TE PUAWAI

The Blossoming

The Professional Update for Registered Nurses

May 2019

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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Editorial

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

Happy Nurses

Recently I had the pleasure of meeting a team of happy nurses. By happy, I mean nurses who expressed high levels of job satisfaction and enormous pride and commitment in the service they were able to deliver to the enrolled population. As we all know this is not always the case.

Subsequent to meeting these nurses and listening to them I have pondered on what made the difference. Quite simply it came down to the fact that their capacity and potential was being utilised absolutely fully and they were delivering a superb range of nurse led services to their patients.

Professor Jenny Carryer

Arising out of that job satisfaction I noted some really interesting features of the practice setting. As the literature notes, teams work best when all members of the team feel they have clear autonomy and the ability to influence their own practice and to contribute as equals to the direction and actions of the whole team. It was very clear that these nurses with significant autonomy were part of a genuine team in the very best of ways.

All of us are aware of some of the oppressed group behaviours often exhibited by nurses such as resentment of those who have achieved through postgraduate study and a tendency to be pretty hard on our new graduates. In this practice I noted with joy the absolute pride extended towards the nurse who had recently become an NP. This contrasted so strongly with the attitude of “who does she think she is” that I have heard all too often in other settings. Similarly the most recent graduate was spoken of with admiration and support and I could see what a nurturing environment she was enjoying. There was also significant longevity and stability in the team.

An additional characteristic which clearly made a difference was a significant investment in professional development for all of the nurses thus contributing directly to confidence, competence and sense of being valued as lifelong learners. Finally there was a visible and active nurse leader who was described as providing powerful advocacy for the nursing team.

I think back to the days in 2003 when we wrote a document called *Investing in Health* to follow the launch of the Primary Health Strategy. In that document we said (in summary) that in order to release the potential of primary health care nursing there needed to be attention to aligning nurse's practice to community need, investment in professional development and post graduate education and the establishment of clear and respected leadership structures. My experience of this team affirms the accuracy of those goals set in 2003 and makes me sad that this is not the lived experience of all nurses working in primary health care.

Please enjoy this copy of Te Puawai which contains a great deal of very interesting reading.

Warm regards
Jenny Carryer

Moving House or Changing Job

Please remember to update your contact details with the College office

Email: admin@nurse.org.nz

Healthy People, Healthy Planet.
Can what we eat help save the world?

Article by: Rebecca Sinclair, RN, PGDip, SCPHN, member of Ora Taiao: The NZ Climate and Health Council

In January this year over 37 experts from the EAT Lancet commission published 'Food in the Anthropocene' (2019a), a new way of looking at food that is both healthy for people and sustainable within planetary boundaries. Radical changes are required to feed around 10 billion people by 2050 and limit harmful pollution and greenhouse gases (GHG). It has been dubbed The Great Intergenerational Food Transformation. Presently around 820 million people go hungry and are undernourished, while over 2 billion adults are overweight or obese or suffering the health consequences from diets high in fat, salt and sugar such as heart disease, cancer and Type 2 diabetes. A third of New Zealand children are either over a healthy weight or obese, and rates are higher amongst Māori and Pasifika children (Health Navigator, 2019), leading to further inequalities in health.

The World Health Organisation states that climate change is the biggest threat to global health in the 21st century. The Intergovernmental Panel on Climate Change (IPCC) has given stark warnings to drop our emissions to net zero by 2050 to limit the earth's temperature rising to less than 2°C, or better 1.5°C. For this to be achievable, we need to halve our emissions over the next decade which requires unprecedented support from government, corporations, communities and households. However, if we continue with "business as usual", we are currently tracking towards a 4°C temperature rise. We need to quickly transition away from our reliance on fossil fuels like oil and coal to renewable energy sources.

The effects of climate change are already being felt and will continue to lead to an increase in extreme weather events, water and food insecurity, sea level rise, mass migration, species extinction and increased conflict. This impacts directly on the basic determinants of health such as clean air, water, food and a safe environment. Here in New Zealand, the Government has ratified the Paris Agreement in 2016 and is aiming to reduce our emissions to net zero by 2050 through the Zero Carbon Act, which is currently under development and due out later this year.

The recent School Strike 4 Climate student protests inspired by Swedish teenager Greta Thunberg, in which tens of thousands of NZ school students took part, and the global Extinction Rebellion movement, show that the public are demanding more action on climate change. This has also been supported by the recent BBC series 'One Planet' and the 'Climate Change- The Facts documentary narrated by Sir David Attenborough, which further raises awareness of climate change with the public.

What is New Zealand's role in this? Almost half of our GHG emissions are from agriculture (dairy, sheep, beef and other). Cow's produce methane and although it has a shorter life span it is much more potent than carbon. Energy use makes up around another 40%, just half of which is from

transport. Food production is responsible for up to 30% of GHG emissions in New Zealand. Our native forests have been extensively cleared with our largest land cover now being pasture. We are currently using masses of nitrogen fertiliser to enable productive crop yields, however this is a finite resource and is affecting water quality in New Zealand. Water quality is a concern for many people in New Zealand as many of our rivers and lakes are no-longer safe to swim in or drink from.

More than half of New Zealanders are concerned about the impact of climate change (Colmar Brunton Better Futures Report, 2019) and there is growing concern among the public about plastic use. These three global pandemics of malnutrition, obesity and climate change are all linked. Changes to our food system are urgently needed and have the potential to improve the health of people and promote environmental sustainability. “Healthy and sustainable diets are a win-win for people and the planet” states Dr Rhys Jones Co-convenor of Ora Taiao: The NZ Climate and Health Council.

How does this impact on our practice as Registered Nurses?

The International Council of Nurses acknowledges the risks of climate change to health and has called for increased leadership within nursing to combat the effects of climate change on health. Nurses make up the largest health workforce in New Zealand and are well trusted by the public. The American Nurses’ Association has included sustainability as part of their core nursing competencies. With over 56, 000 of us in NZ we are in a key position to talk to clients about the link between dietary choices and health and are well placed to offer evidence-based lifestyle information to clients. The British Dietetic Association has released the One Blue Dot summary and the Canadian Government has recently updated their national dietary guidelines. Both of these are in alignment with the EAT Lancet report on healthy diets from sustainable food systems.

In New Zealand The Ministry of Health updated its online healthy food guidelines in 2018. The traditional “food pyramid” is out and the new focus is on enjoying a variety of nutritious foods, split into four main categories:

- plenty of vegetables and fruit
- grain foods, mostly whole grain and those naturally high in fibre
- some milk and milk products, mostly low- and reduced-fat / plant-based milk
- some legumes, nuts, seeds, fish and other seafood, eggs or poultry, or red meat with the fat removed.

So how does this compare to the new Planetary Health Diet? There are many popular diets and what EAT Lancet has done is take the best evidence for a healthy balanced human diet that is achievable within planetary limits. Guidance is given on the healthy range of foods that can be eaten and this is flexible to allow for different dietary patterns, health needs and cultural considerations and preferences. Well planned plant-based diets can meet nutritional requirements with some possible special considerations for pregnant women, children and adolescents and

those with chronic medical conditions.

The Planetary Health Diet

- Proteins should primarily be sourced from plants where possible, fish or alternative sources of omega-3 fatty acids several times per week, and with optional modest consumption of poultry and eggs alongside low intakes of red meat, if any, especially avoiding processed meat.
- At least five servings of fruits and vegetables (500 grams) should be consumed per day excluding potatoes: 200 (100–300) grams of fruits and 300 (200–600) grams of vegetables per day.
- At least 50 (0–75) grams of nuts and 75 (0–100) grams of legumes per day including dry beans, lentils and peas.
- Aim to limit to no more than 98 grams of red meat (pork, beef or lamb), 203 grams of poultry and 196 grams of fish per week.
- Fats should mostly come from unsaturated plant sources with low intakes of saturated fats and no partly hydrogenated oils: 40 (20–80) grams of unsaturated oils per day and no more than 11.8 grams of saturated oils per day.
- Carbohydrates should primarily be sourced from whole grains with low intake of refined grains and less than 5% of energy from sugar.
- Recommend consuming 232 grams of whole grains per day including rice, wheat and corn and 50 (0–100) grams of tubers or starchy vegetables per day including potatoes and cassava.
- Moderate levels of dairy consumption is an option: 250 (0–500) grams of dairy per day.

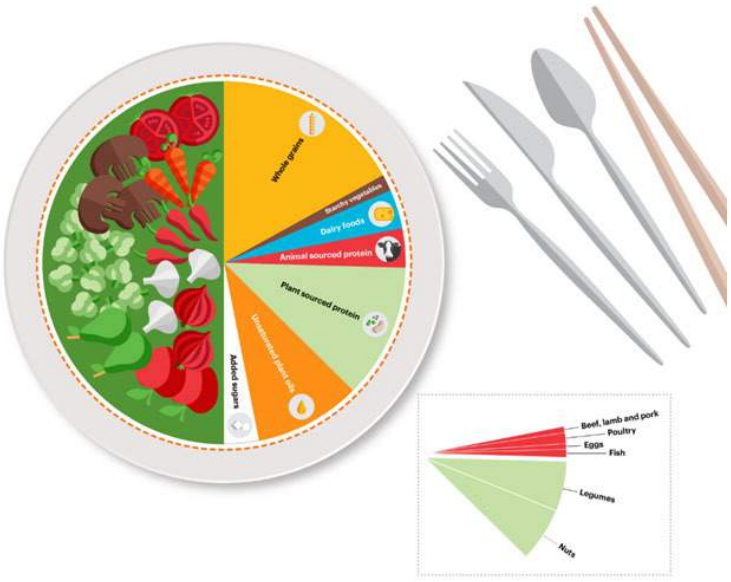
Source: EAT Lancet Commission Brief for Healthcare Professionals (2019) pg 2.

The Planetary Health Diet over one day could look like this:

Source: EAT-Lancet

Visually, in one meal this looks like half a plate of fruit and vegetables (not including potato). Around 50g of potato or kumara is considered a serve. Recent dietary advice has concluded that

six hot chips is considered a serving size, which is much less than a typical “scoop”. Whole grains include rice, wheat and corn. This is important to note for anyone currently following a low-carb or keto diet as they may be missing out on essential nutrients from this food group. Vegetables should include a mix of dark green leafy vegetables and a variety of colours. At least 2 serves of fruit a day, so overall, we can still advise 5+ day. Although dairy has long been encouraged for its nutritional benefits for bone health and reducing fractures, in fact it has been noted by the WHO that countries with low dairy consumption actually have lower fracture rates. The reference diet states that dairy can come from either animal or plant-based sources. Fish, which is high in omega 3 fatty acids, should come from sustainable sources, however certain types should be avoided by pregnant or breastfeeding woman due to the high levels of mercury. The recommendation for eggs is about one and a half a week, however low-income populations with poor diet quality would benefit nutritionally from a higher intake. Nuts and seeds are a powerhouse of energy and should be encouraged.



Source: EAT-Lancet

Around the world in 2017 the intake of almost all healthy foods and nutrients was less than recommended while the intake of unhealthy foods was too high, particularly for sugar sweetened beverages, processed meat and sodium (The Lancet, 2019b). We need to focus on eating more fruit and vegetables, nuts, legumes (beans, peas, chickpeas, soy beans) and wholegrains. For some, this will also mean a shift towards eating less red meat and dairy products, not only for health but particularly as these have the highest GHG emissions. People may still include small amounts of animal protein, however it no-longer considered a necessity. There are also benefits to a diet that is higher in fibre, such as reduced constipation, heart disease, stroke, type 2 diabetes and bowel cancer.

Some people will already be following certain dietary patterns so it pays to be familiar with them,

such as:

- Omnivore – Meat and plants
- Pescatarian – Plants and no meat except some fish and seafood
- Vegetarian – Plants and no meat
- Vegan – Plants, no animal products (meat, cheese, milk, honey, eggs, gelatine etc…)
- Wholefood Plant Based – Plants, no animal products, with an emphasis on healthy unprocessed food.

Veganism and whole food plant-based eating are already on the rise globally with around 1 in 10 New Zealanders going mostly meat free in 2018 (Colmar Brunton Better Futures Report, 2019). However, a focus on eating more plant-based foods and reducing meat and dairy consumption linked to personal health and sustainability is likely to be more acceptable than suggesting a shift towards a vegetarian or vegan diet. Note that supplementing with Vitamin B12 is essential for those following a vegan diet. As Michael Pollen states, vote with our forks. We know that consumer driven shifts in dietary choices are met through the market, as we have already seen an increase in vegetarian and plant-based options hitting mainstream supermarket shelves. There is already a vast amount of knowledge in this area due to being such a multicultural and globally connected society.

How we grow food, what we choose to grow and how we transport it all need to be considered. Other key messages are to avoid food wastage as this contributes significantly to unnecessary GHG emissions. Plan meals ahead and cook more at home. Also, to buy locally grown, seasonal foods and to grow your own food if able. Less food waste saves money and reduces waste.

All nurses have a duty to adhere to the principles of working in partnership, protection and participation with Māori in accordance with Te Tiriti o Waitangi. Knowledge about caring for the environment and the interconnections with human health and wellbeing is not new. For Māori, as tāngata whenua, there is a key link between health and care for Papatūānuku (the land), Rangi-nui (the sky) and Rongo-mā-Tāne (the atua of cultivated vegetables) among others. Sir Mason Durie, renowned for Te Whare Tapa Whā, a holistic model of health in Aotearoa, has recently extended Te Pae Mahutonga, a health promotion model, to include the Matariki constellation of stars. One of the stars in the original framework, waiora, embodies the health of the physical environment. The Matariki framework is broader and goes on to include the links between the rights of indigenous peoples, families, communities and the whole environment. Because of these deep relational understandings that are embedded in Indigenous worldviews, knowledges and practices, Māori are well-placed to demonstrate leadership in Aotearoa around climate change and environmental sustainability. For example, one rising young entrepreneur, Raniera Rewiri, also known as The Plant Based Māori on social media, is sharing the plant-based message from a Māori perspective. His work supports others to be more mindful about their food choices. The change is already coming with the largest Marae in Aotearoa serving vegan meals to improve people's health.

As we talk to patients about lifestyle choices it means having brave conversations about the new planetary health diet. Nurses have an ethical duty of care to act in the best interests of health. People will have different incentives for making changes in eating habits, this could be personal health, environmental concern or animal welfare. By creating a space where healthy and sustainable diets are normalised this helps people move towards them. By focussing on encouragement rather than what needs to be reduced, this is more likely to have a positive effect. Already in Norway over the last year, one in five people have reduced their meat intake and almost half have reduced their food waste, because of concern about climate change.

Nurses have a key role in supporting the great food transformation, in their work with clients, the workplace, their own lives, with their family and local communities. The changes required of the next decade are immense. Rather than feel overwhelmed by the task ahead, focus on what we can do, which is what nurses are already so good at. When there is an emergency or the call bells are ringing, nurses don't sit down and feel the problem to is too big, they prioritise, roll their sleeves up and jump to action. Prime Minster Jacinda Ardern has said that climate change is our nuclear free movement. Nurses getting behind the cause and supporting change around what we eat, this could have big impact on reducing our GHG's and enhancing people's health, for the well-being of our planet and for the benefit of all beings.

Go easy on meat, sugar and dairy.

Increase fruit, vegetables, beans, lentils, nuts, seeds and whole grains!

REFERENCES

Colmar Brunton (2019) Better Futures Report. https://www.colmarbrunton.co.nz/wp-content/uploads/2019/02/Colmar-Brunton-Better-Futures-2019-MASTER-FINAL-REPORT.pdf 16.4.19

GBD 2017 Diet Collaborators (2019) Health effects of dietary risks in 195 countries, 1990-2017: a systematic analysis for the global burden of disease study 2017. The Lancet. Published online April 3, 2019 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30041-8/fulltext

Health Navigator (2018) Obesity - Children. https://www.healthnavigator.org.nz/health-a-z/o/obesity-children/. Accessed online 16.1.19

Ministry of Health (2018) The four food groups https://www.health.govt.nz/your-health/healthy-living/food-activity-and-sleep/healthy-eating/four-food-groups Accessed online 16.4.19

EAT-*Lancet* Commission (2019a) Brief for Healthcare Professionals. Healthy diets from sustainable food systems https://eatforum.org/lancet-commission/healthcare-professionals/ Accessed online 16.4.19

EAT-*Lancet* Commission (2019b) The Global Syndemic – A policy Brief. https://eatforum.org/content/uploads/2019/04/EAT-Lancet_Commission_Summary_Report.pdf Accessed online 29.4.19

Dr Rhys Jones (2019) Quote
http://www.orataiao.org.nz/agricultural_sector_must_be_held_accountable_for_climate_and_health_harm
accessed online 29.4.19

The Association of UK Dietitians (2018) Eating patterns for health and environmental sustainability. www.bda.uk.com Accessed online 29.4.19

Competencies for Managing Workplace Bullying – New Research Findings

Article by: Dr Kate Blackwood and Dr Natalia D'Souza

Workplace bullying is a known problem for the nursing profession in Aotearoa and internationally, and our managers play an important role in the solution. Research, funded by the College of Nurses Aotearoa and carried out by members of Massey University's Healthy Work Group, has identified the management competencies required to effectively manage bullying and foster healthy work environments in nursing. This article, written by the researchers, discusses the importance of management competencies in addressing bullying, highlights the key competencies identified in the report, and offers some suggestions and considerations for healthcare organisations seeking to adopt the competency frameworks in practice.

Why is management competency important for managing bullying and fostering healthy work?

The behaviours and competencies of line managers can significantly impact the work environment and work experience for staff. Line managers' proximity to and frequent interaction with staff members means that they are optimally placed to deal with interpersonal conflict within the team and, through their actions and inactions, have a considerable impact on team dynamics.

There is a growing body of research that points to the importance of line managers in addressing workplace bullying within their teams. Although bullying is a systemic issue, line managers are often the first point of contact for complaints of bullying and are often best placed to identify and deal with a situation that may escalate into bullying, early and informally. Indeed, WorkSafe's guidelines for *Preventing and Responding to Bullying at Work (2017)* emphasise the role of the line manager, particularly in investigating complaints of bullying and supporting positive workplace cultures.

However, research indicates that managers often lack the skills and confidence to deal with bullying and, as a result, complaints of bullying often go unaddressed. Further, in some contexts, allegations of bullying against line managers make up more than half of bullying complaints. Understanding the competencies required to address bullying and foster healthy work may assist line managers to address bullying and foster an environment within their team where bullying is not tolerated.

What competencies of managers are required to manage bullying and foster healthy work?

This study aimed to determine the management competencies required to prevent and respond to workplace bullying in the nursing profession. Two partially-overlapping competency frameworks, each representing 10 key competencies, were developed – one reflecting the competencies for

fostering a healthy work environment free from bullying (i.e. preventing bullying), and the other reflecting the competencies required to effectively manage existing cases of bullying.

Key competencies that were found to be important for both preventing and managing bullying included demonstrating clear and consistent communication, demonstrating consideration and support for staff and their individual needs, having confidence and resilience to deal with work problems (both within the team as well as external pressures), and being available to staff. Self-reflection was also found to be important, in terms of recognising your own limits and acknowledging fault.

Specifically in relation to managing bullying, the findings highlight the importance of a line manager's awareness of what is happening within their team and subsequent proactive and early intervention in cases where bullying behaviours are occurring or likely to escalate. Awareness can be fostered through consistently and effectively dealing with known interpersonal issues as well as being available to staff, as this fosters trust and encourages early reporting. Coaching and mediation skills were also found to be important, particularly in providing advice and guidance to staff around the options available to them and, where appropriate, creating a safe environment for facilitated staff discussion.

For more detail of the management competencies identified, and examples of how the competencies can be demonstrated, access the full report here.

How might these competency frameworks be used to improve management competencies in healthcare organisations?

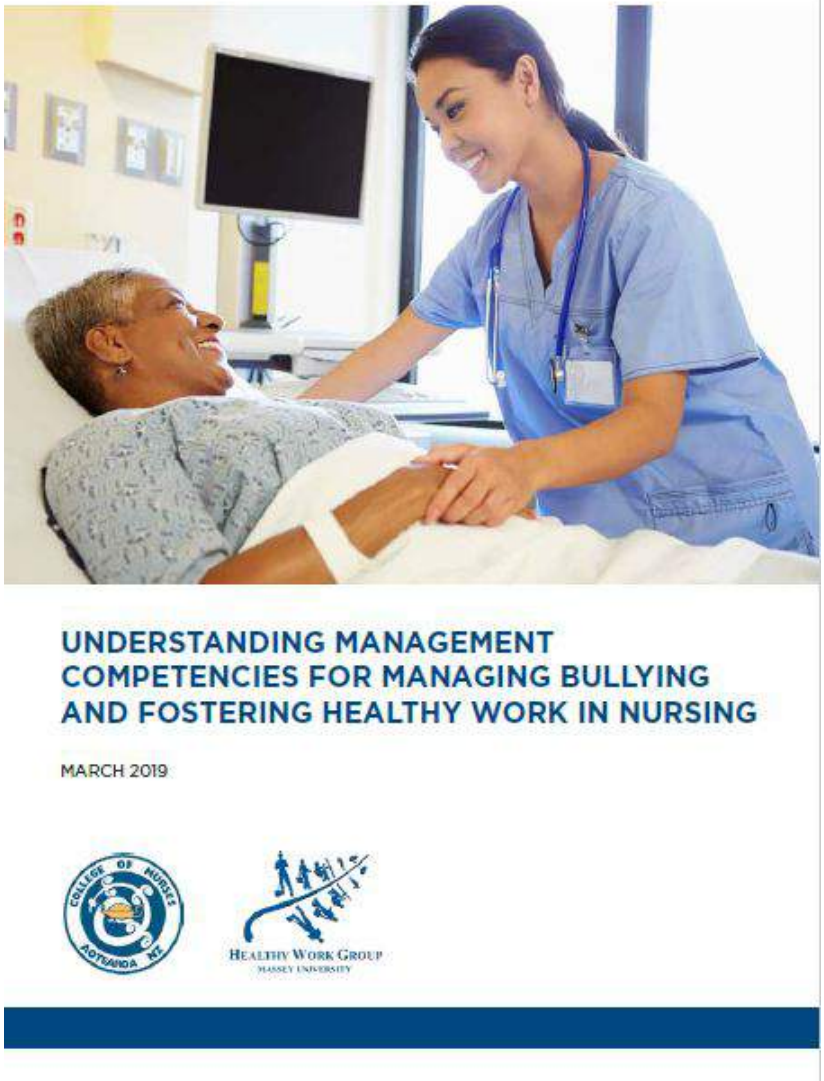
The competency frameworks are a helpful resource for managers to reflect on their own managerial style and the impact it may be having on team dynamics and the presence of bullying in the team. We also propose that the frameworks might be helpful for healthcare organisations in tailoring training for managers, and could also be incorporated into performance appraisals and promotion processes for managers.

That said, while line managers play a central role in preventing and responding to workplace bullying, it is important to recognise that bullying is a systemic problem - research indicates that organisational factors, such as the nature and design of work, workloads, reward systems, and hierarchical structures, all play a significant role in enabling and encouraging bullying. Thus, factors beyond the responsibility and control of the line manager are also likely to influence their ability to address bullying.

Drawing on the data collected for this research, the report identifies a range of factors that restrict line managers' ability to enact competencies and/or inhibit the effectiveness of the enacted competencies. One such example is external pressures, such as increasing patient acuity and staff shortages, which cause frustrations and stress which can develop into bullying. These pressures, coupled with an embedded culture of tolerance for bullying at the team or organisational level, may impact the ability of managers to enact competencies or the efficacy of enacted competencies. Further, a lack of perceived support from HR and senior management may discourage managers

from demonstrating the desired competencies, such as consistently addressing bad behaviours and having the confidence to escalate serious concerns.

Having clear organisational policy and process with regards to bullying, strong messaging from senior management, training and support for managers and staff, and other relevant interventions throughout the organisation targeted at culture change is required to effectively prevent and manage bullying. Therefore, the management competency frameworks and subsequent initiatives aimed at developing competency should be considered an important puzzle piece in combatting bullying, rather than relied upon in isolation.



Management of acne in primary health care: the good, the bad and the ugly

Article by: Marie-Lyne Bournival BSc, PG Dip (Health Sc), MN, Nurse Practitioner

"It is important to look beyond the physical scarring, for there is no disease that has caused more insecurity and feelings of inferiority than acne" J.Koo

In the era of selfies and social media, young people are more than often omni-present on public platforms. For those experiencing acne, it can be greatly distressing. This article is an overview of the management of acne in primary health care.

There are several types of acne. Up to 85% of the population aged between 11 to 30 years old will experience acne vulgaris. International literature progressively shows that acne increasingly starts manifesting itself at a younger age. In an effort to understand the reasons behind this phenomenon, there is significant body of research on the subject. Particularly, ten years ago Sandra Steingraber undertook a meta-analysis of existing data on early puberty in girls. In "The Falling Age of Puberty in US Girls" published in 2007, Steingraber traced the intricate weaving between menarche, physiological, psychological and environmental conditions, and the consequences for the maturation process of young women.

Some basic vocabulary:

Sebum: Oil produced by sebaceous glands within the hair follicle.

Keratin: Protein inside the cells mainly in the epidermis.

1. Holds skin cells together to form a barrier.
2. Forms the outermost layer of the skin that protects from the environment.

Keratinisation: Process by which the cells mature as they move from deep inside the skin up to the surface and produce keratin.

Comedone (plural) = Comedo (singular): Small elevations of the skin surface caused by the occlusion of the follicle by sebum and keratin.

Open Comodone: Plug of melaninised keratin blocks the opening of the follicle (Blackheads).

Closed Comodone: When the follicles are completely blocked (Whiteheads). Both can occur with or without acne.

Papules: Solid elevation without presence of fluid. Usually erythematous in acne.

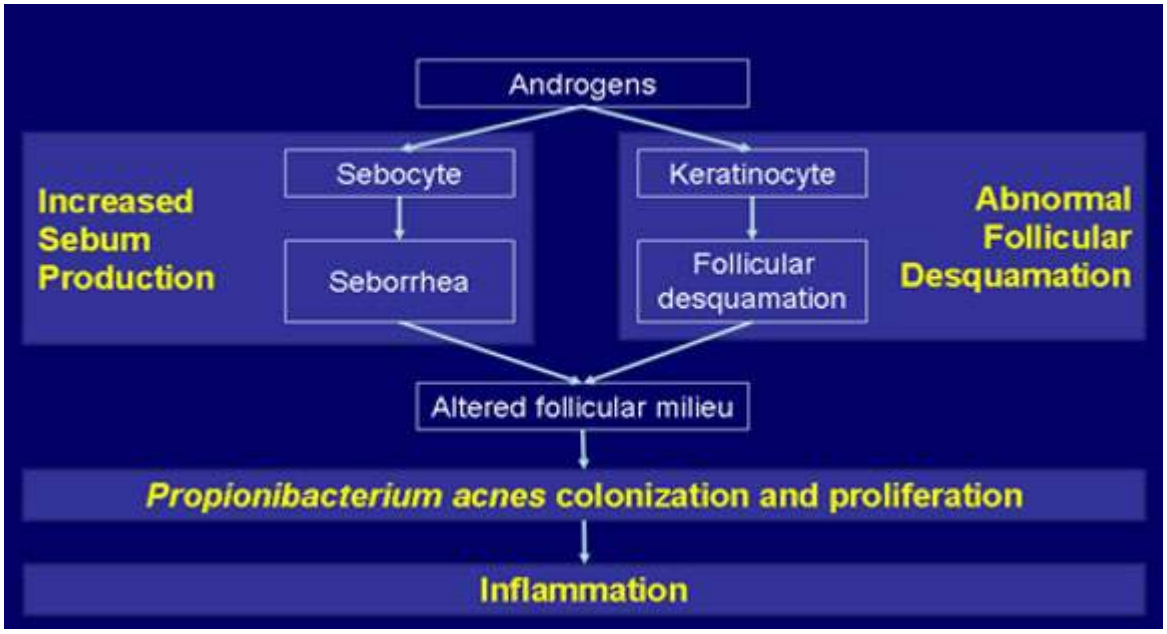
Pustules: Elevation of the skin containing purulent material made of necrotic cells and neutrophils.

Nodules: Firm dome-shape elevation usually erythematous and painful. Usually < 5mm.

Pseudo cysts: Fluctuant lesion usually > 5mm may or not be inflamed. Pseudocysts are firm lesions that contains fluid or semi-fluid material. Unlike cysts, pseudocysts are not surrounded by capsules.

Pathogenesis

Four pathways:



Androgens: Testosterone, Dihytestosterone (DHT), Androstenedione, Dehydroepiandrosterone (DHEA) and dehydroepiandrosterone sulfate (DHEAS), Androstenedione

Sebum production: Oil produced by sebaceous glands within the hair follicle. Increased production during adolescence due to hormonal change.

Increase follicular Keratinisation: Occlusion of hair follicles and sebaceous ducts. This allows the formation of open and closed comedone.

Colonisation of Propionibacterium Acnes *(P. Acnes):* P. acnes is an anaerobic bacteria. It breaks down sebum into fatty acids and peptides and rupture the follicle wall. Plays a large role in the development acne.

This leads to the release of inflammatory mediators: Formation of papules and pustules. Deeper inflammation leads to nodules and cysts.

Causes:

The evidence is inconclusive but diets with excessive dairy products, high in sugar, high meat protein and diets low in zinc (red meat, poultry, beans, nuts, certain types of seafood such as crab and lobster), whole grains, fortified breakfast cereals, and dairy or high in iodine products (seaweed, dairy, tuna, shrimp and eggs) are believed to worsen pustular acne.

Genetic factors (family members having bad acne).

Hormonal factors (higher levels of male/androgenic hormones) due to:

- PCOS (common).
- Hyper insulinaemia and insulin resistance are characteristically found in women with PCOS who are prone to acne among other problems.
- Psychological stress and depression.
- Although rarely seen, excessive corticosteroids e.g. Cushing disease.
- Very rarely seen but enzyme deficiency such sterol hydroxylase deficiency.

Environmental factors such as:

- High humidity causing swelling of the skin
- Cosmetics such as foundations and moisturisers.
- Products containing lanolin, petrolatum, vegetable oils, lauryl alcohol and oleic acid are known to induce acne.
- Nicotine increases sebum retention and scale within the follicles, forming in turn comedone.

Medicines such as:

- Lithium: The brain produces neuropeptides with the predominant role of controlling moods and emotions. Neuropeptides stimulates sebaceous glands and produce sebum – it is believed that it may play a role in the development of breakouts. Neutrophils in turn increases and when moving from the bloodstream to the skin they cause an inflammatory response and the development of pimples.
- Antipsychotics (risperidone- quetiapine - olanzapine): Can cause hyperprolactinaemia. This condition is known to increase androgenic activity in the body in some women which in turn can cause acne as well as hirsutism on a women's face, chest, and back.
- Contraception: progesterone only pill, Depo and implants are known to make acne worst.

- Street drugs: Evidence is more conclusive on certain street drugs: eg: cocaine, MDMA (ecstasy), and marijuana which increased androgen production (male hormones like testosterone) and are connected with acne development. As a general rule, the higher the androgen level, the more acne we see. Marijuana, cocaine, MDMA, and methamphetamines have all been shown to increase cortisol levels as well. Cortisol is the main stress hormone in the body and has been linked with acne. Some drugs also stimulate inflammation in the body. Acne is at its core an inflammatory disease, so medication or drugs that increase inflammation could theoretically worsen acne e.g.: marijuana.

HISTORY TAKING

Taking a thorough history will also help understanding the patient's lifestyle, their attempts to remedy the situation, their health literacy and also the impact on their emotional and mental health.

- Duration of acne symptoms (may influence your approach to pharmacology)
- Possible aggravating factors (cosmetics, sunscreens, skin products, smoking)
- What have they tried? How long? *OTC*
- Use of medicines e.g.: lithium, anti-psychotics, contraception, *street drugs*
- In females: menstruation history? Differential *PCOS*
- Psychological
- Self-harming /suicidal thought/plan
- HEADSSS assessment - Lifestyle
- Kessler-10 (Distress and anxiety)
- Patient Health Questionnaire - 9 (Depression)
- Social (bullying/ Social Media platforms)

PRE-PHARMACOTHERAPY

Step-wise approach regardless of severity:

- Wash face gently with warm water and mild soap or cleanser
- Un-medicated soap is fine. Products containing benzoyl peroxide or salicylic acid can be effective
- Avoid scrubbing, if dermatitis, avoid soap and anti-acne cleansers
- All products should be applied to all areas and not each lesion itself
- Inform patients that it can take several months to see significant results
- Make sure that their usual facial products do not contribute to their acne e.g.: cosmetics/sunscreen – look for skin care products labelled *"NON- COMEDOGENIC"*
- If smoking, consider quitting
- Try not to pick nor scratch the lesions
- Exposure to the sun through glass window may help

<table>
<tr><th colspan="3">TREATMENT</th></tr>
<tr><td>Mild Acne</td><td>Moderate Acne</td><td>Severe Acne</td></tr>
<tr><td>Topical benzoyl peroxide

Concentrations vary between 2.5% to 10%. Start lowest concentration

Antiseptic with keratolytic and comedolytic effects</td><td>Continue topical benzol peroxide or topical retinoid</td><td rowspan="4">Isotretinoin

Can be used in moderate acne that causes distress or scarring or not responding

Acts on the 4 pathogenesis of acne
Reduces sebum production, shrinks the sebaceous glands, reduces follicular occlusion, inhibits growth of bacteria, anti-inflammatory properties.

Teratogenic - Commence treatment day 2 or 3 of menstrual cycle – Bullet proof contraception x2

Caution in Breastfeeding
Hepatic Impairment
Hyperlipidaemia
Mental Health

Technology

• Intense-pulsed light therapy
• (IPL)
• Light Therapy
• Laser therapy
• Photodynamic</td></tr>
<tr><td>Salicylic acid 0.1 – 2% cream is an alternative to benzoyl peroxide. Proven less effective and can cause dry skin.</td><td>Doxycycline 50-100mg daily for 4 to 6 months. Can increase to BD if tolerated. Can do every other day if good response after 2-3 months</td></tr>
<tr><td>Topical retinoid (derived of Vitamin A).

Reduces proliferation and keratisation</td><td>Erythromycin (efficient anti-inflammatory effect) 400mg BD
Inform patients of potential side effects of antibiotics AND be aware of antibiotic resistance</td></tr>
<tr><td>Topical erythromycin and clindamycin

Reduce the number of P. acnes on the surface of the skin, the hair follicles and sebum ducts.

Anti-inflammatory effects.</td><td>Androgen receptor blockers act on the sebaceous gland and base of the hair follicle
In female patients this include; Combined contraception pill containing an androgenic progesterone and an oestrogen (cyproterone acetate, drospirenone, or dienogest)

In females over 30, Spirolactone 25-200 mg daily may be also be considered.</td></tr>
<tr><td colspan="3">Dermnet keeps the brand names updated: https://www.dermnetnz.org/topics/acne-treatment/</td></tr>
</table>

REFERENCES:

Arowojolu A, Gallo M, Lopez L, Grimes D. Combined oral contraceptive pills for treatment of acne. Cochrane Database Syst Rev 2012;(7):CD004425.

Davidovici,B. & Wolf, R. (2010). The role of diet in acne: facts and controversies. Clinics in dermatology. 28. 12-6. 10.1016/j.clindermatol.2009.03.010.

Dreno B. Recent data on epidemiology of acne. Ann Dermatol Vener 2010;137(12):3–5.

Duester G. Retinoic acid synthesis and signaling during early organogenesis. Cell 2008; 134:921–31.

Garner S, Eady A, Bennett C, et al. Minocycline for acne vulgaris: efficacy and safety. Cochrane Database Syst Rev 2012;(8):CD002086.

Kraft J, Freiman A. Management of acne. CMAJ 2011;183(7):430–5.

Koo, J. The psychological impact of Acne: aptient's perception. J Am Acad Dermatol. 1995 May;32(5 Pt 3):S26-3

Moodie P, Jaine R, Arnold J, et al. Usage and equity of access to isotretinoin in New Zealand by deprivation and ethnicity. N Z Med J 2011;124:34–43.

New Zealand Formulary (NZF). NZF v55. 2016. Retrieved from https:// www.nzf.org.nz

Nguyen R, Su J. Treatment of acne vulgaris. Paediatr Child Healt 2011;21(3):119–25. Oakley A. Acne vulgaris. DermNet NZ, 2014. Retrieved from https://www.dermnetnz.org/topics/acne-vulgaris/

Oakley A. Isotretinoin. DermNet NZ. 2016. Retrieved from https://www.dermnetnz.org/topics/isotretinoin/

Prevost N, English III JC. Isotretinoin: Update on Controversial Issues. J Pediatr Adolesc Gynecol 2013;26:290–3. http://dx.doi.org/10.1016/j.jpag.2013.05.007

Rademaker M. Adverse effects of isotretinoin: A retrospective review of 1743 patients started on isotretinoin. Australas J Dermatol 2010;51:248–53. http://dx.doi.org/10.1111/j.1440-0960.2010.00657.x

Rademaker M, Wishart JM, Birchall NM. Isotretinoin 5 mg daily for low-grade adult acne vulgaris--a placebo-controlled, randomized double-blind study. J Eur Acad Dermatol Venereol JEADV 2014;28:747–54. http://dx.doi.org/10.1111/jdv.12170

Rademaker M. Making sense of the effects of the cumulative dose of isotretinoin in acne vulgaris. Int J Dermatol 2016;55:518–23. http://dx.doi.org/10.1111/ijd.12942

Rademaker M. Isotretinoin: dose, duration and relapse. What does 30 years of usage tell us?

Reid R, Leyland N, Wolfman W, et al. Oral contraceptives and the risk of venous thromboebolism: an update. Society of Obstetricians and Gynaecologists of Canada; 2010. Available from: www.sogc.org

Thiboutot D, Gollnick H, Bettoli V, et al. New insights into the management of acne: an update from the global alliance to improve outcomes in acne group. J Am Acad Dermatol 60(5):S1–50.

Seaman H, De Vries C, Farmer R. The risk of venous thromboembolism in women prescribed cyproterone acetate in combination with ethinyl estradiol: a nested cohort analysis and case-control study. Human Reproduct 2003;18(3):522–6.

Strauss J, Krowchuk D, Leyden J, et al. Guidelines of care for acne vulgaris management. J Am Acad Dermatol 2007;56:651–63.

Williams HC, Dellavalle RP, Garner S. Acne vulgaris. Lancet 379(9813):361–72.

Whitney K, Ditre C. Management strategies for acne vulgaris. Clin Cosmet Investig Dermatol 2011;4:41–53.

Zaenglein AL, Pathy AL, Schlosser BJ, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol 2016;74:945–73.e33. http://dx.doi.org/10.1016/j.jaad.2015.12.037

Factors Affecting Nurses' Engagement with PDRP

Article by Dr Samantha Heath

Introduction

This article describes the findings of a mixed methods enquiry which sought to explain the factors affecting nurses' engagement with Professional Development and Recognition Programme (PDRP). Eighty-two nurses (64% return rate) responded to a postal survey about knowledge of their voluntary PDRP programme, their attitude to learning and consideration of factors affecting engagement with continuing professional development (CPD). Thirty-six survey respondents self-selected for follow-up interviews. Fourteen were completed.

Nurses demonstrated that a personal landscape of factors existed and that their decision to participate was made in the context of often complex situations and multiple factors. In discussing their decision-making, nurses raised the significance of the impact of exposure to less than positive vicarious learning experiences from those who had already attempted or completed PDRP. Further, explanation included the critical importance of the direct manager in creating a workplace culture of supporting PDRP, promoting a narrative of encouragement and in assisting nurses to navigate the complexities of the employment/regulatory context in which programmes operate. Regulatory requirements appeared to overshadow the educational benefits of PDRP which was not seen as a legitimate tool for professional development among the nurses in this study.

PDRP as a legitimate option for CPD

On the face of it, PDRP provides a framework that supports a broad range of educational outcomes from a variety of stakeholders. Widely used by public and private healthcare organisations in New Zealand, programmes are tailored to support the development and assessment of work-based specialty nursing skills. PDRP can further assist nurses to meet annual practising certificate requirements and potentially promotes the development of their clinical expertise. The influence of Nursing Council of New Zealand (Nursing Council), the New Zealand Nurses' Organisation (NZNO) and employers have all helped to shape these programmes. Currently, PDRP not only serves the individual educational or regulatory objectives of the nurse, but programmes also support the regulator to meet its statutory obligations and provide a mechanism within which nurses who participate in higher levels can be rewarded financially. Yet, voluntary programmes continue to yield participation rates of little more than 20% (National PDRP Co-ordinators, 2015, 2016, 2017).

Previous research had not ascertained nurses' views about PDRP and little was understood about making a decision to participate. Considering the resource required by employers to sustain a PDRP programme and the extent of nurses' personal investment in completing PDRP and low

voluntary engagement rates, it was important for nurses to contribute to the conversation about factors that affected their decision to participate.

Explaining engagement with education

Review of the literature demonstrated the myriad of factors that might affect a nurses' engagement with CPD as a whole for example, time to complete, life transitions; associated costs; support from the employer; impact on career prospects, the learning task at hand (Gallagher, 2007; Gorard & Smith, 2007; Gould, Drey & Berridge, 2007). Visualised in Cross' (1981) Chain of Response model, the likely complexity associated with nurses' decisions became apparent.

What affects nurses' decisions to participate in PDRP?

Portfolios and Nursing Council requirements

Nurses agreed that their personal appreciation of portfolio requirements was a large factor in decision-making about PDRP participation. Specific difficulties highlighted included understanding what was actually required. Lack of understanding about any of the elements of a portfolio affected perception of the entire task and the likelihood of satisfactorily completing the outputs needed for portfolio submission. Nurses reasoned that if it was difficult to understand, it was difficult to write about. Nurses who were new to PDRP were not confident they could complete the requirements.

Nurses who had already completed or who had experience of working on PDRP portfolios added further detail. For PDRP options work, some forms of assessment were more acceptable than others. Nurses indicated that presentations were least favoured, although others, like case studies, were considered to be challenging because of the writing style required or volume of work anticipated. For others, the relevance of any of the written work to the development of their clinical practice was not immediately obvious. Nurses also identified that it was difficult to interpret Nursing Council competency statements and that it was difficult to tell what kind of evidence would be suitable to validate them.

Nursing Council Competencies

Validation of Nursing Council competencies caused anxiety for many. Nurses reported a range of issues and it appeared that both self and peer assessments had been problematic. Various examples were provided about the associated difficulties of writing competency responses and the impact this had on PDRP,

> *If you are not sure how to do it, it is actually quite hard to try and write*
>
> *that stuff down and so I know that some people are struggling with*
>
> *that and I think they just give up.*

Understanding how competencies should be completed and the quality of the evidence to be provided, concerned nurses. Another nurse related,

…for people who have never done it, it is quite hard to get your head around writing your competencies and what goes where and who you need to get to do your peer review and how it all works.

Nurses appeared to struggle most with translating their practical everyday work into words that would usefully validate their professional competencies.

The role of the Charge Nurse

The role of the Charge Nurses was crucial to successful PDRP completion. Nurses identified that Charge Nurse support was needed right from the initial decision to participate until PDRP completion. Without a PDRP-friendly Charge Nurse, a culture of completion did not exist in the clinical area and engagement with PDRP at all was of low priority. The Charge Nurse was pivotal in setting the educational tone. Their encouragement clearly impacted on participants' belief that they could actually achieve a portfolio. However, the difficulties for the Charge Nurse in granting study leave fairly appeared to be a task never fully understood by participants. An apparent lack of support for study leave when requests were not honoured was interpreted as managers not viewing PDRP as a high enough priority.

Vicarious learning

Nurses reported paying close attention to the behaviour of others both before and during PDRP participation. Importantly, how participation was role-modelled contributed to PDRP uptake and completion within each clinical area. As an experience was related it became another nurse's vicarious experience and impacted on the way others thought about PDRP. It was possible to see that vicarious experiences also came from watching others attempt to navigate the PDRP process:

She actually submitted her portfolio three times and had it sent back … it impacted on me because she … was an epitome of an expert and you sort of think – oh god. What else do you want from me? Do you want a pound of flesh as well?

Nurses narratives also showed how they held on to and talked about their own and others experiences from one employment situation to another. The experience of seeing someone else going through what appeared to be a tough submission process in one organisation could be brought to bear in their next position even though the PDRP might have different goals or requirements. The effects could be seen years later. In one interview, a nurse reported that she had never engaged with PDRP directly as a consequence of her vicarious experience. From another perspective, a different nurse outlined the strength of character it took to overcome what she called 'second hand information' even before starting the PDRP submission process.

Valency of the activity

In the survey, nurses indicated that they knew exactly what they would get out of their engagement with PDRP. Yet, explanation drawn from the narratives showed that the valency of PDRP (whether the learning proposition provided reasonable expectation that a learner could meet their learning needs or aspirations) was not related to PDRP pedagogy or becoming an expert practitioner. More, valency seemed to be related to the avoidance of recertification audit by Nursing Council. As a reason to engage with PDRP, the development of expertise or clinical skill were conspicuous by their absence. These aspects of professional development were not the basis upon which nurses felt compelled to engage with PDRP. PDRP simply seemed to be viewed as another task to be completed and occasionally, as a means by which mandatory professional development hours could be achieved. The reason to complete it was external to the nurse.

Financial reward

A casual attitude towards the financial allowance was noted across the study where only one nurse made a case for the significance of the financial allowance associated with PDRP. The low priority of the PDRP allowance is an interesting finding since anecdote might suggest that money motivates engagement. The New Zealand Nurses Organisation (NZNO) include renegotiation of PDRP allowances at each iteration of the MECA (Multi Employer Contractual Agreement) and these have been steadily increasing over the last decade. Yet, it was certainly not the view of nurses in this study that the allowances were sufficient to encourage engagement in their own right. Nurses explained,

> *It had no bearing on my decision, none whatsoever.*

Notwithstanding the bonus of financial reward however, there was a limit to what nurses would endure for such a reward. The prospect of a financial reward lost its attractiveness for one nurse who had returned her portfolio numerous times for review with apparently no progress:

> *The extra money wasn't a factor in the end…. Whether I was getting paid*
>
> *five, ten, fifteen thousand dollars extra – it wasn't worth the stress.*

Time to complete a portfolio

Nurses explained time as if it 'belonged' either to a person or an organisation. Classifying time in one of three ways: personal time, work time, or having time, the 'owners' could be recognised and judgements made about the appropriateness of the use of a particular type of time. How the use of time was viewed seemed to be related to whether the individual had an interest in completing PDRP or not. Some nurses identified PDRP as a purposeful use of their time whilst others used time as a reason not to engage with the process.

Some of the nurses who had completed their portfolio explained they were not unhappy about the personal time involvement. In fact, they saw completing a portfolio as an investment in their

careers; personal time for completion was an expectation. Others though, explained that the notion of time ownership meant there were commensurate responsibilities. If personal time was used, there was an inference that the activity was the nurse's responsibility. Contrastingly, where the activity was undertaken during work time, it was an employer responsibility. Adding to this situation was the allocation of study leave for portfolio preparation as part of MECA. The inclusion of a stipulated amount of study leave within the contractual arrangement inferred a level of employer responsibility for some. This clause has perhaps created the expectation that PDRP should be completed in the employer's time and that completion is exclusively an employment matter.

As well as having an owner, explanatory narratives connected time with novel perspectives on PDRP. Nurses spoke of the need for the development of additional skills before PDRP activity could begin. Skills included writing self-assessment or peer assessment competencies for Nursing Council. Other skills were typing and word processing skills. Time for learning these new skills had to be taken into account when making the decision to participate in PDRP. Also revealed was an unexpected consequence of PDRP completion. Here, nurses discussed how, after completing their own portfolio, colleagues expected them to be able to assist them by undertaking peer assessment for example. This consequence was not universally welcomed because of the significant amount of time perceived to be involved in preparing competency validation for a colleague.

Personal PDRP landscape

PDRP landscapes were observed when personal responses to factors affecting an individual decision to participate in PDRP were reviewed. Individual responses and explanations demonstrated that each PDRP landscape was unique. The factors, for example the workplace culture of completion lead by the Charge Nurse; the support networks provided by Nurse Educators among others, created a personal learning environment which blended both professional and personal factors.

Conclusion

It is in the observation of the unique array of personal and professional circumstances that that strategies for encouraging participation might be found. Interpretation of the boundaries created between participating and not can be identified with the result that personalised learning support to overcome any initial and ongoing issues in navigating and completing the PDRP process can be implemented.

Noteworthy too, is the influence of the behaviour of those who do participate. The type of vicarious participation experience to which nurses are exposed, strongly influences decision-making. Not always the most accurate or inspiring, these sources help to shape the culture and context in which nurses consider PDRP. The messages they provide are arguably some of the most powerful even where a PDRP friendly manager supports the participation process. This adds meaning to the need to create a positive experience for participants; the narrative of encouragement is not always reflective of recent experience and poor experiences endure between employers and across careers. PDRP Co-ordinators and portfolio assessors have a significant role to play in ensuring

that the processes they use are clear and support nurses through a positive and purposeful PDRP experience.

The educational propositions of PDRP were not the principal reasons for nurses to engage with this programme. Intended as a practical outcome, PDRPs have included Nursing Council continuing competence requirements as part of portfolio submissions on approved programmes. However, nurses here appeared not to place emphasis on the connection between completing PDRP and meeting regulatory requirements. Paradoxically, their reasons to participate in PDRP included the intention to avoid the regulatory scrutiny of recertification audit. This means that the altruistic action of embedding of regulatory requirements within a voluntary programme may have obscured PDRPs primary educational purpose. It is certainly worth further exploration of this aspect of participation given the intention signalled by Nurse Executives of New Zealand (2017) for PDRP become a national programme.

References

Cross, P. (1981). *Adults as learners*. San Francisco, CA: Jossey-Bass.

Gallagher, L. (2007). Continuing education in nursing: A concept analysis. *Nurse Education Today, 27*(5), 466-473.

Gorard, S., & Smith, E. (2007). Do barriers get in the way? A review of the determinants of post-16 participation. *Research in Post-Compulsory Education, 12*(2), 141-158. doi: 10.1080/13596740701387437

Gould, D., Drey, N., & Berridge, E. (2007). Nurses' experiences of continuing professional development. *Nurse Education Today, 27*(6), 602-609.

National PDRP Co-ordinators. (2014). *Minutes of the Annual meeting 2014*. Auckland: National PDRP Co-ordinators.

National PDRP Co-ordinators. (2015). *Minutes of the annual meeting 2015*. Auckland National PDRP Co-ordinators.

National PDRP Co-ordinators. (2016). *Minutes of the annual meeting 2016*. Auckland: National PDRP Co-ordinators.

Nurse Executives of New Zealand. (2017). *National framework and evidential requirements for New Zealand Nursing Professional Development and Recognition Programmes (PDRP)*. Wellington: Nurse Executives of New Zealand. Retrieved from https://www.nzno.org.nz/support/professional_development

Dr Samantha Heath is happy for nurses who are in a small centre with a mandatory programme to get in touch with a view to potentially repeating the study.

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Medical Devices and Safety

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Why aren't medical devices regulated like drugs?

One of the *British Medical Journal's* editors, Fiona Godlee, asked this very pertinent question and reported that "a major international investigation, involving 59 organisations and including the *BMJ*, finds device regulation unfit to protect patients from harm."

Surgical mesh has had a lot of publicity of late – both nationally and internationally – and deservedly so, but mesh is only one of many medical devices unleashed upon a largely unsuspecting public only for things to go very badly wrong for many patients.

Ms Godlee asks *BMJ* readers, who are predominantly practicing doctors and physicians, "How much do you know about the safety and effectiveness of the implanted devices your patients are offered? You may assume that pacemakers, neurostimulators, joint prostheses, and breast implants have been tested rigorously before being licensed for widespread use."

Sadly, and at times catastrophically, that is not the case. Volume 363 of the *BMJ*, published in the last week of November 2018, features four articles on medical devices and the international investigation into their safety:

- How lobbying blocked European safety checks for dangerous medical implants
- Surgeons call for compulsory registers of all new medical devices
- What happens when the world's biggest medical device maker becomes a "health services provider"?
- FDA recommends "Modernizing" review of devices in wake of global investigation.

In Europe, the investigation, which involved 250 journalists and 8 million device related health records, found that "sources of harm to patients include a lung sealant that leaked, breast implants that went rancid, implanted pacemakers that stopped working, and deep brain stimulators that had to be removed."

The website *Implant Files* (www.icij.org/investigations/implant-files/) is devoted to the first-ever global examination of the medical device industry investigation, which has found that health authorities across the globe have failed to protect millions of patients from poorly tested implants.

The investigation found that when flaws are found in medical devices and safety alerts and recalls are triggered, all too often these warnings fail to reach doctors and patients. Recalls, withdrawals and bans on devices are not uniformly applied from country to country causing confusion and raising risks to patients where insufficient action is taken.

Surgical mesh is specifically mentioned as an example of how variable the response to problems with devices is, "even when devices have received intense public scrutiny."

"Sales of a controversial variety of pelvic mesh device for organ prolapse repair and incontinence treatment, for instance, were halted over the last year by authorities in New Zealand*, Ireland, Scotland and England — but sales continued in other countries, including Canada and South Africa."

Another device that we have covered in this Newsletter, Essure, is mentioned in the *Implant Files*:

"Despite years of outcry from patient advocates, the controversial Essure birth control device remains on the market in the US until the end of 2018, more than a year after its removal from other markets around the world. Despite being removed from these markets, you won't find much trace of the product in ICIJ's Medical Device Database because its maker, Bayer, maintains that it removed it from countries around the world ***for business reasons, not safety concerns."*** [our emphasis]

Hip implants, pacemakers and defibrillators, breast implants… the list seems to go on and on. Despite New Zealand being one of the countries mentioned with "established national or regional device registries" we don't have registries for all devices. Mesh Down Under have been pushing for a mesh registry for some time and we still don't have one, and when we investigated the use of Essure in New Zealand in early 2018 it was clear that there was no centralised record of who had the device implanted or even how many women there were with the device, let alone any registry of problems or adverse reactions reported.

The *Implant Files* investigation found that the medical devices industry has massive financial resources and broad influence allowing it to spend "hundreds of millions of dollars developing close relationships with doctors and hospitals and on lobbying governments for deregulation, easier approval systems for new devices, and more." In 2017, device manufacturers "made payments to doctors and teaching hospitals for research, travel, royalties, consulting fees and more," and that in the US the average time for a new device to be approved has dropped by more than 200 days in the last 20 years. Faster approval goes hand in hand with minimal testing and a 2016 study in *BMJ* found that devices approved **first in the EU were associated with a higher rate of safety alerts and recalls** than those approved in the US."

While the *Implant Files* make chilling reading, the key findings of the study are particularly galling, and the final finding confirms what many of us already knew

– **that women bear the brunt of the greed of manufacturers and incompetence of regulators and governments**:

- Medical devices improve and save lives, but governments have allowed products on the market with little or no human testing that went on to cause great harm.
- Devices pulled off the market in some countries over safety concerns remain for sale in others.

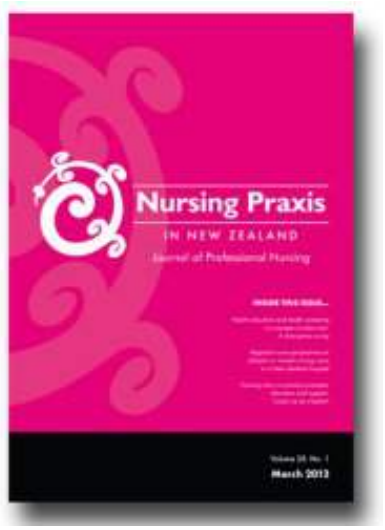
- The device industry, and the regulators that oversee it struggle to quickly identify hazardous implants after they are released, leaving patients exposed.
- Manufacturers, doctors, and others potentially linked more than 1.7 million injuries and nearly 83,000 deaths to medical devices in reports to US regulators over the last decade.
- Some of the highest-profile controversies in recent years involve products marketed to women, including contraceptive coils, vaginal mesh, and breast implants.

The results of this international investigation should be required reading for our health agencies and policy makers. Policy makers and regulatory agencies in New Zealand it is time you sat up, took notice and protected patients from harm.

* Even now, those fighting for action over surgical mesh in New Zealand believe that the action taken here is insufficient to adequately protect patients, as has been discussed on several occasions in the AWHC Newsletter and on our website.

Nursing Praxis in New Zealand

Journal of Professional Nursing



First published in November 1985, Nursing Praxis in New Zealand, the first nursing journal in New Zealand, continues its long history as New Zealand's regularly published peer reviewed nursing journal.

To subscribe to Nursing Praxis in New Zealand please click the following link:

http://www.nursingpraxis.org/

College of Nurses Aotearoa (NZ) members are automatically subscribed to Nursing Praxis in New Zealand as part of their College of Nurses membership. For more information on College of Nurses membership, please click the following link:

https://www.nurse.org.nz/membership.html

Focus on: Professional Supervisors

Article by Liz Manning, Operations Manager, CNA(NZ)

The College of Nurses has a belief that Professional Supervision can be a significant tool to support any nurse in professional nursing practice, whatever the practice area. It aids reflection on a situation and promotes consideration of options in a supported, confidential environment. Te Puawai focused in the last edition on professional nursing supervision in an article by Dr Catherine Cook

In this edition we wanted to continue to promote this important practice support service by profiling the Professional Nursing Supervisors on the pages of the College of Nurses Professional supervisors' webpages. We have included some of their thoughts on providing supervision and also the benefits of supervision and its place in reflective practice, especially for nurses moving into management and leadership roles.

Problems can arise when looking for an appropriate supervisor, where do you look and who is the most appropriate person? The College has endeavoured to make this search a little easier by providing active professional nursing supervisors the opportunity to profile their service on the College website. We currently have 10 supervisors on the webpages, with room for plenty more. All are registered nurses or nurse practitioners, offering a diverse range supervision underpinned by expert nursing knowledge and practice experience.

Supervision can now be offered in a number of ways, including traditional face to face, and now also videoconference and phone calls. We asked some of the supervisors for feedback on the benefits of supervision and also what they enjoyed about providing supervision:

- **Anna Blackwell**, Director/Private Contractor: Leader /Coach / Professional Supervisor/ Mentor/Change Agent. Based in Palmerston North

  - *"Supervision provides dedicated time to stop, think and reflect. It allows a safe space for nurses to verbalise what they are proud of and what they've done well which can add a lot more balance and value when discussing any areas of concern or dilemma. We are all prone to focus on our faults and then that thinking can over shadow the difference we are making or the enjoyment that has been present also. I find supervision draws RN's out of their day to day experience and are able to spend a bit of time being visionary again.*

  - *I thoroughly enjoy guiding nurses into a more positive space with a toolkit to manage challenges without feeling the need to absorb the negative. Seeing the face light up when nurses take the time and can see the difference they make and remember why they started this career choice. Being able to challenge nurses to reflect and see the opportunity in challenges makes my supervision time really valuable."*

- **Dr Catherine Cook**, Senior Lecturer, School of Nursing, College of Health, Massey University, Albany. Based in Auckland

  - Professional supervisors: An argument for protected time to reflect –

    https://www.nurse.org.nz/professional-nursing-supervisors.html

- **Cathy Gifford**, Registered Nurse. Based in Auckland

  - *"As an experienced manager in health care, I have noticed that nurses in new management roles really benefit from supervision. The facilitation of awareness around boundaries between non-nursing managers in their organisation and the manager who is a nurse, is like watching a rose open and blossom. In my experience nurses who have supervision grow and develop the skills to navigate this dynamic successfully and quickly which negates a litany of traumatising mistakes."*

- **Dianne Macdonald**, Professional Supervisor/RN Clinical Nurse Lead (Nehi Arahanga). Based in Nelson/ Marlborough

  - *"I think the main benefits for nurses having supervision would be to have a sounding board, a space just for them, controlled by them. It provides confidentiality and a place to talk through the pros and cons of a situation with someone who is removed from the environment. I have noticed this especially for nurses who are being bullying and for nurses who are extremely stressed and make the decision to leave their current role. It empowers nurses to see what they can control and what they can't, and challenges them as to why they think this. The relationship building over time is vital. To be the trusted backstop when the wheels of life /work get the speed wobbles.*

  - *I see supervision like exercise, a small bit often, keeps us going, as it is accountable, regular, and the supervisor is like the personal trainer, strengthening the areas that are not supporting the whole body, encouraging, challenging, and tuned into the strength, health and ability of the supervisee. The supervisor cannot do the work the supervisee is the one in charge.*

  - *I enjoy that the nurses have the answers, they just need support/ tools to identify and undo the layers of busy-ness that shadows their thinking, I enjoy working with them as they discover the path. I have a therapeutic relationship with them which is professional, meaningful and connected.*

  - *Reflection is high on my list. To understand what has happened and allow my mind to catch up with the pace of life. We have all had traumatic experiences and absolutely fabulous ones and, in the moment, we often don't have clear a perspective. Through reflection you can stand back and experience the same event with new eyes. This process allows us to get rid of emotional baggage, or celebrate our success. If this process is not undertaken and we do not deal with what has happened it often can deal with us in ways that we do not expect or are not healthy."*

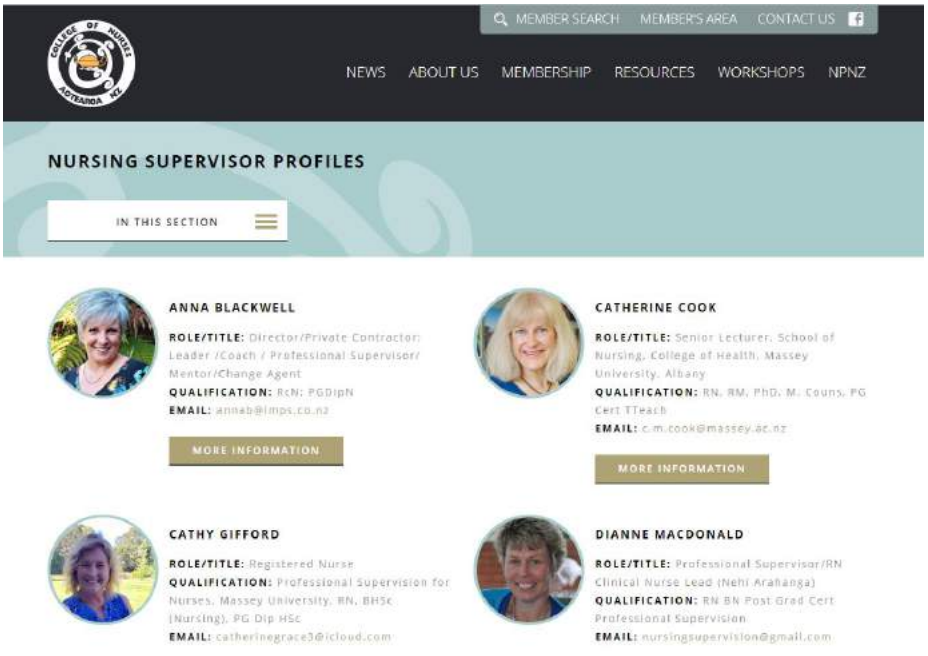
- **Michelle Rohleder**, Professional Supervisor/Registered Nurse. Based in Waikato

  ○ *"Lately, I've been reflecting on how much I've enjoyed working with several nurse managers over the past two years; what a privilege it's been to watch them give themselves permission to set time aside for themselves and how they take the 'Aha! Moments' and pay it forward to their teams, who in turn pay it forward to patients. There are so many 'wounded healers.' If we don't demonstrate to the next generation of nurses that this isn't okay and that we need to take care of ourselves, we will never break the cycle. This is how we create global change in the culture of nursing. One person at a time. It's a privilege to be part of it."*

Also, on the site are:

- **Heather Laxon**, Professional Supervisor/Registered Nurse. Based in Auckland
- **Karen Le Mar**, Professional Supervisor & Counsellor. Based in Palmerston North
- **Lynelle Dagley**, Nurse Practitioner. Based in Auckland
- **Victoria Perry**, Nurse Practitioner. Based in Palmerston North
- **Viona Jane Wulff**, Professional Supervisor. Based in Nelson

For more information check out the webpages: https://www.nurse.org.nz/supervisor-profiles.html



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SUPERVISION LEARNING OUTCOMES

Following participation in this course, you will be able to:

- Discuss the role of critical reflection in supervision
- Explore the functions of supervision
- Demonstrate key communication skills that encourage reflective practice
- Identify the scope, limitations and boundaries of the supervisory role
- Identify the importance of Kaupapa Māori supervision and cultural supervision
- Cultivate the optimum 'climate' for supervision
- Outline the significance of professional regulation to supervision

ABOUT THE FACILITATOR

Catherine Cook
RN, PhD, M. Counselling

Catherine has a strong interest in the human factors in healthcare and the role of critical reflection in enhancing communication. She provides professional supervision to a range of health professionals as part of her consultancy work through Massey University. Her commitment to adult teaching and learning principles ensures that this short course provides an engaging and supportive environment full of practice opportunities.

ADVANCED PRACTICE IN PROFESSIONAL SUPERVISION

This two-day short course is an opportunity for health professionals who are already offering professional supervision to come together with colleagues to refine and extend skills.

This course provides 22 hours of professional development. A certificate of completion will be issued..

9.00am - 4:30pm Thursday & Friday 21 & 22 November 2019
Massey University, Library Seminar Room, Albany campus, Auckland
Cost: *$700 inc gst*

ADVANCED SUPERVISION LEARNING OUTCOMES

Following participation in this course, you will be able to:

- Reflect on the challenges and opportunities for practitioners in 21st century
- Review your supervisory practice identifying strengths and learning edges
- Apply ethical concepts and decision-making frameworks to complex problems
- Demonstrate a strengths-based focus to foster resilience
- Explore creative approaches to enhance reflection
- Explore the rationale, skill set and strategies for group supervision
- Revisit courageous conversations and feedback
- Demonstrate the process of reviewing the supervisory relationship

Also available in 2019

LEADERSHIP THROUGH REFLECTIVE PRACTICE

This one day course is available on request across New Zealand for groups of nurses (max 16)

REFLECTIVE PRACTICE

Engaging in reflective practice is a fundamental competency that has numerous benefits: reflective practice contributes towards patient safety and satisfaction; increases the likelihood of attention to culturally safe and ethical care; optimises clinical teaching; enhances resilience in individual nurses; and provides communicative frameworks for collaborative leadership and teamwork. Ideally, reflection is considered integral to practice; need to have, not merely nice to have. Skilled nurses commonly engage intuitively in reflective practice but don't know how to facilitate this process with peers and more junior collegues.

FOR FURTHER INFORMATION AND TO REGISTER FOR SUPERVISION
www.ivvy.com.au/event/59AFZ9/

Anne-Marie Ngan, Programme Coordinator, Professional Development, PaCE, Massey University
Email: a.m.ngan@massey.ac.nz, **Ph:** 0800 627 739 ext. 63184

NPNZ Conference 2019

Report by Diane Williams NP, Conference Co-Ordinator

It was the event of the year with celebration for Nurse Practitioners and colleagues who attended the very recent NPNZ [R]evolution Conference held in Blenheim on the 10-12th April.

This year's theme was revolution/evolution of the NP role in NZ and workforce development. NPNZ reflected on the growth, capability and the many hard-won changes that have come about in the 20 year history of NP registration.

It was a conference of many firsts;

- ✓ It was the first time we have held concurrent sessions with over 70 speakers in just 2.5 days
- ✓ It was the first time the Minister of Health has presented in person
- ✓ It was the first time for a trade exhibit of this size and level of sponsorship
- ✓ It was the first time the Ministry of Health has given NPNZ a substantial seeding grant to help cover professional development for NPs
- ✓ It was the first time RCGPNZ awarded CME points for GPs who attended
- ✓ It was our first provincially held conference in the South Island

Key Note speakers included Hon Dr David Clark MoH, Chief Nurse Margareth Broodkoorn, Professor Jenny Carryer Executive Director CNA(NZ) and Judge Deborah Marshall Chief Coroner.

The concurrent speakers were drawn from a vast range of specialist fields, expert clinicians and nursing leaders to inspire, guide and inform delegates on topics from cradle to grave and all that's between, including several international NPs in attendance. The most outstanding speaker in each concurrent session was recognised and awarded a sponsored gift for their presentations. Repeat workshops on Serious Illness Conversations and plaster casting methods gave additional skills to take home.

A delighted Dr Michal Boyd was honoured by her peers, for her tireless work to progress NP skills and workforce development in NZ. She was presented with a specially carved West Coast greenstone display piece, at the Conference Dinner held at Wither Hills, attended by 100 guests.

The Chief Nurse also reminded us, '"Kua táwhiti ké tó haerenga mai, kia kore e haeretonu. He nui rawa o mahi, kia kore e mahi tonu" [Tá Himi Henare Ngáti Hine Elder & leader] "You have come too far not to go further, you have done too much not to do more".

The Nurse Practitioner in NZ has grown from just an idea in the 1990's, to an unknown rarity in the early 2000's. It took 10yrs to reach the first 50 NP registrations. With the number of registered NP's reaching 373 at the time of the conference, NP evolution is now well underway … and it is a revolution of healthcare in NZ.

Dr Michal Boyd holds a West Coast Greenstone carved in her honour

Left to right: Dr Michal Boyd NP Older Persons, Di Williams NP PHC, Andy McLachlan NP Cardiac, Hon Dr David Clark MoH, Mark Baldwin NP Mental Health/NPNZ Chairperson, Louise Leonard NP AOD.

Abortion and the Housing Crisis

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

We have a housing crisis in Auckland. In fact, we've had a housing crisis for a while now, and it doesn't seem to be getting any better for our most vulnerable Aucklanders; those living in poverty and in the areas of highest deprivation. While the media reports of people living in their cars have tailed off a bit, there are still occasional articles about people living in grossly substandard situations — converted garages, overcrowded houses and so on.

The rental market is astonishingly stressful — rent is often more expensive than mortgage repayments except for the fact that many families can't save for a deposit that would enable them to get into their own homes. For every rental advertised there seems to be tens if not hundreds of interested tenants. Some landlords have taken to asking for not just references but CVs to winnow out the least desirable potential tenants from those they would be prepared to rent to.

So, is it now so bad in our city that women are choosing abortion over having a baby because they have nowhere to live?

This is the view expressed by Professor Dame Linda Holloway, chair of the abortion supervisory committee in an interview on National Radio* on the 29th of November last year. She pointed out that Auckland was the only region that had had a rise in abortions. Over time with increasing population, a rise in the absolute number of abortions is to be expected. However, Dame Linda said that while Auckland was not the only area that has had a population increase in the last year it was the only one that has had a rise in abortions; and the rise was not consistent across age groups either.

She told Radio NZ that the affected age group – women between 25 and 35 years old – was when women were traditionally starting families and she speculated a lack of housing and increased living costs could be to blame.

Housing Minister Phil Twyford said the association between the housing crisis and the abortion rise in Auckland seemed plausible, but he was keen to get further advice. Similarly, Justice Minister Andrew Little, who in 2018 asked the Law Commission to report on potential changes to the abortion legislation, also agreed that it seemed like a "credible explanation" although he had not seen the figures.

As is so often seen, health and well-being, or the lack of it, is not a simple equation. Before we can adequately address the physical and mental health and wellbeing of New Zealanders, we need to address far more than the inadequacies and under- resourcing of our health sector. We need to address poverty, social issues, education and housing. Only then will we truly start to improve the health and well-being of those currently experiencing inequities and inequalities. That the current housing situation in this country might be impacting on the difficult decisions that some women must make about the future of their pregnancies should be no surprise.

* Jo Moir: Housing shortage in Auckland linked to increase in abortions. Radio New Zealand, accessed at https://www.radionz.co.nz/news/national/377101/housing-shortage-in- auckland-linked-to-increase-in-abortions?

Find Locum work with BeeFound

BeeFound is a New Zealand website that matches Locum availability with General Practice need and is completely free for Locums to use. It is the only Locum platform currently available to Nurse Practitioners. As a Locum, you can build your own schedule on BeeFound - you can choose how often you'd like to work and at what practices. Bookings will be instantly received by text, and with the mobile app, you can also confirm bookings and update availability while you're on the move. As a Locum, you can create a profile, upload documents, add your daily availability, and choose where you'd like to work.

BeeFound assists general practices to find short-term GP, Registered Nurse, and Nurse Practitioner locums.

For more information, visit BeeFoundNZ -

www.beefound.co.nz

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