Te Puawai

The Blossoming

The Professional Update for Registered Nurses

March 2017

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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Executive Director

Professor Jenny Carryer

Recently I attended the Ministry of Health Symposium entitled, *Explore, Innovate, Transform.* This was a two day event consisting of a range of speakers addressing a gathering of health sector professionals from a wide spectrum of locations. The event was a follow on from the symposium last year at which the refreshed NZ Health Strategy was launched and discussed. The intention of the 2017 symposium was to focus on transition and implementation and to challenge the sector to think and act differently.

The event was rousingly facilitated by Pinky Agnew a Wellington based MC, actor, social commentator, celebrant and writer. The day was also opened with a speech from Dr Jonathon Coleman, the Minister of Health. I felt he seemed exceedingly optimistic and unaware of the high levels of stress for both consumers and health professionals alike as the system struggles increasingly to cope with rising demand and scarce resources.

It is especially salutary now to read the endless reports of increasing chaos in the NHS (UK Health System) and to note how very recently NZ regularly brought experts from the NHS to NZ to provide advice and guidance to the NZ Health Sector. For me our response to impending change will very much determine whether or not we find ourselves facing the challenges currently besetting the NHS.

A range of speakers then spoke to the extreme rapidity with which changes are occurring in the digital world many of which are or will affect the way we do things in health services. The theme was exponential technologies, meaning that the rate of growth and change in technology capacity is doubling in increasingly short periods of time. Speakers provided highly dynamic, well designed and thought provoking presentations not always directly relating to health but always with significant relevance to health. Day two focused on disruptive innovations also now popping up with exponential speed and offering rapid transformation of life as we know it. A recurrent theme was the ability of technology to now do with greater speed and far greater accuracy some of the investigative and diagnostic work currently done by humans. In addition it is apparent that consumers will be able to take increasing charge of their health care through a range of technological links largely smart phone driven.

On a slightly different but very important note; we heard a brief presentation by Dr Swee Tan an eminent plastic surgeon now devoting much of his time to cancer research. I may not have the details exactly right but as I understood it in the process of researching and treating strawberry birthmarks Dr Tan and colleagues have gained new understandings about cell regulators and the ability to turn them on and off with the use of a simple and inexpensive drug regime which has

none of the horrible side effects of current cytotoxic chemotherapy. Early evidence of its efficacy is compelling and the potential for saving money, time and enormous human distress is almost beyond comprehension. Tan and his team need several million dollars to conduct the kind of large clinical trial needed to provide absolute proof of the value of what he has discovered. Raising such money in the current environment needs to be philanthropic which is an interesting reflection on the challenges of breaking through our current ways of doing things.

Another speaker was psychiatric nurse Claire Aitken who is program director of Moana House, Therapeutic community in Dunedin. This service provides people who have hit rock bottom with real ways to turn around their lives addressing addictions and related problems. Her talk was rich in humanity and compassion and an underlying frustration that such services are always running on the barest minimum of funding. Third in this section was GP Dr Lance O'Sullivan who has pioneered iMoko which uses I pads to take services into places and to people who might otherwise struggle to access services. His vision is to reach 300.000 people in the next three years.

So what to make of all of this? What are the take home messages?

- Passion, innovation and potential are present in unlimited quantities in the NZ Health Sector
- Changes are coming faster than we can even begin to imagine
- The focus of the workshop was especially geared towards advances in medical management of diagnosis and disease
- Discussion of workforce implications was conspicuously silent

I could not help but listen to all the speakers wearing my hat as Chair of the HWNZ Nursing Governance Group for Nursing workforce. I am critically aware of the current review of funding of postgraduate training for medicine, nursing and allied health bearing in mind that the vast proportion of this fund (approx 200 million) is invested in post entry medical training; nursing comes a very poor second and allied health and midwifery barely a whisker! At workshops to debate this review, questions are asked about how can we train more palliative care physicians, what to do about a significant shortage of dermatologists or GPs or how to respond to the need for colonoscopy as bowel screening is rolled out. Much is made of the need to move with caution and awareness that diplomacy is essential.

Many present at the Ministry symposium would probably argue that these are very short sighted and backward looking questions which simply display our reluctance to seriously do anything especially differently; indeed our eyes seem closed to the very disruptive innovations long spoken of. Furthermore I am not at all sure we have the luxury of time for caution and diplomacy.

It seems to me that some (at least) of our traditional medical roles may well become redundant as technology advances with incremental speed. It seems we have the capacity also to rapidly improve access to treatment for those with issues of poverty and diminished access. As the two days progressed I found myself thinking more and more about issues of health literacy, social justice and wellness promotion. Our whole focus now should be on preventing the need for medical services through building the resilience, capacity, knowledge and access to a healthy lifestyle for those who experience the greatest disparities. Yes we can treat their cellulitis and bronchiectasis by remote diagnosis and prescribing and yes that is important, but nurses I think care more for a world where such ailments are prevented rather than treated.

I can see a greater need than ever for nurse navigators who partner people to understand and use the technology to greatest advantage, who work alongside communities as health promoters, increasing health literacy and negotiating access to a better lifestyle and expert health services in whatever form they currently take. I also acknowledge the growing international evidence that Nurse Practitioners provide highly cost effective equivalence to a great deal of medical care but do it with enhanced levels of patient enablement, patient education and patient satisfaction.

People will always face the challenges of parenting, mental illness and terminal illness with associated need for palliation. Humans thrive on connection; loneliness is known to have a significant impact on health outcomes and the despair and grief of loss should never be experienced in isolation. Whatever our use of technology, people need people especially at their most vulnerable.

As we advance into a technically efficient new world of health service provision, debating the potential for increasing use of virtual, remote and robotic care we also need some very focused conversations on workforce planning. Given the lag time between deciding and doing when it comes to workforce change such discussions are urgent and must set aside tact and diplomacy and fear of challenging vested interests.

The Health Strategy argued for people power. If we keep people and their need for human connection, the removal of disparity and achieving the most basic aspects of health access and lifestyle impact alongside embracing new technology and medical expertise we may achieve some significant gains. Nursing needs to get cracking and ensure that our advocacy role especially at the policy level remains to the forefront.

Moving House or Changing Job

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

Email: admin@nurse.org.nz

Doctors In Denial

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

Members of the AWHC were among the almost 200 people who attended the book launch of Professor Ron Jones' book, "*Doctors in Denial – the forgotten women in the unfortunate experiment*" which took place on Monday 13 February.

Ron Jones is a retired obstetrician and gynaecologist and former clinical professor at the University of Auckland. "*Doctors in Denial*" is his account of Herbert Green's study into the natural history of carcinoma in- situ of the cervix (CIS) that took place in the 1960s, 70s and 80s at National Women's Hospital (NWH), a study that subsequently became known as the "unfortunate experiment." The book documents what happened at the hospital; Jones' co-authorship of the 1984 scientific paper on the outcome for the women that was published in the prestigious medical journal *Obstetrics and Gynaecology*, which then led to the publication of an article by Sandra Coney and Phillida Bunkle in *Metro* magazine in June 1987; and the setting up of a ministerial Committee of Inquiry – the Cartwright Inquiry.

Ron Jones joined the staff at NWH in 1973 and soon became what he describes as a silent observer to the "dark secret that was beginning to surface" at the hospital. He met Bill McIndoe, an older doctor who took him into his confidence, and slowly became enmeshed in the resulting national scandal and controversy over Green's experiment on women who had been referred to the hospital with CIS and, under Green's management, went on to develop invasive cancer. Many of these women died.

The hospital's failure to address the concerns expressed by those at the bottom of the hospital's hierarchy who were observing and documenting the harm being done to these unwitting victims of Green's study is what led to Ron Jones co-authoring the 1984 paper that blew the whistle on Green. The paper came to the attention of the two well-known feminists, Sandra Coney and Phillida Bunkle, who wrote the *Metro* article which led to the ministerial inquiry and a great deal of media attention.

As Ron Jones writes, the Cartwright Inquiry has had more impact on the practice of medicine in New Zealand that any other single event. It resulted in the establishment of a national cervical screening programme, the formation of the office of the Health and Disability Commissioner and the patient advocacy system, the development of a Code of Consumers' Rights that is enshrined in legislation, and the setting up of ethics committees that placed the welfare and protection of patients at the heart of the approval process for research studies.

"*Doctors in Denial*" is an absorbing story that begins with two chapters that set the scene for the events that unfolded at NWH. Ron Jones describes the patriarchal, hierarchical attitudes and behaviours of medical practice within the hospital in the 1950s and 60s, the personalities of those involved including Professor Denis Bonham, Associate Professor Herbert Green, colposcopist Dr

William McIndoe, and pathologist Dr Malcolm (Jock) McLean, as well as society's deferential attitude towards doctors. He also describes how NWH was structured in terms of the medical administration of the hospital.

The third chapter deals with the proposal that Green put before the Senior Medical Staff Committee which was then rubber stamped by the Hospital Medical Committee on 20 June 1966. He writes: "There was a well-established medical hierarchy within the hospital, with academic members of the postgraduate school at the top and non-academic medical specialists making up the bulk of the staff. In matters of research the latter deferred to the academics, whose role included the critical examination of scientific evidence. It was not surprising that when McIndoe, a quietly spoken doctor at the bottom of the pecking order, spoke out against Green's proposal, his opinion was taken less seriously than it should have been."

Chapters 4 and 5 record the concerns that were subsequently expressed both nationally and internationally by academics and health professionals about Green's study and the risks it posed to women. When McIndoe and McLean raised their concerns about the numbers of women developing cervical cancer with the then medical superintendent-in-chief, Dr Fred Moody, he declined to become involved. A subcommittee was set up to examine the 29 cases of concern, but for reasons unknown 15 cases were excluded. The subcommittee's report was basically a whitewash, leaving both McIndoe and McLean upset but not that surprised.

Chapter 6, "Phoebe's story" is the first of two chapters that tell the stories of two very different women who were part of Green's experiment. Phoebe was a widow who had raised several children on her own and whose life had not been easy. Chapter 12, "Mabel's story," tells the story of another of Green's patients, a doctor's wife, at the other end of the social and economic spectrum who was also involved in Green's study.

Chapters 7 and 8 describe the events leading up to the publication of the 1984 paper in the journal "*Obstetrics and Gynaecology.*" It took six years to get this paper written and then published. The reasons for this lengthy timeframe make for compelling reading. While the truth was then well and truly out in the international medical and research arena, there was a deathly silence within the hospital. Nobody talked to the authors of the paper. And nobody did anything about the women who were at increased risk of developing cancer.

Chapter 9 deals with the *Metro* article written by Coney and Bunkle that was published in June 1987, and led to the setting up of the Ministerial Inquiry into treatment of cervical cancer at NWH. Ron Jones records that he "considered their article to be a reasonably fair and balanced account. Their only mistake was to comment that Group 1 patients had had treatment with conventional techniques, and normal smears." This error was subsequently seized upon by those he describes as revisionists and is still misunderstood by those who continue to deny there was an experiment.

Chapters 10 and 11 document the early backlash to the Cartwright Inquiry and the ongoing refusal by senior doctors at NWH to accept the findings and recommendations contained in the report. In July 1990 *Metro* published another article titled "Second thoughts on the unfortunate experiment at national women's." Did Sandra Coney know what she was doing? Did Judge Cartwright? Did Professor Green get a fair go? Or was the cervical cancer inquiry a witch hunt? These questions featured on the front page of the magazine. These two chapters also describe

the contradictory responses to the report by health professional bodies, NWH, the Medical School and the university, and what happened to the authors of the 1984 paper. Ron Jones' grief at the lack of concern by those responsible for the ongoing welfare of the women at the centre of the Cartwright Inquiry and the danger that many of them were still in of developing cervical cancer comes through very clearly in these and earlier chapters.

Chapters 13 and 14 put the events that led to the Cartwright Inquiry into context. Ron Jones writes: "The very traditional male medical environment in which Green was so dominant was challenged by the feminism that was well established in New Zealand by the 1970s and 1980s. Older doctors were generally uneasy and uncertain what feminism actually meant and how it would affect them and their women patients." He laments the lack of remorse from the doctors who have continued to maintain a 'defend and deny' stance during the almost three decades since the Cartwright Inquiry, but welcomes the fact that the victims are at last being heard. "It is interesting that many of those closest to this tragedy have admitted to the truth in late life mea culpas, while some with more tenuous connections continue to defend Green's actions."

"*Doctors in Denial*" ends with a brief postscript on the revisionism and denial that has emerged in recent years in books published by associate professor of history Linda Bryder. Bryder has consistently failed to acknowledge the impact on women of Green's study, and in writing her books she has chosen to interview documents rather than any of those who were witness to events during the 1960s through to the 1980s at NWH. In doing so she has told a "distorted story of blameless doctors, grateful patients, and normal scientific conduct" which if accepted will "set back the profession's difficult task of acknowledging and trying to learn from error," Professor Charlotte Paul is quoted as saying. (1)

However, there is a sense in which we can be grateful to Bryder as it was her rewriting of history that motivated Ron Jones to write his book and set the record straight. It was also made possible by the fact that he kept and still has in his possession numerous letters, memos, minutes of meetings, articles and papers, and various other documents from that time.

While "*Doctors in Denial*" is Ron Jones' personal story, it is also a riveting account of professional arrogance and misplaced loyalties, of doctors who turned a blind eye or denied the truth, and more importantly a story that focuses on the needless suffering of the women at the heart of this most unfortunate of experiments.

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1. Ronald W. Jones. "Doctors in Denial: The forgotten women in the 'Unfortunate Experiment."Otago University Press. 2017. Page 194.

See also:

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Nursing Taskforce on Task

Article by Professor Jenny Carryer

First Printed in Nursing Review, February/March 2017

Nurses will be aware that Health Workforce NZ is currently supporting a series of taskforces or Governance Groups addressing workforce challenges for nursing, medicine, midwifery and the kaiawhina workforce. As Chair of the National Nurse Leaders group I have been chairing the nursing taskforce and would like to take this opportunity to share the project with the wider profession. The views of the taskforce are independent of the Ministry of Health.

The taskforce is multi-disciplinary and members are drawn from

- DHB Chief Executive Officers (CEOs)
- DHB Directors of Nursing
- CEO Primary Health Organisations
- CEO New Zealand Aged Care Association
- Pacific nursing representative
- Māori representatives from Te Runanga o Toa Rangatira Inc
- National Māori PHO Coalition representative
- Consumer representative

Sponsors

Dr Jane O'Malley, Chief Nurse, Office of the Chief Nurse

Steven Barclay, Chief People and Transformation Officer, MoH

The major issues addressed by the taskforce in 2016 were:

Models Of Care Or Models Of Service Delivery

We agreed that the primary health care and community health nursing workforce needs to be better aligned to the needs of the community and more able to deliver the patient or person centered care signaled by the refresh of the Health Strategy. This strongly echoes the goals of the *Investing in Health* document produced by the primary health care nursing expert advisory group to the MoH back in 2003.

We consider that current siloed approaches to funding, contracts, and some employment relationships are limiting the best deployment of primary health care nurses. Community based and primary health care nurses should be pivotal to the achievement of better-integrated services across the full continuum of wellness promotion to management of long-term conditions.

We are not convinced that levers are yet in place to ensure the necessary changes.

Issues discussed by the taskforce include:

1) The need for greater investment and uptake in postgraduate funding of primary health care nurses

2) Increased deployment of Nurse Practitioners in General Practice and in boundary spanning roles between primary and aged care and child health settings

3) More courageous and speedy consideration of innovative models of service delivery

4) Better alignment between aged care and primary health care nursing

Aged Care

The aged care nursing workforce is forecast to decline at the same time as demand is increasing with growth in volumes for the older population.

Aged care considerations should be refocused to be:

- inclusive of all of the aged care workforce
- focused on the care people require wherever they are
- mindful that the aged care workforce needs to be linked to primary and community teams

Levers to assist the nursing aged care workforce are considered to be:

- Nurse Entry to Practice (NETP) funding
- Voluntary Bonding (more dollars for working in aged care)
- removing aged care from the immigration essential skills list (noting this will need to be a staged approach)
- review of the allocation of postgraduate nursing funding

It was noted by the taskforce that pay parity is not expressed as an issue in the workforce in the Health of Older People's strategy.

Māori Nursing Workforce

The taskforce has accepted a goal of parity between Māori nurse numbers in the workforce and the percentage of Māori in the population by 2028. This is a demanding but critically important goal.

Four levers have been accepted so far to encourage the growth of the Māori nursing workforce:

- Establish and lead a cross government working group

- Strengthen DHB regional planning guidance towards increased participation of Māori and Pacific in the health workforce
- Require organisations receiving HWNZ funding to have an action plan for workforce diversity
- Publish a biennial report tracking progress towards Māori nursing workforce matching the proportion of Māori in the population

In addition it is agreed that:

- There need to be more Māori /Pacifica nursing academics as this is fundamental to student retention in the BN program
- Areas/populations need to reflect the demographics they serve e.g. Auckland has a high Pacifica population

Nurse Practitioners

Members are universally committed to the need to support and increase the NP workforce especially but not exclusively in the areas of primary health care and aged care.

Review Of Vocational Training Funding

The taskforce agrees that historical patterns of post entry education funding need to be examined to see how closely they align with meeting the needs of the population in the most cost effective manner.

Opportunities exist to influence the future direction of postgraduate funding for nursing, especially in the context of the New Zealand Health Strategy and revisions to HWNZ's medical vocational funding. We see postgraduate funding as crucial to ensuring nursing is well placed to contribute effectively to future health need and will remain fully engaged in all relevant discussions.

In Summary

The nursing taskforce will consistently argue for a whole of workforce, fresh approach to aligning the workforce to identified person, patient and community need. Instead of looking to fund, train and replicate old styles and roles of delivery we see value in asking what disruptions would support cost effective and more sustainable service delivery.

Review of the National Nursing Consortium – Knowledge & Skills Frameworks

Executive Summary

The National Nursing Consortium (NNC/ Consortium) is tasked with providing a national nursing endorsement mechanism for specialty practice standards or Knowledge and Skills Frameworks (KSF) within New Zealand. Since its creation in 2011, specialty practice nursing groups have sought national recognition through the Consortium's endorsement process for specialty standards or KSF.

In early 2016, following Consortium committee discussions with New Zealand Nurses Organisation (NZNO) professional nurse advisors, it was decided to review the KSF toolkit and process for endorsement in terms of delivery against the Consortium objectives.

The intent of this review process was to:

1. Gauge the usefulness of the currently available toolkits to assist in the development of new KSFs.
2. Explore the accessibility of the documents
3. Assess the reach of the KSF documents into practice settings

The review was achieved using two surveys; one for KSF 'developers', those nurses who were part of the teams which developed each KSF and another broader 'user group' survey for all nurses. Within the user group survey was a section for organisational nursing leaders, to establish how and if, the frameworks are promoted within the profession.

The three most notable findings were;

- 40% of the 530 respondents in the user group survey had never heard of KSF.
- Though the Consortium was created to provide an endorsement framework, the proliferation of non-endorsed specialty standards continues.
- There are inconsistencies and opposing views from development through to practice utilisation.

This document contains the findings of the surveys and resulting recommendations with the aim of informing a discussion at the meeting of the National Nursing Organisations (NNO) group. There are 3 options to consider:

1. Disband the Consortium
2. Continue with the current Consortium KSF process
3. Refresh the Consortium intent and processes including leadership investment

NNO group has reviewed this report from the review and is concerned with regard to the evidence of significant issues and there was support for not continuing the current process. NNOgroup members suggested instead that focus for NNC could be on development of principles for standard setting and to not continue endorsements.

Professor Jenny Carryer
Chair NNOGroup

Professional Support Resources

A suite of professional resources is to be provided on the College of Nurses website. The four presentations cover common themes coming from College members and provides general advice to follow before needing to contact the College.

Topics included are:

- About the College - an overview of what the College offers.
- Portfolios - why we do portfolios and how to set up a portfolio – e-Portfolio or hard copy
- Bullying- Being bullied? Managing a bullying situation? - Some initial helpful information.
- Performance management - being performance managed? Leading performance management? Some key points to help you along the way.

The presentations are simple self-paced and provide accessible pragmatic advice and information and will augment the support the College already offers.

Supervisors for NP Candidates Video Resource Toolkit

Liz Manning, Kynance Consulting Ltd: Project Manager

A Web-based Resource For Supervisors

The College of Nurses (NZ) has been working for the last 6 months, on a project to provide new online resources, support and information to the supervisors of NP interns, recognizing that this group are often under-supported but vital to the continued development of New Zealand's nurse practitioner (NP) workforce.

The project has had a strong project team sponsored by the College Executive Director Professor Jenny Carryer, with Dr Mark Jones as the project lead. The project team has representatives from the Nursing Council, NPs including NPNZ chairperson Jane Jeffcoat, post graduate academic staff, a General Practitioner and College administrator. Alongside the project team are some key sector experts who have brought different skills and knowledge to the project.

Liz Manning, Director, Kynance Consulting Ltd was the Project Manager and Tanya McQueen, Director of Global spirit films filmed and edited the video clips.

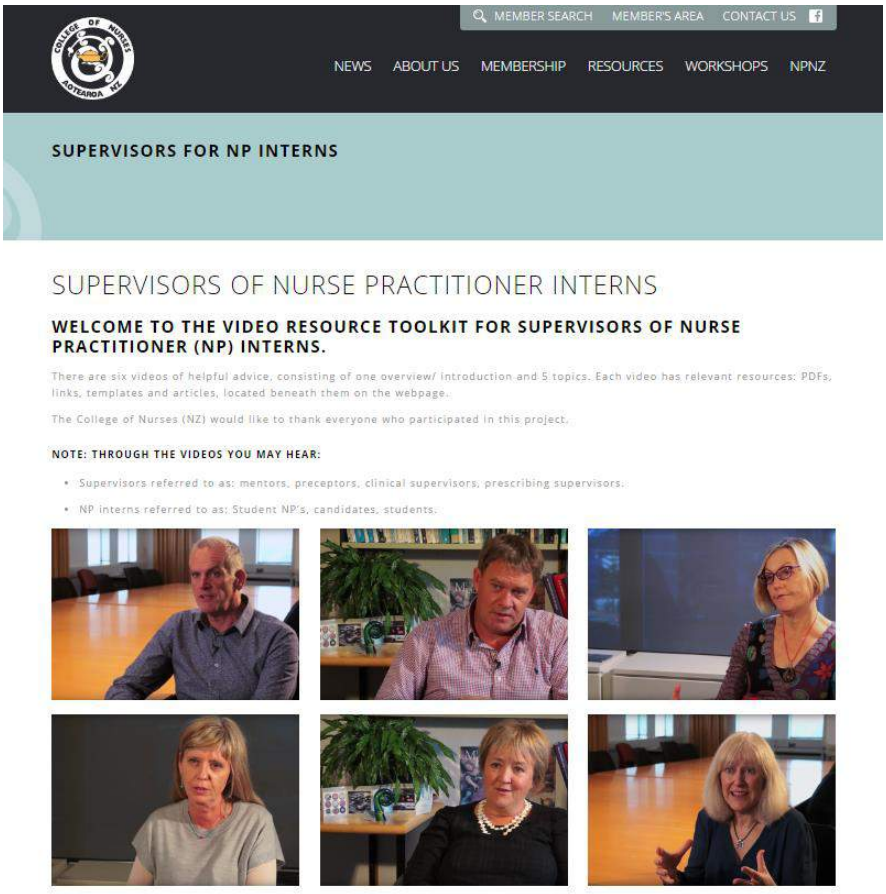
The outcome of the project is a multimedia mix of short video clips, web links, key documents and guidelines, aimed to concisely deliver important messages to very busy people about becoming a supervisor to an NP intern in a variety of settings including DHBs and GP practices.

The topics included are:

- Supervising to best effect: The NP intern supervisory process, how to best observe and facilitate reflective practice.
- NP scope, domains and competencies- what they are and how to use them.
- NP application process- evidential requirements.
- Prescribing practice- reviewing practice against prescribing competencies
- Employing NP interns- contractual and employment considerations.

The College welcomes health professionals who are undertaking or have been approached to be a supervisor, to view these resources.

The webpages are available via the new College website www.nurse.org.nz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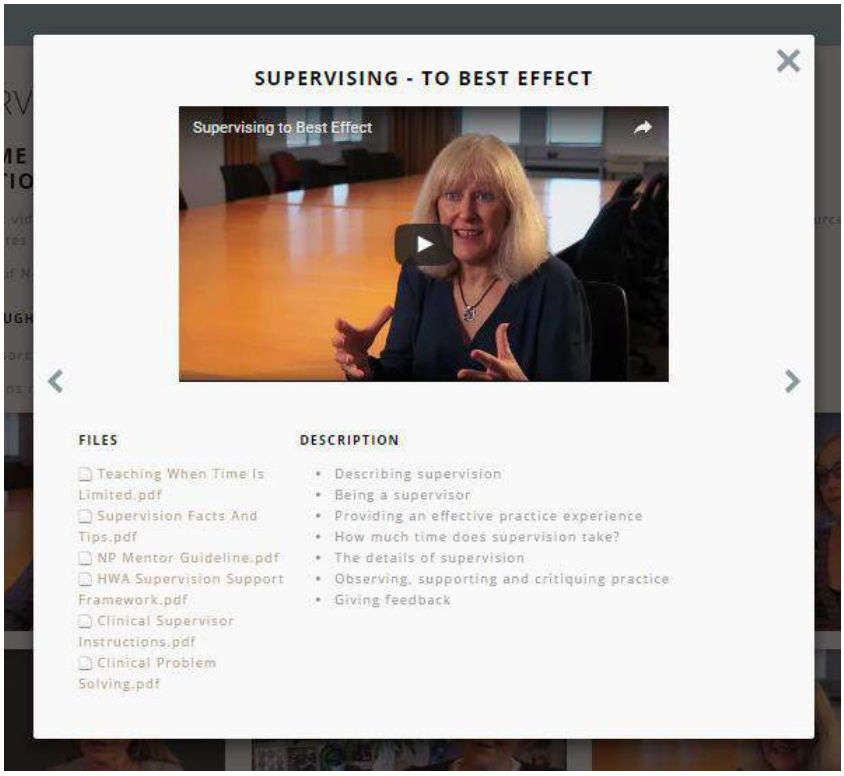
SUPERVISORS FOR NP INTERNS
SUPERVISORS OF NURSE PRACTITIONER INTERNS
WELCOME TO THE VIDEO RESOURCE TOOLKIT FOR SUPERVISORS OF NURSE PRACTITIONER (NP) INTERNS.
There are six videos of helpful advice, consisting of one overview/ introduction and 5 topics. Each video has relevant resources: PDFs, links, templates and articles, located beneath them on the webpage.
The College of Nurses (NZ) would like to thank everyone who participated in this project.
NOTE: THROUGH THE VIDEOS YOU MAY HEAR:
Supervisors referred to as: mentors, preceptors, clinical supervisors, prescribing supervisors.
NP interns referred to as: Student NP's, candidates, students.


SUPERVISING - TO BEST EFFECT
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Supervision Facts And Tips.pdf
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HWA Supervision Support Framework.pdf
Clinical Supervisor Instructions.pdf
Clinical Problem Solving.pdf
DESCRIPTION
Describing supervision
Being a supervisor
Providing an effective practice experience
How much time does supervision take?
The details of supervision
Observing, supporting and critiquing practice
Giving feedback

2016 Travel Scholarship Award Conference Report

Report by Dr Patricia McClunie-Trust PhD, MA, PG Cert, Prof Supv, RN

I would like to thank the College of Nurses, Aotearoa (NZ) for awarding me the 2016 Travel Scholarship. The scholarship supported my travel to Ontario for the Canadian Health Workforce conference, which was attended by an international group of health professionals, researchers and policy makers. I was also able to connect with providers of Nurse Practitioner education during my time in Toronto, and was then able to stop over for the Qualitative Health Research Conference in British Columbia.

Conference Report:

The Canadian Health Workforce Conference (CHWC) was held in Ottawa 3-5 October 2016. It brought together people with an interest in, and responsibility for, health workforce planning, such as academics, researchers, and policy makers. The Conference was organised by the Canadian Health Human Resources Network (CHHRN), which identifies Health Workforce New Zealand among its international contacts. The theme for the CHWC was “Optimising the Health Workforce”, building on recent Canadian and other international reports, including the Naylor (2015) Report on health innovation, the OECD Report (2016), and the WHO Global Health Strategy (2016). My interest in this conference was the focus on optimising scopes of practice and seeking ways to both conserve and increase capacity in our existing New Zealand nursing workforce.

Theme 1: Optimizing health professional scopes of practice

Sessions focused on the idea the current health professional scopes of practice are not aligned to population health needs. Instead they are shaped along traditional political lines reflecting the policy legacies of past times. Presentations included;

- Ideas about groups of practitioners with team output measures in the context of practice with communities or populations in place of traditional roles and scopes of practice
- Interprofessional collaborative care approaches, with advanced collaborative practice competencies and evidence based guidelines
- Myth busting – nationally coordinated regulatory approach is needed (eg. Australia) Canada currently has different legal jurisdictions for the regulation of health care practitioners across its different provinces – see ‘tools’ portal on CHHRN website for more information about ‘myth busting’
- Some health professions, especially Nurses, are ‘underperforming’ in health care because of structural barriers that disable them, and they may be doing some work that could be delegated to, or shared with, other health workers. Presenters argued that legislation needs to enable health practitioners to work in ways that are broader – some interventions need ‘a suitably qualified practitioner’.

Key findings of the Naylor (2015) Report on health Innovation include the need to close the gap between the rhetoric of patient centered care and the reality experienced by many people using health services. Co-designing better integrated services with clients as central has the potential to create more collaborative and better focused health care delivery, particularly with the innovative use of mobile and other health technologies. The Report of the Canadian Expert Panel (2014) on optimizing scope of practice argues that determining optimal scopes of practice for health care providers is an essential element of this transformation. It suggests that systems that define and regulate scopes of practice for health professionals have been developed according the historical requirements of past health systems, population health needs, and the interests of specific health professions. The fit between scopes of practice and models of care is key to transforming health care system to meet current population health needs. The OECD report (2016), referred to by several presenters at this conference, provides comprehensive data sets on social, health and economic references for OECD countries. Health workforce migration, non-medical determinants of health and health care quality indicators are also included.

Theme 2: Global health workforce strategy

James Campbell, WHO Director of workforce development, presented findings from the Report of the High-Level Commission on Health Employment and Economic Growth. The report identifies a need for new narratives in health care, including;

- Recognising that job creation adds to the economy. The health workforce generates wealth, with multiple impacts, rather than being a cost or drain on the economy of a country
- Gender equality and women's rights such equity in leadership roles within health services and the impact of a feminized health workforce, pay and conditions
- Health education and training that is fit for purpose – the right person in right place at the right time. Transformative educational approaches, skills and job creation
- Technology both in education and health care is a critical issue underpinning the effectiveness of the health workforce
- Health workforce planning on a global basis with migration accounted for both in home countries and rights and conditions in adopted countries – understanding credentialing and employment across borders

New Zealand was identified as the country most dependent on migration for health workers with one third of medical migrants leaving one year after full registration and residency was acquired. Internationally there is significant pressure on regulatory bodies to register a wide range of migrant health professionals, but often the regulatory frameworks in recipient countries were never designed for the current issues in migration. See the WHO (2014) report *Migration of health workers: the WHO code of practice and the global economic crisis* for information about challenges in implementing the code of practice.

Theme 3: Interprofessional education – optimizing human capital

One of the panel sessions emphasized interprofessional teams as integral to a transformed health care system. This session explored the following themes with panelists;

- Organizing health care delivery to optimize the health workforce;

- The number and types of health care providers that are needed;
- Whether interprofessional models of care improve the delivery of care in terms of quality, efficiency and effectiveness; and
- The data standards, data and tools needed to measure these models of care, as well as their design and development.

The WHO (2010) report on a *Framework for Action on Interprofessional Education & Collaborative Practice*, informed key aspects of this discussion. John Gilbert's presentation explored some of the challenges in moving towards an interprofessional in undergraduate education. Gaetan La Fortune also discussed the potential for interprofessional teams to optimize health care delivery, and reduce the waste of human capital in the existing health workforce. He argued that nursing is the largest proportion of the health workforce and potentially the group that health services could derive the most benefit from in terms of shared or expanded scopes of practice. He argued that nurses who have a master's degree are those most likely to be under-utilized in the Canadian health workforce, so there is a significant capacity to enlarge the role that nurses play in the delivery of health care.

Research – *Professional lives 'lost' to the health workforce: A case analysis*

The CHWC and Qualitative Health Research Conference also provided opportunities to present my research on professional misconduct.

Each year in New Zealand, there are professional 'lives' lost to the health workforce through disciplinary action for misconduct. However, the practitioners found guilty of misconduct have often been well educated and are experienced in their field. It is important to notice the factors leading to disciplinary action against health practitioners in order to prevent the loss of knowledge, skill and other capabilities from the health workforce.

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Innovation For Change

Article by Amber Kirkman RN

Amber Kirkman

When I graduated as a registered nurse, my hopes were high. I knew I would be working in the privileged position of helping people achieve their goals for wellbeing. Throughout my nursing studies I had inspiring lecturers who instilled a deep sense of the responsibility nurses have to deliver holistic, equitable and innovative care, tailored to the needs of people. I understood there wouldn't always be ideal work conditions, but I was unprepared for the extent of the dysfunction I encountered in the health sector generally.

As a new graduate in a general surgical ward I quickly became familiar with IV and CV lines, medication administration, tracheostomies, chest drains, stomas and catheter insertions. There were charts for drugs, bowels, urine, eating, fluids, bladder irrigations, observations, care plans, dressings, wounds, mobility, falls, repositioning, and skin care. Somewhere in there I multitasked patient hygiene, comfort, happiness, questions, meals, oral care, family members and doctors! After delivering the perfect handover to the scary nurse manager and staff for the next shift, I would stay late to write succinct patient progress notes that included only the *important* information.

I wanted to be good at my job, but something was not quite right. Although I had the title of 'nurse', I was not satisfied. I felt inadequate and worried about the poor patient care I provided. I knew I could give more – if only I had the support, time and resources. There were too many patients and too many complex needs.

My dissatisfaction led me to wonder if I was just in the wrong place. I went about changing departments from oncology to paediatrics, to general surgery in a different hospital, to casual pool nursing, and to general medical in an Australian hospital. Eventually, I made the move to general practice, thinking I could perhaps make a difference before people got sick enough to need the hospital. Here I encountered even more frustrations related to patient co-payments, provider-centred care, and the 'bottom line' of the business of primary care.

My journey through departments and across sectors has led me to realise that the ideal standard of care to which I aspired, is achievable. For it to be equitable, sustainable, community-centred, and universally accessible, however, is going to take a radical change in delivery.

Yet there is nothing new about my realisation. The Alma-Ata declaration of 1978 emphasised the urgent need to protect and promote the health of all people (World Health Organisation, 1978). It affirmed that health encompasses physical, mental and social well-being and is a fundamental human right. Primary health care was identified as key to reaching the social goal of health for all. Despite a universal access policy to primary care services in New Zealand, the recent annual

Health Survey (Ministry of Health, 2016) reports disproportionately high rates of illness and hazardous lifestyle behaviours amongst those living in most deprived areas. It is clear that New Zealand's primary care sector is in a critical condition and it is time to consider what nurses can do to transform it.

This year I have embarked upon a research project to complete my master's degree. My supervisor, Dr Jill Wilkinson, suggested some possible topics, among which were ideas about 'social entrepreneurship'. These words struck a chord with me. I had no idea what they meant or what it might have to do with nursing, but I was intrigued. I have subsequently come to believe that social entrepreneurship offers possibilities to understand primary health care delivery in ways that can sustain the health of communities as well as being financially sustainable.

At first glance social entrepreneurship is a difficult concept to comprehend as a nurse. The word 'entrepreneur' is usually associated with profit-making business endeavours that involve a measure of risk. Social entrepreneurship, however, holds the wellbeing of society as central and is therefore well aligned with a nursing philosophy of holistic, equitable and innovative care, tailored to the needs of people.

In fact, social entrepreneurship is all about innovation that channels action towards, meeting social goals. It does this by applying entrepreneurial principles to achieve large-scale transformation and resolve social problems which neither the public or private sector have been able to achieve (Kuratko, 2016). Social entrepreneurs are resourceful and use what they have to meet the challenge of people's need in innovative ways. Nurses are resourceful and innovative, yet are often constrained by a health sector that gravitates around medical solutions. Nurse Practitioners are uniquely positioned in primary health care to transcend many of these constraints and are doing so in a range of different ways.

It is my intention, therefore to find out more about the innovative and social entrepreneurial activities of New Zealand Nurse Practitioners who work in primary health care settings. Their experiences as innovative practitioners are largely untold, yet have the potential to transform the sector in New Zealand.

If you are a Nurse Practitioner working in primary health care and would like to be part of this research by agreeing to an interview with me, please get in touch and I'll send you some more information. I hope you will become intrigued, like me, in how ideas about innovation and social entrepreneurship can begin to transform primary health care delivery in New Zealand.

My email address is: amberkirkmanrn@gmail.com

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College of Nurses ePortfolio

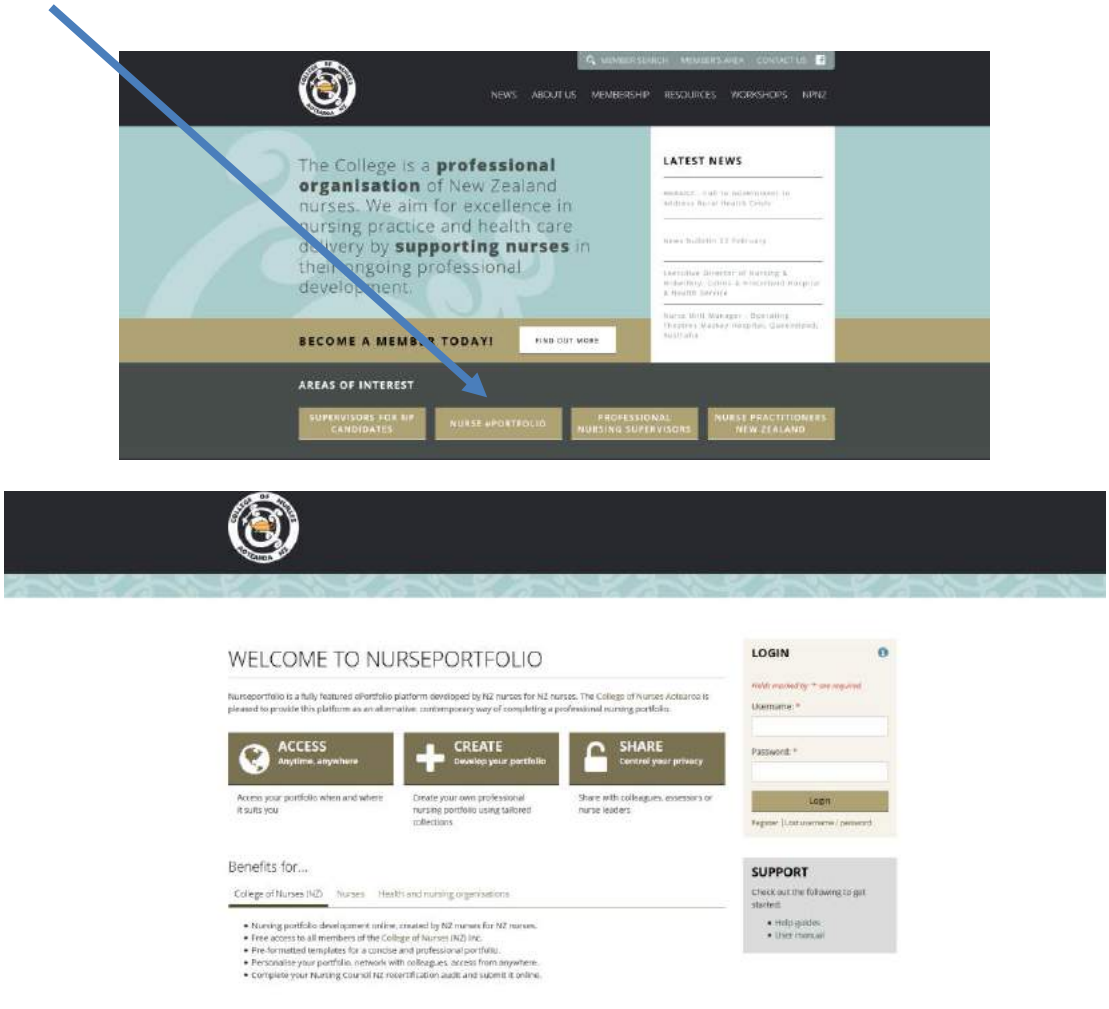
Membership of the College of Nurses Aotearoa (NZ) offers a number of advantages and opportunities. One of these is free access to the nursing ePortfolio site.

Nurseportfolio is a fully featured ePortfolio platform developed by NZ nurses for NZ nurses. The College of Nurses Aotearoa is pleased to provide this platform as an alternative, contemporary way of completing a professional nursing portfolio.

ePortfolio is a tailored electronic storage platform for holding your evidence of competence in nursing practice. You can use it to present basic competence for a Nursing Council random recertification audit, store your nursing documents or use it to present your Professional Development and Recognition Programme (PDRP) documents.

Please find the link to the new ePortfolio (Nurseportfolio.nz) on the College website www.nurse.org.nz

Organisations who wish to set up their own pages on the site should contact the College office.



Professional Nursing Supervision Online Service

Nursing Supervision Provided By Nurses For Nurses

The College of Nurses (NZ) recognises that nurses can often find it difficult to locate professional nursing supervisors. As a result, **the College has created the Professional Nursing Supervision webpages, which enable registered nurse supervisors to have their profiles on the College's new website.**

Supervisors apply via the online process to have their profile endorsed, the applications will be reviewed by a 2-person panel of College fellows, experienced in supervision. There is a small application fee and an annual administration fee. Endorsed profiles will be uploaded to the 'Professional Nursing Supervision' webpages. Nurses can then choose which supervisor they would like to approach independently of the College. Supervision arrangements and costs are between the supervisor and supervisee.

Supervisors do not have to be College members, but do need to be a practising registered nurse or nurse practitioner with an annual practising certificate. Supervisors can apply for a profile through the new website http://www.nurse.org.nz/professional-nursing-supervisors.html

The Netherlands

Care -Metric invites you to join a second study tour of healthcare in the Netherlands. In this year's study tour you have the opportunity to observe some of these innovations and strategies close at hand. The aim of this tour is to help you think outside the box about of what is possible and impossible for you. You will hear about the good and the bad and take home ideas and suggestions that inspire you to bring creative solutions to some of your "impossibilities".

The Netherlands is one of the densely populated countries in the world with a population of 17,000,000. Due to their historical focus on trade, the Dutch are well known across the world. New Zealand got its name from Abel Tasman. As he sailed alongside the Marlborough sounds and thought the coastline looked very similar to that of the Dutch province "Zeeland" and so called it New Zealand. Innovation and design are important characteristics of the Dutch culture. These are reflected in its health care system, as it continuously adapts to changes in society, medical innovation and advanced technology.

Last year's tour.

Last years study tour was considered a great succes. "What we saw (with regard to healthcare innovation) in the Netherlands both affirmed what we are doing in NZ and suggested many opportunities for thinking differently (Professor Jenny Carryer)"

Six participants, working in a range of different fields of healthcare in New Zealand,visited aged care facilities, universities, hospitals and quality improvement organisations to get a better understanding of the Dutch healthcare system. Participants got a better understanding what's gone well in New Zealand and also learned new things from the different approaches in the Netherlands.

Programme

Day 1: Sunday 28 May

Our first get together starts at 19.00 hrs at the Van der Valk Hotel in Breukelen. Here you will meet the study tour organisers and the rest of the group. While enjoying a cup of Dutch coffee and home baked Dutch apple cake we will introduce ourselves to one another and share our our expectations for the week. This is followed by a going through the week's programme so everyone is on the same page with regard to expectations.

Day 2: Monday 29 May

Morning:

We will leave the hotel by 08.00 and drive by car to Tilburg for our first visit to the hospital: St Elisabeth Gasthuis. In 2009 this hospital started a program called "Menslievende Zorg" (people loving care). The essence of the programme is to enable all health professionals to get a deep understanding of everything the patient, resident or client is confronted with. The nursing and medical care may be excellent but it is not always experienced that way by the client. The programme challenges healthcare professionals to look differently, act differently and as a result learn different about the needs of patients in hospital.
The programme is introduced by Rita Arts who has been the driving force behind this for the last 5 years. After an introduction and discussion we will tour the hospital where we will see examples of how "Menslievende Zorg" is acted practised on a daily basis. There will be plenty of time for asking questions and discussion. The morning will concluded with a lunch at the hospital restaurant.

Afternoon

Everyone in the Netherlands has compulsory private health care insurance. Understanding how this system works is critical to appreciate why care is organised differently in the Netherlands to countries that have a public healthcare system. In the afternoon we will visit one of the large health insurance companies, "Achmea- Zilveren Kruis" to give us a deeper insight into how care in hospitals and aged care is financed by the Dutch. Last year hearing about the different models of healthcare insurance stimulated profitable discussions through exchanging different viewpoints. The Achmea-Zilveren Kruis organisation is also famous for the introduction of its approach to team work, "het nieuwe werken"
At the end of the day we drive back to Breukelen:

Day 3: Tuesday 30 May

Morning and afternoon

After breakfast we will spend the morning with two Dutch experts on integrated care and quality of care, Prof Guus Schrijvers and Dr Wim Schellekens. Prof Schrijvers recently published the book "Integrated care, better and cheaper" in which he demonstrates that an integrated care approach to healthcare is the way forward to make the best possible care available for everyone. Prof Schrijvers is a health economist and founder and chair of the International Foundation of Integrated Care.
Dr Wim Schellekens was the CEO of the Dutch Institute for Quality Improvement and Chief inspector of Curative Health Care at the Dutch Healthcare inspectorate. He is known for he is his challenging view on the use of data for healthcare quality indicators. In addition to what is going well in the Netherlands, they will both be quite frank about the current challenges in the Netherlands and will be interested what they can learn from New Zealand.

Following an inspirational morning and lunch, we will be visiting a modern age care facility in the afternoon. We visit aged care facility: de Vliedberg in Ouddorp where we will meet Anne-Mieke den Ouden MSc. Anne-Mieke is specialist in dementia care and program leader of the National program for reduction of incorrect use of psychotropic drugs in dementia care and coach / consultant at various healthcare organisations to support them by improving the quality of care.

Day 4: Wednesday 31 May 2017

Morning

We start the day with a vist to the "Buurtzorg" organistion. This organisation has attracted worldwide attention for its revolutionary concept of community care. A self-governing and autonomous team of 12-15 community nurses provides care to a specific local area. The main driver behind this is to empower the best possible care to the client without undue interference above. All professional and management related issues are solved by the team itself with optional coaching support from head office. In 2015 Buurtzorg employed 8,000 nurses in 700 teams nationwide caring for approximately 65,000 clients per year. We will hear how this movement has grown to such a large organisation since began in 2006. They call this new management approach "integrating simplification", which is characterised by a simple flat organisational structure through that provides a wide range of services facilitated by information technology. This will be another exciting morning with the word innovation high on the agenda.

Afternoon

After two and a half days of intense listening, observing and experiencing it is time to relax. From Almelo we drive to the city of Deventer, the city of books. You will have the afternoon and evening off to enjoy this wonderful town alongside the river the IJssel.

Day 5: Thursday 1 June

Morning

During the morning we will meet Marjon van Rijn, PhD candidate, Academic Medical Centre and lecturer at the school of Nursing at Amsterdam University of Applied Sciences. Together with Corine she will tell us more about the successful implementation of the Transitional Care Bridge programme at the Academic Medical Centre (AMC) This program focuses especially on preventing poor outcomes in frail and elderly patients after (acute) hospital admissions.

Afternoon

Around 14.00 hrs we will arrive at the Hogeweijk dementia village in Weesp. This concept of a "closed village" creates a safe environment for people with dementia. Residents live in groups of six in little villas, each villa radiating a specific culture that reflects the client's own (farming, urban, contemporary etc.) The village has its own supermarket, travel agency, restaurant and cinema. We will have a 2.5 hrs guided tour through the village telling us all about the history and innovations that have taken place their over time. Those that participated in last year's study tour rated the visit as the highlight of the week.

Day 6: Friday 2 June

Morning:

In the morning we will meet with officials of the Dutch Healthcare Inspectorate. They will show us how the Dutch government ensures the care for our elderly in the community and aged care facilities is safe and of good quality. This is looking at the care for the elderly from another perspective, the government one. This presentation last year was rated by the group as very informative

Afternoon

In the afternoon we will visit Ambassador Lowe from the New Zealand Embassy in The Hague. She has kindly given an hour of her time to hear how you have experienced engaging with the Dutch Healthcare system. The embassy is a small part of New Zealand on Dutch soil which last year's group found to be a "home from Home". The staff at the Embassy are extremely welcoming and will be very interested to hear about the good the bad and the ugly learnings from the study tour.

Costs

The cost for this study tour are: NZ$ 6,350.00 (GST included)

This includes:

- Costs involved visiting the different organisations
- Travel by car to the various places and organisations
- Wednesday night tour dinner (excluding drinks)

The price **excludes** the cost for the hotel and travel costs to and from the Netherlands / Van der Valk Hotel Breukelen. It also excludes the cost for lunches and other dinners during the week when they are not provided by the hosting organisations. Our place to stay for the week is at the Van der Valk Hotel in Breukelen. This hotel has excellent train connections to either Amsterdam or Utrecht, two famous cities to explore during pre summer evenings. We have made a reservation for a number of rooms at a reduced price (79 Euro per night). The price includes breakfast, WIFI, use of the swimming pool, fitness center and sauna. If you want to make use of this arrangement we can make the booking for you after you paid for this. You are free to stay in another hotel, but you have to look after your own transport from and to the Van der Valk Hotel.

Registration.
The minimum number of participants that must take part is six and the maximum is eight. If you want to take part in this "once in a lifetime" study tour you need to register with the attached form. Your place in taking care for this tour is secured when NZ$ 3000.00 is paid to Care-Metric. The remaining of the cost need to be in our bank account before the 15th of May.

When you are interested to take part in this hosted study tour or want more information please contact Jan Weststrate via email jan@care-metric.com / mobile 021-897605. We look forward to hear from you!

Your personal study tour hosts

Your hosts for this Healthcare study tour are Dr Jan Weststrate and Corine van Maar, MBA. Jan is organising the study tour at this side of the Globe and Corine make sure we are well received in the Netherlands.

Corine is an expert in Transitional elderly care and chair of the 'Care Bridge" learning community. The "Care Bridge learning community gathers knowledge and information at a national level around the care for the elderly in the community, hospitals and aged care facilities and makes this available to the wider public.

Jan heads up Care-Metric, a business that focuses on learning and knowledge development from analysing incident and quality of care data. He also has a position as a Research Fellow at Massey University and is part of the team that organises the National Survey Care Indicator programme in New Zealand.

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
27 April 2017	9.00 am to 1.30 pm	Wellington	Brentwood Hotel Wellington

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 24 March 2017

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
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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.

Nurse Practitioners New Zealand Conference Cluster 2017

Brentwood Hotel

Wellington

NP Development Day - 27th April 2017
Prescribing Workshop - 28th April 2017
NPNZ Professional Issues Day - 29th April 2017

Nurse and Health professional prescribing is gaining momentum within the New Zealand health system and nursing is leading the way with Nurse Practitioner prescribing and now Registered Nurse prescribing well on track to reality.

This conference cluster supports the development of nurse and health practitioner prescribing. This 3 day event covers portfolio preparation and presents comprehensive prescribing practice over 5 prominent areas of nurse prescribing practice. The official NPNZ Professional Issues Day extends the dimension of Nurse Practitioner role presenting NP research and NP models and business opportunities that allow NPs to work at the full extension of their scope.

As we move in to the future with health practitioner prescribing the question that becomes evident is "***are we making a difference to health care delivery***". This question will be the topic of debate on the Professional Issues Day.

These conference events are open to all those with an interest in prescribing medication and advanced nursing practice. Attendance at this conference cluster will be a favourable professional development component for any health professional considering a future in prescribing.

Register Online:
www.nurse.org.nz/workshops

Nurse Practitioners New Zealand

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

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

www.nurse.org.nz

College of Nurses Aotearoa (NZ) Inc
Life Members

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