. We visited a senior friendly hospital, the University Medical Centre Utrecht, which ensures that all admissions over the age of 70 are specifically focused on an assessment of that persons level of frailty so their care can be developed accordingly.

“We also visited Vilans, Centre of Knowledge of Long-Term Care, and saw how they connect with key stakeholders in the community to generate research problems and how they work to ensure transferability of knowledge created.”

The meetings highlighted that the challenges with ageing populations are universal and the visit validated some of the New Zealand thinking and approaches. “In New Zealand, we tend to look to the United Kingdom to guide service development, however, what we saw in the Netherlands took many concepts to a higher level.”

The trip was organised and hosted by Dr Jan Weststrate from Paekakairiki who is an Honorary Research Fellow in the School of Nursing at Massey University and an independent researcher.My trip was generously supported by the University.

Typical Dutch architecture

Surgery: The Ultimate Placebo

Professor Ian Harris is an orthopaedic surgeon with a clinical practice in Sydney. He also directs a research unit that focuses on the outcomes of surgery. Earlier this year he published a book, "*Surgery: The Ultimate Placebo*" which is a must read for anyone contemplating surgery. (1)

Professor Harris begins his book by stating "This book builds a case for a placebo effect of surgery, something that is often underestimated when assessing the effectiveness of surgical procedures." The first three chapters are devoted to exploring the placebo effect, the important but often unacknowledged role it plays in the science of evidence-based medicine, and how to create the perfect placebo.

Chapter four provides some fascinating examples of studies using sham surgery. They include surgery for the following conditions – angina, Parkinson's disease, Meniere's disease, migraine, knee arthroscopy for arthritis and for a torn meniscus (the C-shaped cartilage in the knee), IDET (intradiscal electrothermal therapy) for back pain, tennis elbow, and high blood pressure.

Chapter five lists the operations that have been assigned to the surgical scrap heap due to a lack of effective-ness. However, a brief internet search will reveal that some of them are still being done. The procedures described in this chapter were not tested against a placebo, but were shown to be ineffective or unnecessary in other ways. They include bloodletting (more about this in the July newsletter), radical mastectomy, lobotomy, extracranial and intracranial bypass surgery for strokes, and surgery on the knee for plica syndrome which Professor Harris describes as one of a number of "made-up conditions" which surgeons then devised an operation to treat. He writes: "But without ever validating the diagnosis or doing any comparative trials of treatment, we have no idea whether this is a real condition or not, let alone whether the treatment really does anything. But there is no incentive to do such a trial, as long as the public keeps trusting surgeons to "diagnose" it, and pays them to treat it; and as long as some of them say they feel better afterwards, there is no need to rock the boat."

Chapter six describes current but questionable surgical procedures that are today's placebo surgeries. They include back fusion surgery, surgery for multiple sclerosis, hysterectomy, caesarean section, knee arthroscopy, appendicitis, coronary stenting, shoulder surgery for impingement, surgery for floating kidney, tendon ruptures, laparoscopy for bowel adhesions, and fracture surgery.

Stents

The section in this chapter on coronary stenting was particularly interesting given the large numbers of people who have stents. Professor Harris refers to the debate between the cardiothoracic surgeons who prefer coronary artery bypass grafts in which blood vessels from other parts of the body are used to bypass obstructed arteries in the heart, and the interventional cardiologists who prefer angioplasty/stenting in which tubes are place inside the blocked heart arteries to re-open them. 5 "Everyone wants to know which one is best," he writes. "But I am more interested in whether either of them is better than *not* doing them."

"The best evidence tells us that there is no difference between these two methods when it comes to the chance of dying, and not much difference for anything else, except that you are more likely to need another 'revascularisation' with stenting."

Chapter seven examines the reasons behind the persistence of surgery that is not effective, and chapter eight presents the case against using the placebo effect to justify doing the surgery.

Chapter nine outlines what "we" can do about all this unnecessary surgery, "we" being patients, doctors, researchers, funders and society.

Professor Harris states that patients can get good advice from their treating doctor by asking the right questions, and that the best question is to ask about the difference between the results of any proposed surgery compared to the best non-operative alternative. If patients cannot get good advice from their treating doctor he recommends seeing another doctor, or another two doctors. "Surgeons know that second opinions can be helpful for them and for the patient," he writes.

The 30 April issue of the *Listener* featured a major article by Donna Chisholm on Professor Harris' book (2). She writes that "the book is being welcomed here, and although several influential surgical leaders disagree with some of Harris' "don't do" list of operations, they support its basic arguments." Auckland anaesthetist Professor Alan Merry, Chair of the Health Quality and Safety Commission, is quoted as saying that he "accepts some operations are being done "just for the sake of doing something" for patients with ongoing problems.

"There is a widespread expectation that the fact a patient is in pain or otherwise suffering is a reason to do something. That's not logical. The reason to do something is because there is an expectation that what you are going to do will help," he says.

Professor Merry also points out that "there is a debate that says medicine is unaffordable because of progress. Everything becomes more expensive and you can't keep up … the newer stuff comes out with a hiss and a roar and everyone wants it and five years later you find it doesn't really work and you've done bad things. There are lots of examples of that. If we give people only what we have good reason to believe works, and what really aligns with what they need and want, medicine is affordable." (2)

Asking the right questions

Professor of surgery, Ian Civil, Chair of the commission's Safe Surgery NZ, also agrees with Professor Harris' emphasis on the importance of patients asking the right questions. 'If I have this operation, will I be more likely to be better in five years than if I didn't have it,' and 'What are the chances I'll be worse," are great questions," he says. (2)

References

1. Ian Harris. "Surgery, the Ultimate Placebo." Pub. NewSouth Publishing. 2016

2. Donna Chisholm. "Cutting Through the Evidence." *Listener* 30 April 2016.

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National Rural Health Conference 2016 Dunedin 31 March – 3 April

Report by Rachael Pretorius NP

Rachael Pretorius NP

This year was the first Rural Health Conference I have attended - after having left a life of working and living in Auckland in July 2015 to work in a rural practice in the small village of Martinborough in the South Wairarapa. Not unexpectedly, rural health and rural issues are new to me and the last nine months has been an eye opener to life in a rural community.

Martinborough Health Services is the most rural of practices in the South Wairarapa with some patients having to travel over an hour from the coast or from large farming stations to get to the practice. Ambulance services can be on average an hour or longer away depending on if it is coming from over the hill in Wellington or from somewhere else in the Wairarapa. We regularly host student nurses from UCOL, student doctors and trainee interns in the rural immersion programme.

This year the rural health conference had record attendance with 530 delegates including approximately 100 students of Nursing, Medicine, and Pharmacy and other health fields. The conference was hosted by New Zealand Rural General Practice Network, in association with RHAANZ (Rural Health Alliance Aotearoa New Zealand) and the New Zealand Rural Hospital Network. The theme for this year's conference was 'Wai Ora, Healthy Environments'.

The College of Nurses very kindly offered me the opportunity to attend the conference as I represent the College of Nurses on RHAANZ. I fell into the role of the College of Nurses representative when friend and Wairarapa colleague NP Anna Reed (scope Older Adult) decided to step down from RHAANZ, believing that they needed an NP working the coal face in 'rural practice' to be a Council member. Having limited knowledge of rural health and little idea of who and what RHAANZ was, I frantically read as much as I could on the RHAANZ website and their e-zines. I sent out an email to rural NPs with the College of Nurses to find out what were the most pressing rural issues that concerned my NP colleagues throughout New Zealand and fronted up to the RHAANZ Council meeting in Dunedin the day prior to the conference feeling a little out of my comfort zone. Trying not to feel intimidated in a meeting with CEO's, Boards of Directors of all manner of rural business and innovation I soon realised that a nursing voice was highly valued and appreciated.

Farming injuries, gastrointestinal illnesses along with poor rural broadband and mobile connectivity have stood out to me in rural practice so my mission at this year's conference was to find out more

about these issues. I decided I would like some take home messages from speakers who were not necessarily clinically focussed but who discussed issues critical for rural communities.

Increasingly intensive farming practices in New Zealand and the negative impact this has on the environment has implications for the whole of New Zealand in terms of water and soil safety, crops grown to feed our country and the mental health and wellbeing of our farmers struggling with economic downturn and poor pay outs for milk solids, beef and lamb. With increasing costs of feed and irrigation and high mortgages, this leads to a vicious cycle of more intensive farming to try and break even. Implications are contamination of ground water and aquifers used for drinking or irrigation of crops by dairy, beef and lamb has the potential to cause outbreaks of disease (think back to 2014 and the Yersinia outbreak thought to be a result of contaminated water irrigating lettuces and carrots which quickly spread throughout the country). Antibiotic use in farming leads to contaminated soils (animal faeces) and worrying anti-microbial resistance especially when some of the same antibiotics are used in animal and human health. Therefore, protecting our environment for generations to come is a challenge for New Zealanders. Maybe looking to other crops as a source of income rather than beef and dairy is the way of rural New Zealand in the future?

Telehealth as an example of what is happening on the West Coast of the South Island was inspiring. Practices are using IT systems able to work with low band-widths and slow internet like ADSL to have virtual consults using web cams in areas where nurses run health services and there is no local doctor. This enables patients in rural and remote communities to have access to GP and specialist care when needed. This looked very exciting as there is scope for virtual meetings and continuing education for nurses and doctors working in areas with little to no internet and mobile connectivity (who would have ever thought coming from Auckland this would be an issue for colleagues throughout New Zealand?)

I felt very humbled to attend a conference with some very experienced and amazing nurses making a huge contribution in their communities despite limited resources, adversity and often no GP colleagues! At the awards ceremony some of these outstanding nurse specialists and Nurse Practitioners were recognised for their services to rural nursing and practice and I realised working in rural practice takes nurses with guts, tenacity and high level of skill and innovation to provide excellent health services to serve our communities. Rural practice would not be what it is without them.

It was an honour to be a part of the awards ceremony- the RHAANZ/NZ Doctor/NZRGPN rural practice of the year (as nominated by the public) was awarded to the very practice I work at - Martinborough Health Services.

More information on the National Rural Health Conference 2016 including slides from presenters can be found at www.conference.co.nz/nrhc16

Rachael Pretorius
Nurse Practitioner (Primary Care)

NOTICE OF

ANNUAL GENERAL MEETING

for

College of Nurses Aotearoa (NZ) Inc.

to be held

5.30pm
Thursday, 6th October 2016

at the

The Cooperage
723 Main Street
Palmerston North

Speaker To Be Announced

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 **2nd September 2016.**

A copy of the College rules is available on the website

www.nurse.org.nz

National PDRP Document Review Project

Report Supplied By Liz Manning

The Nurse Executives of New Zealand (NENZ) is leading a project to review the two[1] underpinning documents for Professional Development and Recognition Programmes (PDRP).

Project co-leads, Karyn Sangster, Chief Nurse Advisor Primary & Integrated Care Counties Manukau DHB and Carey Campbell, Chief Nurse Advisor (National) Southern Cross Hospitals , are leading on behalf of NENZ, a small project team with representatives from key PDRP stakeholders, including National PDRP coordinators, Nursing Council NZ, New Zealand Nurses Organisation, College of Nurses (NZ) and Te Kaunihera o Nga Neehi Māori o Aotearoa- National Council of Māori Nurses, to undertake the initial preparation of the documents for a broad consultation process.

Initial development of the documents required expertise and collaboration across nursing. To maintain the validity of the documents, they require review every few years as PDRP programmes and processes continue to evolve.

The planned consultation will look at:

- Addressing the sections of the documents which require clarification.
- Refreshing the documents to reflect current trends and requirements.

The project will reflect the values of NENZ and approach this review to show the breadth of PDRP nationally across all organisations which utilise PDRPs. The project will not be reviewing PDRP documents in relation to the DHB/MECA agreements.

The project has only just begun, with initial project team meetings. The aim is for a consultation to be released within the next few weeks.

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[1] National Professional Development & Recognition Programmes Working Party. (2004*). National framework for nursing professional development & recognition programmes & designated role titles (reviewed and updated December 2005).* New Zealand: Author.

PDRP Evidential Requirements Working Party. (2009). *PDRP evidential requirements working party report final.* New Zealand: Author.

Update On Surgical Mesh

The Health Committee recently released its report on the petition of Carmel Berry and Charlotte Korte requesting an inquiry into the use of surgical mesh in New Zealand. (1) It makes for sobering reading as among other things it details Medsafe's response to the issues raised by the petitioners and their call for an inquiry. The incredible damage the mesh has caused to the bodies and lives of hundreds of New Zealanders, the millions of dollars paid out in ACC claims (new figures show that ACC has paid out $10 million in treatment injury claims from botched surgical mesh implants), and the lack of informed consent reported by mesh implant sufferers were not enough to persuade the Health Select Committee that an inquiry was warranted.

However, the Health Committee did make seven recommendations to the government. They are:

- That it work with relevant medical colleges to investigate options for establishing and maintaining a surgical mesh registry

- That a registry be informed by the International Urogynaecological Association classification for recording mesh surgery complications

- That it suggest that the Colleges take note of the petitioners' and others' experiences and review best practice around informed consent for mesh procedures

- That it encourage health providers to ensure that coding for mesh surgery is consistent. This should include a system to allow patients with mesh complications to be identified and monitored

- That it encourage utilisation of the adverse events reporting system as applicable to medical devices

- That it endorse the provision of ongoing education for surgeons on the use of surgical mesh and mesh removal surgery

- That it consider expanding Medsafe's role over time to assess the quality and safety of a medical device before it can be used in New Zealand.

The Committee's report records that Medsafe did not support a New Zealand registry of surgical mesh as they did not believe it would improve patient safety.

The petitioners asked for mesh devices to be reclassified as a class III (high risk) device. Medsafe did not support a change to the classification of mesh as it would require a change to the regulations, and a change would not necessarily prevent a device from being made available in New Zealand.

Medsafe also did not support the petitioners' recommendation that the reporting of all device-related adverse events should be mandatory for surgeons and GPs.

Medsafe's response to the horrendous complications associated with the use of urogynaecological mesh is completely unacceptable.

On 20 June Kathryn Ryan interviewed Patricia Sullivan, another eloquent and informed mesh victim. (2)

References

1. http://www.parliament.nz/resource/en-nz/51DBSCH_SCR69220_1/2ebf5e03f6fae9f78e731ff8ebfce8ded2df857f
2. http://www.radionz.co.nz/national/

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Moving House or Changing Job

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

Email:

admin@nurse.org.nz

NI2016 – The 13th International Congress In Nursing Informatics

Report By Dr Michelle Honey

College of Nurses Aotearoa (NZ) Inc 2016 Travel Scholarship Recipient

NI2016 – the 13th International Congress in Nursing Informatics, was held in Geneva, Switzerland June 25 to 29, 2016. The theme of the conference was eHealth for all: Every level collaboration – from project to realisation. This is the major event for the International Medical Informatics Association – Nursing Informatics Special Interest Group (IMIA-NI), of which New Zealander Lucy Westbrooke, was the current chair.

New Zealand was well represented by Lucy Westbrooke (Auckland), Denise Irvine (Waikato), myself attending, and also a keynote speaker, Dr Frances Hughes, who spoke in her role as Chief Executive Officer of the International Council of Nurses (ICN). There were nearly 600 attendees at this event, from 43 countries – so truly an international gathering. There was a strong presence from Asia, with a number of nurses from Taiwan, China, Korea and Japan, though the largest contingent of nurses came from the USA. For the first time at an IMIA-NI congress nurses from Iran were also welcomed.

In total 335 submissions were accepted (66% acceptance rate), and these were arranged into a very full programme of tutorials, workshops, panel presentations, demonstrations, papers or posters. Themes identified during the congress included:

- Home health and consumer engagement in their care, sometimes called participatory health
- Personal health records – their development and use.
- Sharing health data at local, regional, and national levels and across nations (notably within the European Union (EU)) to ensure that the health information is available wherever it is needed.
- Interprofessional ways of working to maximise care and the use of valuable resources towards the common goal of providing safe and effective healthcare.
- Simulation in nursing education
- Big data and the use of large data sets, particularly when the data can be used to show the nursing contribution to health care.

A favourite keynote was delivered by Dave DeBronkart on how e-patients are changing healthcare. He described how the internet, information and communication technologies and digital devices are giving patients new information, so that e-patients are “empowered, engaged, equipped and enabled” to partner with health professionals in their care. Dr Judy Murphy described Kaiser Permanente in the US, which serves a population of over nine million, twice that of the total

population of New Zealand, in her keynote on “Re-imagining care delivery: The power of nursing informatics”. She talked about total care that includes environmental, social, family history, genetic, lifestyle and medical care – redefining what holistic care could look like.

A highlight of the NI2016 congress was the emphasis on innovative mobile and wearable devices. These included mobile apps, such as one that was used for wound management in conjunction with a camera, so regular photos of the wound could be taken, the wound size could be measured and this could be collected and stored alongside other wound assessment data. Another example was an instrumental shoe which allows for real-time activity monitoring, and a final example, of a robot that can assist an older person with their medication management.

“Kiwis at NI2016 – (from left to right) Michelle Honey (University of Auckland); Denise Irvine (Waikato); Frances Hughes (ICN CEO), and Lucy Westbrooke (Auckland)

Dr Michelle Honey

Following NI2016 – the 13th International Congress in Nursing Informatics, that was held in Geneva, Switzerland June 25 to 29, 2016 Dr Michelle Honey attended an invitation-only post-conference meeting at Villars-sur-Ollon, about two hours drive northeast of Geneva in the mountains. Michelle, who is a Senior Lecturer at the School of Nursing at the University of Auckland was one of only 32 people internationally (and the only person from New Zealand) to join a three day workshop led by Judy Murphy and William Goossen considering nursing informatics competencies from a global perspective. Outcomes from the workshop will be published later this year by IOS Press.

Denise Irvine
Telehealth Coordinator
Waikato District Health Board

Waikato Nursing Star Off To Mexico to Address Our Ageing Society's Healthcare Needs

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Passionate about healthcare, travel and philanthropy Waikato DHB registered nurse, Kathryn Van Der Maas, has already completed two volunteer trips, one in Samoa teaching deaf children sign language, and three weeks nursing in Vanuatu, and now at the ripe age of 23 she's off to Mexico.

Kathryn along with two other New Zealander representatives and approximately 100 international attendees will participate in the Universitas 21 Conference, '*A Global Perspective on Ageing Societies'*, in Te de Monterrey in Mexico, 11-16 July.

"Population ageing is arguably the single most influential factor that will face the New Zealand Healthcare sector in the next 10 to 20 years," says Kathryn.

"I'm really excited about attending Universitas 21. The conference has participants from all industries, not just healthcare, and I'm hoping to bring back valuable learnings from all corners of the world about how to influence positive change in an ageing society of healthcare needs."

Kathryn is in her first year of the Waikato DHB / University of Auckland's Bachelor of Nursing (Honours) programme.

Her research topic seeks to address the factors that influence trauma patient's care transitions from specialty surgical wards at Waikato Hospital to regional domicile hospitals.

With multiple services involved to address trauma patients complex physical and psychological needs the care transition needs to be a comprehensive, collaborative process and Katheryn will be taking a holistic view at how these affect the quality of their care continuation.

“I’ve always been interested in community healthcare and empowering patients to succeed with their recovery plans when they leave the hospital.

“Transition for trauma patients can be a time of turmoil and vulnerability in their journey, in particular older persons.

“With a higher proportion of the population over 65, and as tertiary acute hospital service needs continue to increase, healthcare delivery has to be challenged to meet these needs closer to home.

“My Honours study will address all transition factors and opinions from health professionals, patients, and family members.

“The opportunity to network in Mexico and widen my research will strengthen my report findings and insights for the Waikato DHB.”

The driving force behind Waikato’s involvement in the Honour’s programme and Director of Nursing & Midwifery, Sue Hayward said choosing Kathryn to be an Honour’s student and supporting her to attend the Mexico conference was an opportunity for her as an individual and us as a DHB that we could not pass on.

“We need to foster and grow exceptional talent like Kathryn.

“Her commitment and will to support patient journeys and Waikato DHB’s need to gather fresh insightful information on this research topic is critical to help us improve our quality of care in and out of the hospital to create a more sustainable workforce.

“Waikato DHB is committed to continuous development and investing in young stars to becoming specialists in their field.”

About the Waikato DHB / University of Auckland Nursing (Honours) Programme

Now in its fourth year, Waikato DHB / University of Auckland Honours Programme mentors and supports high achieving students with leadership potential.

Only four DHBs: Waikato, Counties, Bay of Plenty, and Auckland are involved in the Honours programme.

The programme supports academically excellent (minimum GPA 8.0) and clinically highly competent young registered nurses to participate in an Honours programme that not only prepares students for doctoral study but also engages them in leadership preparation.

To date, around 75 percent of graduates continue to doctorate level.

The programme only accepts four students a year from the Waikato DHB.

The Honours Programme At Auckland University

Report Supplied by Dr Mathew Parsons

The integrated Honours programme was first established in 2012 as a collaborative venture between Waikato DHB and the University of Auckland and over the last three years has progressively rolled out to Counties Manukau Health, Bay of Plenty and most recently Auckland DHBs. An Honours programme has been available through the University of Auckland for many years and was intended as a fast track to doctoral studies for students achieving academic success in their bachelor of nursing programme. However, the programme was always undertaken in isolation to the DHB and there was little interaction between the university and DHB.

The integrated Honours programme provides a completely different approach, with the DHB leading the engagement of students, identification of projects as well as on-going support. The Honours programme is equivalent in points to a postgraduate diploma and consists of the first NETP paper, a research methods paper and a 60-point dissertation. Nurses are working within the clinical area at the time of enrolment. Those nurses who have an 'A-' minimum in their first degree and an A in their NETP paper are invited to apply to join the programme. The nurse's clinical area must support the student and recognises future leadership potential. All students are interviewed.

Generally, up to four students per year, per DHB enrol in the project and a senior research active academic from the University of Auckland is assigned at commencement to support and supervise the student. Topics that will be explored during the programme by the student are provided by the clinical area and are of particular interest to the DHB. The Director of Nursing remains the sponsor for the programme and meets with the students regularly to provide support and often careers advice.

Concurrent to the taught and research programme, nurses participate in a series of structured 'conversations' with senior managers around key topics. Sessions take up to an hour and focus around key topics identified by the manager. The aim of the 'conversations' is to enable nurses to identify key DHB drivers and motivations as well as meet general managers across the DHB.

The diagram might help get an understanding of the programme.

To date, six of the Honours students have gone on to undertake PhDs.

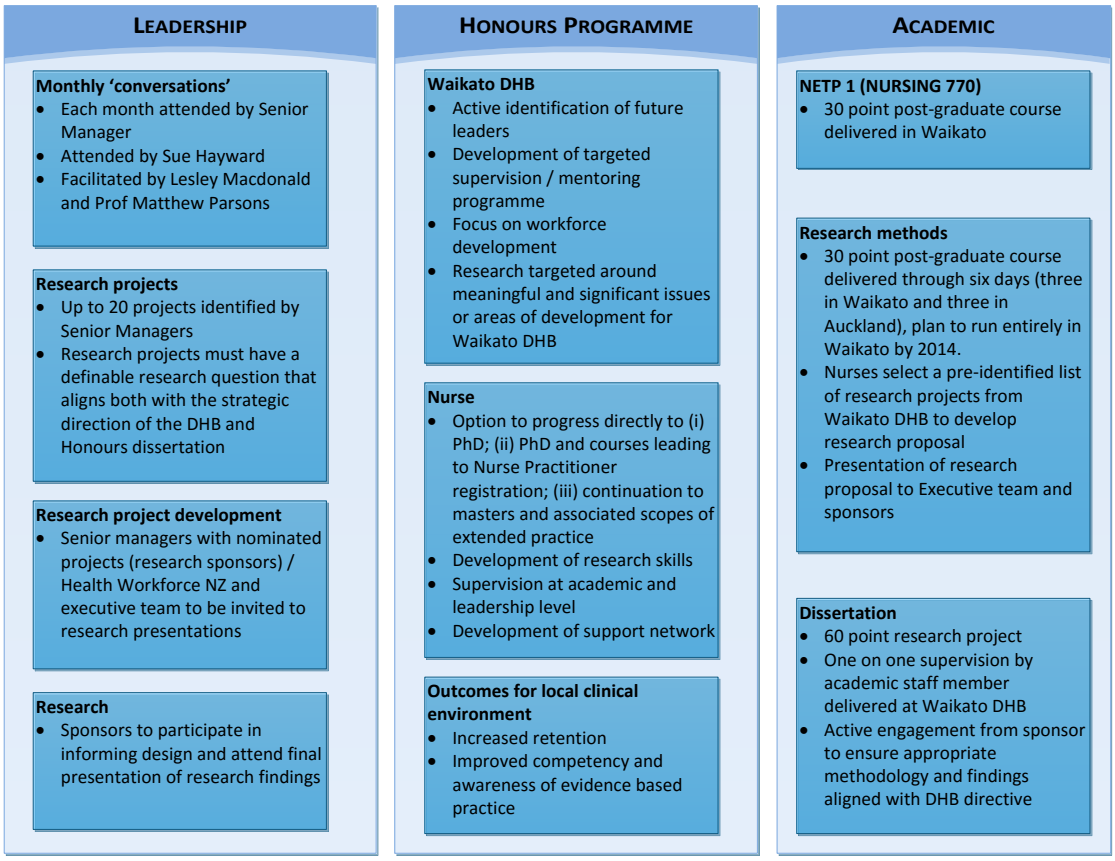

Figure 1: Waikato DHB Honours programme

Nurse Practitioners New Zealand

Nurse Practitioner Development Day

Presented By
Dr Michal Boyd &
Bernadette Paus

Wanting to become a Nurse Practitioner or develop a Nurse Practitioner role in your service?
Are you unsure of where you are in the process?
Or just unsure of the process and what is expected altogether?
Or thought about it but been put off by the process?
Or are you just totally confused???

Join us to dispel the myths and gain a clear understanding of the Nurse Practitioner role

Date	Time	Location	Venue
22 August 2016	9.00 am to 1.30 pm	Auckland	Building 732 Room 201 Tamaki Campus The University of Auckland

College of Nurses Member Registration Fee $175.00
Non College of Nurses Member Registration Fee $195.00
Earlybird Discounted Fee $175.00 if paid by 25 July 2016

AGENDA FOR THE DAY

9.00 am to 11.30 am
Bernadette Paus: *Portfolio Development Using the Latest NCNZ Guidelines*

11.30 am to 12 noon
Light Lunch

12 noon to 1.30 pm
Dr Michal Boyd: *NP Panel Interview and Position Development*

Certificates for professional development hours will be issued to attendees at the end of the day

REGISTER ONLINE - www.nurse.org.nz/event-registration-form

For more information on this or other workshops go to the 'workshops' tab @

www.nurse.org.nz

NPNZ – Nurse Practitioners New Zealand
is a division of the
College of Nurses Aotearoa (NZ) Inc
PO Box 1258, Palmerston North 4440
E: admin@nurse.org.nz
P: 06 358 6000

The College of Nurses reserves the right to cancel/postpone a workshop. A refund of the registration fee or transfer of registration to a future workshop will be offered. Please see www.nurse.org.nz for our full cancellation policy.

PRIMARY HEALTH CARE
2 DAY LEADERSHIP WORKSHOPS

TO SUPPORT EXISTING, EMERGING AND POTENTIAL NURSE LEADERS IN PRIMARY HEALTH CARE SETTINGS

The programme will include core knowledge regarding:

- Primary Health Care Funding and Infrastructure
- Aligning Nursing Practice with Community Need
- Becoming a Resilient Leader

A detailed programme is available on the College of Nurses website www.nurse.org.nz

Speakers and Facilitators include:

Professor Jenny Carryer RN PhD FCNA(NZ) MNZM
Kim Carter RN FCNA(NZ) NZCPHCN (NZNO)
Taima Campbell RN, MHSc (Nsg) PG Dip Bus (Māori Dev)
Dr Mark Jones FCNA(NZ) FACN

Location	Venue/Date	Time	Earlybird Discounted Fee If Paid By
Dunedin	14 & 15 November 2016	9.00am-4.30pm	18 October 2016

Register now - www.nurse.org.nz/workshops

College of Nurses Member Registration Fee $475.00
Non College of Nurses Member Registration Fee $495.00
Earlybird Discounted Fee $450.00 (see dates above)

Certificates for professional development hours will be issued to attendees at the end of the workshop

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PRIMARY HEALTH CARE
2 DAY LEADERSHIP WORKSHOP

Feedback Received from 2015 Workshops

"Excellent and highly appropriate and relevant topics. Most highly qualified and educated lecturers – thank you! Feel very motivated in my leadership pathway, you have planted seed in my mind and heart."

"At first I felt this workshop was not what I had expected but by the end of the 2 days I really felt I benefited from the total approach. I was impressed by the quality of all the speakers."

"Presentations were all clearly given by good, confident leaders and role models. Very empowering couple of days – Thank you."

"All speakers were clear and concise in their delivery and extremely knowledgeable. Good that there was plenty of time for discussion with the nurses attending the workshop which produced some interesting and informative debate. Plenty to think about to take nursing forward."

"What a fantasic array of speakers, so interesting, knoweldgeable and inspirational. Hugely relevant content to working in the current primary health care environment."

"Inspiring – my horizon has been widened – candle has been lit - and now actions will be taken."

"Excellent presentation. Inspiring speakers. Plenty of opportunity for interaction and positive learning. Thank you. Would happily recommend this workshop to colleagues."

Nurse Executives of New Zealand Inc.
DEVELOPING NEW ZEALAND'S NURSING LEADERS

ONE DAY SYMPOSIUM

NAVIGATING OUR WAY ACROSS NZ HEALTHCARE SYSTEMS

(for all nurses working across the Northern region)

Waitakere Conference Centre, Waitakere Hospital
55–75 Lincoln Road
Henderson, Auckland

Thursday, 22nd September 2016

9.00am – 4.15pm

Join Us For A Day Of Networking And Exploring:

- *How we can more effectively and safely navigate across health systems as clinicians and improve the patient experience of care.*
- *How we foster healthy workplaces, self-care and resilience.*
- *How we ensure safe, legal and competent practice behaviour.*
- *How we can through cross working or joint working ease the patient journey and help define the models of care we deliver.*
- *How we align with the NZ Health Strategy and ensure patients/people have choice, are empowered and understand how they can choose the best options to live well, stay well and get well.*

Register Online www.nurse.org.nz/workshops

Registration Fee $75.00

Light Refreshments will be provided
Certificates for Professional Development Hours will be issued to attendees

College of Nurses Aotearoa (NZ) Inc. PO Box 1258 Palmerston North 4440
Ph: (06) 358 6000 E-mail: admin@nurse.org.nz
www.nurse.org.nz

College of Nurses Aotearoa (NZ) Inc
Life Members

Name	Date Awarded
Judy Yarwood	October 2014
Dr Stephen Neville	October 2015
Taima Campbell	October 2015