LOGIC.
LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION
The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO
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NZ College of PHC Nurses, NZNO 2016 Timaru Symposium

Sexual Health

Diabetes

Immunisation Update

Skin Tears

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In this issue….

Chair's Report

Kim Cameron
Chairperson

Life is one gigantic journey made up of legions of smaller expeditions. Will it be our passion which lights our way?

For the last two years I have been on a professional journey to become a diabetes clinical nurse specialist and I am proud to say that with support from those around me and the completion and successful PDRP submission to nursing expert I have finally reached one of my nursing goals. Accomplishing this goal offered me an opportunity to meditate and reflect on my journey. Here's what I came up with...

According to the dictionary a journey can be defined as the process of changing or making changes. In some cases change can be forced upon you or someone might challenge or expect you to change. Sometimes we ourselves may want or desire change.

Journeys are about learning and growth; they can define who you are, reveal your shortcomings and teach you about life and the communities and societies you live in. How you interact and respond on your journey will influence whether you reach your desired destination or not. Reaching your desired destination will also depend on your attitude. Someone once wrote "Achieving your greatest potential in life is to learn to monitor your attitude and its impact on your work performance, relationships and everyone around you". A positive attitude can be displayed in many ways such as positive, creative and constructive thinking. As well as optimism, motivation and the energy to create and to make the changes and to accomplish your goals which you frequently set yourself along the way.

Journeys can sometimes be long and arduous or quick and painless; they may be satisfying or leave you feeling exhausted, disappointed and fed up. Throughout these journeys you will be challenged and confronted by many different situations which could block your path causing you to falter, stumble or fall flat on your face.

A power we all have is the ability to choose whether to get back up again through self-motivation and self-encouragement or to wallow in self-defeat and pity and refuse to go further. However, it is the obstacles, as well as the challenging situations which test your ability, capabilities and capacity, as well as your courage. They also help you to find your strengths and

weaknesses, and build your self-resilience and determination to reach your ongoing aspirations and goals. Accomplishing your goals is a great feeling so take the time to tell yourself "well done" but also reflect and consider how you got there. What did your journey teach and show you about yourself; what did you learn along the way; what changes did you make; what went well and what did not; was the journey a negative one or was it everything you expected it to be?

We all know, nursing and nursing care has been through some remarkable changes. In most cases nurses have adapted and dealt with change however in other aspects we have stumbled but in order to keep up with the ever changing face of New Zealand's healthcare system; an ageing population and advancing technology nursing will have to continue to adjust, modify and redesign nursing services.

We all know trying to change any established behaviour is exceedingly challenging but it is particularly difficult in the healthcare arena due to the vast and complex relationships between a wide range of organisations, health care professionals, clients and carers. We all know that in order for change to occur we need to identify, understand and overcome the barriers to change; within ourselves; our nursing services and organisations and within our communities, also at a national level. In order to break down these barriers to change; we also require knowledge and awareness, motivation, acceptance and belief and the skills necessary to carry us and sustain us throughout the journey.

Our future nursing journey will not be easy and it will be strewn with challenges, like

- How do we improve consumer health literacy?
- What policies and local service/organisational changes are required?
- What legislative and system changes are required?
- What professional changes are required?
- How do we involve and respond to consumers?
- How do we create and sustain comprehensive access to quality healthcare services?

As nurses we all need to take this journey together. To move into the future we will need unite, to plan, rewrite and implement change in whatever capacity that might be, so we do not lose step backwards but to build on the gains which we have made: We cannot delay - *"let our passion be our guiding light"* so all New Zealander's (whom we serve) will continue to receive optimal care and treatment from a proud and successful nursing workforce.

Here is a web page that I stumbled on whilst doing a little reading…

https://www.nice.org.uk/media/default/about/what-we-do/into-practice/support-for-service-improvement-and-audit/how-to-change-practice-barriers-to-change.pdf

Furthermore:

To all of our nursing peers in and around Kiakoura and Christchurch our thoughts and prayers are with you.

"Ehara taku toa i te toa takitahi engari he toa takimano"

My strength is not that of an individual but that of the collective.

"E waka eke noa".

We are in this together.

Stay strong Aroha nui

<u>But that's not all….</u>

Just to let you all know that the NZCPHCN symposia in Timaru went very, very well. Thank you to all of the speakers who gave up their Saturday afternoon to share their knowledge and skill with those who attended. Thank you to all those nurses who attended. Also a big 'thank you' to the organising committee you did an amazing job. We look forward to next year's symposia in Auckland and Christchurch (fingers crossed)

<u>Last but not least…..</u>

As this will be our last journal for the year I would like to take this time to say Meri Kirihimete/Merry Christmas and a Happy New Year to all of. May you and your whanau stay safe as you enjoy the festive season.

Karakia/blessing

Chief Nurse's Report

Jane O'Malley
Chief Nurse

A call to action for primary care nurses

The 2016 New Zealand Health Strategy (NZHS) has a strong emphasis on primary prevention and early intervention to ensure New Zealanders *live well, stay well, get well*. Realising the vision of the health Strategy vision will require maximal effort of the health workforce.

Nurses, as well as utilising their traditional nursing knowledge and skills, will need to respond to whatever situation presents itself and treat it as an opportunity to support people to *live well, stay well or get well.* They will need to activate and demonstrate ability in assessment and supportive interventions for, for example parenting, smoking cessation, nutrition and exercise management, health literacy, brief counselling for mental health maintenance and supported self-directed care, system navigation and cross agency (education, welfare, housing) collaboration.

Recent discussions with nurses, at the Coromandel Nurses Forum and at the NZNO College of Primary Health Care Nurses workshop in Auckland, tell me that nurses understand what the NZHS is requiring and that the call to prevention and early and upstream intervention makes absolute sense to our profession. They also understand that the current models of care, systems of funding and pathways of care are fragmented, reactive and create access issues and inequalities. In other words they understand the need for change. But change is not easy and in the hubbub of everyday demand, often seems nigh on impossible.

Nevertheless change is possible and indeed happening and I want to share with you two presentations from the Auckland meeting that I found tremendously motivating

Karen Hoare, general practice owner/partner at Greenstone Family Clinic in Manurewa, nurse practitioner and Auckland University academic talked about her experience with colleagues in delivering care to young people. She told us how the practice has been very thoughtful about the needs of the population and how utilising the available workforce differently can better serve people. Karen noted that a "well organised primary care can compensate for substantial social disadvantage". The ratio of GPs to nurses is changing as the NP role is embedded and nurses pick up more responsibility for care.

The practice has embraced the need to induct and support young practitioners in to primary care and since 2008 the practice has employed seven new graduate nurses. The growth of new graduates' appetite for primary care starts with placements in their

undergraduate programme. Postgraduate study amongst the practice nurses is also encouraged and a new graduate of a few years ago is almost ready to submit her NP portfolio.

Karyn Sangster Chief Nurse Advisor Primary and Integrated Care at Counties Manukau DHB told the group about significant practice change spurred on by GP Dr Tim Hou's observation that the traditional primary care model wasn't working well for people with long term health conditions. In order to better meet the needs a planned, proactive care programme has been developed. The programme is overseen by a clinical governance board with nurses, allied health and doctors supported to provide more purposeful assessment, care planning and care coordination to over 21,300 people with long term conditions. All the people in the programme now have an electronic shared care plan visible across the health system.

A strategic narrative for change

A recent discussion with a senior primary care nurse has motivated me to consider further developing, with the sector, a strategic nursing leadership narrative for guidance, use and adaptation by NZ nurses to assist in the journey of change. A strategic nursing leadership narrative would align itself with the vision of the NZHS. I imagine the call to action will be *every place is the right place*, for responding to the health needs of people. A substantial shift will be required away from traditional places of care (hospitals) to care closer to peoples home and as directed by their needs. Corresponding shifts in nursing education and in models of care, alongside ongoing removal of any barriers to innovation will need to occur. I look forward to sharing the early draft of a strategic narrative with you early in the New Year.

In the meantime I want to thank you all for the remarkable work you do in primary and community care for New Zealanders, I wish you a very safe and happy Christmas and a wonderful 2017.

Co-Editor's Report

Co-Editor Yvonne Little,

Nurse Practitioner Primary Health Care

Welcome to our fourth and final e-journal for 2016. It is hard to believe that at this time last year we were preparing to make the change from a hardcopy to an online journal.

We hope you are enjoying our new look journal and once again thank you for your patience, especially with the first two issue delays, whilst we have learnt the art of putting together the e-journal. There is a saying "The road to success is always under construction", and that is certainly how we as a committee have felt over the past 12 months.

Thank you also for your feedback both constructive criticism and positive alike, we listened and this has helped us to redefine and make the journal reflective of what our members wish to see. We apologise for the fact that the link didn't work for everyone and we have now remedied that by having both the link and a PDF version that you can download.

As you can imagine it has been learning curve for our team, we are not journalists or publishers but regular hard working nurses like yourselves.

Please keep the feedback coming, our aim is to provide a journal that meets your needs, so if you feel we are missing areas of practice then please let us know, write an article or talk one of your colleagues into writing one. It is contributions from our members that make the journal a pleasure to work on.

This year the NZPHCN has embarked on another break from tradition, moving away from a two-day conference in Wellington to two symposia one in the North Island and one in the South Island. We had a very successful (although some would say stressful) symposium in Auckland (August 27th) and have just completed a smaller but no less successful symposium in Timaru (October 29th). Rather than use international speakers we also utilised our own home grown expertise and concentrated on knowledge and skills as our members had requested.

I would like to congratulate my colleagues on their successes this year (gaining NP status – Kate Stark, Katie Inker and wishing Donna Mason the best as she goes before Nursing Council in December for her NP status) and a big thank you to Celeste for stepping up to the publisher role, despite your heavy workload and symposia committee commitments you have fine- tuned the e-journal with each issue.

We added a new member to our team at the AGM – Welcome aboard Irene Tukerangi.

We bid farewell to a long-standing, hardworking member and wish her and her family the best – thank you for your support over the years Lynette Law.

Recently at our face to face in Christchurch before the symposium we seconded

another member to our team – Welcome aboard Emma Hickson, some of you may know that Emma has been on the Professional Practice Committee before, she has a wealth of knowledge to bring with her.

In this issue we have:

Symposia photos, articles from speakers and a snapshot of our members who attended (thanks to our roving reporters Donna Mason and Katie Inker.

Elder care; Skin; Sexual Health; Diabetes; Immunisation update

What are our plans for 2017?

We have a new feature article planner already to go and you can see on the side bar here what our main topics for 2017 will be, but that does not mean we don't want other articles from you our members, so please keep them coming in.

Also, you will have noticed a lack of advertising this year, that is mainly because we have been working on getting the e-journal articles looking professional, we now have a new rates card and contract sorted to send out to our previous advertisers and have had many contact us already about continuing with advertising in the journal, so watch this space for University courses, product information and the likes.

We will bring to you in each issue information around our symposia for 2017.

It is also good for you to know a little about our committees, therefore our aim in the first three issues is to have each of the committees have a group photo (with names) and a short bio about them. We will be starting with the LOGIC committee in the March issue, National Executive committee in June issue and Professional Practice committee in September issue.

We will also have information about Regional Representatives and if you are interested and your area doesn't have a name listed then please contact the National Executive to discuss.

Apart from our everyday work and NZCPHCN committee work, many of us are External Representatives on other committees and we will keep you up to date with who these people are and their roles.

Personally, I would like to say thank you to an amazing, strong, forward thinking group of women become stronger and after Timaru I think we know each other so much better having been housemates for a few days and the road trips to and from Christchurch.

From the LOGIC committee I would like to extend a big thank you to our article and report writers.

On behalf of the team I wish everyone a safe holiday season, enjoy time with family and friends and thank you to those who will be working on Christmas and New Year.

March 2017

- Respiratory (bronchiectasis, bronchiolitis, children, adults, spirometry, pneumococcal disease)
- Mental Health
- Diabetes
- Rural Muster
- Education – cultural linked to feature topics
- Events – for upcoming 3 months

June 2017

- Orthopaedics/musculoskeletal
- NGO's
- Support agencies
- Mental Health
- Diabetes
- Rural Muster
- Education – cultural linked to feature topics
- Events – for upcoming 3 months

September 2017

- Skin
- Telehealth
- Cervical Screening
- Prostate screening
- Mental Health
- Diabetes
- Rural Muster
- Education – cultural linked to feature topics
- Events – for upcoming 3 months

December 2017

- Party Health (sexual health, alcohol, recreational drugs, violence, gastro bugs)
- Mental Health
- Diabetes
- Rural Muster
- Education – cultural linked to feature topics
- Events – for upcoming 3 months

RURAL MUSTER #1

Kate Stark – Nurse Practitioner

Welcome to the first of our new column with a rural flavour for primary health care nurses. This week's column will describe the nuts and bolts of the current review of PRIME services (Primary Response in a Medical Emergency) which began in July.

Being part of the PRIME Review Steering Committee has been a timely reminder of the uniqueness of being rural. In response to feedback from PRIME Practitioners across New Zealand to NASO (National Ambulance Sector Office) in June 2016, a national review was launched. The key aim underpinning the review is to ensure there a safe, sustainable future for PRIME.

It has already been established that PRIME adds value to the emergency health services rural people have access to.

Simultaneously it has been identified those working at the coal face need to be well supported for this to continue to be a successful adjunct to rural primary health care. Primary health care nurses and doctors are key to the continuation of PRIME and should be applauded for their ongoing dedication to what is a challenging, isolated and often anxiety provoking role.

The current review aims to ensure that going forward, PRIME functions in the best interests of patients, PRIME staff and key stakeholders such as St Johns, The Ministry of Health, (MOH) and the Accident Compensation Corporation, (ACC), while being centrally and locally balanced with strong governance. While there is no extra funding for PRIME, there is a need to utilize the current funding smartly to ensure continuation of this critical service for patients residing rurally.

The Review consists of a PRIME Review Steering Group and five working parties including Funding, Administration, Clinical Governance, Training, Syllabus and Equipment and Kit and Medicines. Each group has representation from individuals such as PRIME Practitioners, organisations such as The New Zealand Rural General Practice Network, The New Zealand Royal College of General Practitioners, secondary care specialists with a strong link to PRIME, The College of Primary Health Care Nurses as well as members of St John, ACC and MOH.

Representing the College of Primary Health Care Nurses and being a rural primary health care nurse who is passionate about PRIME has given me a great opportunity to be involved in this review. Primary health care nurses all work hard as part of a team to make health care accessible to the rural community, with many

nurses practising in rural areas in the PRIME role. Nurses work in varying degrees, some rural, some more rural, some remote and some very remote. Regardless of the degree of rurality, one thing remains constant- we face challenges different to being urban. We must ensure that PRIME going forward is sustainable and fit for purpose for recipients of care and service providers alike.

This project has been exciting, undoubtedly challenging and intense with a short time frame. The PRIME Review Steering Group will receive recommendations from the five working parties to the overall PRIME Review Steering Committee by the end of October. The Steering group met in November and are in the process of reviewing the recommendations received from the work streams and will compile a final report to NASO.

This review has been undertaken on a voluntary basis by members of the various groups involved and I salute you all for your varying contributions. The project's completion is scheduled for April 2017 and we hope to see a stronger more sustainable future for PRIME services going forward.

Leadership

Seven Common Misconceptions

Let's start with some myth-busting…

I believe there are many misconceptions surrounding leaders and leadership development. These misconceptions alienate people from starting the learning process and can even stop individuals from thinking of themselves as leaders. Let me explain.

Myth One: You have to have a title to lead

I often hear people say that leadership is purely the responsibility of CEO's and managers, people with a formal title in their role. I disagree. Some of the most amazing leaders I have come across have no formal position at all.

I think of the hospital orderly who, when asked about his job, described it not as pushing beds from ward to ward, but as being the eyes and the ears of the hospital, helping people when they were looking lost or seeing spills before anyone else and cleaning them up even when it wasn't his job. Seeing what needed to be done and doing it. He said he saw his role as one of serving the people he came into contact with on a daily basis, any way he could. He didn't have 'leader' in his job title but I think he showed great leadership.

Leadership doesn't require a title. In fact sometimes people with leader in their title show very little leadership. Leadership is about your everyday behaviour and actions. It's about who you are being while you're doing what you're doing. As Stephen Covey astutely noted *"leadership is a choice not a position".*

Anyone can lead. You can lead. Yes you.

Myth Two: You need to have qualifications to lead

Without wanting to offend people with qualifications I have met many individuals with post-graduate qualifications in management and/or leadership that I would not let loose with my goats, let alone let them

One of New Zealand's most respected adult educators, Linda Hutchings is on a mission to dramatically improve the way we develop and support our aspiring leaders. Linda chooses to work with people who want to make a profound positive difference in their family, in their community as well as their workplace. With over 25 years' experience as a catalyst for learning, Linda has a phenomenal reputation for making learning thought provoking and her sessions are life changing and, heaven forbid, even enjoyable! She is fascinated by what works in practice and while theory underpins her work, she is always driven by the question – "how do you actually do that?" Whether it's facilitating a meeting that encourages vigorous, healthy debate, raising that uncomfortable body odour issue with a team member or influencing team culture you can be sure Linda has done the research and thinking around how best to develop the competence and confidence to tackle the issue.

lead people. Knowing about leadership and actually doing leadership are not one and the same!

In my community there is a young lad called Jack. When Jack was eight he learned about the struggle elephants had surviving in Thailand and that it can take $20,000.00 to save one. Well, Jack set about saving one. He started offering to wash cars, he made scones and pikelets and sold them as he enlisted other young people and the local community in his vison. Within 2 years Jack had raised the $20,000.00 he needed to save his first elephant who he named *Kwan Jai*, Thai for beloved. At the time of writing, Jack is now busy saving for his third elephant and held an exhibition of his elephant drawings at our local Museum. Jack has no formal leadership qualifications just a burning desire to make a difference. I follow his life with interest!

Don't get me wrong, there is amazing research being done to understand how we can become better people and better leaders. But reading and learning doesn't guarantee application. Knowledge is not useful unless it is applied. It is not what you know about leadership that makes a difference, it's what you do and what you apply over and over again until it causes you to transform your new knowledge into a new behaviours. This will not happen from just getting a qualification in leadership, attending a leadership workshop or reading this article. Believe me, I know. You can read all the diet books in the world and never lose a pound! The key then, is not knowledge but doing, experimenting and practicing. Lots and lots of practicing.

Practice what you know. And then practice some more.

Myth Three: There is one right way to lead – the latest leadership fad

There are lots of leadership models, and I mean lots. This often leads to the supposition that the latest book or theory is the way we should be leading – the latest fad. For example, we all need to become 'transformational leaders' or 'charismatic leaders', or maybe 'servant leaders'. I have numerous aversions to this thinking, not the least being that this involves all leaders trying to be the same!

Rather than just accepting someone else's take on what it means to show leadership, part of leadership development is working out what matters to you and why. As Socrates said *"the beginning of wisdom is the definition of terms".*

One of the best examples of I can think of here is Sam, the Canterbury University student who, through his social media prowess, marshalled hundreds of students and then farmers and many others to help shovel tonnes of liquefaction after the Canterbury earthquakes.

Having met Sam a few years ago when we both spoke at the Mental Health Nurse's Conference in Christchurch I am confident that Sam didn't wake up at 2.00am asking himself which leadership model or approach he should follow. He just did what was right for him, using the strengths, skills and knowledge he had. He took action.

Sam would be the first to admit that there were a number of things he had no idea how to do when he started. But that didn't stop him. He was willing to ask for help and let others use their talents and strengths. He wasn't following a particular leadership model though. He just listened to his heart and his head and acted. I can see why UNISDR (United Nations International Strategy for

Disaster Reduction) would want him on their team.

Start with your talents and strengths. Anywhere.

Myth Four: Leaders are born, managers are made

This is of course the great nature / nurture debate. Is leadership an innate quality? Are some people just lucky enough to be born with the right leadership genes? Or is leadership (and management) a set of skills and behaviours that anyone can learn given the motivation and opportunity?

Of course if you were born with the right bunch of qualities and skills we could just do a quick test to see if you had the right stuff or not. If you didn't, well then we could just pack you on your way and suggest you look at alternative career options! But it's not quite as simple as that.

I believe leadership is learned. All the good leaders I've met seemed to have worked hard to learn, practice, reflect on their mistakes and then learn, practice and reflect on their mistakes in a permanent ongoing cycle.

I think what's more important than the nature / nurture debate is the work of Carol Dweck. Her research focuses on whether we have adopted a **'fixed mindset'** (where we think our intelligence and abilities are fixed and can't be changed) or whether we have a **'growth mindset'** (where we believe that our intelligence, skills, personality and behaviour can develop and improve with intentional effort).

Personally, I would rather spend my time and energy focusing on identifying the core skills and behaviours of great leadership and working out the best ways I can to improve these skills. Like building relationships, leading change and growing more leaders.

Your skills, personality and behaviour can improve. What are you working on? Today.

Myth Five: Leadership is other people's responsibility – it's not my job

This is a line I hear a lot, well it's the manager's responsibility, or the last person should have sorted this, or the Government or someone, anyone other than me 'should' step up and lead.

A great example of not waiting for others to lead is provided by another young person in my community, Emily. Pumpkin Patch is her favourite clothing store but she was unhappy about the models they used. She got a petition together, visited the local MP's office and wrote to Pumpkin Patch's marketing department saying *"I never see children like me with freckles or like my friend Ashleigh with red hair or Lauren with glasses. I never see children like my friend Christine from Africa or my brother who has a wheelchair either.''*

While some children might complain about the situation, few would probably take action like Emily did. She reinforced her point to Pumpkin Patch *saying ''It would be excellent if you could consider everyone as catalogue 'models'. I hope Pumpkin Patch know about campaigns like the Dove Real Beauty programme and the Dove Self Esteem Fund. Dove is helping people and children feel better about themselves, promoting equality and inclusion.''*

Emily says she wasn't sure Pumpkin Patch would reply or whether they would even be interested in what she thought. But the Marketing General Manager provided an immediate response, thanking Emily for her feedback and for raising her concerns. Pumpkin Patch then arranged a special

model shoot for Emily and her friends.

You might be noticing a theme here that leadership is an action-oriented activity which anyone can step into – if they so choose.

Leadership is about action. Your action.

Myth Six: Leadership is about being perfect!

I've yet to meet the perfect leader – in fact I doubt they exist! Most of the best leaders I have come across have made many mistakes, with some making some real doozies. However, it's those mistakes, the hiccups, screw-ups and total embarrassments they made that often helped to make them a better leader. Well… not so much the actual mistakes, but their willingness to learn from them.

By examining their own behaviour, admitting and learning from their mistakes these leaders have fast tracked their leadership development. They searched their stuff-ups for valuable lessons. They have been willing to be vulnerable, 'fessed up' and often sought wise counsel from trusted mentors and advisors. As Porras, Emery & Thompson suggest in their book Success Built To Last *"they got greedy about extracting all the learning".*

The best leaders go further though, they don't just reflect and learn from their mistakes, they share their mistakes and their learning and by doing so, display both vulnerability and humility – two key leadership behaviours which help earn deep trust and respect.

Many leaders have been unmasked by trying to have a perfect front and hiding what makes them human – their mistakes! Don't worry about being perfect, focus on being transparent. We are in the era of leadership in a gold fish bowl, where everything we do can be photographed, tweeted or blogged about. So if you don't 'fess up', someone else is likely to do it for you!

So, don't waste your mistakes by dismissing them. The next time you make a doozy of a mistake ask yourself what I can I harvest from this? And who can I share it with!

Extract every bit of learning. Get greedy!

Myth Seven: Leadership is complex

I sometimes wonder whether we have made leadership sound like a complex topic to scare people off from learning it. I mean, if nine year olds can lead without studying it for five years yet some of our most highly qualified leaders can embezzle superannuation funds or create highly toxic workplaces then what does that tell us about learning how to lead?

I think leadership is simple. Note that I didn't say it was easy. Simple and easy are quite different concepts. For example it's simple to lose weight right? We all know what we need to do to lose weight - eat less, exercise more! But just because we know what to do that doesn't it make it any easier to do. As I often say, if leadership was easy everyone would be doing it and everyone would be doing it well. However, this clearly isn't the case.

So what I mean when I say leadership is simple is that we know a lot about the core skills and behaviours required to lead. And that's both to lead ourselves and others. However, getting ourselves to apply that knowledge is much more of a challenge. As Suzanne Mercier said *"the hardest person you will ever lead is yourself".*

Leadership is a privilege and is one of the most rewarding

roles anyone can have. It is messy, challenging and unpredictable. And hard. At times very hard.

A good place to start is right now. By taking the time to write answers to these questions:

1. What does 'leadership' mean to you?
2. Why do you want to lead?
3. Who are your leadership role models? Why

It is a privilege to lead. Are you up for the challenge?

What do you think?

Are these the only misconceptions about leadership? NO! There are definitely others, but these are the ones I most commonly encounter that hold many good people back from leading or pursuing leadership roles. People I would love to see step up and lead.

So, here's my take:

1. Anyone can lead. You can. If you choose.
2. There is no one right way to lead. Use your unique passions, strengths and talents and start. Anywhere.
3. Learn as much as you can. Remember the litmus test is whether you use what you know. Practice. Often.
4. Adopt a growth mindset. Work on improving you. Today.
5. If you see a need, do something. Take action. Step up. It's what leaders do.
6. You are human. You will stuff up. 'Fess up, get greedy on the learning and move on.
7. In theory, leadership is simple. In practice it's messy. Therein lies the joy.

There is no finish line with leadership learning. The sooner you start the better. Encourage others to start learning too.

More information

Linda offers a range of leadership development progammes and seminars and is a frequent keynote speaker. If you would like more information visit www.lindahutchings.com or contact our office by emailing fleur@lindahutchings.com or phoning Fleur on 0273 346450.

Skin tears

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Nurse Practitioner – employed part time by Health Care of New Zealand – an organisation in Primary Health Care where I work within the ACC nursing contract seeing acute wounds and clients with serious injuries and wounds. I am a designated provider for ACC carrying out assessments as requested on clients who have wounds that are slow to heal

I am also employed part time by Massey University as a Senior Professional clinician where I run a Post graduate wound management paper for registered nurses.

Skin tears are traumatic injuries which result in full or partial separation of the outer layers of the skin (Stephen-Haynes & Carville, 2011) and can become chronic wounds if not managed well There are a variety of causes, including blunt force trauma and falls where shearing or friction forces are applied to vulnerable skin. The highest risk group for skin tears are the elderly and anyone with fragile skin such as the very young or critically ill. There is a dearth of data around the size of the problem in New Zealand but a 3 year study in Western Australian hospitals found a prevalence of 8-11%, the third largest group of wounds (Wound West, 2009). If the become chronic wounds skin tears end up costing the health provider in monetary terms and the patient with loss of quality of life.

Skin tears occur most frequently on the extremities and the pre-tibial regions is a common site for the elderly and one which can be difficult to heal.

Skin changes in the elderly

These are one of the main reasons why the elderly are at a high risk of developing skin tears following injury. The changes which occur include:

- Thinning of the epidermis (Baranowski & Ayello, 2004)
- Flattening of the dermo-epidermal junction – both of these increase the susceptibility to damage from mechanical forces such as shear.
- 20% reduction in the thickness of the dermis and resulting reduction in blood vessels, nerve endings and collagen
- Reduction in immune response and ability to regenerate (Wounds UK, 2012)

Assessment of patients with skin tears

All patient's must have an holistic assessment particularly including the risk factors as identified in Box 1. An assessment of the skin tear should categorise it. There are 2 tools used for this, Payne Martin and STAR. Payne Martin has 3 categories and 2 sub categories, but was poorly utilised in Australia which led to the development of STAR (Stephen-Haynes & Carville,

2011) which uses 5 categories – see figure 1.

Management of skin tears

The principles of management of skin tears are:

- Preservation of the skin flap where possible
- Reducing the risk of infection
- Controlling oedema

Approximating the skin flap:

The wound should be cleaned with warm saline or water to remove any residual debris and the skin around gently patted dry. If the skin flap is still viable, it should be ease back into place without pulling or applying tension (The all Wales Tissue Viability Forum, 2011) a dampened cotton bud is the most effective, forceps can be used with extreme care but it is easy to tear the flap and this should be avoided. A moistened non-woven gauze swab can be used a placed over the flap for about 10 minutes if the flap is dry.

The dressing should be a silicone one to reduce the risk of adherence and further damage; there are now several of these on the market. Steristrips can be used sparingly, but there must be room between them to allow drainage of fluid. Neither steristrips or sutures are recommended for pre tibial skin tears, but are still commonly used in Emergency departments (Beldon 2008). Sutures in particular often tear the fragile wound edges and steristrips stretch the skin and are often applied in a way which impairs fluid drainage and results in build-up of a haematoma. When a dressing is applied, it should have an arrow on it to indicate the way to remove it to prevent damaging the flap on dressing change.

Prevention of infection:

Infection can be a problem if the skin tear was caused in a dirty environment, other factors are presence of non-viable tissue in the wound and presence of an unresolved haematoma. If a wound occurs in a dirty environment, betadine is still an effective first aid cleansing agent after the wound has been thoroughly cleaned, but its effectiveness is short term. An anti-microbial product can be useful in the first dressing – examples of these include silver, honey and iodine (slow release). Unless there is a presence of inflammation more than 2 cm from the wound edge, antibiotics may not be needed (Australian Wound Management Association, 2011*).* In the early stages the wound should be monitored for signs of infection either by the staff or the patient themselves.

Managing Haematomas:

A Haematoma is the result of shearing separating the skin and subcutaneous tissue from the muscle fascia creating a space for blood to pool. This creates a high pressure force and results in tissue necrosis, even if necrosis does not occur there is normally a permanent raised skin defect which is prone to future damage (Pagan & Hunter, 2011). If allowed to solidify, the blood in the haematoma provides the perfect medium for bacteria to thrive. Haematomas must be removed, either by someone skilled in sharp debridement or by autolytic debridement combined with an anti-microbial – for example medical honey.

Controlling oedema

This is particularly important in the lower limbs, and can speed up healing and help prevent infection and formation of haematoma. Oedema reduces blood supply to the wound and increases the risk of necrosis and infection. Firm toe to knee bandaging (a 10 cm wide soft cotton layer and a 10cm crepe) should be applied on all but patients who have compromised arterial supply. This may only be necessary for the first week, but if oedema does not resolve, a vascular

assessment should be completed so that compression bandaging can be applied if appropriate.

Preventing skin tears

People with history of skin tears should be targeted for prevention. If specific risk factors have been identified these should be addressed e.g. skin care, improving nutrition and hydration, limb protectors, exercises to improve balance, advice to patients around first aid treatment and the need to see their Primary Health Care Practitioner as soon as possible. As nurses we need to ensure we do all we can to reduce the health costs to the provider and more importantly improve the quality of life for those who develop skin tears by reducing the risk of a chronic wound developing.

References

Australian Wound Management Association (2011) Best Practice Statement; Bacterial impact from contamination to infection. Australian Wound Management Association.

Beldon, P. (2008). Management options for patient with pretibial lacerations. *Nursing Standard 22* (32) 53-60

Pagan, M. & Hunter, J. (2011). Lower leg haematomas: Potential for complications in older people. *Wound Practice and Research 19*(1) 21-28.

Stephen-Haynes, J. & Carville, K. (2011). Skin Tears Made Easy. *Wounds international 2* (4) www.woundsinternational.com downloaded October 2016.

The all Wales Tissue Viability Forum (2011). Best Practice Statement; The assessment and management of skin tears. The all Wales Tissue Viability Forum.

Wounds UK (2012). Best Practice Statement: Care of the Older Person's Skin. Second edition Wounds UK.

RISK FACTORS

Age and gender

History of previous skin tears

Dry, fragile skin

Medications that thin the skin (e.g. steroids)

Echymoses – bruising of the skin resulting from leakage of blood into underlying tissues

Impaired mobility or vision

Poor nutrition and hydration

Cognitive or sensory impairment

Comorbidities compromising vascularity and skin status

Dependency for showering and mobilising.

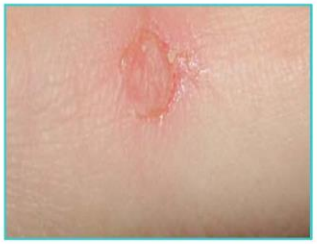
(Stephen-Haynes & Carville, 2011)

STAR Skin Tear Classification System

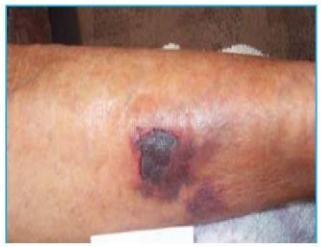
STAR Skin Tear Classification System Guidelines

1. Control bleeding and clean the wound according to protocol.
2. Realign (if possible) any skin or flap.
3. Assess degree of tissue loss and skin or flap colour using the STAR Classification System.
4. Assess the surrounding skin condition for fragility, swelling, discolouration or bruising.
5. Assess the person, their wound and their healing environment as per protocol.
6. If skin or flap colour is pale, dusky or darkened reassess in 24-48 hours or at the first dressing change.

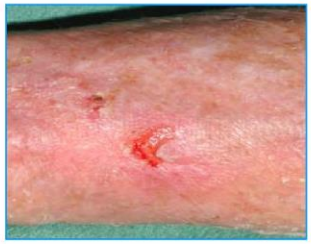
STAR Classification System



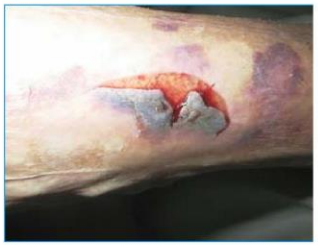
Category 1a
A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is not** pale, dusky or darkened.



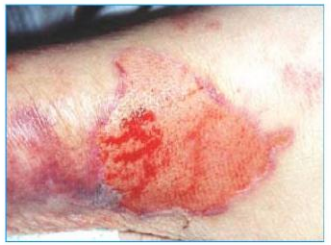
Category 1b
A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is** pale, dusky or darkened.



Category 2a
A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is not** pale, dusky or darkened.



Category 2b
A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is** pale, dusky or darkened.



Category 3
A skin tear where the skin flap is completely absent.

Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010.

STAR Skin Tear Classification System Glossary

- ***Skin Tear:*** "a traumatic wound occurring principally on the extremities of older adults, as a result of friction alone or shearing and friction forces which separate the epidermis from the dermis (partial thickness wound) or which separate both the epidermis and the dermis from underlying structures (full thickness wound)"[1].
- ***Pale, dusky or darkened skin or flap colour:*** when compared to the individual's 'normal' surrounding skin, may indicate ischaemia or the presence of haematoma, which may affect skin or flap viability.
- ***Ischaemia:*** inadequate tissue perfusion as evidenced by pale, dusky or darkened tissue.
- ***Haematoma:*** a collection of blood or clot under the flap or realigned skin.
- ***Realign:*** to replace the skin or flap into the normal anatomical position without undue stretching.
- ***Linear skin tear:*** a skin split or the skin splitting in a straight line.
- ***Flap skin tear:*** a segment of skin or skin and underlying tissue that is separated from the underlying structures.

References:

1 Payne, R., & Martin, M. (1993). Defining and classifying skin tears: Need for a common language … a critique and revision of the Payne-Martin Classification system for skin tears. *Ostomy Wound Management, 39*(5), 16-20.

2 Photographs courtesy of the Skin Tear Audit Research (STAR) photographic library, Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology.

3 Carville, K., Lewin, G., Newall, N., Haslehurst, P., Michael, R., Santamaria, N., & Roberts, P. (2007). STAR: A consensus for skin tear classification. *Primary Intention, 15*(1), 18-28.

Sexual Health in Primary Health Care: Premature Ejaculation

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Nurse Practitioner Primary Health Care across the lifespan, I have an interest in Youth health, Women's Health and Sexual Health. I work at Carterton Medical a middle size practice in beautiful Wairarapa, also providing sessions within the colleges for student in the Wairarapa.

As soon as we talk about "sexual health" the first thing that probably comes to mind are adolescents and young adults with sexual transmitted diseases. Chlamydia, herpes and genital warts are often the first issues we may think about. True, in my daily practice as Nurse Practitioner in a medium size general practice (6000 patients) and in my school based youth health clinics I mostly talk about sexual transmitted diseases, safe sex and contraception. Most people are quite happy to address this. However there are a few topics where we do not often talk about, at least not openly. One of them is premature ejaculation.

Sometimes I find myself in consultation where my fifth sense tells me that the patient wants to talk about something else, but they are not forthcoming. I try to be as approachable as possible and when the male patient stands on the threshold of my room the bullet is finally bitten and I hear the question: "I would really like to ask you a question about something else but it is so embarrassing! "I ejaculate far too early".

Premature ejaculation is an ejaculation that happens sooner than desired. It happens just before or soon after penetration of the vagina (within < 2minutes) (Murtagh, 2015). It happens with minimal sexual stimulation and it causes enormous distress and frustration for both partners. It is a very common problem with a prevalence of 24% in 16-60 year old males (Murtagh, 2015) and most men do experience it once in their lifetime.

Causes of premature ejaculation:

A thorough history taking is necessary as we should not confuse premature ejaculation with erectile dysfunction (not able to maintain an erection of sufficient quality). Premature ejaculation can be caused by medical conditions such as hormone problems, prostate problems, STI's, genital sensitivity or an injury. It could be equally be an unwanted side effect of prescription medication, alcohol or recreational drugs. The problem can also be a result of anxiety. It may occur in certain sexual situations such as first time sex, being with a new partner or due to emotional pressure in a relationship (performance anxiety). A religious upbringing, depression, anxiety and stress can all influence premature ejaculation (WebMD, 2016).

Treatment:

Premature ejaculation might become less of issue overtime

without any treatment. For example adolescents or young adults who obtain more experience with sexual intercourse and overcome the issue without seeking medical advice. For some man simple advice to cut down on alcohol and/or recreational drugs will do the trick. For others, further advice on strategies and/or treatment may be required.

First line strategies may include altered sexual technique. For some men wearing a condom is sufficient as a condom reduces the sensation to the penis. For other couple the "stop-start-technique": the couple slows down or pauses during intercourse to delay ejaculation, might be the solution.

Another strategy to suggest is the "Master and Johnson squeeze technique". In this technique the man withdraws the penis just before ejaculation and squeezes the top of the penis just where the glans joins the shaft. 30 - 40 seconds after this the sensation of ejaculation will have reduced and sexual intercourse can restart. Another advice may include a longer period of foreplay and getting the partner as close as possible before penetration.

Should those strategies fail, medical interventions my come in form of a tablet or topical treatment. Topical treatment with local anaesthesia (lignocaine2.5% with prilocaine 2.5 %) applied sparingly to the glans and shaft of the penis 10-20 minutes prior intercourse can be helpful (Murtagh's, 2015). Side effect of this is that it might reduce the sensation of the partner too. Antidepressants are a potential treatment option as the side effect of this medication is inhibition of orgasm (WebMD, 2016). Paroxetine and Sertraline once a day and three hours prior sexual intercourse has been reported as effective (Murtagh's, 2015). This treatment should be trailed for 3 months and if effective it should be slowly titrated down.

Summary:

Premature ejaculation is a common problem that will affect the sex lives of many. It is important to consider underlying physical and mental/emotional issues that have been linked to this problem. Should a man raise this issue in your clinic it is important that the patient understands his conditions and is educated about the possible strategies. With this your patient hopefully can return to a happy sex live!

Reference:

Murtagh, J. (2015). Murtahg's General Practice 6th edition. MsGraw-Hill, Australia.

www.WebMD.com/men/tc/premature-ejaculation

Vaccines to protect older adults

IMAC

The administration of a vaccine is the single most effective heath care intervention a nurse can deliver to their patient (WHO 2013). Healthcare professionals know that vaccines save thousands of lives throughout the world, every year.

New Zealand's national immunisation health targets have focused on delivery of vaccines to children under two years old, and more recently to those under eight months of age. This is extending to a more whole of life approach moving targets to older age groups including 5 year olds and the HPV programme

With the knowledge that delivering vaccines reduces morbidity and mortality, what can we do in our practice to extend the protection that vaccines offer to our older adult (i.e. over 65 year old) population? And, are we confident that we know which vaccines to recommend this group?

When reviewing an older person's immunisation status consider the following:

1. Are they up-to-date with their 'routine' national schedule vaccines?
2. Do they have health issues that make them eligible for additional funded vaccines?
3. Which non-funded vaccines could be recommended for purchase?

Routine national schedule vaccines

The challenge in primary care is ascertaining the immunisation history of older adults. Records, if they exist, are often paper-based and archived. Patients may not know if they were vaccinated as a child: if there is any doubt then the assumption should be made that they are not.

Primary course doses of diphtheria, tetanus (Td) and polio (IPV) vaccines are fully funded for all adults (i.e. the immunisation benefit can be claimed). Annual influenza vaccine is fully funded for adults from 65 years. Booster doses of diphtheria and tetanus vaccine (Td) are funded but the full immunisation benefit cannot be claimed (i.e. the vaccine is funded but not the administration of the vaccine). Most providers charge a small administration charge for these booster doses. Where a patient has received some but not all doses in a *primary course*, the vaccine doses needed to complete the course are funded. Remember that there should be six months between doses two and three of IPV (MoH 2014).

Additional funded vaccines

Over 65 year olds may have comorbidities that increase their risk of some vaccine-preventable diseases. In recent

years PHARMAC has extended the eligibility and funding of vaccines to protect these vulnerable patients. Current information on eligibility can be found on the PHARMAC and IMAC websites (IMAC 2016). The following vaccines are funded for high-risk patients: *Haemophilus influenza* type b, hepatitis B, meningococcal, pneumococcal and varicella vaccines.

Non-funded, recommended vaccines

Some additional vaccines are recommended but not funded for older people. Patients can purchase these vaccines. It is important that vaccinators do not use ProPharma supplied, funded vaccines for these patients but purchase them from Health Care Logistics. Nurses authorised vaccination status does not cover these vaccines. They must be administered under a standing order or prescription.

Pertussis (whooping cough): Older adults may choose to purchase pertussis vaccine:

a) to protect their mokopuna as part of a cocooning strategy for infants who are too young to have been vaccinated themselves(McIntyre P, Wood N 2009) as well as,

b) for the personal protection it provides

Pertussis vaccine is available in combination with diphtheria and tetanus as Tdap. Patients may choose to purchase Tdap over the funded Td vaccine at 45 years and 65 years, or at any other time. There is no spacing requirement for Tdap after a Td vaccine (CDC 2011).

Invasive pneumococcal disease (IPD) from *Streptococcus pneumoniae* risk increases with age; it is high in older people, and highest in those over 85 years (ESR 2016). Two types of pneumococcal vaccine are available for protection from IPD:

1. Pneumococcal conjugate vaccine (PCV; Prevenar13®). Vaccinators are familiar with the use of conjugated vaccines in infants and young children. Recommendations for use in adults are still unclear. They are unlikely to have an important role for healthy elderly, but should be offered to elderly at higher risk of pneumococcal disease such as those with COPD and other respiratory conditions.

2. 23 valent polysaccharide pneumococcal vaccine (23PPV; Pneumovax® 23) protects against 23 strains of *S. pneumoniae*. A major disadvantage of polysaccharide vaccines is that, while protection is *broader* than that provided by PCVs, the immune response generated is T-cell independent and this results in poor memory cell projection. Therefore, it is difficult to boost the immune response following 23PPV immunisation. In fact, repeated use of polysaccharide vaccine may inhibit the ability of the immune system to respond to *S. pneumoniae* infection. There is evidence that 23PPV vaccines have some effect against invasive pneumococcal disease but not against non-invasive disease.

The current recommended immunisation schedule for any, particularly elderly who is at higher risk of pneumococcal disease is PCV13 followed between 8 weeks and 12 months later by 23PPV. When the adult has previously received 23PPV, 12 months should elapse before administering PCV13.

Herpes zoster (shingles): Following chickenpox infection, the varicella-zoster virus remains dormant in basal ganglia for many decades. The risk of the virus re-emerging, as shingles, increases with age as the immune system becomes less effective at protecting the body. Shingles may affect patients with no clinical history of chickenpox as they may have had a sub-clinical infection following exposure as a child.

The shingles vaccine (Zostavax®) is produced in the same way as chickenpox (varicella) vaccine but contains significantly more antigen. It appears to be more effective in preventing shingles when given to younger adults aged 50 -60 years but the risk of severe disease and sequelae (particularly neuralgia) is greatest in the elderly aged over 70 years of age. In these older age groups, the role of the vaccine is particularly for reducing the incidence of debilitating pain and long term complications. Duration of immunity has yet to be ascertained so the optimum age at which to give shingles vaccine is unknown. The US Advisory Committee on Immunization Practices (ACIP) current recommendation is that one dose of shingles vaccine is administered to immune-competent adults aged from 60 years (Hales et al 2014) In the UK and Australia (from November 2016) it is offered on the national schedule to all at 70 years of age.

Knowledge about which vaccines to offer and recommend older patients is important but is unlikely to do much to improve protection unless vaccinators discuss within their practice strategies to deliver these vaccines. As mentioned at the start, we can build on the skills developed through vaccinating our youngest patients. Some actions we can consider include:

1. Raising awareness with ALL provider staff so that they can play their part. Discuss incorporating adult immunisation into your services provision and how staff and time can be dedicated to this, with practice managers

2. Utilise your patient management system's audit and status query tools to identify un(der)-immunised older adults and put pre-call and recall systems in place

3. Adopt an opportunistic immunisation approach at all consultations with older adults

4. Be aware of which adult vaccines are added to the National Immunisation Register (NIR) and include discussion of NIR in your consent process with older patients

5. Have up-to-date, age-appropriate vaccine information available in your waiting areas and consultation rooms, and use these in vaccine conversations with your patients. Examples include Ministry of Health resources; *Adult tetanus and diphtheria immunisation* (HE1514), *After your immunisation* (HE2505) and annual influenza resources from the National Influenza Specialist Group resources (see your 2016 Influenza kit)

As primary health care nurses we can do more to protect our patients through immunisation. You have taken the first step by reading this article. Now have discussions with your team to see what you can do in your practice to protect your vulnerable older adult population.

References

CDC (2011) Updated Recommendations for the use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine from the Advisory Committee on Immunization Practices, 2010 Morbidity and Mortality Weekly Report 14/1/11 60 (1)

ESR (2016) Surveillance Report: Invasive pneumococcal disease in New Zealand 2014. Available at https://surv.esr.cri.nz/PDF_surveillance/IPD/2014/2014IPDAnnualReport.pdf

Hales CM, Harpaz R, Ortega-Sanchez I, Bialek SR (2014) Update on Recommendations for Use of Herpes Zoster Vaccine. Morbidity and Mortality Weekly Report August 22, 2014 63 (33)

Immunisation Advisory Centre (2016) IMAC Factsheet: Guide to additional vaccines for special groups from 1st March 2016. Available at http://www.immune.org.nz/sites/default/files/resources/Programm

eScheduleChanges20160301V01Final.pdf

McIntyre P, Wood N. (2009) Pertussis in early infancy: disease burden and preventive strategies. Current Opinion in Infectious Diseases 22(3): 215–23

Ministry of Health (2016) Immunisation Handbook 2104 2nd edition. Available at http://www.health.govt.nz/publication/immunisation-handbook-2014-2nd-edn

World Health Organization (2013) Global Vaccine Action Plan 2011-2020. Available at http://www.unicef.org/immunization/files/GVAP(1).pdf

Management of Sexual Assault/Abuse

Kylie McKee, CEO - BOPSASS

Kylie McKee (MPH, BHSc) has worked in public health settings including breast & cervical health promotion and the Heart Foundation, bringing a tertiary prevention strategy to the work of Bay of Plenty Sexual Assault Support Services (BOPSASS). In her time with BOPSASS, they have successfully tendered for a Sensitive Claims contract through ACC and a Crisis Support service through the Ministry of Social Development.

Ms McKee is focused on ensuring the experience of the client is as smooth as possible as they transition from acute presentation through to long term counselling, with a philosophy of providing 'training wheels', advocating for their empowerment and self-determination at the earliest possible stages

One third of women in New Zealand have survived sexual assault. One in three girls and one in six boys will experience abuse before the age of 16 in this country.

Reporting is woefully low, and there are a number of reasons for that – ranging from feelings of shame/guilt, through to fear of consequences if a disclosure is made.

Expert intervention at an early stage is vital to reduce the risk/impact of PTSD and manage other potential health and well being risks following a sexual assault.

Consequences of Sexual Abuse on Children

There is good evidence that sexual abuse has a negative impact on normal psychological development, particularly if there is repeated abuse by a trusted adult; if the child is not able to seek help to stop the abuse; and/or if the child is not believed.

As a child they are more likely than normal to have:

- Poor self esteem, Anxiety and phobias, Poor social skills, Anger and hostility, absconding from home, Conduct Behavioural disorders, Post traumatic stress disorder, Dissociation disorders, impaired development and learning.

As an adult they are more likely than normal to have:

- Chronic Ill health, Depressive disorder, Anxiety disorder, Eating disorders, Alcohol and drug dependence, Self mutilation behaviour, Suicidal behaviour, Personality Disorders, and need to be a psychiatric inpatient.

As an adult they are also more likely than normal to have:

- Teenage pregnancy, a decline in socio-economic status, multiple relationships, an abusive relationship with a partner, Dissatisfaction with sex life, Have a child who is sexually abused, and medical conditions including Irritable Bowel Syndrome, Fibromyalgia, Chronic Pelvic Pain, Headaches.

With early intervention it is hoped that the abuse cycle can be stopped, and with support /

counselling we can prevent some of the consequences of sexual abuse.

Reporting To Authorities – Child Youth and Family (CYF)

All cases of child sexual abuse should be reported to CYF, as this is only way to get legal protection for the child. The major power issues in sexual abuse is secretiveness. Most families on their own do not have the resources to manage this - it is difficult to enforce /maintain long term non access with the abuser unless the abuse is out of the closet.

Definition of Sexual Assault

Sexual assault is "any form of sexual contact without voluntary consent, and that violates a person's sense of autonomy, control and mastery over their body" (Rose, 1986).

In the case of children under the age of 16, sexual contact is never consensual.

BOPSASS

In 2010 Bay of Plenty Sexual Assault Support Services (BOPSASS) was established as a Charitable Trust to provide and co-ordinate medical services for clients in the BOP DHB area who have experienced sexual assault or sexual abuse.

BOPSASS was founded by a group of doctors and nurses who recognised that there was a lack of service co-ordination / follow up for clients and NO crisis counselling service existed.

The service provides care for all clients and their families including children, adolescents, and adults. These services are provided by a range of professionals, including paediatricians, GPs, nurses, counsellors, psychologists and psychotherapists.

Acute cases are managed via a region-wide nurse led triage phone service (**0800 227 233**), and referrals are also received via email to refer@bopsass.co.nz from all sources: friends and family, doctors, counsellors, police, community groups, schools etc.

Options

Clients are able to access a range of services from BOPSASS, including:

- Medical assessment completed by doctor and nurse
- Forensic medical examination (collecting evidence of police)
- Therapeutic Examination including STI and pregnancy prevention
- Initial psychological and emotional support / Brief crisis intervention counselling
- Follow up support and advice / Follow up STI screen / Follow up medical assessment
- Assistance to seek ongoing counselling via Sensitive Claims process
- Ability to call crisis support helpline 24/7.

When a Disclosure is Made…

Do you ask?

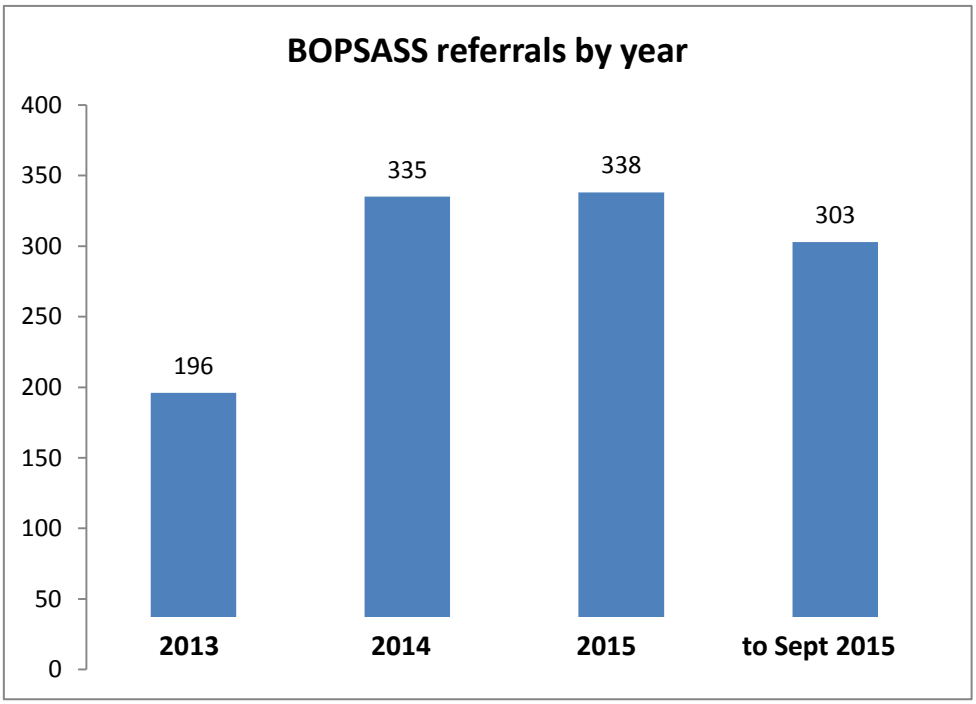
- It is often the policy at hospitals or practices to screen for domestic violence – don't forget sexual violence.

HOW TO MANAGE A DISCLOSURE

- Validate and reassure – you've been brave, thank you for sharing, we take this seriously, I will make sure that you get some help
- Give them details of the SAATS provider that will manage the medical assessment/forensic examination
- Phone through a referral rather than leaving the patient to contact the service – do it with them there
- Phoning a referral means no paper trail needs to be left, ie; patient confidentiality is maintained.
- Please be very aware of what you put on a

patient's medical record - perhaps "referral to BOPSASS" is all that is required?

BOPSASS accepts referrals from ANYONE – doctors, nurses, health care assistants, receptionists, cleaners, patients…



MORE ABOUT FORENSIC EXAMINATIONS

- These can be done JUST IN CASE ie whether or not the patient has decided to involve the police. Kits can be stored in our secure fridge for 6 months.
- These are a medico legal process
- we collect enough history to identify what examination and swabs are required
- The kits are not sent away to ESR unless the police have decided that the results will help a prosecution (ie they are not sent "just in case" to see if DNA is found)
- See kit/MER

References

Rose DS; "Worse than death": psychodynamics of rape victims and the need for psychotherapy. Am J Psychiatry. 1986 Jul; 143(7):817-24.

Wairarapa Skin Project Success – "LOVE THE SKIN YOU'RE IN!"

Katie Inker – Primary Health Care Nurse Practitioner

My name is **Katie Inker** and I have been living in the Wairarapa for the last 13 years.I work for a Maori Health Organisation providing health care for predominantly Maori, Pacific and low income families.

My scope of practice as Nurse Practitioner is **"Primary health care across the lifespan"** with a particular focus on the vulnerable client.

In today's complex world, achieving and maintaining good health can be complicated. I love working alongside clients, communities and other health practitioners to make health journeys less complicated.

Approximately 60, 000 children present to a GP each year with a skin infection. This figure may actually be higher as this does not include kids who present directly to a hospital, or who fail to present at all and just live with recurrent ill skin health.

In the Wairarapa, skin infections were the 6th leading cause for children to present to our Emergency Department. This is sad because the majority of skin infections for children are avoidable.

Living with sores or poor skin health causes a multitude of issues. Pain, time off work and school, exclusion from activities, teasing from peers, lack of sleep from itching which in turn affects behaviour, mood and increases stress for the entire family. It is also very costly to have a child with sore skin. On-going prescriptions, costs of travel to appointments, cost of actual appointments etcetera are all factors families unwillingly experience

Since being selected to pilot a skin improvement pathway (instigated by Hutt and Wellington), the past 3 years has seen the Wairarapa working collectively as a region to try and reduce the number of avoidable hospital admissions for skin infections. Services have collaborated, networks been strengthened, protocols introduced and barriers identified and broken down. As a result, recent statistics demonstrate that skin infections for children in the Wairarapa have declined.

One key reason to improvements in statistics is that Whaiora, a low cost general practice that works predominantly with Maori, Pacific and low income populations have been running a skin workshop and service that compliments the above work and is tailor made for the population it works alongside.

At Whaiora, General Practice working alongside community health workers has truly assisted whanau to achieve and enjoy improved skin health. Whanau experience a wraparound service which is best provided when clinicians and community health professionals collate information and join forces. Clinicians provide assessment, skin care education and plans that are provided at health literate levels. Clinicians also provide regular follow up and access to medications and other necessary services.

Community health workers are the eyes of the community. They can assess home situations to highlight potential risks that may affect skin health, report gaps, trials, failures, and successes of treatment plans and navigate and walk alongside whanau. Community health workers assist whanau to implement their plans and advocate if barriers appear. It appears that whanau who engage with clinician plus community health worker make the biggest skin health improvements. For us at Whaiora, it seems really understanding, supporting patient context and working together is key to positive health outcomes.

Whaiora host a 'Love the skin you're in' workshop. Whanau identified with poor skin health are invited to meet with us in a kaupapa Maori environment which takes the form of a morning seminar. Whoever cares for the identified child is invited to attend this seminar, so that key messages are heard by ALL carers who participate in the day to day care of the patient. This initiative is intended as a final compliment to all skin work done up until this stage. Seminar numbers are kept small to reduce whakamaa/embarrassment.

Seminars are opened with waiata, karakia and whaangangutanga, and end with shared healthy kai. The skin seminars bring all professionals who have some key part to play in maintaining skin health to one venue. Work and Income, Healthy homes speakers, a nutritionist, a Rongoa practitioner, clinicians and community health workers are usually invited. Whanau from previous seminars are invited as champion speakers to give personal success stories. Seminars strive to cater for all types of learners with visual, hands-on activities, group and individual time. Resource gaps are identified at seminars so that whanau who may need sheets or towels, or families with no bath etcetera are realised, and then strategies and resources can be directly applied to allow an environment that may better improve skin health. All families who attend leave with a complimentary kete as a thank-you for engaging and participating.

Feedback from whanau so far suggests that families who attend our workshops leave with a much better understanding of their skin, feel safe to ask questions, become competent at identifying infections at earlier stages and become self managing with their prescription creams. Families who have attended programs have continued to engage with our services, present with skin flare ups much earlier than before and have become champions of skin health within their circles, which has had a ripple effect on the wider community.

As this approach works appears to work so well with whanau, we truly believe that this initiative could roll out wider, to early childhood, other health centres, or identified groups of patients and families. Whaiora believe this approach could certainly assist to reduce skin infection rates in New Zealand.

Let's get Community health workers alongside Clinicians and other health professionals to assist whanau in becoming champions in restoring and maintaining skin health.

DEFINING REMISSION OF TYPE 2 DIABETES

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Janet Titchener is the Clinical Director of GPSI Diabetes, a Primary care based diabetes specialty service in Hawkes Bay and Auckland. Janet completed her training as a Primary Care Physician with specialisation in diabetes at the University of Pennsylvania School of Medicine/Lancaster General Health (USA).

Mrs C is a 57 year old with type 2 diabetes, hypertension and hypercholesterolemia. Her diabetes, blood pressure and cholesterol have been well managed on a moderate dose of metformin, two anti-hypertensives and a statin. Mrs C attends her appointments regularly for diabetes review, cardiovascular risk monitoring, foot checks and retinal screening. However, 18 months ago, Mrs C declared she was tired of swallowing so many pills. She stated that she had put herself on a rigorous exercise programme and changed her diet with the intention of 'curing' her diabetes.

Can Mrs C 'cure' her diabetes? If so, how does one define cure? If Mrs C is successful should she remain on metformin? And can Mrs C's recalls for cardiovascular risk management, retinal screening and foot checks be removed?

Type 2 Diabetes

It is well understood that while multiple pathologies contribute to the elevated blood sugars of type 2 diabetes, it is insulin resistance and pancreatic insufficiency that contribute the most.[4,5,7]

Until relatively recently peripheral insulin resistance, reducing cellular up-take of glucose, was considered the primary pathology leading to the development of type 2 diabetes. Early on in disease progression, pancreatic β-cells increase insulin production to overcome this peripheral insulin resistance and blood sugars remain normal. However, over time the β-cells begin to fail. The reduced insulin levels are no longer sufficient to overcome insulin resistance, the cellular glucose uptake is reduced, blood sugars rise and the person is diagnosed with diabetes. Thus, historically, type 2 diabetes was thought to present as hyperinsulinemia (pancreatic sufficiency) with relative insulin deficiency secondary to insulin resistance, later progressing to pancreatic insufficiency with absolute insulin deficiency.

However, it has become clear that the essential component for developing type 2 diabetes is impaired pancreatic function – not insulin resistance.[6] Whether a person develops type 2 diabetes or not is dependent on what their baseline pancreatic function is prior to developing insulin resistance. If a person has excellent pancreatic function, any number of poor choices around lifestyle (e.g. poor diet, smoking, weight gain) can significantly elevate insulin

resistance, but the pancreas will rise to the challenge and the person will never develop diabetes; while in a person who has a relatively low functioning pancreas, one poor choice around lifestyle may be all that is needed to create enough insulin resistance to initiate hyperglycaemia. So while environmental factors such as obesity and lack of exercise are major contributors to the development of type 2 diabetes, poor lifestyle choices alone do not cause diabetes. Indeed, most obese people do not develop type 2 diabetes.[3]

Genetic markers for type 2 diabetes have now been identified and most are related to β-cell dysfunction; individuals with glucose intolerance have a 40% reduction in β-cell mass while those just diagnosed with diabetes have a 60% reduction in β-cell mass.[3] Furthermore, β-cell function continues to decline over time and it is this decline that is primarily responsible for the progression of type 2 diabetes – not worsening insulin resistance.[2]

Mrs C

So, it was pointed out to Mrs C that her high sugars were the result of an interplay between her peripheral insulin resistance (i.e. lifestyle choices) and her pancreatic function and that if her peripheral resistance was the predominant issue then losing weight and exercising may very well normalise her blood sugars. However, should she have relatively little insulin resistance and more of a dysfunctional pancreas, then lifestyle changes may not resolve her high sugars i.e. not ALL people with type 2 diabetes can normalise their blood sugars with lifestyle changes alone.

It was further pointed out to Mrs C that should she succeed in normalising her blood sugars through lifestyle changes, we would not actually consider the diabetes 'cured' but rather, we would consider the diabetes to have gone into remission.

In medicine, cure is defined as restoration of good health through complete removal of the underlying pathology causing the disease. The management of infectious diseases is a good example of 'cure' as antibiotics eliminate the bacteria causing the infection. In contrast, remission is the disappearance of the signs and symptoms of a disease but the underlying cause of the disease remains, allowing the possibility that the disease may return.[1] Examples might be cancer or HIV.

If Mrs C normalises her blood sugars, the pathologies contributing to the original diagnosis of diabetes are not removed. A reduction in her peripheral insulin resistance will allow her current insulin production to normalise sugars. However, the pancreatic insufficiency remains. In other words, lifestyle management for type 2 diabetes does not eliminate pathology, it simply rearranges the balance between the pathologies, leaving the patient at risk for relapse.

In 2009, a group of experts provided a consensus recommendation for the classification and management of people with type 2 diabetes who have successfully normalised blood sugars.[1]

Classification of Remission for Type 2 diabetes

1. Partial Remission – glycaemic parameters in the pre-diabetes range (HbA1c 39–49 mmol/mol) for 1 year or more, on no medications and without gastric surgery
2. Complete Remission – glycaemic parameters within normal range

(HbA1c ≤ 38 mmol/mol) for 1 year or more, on no medications and without gastric surgery

3. Prolonged Remission - is complete remission for 5 or more years

Management of Remission for Type 2 diabetes

If in partial or complete remission for less than 5 years, treatment of comorbidities (hypertension and dyslipidaemia) and monitoring for retinal/renal disease should remain the same as for those with diabetes.

When in complete remission for 5 years or more the clinical targets and management of co-morbidities should be the same as for a person without diabetes - as long as the person remains in remission. If there is no renal or retinal disease then screening for these should be stopped. If there is background renal or retinal disease monitoring should continue.

Mrs C

At her most recent appointment, Mrs C had lost 8 kg, she was attending pilates 3 times a week, walking the dog every day and adhering to a low carb diet. She was no longer on Metformin or any blood pressure medication. For the past 18 months her HbA1c values have been less than 38 mmol/mol. It was explained to Mrs C that her diabetes was in complete remission and, as she has no retinal or renal disease, she would be removed from retinal screening recalls. Mrs C was advised that she would continue to receive annual recalls for cardiovascular risk management.

REFERENCES:

1. *Buse, JB. Caprio, S. et al. (2009). How do we define cure of diabetes ? Diabetes Care 32:2133-2135*
2. *DeFronzo, RA. Abdul-Ghani, M. (2011). Type 2 diabetes can be prevented with early pharmacological intervention. Diabetes Care34:S202-S209*
3. *Eckel, RH. Kahn, SE. et al. (2011). Obesity and type 2 diabetes: what can be unified and what needs to be individualized ? Diabetes Care 34:1424-1430*
4. *Gastaldelli, A. Baldi, S. et al. (2000). Influence of obesity and type 2 diabetes on gluconeogenesis and glucose output in humans: a quantitative study. Diabetes 49:1367-1373*
5. *Gastaldelli, A. Toschi, E. et al. (2001). Effect of physiological hyperinsulinemia on gluconeogenesis in nondiabetic subjects and in type 2 diabetic patients. Diabetes 50:1807-1812*
6. *Kanat, M. Winnier, D. et al. (2011). The relationship between β-cell function and glycated haemoglobin. Results from the veterans administration genetic epidemiology study. Diabetes Care 34:1006-1010*
7. *Wahren, J. Ekberg, K. (2007) Splanchnic regulation of glucose production. Annu Rev Nutr 27:329-345*

Will our health services survive the next thirty years?

I am a retired renal physician. I am currently a clinical ethics advisor at Capital and Coast DHB, Wellington. I have worked in many different countries including USA, Canada, UK, Vietnam, East Timor, Iraq and Abu Dhabi. For the last 10 years I have been increasingly involved in clinical ethics. I am fortunate to be still working in the public sector, especially so because the first publicly funded health service originated in New Zealand in 1938! I believe that my current passion for clinical ethics and my experience in the public health system will help me to navigate and understand the future challenges in delivering good health care. I think that clinical ethics does not need to be complicated; furthermore I believe that "Clinical ethics is everyone's business"

The title of this article may seem a bit melodramatic but it's worthwhile reflecting on how New Zealand society will manage the health and disability problems that will occur in our ageing population. A recent Ministry of Health report echoes these sentiments to the extent that "it is essential that we find new and sustainable ways to deliver services and invest in resources in a way that will provide the best outcomes possible for people's health and wider wellbeing" (1)

In trying to address this issue I would like to highlight a specific concept, that of "frailty". Our success, or otherwise, in managing this problem will depend upon society's health care decisions being made on the basis of good information and effective communication.

As primary care nurses you will have first hand experience of what frailty is. Aspects of frailty include an unintentional weight loss of 5 kg, exhaustion, decreased activity and sometimes a decline in cognitive function. Frailty is not an inevitable consequence of ageing. However the prevalence of the condition increases with age. The population aged over 85 years will double over the next 25 to 30 years, this means that the number of frail people is likely to at least triple!

I've just visited the New Zealand College of Primary Health Care Nurses website. You and your organisation collectively espouse:

"A strong foundation for an effective Primary Health Care nursing network responsive to the health needs of our whanau, hapu, iwi and communities"

1.

If I paraphrase this powerful statement, it is in harmony with my thinking that the basis for good health care is the promotion of patient centred care and shared decision making.

In primary care it's fair to suggest that you would mostly know your patients better than your colleagues in secondary care. In addition you are better placed to appreciate your patient's health problems in a functional and social context. If frailty is recognised as an issue for a patient, you are better placed to move beyond the biomedical model and really understand the significant

limitations that a diagnosis of frailty imposes.

Being independent and thriving is a real bonus as we age. Basically the ability to easily move from one place to another defines a degree of fitness. Being physically weak, having poor balance and a lack of endurance are challenges for individuals to remain independent and at home. The presence of a combination of these factors is strongly suggestive of a diagnosis of frailty.

Let's suppose that your patient needs hip surgery. Part of the frailty diagnosis includes an increased risk of an associated impaired cognition. How might this influence the integrity of the informed consent process? The presence of frailty is likely to increase the time for rehabilitation. Of equal importance is a discussion as to how this operation is likely to improve the patient's quality of life at home?

In a recent paper (2) frail patients were three times more likely to die in the first year after an elective hip arthroplasty. They also had higher rates of admission to ICU, discharge to institutional care and readmission compared with non-frail patients. The presence of frailty was also associated with a prolonged post-operative recovery period. There was an increased risk of developing delirium and this was associated with an increased risk of cognitive decline. This sequence of adverse outcomes means that there was an increased risk of requiring long term institutional care. As would be expected the health care costs in the frail group were significantly higher.

Increasingly surgeons have to make difficult decisions about emergency surgery in elderly patients with significant co-morbidities. These operations are high risk procedures. In the heat of the moment, it's possible that a prior diagnosis of frailty might be overlooked. Had frailty been diagnosed in the primary care context, then this might well be a reason for declining surgery.

Even if the patient survives an emergency operation, there are still significant risks of a worsening of quality of life. Further research is needed to learn how to best structure these challenging conversations in the emergency surgical setting. The pivotal role of good communication skills is self evident in trying to achieve difficult but enlightened decisions. (3)

If a patient's conditions continues to decline timely discussions about end of life issues should be considered. To do so respects an individual's autonomy. Problems in this area were highlighted in a survey of 1500 physicians by the Royal Australasian College of Physicians. (4) This report indicated that that *"one-third observed, at least once a week, the delivery of treatments with little chance of significant benefit."* Not only did such practice fail to promote the patient's autonomy it also did not fulfil the concept of stewardship.

The idea of stewardship involves avoiding or eliminating wasteful expenditure, with the aim of maximising quality of care and protecting patients from harm, while ensuring affordable care in the future. The Australian Medical Association has recently issued a position statement on "The Doctor's Role in Stewardship of Health Care Resources" (5) indicating that "Doctors are important stewards of health care resources and good stewardship is an important part of ethical, best practice care"

Well…… it's my belief that the type and intensity of health care that a patient receives is ultimately determined by a conversation. In other words, what happens to a patient depends not only upon your

technical skills as a doctor; it also depends on your ability to communicate well.

The combination of a timely diagnosis of frailty, good communication and decision making, together with stewardship are good ways of illustrating the true meaning of another goal espoused by your organisation which is: *"Maximising the nursing contribution to positive health outcomes for the New Zealand Population"*

Frailty is important for us all to recognise and include our collective decision making. This is but one way that we can ensure the sustainability of our health and disability services. We have a duty to future generations to ensure that they inherit a robust heath and disability service that will cope with unforeseen future challenges.

References

1) http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf
2) D. I. McIsaac, P. E. Beaulé, G. L. Bryson, C. Van Walraven The impact of frailty on outcomes and healthcare resource usage after total joint arthroplasty A POPULATION-BASED COHORT STUDY. *Bone Joint J*2016; 98-B: 799–805.
3) Pitfalls in Communication That Lead to Non-beneficial Emergency Surgery in Elderly Patients with Serious Illness Description of the Problem and Elements of a Solution. Zara Cooper, Andrew Courtwright, Ami Karlage, Atul Gawande, Susan Block,
4) https://www.racp.edu.au/docs/default-source/advocacy-library/pa-pos-end-of-life-position-statement.pdf?sfvrsn=6
5) AMA Position Statement on the Doctor's Role in Stewardship of Health Care Resources https://ama.com.au/.../doctors-role-stewardship-health-care-resources-2016

Cervical screening is changing (again)

Dr. Richard Massey MB ChB, FRCPA

Anatomic pathologist, Pathlab, Bay of Plenty

Dr Richard Massey MB ChB, FRCPA is an anatomic pathologist based at Pathlab Bay of Plenty in Tauranga. He is charge pathologist for cytology. Current responsibilities include membership of the NCSP monitoring group and the NCSP technical resource group which is leading the transition to HPV based screening.

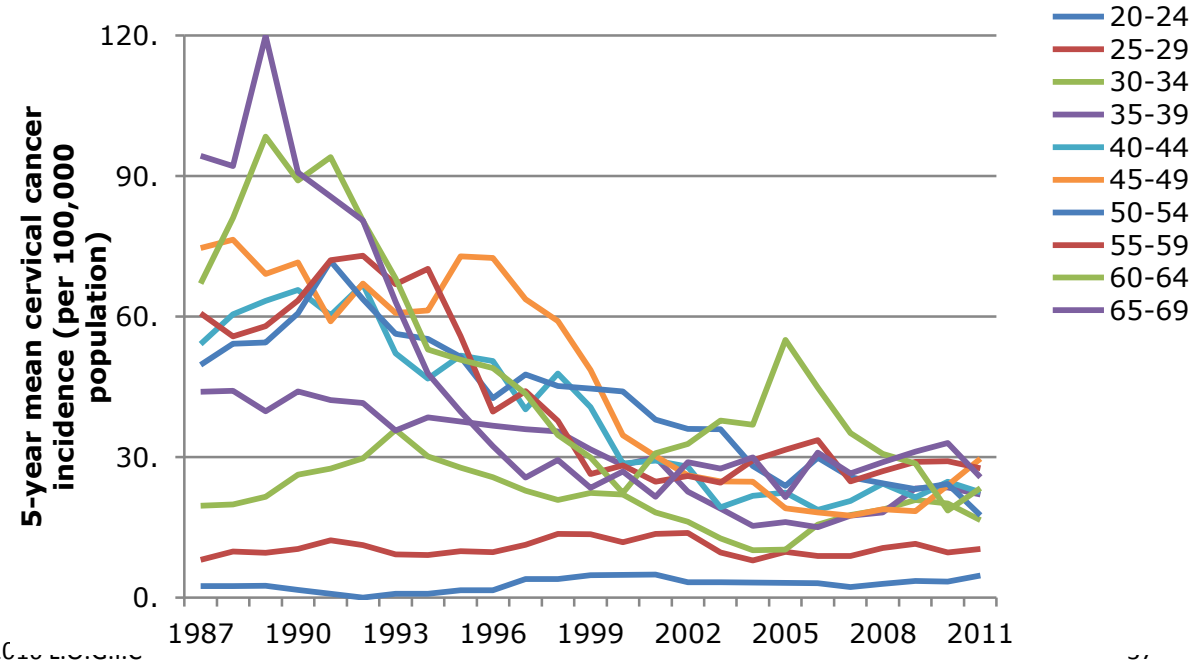
The New Zealand National Cervical Screening Programme (NCSP) will be changing its testing methodology from cytology to HPV detection as the primary screening step. The goals of this change are to improve the sensitivity of the screening programme, reduce screening associated harm and open the door to possible alternative screening strategies.

This change should be seen as part of the history of continuous improvement of New Zealand's cervical cancer control strategy.

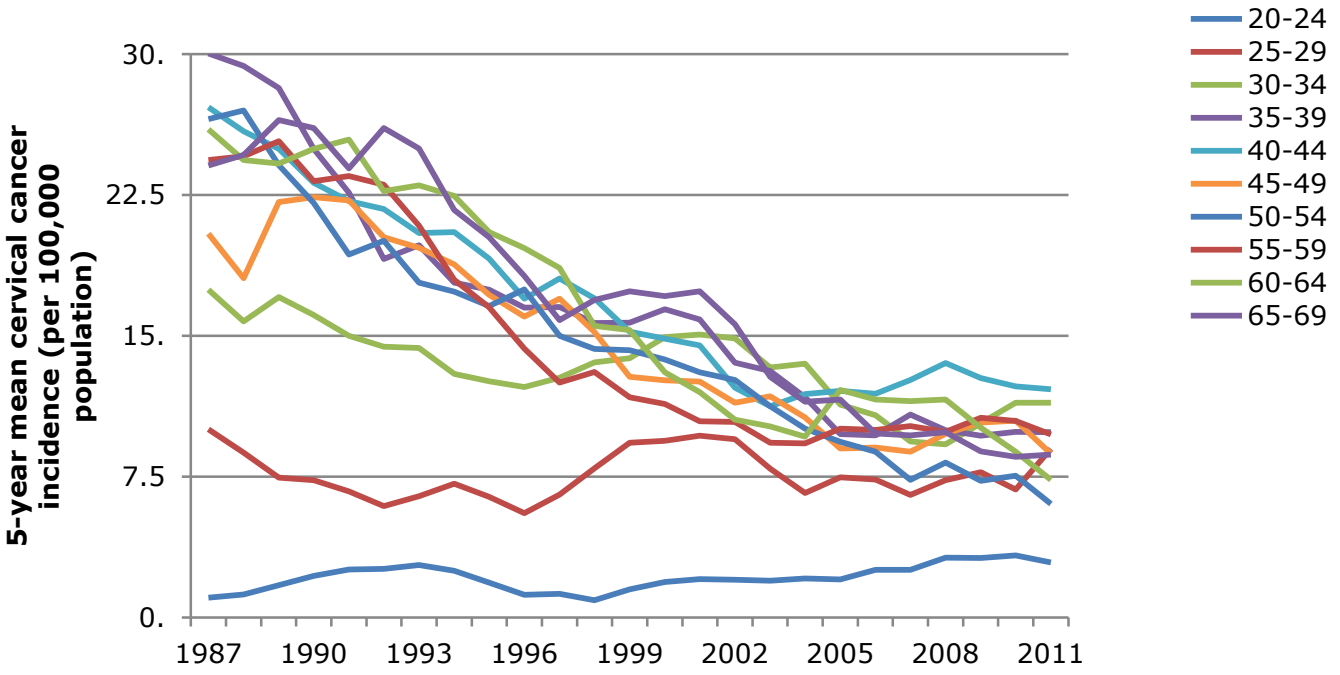
Cervical cancer emerged as an epidemic in the 1960's and it's origins as a major health burden have been traced back to World War 2. In response, the Papanicolau smear was pressed into service in ad-hoc screening programmes. New Zealand introduced organised screening in 1991 with the NCSP and is continually improving with ongoing technological changes, well defined clinical pathways and comprehensive monitoring. The most recent change has been the introduction of HPV vaccination as the primary cervical cancer control strategy and the consequent relegation of screening to a secondary role in cohorts which have been offered vaccination.Over the last 25 years since the conversion to an "opt off" programme there has been a steady reduction in the incidence and mortality of cervical cancer in New Zealand with a reduction of approximately 50% over this time.

Figure 1. Five-year average cervical cancer incidence in women aged 20–69 years by age

a) Māori women



b) Non- Māori women



Year is the middle year of the five-year period for which the average is shown.

(Health, 2016)

This is a remarkable achievement and places New Zealand in an elite group of countries with the lowest incidence and mortality rates in the world (Bruni, Barrionuevo-Rosas, Albero, Serrano, Mena, Gómez, Muñoz, Bosch, & de Sanjosé, 2016). However Australian and NZ data also show that in European women over 25 rates are plateauing and in the under 25's there has been no decrease in incidence [in NZ actually a slight rise]. These findings tie in with a long history of findings suggesting the screening is ineffective (at a population level) in the under

what is possible with a cytology lead programme (Health, 2016).

Direct detection of high risk HPV offers an opportunity to redesign the screening programme, taking advantage of both current knowledge of the biology of HPV and available technology.

There is extensive validated modelling available which indicates that a primary HPV based screening programme with reflex cytology starting at 25 with a 5 year interval offers significant advantages in performance, quality, harm and cost over current strategies. This advantage applies to both vaccinated and unvaccinated cohorts (Lew, Simms, Smith, Lewis, Neal, & Canfell. 2016) and is consistent with both modelling and future changes

of other international screening programmes e.g. Australia, UK, Netherlands.

The impact of change is not small. In particular there is a complete review of clinical and laboratory pathways, guidelines and standards with a complete redesign of the Register. This is a large task and work on the clinical pathways is well underway and out for public consultation and the laboratory pathways work and Register redesign process is also underway.

New Zealand is only one of 2 screening programmes which use 100% liquid based sample collection and HPV testing at a national programme level. All of the laboratories in NZ also use automation assisted screening technology. These

features place us in a privileged position as all the required technology and expertise needed for the transition to HPV screening is already in place in every laboratory in NZ which currently processes cervical cytology.

For those who collect samples there will actually be surprisingly little change. The exact same liquid based systems currently used will continue. The reports will be led by the HPV testing results and will have a cytology result only if the HPV result is positive or there are clinical indications for cytology to be performed. It is anticipated that the recommendations for follow up and repeat screening will look similar to the current process. The most obvious changes are the raising of the starting age to 25 and the increase of the screening interval to 5 years.

One opportunity primary HPV based screening introduces is the possibility of self collected sampling. Unfortunately this is not without its drawbacks with reduced sensitivity and the possible requirement of a second clinician collected sample following a positive result. There is however active research underway to assess the viability of this option, in particular targeting under screened priority groups.

We must also remember that cervical screening is now one of two tools in our cervical cancer control strategy and that vaccination is now our primary strategy.

In January there will be two major changes to the HPV vaccination programme (PHARMAC, 2016). The vaccine being used will change to Gardasil 9 which covers 7 high risk HPV strains and the 2 predominant genital wart strains. The vaccination programme is also being extended to boys with a catchup extension to the age of 27 .

Key take-home messages

- Vaccination is now the primary cervical cancer control strategy.
- January 2017 sees introduction of nonavalent HPV vaccine and extension of vaccination to boys.
- Cervical sample collection systems will not change.
- Entry age rises to 25.
- Screening interval rises to 5 years.
- There is a well grounded expectation that these changes will lead to further reductions in cervical cancer beyond what is currently achievable.

The NCSP website for health professionals (*https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme*) is a rich resource for those interested in the performance of the programme and the upcoming changes. There will be regular announcements and consultation requests made as the transition work progresses.

References:

Bruni L, Barrionuevo-Rosas L, Albero G, Serrano B, Mena M, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in the World. Summary Report 7 October 2016. Accessed 9 October 2016. Retrieved from http://www.hpvcentre.net/statistics/reports/XWX.pdf

Health, M. o. (2016, September). Evidence supporting decision to stop cervical screening in women aged 20–24 years. Wellington: Ministry of Health. Retrieved October 9, 2016, from https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/primary-hpv-screening.

Lew, J., Simms, K., Smith, M., Lewis, H., Neal, H., & Canfell, K. (2016). Effectiveness modelling and economic evaluation of primary HPV screening for cervical cancer prevention in New Zealand. PLoS ONE, 11(5), e0151619. doi: 10.1371/journal.pone.0151619

PHARMAC. o. (2016). Over 100,000 people set to benefit from PHARMAC vaccines decisions. Wellington: PHARMAC. Retrieved October 9, 2016, from https://www.pharmac.govt.nz/news/media-2016-07-28-vaccines/

THE IMPORTANCE OF ADULT IMMUNISATION

Commenced nursing training at Tauranga Hospital in 1970. On graduation in 1973 moved to Auckland, worked with a nursing agency for a short time, before becoming a practice nurse in March 1974 as part of the Selwyn Carson initiated practice nurse subsidy scheme worked in 5 Auckland general practice settings until 1998 at which time I returned to the BOP and worked for the following 10 years at Otumoetai Doctors in Tauranga where diabetes and wound management was an interest of mine. In 2008 I joined the IMAC Team as WBOP Immunisation Facilitator June 2008, then in October 2010 became the IF for the whole of the BOP. Completed a PG Diploma in Primary Health Care in 2011. In January 2012 the role was devolved from IMAC into the BOP DHB. I am passionate about immunisation, improving immunisation service delivery and access with a philosophy that "immunisation is for whole of life".

I have previously been a member of the NZCPNs National Executive, and joined the LOGIC Journal Editorial Committee in 2010.

As health care professionals (HCPs), we have the knowledge, within our professional toolkits, that administering vaccines reduces morbidity and mortality of vaccine preventable diseases (VPDs) throughout life, regardless of age.

Being immunised is a lifelong and life-protecting process, (Immunization Action Coalition, Vaccinations for Adults 2016) with the WHO stating that the giving of a vaccine is the "single most effective health care intervention that can be delivered by a health care professional". (The WHO 2013)

In the busy general practice setting, adult immunisation often doesn't receive the same attention that childhood immunisation does, mainly due to the focus on achieving the eight month, two year and five year Ministry of Health immunisation targets.

For healthy adults, it is the responsibility of the HCP to provide patients/clients with information on protecting themselves against VPDs throughout their lives regardless of age, and to increase awareness on the availability of funded/non-funded vaccines.

Raising the awareness of age-related changes to the immune system that can result in a greater susceptibility to infection; and reduced responses to vaccines (known as "immunosenescence") are also part of the information-sharing process.

The main features of immunosenescence are:

- Impaired ability to respond to new antigens
- Unsustained memory responses
- Increased autoimmune responses
- Ongoing low-grade inflammation due to degenerative diseases, including cardiovascular disease, neurodegenerative diseases and frailty. (Goronzy J.J 2013)

Other important aspects for adult immunisation are protection for their children/tamariki and mokopuna; reducing personal health risks; the increased risk of disease (eg: Shingles); ongoing protection (tetanus/diphtheria boosters); travel, lifestyle and occupation.

The major barriers to adult immunisation are a lack of awareness of their importance; poor record-keeping where there is multiple health providers, poor IT recall systems, and the cost of service.

With all staff within the general practice setting always busy, ask yourself the question "who is the least busy?" during a health visit. The answer is, of course, the patient/client waiting to see the doctor or nurse. This presents the ideal opportunity to provide a written resource (other than a poster on the wall that is often missed) for the patient to peruse while waiting for the appointment.

Attached is a resource designed to be given to the patient upon reporting to reception staff. The waiting patient/client has the time to read, have awareness raised, and provides the opportunity for discussion with their HCP. Research shows that a HCP recommendation is a key predictor of whether patients receive needed vaccines. (Immunization Action Coalition, How You Can help Overcome Low Vaccination Rates among Adults 2016 July). The HCP:

- Assesses the vaccination status of the patient
- Strongly recommends the required vaccines
- Makes vaccination services as convenient as possible for patients
- Ensures the events are accurately recorded on the National immunisation register (NIR) where applicable.

References:

Immunization Action Plan; Vaccinations for Adults-You're never too old to get immunized! 3/16. http://www.vaccineinformation.org/adults/schedules.asp.

World Health Organisation (2013) Global Vaccine Action Plan 2011-2020. http://www.unicef.org/immunization/files/GVAP(1).pdf.

Goronzy J J & Weyand Cornelia M. Understanding immune senescence to improve vaccine responses. Nat Immunol. 2013 May; 14(5): 428-436.

Immunization Action Coalition; Technically Speaking: How You Can Help Overcome Low vaccination Rates among Adults. Vaccination Update for Healthcare Professionals- Jul 27, 2016. http://www.immunize.org/technically-speaking/20160727.asp.

Important Adult Immunisation Notice

The staff at ……..are focussed on making sure all adults over 50 years have been offered the following important vaccines for disease prevention and healthy ageing.

Influenza: Everyone should consider an annual influenza vaccine to reduce the chance of contracting and sharing influenza. Influenza can be a very serious disease. Every year there are many cases of pneumonia as a result of influenza, and many reported deaths.

Tetanus – Diphtheria-Pertussis: Administration of this combined vaccine simplifies Tetanus related wound management & helps prevent Diphtheria. The addition of the Pertussis (whooping cough) component in the vaccine is especially important if you have contact with small babies and children. Having this vaccine will protect big and little people from the devastating impact of whooping cough.

Shingles: If you've had chicken pox, and most New Zealanders have, you're carrying the virus that causes shingles. The virus that causes chicken pox can re-emerge as shingles at any time. As we age, the consequences of shingles can be more serious, sometimes resulting in long periods of intense pain.

Pneumococcal Disease: This important vaccine group protects you against Pneumococcal disease and perhaps more importantly invasive pneumococcal disease or IPD. IPD usually results in hospitalisation. The bacterium which causes pneumococcal disease can cause disease of the bloodstream, brain and lungs.

50-65 years

Vaccine	Used to prevent	Funded?	Funding info	Cost
Influenza	Influenza	Maybe	Depends on risk factors	$0 or $
Td	Tetanus + Diptheria	Yes	Funded for all at age 45 with catch up if not administered at 45	$0
Tdap	Tetanus + Diptheria + Pertussis (Whooping Cough)	No		$0
Zostavax	Shingles	No		$0

65 years +

Vaccine	Used to prevent	Funded?	Funding info	Cost
Influenza	Influenza	Yes	Funded for all 65 +	$0
Pneumococcal Disease. Two types: Conjugate – Prevenar 13 Polyvalent – Pneumovax 23	Pneumococcal Disease	 Maybe Maybe	 Depends on risk factors Depends on risk factors	 $0 or $ $0 or $
Td	Tetanus + Diptheria	Yes	Funded for all at age 65 with catch up if not administered at 65	$0
Tdap	Tetanus + Diptheria + Pertussis (Whooping Cough)	No		$
Zostavax	Shingles	No		$

Note that an additional nurse charge of $.... per session will apply to non-funded vaccines. All prices include GST.

Immunisation for adults is important. Please talk to the nurse or Doctor about your immunisation requirements.

Why is workplace bullying so hard to address?

Kate Blackwood is a lecturer in the School of Management at Massey University, Palmerston North. She is a member of the Healthy Work Group, a multidisciplinary team of researchers from Massey interested in psychosocial factors in workplace health and safety. She completed her PhD in 2015 which explored interventions in nurses' experiences of workplace bullying. Kate's research interests include workplace bullying, ill-treatment, and healthy work, and she is particularly interested in the healthcare context.

Dr Kate Blackwood, Lecturer, Massey University

Workplace bullying is a costly and pervasive workforce issue in New Zealand's healthcare sector. If research statistics (Bentley et al., 2009) are applied to New Zealand's 50,000 strong nursing workforce, it can be estimated that approximately 10,000 of New Zealand's nurses have experienced workplace bullying in the past six months, and that approximately 43,350 (87%) have been exposed at least to occasional negative behaviours. In 2015, I completed my PhD research which explored nurses' experiences of workplace bullying and found that, for only one of the 34 nurses I spoke to, had their organisation been able to take action to resolve the bullying experience. In this article, I outline the findings of the research which explain why so many cases go unresolved, and conclude by offering suggestions for organisations seeking to improve the way in which they manage workplace bullying.

An overview of the bullying experiences

The 34 victims who participated in the study all agreed that their experience fit with the definition of bullying; for the purpose of this research, bullying was defined as 'numerous negative behaviours towards a single target over a period of time, that makes the target feel powerless and causes personal harm'. Victims described having been subjected to a range of behaviours, the most common of which included criticism of their work, micro-managing and controlling behaviours, general aggression and intimidation. They explained how being subjected to these behaviours repeatedly, over an extended period, caused them to feel "*absolutely broken*", "*drained*", and "*frightened*". They reported crying, sleeplessness, and taking sick leave. Many explained that the bullying made them feel incompetent and caused them to make errors at work. They spoke about how the bullying made them want to resign, and many eventually did.

Victims' experiences lasted anywhere from 2 months to 10 years. Of the 34 victims, 15 experiences were continuing at the time of the interviews, and 12 victims had already resigned from their role. In two experiences the perpetrator had resigned, and five victims felt that despite still working together the bullying had stopped, for at least the time being – only one of these had stopped as a result of the organisation taking action to resolve the experience. Of the 34 victims, 28 had reported it to a manager or Human Resources (HR) at least once during their experience, and of those 28 who reported, action was taken in only 15 cases.

The three key barriers to bullying intervention

Workplace bullying victims cannot address their experience alone. Research shows that victims cannot depend on their personal coping mechanisms to defend against long-term bullying; indeed, as a victim is repeatedly targeted, loses confidence and becomes increasingly demoralised, their coping strategies will become depleted and they will most often resign from their role. With this in mind, organisational intervention is most often required in order for cases of workplace bullying to be resolved. This research identified three key steps through which a victim of bullying must progress to find a resolution to their experience: 1) Making sense of the behaviours; 2) The decision to report; 3) Organisational action.

1) Making sense of the behaviours

Many workplace bullying behaviours are subtle and, if considered in isolation may seem petty or trivial; instead, it is the frequency and persistency of the behaviours that causes harm to a victim of bullying. Further, work-related behaviours, such as being given excessive workloads and unreasonable deadlines, and withholding information, are often easily justified as being within the scope of a perpetrator's role. As such, victims may struggle to make sense of bullying behaviours and identify them as unreasonable. Many victims in this study experienced months of feeling as though it was their fault that they were being subjected to the behaviours.

> *"My self-confidence went down and I figured that it was all me. I used to think I was over dramatizing it and it shouldn't hurt me like it did".*

It was only when victims were able to realise that the behaviours were unreasonable and alleviate feelings of fault, that they would consider taking action to stop the bullying.

2) The decision to report

Workplace bullying often goes unreported. Research suggests that low levels of reporting are due to perceived tolerance and acceptance of bullying in organisational culture, unclear or unsafe reporting channels, lack of support from management, and a fear of further victimisation. In this study, 28 of the 34 victims reported their experience at least once. However, victims explained that they were hesitant to report because they felt that management or HR would not agree that the complaint was worthy of action, that they could not do anything about the behaviour, and that there would be repercussions as a result of reporting.

> *"I really didn't want to make too many waves because I didn't want them to turn it around to think it's me"*

3) Organisational action

Of those victims who did choose to report, 13 received no response to their complaint and instead, as many had predicted, experienced management or HR disagreeing that the complaint was worthy of action, or excusing action on the grounds that there was nothing that they could do. Such responses are not confined to the New Zealand nursing context, and are well-documented in the existing literature.

> *"She just said that she couldn't really*

do much from her end and that it was best kept low level".

"Of course, they're going to mask the issue, and they were saying it was me all the time. So I guess my manager got worn out".

Studies have identified a number of reasons why managers/HR fail to respond to complaints of bullying, including lack of confidence and/or leadership competencies, lack of time and resources, a tolerance and acceptance of bullying in organisational culture, lack of senior management support, and general perceptions that workplace bullying is not a problem that needs to be dealt with by the organisation.

Of course, in 15 cases in this study, management or HR did take some action including, for example, putting in place policies to clarify roles and responsibilities, mediation, team building, team meetings, and buddy systems. Unfortunately, however, in all but one case these strategies failed to resolve the experience from the victims' perspective.

Recommendations

The findings of this study highlight the importance of early intervention in workplace bullying and support the claims of existing studies that effective intervention in escalated cases of workplace bullying is almost impossible. Interventions in workplace bullying should focus on accurate and early identification of bullying, encouraging reporting, and encouraging manager/HR intervention.

Interventions that may be useful include bullying awareness training for all staff, leadership training for managers, training for managers on how to identify and address bullying, and creation and communication of safe reporting channels. Finally, organisations should be aware of the impact of organisational culture on the efficacy of bullying interventions.

For a more comprehensive overview of the findings of this study, click here. If you would like more information about this study, or any of the studies referred to in this article, please contact Kate on (06) 951 9202 or k.blackwood@massey.ac.nz.

References

Bentley, T., Catley, B., Gardner, D., O'Driscoll, M., Trenberth, L., & Cooper-Thomas, H. (2009). *Understanding stress and bullying in New Zealand workplaces. Final report to Occupational Health and Safety Steering Committee*. Auckland, New Zealand.

SEXUAL HEALTH IN OLDER PEOPLE

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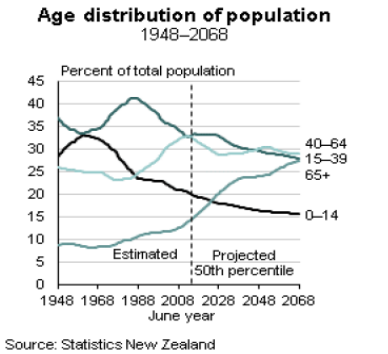
BACKGROUND: AN AGEING POPULATION

The New Zealand (NZ) national statistic projections indicate a short to medium term growth of the future population, which is expected to pass the 5 million mark between 2018 and 2025, reflecting significant gains from net migration.

In the longer term, we can expect increasing numbers and proportions of the population at the older ages: the population aged 65+ (0.65 million in 2014) will almost certainly reach 1.28–1.37 million in 2041 and 1.58–1.81 million in 2068. The proportion of the population aged 65+ (14 percent in 2014) will be the fastest growing age bracket, increasing to 22–25 percent in 2041 and 24–32 percent in 2068 (see Figure 1 below).



Source: Statistics New Zealand

AN UNDER APPRECIATED ISSUE

Many healthcare practitioners do not realise that older adults remain sexually active well into advanced ages, and that condom use rates among older adults are low. Older adults have a perception of not being at risk for sexually transmissible infections (STIs), as these are commonly linked to younger age and the risk of unintended pregnancy. In addition, older men suffer more frequently from erectile dysfunction, which makes condom use more challenging. The advent of oral medications for erectile dysfunction (like sildenafil and others), on the other hand, is allowing more older men to resume or continue the sexual activity, therefore exposing themselves and their partners to the risk of STI transmission.

CHLAMYDIA

Among women, *Chlamydia trachomatis* (CT) infection is predominantly a disease of the young age, likely because the target cells for CT (i.e., the columnar epithelium, which is present on the cervix of young women) is replaced by squamous epithelium with age. In NZ, the published ESR data on STI group together all age brackets above 40 years. With this limitation in mind (which applies to most of the STIs), it is quite striking that the biggest increase in CT rates for males from 2010 to 2014 was in the 40+ age group (24.9%), as opposed to a decrease of 17.5% in the 15-19 age group. CT rates, on the other hand, declined in all age groups for females (6% decrease in the 40+ group).

GONORRHOEA

Like chlamydia infection, the stereotype view is that disease due to *Neisseria gonorrhoeae*

(NG) is predominantly seen among adolescents. Again, in NZ from 2010 to 2014 there was a 32.3% increase for males aged 40+, more than for any other age group. The rate for females aged 40+ was, on the other hand, fairly stable.

SYPHILIS

The rate of incidence of early (recently acquired) syphilis is thought to be low among older adults. Late latent syphilis and, on occasion, neurosyphilis and tertiary forms of syphilis are arguably more common in this age group. Strokes due to meningovascular syphilis usually occur 5–12 years after infection. Later neurological manifestations, which occur decades after infection and usually present in older adults, may include dementia (general paresis), ataxia due to tabes dorsalis, VIIIth nerve deafness, or optic atrophy.

Older adults may be tested for syphilis as part of a workup for strokes, dementia, or other neurological disorders. However, routine use of treponemal tests for older adults with strokes or dementia is not routinely recommended, as the yield of such tests is low and the correlation with symptoms usually questionable.

In the Pacific, we have also the additional challenge that yaws (an endemic, non-sexually transmitted treponematosis, which cross-reacts with the syphilis serology) was endemic in most of the Islands until the late 60s-early 70s. Pockets of ongoing transmission are still present in Papua New Guinea, Solomon Islands, and Vanuatu. Pacific people who migrated to NZ after spending their childhood in the Islands while yaws was still endemic, are now getting older and developing dementia due to other causes. Unfortunately, they will test positive for syphilis due to the cross-reactivity with yaws, triggering unnecessary anxiety, psychological distress, and invasive investigations (lumbar puncture). It is important that primary healthcare providers are aware of this issue and expect the syphilis serology to be positive (due to yaws) in most Pacific Islanders now in their 70s and 80s.

Figure 2: Infectious syphilis case numbers reported by SHCs by age group and sex, 2014 (source: ESR: Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2014)

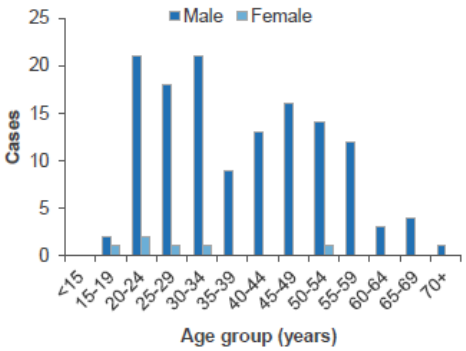
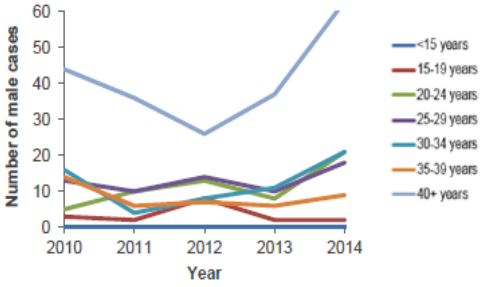


Figure 3: Number of Infectious syphilis cases in SHCs in males by age group, 2010–2014 (source: ESR: Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2014)



In NZ, we have had so far a voluntary, enhanced notification scheme for syphilis, which includes a more detailed split into age brackets over the age of 40. In Figure 2, it is striking that the cases in males over 60 are still reasonably frequent, up to age 69. Also, Figure 3 shows that the steepest increase of syphilis cases in males from 2012 onwards was actually in the 40+ group.

HERPES

HSV 2 is usually sexually transmitted, although it is not uncommon to see sexually transmitted (via oral sex) HSV 1 too. The seroprevalence starts to increase after the sexual début. On the other hand, the clinical symptoms and the viral shedding decrease over time. In 2014, the mean age of the genital herpes cases in NZ was 31 years (as reported by the Sexual Health Clinics).

HUMAN PAPILLOMAVIRUS

HPV infection is considered to be the most common STI. Up to 60% of the population have evidence of previous infection by age 49. The clinical experience suggests that genital warts are less commonly seen in older adults, who, on the other hand, bear the biggest burden of the oncogenic HPV types: approximately 25% of the new cases of invasive cervical cancer occur among women aged 65+. Anal cancer due to HPV is a rising concern particularly in gay, bisexual, and other men who have sex with men (GBM) and heterosexual women, while the group most affected by oropharyngeal cancer due to HPV are heterosexual men.

VAGINITIS

Vaginal discharge is a common complaint among women of reproductive age, the 3 main causes being bacterial vaginosis (33%), thrush (20%), and trichomoniasis (10%). In postmenopausal women, on the other hand, atrophy due to oestrogen deficiency is the most common cause of vaginitis. Atrophic vaginitis is also the most persistent menopausal symptom over time, well beyond the five or so years that the vasomotor symptoms (night sweats, hot flushes) normally last. Luckily, the topical vaginal oestrogen preparations are very active and cause only minimal systemic oestrogen absorption, hence can be used for many years even by women with contraindications to other oestrogen formulations.

HIV

HIV prevalence among those aged 50 years of age and older has been rising over the past decade. The increasing trend of ageing with HIV is not only the result of longer survival due to treatment; older adults accounted for 12.9% of newly reported cases of HIV infection in 2007 in Europe. When examined, HIV knowledge amongst older adults has been variable; while some exhibit adequate knowledge, many do not consider themselves to be at risk as HIV is mostly considered an illness of younger people. In NZ, the latest report (2015) from the Otago AIDS Epidemiology Group showed that, among GBM, the age range at diagnosis extends to 80 years; 25% of cases were in GBM aged 50+. Also among heterosexual men and women, 24% of the new infections were among people aged 50+.

SEXUAL ORIENTATION AND GENDER IDENTITY IN OLDER AGE

Healthcare professional working in the aged care sector (rest homes) must not presume that the gender identity and sexual orientation of their clients is necessarily cis* (i.e. gender identity conforming to the biological sex) and/or heterosexual. Sadly, trans* and/or same-sex attracted older people have been forced to go back into the closet when moving into a retirement home, adding further psychological suffering to the distress of losing their home and, perhaps, their long-term partners. NZ is at the forefront of the international movement to change this unfortunate situation: the Silver Rainbow programme by Affinity Services

ensures that the aged care sector is equipped with the tools to make Lesbian, Gay, Bisexual, Transgender, and Intersex older people feel welcome and safe into their new homes.

REFERENCES

- National Population Projections: 2014 (base) - 2068, Statistics New Zealand - Tatauranga Aotearoa, available at www.stats.govt.nz
- The Institute of Environmental Science and Research Ltd. Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2014 (Porirua, New Zealand), available at www.surv.esr.cri.nz
- AIDS New Zealand, issue 75, May 2016, available at www.otago.ac.nz/aidsepigroup
- Calvet HM, Sexually Transmitted Diseases Other than Human Immunodeficiency Virus Infection in Older Adults, Clinical Infectious Diseases 2003;36:609–14
- Negin J et al., HIV behavioural interventions targeted towards older adults: a systematic review, BMC Public Health 2014,14:507

EAR ASSESSMENT

Theresa O'Leary (NZRN)

Ear Nurse Consultant

TOLBECS Ear Centre Ltd | EARSmadeEasy – a comprehensive course on ears

PO Box 4178, Hamilton New Zealand

At TOLBECS our quest is to share our expert skills and knowledge so that everyone can have the healthiest ears and best hearing possible! Imagine a world with many more health professionals confidently looking into ears, knowing what to do with what they see, empowering people of all ages – and gaining great job satisfaction on the journey! This article will summarise some important points to begin the nursing process – assessment of ears.

Otoscope Begin with the best tool – TOLBECS recommends a Welch Allyn Macroview otoscope head. It offers 30% more magnification and twice the visual field, giving a nearly complete view of the eardrum. Better clarity and definition of landmarks allow for a confident diagnosis, better learning and no confusion! The focus can be adjusted for near and far viewing sites and for farsighted eyes. The Macroview head can be attached to either the standard or lithium-ion power handle.

Figure 1 Welch Allyn Macroview head: wide, close viewing to improve diagnostic accuracy

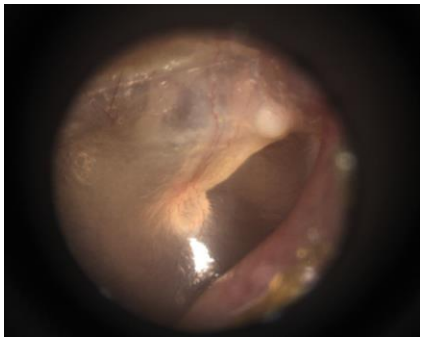


Figure 2 Macroview picture of a normal eardrum

Theresa O'Leary is Director of TOLBECS Ear Centre Ltd (2001), a nurse led private clinic in Hamilton New Zealand. A Registered Nurse with post-graduate training in the speciality nursing area of ears, she has been looking into and learning about ears since 1987, ie for 24 years.

TOLBECS ear nurse therapists offer assistance to children and adults who are experiencing outer, middle or inner ear troubles. They network with nurses, general practitioners, ENT specialists and audiologists, both local hospitals and in the community to bring about optimum outcomes for their clients.

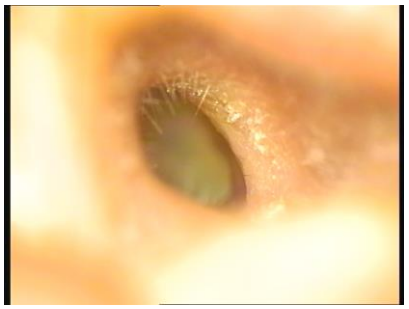


Figure 3 A normal entrance - eardrum in the distance

Continue to assess as you work your way in – where is the main problem? Listen well to what is reported.

- If the ear canal or middle ear is blocked it will sound loud and weird if they tap their jaw – autophony is present
- If the main complaint is pain – is it canal or middle ear – ask if it hurts to move their pinna?
- Can they pop their ears? if they can the middle ear is functioning normally and the eardrum is intact

Pinna Assessment Points:

- Any lesions surrounding the entrance are likely to have spread from an ear canal infection, exudate in an ear tickles, relieved 'and spread' by fingernail scratching
- If the pinna is painful to move or chew, the entrance or canal are the site of infection NOT the middle ear.

Ear Care Assessment Points:

people who put things into their ears (objects: ear plugs, hearing aids, or liquids: drops, soapy water etc) are more likely to run into trouble with blocking and infection, learn to ask an open question to find out their habits

- How do you clean your ears?
- What do you put into your ears?
- Do you use anything to clear the wax?

Canal Assessment Points:

- Discharge? has a swab been taken? a must to identify exactly what is present and causing trouble
- Assess the exudate:

– colour: pseudomonas emits a blue dye so if present the exudate will be green, blue or bright yellow

– odour: gram positives smell sweet, gram negatives, smell sour

– consistency: thick and scant = canal, copious and mucoid = coming from the middle ear via a perforation or grommet/ T Tube

- Itchiness? extreme = candida
- Pain? extreme pain and rapid onset are nearly always signs of a pseudomonas infection
- Can you pop your ears? if yes, that proves that the eardrum is intact

Middle Ear Assessment points:

if nasal function is poor, middle ear problems are likely to be prolonged and repetitive.

Ask:

- Do you sniff or blow your nose?
- Do you breathe through your nose or through your mouth?
- How many middle ear infections have you had this year?
- Does the fluid go away in-between?
- Can you smell bad breath? is green crusty discharge present from the nose entrance and eyes?

– the upper respiratory tract may be hosted by troublesome bacteria.

- Can you pop your ears?

– if they can, this proves that the eustachian tube is open, 4 big pops and the middle ear can be cleared of fluid, they will hear the bubbles and squeaks as the air replaces the fluid.

- Which ear hears the best?

– this question is especially good for children.

- Are your body noises loud?
- tap your cheek, rub your whiskers.
- does it sound the same on both sides?

- Autophony will be present when the hearing pathway is occluded – within the canal or middle ear

- Otoscopy will show visible radial vessels in the eardrum when fluid is present – effusion.
- With acute infection erythema will also be evident.

Inner Ear Assessment Points

- Can you pop your ears?

- if they can this indicates the eardrum is intact and the middle ear is clear.

- In what situations do you have trouble hearing?

- Compared to last (week, birthday, Christmas etc) how good is your hearing?

With recent onset deafness, vertigo or tinnitus:

- Has the change been sudden or gradual?

- Is it there all the time or comes and goes?

- Is it getting better or worse, or the same?

- How do you protect your hearing?

- Dizziness versus vertigo - is it like getting out of a hot bath or like you've had a third brandy?

ENT danger signs

- Foul smelling discharge.
- Unilateral symptoms.
- Hoarse voice for longer than 3 weeks.

- Lump in throat.
- Adult unresolved effusion.

These points may inspire more questions and learning needs? Would you like to learn more? ….. come on one of our comprehensive EARSmadeEasy courses.

6 hours of intensive learning in a small class: practical sessions on how to perform otoscopy safely to gain the best view. Then … what to do with what you see!

Please register your interest in joining us for more learning in 2017 by emailing us at eme@tolbecs.co.nz or phone 07 856 0002

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South Island (Timaru) Symposium Snapshots

PICTURE 1

Anna Tipa (left) works at Servants Health Centre in Central Dunedin. This is a FREE health centre for marginalised persons experiencing violence, homelessness, financial or other distressors. They offer breakfasts on site and all RN's, GP's, councillors and health practitioners donate their time to this service free of charge. Anna loves the connections she has made and feels privileged to journey alongside patients who are experiencing hard times. Anna spends much of her time facilitating change and networking.

Jennifer King (right) is a registered nurse working at two medical centres in Upper Hutt. The practices have markedly different sized and enrolled populations. Jennifer loves the challenges she faces working with these differences and her flexibility required to help individuals and families at either centre achieve positive health outcomes.

PICTURE 2

LULU PURDA works for Te Piki Oranga in Nelson and is a Tamariki Ora and Community nurse working under a whanau ora model. She predominantly home visits her patients and truly feels this increases her relationship building platform. Her reputation now precedes her and her increased insight into whanau's lives means that she can better tackle determinants of health impacting on wellbeing. Lulu links in with comprehensive agencies meaning people get connected to the services they require. Working this way has meant health outcomes have been better realised and achieved.

Picture 3

Kathy Hines (LEFT) and **Theresa Hand (Right)** both work at Greymouth Practice on the West Coast which is unique in that it is completely nurse owned. Their community have been nothing but supportive and encouraging since these changes occurred. The thing that they love about their unique situation is their 'by nurses for nurses' environment where collegiality is high and nurses are able to converse, set up initiatives and problem solve amongst peers who understand a nursing lens. Networking is a priority for them all.

The presentations from the 2 symposiums are available at:

http://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_primary_health_care_nurses/resources#Past

Conference Presentation

NZNO Research, Policy and Publications Report

Jill Clendon - Nursing Policy Advisor/Researcher

Jill Clendon reports to us that a project on nurse attrition has just been commenced. This involves the surveying and interviewing of nurses who have left the profession in order to examine factors contributing to nurses choosing to exit the nursing workforce. This will also provide further information as to what interventions may help reduce such attrition. The study has recently received ethics approval and the survey went out last week. We have already had an excellent response rate with what looks to be some very rich data. We are looking forward to analysing this once the survey has closed. Interviews will follow in the new year.

We have had a number of recent publications that LOGIC readers may be interested in. Aside from the first paper which is still in press, the remainder are all available directly from the NZNO library (library@nzno.org.nz):

- Clendon, J., & Walker, L. (In press). Nurses as family caregivers - Barriers and enablers facing nurses caring for children, parents or both. *Journal of Nursing Management.*
- Walker, L., Clendon, J., Manson, L., & Nuku, K. (2016). Ngā Reanga o Ngā Tapuhi. Generations of Māori Nurses. *Alternative, 12*(4), 356-68.
- Walker, L., Clendon, J., & Cheung, V. (2016). Family responsibilities of Asian nurses in New Zealand: implications for retention. *Kai Tiaki Nursing Research.*
- Clendon, J. (2016). Primary health ethos missing from strategy. *Kai Tiaki Nursing New Zealand, 22*(7), 34-35.
- Clendon, J., & Walker, L. (2016). Juggling nursing and family care. *Kai Tiaki Nursing New Zealand*, 22(2), 26-28, 43.
- Clendon, J., & Walker, L. (2016). The juxtaposition of ageing and nursing: the challenges and enablers of continuing to work in the latter stages of a nursing career. *Journal of Advanced Nursing. 72*(5), 1065-1074. doi: 10.1111/jan.12896

The biennial NZNO employment survey will be going out in the new year and the joint NZNO and Massey University, Health Research Council funded survey on fatigue and shift work will be going out sometime in the next few weeks.

From a publications perspective, the following new publications are now available on our website:

2. - NZNO and its international relationships
3. - Medical marijuana
4. - Nursing, technology and telehealth
5. - Privacy, confidentiality and the use of exemplars in practice and journaling

The NZNO Library

Resources For Nurses

NZNO Library

The NZNO Library has a wide range of hardcopy and online resources available to support the information needs of members.

Check out the updated NZNO Library resource lists. http://www.nzno.org.nz/resources/library/resource_lists

Articles - Sexual Health

Copies of these articles can be provided to NZNO members free of charge. Email Library@nzno.org.nz and let us know which ones you are interested in.

1. Bray, Susan. Partner notification an important part of management of most STIs. (2015). *New Zealand Doctor*, 04/03/2015: 35

The article offers tips for general practitioners on how to perform partner notification for patients diagnosed with sexually transmitted infections (STIs) which include providing patients with reasons for the notification, the use of non-judgmental phrases and not to make assumptions about sexuality. It suggests practitioners to encourage support with back up if patients choose to do the notification and providing information leaflets.

2. Claydon, Lorna. (2014). Taking sexual histories in the techno-sexual era. *New Zealand Doctor*. 05/11/2014: 30.

The article offers information on the sexual histories in New Zealand. Topics include the effect of online sexual activity, such as sexual partnering, online pornography, and sexting, the use of condom and contraception to lessen chlamydia and pregnancy termination rates, and the sexual health checks among young people in the country.

3. Eglseder, Kate. (2016). Addressing Sexuality in the Clinic: Simple Steps for Practitioners. *OT Practice.* 21(17) : 21-23.

For many, sexuality is an important part of the human experience. In fact the American Occupational Therapy Association (AOTA, 2014) identifies sexual activity as an activity of daily living (ADL). Despite the knowledge that sexual health and intimacy are important aspects to

consider when working with individuals with disabilities, research has demonstrated that education is often inadequate to facilitate a successful return to this ADL.

4. Habraken, Nikitah & Wheeler, Emily. (2015). Chlamydia in men - are you thinking about it? Australian Nursing and Midwifery Journal, 23(5): 45

Chlamydia is the most commonly reported communicable disease in Australia (The Kirby Institute, 2014), frequently affecting sexually active young men and men who have sex with men (MSM.)

5. Hughes, A.J & Saxton, P. J. (2015). Thirty years of condom-based HIV prevention by gay men in New Zealand. New Zealand Medical Journal 128(1426): 19-30

Three decades after the first government-funded HIV prevention campaign in 1985, gay and bisexual men (GBM) remain the population most at risk of infection in New Zealand. We review the major determinants of the elevated HIV risk for GBM, describe New Zealand's prevention response over the first 30 years, and summarise the public health record.

6. Johnston, Karen; Harvey, Caroline; Matich, Paula; Page, Priscilla; Jukka, Clare; Hollins, Jane & Larkins, Sarah. (2015). Increasing access to sexual health care for rural and regional young people: Similarities and differences in the views of young people and service providers.

Australian Journal of Rural Health. 23(5):257-264

This study aims to describe the views of sexual health service providers on access issues for young people and consider them together with the views of young people themselves. Service providers frequently identified structural barriers, confidentiality and lack of awareness of SRH services as barriers for young people seeking SRH care.

7. Lorenz, Tierney, PhD; Rullo, Jordan, PhD, LP; Faubion, Stephanie, MD. (2016). Antidepressant-Induced Female Sexual Dysfunction. *Mayo Clinic Proceedings* 91(9): 1280-1286.

Because 1 in 6 women in the United States takes antidepressants and a substantial proportion of patients report some disturbance of sexual function while taking these medications, it is a near certainty that the practicing clinician will need to know how to assess and manage antidepressant-related female sexual dysfunction. Adverse sexual effects can be complex because there are several potentially overlapping etiologies, including sexual dysfunction associated with the underlying mood disorder.

8. Robertson, Anne. (2014). Antibiotic-resistant STIs: The chief culprit is Neisseria gonorrhoeae. *New Zealand Doctor*. 03/12/2014: 30

The article discusses the high rates of gonorrhoea in New Zealand as of December 2014 due to the antibiotic-resistant organism Neisseria gonorrhoeae. It discusses the use of nucleic acid amplification testing (NAAT), which specimens to collect for diagnosing the disease, and the appropriate treatment for uncomplicated infection.

9. Tung, I. L. Y., Machalek, D. A., & Garland, S. M. (2016). Attitudes, knowledge and factors associated with human papillomavirus (HPV) vaccine uptake in adolescent girls and young women in Victoria, Australia. *PLoS One*, 11(8) doi:http://dx.doi.org/10.1371/journal.pone.0161846

Human papillomavirus (HPV) vaccination targets high-risk HPV16/18 that cause 70% of all cancers of the cervix. In Australia there is a fully-funded, school-based National HPV Vaccination Program which has achieved vaccine initiation rate of 82% among age-eligible females. Improving HPV vaccination rates is important in the prevention of

morbidity and mortality associated with HPV-related disease. This study aimed to identify factors and barriers associated with uptake of the HPV vaccine in the Australian Program

10. Veukiso-Ulugia, Analosa. (2016). 'Good Samoan kids' - fact or fable?: Sexual health behaviour of Samoan youth in Aotearoa New Zealand. *New Zealand Sociology* 31(2): 74-95

An account of the sexual health behaviour of Sāmoan youth in Aotearoa New Zealand is presented, and some implications of this sexual behaviour are outlined. The findings are from a mixed methods nation-wide study which explored factors that influence the sexual health knowledge, attitudes and behaviours of Samoan secondary school students in Aotearoa New Zealand

11. Wong LP, Raja Muhammad Yusoff RNA, Edib Z, Sam I-C, Zimet GD. (2016) Nationwide Survey of Knowledge and Health Beliefs regarding Human Papillomavirus among HPV-Vaccinated Female Students in Malaysia. *PLoS ONE* 11(9): e0163156. doi:10.1371/journal.pone.0163156

The National HPV Immunization Programme, which offers free human papillomavirus (HPV) vaccines to teenaged female students, was launched in Malaysia in 2010. HPV vaccination paired with adequate knowledge about HPV infection provides the best protection against cervical cancer. To identify the level of knowledge and the health beliefs towards HPV and the HPV vaccine among HPV-vaccinated female students in Malaysia.

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