



TE PUAWAI

The Blossoming

The Professional Update for Registered Nurses

May 2018



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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



Professor Jenny Carryer

Health Workforce NZ has just hosted two one day workshops to consider nursing, midwifery and the medical workforces. The days followed a high-profile workforce conference in Queenstown attended by a number of world recognised experts in health workforce development. The purpose of these two days was to share the experts with a wider audience and to progress thinking about workforce challenges.

Day one was to consider medicine and was attended by medical personnel, midwifery, nursing and the Kaiawhena workforce representatives along with HWNZ staff. Day two examining nursing and midwifery was almost exclusively attended by only nursing and midwifery representatives as well as HWNZ staff again. I was most intrigued that only nursing and midwifery seem to understand and respect the need and impetus for us to think in a multi-disciplinary

fashion. I was especially surprised that Kaiawhena workforce leaders chose the medical day rather than the nursing day given how closely our particular workforces connect on a daily basis.

Many of the international experts present made thought provoking contributions and in this brief editorial I would like to share some snippets of that wisdom and reflect on its relevance.

Dr Tom Aretz, Partners Healthcare International USA noted that health is what happens *between* visits to clinicians. He suggested that health is 40% personal behaviour, 30% genetic, 15% social determinants and 15% clinical care. Obviously as nurses we recognize that behaviour and the impact of social determinants are also closely related so the message is clear. Making a difference to health requires attention to the most broad determinants of health and requires us all to act beyond the limits of clinic walls.

Prof Erin Fraher PHD, MPP, Assistant Professor – UNCChapel Hill made the unequivocal statement that thinking of workforce in terms of the numbers needed is completely wrong. Rather we should be thinking about people and patients and asking ourselves what it is they need. Erin introduced a model of plasticity wherein we consider shifting responsibilities both between professions and between settings.

Professor Ivy Bourgeault from the University of Ottawa delivered a strong message that gender matters!! And that gender always matters!! She noted how highly gendered the workforce is but how rarely we focus on female friendly workplaces and conditions. She noted the endless increase in the focus on measurement, increasing violence from patients, families and colleagues and the sheer stress of many clinical positions. Prof Bourgeault talked about increasing cognitive dissonance for health workers as they battle compassion fatigue and moral distress.



On day two there was a focus on retention and some key points which enhance retention. These seem enormously pertinent to nursing and include: the need for flexibility, family friendliness and work life balance. She noted it is important for nurses to have a voice at all levels of the organization, control over their practice and the presence of genuine teamwork with multidisciplinary respect.

In the same week that I attended this workshop I was marking a practice exercise completed by 15 masters students (primary health care nurses) at Massey University. In the course of this exercise students shared a weekly practice scenario with another student then cross reflected on those scenarios asking several questions about alignment with community and patient need and systems issues that impact on service delivery. Having read all of them now I am both profoundly moved and deeply frustrated. It is clear to me having now marked this exercise three years running that the level of clinical responsibility taken by nurses especially in general practice has escalated significantly. That is a good thing and to be welcomed. However, there is no concomitant recognition either personally or monetarily and the illusion is strongly maintained that these nurses are simply assisting the GP in his or her great work. Those in aged care settings make very clear also the constant tension between the motives of private business and the agenda of patient welfare.

I felt enormous frustration reading student accounts that there is almost no attention paid to any of the matters outlined by our visiting experts. Registered nurses in these settings are working incredibly hard, have taken on enormous additional responsibilities in many cases, and have invested time and energy and often money as well in postgraduate education. At the same time their contribution is very much taken for granted, often rendered invisible and certainly not significantly remunerated. Most importantly they all report little opportunity to really align their service with community or patient need thus causing the very cognitive dissonance and moral distress that our visiting speakers outlined.

Moving House or Changing Job

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Registered and Enrolled Nurses' Experiences with Direction and Delegation

Article by Dr Margaret Hughes, Dr Ray Kirk and Dr Ali Dixon

Introduction

This article describes the findings of a narrative inquiry into Registered and Enrolled nurses' experiences with direction and delegation. Thirty-six nurse participants shared their stories about the delegation interactions they had been involved in, and in doing so revealed how they made sense of both direction *and* delegation. When the nurses' stories were brought together as a final narrative it was clear that each nurse understood direction and delegation in different ways, however a desire to nurse professionally, and to keep the patient safe shaped all the delegation decisions they made.

Meeting direction and delegation competence

While the Nurse Practitioner Scope of Practice does not mention direction or delegation (Nursing Council New Zealand, 2017), the Registered Nurse, and the Enrolled Nurse are required to provide proof of continuing competence based on the competencies associated with their Scope of Practice. For the Registered and Enrolled Nurse, this includes an understanding and competence with the role of directing and delegating, or being directed and delegated to, in order to continue to receive the annual practicing certificate (Nursing Council New Zealand, 2007, 2012; Nursing Council of New Zealand, 2011b).

Direction, delegation, allocation or supervision?

In order to know and understand how to carry out this professional accountability, nurses need to be able to define and explain the terms. In this study the nurse participants have used the terms direction or delegation interchangeably, or the three words, *direction and delegation*, were continually run together to form one phrase. While, some of the nurse participants were able to provide a definition of direction or delegation from the guidelines (Nursing Council of New Zealand, 2011b), when asked to distinguish between direction or delegation and the meaning of the terms in practice, most of the nurse participants were not able to do so. Nearly all participants interviewed failed to meet the criteria for a *delegation* interaction (Nursing Council of New Zealand, 2011b) and when asked about their delegation experiences, described a form of *allocation*. An allocation model omits the many skills required of safe and effective *delegation* interactions such as a diplomatic assessment of the Enrolled Nurse, advanced communication and leadership skills.

In addition, even though the term *supervision* has not been in use for some years, many nurse participants continued to use this term.

Who is accountable and when?

While Enrolled Nurses in this study were clear that they were responsible for the nursing care they delivered, most of the Registered Nurse participants incorrectly believed that they were responsible for the Enrolled Nurses practice. Additionally, the Registered Nurse failed to recognise that they were responsible for delegating or directing, not the Enrolled Nurses' practice.

Both Registered and Enrolled Nurses were confused about what an Enrolled Nurse could and could not do in different workplace settings. Compounding this was a lack of "local area policy" to guide them in their decision-making, as the tasks and skills that could be safely delegated could change between specialised practice settings. Local area policy was a term coined in the study that represented access to up to date, workplace relevant guidance related to what an Enrolled Nurse could do in a specific workplace setting. Although there were District Health Board policies available in some places these merely reflected minor aspects and generic information taken directly from the guidelines, such as definitions, but did not provide the relevant roles and responsibilities information nurses indicated that they needed.

Some new and inexperienced Registered Nurses did not delegate to experienced Enrolled Nurses because they felt that it would "not be tolerated". Conversely, some Enrolled Nurses did not encourage a delegation interaction from a Registered Nurse because they did not trust the knowledge of the new (to the specialised workplace), inexperienced nurse, or casual (agency) Registered Nurse. Inexperience for the purposes of this study, was defined as less than five years' nursing experience. One Enrolled Nurse described, "going higher" to get the advice she needed to keep her patients safe, as she did not trust the advice from her often new or casual Registered Nurse buddy. Other Enrolled Nurse participants described doing their own assessment of the Registered Nurse, and deciding to work alone as they were concerned about the lack of competence of the Registered Nurse in their specialised clinical setting. This concern then led to questioning the Registered Nurse's ability to delegate tasks and skills. There was no recognition from either the Registered or Enrolled Nurse that these situations meant that both the Registered and Enrolled Nurse was "working outside the Scope of Practice" because they were not in a delegation relationship. This often-used phrase represented a nurse doing a task they should not be doing, and overwhelmingly referred to administration of medications only.

Another variant of this pattern within the nurses stories was that some Registered Nurses over managed the delegation interaction by becoming over-involved once the task had been delegated, and some under-managed by refusing to help the Enrolled Nurse, or refusing to sign off the Enrolled Nurses progress notes when required.

Access to information about direction and delegation

All the nurse participants expressed frustration with the lack of information related to delegation from nursing leadership. Nursing leadership in this context refers to nurses in authority and influence who could lead and develop practice and who were responsible for service delivery (Carryer, Gardner, Dunn, & Gardner, 2007). The stories the nurse participants shared centered around three main areas of responsibility. Firstly, nursing leadership at workplace level who had not provided guidance, leadership or in-service sessions about the Enrolled Nurse role, change in Scope of Practice, or direction and delegation roles and responsibilities. While in-service sessions

such as smoking cessation, ISBAR and falls prevention was compulsory, guidance related to direction and delegation interactions was absent and this led to misunderstandings related to the role. One Registered nurse participant described this as “remiss” of nursing leadership, and another described how she had received information about delegation through an email attachment. Her perception was that nurses were expected to know “inherently” how to delegate, and this was not the case in her experience. Additionally, Nurse Leaders as managers did not factor delegation in to nursing workloads. One Registered Nurse, in describing the advanced skills she uses during delegation, showed that good delegation took time, and the skills were invisible to the uninitiated.

Nurses in this study have described working within either a geographical or a primary model of nursing care even though team nursing has been identified in the Enrolled Nurse Scope of Practice as the model of nursing care required for Enrolled Nurses in acute settings (Nursing Council New Zealand, 2012). A team model of nursing supports the *delegation of patients* rather than an *allocation of patient load*. *Delegation of patients* is based on the level, confidence and experience of the nurse being delegated to, the complexity of the tasks or skill or patient condition being delegated, the skill mix, the supports and resources available in the environment and the acuteness or otherwise of the environment where nursing work takes place.

Secondly, some of the nurse participants pointed to a lack of guidance and information from the national level of nursing leadership. Most of the nurse participants found the current guidelines (Nursing Council of New Zealand, 2011a, 2011b) so generic, that they were not helpful. The nurse participants called for more information about what an Enrolled Nurse could do, and strategies, problem-solving examples, consequences of poor delegation and FAQs related to how to do both delegation *and* direction, safely and effectively.

Lastly, many of the nurses questioned the direction and delegation knowledge taught to students. One Registered Nurse participant pointed to the influence that the Dedicated Education Unit had in her area to role model the skills and knowledge needed for “good” delegation interactions. Many of the nurses though were not new to the nursing world, but had graduated at a time when a Registered Nurse only workforce had been encouraged, and they had not worked with an Enrolled Nurse. This influenced their knowledge of direction and delegation, and working with a second level nurse. This was especially true for new inexperienced Enrolled Nurses who graduated expecting to be directed or delegated to, but had to seek it out, or search for it.

Conclusion

While there is no dispute that there is some guidance for New Zealand nurses about the professional accountability to direct or delegate, and a broad approach to disseminating information about direction or delegation is required, there appears to be a lack of guidance and information that both Registered and Enrolled Nurses indicated they needed. A lack of leadership by nurse leaders resulted in a paucity of guidance relevant to the specific nursing workplace. There was also a perception that delegation was time consuming. Coupled with poor partnerships between Registered and Enrolled Nurse a reluctance to be delegate, or be delegated to, resulted in a failure to lead the delegation interaction or assess the other level or category of ‘nurse’.



These barriers to safe and effective direction and delegation relationships are not insurmountable, but left untreated can inadvertently lead to reduced quality care and reduced patient safety.

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Nurse Led Footcare: Managing Toenails in Elderly and Disabled Patients

Article by Heather Woods RN

Introduction

Registered nurses conducting assessment and care planning are in a position to make a substantial difference to the health, wellbeing, and safety of patients. Elderly and/or disabled patients often present with foot conditions which they find difficult to manage and may initially look to primary healthcare services for information regarding how best to care for their feet. The purpose of this article is to raise awareness for registered nurses regarding the importance of foot health, and to showcase a nurse entrepreneur.

Challenges: Why foot care may be difficult to manage.

“Foot Care is a very important part of Personal Care, especially for those who are unable to care for their own feet due to comorbidity such as diabetes, or advanced age.” (Waitemata District Health Board, 2018). Anyone who has damaged their own toe will agree, there’s no doubt that foot hygiene and health is important for a sense of well-being and has a significant impact on comfort and mobility. Research supports the fact that 80% of people over the age of 80 years find managing their nails difficult. This may be due to poor eyesight, poor balance, reduced flexibility, arthritis obesity, shortness of breath, pain, tremor, weak hand muscles, dizziness or other chronic health conditions such as diabetes (Daly et al., 2014) or rheumatoid arthritis (Rome, Gow, Dalbeth, & Chapman, 2009).

As a result, there may be problems with the feet such as overlapping toes, tenderness, or open areas. Nails may also present problems with shape, thickness, fungal infection, or edges that are prone to in-grow. Previous injury to feet, toes, or nails can also make them difficult to manage. Nail care is an important part of personal care, and registered nurses are in a pivotal position (Daly et al., 2014; Peterson & Virden, 2013) to help meet challenges that increasing demand for assistance with personal care and support for our aging population presents (University of Auckland, 2017).

Risk related to unidentified need for assistance with foot care:

Pain: The patient may be suffering pain from long nails dragging on sheets, carpet, socks, or shoes. Long toenails may be digging into the toes in various ways. Corn or calluses may be present on the toes or soles, making each step a challenge.

Reduced mobility: This pain can result in reduced or unstable mobility, which can negatively affect quality of life, independence, exercise, concentration, demeanour, and mood.

Injury: Long toenails can cut either the underside of the toe if they curl under, or the side of an adjacent toe.

Accidental injury. People can accidentally cut their toes when they are trying to cut their toenails, unfortunately these injuries can become infected, or in the case of patients with diabetes (Daly et al., 2014) extremely difficult to heal. Keller-Senn, Probst, Imhof, and Imhof (2015) note that any changes in feet, nails and skin of patients with diabetes should be assessed and treated as soon as possible. In extreme cases gangrene can become established if circulation to the feet and toes is compromised, resulting in amputations that could have been avoided.

Practicalities: What you can do to help.

There are a number of simple, practical ways to assist with foot care. Number one is regular assessment of the feet of people with diabetes (Keller-Senn et al., 2015), or patients who complain about painful feet, nails, or other related issues. This is a significantly important part of patient assessment. Nurses are then able provide these assessments and then plan care, monitoring and guidance regarding foot care. This may include advocating regular professional foot care or referral to a specialist provider.

As part of the holistic care you provide, you should often ask elderly and disabled patients how they manage their foot and nail care, undertake a general assessment and discuss ongoing management options with them.

Process: Access to Foot Care providers:

There are a variety of foot care services in the general community, including podiatry clinics, community foot care clinics, beauty therapy clinics, and visiting registered nurses providing basic foot care in the home. Clients may need assistance from a GP or practice nurse (Keller-Senn et al., 2015) to access these services.

Procedure:

Any initial registered nurse assessment (Rome et al., 2009) of feet and nails should include, contact details, clinical history and expectations. Examine skin, feet, toes and legs for colour, oedema, inflammation, deformity, pain, evidence of disease or injury, skin integrity fragility and elasticity. Nails are examined for pain, thickness, brittleness, shape, contour, and infection. A plan of care is discussed with the client regarding the immediate needs and ongoing care of their feet and nails.

Basic foot care includes: trimming and filing of toenails, reduction of corns and calluses, cleaning and dressing of any open areas, and sanitiser with moisturiser is applied to the feet and toes. Cream may be massaged into dry skin. Fingernails may be cut and filed at the same time that foot care is provided, if requested by the client and/or offered by the service provider.

Ongoing care a follow-up appointment may be made at either a 4-6-8 or 12-week intervals, dependent upon client requirements, or a client may be directed to a Mobile Foot Care Community Clinic if they wish to explore that option.

Cost:

The cost of footcare may range from \$45 to \$105 per visit, or \$25 at a Community Clinic.

Clients with Diabetes can access some free foot care from a Podiatrist via a GP referral.

WINZ may reimburse foot care costs using the Disability Allowance via receipt.

ACC: <https://www.acc.co.nz/im-injured/injuries-we-cover/treatment-we-pay-for/>

Clinical Example:

Mobile community foot care clinic: Registered Nurse provider

I am a registered nurse based in the Canterbury region. Requests for affordable foot care for people unable to travel to clinics were received from GPs and practice nurses were made directly to me. This section describes my journey in setting up and managing 'Mobile Foot Care'.



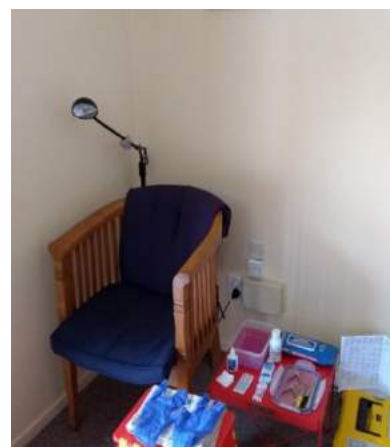
I initially had to invest time and finances to prepare for the role by working as a Foot Care Assistant with a Podiatrist for a year. During this time, I learned basic foot care, including care of nails, corns, and calluses. The training Podiatrist was enthusiastic and supportive about a registered nurse providing a low cost, mobile, domiciliary, foot care service, because he could see the need for it and believed that Podiatrists would not be interested in providing such a service. I would refer clients needing advanced care back to him.

There is certainly benefit in a registered nurse providing this service, and combining Nursing knowledge, assessment skills and nursing philosophy within a Foot Care Service. As a registered nurse I can also assess, plan, evaluate and understand specific,

unusual, or challenging needs or behaviours related to disabilities such as physical, psychiatric, neurological, sensory, intellectual disability or dementia.

At the time of my preparation, I also completed a Person-Centred Counselling Diploma at Christchurch Polytech which fine-tuned my ability to listen and respond effectively during the inevitable conversations which arise during home visits (New Zealand Nursing Review, 2014). Broader health related questions often arise, providing the opportunity for health education and if required, referral to a GP or other Health Service.

The home visit by a friendly, professional registered nurse is often as valued by the client as much as the foot care. Patients have reported a feeling of *total wellbeing* following the consultation, not just the fact that their feet feel much better.



Community Foot Care Clinics:

At the request of a rural GP, I established community Foot Care Clinics in Kaiapoi and Christchurch, which I run one day per month. In this service, which is at a minimal charge, toenails and fingernails are cut and filed, and feet receive basic foot care.

Heather Woods is a Registered Nurse Clinical Nurse Specialist who has been operating Mobile Foot Care for 28 years, it is a private business based in North Canterbury.



Heather Woods RN

Collaborative approach:

Foot care involves liaison between many health professionals, including GP's, practice nurses, district nursing, hospitals, occupational health, palliative care, ACC, aged and residential care facilities, podiatrists, chemists, carers, beauty therapists, emergency care workers, diabetes centre, elderly day care centre staff, and social services. Nurses retain a pivotal role in helping to coordinate and plan (Keller-Senn et al., 2015).

Foot care services are currently being reviewed in other regions of the country (Waitemata District Health Board, 2018), though not using Registered Nurses.

Education for registered nurses in basic and advanced foot care:

The Ontario College of Health Studies in Canada has a well-established Foot Care Nurse System and offers online education (College of Health Studies, 2018) to registered nurses and nurse practitioners worldwide.



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HQSC Inaugural ‘Let’s Talk: Our Communities, Our Health’ Conference

Report by Faith Mahony RN

The Health Quality & Safety Commission New Zealand held their inaugural ‘Let’s Talk: Our Communities, Our Health’ conference at Te Papa Tongarewa, Wellington, on the 8th and 9th of March 2018. The conference was attended by more than 250 health professionals, providers and consumers.

The aim of the conference was to engage with people and communities to improve the quality and safety of the health and disability system. There was a strong focus on consumer engagement and giving consumers a forum to share about how they manage and advocate for their and their loved one’s health care.

The first speaker, Te Rina Ruru shared her experience of what happened when her brother sustained a significant brain injury. Her talk covered not only what happened to her brother but also the impact on the family and how the health system didn’t always provide the expected care and support.

“What is normal – our normal changed in an instance. No one explained what had happened to him (he looked perfect) and what was ahead. The weight of trying to cope, the costs and complexity of navigating the health system. A 16-year-old sibling coping alone”

I found this talk challenging and painful to listen to. I felt for their pain, I despaired over the gaps in care and I recalled instances from my own family when more support could have addressed issues that had lasting impact.

Dr Lynne Maher the Director of Innovation at Ko Awatea, Counties Manukau Health in her excellent talk about co-design caused me to really stop and reflect when she spoke about a consumer’s comment;

“I am the only one who is consistent in my care. I am the expert in me.”

During a session about measuring and improving the patient experience, questions that were explored were; Did the consumer get told information in a way they understood? Was communication effective, were health and consumer in partnership, did coordination of care occur and were physical and emotional needs met?

In Janine Shepherd’s talk ‘A broken body is not a broken person’ she shared about her recovery following a serious accident. Janine is alive because the paramedic refused to accept a clinical decision.

“She’s not going to die on my watch. There’s more we can do”

Janine asked us to speak out. How can I enable staff to challenge the status quo?



Jake Bailey, who rose to fame at 18 for his inspiring end of year talk, shared about the litany of problems that occurred during his care. Despite these issues Jake stressed his gratitude to the team who looked after him.

*“What set them apart;
Saw us (Jake and family) as part of team
Asked for difficult questions
Awareness of loneliness of isolation
Balance of caution vs comfort
Made an effort to get to know me
Passionate
Humble
Visited me, hugged me”*

I presented on Improving Health Literacy for Patient's with CVD on behalf of Dr Sue Well and the co-investigators. Our study was undertaken in the cardiology outpatient departments of Counties Manukau and Hutt Valley with Māori, Pacific and others. The study explored on-line health information needs to support cardiovascular health literacy and lifestyle behaviour change. When there is difficulty searching for health information some of the users of any resulting information have a heightened chance of finding miss-information rather than soundly based information. Our study has subsequently developed a theory of increased vulnerability relating to this difficulty searching. This information suggests focus on supporting health and computer literacy is a vital component of addressing health needs in this population.

I highly recommend more nurses consider attending this conference next year. I thought I was sensitive to the needs of patients / consumers / family, I came away humbled. I'm checking in more with those I have the privilege of interacting with that what I'm doing is of help and they and I understand what is happening. They are the expert in them and their needs.

I am very grateful for the support provided by the College of Nurses scholarship fund which enabled me to attend this conference.

Sustainability In Healthcare

Report by Rebecca Sinclair, RN PgDip SCPHN, Public Health Nurse



Rebecca Sinclair

In November last year, I had the pleasure of attending the inaugural Sustainability in Healthcare Forum in Wellington on behalf of The College of Nurses Aotearoa. It was organised by OraTaiao: New Zealand Climate and Health Council, which is a group of health professionals calling for urgent action on climate change. It was fast paced, informative and very inspiring. Around 80 health professionals from many disciplines all over the country were in attendance, with many more tuning in online to view the live-stream event.

The day started with a reflection on the public health revolution, then the high-tech revolution, and now we enter into the environmental revolution. Both The Lancet medical journal and the World Health Organisation recognise that “Climate change is the greatest threat to global health in the 21st century” (WHO, 2015) and at the same time, also offers us the greatest public health opportunity to improve health and a fairer distribution of health.

There was an update on the science around climate change and what we can expect, such as weather extremes, heatwaves and higher temperatures, sea level rise, increased frequency and severity of storms, heavier rain fall and more droughts. These can impact negatively on health and will have the greatest impact on those already experiencing inequality in health or social disadvantage. If the planet warms by 3-4°C half of the world’s coastal cities would be gone, displacing 100 million people, including some of our Pacific Island neighbours where the islands will disappear under rising seas. Overall, human health is better than ever before, however there are still huge disparities in lifespan between the rich and poor.

The Royal Society Te Aparangi (2017) have published an evidence summary of the Human Health Impacts of Climate Change specific to New Zealand. This goes into detail about the building blocks of health, with which we are all familiar, such as air, food, water, shelter, disease, community, temperature and well-being, and what the implications are of climate change, such as increased flooding, fires, damage to infrastructure, changing disease outbreak patterns. Threats to health can be direct such as causing injury or worsening illness, or changing patterns of infectious diseases, changes to water and food supply, change of livelihood, community disruption, forced migration and conflict. Globally, 2016 and 2017 were the hottest years on record, with New Zealand having the hottest January ever in 2018. If greenhouse gases continue to rise, many parts of New Zealand may experience more than 80 days a year with temperatures above 25°C by the year 2100, which is more than double what we experience now, and would contribute to more heat related deaths.

There were 19 presentations on a variety of topics and these are available on the Ora Taiao website. Some of my personal highlights were: Dr Hayley Bennett (Public Health Physician) who

spoke about the co-benefits to the health sector of sustainability, climate change mitigation and adaptive action. We will need more of that adaptation as there are limits to this strategy. Some of the wins include health gain, cost savings, quality, equity and increased resilience. The health sector is responsible for around 3-8% of total greenhouse gas emissions in New Zealand. (The agriculture and energy sectors are the two largest contributors to New Zealand's gross emissions).

Another consideration is Te Tiriti O Waitangi and how we work together to protect the impact of climate change on the hauora (health) of Maori.

Dr David Galler (Intensive Care Consultant) spoke about his work to reduce highly potent anaesthetic gases as these are many times more damaging to the warming of the atmosphere than carbon. By working with anaesthetists he's been able to support them in choosing a less potent option and contribute to the reduction of the carbon footprint at Counties Manukau DHB.

William Van Ausdel spoke about Woodford Community Gardens on the hospital grounds which supports those clients who have experienced mental ill health with opportunities to learn how to grow their own vegetables and for personal growth e.g. communication skills and shop keeping. The produce is organic, locally grown and available for both clients and staff.

A highlight of the day was a visit from Julie Ann Genter MP, who announced that her new role as Associate Health Minister will, for the first time, include climate change. This is such a positive step to have these roles together as they are so closely intertwined with the changing climate having a direct impact on human health and well-being. The New Zealand Government has set the target to reduce our carbon emissions to zero by 2050, by which time I'll (hopefully) be in my 70's. We are certainly going to need more than just recycling to get our emissions down.

As Nurses we have a unique role as trusted health professionals working with individuals and their families and we are also able to call for policy change. We can be role models and advocates at both local and national levels. The actions we take now may not show up in the environment for another 20 years, but the benefits to our health start now!

So, what can we do?

Action to reduce our greenhouse gas emissions can bring co-benefits to both human health and the environment. "Health gains are possible for heart disease, cancer, obesity, diabetes, respiratory disease, and mental health", which would also have cost savings for the health system and help reduce greenhouse gas emissions (Ora Taiao, 2017).

We can educate ourselves around climate change and the risks to health, particularly as they relate to our area of clinical practice. For example, respiratory health where George et al, (2017) describe the eight deaths that occurred in Australia after a severe thunderstorm triggered asthma attacks after a release of dangerous levels of pollen, or where older people are disproportionately affected (Leyva et al, 2017), and also women, children, marginalised communities and those living with mental health disorders are more vulnerable (Kurth, 2017). Nurses in community settings can help clients access support for home insulation as this reduces energy emissions and those who live in warm, dry homes experience better health and less hospitalisations e.g. children with asthma.

As we discuss lifestyle options with clients around physical activity, walking and cycling, this reduces transport emissions that contribute to air pollution and improves fitness and reduces the risk of heart disease, obesity and diabetes. Another benefit of nurses supporting clients to maintain healthy weight and lifestyles is a reduction in the need for surgery and use of highly potent anaesthetic gases that are released into the atmosphere. Reducing red meat intake and eating a more plant-based diet of fruit, vegetables and legumes helps cut greenhouse gas emissions from animal agriculture and decreases the risk of bowel cancer and heart disease. There is also an opportunity for us to lead the way as health professionals in choosing these lifestyle options for ourselves, for example learning how to cook a vegetarian or vegan meal, if we don't already know how, or cycling and advocating for safe streets to ride on. Choosing tap water and reusable cups or bottles over single use plastic bottle drinks saves money and reduces plastic in the environment which can take hundreds of years to decompose, is cluttering up the oceans and is making its way into the food chain e.g. tiny pieces of plastic are being found in fish.

Climate change is in the media on a daily basis and it seems as though there is an increasing shift in perception from "is it real?" or "that's not a problem", to people being more concerned and seeing the effects of global warming and extreme weather events as happening already. Here I can see a parallel with my work around immunisation and antivaxxers. We speak from an evidence-based perspective and work alongside patients to help them make informed choices around their health, and in this case, the health of the environment too.

Nurses can promote efforts to reduce the carbon footprint in the workplace e.g. waste, purchasing and energy use. Carbon footprints could become standard parts of care pathways and taken into consideration for any new service development or project work. We can develop Green Teams in our work settings and consider the items we use. Do we really need so many disposable single use items? Think refuse, reduce, reuse, recycle. Switching off the computer at night saves energy and around \$120 per year. Or, taking turns to take home food waste to compost and save on waste. It just takes one person to get started and get the team on board. Start with the changes that are the easy changes!

We can speak up about the use of coal in the health sector. For example, there are currently 37 coal boilers in New Zealand hospital's which impacts on both the health of the environment and on the local community's air quality. There is a paradox in that the health system is here to keep us well but is also causing harm and contributing to poor air quality and pollution.

Nurses working in primary health care may be interested in the 'Greening Your Practice Toolkit' (2010) which has been "developed to assist with individual general practices making environmentally responsible changes where possible in the day-to-day running of their practice". For example, it was discussed during the forum that some people, particularly the elderly, can feel the need to come away "with a script" to make the visit to the doctors worthwhile, then end up with boxes and boxes of unused medicine at home. Practice nurses could spend time with clients to review medications so they are not being prescribed more than they need or are using. This both enhances their health and reduces unnecessary waste and carbon emissions.

We can write to the local paper or tell our MP what local issues we care about and want to see action on. We can change our bank and superannuation provider to one that doesn't invest in fossil fuels and tell others about what we are doing and why. We can offset our emissions at www.ekos.org.nz.



We can talk to friends and family about the issues that concern us and changes we are making.

Nurses are well respected and trusted members of society and it is our duty of care to advocate for the biggest threat to public health that our generation faces. Nurses are the largest group of health professionals and together we can make a difference. As we transition to a more sustainable and resilient way of life, this will offer huge benefits to human health and the environment. Hopefully this event will be on again next year as it was inspiring, provided a wealth of information and the opportunity to network with other health professionals also passionate about climate change and health.

To join Ora Taiao: The NZ Climate and Health Council visit: http://www.orataiao.org.nz/join_us

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Self -Employment Resources For New Zealand Registered Nurses and Nurse Practitioners

A suite of resources has been created to support nurses considering self-employment or building a business

Planning a new business can feel daunting, especially for registered nurses and nurse practitioners, as unlike midwifery, physiotherapy or general practice, the New Zealand nursing profession does not have a strong history of self-employment. Setting up a business in New Zealand is relatively easy but there are pitfalls and complexities to be aware of for the ongoing running of a business big or small.

If you are considering solo-self-employment or becoming an employer, there are links in this specially designed resource kit to support you at each stage, from set-up to self-care, as well as how to maintain your money and your professional nursing registration.

The number of self-employed RN and NP is still an extremely low proportion of the nursing workforce but it is slowly and steadily growing. Often, nurses have the skillset to be able to provide a service but lack the knowledge of how to manage the finances, taxes, insurances and regulatory requirements for business set up.



Whether you are considering solo self-employment or becoming an employer, sole trader or limited liability company, this College of Nurses (NZ) resource, will guide you to links and supports to help you on the next chapter of your career.

The resource sections are:

Planning, first steps: Information to help you make decisions around the direction you want to take, how to position your business, how to check your markets and to assess how you will get work.

Set up, business structure, marketing, tools for business: Businesses come in many shapes and sizes, but there are some fundamental similarities. These include needing a memorable name, registering your company, filing an annual return and deciding on your business structure.

Finance: Invoicing and tax: Finance, invoicing and tax considerations are often the steepest learning curve for people new to running a business. Let's face it, you are probably an expert in the work, but not many nurses have had to calculate bi-monthly GST or send monthly invoices before.

Security/ Insurance/ Indemnity/ privacy: Security and insurance is not something nurses need to consider as employees, however as an employer or solo self-employed, your insurance and security become vital.

Nursing regulatory requirements: Nurses who move into self-employment in *non-clinical* roles will often ask if they need to maintain an Annual Practicing Certificate (APC) from the Nursing Council of New Zealand. Check in these links to make sure you meet your regulatory requirements.

Self-care: Research shows that people running their own business often forget to look after the one person needed to keep things going, themselves.

SELF-EMPLOYMENT RESOURCES FOR REGISTERED NURSES AND NURSE PRACTITIONERS

IN THIS SECTION







THIS SUITE OF RESOURCES IS DESIGNED TO SUPPORT NURSES CONSIDERING SELF-EMPLOYMENT OR BUILDING A BUSINESS.

Planning a new business can feel daunting, especially for registered nurses and nurse practitioners, as unlike midwifery, physiotherapy or general practice, the New Zealand nursing profession does not have a strong history of self-employment.

You may be considering solo-self-employment or becoming an employer. Whichever you chose there are links in this resource kit to support you at each stage, from set-up to self-care, as well as how to maintain your money and your professional nursing registration.

The resource comes with links to the professional supervisor's page on the College of Nurses website, but for specific enquiries about setting up a business in nursing please contact the College office on admin@nurse.org.nz

**Note: We have provided examples of service providers in the supplied links. These are only examples, not recommendations; please do your homework before selecting a service provider, make sure they suit your personal business requirements, location and budget.*

 Planning, first steps	 Set up: Business structure, marketing, tools for business	 Finance: Invoicing and tax
 Security/ Insurance/ Indemnity/ privacy	 Nursing Regulatory requirements	 Self-care

[Self-Employment Resources for Registered Nurses and Nurse Practitioners](#)

Liz Manning
Operational Manager
College of Nurses Aotearoa (NZ) Inc

Aged Care In Japan

Article by Alyson Kana, Senior Policy Analyst, New Zealand Aged Care Association

In the last two weeks of February I had the privilege of being invited by the Japanese Government to participate in the *Community Core Leaders Development Program* for the 2017 fiscal year. I joined a delegation of 13 New Zealanders between the ages of 23 and 40 from not-for-profit organisations who worked in the fields of older people, youth and disability alongside delegations from Austria and Germany.

Each year the Japanese Government offers this programme to three countries inviting delegates in from the three fields of older people, youth and disability to share their knowledge and experience from their own country and to learn what is happening in the same fields in Japan.

Preventative care

During my time in Japan, and specifically in Oita Prefecture as a member of the field of older persons delegation, I gained valuable insight into how Japan has prepared and is preparing for its ageing population. This is an area in which our country, in my view, is yet to make significant progress.

In 2012, Japan underwent a fundamental shift in the way it viewed its older population. It recognised that due to the sheer number of people reaching older age in Japan and living longer, that by 2025 services for this population group would no longer be sustainable. This resulted in a holistic shift in the way services and care are provided from that of supportive care to a preventative care model. Part of this shift was led by a top-down approach from the Japanese Government, including the law stating Japanese people must strive to maintain their health.

Not only is there a top-down approach about the services and care for its older population from the Japanese Government but Prefectural and Municipal governments have the same approach. This is what we experienced and were part of in Oita Prefecture. However, not all approaches to the services and care for older people are top-down. There are many examples that are bottom-up, led by members of the community and empowering people to participate for their own benefit. In my opinion the use of both of these approaches is leading to a system that is working effectively towards the overall aim of having a population that strives to maintain its health.

The approach to the services and care of older people in Oita Prefecture was an excellent example of preventative care. With the highest number of older people in Japan and 18% of older people needing care, Oita has a focus on the needs of those with lower care requirements. They are also facing social issues of older people living alone and households with at least one aged family member.

One area of focus in preventative care is daily life support and enabling individuals. The municipal government empowers the older people in Oita to carry out their own preventative care. Older people are encouraged to take part in exercise activities that use local natural resources to increase their health. Our delegation was fortunate to experience the exercise programme in the local onsen (hot spring and bathing facility) with the Yunnaka Exercise Club (Figure 1).

This is an example of the onsen making the exercise easier and is effective for easing stiffness and pain. Attendees experience positive outcomes of increased health factors, level of social wellbeing and mental and physical fitness.



Figure 1: Field of older people delegation participating in the exercise programme in the local onsen with the Yunnaka Exercise Club

Older people in Oita also organise and participate in local groups that increase their overall health. There are community groups of older people in Oita that meet regularly, such as weekly or monthly. Participants are involved in strengthening exercises (Figure 2), talks on nutrition, oral care and cooking, as well as lifestyle related disease prevention, such as co-ordination and brain function activities to prevent dementia. These community groups, although initiated by co-ordinators from the municipal government, are solely organised by local older people who participate in the groups. This means older people are empowered to do things towards their own health.

Health promotion and prevention is not only aimed at the older people in Oita, but it is aimed at all age groups. Nutrition education occurs across all age groups as well as a local walking steps programme. The walking steps programme challenges people to walk a set number of steps every day depending on age. This programme is used to encourage people of all ages to stay active.



Figure 2: Field of older people delegation participating in strengthening exercises with locals who organise the community groups

Workforce issues

The aged care sector in Japan and that of Austria and Germany face similar issues to that of New Zealand when it comes to the recruitment of staff. However, where staff are recruited from in Japan is significantly different to that of Austria, Germany and New Zealand. The latter three countries rely heavily on migration to have the workforce to support their aged care sector. In Austria and Germany migrants come from Eastern Europe to support the aged care sector. An example of this working well is when staff go to Austria and Germany to work but they remain resident in their home country. Two staff rotate a month at a time living where they work in Austria or Germany. They work one month away from home and then return to their home country for a month off, while a second migrant does the opposite. This model is working well for both countries. In New Zealand we also rely on migrants in our aged care sector but due to our location people migrate here permanently¹ (though immigration law changes made in August 2017 have altered migrants' ability to remain in New Zealand permanently). In contrast, in Japan they do not rely on migrants for their aged care workforce. Japan does not have the same type of immigration policies as Austria, Germany and New Zealand that allow foreigners to migrate for work purposes. Instead they rely on encouraging sufficient Japanese people to work in the sector. Japanese participants in the programme were very interested in the models used in the foreign countries for the workforces.

¹ Depending on what type of visa they are able to obtain.

Conclusion

The path that the whole of Japan, being at a community level right through to the national level government, is taking towards preventative care is one that is inspiring to other nations. The impact of an ageing society has been recognised and steps have been put in place to put Japan and all of its communities in the best position to make sure the services and care are available for their older populations as and when they need it. It is also encouraging preventative care to reduce the need for the older population to require services and care. It is great to see that these measures are not only aimed at people in older groups, but people at all stages of life.

Alyson Kana

Alyson joined the New Zealand Aged Care Association in 2008 as a Graduate Policy Advisor and is now the Senior Policy Analyst. Over the years Alyson has gained a great deal of knowledge and insight on the aged residential care industry and has largely been part for the data analysis and policy work carried out by the Association for and on behalf of members.

Alyson is also strongly involved with the organisation of the Association's annual conference, particularly the programme and awards.

Events



October 2018

2 Day Primary Health Care Leadership Workshop
(Date & Location To Be Confirmed)



10-12 April 2019

NPNZ [®]Evolution Conference
Marlborough Region – Save The Date

More information to follow on these events



College of Nurses Aotearoa (NZ) Inc Life Members



<u>Name</u>	<u>Date Awarded</u>
<i>Judy Yarwood</i>	<i>October 2014</i>
<i>Dr Stephen Neville</i>	<i>October 2015</i>
<i>Taíma Campbell</i>	<i>October 2015</i>



Te Puawai