TE PUAWAI

The Blossoming

The Professional Update for Registered Nurses

November 2018

TE PUAWAI

The Blossoming

Whakatauki

Kia tiaho kia puawai te maramatanga

"The illumination and blossoming

of enlightenment"

This whakatauki highlights the endeavours of the College of Nurses as an Organisation which professionally seeks enlightenment and advancement.

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College of Nurses Aotearoa (NZ) Inc

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Editorial

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

Professor Jenny Carryer

A tumultuous year

This last year has certainly been complex in so many ways. It is almost impossible now for anyone (with one obvious U.S exception!!) to deny that across the world weather events and weather-related events (such as fires) are increasing in severity and rate of occurrence. Dissension both political and religious has seen an increasing tide of human misery as more and more people risk everything by trekking from one terrifying situation into one of uncertainty, deprivation and fracture from everything they have known. Across the world the far right is gaining political ascendency in several locations using the human misery of others as a basis to shore up borders and justify their position.

Here in New Zealand it is hard not to revel in our relative protection from these issues although I am not quite so sure about the weather!! Essentially we all live with a high degree of political stability and certainty. On a more micro level however there is clearly much of concern in terms of our levels of disparity, child poverty, domestic and gender based violence and an increasing propensity to drive stupidly resulting in road carnage. Our imprisonment rates are shocking and the statistics about who we imprison and why are nothing to be proud of.

We are also coming to the end of a year in which nurse's anger at the failure to take our services seriously finally boiled over, erupting into industrial action and a great deal of internal angst and considerable nastiness on social media. The signing of the ACCORD will hopefully be a giant step forward but there is still huge concern for nurses in primary health and aged care settings.

It will not be a popular position but I do think we have to take some responsibility for the position in which nursing has found itself. Certainly not all of the responsibility but we have a historical tendency to internalize or displace our anger inappropriately whilst remaining alarmingly silent in many public and professional or multidisciplinary settings. As long as we claim fear or ignorance as the reason for our consistent failure to assert professional authority and worth at every level we will make only temporary gains in our status and value. As long as we snipe at our leadership and express outrage on social media we will be easily divided and weakened.

I am hoping that there will be huge learning from the events of this year. If many nurses are unable to be overtly courageous and assertive themselves hopefully we will not as a profession

cower our brave new graduates into the same behaviours that have dogged us for many years and thus continue the status quo.

So much radical change is needed in the health system and we are so well placed to lead or guide that change. In order to be and do what people and communities need us to do we have to be internally strong, consistently powerfully articulate, to trust and support our leaders at least in public fora. Most critically we need to nurture and empower new graduates at every opportunity to stand tall, take risks (not clinically!!) and be there to catch them kindly when it goes badly. Let's extend the same compassion and concern to each other as we intend for our patients and let's see if we can grow through the events of this year.

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Moving House or Changing Job

Please remember to update your contact details with the College office

Email: admin@nurse.org.nz

Celebrating excellence in nursing leadership, strategy and policy

An interview with Pam Doole, Director of Strategic Programmes, Nursing Council NZ

One of the most significant pieces of work in nursing in the last few years has been the development of registered nurse prescribing. Led by the Nursing Council of New Zealand, it has the potential to have a profound effect on improving access to appropriate and faster healthcare for people all over New Zealand.

Pam Doole FCNA(NZ)

The College of Nurses wanted to acknowledge the Nursing Council's driving force behind this hugely complex, multi-layered and multi-agency project, the Director of Strategic Programmes, Pam Doole. Accordingly, in recognition of Pam's often unseen dedication, success and outstanding contribution to the nursing profession, she has been made a Fellow of the College of Nurses.

We sent Liz Manning to meet with Pam to find out more about her background, experience and her skilled and expert work in managing this 5-year prescribing project.

Can you tell me about your nursing background?

I've always had an interest in people. After I left school, I completed a BA in history at Victoria University Wellington, after that I was unsure of my next steps but I knew I didn't want an office job. As student I had worked in an IHC residential care home for 2 summers, which I really enjoyed. Then, my first job was in aged and residential care. I really enjoyed my time there, meeting the residents, hearing their life stories. I think this was the first indication that nursing may be an option for me.

I trained as a nurse at Wellington Polytechnic and was a staff nurse at Wellington Hospital for about 10 years, initially in general medicine. I moved into more senior roles within the clinical environment, preceptorship and looking at policy and process. One early project was on a medical

assessment unit for management of chronic illness. I would have loved to be a respiratory nurse specialist but those roles were just not there at that stage. I had mentors there who encouraged me to start my Masters study. They were nurse leaders who identified me as someone with potential. My Masters created for me a passion and belief in the difference nurses can make. Also, doing a piece of qualitative research gave me valuable experience which is vital for me today, in thematic data analysis, the discipline of using evidence, writing, thinking skills, listening and hearing what people are saying, using a critical lens.

I moved to ICU for a period of time until I saw a job advertised at Hutt Hospital for a new role, a Clinical Career Pathway (CCP) Coordinator. This position offered me the opportunity to shape the role and to innovate. After a while, I started to realise the CCP work was actually a cultural shift, bringing a largely hospital trained nursing workforce to a place where they could re-look at practice. This was setting nurses up for further education and the future development of more advanced roles, such as the clinical nurse specialist.

I was in the CCP coordinator role for a couple of years at which point Hutt Hospital decided to appoint a Director of Nursing (DoN). I applied and got the role. This was an opportunity to learn more about leadership and reporting to governance boards, presenting problems or nursing issues but always with strategies or solutions to the problems raised.

How did you start working at Nursing Council?

After about 6 years, I left DoN role and not long after I was asked, by Marion Clark, to do some work with the Nursing Council of New Zealand (Council) on Professional Development and Recognition Programmes (PDRP) and the linkage to the continuing competence requirements. This eventually led to me taking up the position of Professional Standards Manager, which initially included work to prepare for the new functions of the Council under the new Health Practitioners Competence Assurance Act (the Act), including recertification audit, continuing competence requirements and organisational PDRP endorsements.

Some of the early work at Council included development of scopes of practice under the new Act, learning the consultation role and how to write policy documents for Council. Then, when we were creating the registered nurse (RN) scope we knew it was important to be valuing and enabling of nurses across the sector not only in clinical practice but inclusive of RN in management, education, policy and research. One of the biggest consultations I did early on was the enrolled nurse (EN) scope review.

What's your current role at Council?

Director of Strategic Programmes. I took up this role around the time of the Code of Conduct work in 2012. My work is determined by the Council and the strategic plan. The projects are generally about moving the profession forward and goals around nursing regulation. Council has a legislative mandate under the Act. We set standards for things such as entry to the register, scope of practice, education programmes and prescribing.

Do you find the work interesting?

I am always interested in the work, learning about new things and thinking about alternative ways of moving things forward. I have learned to do 'deep-dives' into topics I initially know very little about.

The projects are often like jigsaws with big pieces missing. I need to arrange everything so it fits for nursing, Council, patients and within our NZ context. This needs a lot of research and thinking, answers aren't always clear at first. Also, we always try to create things with longevity, so well thought through and consulted on. Carolyn Reed is very supportive and understanding if things are taking longer than expected, which can be all part of the process.

The prescribing work was over a long-time frame, can you talk us through it?

Yes, it took about 5 years, but there were times when we had to wait long periods for governmental processes, including things like the 'Regulatory Impact Report', which then went to Cabinet, then regulations could be drawn up. This all takes a long time to process. Meantime, we worked on education standards for the post graduate Diploma and guidelines for nurses who prescribe. Though it took 5 years I think it was beneficial to have the same person throughout, for the consistency and the detail.

Once the regulation is known, Gazette notices can be written. The regulation gives Council a framework to put in the education and training for first time prescribers. The RN scope had to be changed at the same time to reflect the prescribing regulations.

A comprehensive medicines list is available on the Nursing Council website, this involved looking at every medicine submitted for consideration. Alongside this clinical scope and technical decisions needed to be made to ensure nurses could prescribe under different categories of medicine.

In the Medicines Act 'designated prescribing' only covers specified prescription medicine but we needed other medicines as well. This took a while to clarify how to secure that. Pharmac have now said that non-prescription medicines that Pharmac funds and Nursing Council approve, nurses can write a prescription for.

This sounds really complex, there must have been some difficulties.

Early meetings at the Ministry of Health and with PHARMAC were not easy as it was new for everyone and they were so used to saying who could prescribe what medicine. But then they moved and saw their role as the funder, and it was Nursing Council's role to decide qualification and whether prescribers could prescribe a medicine or not. To achieve that I had to get up to speed and learn their system, which is quite complicated, all the special authorities etc. Pharmac have been brilliant ever since.

The difficulties in the Ministry occurred when they had made changes to the Medicines Act and they created a new category of prescriber which was 'delegated prescriber'. The nursing profession, including Council was very clearly of the view that nursing should fall under the role of

designated prescriber'. Some early difficult conversations were with the architects of the 'delegated prescriber' category.

What were the hardest parts of this work?

The beginning, as I had never been involved in prescribing, either NP or diabetes nurse prescribing. So that was a steep learning curve. Also, we had to position a model of RN prescribing when we already have an independent nursing scope.

Initial conversations with medical groups which were about their support for 'collaborative prescribing'. This meant I felt stuck between two professional groups wanting independent vs collaborative prescribing and the other tension was around 'delegated' and 'designated'.

We did have the diabetes prescribing pilot and roll-out and it was so good that it was there and had already demonstrated safety of registered nurse prescribing in the evaluation reports. Dr Helen Snell was really fantastic for support as she knew the environment and the key players.

There were some difficult meetings and I valued others taking on some of the nursing views, such as Sharon Hansen, Jenny Carryer and Hilary Graham Smith. People who could and would speak out for nurse prescribing. It was vital the nursing profession and Council agreed. They trusted that the Council would do the right thing and the profession stuck together on that. A shared view.

The National Nursing Organisations group (NNOg) was important as well, so the timing was right. Also, the Minister had asked for it because the College of Nurses (NZ) members had spoken out and asked why we hadn't got nurse prescribing, so ministerial support was vital. Mary Louise Hanna at HWNZ and Alison Hussey in the Ministry Chief Nurses Office did a lot of work getting it through government. Other sections of the Ministry were really helpful too.

The Ministry changed to hold quite an enabling view and was quite good at sticking to their role and when they were challenged, said it's up to Council to say if its delegated or designated. This gave Council quite a lot of responsibility for the model and medicines list but it did mean it was nursing driven. The legislation was written so it was generic and we can put what models we want under it, so future proofed and enabling. There's one 'list' that sits under the regulation and that gives Council flexibility.

What was your project process?

I was aware I could have done this in a process way, with an advisory group but had a feeling it needed people who were fairly neutral and didn't have a vested interest in the medicines and could be objective. I did talk to RN and NPs from many different areas such as mental health, cardiology, etc., to understand what nurses need to prescribe. We wanted to start with something fairly conservative, starting with the main health problems, access issues and PHC particularly. We kept away from high risk/ controversial medicines so we could get it across the line and then later increase the formulary. Get it started and it will grow. In the end the Medicines Act brought into provision that lists can be updated through Gazette notices.

Prescriber	Number
Nurse Practitioners	327
RN prescribers in primary health and specialty teams	96
Diabetes RN prescribers	65
Community RN prescribers	58
Total	**546**

Table 1: Prescriber statistics 8 October 2018

How did you feel once you had finished the project?

Relief it was finished. I think the measure of when you've done well is when it comes into place and people are ready and waiting for it. There wasn't a lot of fanfare but people were there with their applications straight away.

It was lovely to go to Nurse Executives NZ in December 2017 and be recognised by the NZ nursing leadership. I think we have created an enabler for nursing, opening up the profession. Nurses have a key role, so we need to let them do it and do it well.

For more information on nurse prescribing, the process of development, gazette notices and competencies for nurse prescriber go to:

http://www.nursingcouncil.org.nz/Nurses/Nurse-Prescribing

https://www.health.govt.nz/our-work/nursing/developments-nursing/registered-nurse-prescribing

The Preciousness of Pacific Nurses

Article by By Pauline Fuimaono Sanders RN BN MPP

Pauline Fuimaono Sanders

Effective leadership in healthcare is an imperative to ensure services are responsive, relevant and importantly, equitable. Ethnic populations are essential not only to deliver frontline clinical services but necessary to influence at the governance and strategic level (National Health Committee, 2007). Nursing leadership is fundamental to improve the delivery of the health care system as a whole. Leadership from nurses has been highlighted as a necessity in the global, regional and local arena. In the NZ context, Pacific nurses are vital in assisting in the design of culturally appropriate and acceptable health services for Pacific People (Finlayson, Sheridan and Cumming, 2009). Nurses comprise the largest regulated Pacific health workforce, at seventy eight percent. Translated into the nursing population, Pacific nurses comprise only three percent of the total nursing workforce, in NZ. Hence, the preciousness of Pacific nurses.

Born in Aotearoa, to a Samoan-Chinese mother and an English-Irish father, my upbringing was gifted with many cultural misalignments. God-fearing vs atheist, collectivism vs individualism, service vs expectation, openness vs caution… to name a few. This was the norm growing up and no training or study could replace how my parents' differing worldviews carved for me, a space in between their worlds. My story is not so uncommon in modern society, when we know that over half of Pacific People are born in NZ and a third of Pacific People are of mixed decent (Statistics New Zealand, 2013).

Who are Pacific People? The term Pacific People is a pseudo ethnic European construct used to describe people who come from the diverse island nations in the South Pacific (Spickard and Fong, 1995). This term implies homogeneity of Pacific People and the acknowledgement of uniqueness and difference can be lost in the implication of sameness. Pacific Peoples descend from many islands with many ways, stories of migration with richness in language and traditions. Distances between Pacific People and their culture vary and as generations have Western influences this creates an environment complex but unique and extraordinary. For the ease of understanding, I will use the term Pacific People but within the entirety of what this means as sovereign Pacific nations rather than the homogenic implication. Why is this important? The imperative is in the appropriate response of the health system to the disproportionate experience of health inequity by Pacific People compared to the total population. So, who can lead the response to such overwhelming health needs for Pacific People?

I would like to state that addressing the health inequity of Maori is of great importance in Aotearoa. Like Maori, Pacific People also experience significant health inequity. Growing the nursing workforce for Maori and Pacific Peoples is an essential element in the strategy to meet the health needs of both communities. Maori Nurse Leadership requires development, so too does Pacific Nurse Leadership. This piece, being Pacific focused, does not presume that the situations that affect Pacific inequity are the same for Maori. There may be issues that look similar for both populations however, the solutions will always be different due to the primacy of Maori in the context of Aotearoa as Tangata Whenua.

In my current role, as Nurse Leader in a Primary Healthcare Organisation (PHO), very quickly I observed that I was often the only Pacific representative within a forum. From a personal perspective, my experiences are an opportunity to contribute to the dialogue as a nurse but also the great responsibility I carry to represent a Pacific view. This responsibility is to support the development of knowledge about the Pacific, for my non-Pacific colleagues and also, the accountability to my Pacific community, to be their voice at every opportunity.

Why is Primary Healthcare (PHC) important? PHC is a crucial component of the continuum of healthcare. The Alma Ata Declaration (World Health Organisation, 1978) recognised the great inequities in health that existed and internationally acknowledged that *PHC is a fundamental human right*. The declaration also acknowledged that people have the right to participate in the planning and implementation of their care either individually or collectively. Governments have a responsibility to provide, for their communities, health and social services. In NZ, the creation of the first Primary Health Care Strategy was agreed in 2003.

PHC in NZ has many challenges due to the contractual nature of its small business structure. Funding algorithms do not account for the complexity in which our Pacific People live. The variability in the application of funding has invariably contributed to the health disparities and health inequities we currently observe, without consequence. There are pockets of organisations that are demonstrating quality health outcomes for Pacific People and utilise the funding rules as a ‘guide’ rather than a rule. These organisations have visionary leaders that do not limit their thinking to the comfort and indifference of the status quo. However, this variability and lack of consequential accountability, has contributed to a system that is failing our Pacific People. Amongst the brilliance and apathy, there remains the fact of ‘don’t hate the player, hate the game’. So, for meaningful impact, we need to change the game.

With my sermon over about PHC, my interest to increase the number of Pacific nurses in similar senior forums I attend, became the focus of my Masters research titled ‘Pacific Nurse Leadership in Primary Healthcare – Where are you?’ through the Aniva Pacific Nurse Leadership Programme. The aim was to explore how Pacific nurses understand nurse leadership, how they apply leadership and the challenges and opportunities in the PHC context. For the purposes of this article I will focus on the stories shared by the participants about their understanding of leadership, from a Pacific perspective and the application to nursing practice.

There is importance in explaining the interactions with the participants throughout the interview process. While I was undertaking qualitative research, through semi-structured interviews, I used

the *talanoa* method structure for my interviews. *Talanoa* describes a process where Pacific people tell their realities through storytelling which creates a "cultural synthesis of information, stories, emotions and theorising… (that) will produce relevant knowledge and possibilities for addressing Pacific issues" (Vaioleti, 2006, p21). *Talanoa* is an exchange between the patient and clinician that has a cultural and emotional reciprocal foundation. It is a concept widely recognized in many Pacific nations whose traditions have oratory origins.

The application of Pacific values and principles are enabled by establishing connections where relationships of trust can develop. This is common practice in Pacific cultures and is founded on relationships as a core component to communal engagement and established through lineage or social linkages to groups ensure community determination and harmony (Health Research Council of NZ, 2014). Both the researcher and the participant exchange experiences and therefore become more enriched from the interaction. The skill, like all interview methods, is to achieve a balance so the researcher gives enough but does not control the dialogue.

The analysis of my research started with centralising the position of knowing for the participants. First and foremost, was fulfilling the needs of family and church commitments, when considering career progression. Pursuing a leadership role was seen as requiring time out of work, taking work home, going to meetings, for which there was no time when the foundation or core priorities were family and church. Family and church, infused with culture, was paramount; and career development would occur if these priorities changed. The Fonofale Model of Pacific Health and Wellbeing provides a framework of understanding as it represents the most important elements in the Pacific way of life. This model uses the Samoan *fale* or house. These elements are represented as parts of the Samoan *fale* – the foundation as family, pillars as physical, spiritual, mental and other, the roof as culture which contextually interacts with time and the environment (Pulotu-Endemann, 2001). Therefore, the participant priorities are reflected in the core elements of life for Pacific people – family and church.

Another way to provide a framework to situate the participants place of knowing, can be related to Abraham Maslow's hierarchy of needs. Griffin (1994) describes Maslow's prepotent needs as those which have the greatest power or influence over our decisions and actions. These prepotent needs determine the ability to engage in self-actualization. Maslow determined that everyone has prepotent needs but these differ among individuals, families, communities and cultures. Applying prepotent needs to the participants reveals that family and church have the greatest influence on a Pacific nurses decision to engage in nursing leadership activities and roles.

All participants had a shared understanding that leadership was through service and this was learned through their up-bringing from family and church. This understanding implies service is innate within Pacific cultures, a way of being for Pacific People. Further to this, participants expressed a strong desire to help their Pacific communities by supporting their team. Success of the team contributed to positive patient health outcomes. This was deemed as a successful leader. Therefore, leadership was ultimately seen as a position to serve the needs of the Pacific people rather that a role in an organisation. From the participants perspective, the more senior a leadership role, the more responsibility there is to meet the needs of the community, superseding individual gain.

The significance of service can be related through the example of understanding service or *tautua* in Samoan society. A Samoan proverb says *'O le ala i le pule o le tautua'* which translated means the pathway to leadership is through service. Essentially, service sets the standard for leadership. In fact, *tautua* is so important and woven into the fabric of Samoan society, that in its absence, everyday interactions would lose their depth and soul (Seloti, 2007). Leadership through service is aligned with the servant leadership style which places value on relationships and the community. However, a healthy debate would discuss Pacific leadership as a way of being compared to the servant leadership 'style' that can be learnt. All participants expressed an understanding that, in their view, Pacific-style leadership was through service.

Leadership selection is a key understanding within the Pacific worldview and conflicts with the traditional, dominant culture leadership selection style. The participants highlighted that it was not in their nature to apply for a leadership role themselves. This is primarily because in the Pacific worldview, leadership selection is by consensus of the team or group. Therefore, it is not the 'Pacific-style' to put yourself forward. As an example, in the Samoan culture, the characteristics of leadership expected from a *matai* (chief) include being knowledgeable, having the ability to analyse, reflect and understand the environment, being pragmatic and exemplifying humility and service (Huffer and So'o, 2005). Therefore, a person is observed for their works, service and interactions with others within their community and selection is made by consensus. This is a total contradiction to current recruitment processes.

One of the key challenges in NZ, is the minimal opportunity to observe the leadership of Pacific nurses due to the low number of Pacific nurse leaders in the sector. Predetermined leadership models and styles have an influence on the career progression of Pacific nurses from the perception of those recruiting nurses. This could be because the Pacific leadership style is different and measured against mainstream leadership styles, therefore being deemed ineffective but in reality it is unfamiliar. Another influencing factor are Pacific nurses perception of themselves. The participants concurred stating low confidence in their own skills as they compared themselves to mainstream leadership styles. Sy et al. (2010) explains that in the absence of leaders and role models of a similar culture there is less belief that leader qualities are possessed and therefore aspirations of leadership are diminished. We have some work to do as a nursing profession and health sector.

The participants highlighted one of the points of difference for Pacific nurses was the ability to bring the Western and Pacific cultures together when navigating the system for themselves and their patients. Understanding their Pacific world and the Western world is an advantage that they use in their nursing practice. This is a significant dimension to Pacific nursing practice and Pacific nurse leadership. The participants highlighted the diversity within Pacific nursing which creates some unique dynamics that are important to understand. This is reflective of the diverse Pacific population of Pacific born, NZ born and multi-ethnic Pacific People residing in NZ. The understanding of these dynamics and dimension places Pacific nurses in a unique position to positively respond to Pacific health outcomes at all levels.

The participants highlighted a need for a more structured approach to support leadership development. One of the key activities was to link with a Pacific nursing network. The network

would essentially become a 'pseudo-village' through which leadership development and career progression could be supported. Networks have a positive impact for minority groups and improve engagement in career advancement through associated mentoring that occurs within a network group (Friedman, Kane and Cornfield, 1998). In the network, there would be opportunities to associate with existing Pacific nurse leaders and therefore someone they could identify with. There are logistical challenges for nurses working in PHC due to clinics being in multiple locations. However, a combination of a network with mentorship can provide significant support in the development of Pacific nurse leaders in this context.

Key reflections from my research include: Pacific cultural principles and values shape leadership from birth; Pacific-style leadership is the innate understanding and application of service; leadership is understood to be recognised and selected by others through observed capability and knowledge; supporting the team will positively support the Pacific community, this is success as a leader; Pacific-style leadership is not ineffective just different and largely unobserved; Pacific nurses weave their Pacific worldview with the Western world when navigating the system for their patients and themselves; within a Pacific nurse leadership strategy, a Pacific nurse network can support the leadership development and career progression of Pacific nurses.

A quote by Dr Loretta Ford resonates close to my heart "Get to the table and be a player, or someone who doesn't understand nursing (and Pacific) will do that for you" (parentheses added). This is a call to Pacific nurses to believe in the knowledge that is yours. The sector needs Pacific nurses for their clinical and cultural expertise which creates a unique space to respond to the needs of Pacific People. As a society, we have work to do to address the health disparities experienced by our Pacific People. As a health sector, growing and developing Pacific nurse leaders is an essential response to supporting our vibrant Pacific People that deserve to have strong families, strong communities, living well longer. And at only three percent of the nursing population in Aotearoa, we must acknowledge, support and respect the preciousness of Pacific nurses.

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The College of Nurses Board and Staff wish all College members a happy, safe and relaxing time over Christmas and New Year.

The College office will be closed from mid-day, 21 December 2018 until 14 January 2019. Phone and e-mail messages will be checked occasionally.

INVOLVE Conference 2018
Looking Back To Move Forward

Report by Suzie King, School Youth Health Nurse
College of Nurses Aotearoa (NZ) Inc Scholarship Award Recipient

The Involve conference 2018 was a collective endeavour by The Society of Youth Health Professionals Aotearoa NZ (SYHPANZ), The Collaborative Trust, AraTaiohi and NZ Youth Mentoring Network. Its purpose was to strengthen connections within the youth health sector, whilst continuing to support the wellbeing of youth in Aotearoa. 900+ attendees were present at the conference, including health care professionals, researchers, youth workers, and others working with youth. Some young people also attended. The goal of the conference was to enable attendees to build positive connections, learn new knowledge and skills, and listen to new and exciting initiatives happening within the youth health sector, ultimately to inspire a transformation of practice, whilst continuing to support the mana of young people.

Keynote speaker Judge Andrew Becroft, Children's Commissioner of New Zealand, opened the conference with stimulating words of hope and encouragement to propel the audience forward towards both professional and personal pursuits over the 2.5 days. Other main speakers Mana Williams-Eade (Youth Advocacy/Youth Advisor), Laura O'Connell-Rapira (Director of ActionStation and Co-founder of RockEnrol), Glenn Colquhoun (Poet/Writer/GP) and Dr Michelle Johansson (TeachFirstNZ, Polynesian theatre director), shared inspiring presentations on their work with youth. Breakout sessions, workshops, open space seminars and snapshot meetings on a variety of youth health topics provided further education and thought provoking discussion. Other learnings included understanding of cultural aspects, youth suicide prevention strategies, holistic health initiatives, and information on problem gaming.

A highlight of the conference was presenting on the Trial and Evaluation of Registered Nurse Prescribers in Community Health, an initiative piloted within Counties Manukau and Family Planning, in collaboration with Nursing Council of New Zealand. This qualification enables registered nurses working in the community to prescribe a limited list of prescription medications for common, uncomplicated conditions such as sore throats, skin, ear, and sexually transmitted infections, contraceptives, low level pain relief and preventative and ongoing treatment for rheumatic fever.

All registered nurses who undertook this course only prescribe to normally healthy individuals using advanced assessment and clinical decision making tools and skills, current best practice guidelines/information and are supported by other health care professionals.

Choosing Wisely

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

Choosing Wisely is a global initiative to help health practitioners and consumers make better choices about medical interventions, especially medical tests. So, what is it all about?

The Health and Disability Commissioner [Code of Health and Disability Services Consumers' Rights] Regulations 1996 (referred to in this article as "the Code") enshrines in law your right as a consumer to make an informed decision about your health and medical care and treatment (services). It carries with it the right to be informed, the right (and obligation) to provided informed consent for health and disability services being offered, and the right to refuse such health and medical care and treatment.

Choosing Wisely is a fabulous campaign that helps practitioners fulfil their obligations and comply with the rights of consumers to provide informed consent, all while helping to avoid tests, treatments and procedures that may be unnecessary. Implemented by practitioners, the campaign will help consumers make better decisions about their healthcare.

According to the Choosing Wisely website (https://choosingwisely. org.nz) the "campaign aims to promote a culture where low value and inappropriate clinical interventions are avoided, and patients and health professionals have well-informed conversations around their treatment options, leading to better decisions and outcomes."

The Council of Medical Colleges[1] is facilitating the initiative in New Zealand and it involves doctors, midwives, nurses and pharmacists, among other health professionals.

The campaign is also supported by partners, the Health Quality Safety Commission and Consumer NZ.

It is described as health professional led and patient focussed. The Choosing Wisely website has sections for both consumers/ patients and health professionals.

The *Patient* section advises that some tests, treatments and procedures provide little benefit and, in some cases, may cause harm. Choosing Wisely recommends that patients ask four questions:

1. Do I really need this test or procedure?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don't do anything?

There is a lot of very helpful information for patients that will help them negotiate with confidence what is often a difficult and stressful situation. Asking questions of a health professional can be intimidating for many people and it is helpful for patients to know that they have a right to ask

questions and be given adequate answers. Choosing Wisely says “You should expect to be listened to – and be given clear and adequate explanations of your condition, any recommended tests, treatment options and the expected results.”

There are also a number of patient and consumer resources on specific tests and treatments.

The health professional section “provides recommendations about tests, treatments, and procedures developed by Australasian and New Zealand Colleges and specialist societies that healthcare professionals and patients and consumers should question.”

For example, for the Australasian Society for Infectious Diseases a recommendation is to “avoid prescribing antibiotics for upper respiratory tract infection” followed by a list of medical literature providing supporting evidence and a list of further resources. Under the New Zealand College of Public Health is the recommendation that health professionals “use absolute risk ahead of relative risk when assessing and communicating risks, harms and benefits”, again followed by supporting evidence.

This section tacitly supports a partnership between consumer and health practitioner, saying the recommendations “are not prescriptive but are intended as guidance to start a conversation about what is appropriate and necessary. As each situation is unique, healthcare professionals and patients should use the recommendations to collaboratively formulate their own appropriate healthcare plan together.”

However, it would have been good for the website to have stated more strongly the statutory obligation of health practitioners to ***fully inform*** patients about the tests, treatments or procedures being offered, including expected risks, side effects, benefits, and costs of each option, and their obligation to obtain fully informed consent from patients. It is clear from reports in the media and complaints to the Health and Disability Commissioner that some health practitioners have a very tenuous understanding of their obligations under the Code of Rights.

Overall, Choosing Wisely is an enormously beneficial campaign and we hope that all professionals in the health and disability sector familiarise themselves with the campaign and the resources available and start having well-informed conversations with patients around their treatment options, which can only lead to better decisions and outcomes.

1 The CMC represents fifteen medical colleges in New Zealand providing support to more than 7000 medical practitioners working across 37 specialties in health system.

Your rights under the Code

Under the Code of Rights, you have the right to be fully informed and to provide informed consent:

Clause 2. Rights of consumers and duties of providers (abridged):

Right 6: Right to be fully informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including—

(a) an explanation of his or her condition; and

(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and

(c) advice of the estimated time within which the services will be provided; and

(f) the results of tests; and

(g) the results of procedures.

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent....

(4) Every consumer has the right to receive, on request, a written summary of information provided.

Right 7: Right to make an informed choice and give informed consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

(2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

(6) Where informed consent to a health care procedure is required, it must be in writing if—

(a) the consumer is to participate in any research; or

(b) the procedure is experimental; or

(c) the consumer will be under general anaesthetic; or

(d) there is a significant risk of adverse effects on the consumer.

(7) Every consumer has the right to refuse services and to withdraw consent to services.

(8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

For the full Code of Rights see https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

Report by Stephanie Clare, RN MHealSc PgDipPHC
College of Nurses Aotearoa (NZ) Inc Scholarship Award Recipient

I joined over 1,200 delegates who attended the International Federation on Ageing (IFA) 14th Global Conference on Ageing in Toronto representing 76 countries, where connections and friendships were made and strengthened. IFA established in 1973 is an international non-governmental organisation with a membership of government, NGOs, academics, industry and individuals. I was not alone in representing New Zealand. Our New Zealand contingency included government representatives, from the Office for Seniors, Auckland and Waikato University researchers, Rauawaawa Kaumatua Charitable Trust members and other health care providers.

The title of the conference "Towards a Decade of Healthy Ageing – From Evidence to Action" with four main themes; Toward Healthy Ageing, Combating Ageism, Age-friendly Environments and Addressing Inequalities is in response the WHO World Report on Ageing and Health. It was a full and varied programme convened between the Chelsea Hotel and Ryerson University.

Honourable Filamena Tassi opening the conference

The conference was opened by their newly appointed Canadian Minister for Seniors, Honourable Filomena Tassi. Her address set the scene for the upcoming days ahead. Highlighting the opportunities such as this global event as an important one to address the growing needs the ageing population. It is also noted that Canada will see a shift in age of eligibility for Old Age Security (OAS) pension from 65 to 67 years. This change will be implemented in 2023. This means that this change will not affect those Canadians who are 54 or older as of March 31, 2012.

Canadians are effectively being given 11- year notice and then 6 years to gradually implement the change. The government has also increased a guaranteed income supplement for single seniors by $1000 per year.

Dr. Jane Barratt, Secretary General of IFA, continued in her introductions saying “Growing older is not for the faint hearted and in sharing ideas and provoking conversations that have the opportunity to make positive impacts”.

On the first day of conference I chaired a Paper Session titled Therapeutic Frameworks to Address the Diverse Needs of Older People in the Age-Friendly Theme. Five speakers covering a varied topic selection; companion dogs, music and non-pharmacological interventions to address dementia, forecasting disability. What I found most useful and interesting about these papers is they reinforced the work of Age Concern. The research described by the presenters showed where the impact on improving the lives of older people through small acts made a significant difference. The act of singing a familiar song, music to lift a mood, having a dog to walk and take care of. All these little initiatives resulted in a life with more meaning.

Session Speakers– lessons and learnings

- Diane English, Positive Experiences Never Get Old
  Highfive for Older Adults: A new Quality Framework Health Promotion opportunities
- Dr Ardra Cole, ElderDog Canada, Supporting Seniors and their Canine Companions
- Hui-Ju Wu, Non-pharmacology Interventions for Dementia
- Jon Parr Vijinski Communication and Music for Dementia Care in Lone-term care using the “Audio-Visual Music Interaction” (AVMI) Intervention.
- Lijia Wang, Forecasting Disability in Singapore using the Future Elderly Model.

On the second day, I delivered my presentation. The theme, Addressing Inequalities bought together five speakers including myself from different countries with different backgrounds in the Paper Session: Housing and Beyond – the experience of under- resources communities.

- Clare, S. Unlocking Community Potential to Increase Social Connection for Older People
- Hatendi, N. Institutional care giving older homeless persons at Melfort Old People Home, Zimbabwe – A Case Study
- Bella, L. Surviving without wheels: Community based strategies for overcoming transportation challenges for rural seniors
- Cassum, L. Exploring the experiences of elderly people who are brought to live in shelter homes in Karachi, Pakistan
- Kola, L. Poverty and health of the elderly: Roles of social capital in a low resource setting

Age Concern knows loneliness is bad for your health and on the rise. Last year Age Concern New Zealand seed funded a number of community projects that have been extremely successful and more importantly sustainable by the communities that set them up. In my presentation I was able to share the effectiveness of asset-based community development based on the principle of identifying and mobilising individual and community assets and instead of focusing on problems, needs or deficits.

On the third day I introduced our peer-led falls prevention programme poster presentation. Being a small nimble country allows for many opportunities and one of these is developing a peer-led falls prevention programme that the rest of the world was interested in. I stood proudly beside a programme that makes a difference in the lives of older New Zealanders. The programme is well researched and continues to be the only evidence based falls prevention progamme for older people in New Zealand.

Stephanie Clare – Poster Presentation: Steady As You Go, Peer-led Falls Prevention Programme

Other useful stuff I liked

- Home4Good is a community group working on three priorities to help older residents remain at home in Bayfield:
- Housing, Information and Transportation www.home4goodbayfield.ca
- Age is More: Challenging Age Discrimination www.ageismore.com and particularly their film project www.ageismore.com/film-project
- A community based, not-for-profit organisation dedicated to supporting the best possible ageing experience www.advantageontario.ca/
- Courses on ageing www.online.unimelb.edu.au/ageing
- Overcoming social isolation www.javaGP.com
- The Clever Companion Programme that connects retired professionals with older lonely seniors www.integracollege.org/clever-companion/
- The Generation Games is a sport for all event, for people for all ages www.generationgames.com

- This is another great link - Health promotion and social connections through food www.shareapot.sg
- Zestful aging: simple and sensible practices for daily wellness and a longer life. A great podcast https://www.nicolechristina.com/podcasts.html
- Health Ageing Promotion Program for You (very similar to SAYGo) https://www.straitstimes.com/singapore/health/happy-hour-helps-seniors-delay-frailty- and-disability and https://www.healthhub.sg/programmes/51/Healthy_Ageing

I want to thank the College of Nurses Aotearoa (NZ) Inc for making my attendance at the International Federation of Ageing Conference possible.

Stephanie Clare with Stephen Neville, Associate Professor & Head of Nursing, Auckland University Researcher and Diane Turner, Office for Seniors

Professional Supervision: an argument for protected time to reflect

nau te raurau naku te raurau ka ki te kete
with your input and my input the basket will be full

Liz Manning in conversation with Dr Catherine Cook *RN, PhD, M. Couns*

Catherine, what motivated you to develop a two-day supervision short course for health professionals?

I have a long history of receiving and providing professional supervision. I was first introduced to the practice in 1996, when I worked at a sexual health clinic and group supervision was available to all staff. I went on to work as a counsellor for 12 years at the University of Auckland, and, similar to social workers and psychologists, regular supervision was mandatory, and undertaken in work time. I found it incredibly helpful to know I had regular opportunities to reflect on my practice and to develop new insights and strategies, through spending time with senior practitioners. I also thought about how the work I was doing was no more complex than the work undertaken by nurses, most of whom never have the opportunity to engage in professional supervision. When I returned to nursing in an academic role in 2010, I began providing professional supervision to a small group of nurses and other health professionals, as part of my consultancy work through Massey University. Talking with nurses, I realised that those nurses who engage in supervision often consult with someone from another profession: a social worker, psychologist or counsellor – sometimes by choice but more often because they are unable to find a nurse who offers supervision.

Although cross-disciplinary supervision can be very satisfying, my experience is that because nurses are at the hub of healthcare, people in other professions don't necessarily grasp the complexities of nursing work; how much of the work is about being part of a team, rather than one-to-one casework. I know that most nurses in senior roles who could potentially offer supervision are not in a position to undertake a post-graduate certificate in supervision, as they are focused on completing a clinical Masters degree or on the Nurse practitioner pathway. Yet I believe that many nurses already have the level of communication skills to offer supervision, and what's needed is a framework and 'toolkit' of concepts and interventions. The two-day course I developed is aimed at this group of nurses. Since 2013 I've facilitated 10 supervision short courses, attended by a total of 140 health professionals, most of whom are nurses and midwives. Here's an example of participant feedback about how the course enhanced a senior nurse's supervision work:

> The course reinforced for me the importance of reflective practice. This is something I've always done, but I had the opportunity to learn some effective methods of

> developing this way of thinking for others. I attended the course in order to refresh my understanding and skills in nursing supervision and reflective practice. It was a wonderful two days and I came away full of energy and enthusiasm to carry on providing supervision. I would recommend to all nurses, whether new to supervision or an experienced nursing supervisor.

I'm keen to do what I can to support nurses to protect their practice and their registration. Through teaching law and ethics for a number of years now, I've become much more familiar with cases that go before the Health and Disability Commissioner and the Health Practitioners Disciplinary Tribunal. What stands out to me about most of the situations where nurses are found to have acted improperly is that these are usually situations of habitual unreflective practice, rather than a one-off error. Healthcare is complex, because it's a combination of often utterly routinized practices, alongside the everyday dynamic chaos and uncertainty of clinical practice.

So is professional supervision an opportunity that you think everyone benefits from?

Supervision is only one of a number of ways to companion colleagues and to be companioned. A new graduate may benefit most from having an excellent preceptor; a guide-on-the-side who gives immediate feedback. A nurse looking to a nurse practitioner role may find that a colleague who is an NP is a terrific mentor for a period of time. A nurse who struggles to practice outside of a very prescriptive, routinised way of providing care, and who needs intensive guidance around critical thinking, may benefit most from working with a clinical coach who role-models best practice. Some organisations are using group processes such as Swartz Rounds, for staff to reflect on emotional aspects of care delivery. Supervision is a good fit for nurses who are interested in what I call 'leaning in' to reflective practice – who see themselves as life-long learners, and can tolerate the degree of uncertainty and experimentation that goes with thinking, "I wonder if there might be another, possibly better way to approach this situation." Here's what a nurse in a senior clinical and managerial role reflected about her experiences of supervision:

> Being able to speak with a trusted colleague who is a place apart from the business, relationships and the challenges of the work of our small isolated health clinic has been invaluable to me as the team leader. Specifically I have found that these conversations have helped me keep my eye on the ball so to speak, to always place the needs of our patients at the forefront of our work, planning and decision making. My supervisor's keen interest in understanding the challenges of our work allows me to truly engage with reflective thinking rather than target or goal-meeting strategizing. It helps me stay grounded in the mahi of the work.

Supervision is most useful for nurses who work in an organisational environment that supports open communication and feedback, and where there's interest and enthusiasm about optimising practice, because supervision tends to lead to creative and critical thinking – "we could try it this way." So it's not a Band-Aid for an unhappy workplace, nor for an under-performing staff member who is not yet ready to contemplate change. A nurse in a leadership role commented about how her initial scepticism about supervision shifted:

> I first started supervision about three years ago. It was introduced by our company and in all honesty I first thought I'd only go a couple of times and wouldn't find it very valuable. Oh how wrong I was! My supervision has helped me in many a different situation and my demanding role. My supervisor has helped me grow, develop my self-reflection skills, handle stressful situations and each session gives me mind food. I come away from the session feeling re-energised and focussed. I've been able to pass on some valuable skills to my colleagues and I always recommend supervision to anyone who values growth and development.

This revitalisation of practice is a common experience linked to the opportunity to engage in supervision.

Who benefits most from supervision?

I think it's more that people benefit differently, depending on where they are in their nursing career. Patricia Benner's novice-to expert framework is helpful for thinking about the aim of supervision for nurses at different career stages. Novices often do want advice; frameworks and 'rules of thumb' to help ease their way in the early, bewildering months of practice. So although a supervisor will encourage problem-solving, there is always a place for sharing practice wisdom. We know too that novices need much more time to reflect after a situation that might be 'everyday' for an expert nurse in that field. Experts often find supervision helpful to bring to the surface their practice knowledge. Experts often don't grasp the depth of what they know, as their work has become for the most part almost intuitive, and so when they want to pass on their knowledge, time to reflect can help put words to what has become taken-for-granted. Nurses who have previously been an expert in a field and are in a transition phase in a new role may also benefit greatly from supervision, as they often grapple with the discomforts of knowledge and practice gaps, and the uncomfortable feeling of "I should know how to do this." They may also be managing the reactions of colleagues who are either expecting too much or too little. A new nurse practitioner commented about how supervision has helped through the transition to becoming an NP:

> Professional supervision gives me the protected time and space to reflect on my practice and my professional identity. I have been able to navigate through some rather tricky social, political and ethical issues with the insight and guidance of my professional supervisor. My professional supervisor often had different insights to the clinical staff I worked alongside and it was through this process that I've been able to develop a wider and deeper view as a nurse practitioner.

What about nurses who are in teams where they debrief about critical incidents – does supervision have a role?

Debriefing is used for extraordinary situations, and is invaluable. However, we know from the literature that it's everyday role-modelling, emotional intelligence, critical thinking and reflective practice that ensure good team morale and patient safety. Micro-aggressions, miscommunication, moral distress and postponed self-care erode teamwork and patient and whanau confidence. It's

so easy not to notice what's everyday – what goes well and what contributes to problems. A nurse leader commented on the value of supervision in her leadership role:

> Supervision provides me with an opportunity to review how work (i.e. my team, my role) has been going since our last session - what has gone well and what have been challenges. Yes, I can do this myself, however supervision provides me with an opportunity to explore these positives/challenges at a deeper level. I use the analogy "peel back the layers of the onion". Only through doing this do I really get clarity of what is going on. Without this opportunity for refection and clarity I cannot consolidate new behaviours/ways of doing in myself as a leader or consider ways where I need to make changes in my way of working or facilitate change in my team.

I see regular supervision as an opportunity for nurses to stay 'up to date' with themselves so that difficulties, such as a collegial communication problem, or a potentially challenging boundary concern with a long-term patient, can be identified, with a well thought out strategy of how to proceed. I often have people who attend my courses who say, "I don't really need supervision because I have great colleagues and we talk about everything." But what they commonly come to realise is that, even with supportive colleagues, given the pressure of work situations, they almost never complete a whole reflective cycle, which includes planning what to experiment with doing more of, less of or differently in moving forward. We know from the literature that nurses experience many interruptions in their everyday work that disrupt being able to hold a train of thought.

Who can offer supervision?

Currently professional supervision in nursing isn't regulated. However, supervision is most likely to be useful for supervisees if the supervisor is proficient or expert in their field; has a broad knowledge of the challenges, opportunities and political and regulatory landscape of contemporary nursing; and demonstrates a commitment to lifelong learning. Supervisors' attention to their own self-care and personal resilience is also important as many nurses seeking supervision are endeavouring to maintain standards in the current care-rationed climate and may be grappling with feelings of cynicism and burn-out. Several tertiary institutions offer a post-graduate certificate in professional supervision. My two-day short course is the only one I know if that specifically focuses on the needs of health professionals, rather than a broad focus on the helping professions. The College of Nurses hosts a platform for supervisors to profile their work. Supervisors are welcome to apply:

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

Catherine offers two-day supervision short courses twice a year, and also provides customised one-day Leadership through Reflective Practice workshops for organisations on request. For 2019 courses and further information contact Anne-Marie Ngan Professional and Continuing Education Co-ordinator a.m.ngan@massey.ac.nz

April 2019 Supervision for Health practitioners
November 2019 Advanced practice in supervision for health professionals

Professional supervision for advancing nursing practice: A fact sheet

Professional supervision: an enriching opportunity to reflect on practice

Supervision draws from principles of life-long learning; the understanding that experience alone doesn't transform practice. There are strong links between ethical practice and reflection. Supervision provides a context for those with the willingness to reflect on practice; considering, for example how to refine patient care, attend to self-care and the opportunity to identify knowledge, practice and systems gaps. It's also a chance to notice what goes well, so that these strategies are harnessed as part of one's 'tool-kit.' Reflection in supervision is sometimes a relatively straight-forward process of having time to think and plan. However, reflection can also be an unsettling process of reconsidering beliefs and values, which is where the companionship of a supervisor can be particularly helpful.

Supervision, a regular, facilitated, uninterrupted, reflective process, provides a safe, confidential space in which nurses turn their full attention to themselves and their own practice. Supervision provides what might be a rare opportunity for nurses to consider their work in a detailed way.

Three key dimensions of supervision

Knowledge: Reflection may identify areas where more information or education may be useful, whether this relates to shared wisdom from colleagues, accessing resources or engaging with further education. Supervision may also be a place to strategically consider short and long-term professional development plans.

Regulatory: Nursing, as a regulated profession, means nurses carry considerable responsibility ethically and legally. Within the workplace there are many structural processes that may enhance or impede practice. Supervision provides an opportunity to reflect on these contexts of healthcare.

Restorative: Much more than navel-gazing! Supervision involves finding strategies to meet day-to-day and exceptional challenges; addressing moral distress; the potential for burnout, compassion fatigue; and vicarious traumatisation. It's also an opportunity to reflect on what contributes to resilience. Maintaining professional boundaries, work-life balance and ways to foster a work-place that's safe in all respects are other areas for reflection in supervision.

So what happens in supervision?

Nurses, either individually or as a group, meet regularly with a supervisor; a suitably educated person from within the helping/health professions (nurse, counsellor, social worker, psychotherapist, doctor, or psychologist). As a facilitator, supervisors typically support a process of exploration, experimentation and evaluation. This process includes giving feedback and goal setting.

Does supervision work?

There is increasing research about the efficacy of supervision in nursing practice. Findings include that supervision increases a sense of support and wellbeing, enables reflection on knowledge and practice, boosts morale and decreases absenteeism.

What counts as supervision?

Supervision differs from formal debriefing after a critical incident or informal clinical review with colleagues. Supervision is usually understood as a process of staying 'up-to-date' with how the nurse is getting on professionally, so that the nurse has a safety-net to identify and respond to hurdles early. Therefore monthly to six-weekly supervision is ideal. Individual supervision is usually one hour and group supervision is usually 1.5-2 hours. The supervisor organises a setting and schedules time in which the supervisee is able to speak privately, uninterrupted by any other commitments.

What's supervision got to do with nursing?

Reflective practice and critical thinking are now recognised as essential for the complexity of 21st century nursing and are included in New Zealand Nursing Council competencies for registered nurses.

Are cultural issues relevant in supervision?

Cultural considerations and opportunities to reflect on cultural safety in patient care and teamwork are always important aspects of professional supervision. Supervisees' needs may differ throughout their careers. Māori nurses may consider that they will experience most benefit from Kaupapa Māori supervision; supervision provided by Māori for Māori reflecting Māori values and beliefs. A tauiwi (non- Māori) supervisee might seek cultural supervision; additional guidance, 'critical companionship' and reflective opportunities with a supervisor who identifies as Māori in order to refine cultural competency in working with Māori. A supervisee might seek a supervisor with a different cultural identity from their own to gain deeper understanding of working in a culturally diverse team or with diverse client groups.

How do I find a supervisor and do I get to choose?

A number of District Health Boards now have systems in place to provide professional supervision 'in house' from another colleague who works for the same DHB. Some organisations pay for staff to receive external supervision. Nurses can choose to pay for supervision privately. This service costs in the vicinity of $80-150 per hour. The College of Nurses Aotearoa (NZ) has a professional supervision webpage where you can view professional supervisors' profiles. If you provide supervision you can add your profile; you don't have to be a member of the College:

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

Ideally, people choose their own supervisor, because for supervision to go well, the supervisee needs to perceive that there is a good 'fit'. It's often helpful to have a supervisor with whom there

will be no dual relationship, as boundary issues can be more complex to navigate if the supervisor is also a person's manager or colleague. However, these dual relationships can be positive if both parties clearly discuss potential conflicts ahead of time.

Are there 'rules' that a supervisor follows?

Professional supervision is a confidential conversation. The wellbeing of the supervisee is the focus of supervision – although supervision is a friendly conversation, this conversation is not reciprocal as such; it is very much about what the supervisee wants to address. However, a supervisor can also respectfully ask about issues a supervisee seems not to have noticed, or seems uncertain about, in order to help support a reflective process.

What sort of topics do nurses take to supervision?

Given the variety of nursing roles and stages of professional practice, there are a wide range of topics nurses might raise. Supervision isn't counselling – the focus is on optimising workplace experiences. However, as the personal commonly affects the professional, there are likely to be some overlaps in what is talked about. Part of a supervisor's role is to discuss with a supervisee when personal issues might be so much to the foreground that counselling or other support would be appropriate. Some common supervision topics are:

- Managing a professional transition
- Deciding about further education
- Strategising to juggle competing priorities
- Working effectively in culturally diverse teams
- Debriefing after a difficult situation
- Considering how to address an ethical dilemma
- Reflecting on how to most skilfully manage a communication challenge with colleagues, teams or patients and families, including giving and receiving feedback
- Sustaining resilience and wellbeing in the care-rationed environment
- Setting goals

Resources

Beddoe, L., & Davys, A. (2016). *Challenges in professional supervision: Current themes and models of practice*. London, UK: Jessica Kingsley.

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10th ICN NP/APNN Conference Rottterdam August 2018

Report by Marie-Lyn Bournival, BSc, PG Dip Health Ss, MN, NP
College of Nurses Aotearoa (NZ) Inc Scholarship Award Recipient

I was privileged to receive a scholarship from the College of Nurses Aotearoa to assist me financially to attend the 10th International Council Nurses Nurse Practitioner/Advance Practice Nursing Network (ICN NP/APNN) Conference in Rotterdam from 26 to 29 August 2018. The underlying thread of the conference was *leadership* at regional, national and international levels and across all our disciplines. Many keynotes addressed different strategies to achieve this, from workforce to clinical engagement. A creative segment which set a positive tone to the conference illustrated the analogy of good and poor leadership with the live performance of the Rotterdam Youth Philharmonic Orchestra during the opening ceremony. The Maestro (boss) was giving different or unclear directions to the musicians (employees) and then asked them individually for their opinion on the given directions (tasks to do) or what they understood (messages) or again how they felt about each other's performance. Throughout the "Four Seasons Winter Allegro non molto of Vivaldi", the performance went from total chaos to pure awesomeness as the clearer the instructions became the more harmoniously they ended up playing together. This was received with laughs and complete awe by all the attendees.

Working in partnership and working together were strong messages from Annette Kennedy the president of ICN whilst Dr Melanie Rogers, Chair of the ICN NP/APN, began the conference explaining the Network's history and where it is now after one decade. With 1500 delegates and 450 concurrent sessions including keynotes, workshops and poster presentations, the Rotterdam conference was the largest in its history. A growing number of clinical presentations and workshops proved to be a success, with a greater balance between academic and clinical presentations.

My presentation on the "Treatment of acne in PHC: the good, the bad and ugly" was included in the dermatology cluster. I presented the pathophysiology, history taking, examination, treatment and the impact of the condition on youth and psychological support to offer in the era of social media and selfies. This generated a good discussion where clinicians shared their different approaches.

Throughout the conference, the keynote speakers discussed leading innovation and the transformation of our role in a global platform. The importance of being political and to engage at all levels regionally, nationally and internationally. "*If we are not invited at the negotiation and decision table with the key players, we must bring our own chair, sit at the table, listen, participate, discuss and we must ensure that we have a voice, our own voice*" said Dr Kennedy. This resonated with me so much as just a few days before heading to Rotterdam, I attended the GP CME conference in Christchurch. There was no NP representation in any of the keynote sessions even though a small number, twenty-five of us, attended that conference and even more in Rotorua. Being a member of the NPNZ committee, these messages were loud and clear!

Some of the keynotes that struck me particularly were the integration of patient's experiences. Marielle Blankestjin who is the founder of IKONE, a Dutch NGO, is a leader in representing people with disability and gave an excellent talk on transformation and integration. Another excellent keynote session was the advanced practice nursing situation in Latin America. Sylvia Cassiani gave an excellent account of the struggles and hope of advanced nurses, with their cultural and gender equality issues. The parallel sessions were numerous, diverse and engaging. I was particularly interested in healthcare in the digital age and attended many sessions on the subject. It was an eye opener to attend the sessions on prescribing and how different countries are working hard on frameworks to integrate this in their practice. Sessions such as screening, under and over diagnosis patients, reflection of NP's autonomy across the health spectrum, and the role of NPs as entrepreNURSE were only a few fascinating sessions I attended. A new initiative included one hour clinical workshops. These varied from the management of the 10 most common infections worldwide to mastering MSK examination and management of dementia where all delivered by NPs. The organizers had not expected these to be so popular, attendees had to stand up and sit on the floor as the rooms were jam-packed.

Sessions called "Meet your peers" were greatly welcomed. These were divided between PHC, Older people health, Children health, Oncology, Mental health, and Hospital care both in-patients and out-patients. This allowed APNs and NPs from all over the world to meet their mutual discipline counterparts. I got to know some of my counterparts working in PHC from the US, UK, Ireland and The Netherlands to name a few. I had great discussions with advanced nurses who are pioneers in their countries respectively from Portugal and France.

As I am the ICN NP/APN Communication co-chair and since being successful in obtaining the CNA(NZ) scholarship, I became a member of the ICN NP/APN core steering group (CSG) and attended many meetings both very early, very late at night and at lunchtime recess! These allowed everyone to attend the different conference sessions during the day. Leading the social media portfolio with the Communication team, I also led all the Facebook and Twitter posts and live videos during the conference. I chaired several poster sessions and I attended the African coalition meeting to see how the CSG can assist five African countries to develop APN and NP academic programmes. This is an important piece of work which will be presented at World Health Organisation in the next 12-18 months.

Dr Isabel Skinner the new ICN CEO alongside Dr Melanie ROGERS concluded the 10th NP APNN conference on a high note with inspiring speeches on who we were, where we are and where we are heading.

A trademark of the ICN NP/APN conference is the Silent Auction. Delegates are asked to bring an item and throughout the conference people have the opportunity to bid on items of their choice. At the conclusion of the conference, the highest bidder gets the item. 100% of the proceeds are allocated to support NPs and APNs from low to medium income countries to attend the conference. The proceeds of this year auction totalled $2,300 NZD.

As I reflect on this amazing conference, I have a great sense of belonging. I belong to a dynamic global NP and Advanced nursing community. I also realised that New Zealand is such an active and important player on the role of NP internationally. The partnership between the College of Nurses Aotearoa and NPNZ is a crucial alliance in my opinion where both scholars and clinicians work together and must continue to advance the NP discipline. It was motivating and inspiring to listen to and exchange with so many advanced practice nurses and NPs who are making such a difference in their patient health journey.

I conclude in thanking warmly the College of Nurses Aotearoa Scholarship selection committee for considering and accepting my application. This scholarship made a huge difference in my ability to attend this amazing and significant conference.

College of Nurses Aotearoa (NZ) History

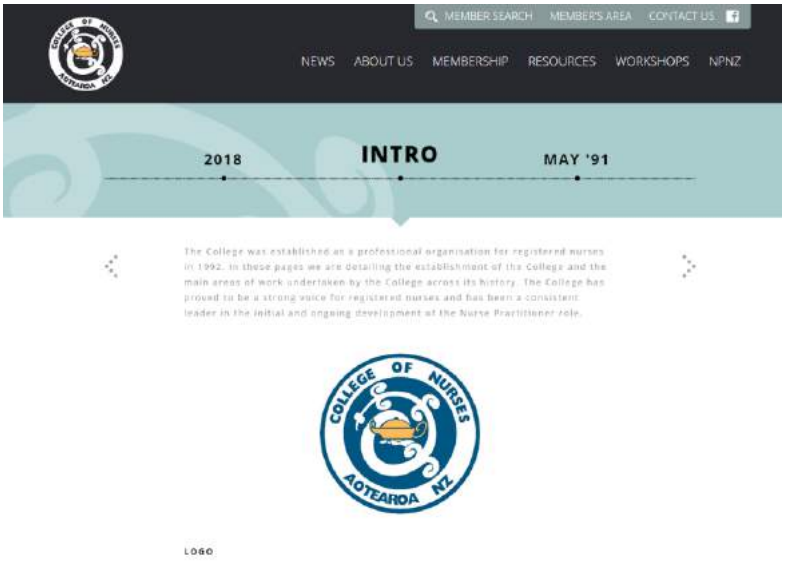
The College of Nurses Aotearoa (NZ) Inc decided in late 2017 to celebrate 25 years since its establishment by collating a timeline of the College's history. At the 11th October 2018 AGM in Palmerston North, the College history timeline went live on the website.

The foundations of the College go back to May 1991, when the editorial board of Nursing Praxis in New Zealand raised the possibility of establishing a 'College of Nursing' and formally invited nurses to attend a 2-day discussion forum on 10-11 Aug 1991. Over the following 10 months the College was established as a professional organisation for registered nurses and on the 24th June 1992, the first enrolment packs were circulated. Since then the College has proved to be a strong voice for registered nurses/ for health policy change and a consistent leader in the initial and ongoing development of the Nurse Practitioner role.

The College timeline provides an overview of the many contributors to the College's development and also to the numerous people who have generously given their time as College Board members. The main events in which the College has taken leadership or has played a significant part are detailed and a number of documents and publications are incorporated, including the very first edition of Te Puawai, the College magazine.

The collation and archiving process will continue and more documents, photos and information will be added.

To view the College history timeline, go to https://www.nurse.org.nz/history.html



Doctoral Research: NPs in Rural Primary Health Care in New Zealand

Liz Manning in conversation with Dr Sue Adams, PhD MSc RN

What made you choose this topic?

I'd been working in a rural general practice in the UK in an advanced practice nursing role – not an NP – but implementing and running nurse-led clinics for the management of people with long-term conditions, as well as triaging walk-ins. I hoped, indeed expected, to become a NP in New Zealand, but I soon realised that it was easier said than done in general practice here.

What were the challenges you faced?

This was back in 2006/2007, and I know some progress has been made, but it seemed that general practices and GPs just weren't ready and didn't have the knowledge of what NPs could do, nor did they seem willing to consider working alongside an advanced nurse with assessment and diagnostic skills who could also prescribe. I felt confused and frustrated by the many mixed messages and information I received from various individuals and organisations across the health and tertiary education sectors. I perceived that there were lots of "fingers in the pie" of the NP project in NZ.

What was your study about?

I wanted to explore how RNs progressed to become a NP and then deliver NP services and understand why the progress to implement NP services in primary health care (PHC) had been so slow, given the Nursing Council's seemingly robust frameworks for education and registration. I used an approach called institutional ethnography (IE) which was developed by a Canadian sociologist and feminist called Dorothy Smith. This approach was perfectly suited to what I wanted to do and how I could begin from my experiences of trying to become a NP. The research approach using IE allowed me to explore how the work and efforts of RNs and NPs was being coordinated and organised by a web of complex information and material being distributed from the many organisations and individuals involved. Ultimately, I wanted to explicate what was happening in the health sector and by doing so would give clues for what could be done to increase the availability of NP services in rural PHC.

What made you focus on rural PHC?

Primarily because rural communities have reduced access to health services, and in NZ we still have an unacceptably high health disparity. Nurses over the past couple of centuries have often

worked in areas which are underserved by the medical profession, delivering services to the poor and underprivileged. The nursing paradigm is concerned with social justice and wellbeing and NPs have this wonderful ability to utilise the medical model in conjunction with their nursing knowledge to provide the best for their communities. The GP workforce is declining, but not only that, NPs offer a different model of care likely to serve our NZ communities very well. International evidence tells us that NP care is at least equivalent to GP care, and often superior. In both Canada and the US, NPs have made significant contributions to the health of indigenous, rural, and deprived communities. However, much of my research is applicable to all PHC.

How did you go about the study?

I began by interviewing NPs and NP candidates from a variety of health providers models and from six DHBs across NZ. Through these interviews I learnt about the incredible effort, determination (known in IE as “work”), and time required to overcome the multiple hurdles faced, as well as what facilitated their journey and spurred them onwards to be a NP. Following the interviews, I traced various policies, processes, regulations, and documentation up through the hierarchy of the health sector to discover how their experiences had been organised institutionally by this material. I also interviewed a range of other people, such as GPs, practice managers, PHO nurse leaders and managers, directors of nursing of DHBs, and senior hospital doctors, to fill in gaps and to understand how things are as they are.

What were your key findings?

There were two key areas – firstly the dominance medicine in the health sector; and secondly, the neoliberal policy environment. The persistence of the bio-medical model, the ownership of PHC by doctors, plus the ongoing policy perception of doctors as leaders of health care, remained problematic. Yet there were also positive examples of GP owners employing and working collegially with NPs. The ongoing use and commitment to locum doctors rather than to train and employ NPs was frustrating to hear. Several of the participants described how they had been encouraged to complete their masters by their employer, but then were not employed as a NP. This makes little sense financially, and certainly does not benefit the patient and community. Instead, the locum doctor model continued. However, there are positive recent examples where NZ Locums are placing NPs into practices, so change is coming.

Secondly, while the neoliberal policy environment in some localities allowed innovation and the development of NPs, the level of competition between providers, and use of general managers, often did not enable RNs to progress along the pathway. Tensions between general practices/other health providers, PHOs, and DHBs often got in the way of NP development. Further the fragmented, contracting environment meant it was hard for local providers and PHOs to implement a sustainable programme of NP implementation and service development, as change and funding occurred all too frequently.

In essence, the development of NP services across NZ was highly variable. What is required is commitment and direction from MoH, HWNZ, DHBs and PHOs, alongside tertiary education and nursing and medical professional bodies, to support and implement the NP workforce. There is

more than enough work to go around, and importantly, we need to provide services to those communities currently underserved.

What was your greatest learning?

I began the study knowing that NPs could make a huge contribution to PHC. Having connected with many people in NZ and elsewhere, and gathered evidence from research and models of care, I am now totally convinced that a NP-led model of rural PHC, working within a collaborative inter-disciplinary team, should be a central goal of the health sector. I completely concur with Rose Lightfoot, an outstanding nurse leader, that we are doing a great disservice to our communities by not providing NP services.

Further reading

Adams, S. (2017). *Nurse practitioners in rural primary health care in New Zealand: An institutional ethnography.* ((PhD dissertation), Massey University, Palmerston North, New Zealand). Retrieved from https://mro.massey.ac.nz/handle/10179/12816

Carryer, J., & Adams, S. (2017). Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study. *Collegian, 24*(6), 525-531. Retrieved from https://www.sciencedirect.com/science/article/pii/S1322769616301895?via%3Dihub doi:10.1016/j.colegn.2016.12.001

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Research Ethics, Medical Injury and Pharmaceutical Companies

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New Zealand has a universal no-fault accident and injury compensation system the envy of much of the rest of the world. The Accident Compensation Corporation (ACC) provides financial coverage and compensation to people injured in a wide range of situations, from the workplace to the sporting field, including at home and traffic-related injuries. ACC also compensates people injured by their medical treatment, and in medical research… but only if that research is not commercially sponsored, that is, funded by a pharmaceutical company.

Essentially what this means is that, if you participate in research in New Zealand that is not commercially sponsored – so, entirely funded by non-pharmaceutical, non-commercial sources, such as universities, hospitals, philanthropic organisations and the Government – and you suffer injury or an adverse event as a result of the research, ACC will provide you with cover and compensate you (for example, medical costs, rehabilitation, loss of earnings, lump sum compensation for permanent impairment, etc.). But, if you participate in research run or sponsored by a pharmaceutical company you are at the mercy of that pharmaceutical company for compensation and recompense.

While pharmaceutical companies are supposed to have insurance that will cover participants' claims to compensation and rehabilitation entitlements in the event of suffering research related injury or harm, the reality is that participants often have to fight to get what they are entitled to, sometimes costing them in legal fees, and they often don't get the compensation they should, if any. The key reason why compensation is not available is because the arrangements put in place in pharmaceutical industry-drafted guidelines governing payment of compensation for injuries suffered in research, state that the sponsoring company's obligation to pay compensation is "without legal commitment." Potential participants, considering whether to enrol, are not required to be given the guidelines, and so are usually ignorant of this crucial fact. The fight for compensation can be protracted and unsatisfactory, and many research participants are poorly informed of their rights or the lack of ability of New Zealand's system to protect them in the event of research- related injury.

The inequities in the rights to compensation between participants in publicly funded research and commercially funded research in this country have been discussed in this Newsletter in the past. Lynda Williams was made aware of the situation several years ago through her attendance at the Health and Disability Ethics Committee (HDEC) meetings. In her tribute to Lynda last year (AWHC September 2017 Newsletter), Prof. Jo Manning wrote:

"I don't know exactly when it was – maybe about two years ago – when Lynda said to me that she had learned from a meeting on research ethics she had attended in Dunedin about the case of a man, a builder, who had suffered some kind of injury to his heart in a pharmaceutical drug trial,

such that he could no longer work. The drug company had successfully resisted paying him any compensation for his injury to that point (they later did reach a confidential settlement with him)."

"Lynda urged me (being an academic medical lawyer) to research the legal and ethical issues relating to the compensation rights of people who are injured in medical research trials... What I was to find shocked us both, more so than either of us expected."

In August 2018 the HDECs amended the recommended wording in their patient information sheet (PIS) template on their website (https://ethics.health. govt.nz/), and in their Winter Newsletter said "We have recently updated the suggested compensation wording for "commercially sponsored" intervention studies. Please use the updated wording in future Participant Information Sheets." (see the boxed section on page 7 for the full updated wording).

AWHC attends the Northern A HDEC meetings on a regular basis and we have noted that researchers have been directed to the updated wording for the PIS template. This is noted in the minutes of recent Northern A HDEC meetings and to a lesser extent the minutes of the other three HDECs.

However, AWHC is concerned that even the new wording is insufficient protection for participants, and furthermore, most potential research participants would not be aware of just how vulnerable and unprotected they would be in the event of harm or injury caused in a study. The current recommended wording states:

> *"If they decide not to compensate you, you may be able to take action through the Courts for compensation, but it could be expensive and lengthy, and you might require legal representation. You would need to be able to show that your injury was caused by participation in the trial."*

The recommended wording also points out to participants that, on their own, the Industry Guidelines are not legally enforceable, and may not provide ACC equivalent compensation.

We are concerned that potential participants may not understand the import of these statements, and believe that only a law change to enforce compensation for harm and injury in commercially sponsored research is acceptable.

While believing that the changed wording is an improvement, Prof Jo Manning still has considerable concerns, and believes that the wording still does not adequately explain to potential participants their true position. She says "It would be better to simply say: 'Sponsors cannot be legally required to pay you compensation for your injury under these guidelines, because they clearly state that their payment of any compensation is without legal commitment.'

"It is incomplete to say that if you sued in a court, 'You would need to be able to show that your injury was caused by participation in the trial.' The injured participant would also have to prove that their injury was caused by the negligence of the sponsor or researcher, which is very difficult to establish."

The New Patient information Sheet recommended wording

As this research study is for the principal benefit of its commercial sponsor [insert name], if you are injured as a result of taking part in this study you won't be eligible for compensation from ACC.

However, [insert name] has satisfied the [insert name] Health and Disability Ethics Committee that approved this study that it has up-to-date insurance for providing participants with compensation if they are injured as a result of taking part in this study.

New Zealand ethical guidelines for intervention studies require compensation for injury to be at least ACC equivalent. Compensation should be appropriate to the nature, severity and persistence of your injury and should be no less than would be awarded for similar injuries by New Zealand's ACC scheme.

Some sponsors voluntarily commit to providing compensation in accordance with guidelines that they have agreed between themselves, called the Medicines New Zealand Guidelines (Industry Guidelines). These are often referred to for information on compensation for commercial clinical trials. There are some important points to know about the Industry Guidelines:

- On their own they are not legally enforceable, and may not provide ACC equivalent compensation.
- There are limitations on when compensation is available, for example compensation may be available for more serious, enduring injuries, and not for temporary pain or discomfort or less serious or curable complaints.
- Unlike ACC, the guidelines do not provide compensation on a no-fault basis:
- The Sponsor may not accept the compensation claim if:
  - Your injury was caused by the investigators, or;
  - There was a deviation from the proposed research plan, or;
  - Your injury was caused solely by you.
  - The injury was caused by <<NAME OF COMPARATOR DRUG>> (include only if holds true for specific study)

An initial decision whether to compensate you would be made the by the sponsor and/or its insurers.

If they decide not to compensate you, you may be able to take action through the Courts for compensation, but it could be expensive and lengthy, and you might require legal representation. You would need to be able to show that your injury was caused by participation in the trial.

You are strongly advised to read the Industry Guidelines and ask questions if you are unsure about what they mean for you.

If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

She goes on to say that she hopes "that potential participants decide that it is too risky to enrol, on learning that they have no legal right at all to compensation from the sponsor if they are injured, nor from ACC. That might prompt the industry to support ACC cover for commercial trials or to put in place access to legally enforceable compensation."

In a recent submission that AWHC made to the National Ethics Advisory Committee on the Draft National Ethical Standards for Health and Disability Research we wrote:

"We believe that all commercially sponsored studies must be required to provide adequate no fault compensation and rehabilitation entitlements. Commercially sponsored research that does not include such provisions must not be approved in New Zealand. The provision of compensation must be legally enforceable and participants must not have to engage legal representation in order to obtain compensation for injuries or harm sustained as a result of participating in research.

While the guidance in the standards requires greater transparency on the part of researchers and their commercial sponsors, there is still a lack of compulsion or enforceability to provide compensation even if the sponsors are required to provide evidence of holding adequate insurance. Injured and harmed participants should not have to fight to get just and reasonable compensation for their injuries. Under the current situation, we also do not believe that most participants/potential participants are made sufficiently aware - before they consent to participate - of their vulnerability in the event that they sustain an injury as a result of the research in which they participate. Recent changes in the PIS template text regarding compensation in commercially sponsored research have improved the situation, but this is still inadequate.

The underlying principle is that there should be no cost financial or to health and well-being – to participants for their participation in research no matter who is sponsoring the research, and in the knowledge that the risk of harm, no matter how small, still exists in each and every study, any participant harmed in any way should be compensated for that harm."

Nurse Practitioners New Zealand (NPNZ) are holding their next conference in the magnificent and beautiful Marlborough region of New Zealand well known for the fabulous waterways of the Marlborough Sounds, many famous wineries and New Zealand's highest sunshine hours.

Joins us for a dynamic program showcasing innovative NP practice, skills, knowledge, workshops and hot topics. Come network with your colleagues!

The two and a half day format will comprise of:
10 April - afternoon sessions with a variety of speakers about the NP pathway in NZ 12.30 - 5.30pm

11 & 12 April - full days of Keynote speakers, significant nation-wide health sector updates and concurrent sessions of field specific case studies including pharmacology.

Conference dinner to be held at the stunning Wither Hills Winery

We encourage you to bring your partner or family and stay for the weekend, or the school holidays in the

"Top of the South"

Register

College of Nurses Aotearoa (NZ) Inc Life Members

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