

**2017 Symposium Angel Flight
Awards Nurse Prescribing
Tuberculosis Prostate Cancer**



LOGIC is the Official Journal of the New Zealand College of Primary Health Care Nurses, NZNO.

Editor Yvonne Little

Publisher Celeste Gillmer, 021 245 0587,
celeste.gillmer@gmail.com

Editorial Committee

Celeste Gillmer, Katie Inker, Emma Hickson, Irene Tukerangi, AnnieTyldesley

Circulation

To full members of the NZNO New Zealand College of Primary Health Care Nurses and other interested subscribers, libraries and institutions.

Editorial Matter

Prepared by the Editorial Committee and the Editor from submitted and invited material. Whilst every effort is made to ensure the accuracy of this information, the Publisher take no responsibility whatsoever for errors, omissions or any consequences of reliance on this material or the accuracy of the information. The inclusion or exclusion of any product or advertisement in no way means the Publisher or the New Zealand College of Primary Health Care Nurses advocate or reject its use in any way.

Correspondence

The Editorial Committee welcomes all correspondence intended for publication. Correspondence should be addressed to:

Yvonne Little: kirkcud04cairn@gmail.com

Please ensure the writer's name appears on the title page of any article or letter intended for publication.

Copyright

This publication is copyright in its entirety. Material may not be printed without the written permission of the New Zealand College of Primary Health Care Nurses, NZNO.

ISSN 2463-5642

September 2017 Vol 16 No 3

In this issue....

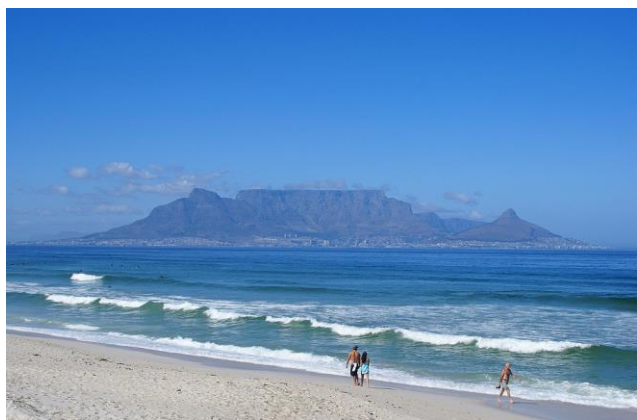
Chair's Report.....	1
Chief Nurse's Report	3
Editor's Report.....	5
Tall Poppy Award – NZ College of PHC Nurses, NZNO	7
NZ College of PHC Nurses, NZNO – Nursing Excellence Award.....	8
RURAL MUSTER #4	9
The MeNZB™ story, a new chapter .	11
Nurses and doctors mend babies' hearts with help from Angel Flight...	18
Community Services Integration (CSI) into Health Care Homes (HCH)	23
A journey to prescribe.....	27
Tuberculosis.....	30
Cervical Screening , Barriers and Cultural Safety	33
PROSTATE CANCER	36
NZ College of PHC Nurses, NZNO – Committees	38
New Zealand College of Primary Health Care Nurses, NZNO – 2017 Symposium	39
The NZNO Library	434

Chair's Report

Celeste Gillmer
Chairperson



Tena Koutou katoa
Ko Table Mountain te maunga
Ko Storm Water te awa
Ko ngāti Africa kite tonga ahau
Ko Waitemata DHB taku roopu
Ko Celeste Gillmer ahau



Greetings everyone,
I am Celeste Gillmer, the incoming chair of the NZ College of Primary Health Care Nurses. It is an honour to be elected into this position and to represent PHC nurses across New Zealand. I was contemplating for a long time what to write in my first

report, but the current struggles in Florida with hurricane Irma made me reflect on my role as a PHC nurse when disaster strikes.

And then of course, there is the upcoming election.

I hope you have all read the policy suggestions and listened to the different debates to ensure you make an informed decision. NZNO also published a document that compares the different parties: **“Comparing what the parties say with NZNO’s priorities”**. I strongly recommend you read this document (it will be available

on the NZNO website and facebook page) before you make a final decision regarding your vote.

We had an amazing symposium on 19th August 2017 at the Holiday Inn, Auckland Airport. The speakers delivered very high quality presentations and we were privileged to have Jill Clendon, Chief Advisor from the Office of the Chief Nurse, Ministry of Health and Jean McQueen, Nursing Director of Primary Care, ADHB & WDHB spending the day with us. It was also an honour to have Nikki Turner (Associate Professor from the University of Auckland) close the day on a high note with her presentation on child poverty in New Zealand. I would personally like to thank Dhyanne Hohepa, Angela Clark and Belinda Fletcher who made this day possible.

It's then on a sad note that we had to farewell our outgoing

national committee, professional practice and LOGIC committee members. On a personal note, I would like to thank Kim Cameron for her leadership over the past 4 years. She steered the national committee and the College with a compassionate but firm hand, always remembering that everyone is a hard working nurse, doing the best possible for their communities and contributing positively to our healthcare system. We will definitely miss her kind and humoristic personality around the meeting table! Also thank you to Dhyanne Hohepa (always willing to help), Karen Smith (our long standing treasurer) and Kim Carter (our reliable, outspoken national committee member, who is always prepared to fight for primary health care nurses/nursing). Also thank you to the following hardworking committee members who completed their terms in August: Marilyn Rosewarne (LOGIC), Trish Wilkinson (Professional Practice) & Donna Mason (LOGIC). We also said farewell to the following committee members during 2017: Kate Stark (co-editor, LOGIC), Lynette Law (LOGIC), Karry Durning (Professional Practice).

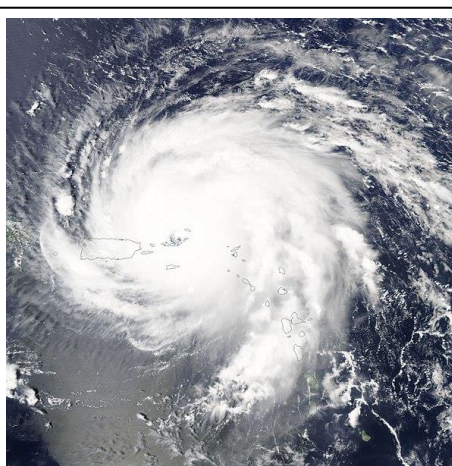
A special welcome to all our new committee members, we appreciate your willingness to

contribute to the NZ College of Primary Health Care nurses and I look forward working with each of you over the next 2 years (these members will be introduced later in this LOGIC edition).

All over New Zealand, new graduate nurses started on the NETP programme on 4 September 2017. We wish them all (specifically the ones starting in PHC!) all the best for their first year of practice.

And of course it's finally spring! Most of us had a very busy winter season, looking after very unwell patients (and colleagues) and maybe had to take sick leave ourselves. It is time to take a step back, enjoy the sunshine and make time for you, your family/whānau. Thank you for your commitment to primary health care nursing and your community.

Tena Koutou tena koutou tena koutou katoa



Are we prepared for when a disaster happens? What are our roles as PHC nurses in such times? I found a very helpful website to help you prepare for disasters: <http://getthru.govt.nz/> but this still didn't answer my question about my role as a PHC nurse during a disaster. I will have to speak to DHB's disaster management teams as well as the Auckland Council...maybe I'll know more by the time of my next report!

Chief Nurse's Report

Jane O'Malley
Chief Nurse

Report on "Nursing and the NZHS: Imagining future health services"

Nursing and other sector leaders have joined forces to think about what the future would need to look like to achieve the New Zealand Health Strategy and nursing's role in shaping and participating in that.

The National Nursing Organisation (NNO) group, in partnership with the Nursing Advisory Group to Health Workforce New Zealand (HWNZ), hosted a highly successful strategic day in April.

From the discussion (based on what the world will look like in 2030 if we were successful in realising the NZHS) came themes and a report as a beginning conversation with the sector. Highlights from the

report are picked out below as a taster.

Digital information has democratised health knowledge, giving power, control and choice to consumers and providers alike. Self-management technology is common-place. Technology has enabled people and their whanau to receive tailored, personalised services to make many of their health decisions autonomously with well-researched benchmarks to monitor safety and quality. Health care professionals provide advice and interventions as required.

The system now has flexible models of access such that there is no wrong door/portal when people identify a need for care. Access to support is easy and effective and systems allow sufficient information to



enable people and their whanau to make informed decision about the supports they want, and who, where and how to access services. Information is in an acceptable format (age, culture and ethnicity).

Primary health care and public health have a strong status with a growth in resources and staffing. The 2018 focus on pre-conception, the early years and support for families has proven effective. Providers of services are accountable for outcomes and in turn are suitably resourced and supported.

Whānau Ora is successful and is widely utilised. The early investment in 'family as THE unit for health care' has supported strengthening family links, improved health knowledge and behaviour and individual and community resilience.

The long aspired to 'generic health worker' has finally been recognised for what it was all along; nursing. Importantly the three scopes of practice; two of which are degree and post-graduate degree prepared, and the ability to supervise and direct an enormous unregulated health workforce, make the nursing workforce the most flexible of all the workforces and the key to leading and managing change.

Nurses' education and experience make them ideal for the roles of health concierge, case manager, triage facilitator and coach. In spite of a dramatic increase in technology driven services, personal interactions remain highly valued by consumers. Nurses continue to relate to people in their lived context and use this as the basis for determining their practice.

The UK All-Party Parliamentary Group on Global Health (APPG) report, [Triple Impact: how developing nursing will improve health, promote gender equality and support economic growth](http://www.who.int/hrh/com-heeg/triple-impact-appg/en/), <http://www.who.int/hrh/com-heeg/triple-impact-appg/en/> provides the platform for a well-constructed, responsible conversation with policy makers and providers to improve the

utilisation of nurses to deliver to their potential, and improve health outcomes.

The role of nursing leadership in working with networks of others to bring about change permeated all themes. The APPG report notes that voice and visibility of capable nurse leaders is required to ensure nursing's key contribution to financial and clinical sustainability in a predicted high cost, high demand future is heard.

Nurse leaders (guided by an agreed and well-rehearsed strategy and supported by sound communications and evidence) will need to purposefully develop connections with the systems movers, consumers and other strategic groups to provide input into policy and implementation thinking.

The report was sent out in early August for feedback and refinement. The National Nursing Organisations and the HWNZ Nursing Workforce advisory group, will develop an initial draft plan of next steps.

Editor's Report

Yvonne Little

Nurse Practitioner



Welcome to the Spring Edition of LOGIC. Hopefully everyone has survived the winter ills and chills which appears to have been the worst we have had for a while.

True to life, not everything goes to plan and due to unforeseen circumstances we have had to make some adjustments to our planned articles for this edition, despite this I hope you enjoy what we have put together.

On the 19th August the NZCPHCN held their symposium: "Future Direction, Your Roadmap" in Auckland and whilst attendance numbers were down on last years, it was still a resounding success with some very talented and experienced speakers. A more intimate number allowed for more networking also.

This year the Executive Committee decided that we would concentrate on two awards, rather than multiple ones and we had some brilliant entries. We were able to give

awards to two very deserving recipients: Tall Poppy Award (sponsored by Jane Ayling) went to Kim Carter – Tasker and the inaugural Nursing Excellence Award (sponsored by NZCPHCN Committee) went to Tim Ryan – please be sure to read their nominators comments in this edition and think about who you would like to nominate for 2018.

Along with the learning, networking and fun at the Symposium, we had to say fond farewells to many of our standing committee members who have completed their terms of office or are having to leave for personal reasons, they are:

Kim Cameron (Chair); Dhyanne Hohepa (Vice Chair); Karen Smith (Treasurer); Kim Carter-Tasker (Executive) ; Bronwen Warren(Professional Practice), Trish Wilkinson (Professional Practice), Karry Durning (Professional Practice); Marilyn Rosewarne (LOGIC). We wish

them well in their future directions and I am sure we will still hear from them in this journal from time to time as we tap into their wealth of experience in their respective fields of nursing.

You will see that we have new committee members, and some of us are staying on in both our previous role but also taking on new ones, so please take the time to read the biographies, if we are from your area then make yourself known to us as we are your voice and want to know what you think and want from the college.

Welcome aboard:

EXECUTIVE

Celeste Gillmer (Publisher of LOGIC) and new Chair

Emma Hickson (LOGIC committee) and new Deputy Chair

Cathy Nichols (Professional Practice) and new to Executive team

Linda Makiha – new to Executive Team

Tasha Morris - new to Professional Practice and Treasurer

LOGIC committee

Annie Tyldesley

PROFESSIONAL PRACTICE

Sarah Van Weersel

Bronwyn Boele van Hensbroek-Miller

Tegan Jones

Lee Ann Tait

Tasha Morris

Continuing on in their current roles are Wendy King as Secretary and myself as Editor of LOGIC.

Finally, I ask each and every one of you to think about what our Future Direction as a college is going to look like. We will be putting out through NZNO a Survey Monkey to find out what your thoughts are so please respond so that we as a committee can work toward what the members want.

We also want to see a stronger regional voice, so if your area does not have a delegate then think about putting your name forward or discussing with a colleague or group of colleagues about this. The best idea is to

have a central contact person but work with a group of like-minded nurses to run the meetings (you do not have to do this alone) and we as a college, in conjunction with NZNO will support you with advice on how to go about this.

I hope you enjoy this issue and the warmer weather to come. If you have any thoughts on articles that you would like to see in 2018 please email me as we are in the planning stages of the 2018 Feature Planner.

December 2017

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

Tall Poppy Award – NZ College of PHC Nurses, NZNO

At this year's NZCPHCN, NZNO symposium, Kim Carter received the Tall Poppy award – donated by Jane Ayling:



Kim Carter-Tasker

Some people may know the story that after a challenging day at work, venting to her partner; she was in turn challenged by her partner to become a business owner and manager herself instead – so she did, becoming one of a small group of nurses who owns or is part-owner of a medical practice.

This sums her up, rising to the challenge, being a role model in her clinical nursing and operationally, striving for excellence in nursing, service and financially.

She has told the story of managing the patient who had hand versus chain saw and thought it would be great to have photo of his injury and the nurse doing the dressing; she however had a different perspective, that of the issue of social media, and had no intention of her image going viral.

From a public health surveillance perspective, she knows what the local circulating influenza virus is that is creating a full waiting room and its effects on individuals clinically.

With the assistance of a colleague, Kim developed an business case proposal economic model for practices considering the economic effect of employing a nurse practitioner and which this week I heard being quoted by a local practice nurse whose practice are investigating what employing a nurse practitioner would involve.

Kim recently provided NZNO on behalf of the College comment on the latest government budget in relation to health spending with the insights of a general practice owner. She has been a representative on the General Practice Leaders Forum, a high level forum that engages with the Ministry of Health and her feedback emphasises the issue of the funding of Very Low Cost Access formula not being sufficient to meet the actual health needs of the populations in these practices.

Completing two terms on the College of Primary Health Nurses Executive, Kim has decided to return to study and has relinquished representation on General Practice Leaders Forum to do so. She is intending to examine nursing education preparation for primary care nursing role; almost immediately, she was invited to attend a nursing workforce workshop and strategy day (invitation only) held by the National Nursing Organisation group, a national forum on the direction of nursing in New Zealand.

Kim's nursing practice encompasses clinical, economic, advocacy aspects and she continues to attend to her own development; but tellingly, this work is actually the preparation and development of primary health care nurses and their practice.

NZ College of PHC Nurses, NZNO – Nursing Excellence Award

*Tim Ryan received the Nursing
Excellence Award at this year's
NZCPHCN, NZNO Symposium*

NZ College of Primary Health Care Nurses Award Nomination Form Nursing Excellence Award 2017

Tim has demonstrated a leadership role in men's health within Korowai Aroha Health Centre. He has achieved PDRP Expert level from Lakes DHB. He is the clinical advisor in the Tane Takitu Ake men's health program and works with 2 community health workers on an innovative men's self help 10 week program. The participants are usually; unemployed, low health literacy, low social economical demographics with high mental health needs, whom may not have engaged in regular health checks and therefore are at risk of becoming high health system users.

Because men have traditionally been hard to engage in health related issues usually when its to late, this program aims to break the cycle and engage in men in a environment that builds rapport with the participants. Taking the clinical outside the consultation room and embedding it into a program by using both western and cultural models of health. This has shown beneficial outcomes for these patients. Whilst Tim stress he does not do this not on his own, but in collaboration with the community and community health workers, this shows leadership for nurses to break down barriers and engage equally with the community. Diabetes, cardiovascular disease, asthma and cancer are all leading causes of death for Maori men and early prevention will create equity amongst this population. Tim has worked in the PHO and using his previous skills in community engagement to advance nursing practice in an intersectoral collaboration that has benefits for educating patients on these diseases. Using his clinical experience he has educated colleagues, community health workers, and most of all the patients on the program to understand their health not only in clinical terms but mental and spirituality essentially the Te Whare Tapa Whare model of health. Tim has always ensured student nurses are exposed to the innovation of taking the clinical education outside the traditional consult room by using analogies, such as 'waka' experiences or martial arts for conflict resolutions, use of the marae to give the patients a deeper understanding of wellbeing and health. It is through these techniques that the "light bulb" moment works for these men. Often Tim will then spend one on one time addressing clinical issues they may wish to talk about, that other wise they would not be disclosed. Tim works to promote the benefits of this program to the clinical workforces such as GP's, community nurses, practice nurses, as a means of innovative engagement with men. Tim's participation in the service delivery of health and wellbeing spearheads the unique rapport model, which he builds with his colleagues over the 10 weeks of the program amongst the men. In doing this it allows for better engagement with the health services. As a result past participants have gone on to have full heart checks, bariatric surgery, attend hospital appointments, engage in healthy lifestyles, better control over anger, issues sort alternatives to release stress engage in mental health services, that otherwise these men have personally voiced "... they would not have engaged....".

RURAL MUSTER #4



Kate Stark – Nurse Practitioner

A recent holiday to the Cook Islands was extremely thought provoking and reminded me that although rural New Zealand has challenges, we in New Zealand succeed in providing a rural health service that takes into account the challenges brought upon by being rural. While there, my daughter became really unwell and my immediate thought was would happen if she is too sick to be managed by available services on the island. A four hour plane flight could make a huge difference to the outcome. On mentioning this to a local in passing, her comment to me was that they look out for each other, and utilise the resources available, and they never take anything for granted. What a wonderful mantra to live by. The peoples of the Pacific could teach us a lot in rural health about

utilising our services to the max and ensuring that the people around us are OK. Not only this, but they take everything in their stride, focus on what's important and are grateful for every day.

Winter has been brutal to say the least, with mother nature showing no mercy across the country. Rates of illness amongst health professionals has been higher than normal, whether it be an outbreak of gastroenteritis, the common cold, or flu-like illness. Rates of depression amongst rural people remains high, and sadly rates of suicide in New Zealand remain one of the highest in the Southern Hemisphere as mental health services struggle to meet population demand.

Accessing health care remains key to achieving population health across rural communities. It is heartening to see such initiatives such as 'Farmstrong' and 'Good Yarn' being taken out to rural communities as well as the work done by RHAANZ in the rural sector, in particular for mental health related conditions which can so often go unnoticed. Stigma has historically been a reason behind mental health concerns not getting reported or addressed by individuals and groups but times are changing. People are talking more about depression and suicide and such discussion has been made more acceptable through the introduction of the above mentioned programmes. This is fantastic progress for the health of all rural New Zealanders and should be applauded. We must

keep up the momentum already initiated.

Recently I was part of the completed national PRIME Review. The Review report was accepted by the Ministry of Health which was very pleasing to all who volunteered a large amount of good will and time to complete this project within the given time frame. The intention of the Review was to look at initiatives to improve the current PRIME service in order to better meet increasing demands for emergency medical and trauma services in rural areas. The Rural General Practice Network will take ownership of the PRIME Review going forward to ensure that the proposed changes are enacted. This will happen through the development of a National PRIME Committee which will work alongside key stakeholders to ensure the goals are met and that changes occur.

The NZ Rural Nurses working party is now underway, with the following rural nurses being elected by survey vote to represent rural nurses across New Zealand in this newly developed group.

[NZ Rural Nurses Working Party.](#)

Emma Dillon - RN, Stewart Island – Remote Representative.

Rachel Pretorius - NP General Practice, Martinborough - Primary Health. Rhoena Davis - NP Whanau Ora, Whangaroa - Maori Health.

Virginia Maskill - Rural Nursing Lecturer, Otago University – Academic.

Debi Lawry - Nurse Director, Clyde – Secondary Care.

Cathy Beazley - NP Primary Health, Hokianga - Primary Health.

Rhonda Johnson - RN, Clyde – Secondary Care.

Kate Stark - NP General Practice, Gore - Primary Health Care.

The first steps for the group include election of officers, developing a Terms of Reference to work by, discussing both the results of the recent survey and planning how the group will work including their focus going forward. This is exciting for rural nurses across New Zealand and the group will be looking for contributions from other rural nurses as the group gains momentum. A key aim will be to represent all rural nurses from both the North and South of New Zealand. There are exciting

times ahead with a group who will represent rural nurses from all realms of rural health care. Let's get behind this group and celebrate this initiative, as well as all the hard work that rural nurses do at the forefront of rural health care that puts us on the map as unique and relentless in our work to ensure optimal health care for all rural New Zealanders.

The MeNZB™ story, a new chapter

Helen Petousis-Harris

*Department of General Practice
and Primary Health Care*

University of Auckland

From the early 1990s until 2008 New Zealand (NZ) was caught in the grip of a devastating epidemic of meningococcal disease. Between 1991 and 2006 there were 6023 cases and 245 deaths (Martin, Lopez, & Sexton, 2007). Many cases were left with significant life-long sequelae. By 1995 it became evident NZ needed a vaccine however, most of the cases were caused by meningococcal group B for which there was no off-the-shelf vaccine. A collaborative strategy to find a vaccine solution was formed in 1998 (Sexton et al., 2004).

While effective vaccines against meningococcal groups A, C, W, and Y have existed for many years, group B has posed a challenge due to the nature of the bacterial polysaccharide, the antigen from which the



Helen is a Senior Lecturer in the Department of General Practice and Primary Health Care. She has a PhD in Vaccinology and is involved in research and teaching on vaccine-related topics.

She is a Member of the WHO Global Advisory Committee on Vaccine Safety and an advocate for science communication.

other polysaccharide and conjugate vaccines are based on. In the case of group B this polysaccharide is not immunogenic in humans, necessitating an alternative approach to vaccine design (Tramont, Sadoff, & Artenstein, 1974). Until recently group B vaccines have been based on the outer membrane vesicles (OMVs) or little blebs, that can be extracted from the bacteria wall (Wang & Pollard, 2017). When NZ looked to a vaccine it was to these OMVs that had already been used in tailor made vaccines for Cuba and Norway.

The NZ tailor made OMV vaccine (MeNZB™) was based on the strain of bacteria causing most of the cases. It was developed in collaboration with the University of Auckland, the Norwegian Institute of Public Health, ESR, Chiron, and the WHO. Between

2002 and 2004 clinical trials established the safety profile and the immunogenicity of the vaccine and in 2004 a roll out to over one million Kiwis under the age of twenty years began (Oster et al., 2005). This was a programme that involved most of the public health and primary care professionals in the country in at least some capacity, the dedication taking a toll on many.

By 2006 the initial effectiveness of MeNZB™ was estimated to be 75% (95% CI; 52-85) (Kelly, Arnold, Galloway, & O'Hallahan, 2007). A further study in 2008, estimated the effectiveness against strain-specific disease among people aged 6-months to 19-years to be 68%. Because there were likely to be indirect effects of the large vaccine programme at play statistical adjustments for confounders including a general programme effect conservatively estimated

the effectiveness to be 56% (95% CI; 17-77%) against group B, and against all meningococcal disease (that include disease caused by all groups of meningococcal) 67% (95% CI; 57-76%). This indicated that the vaccine provided protection beyond just the subtype that it was developed against - it appeared to affect all meningococcal disease (Arnold, Galloway, McNicholas, & O'Hallahan, 2011).

Although the vaccine was demonstrated to be protective, the overall impact of MeNZB™ on the epidemic was modest. It had taken years to develop and deliver and by the time it was rolled out the epidemic had run a fifteen year course then naturally waned (Holst et al., 2013).

By 2008 uptake of MeNZB™ in the infant programme was low with only about half of infants receiving all four doses. The epidemic had waned and pneumococcal disease become a higher priority. However, there was no data to support the co-administration of MeNZB™ with the seven valent pneumococcal vaccine therefore in 2008 the MeNZB™ vaccine was withdrawn. Things on the meningococcal vaccine

front went quiet in NZ, other than a 2011 campaign in Northland to control an outbreak of meningococcal group C (Mills & Penney, 2013).

Gonorrhoea

Gonorrhoea is a bacterial mucosal infection, largely of the genitalia although other sites such as conjunctiva of the eye can also be affected. The *Neisseria gonorrhoeae* bacterium is a close relative of the meningococcus (*Neisseria meningitides*). Complications of gonorrhoea include pelvic inflammatory disease leading to ectopic pregnancy, infertility, and chronic pain in women, as well as the facilitation of HIV acquisition and transmission. This is a disease that has plagued humans for centuries with repeat infections the norm and, until penicillin, no cure.

Then, with the development of antibiotics, gonorrhoea, or the clap, became easily treatable. However, today we face a growing global threat as incidence increases and the bug becomes untreatable. Some strains are now resistant to all lines of treatment. Gonorrhoea is officially a super bug.

In NZ thousands of new cases are recorded each year with Maori women particularly effected (The Institute of Environmental Science and Research Ltd, 2014) and the global burden is 78 million new cases each year. On the 7th July 2017 the World Health Organization called for action on the need for new drugs, with only three drugs in various stages of clinical development (Wi et al., 2017; World Health Organization, 2016). Gonorrhoea vaccine development has not fared well either. Over the past one hundred years four gonorrhoea vaccine candidates made it to human trials and all failed to provide any protection (Jerse, Bash, & Russell, 2014). The outlook for preventing or treating gonorrhoea with medicines appeared austere.

Three days after the WHO released its call to action a study was published in The Lancet that reported moderate effectiveness of a meningococcal group B vaccine against laboratory diagnosed gonorrhoea in a large population (Petousis-Harris, Paynter, Morgan, Saxton, McArdle, et al., 2017). The news went viral appearing in media across the globe, perhaps there

was hope after all. Here is that story.

Epidemiological evidence from Cuba, Brazil, and NZ demonstrated that meningococcal group B OMV vaccines can provide broad protection against meningococcal disease (Harder, Koch, Wichmann, & Hellenbrand, 2017). This led to the hypothesis that they may affect a more distantly related bacteria. Eyeball observation of graphed surveillance data make clear that incidence of gonorrhoea declined markedly in Cuba following implementation of their meningococcal OMV vaccine (VA-MENGO-C-BC®). This was in contrast to syphilis and genital warts which remained the same (Pérez et al., 2009). A double peak and a lag before the decline can be observed in graphs which coincides with the mass catch up campaign and then the age of sexual onset in birth cohort (Pérez et al., 2009).

Inspection of the reported gonorrhoea in NZ shows a decline during and after use of MeNZB™ before climbing again. No other sexually transmitted infections (STIs) reported in the NZ national surveillance reports

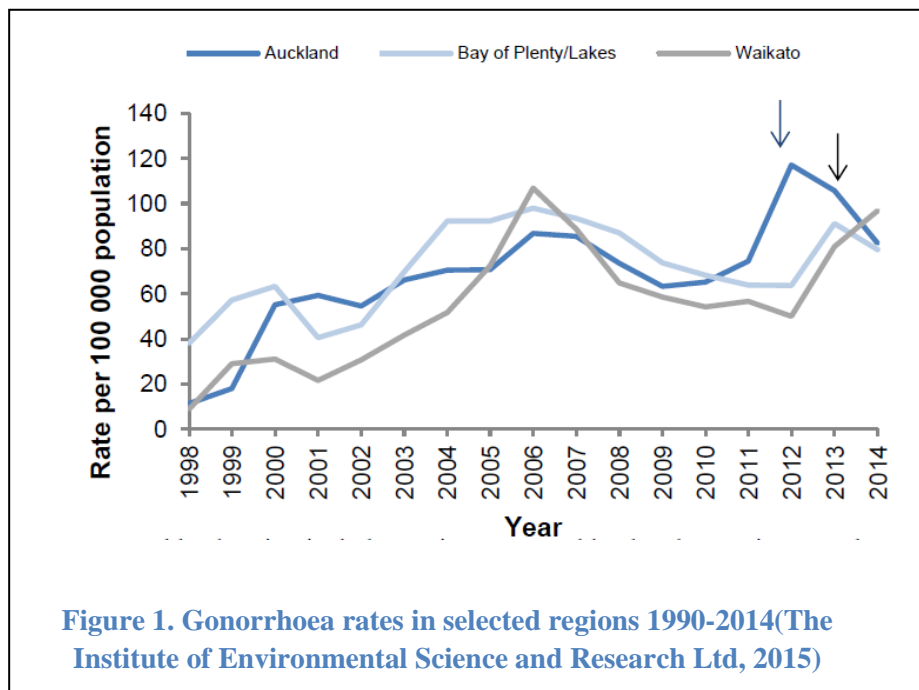


Figure 1. Gonorrhoea rates in selected regions 1990-2014(The Institute of Environmental Science and Research Ltd, 2015)

declined during this period. These 'eyeball' observations suggest that it is at least possible these OMV vaccines offered cross protection against gonorrhoea (The Institute of Environmental Science and Research Ltd, 2015).

One of the legacies of the MeNZB™ programme is the National Immunisation Register (NIR). Every dose of MeNZB™ vaccine has been recorded in that database. This tool, along with the National Health Index Number that each New Zealander has, allowed the vaccine status of gonorrhoea cases to be verified. This provided us the opportunity to conduct two studies to see if MeNZB™ vaccine reduced the risk of getting gonorrhoea.

The first study was a retrospective case-control study that examined the records from nearly 15,000 visitors to 11 Sexual Health Clinics across NZ who were eligible to have received the MeNZB™ vaccine between 2004 and 2008. Patients were confirmed to have either gonorrhoea, or chlamydia, or coinfection with both. Those who had gonorrhoea were significantly less likely to have received the MeNZB™ vaccine than those diagnosed with chlamydia. The difference in the odds ratio equated to a vaccine effectiveness of 31% against gonorrhoea (Petousis-Harris, Paynter, Morgan, Saxton, McArdle, et al., 2017).

The second study has not yet been published but the findings

were presented at a conference in Cuba. In a cohort study of over 600,000 individuals, the effectiveness of the vaccine on gonorrhoea hospitalisations was estimated to be 45% (Petousis-Harris, Paynter, Morgan, Saxton, Goodyear-Smith, et al., 2017).

The exact mechanism for the observed cross protection is not yet known, however both these *Neisseria* species share between 80% and 90% of their primary genetic sequences, they are kissing cousins. We also have clues from the studies evaluating the OMV vaccines.

OMV vaccines more immunogenic in older age groups, a feature which is observed by the strong boosting against heterologous strains in older ages (the immunity broadens after boosters in older children and adults) (Rosenqvist et al., 1995; Ruijne, Lea, O'Hallahan, Oster, & Martin, 2006). Some evidence suggests that when superimposed on naturally acquired immunity (from the carriage of either commensal or pathogenic *Neisseria* species), an OMV vaccine can selectively re-programme immunity (Davenport et al., 2008). This provides one possible

mechanism for the observed effect of the group B meningococcal vaccines on gonorrhoea.

So where to from here?

There are two meningococcal group B vaccines in wide use and they both appear to provide broad protection against their meningococcal target diseases. These vaccines are Bexsero®, from Novartis/GSK and VA-MENGOC-BC® from the Finlay Institute, Havana, Cuba. Both these vaccines are likely to offer cross protection against gonorrhoea to a greater or lesser extent. While Bexsero® has not yet been formally assessed against gonorrhoea it not only contains the antigen that has been (the NZ OMV from MeNZB™) but in addition two of the three recombinant proteins in the formulation are variably expressed in gonorrhoea isolates (Hadad et al., 2012). While also not formally assessed, VA-MENGOC-BC® appears associated with a notable decline in gonorrhoea disease incidence in Cuba since its introduction (Pérez et al., 2009).

Of course these meningococcal vaccines are not gonorrhoea vaccines. The observed effects are effectively welcome side effects. However, mathematical modelling suggests that even a moderate efficacy, such as that

which has been observed, could have considerable public health impact with respect to gonorrhoea (Craig et al., 2015; Régnier & Huels, 2014; Seib, 2017).

There are two main avenues from here. One is to assess the currently available vaccines in randomised controlled trials to determine causality. The other is to unravel the mechanisms behind the effect in order to inform vaccine development.

One practical strategy that we may have at this time to try and mitigate the gonorrhoea problem is consideration of a booster dose of one of these vaccines at an age prior to sexual debut. Evidence shows that a broad immune response occurs in older age groups after commensal carriage and possibly priming with an infant dose of OMV vaccine. This heterologous boosting could be worth exploring as a strategy to not only enhance immunity against meningococcal disease but to also alleviate the growing burden of gonorrhoea.

Whatever the future holds, these OMV vaccines very likely hold clues to inform effective gonorrhoea vaccine development. We may also have vaccines available that could mitigate some of the rising tide of super-gonorrhoea.

References:

- Arnold, R., Galloway, Y., McNicholas, A., & O'Hallahan, J. (2011). Effectiveness of a vaccination programme for an epidemic of meningococcal B in New Zealand. *Vaccine*, 29(40), 7100-7106. [10.1016/j.vaccine.2011.06.120](https://doi.org/10.1016/j.vaccine.2011.06.120)
- Craig, A. P., Gray, R. T., Edwards, J. L., Apicella, M. A., Jennings, M. P., Wilson, D. P., & Seib, K. L. (2015). The potential impact of vaccination on the prevalence of gonorrhoea. *Vaccine*, 33(36), 4520-4525. [http://dx.doi.org/10.1016/j.vaccine.2015.07.015](https://doi.org/10.1016/j.vaccine.2015.07.015)
- Davenport, V., Groves, E., Horton, R. E., Hobbs, C. G., Guthrie, T., Findlow, J., . . . Williams, N. A. (2008). Mucosal Immunity in Healthy Adults after Parenteral Vaccination with Outer-Membrane Vesicles from *Neisseria meningitidis* Serogroup B. *Journal of Infectious Diseases*, 198(5), 731-740. [10.1086/590669](https://doi.org/10.1086/590669)
- Hadad, R., Jacobsson, S., Pizza, M., Rappuoli, R., Fredlund, H., Olcén, P., & Unemo, M. (2012). Novel meningococcal 4CMenB vaccine antigens—prevalence and polymorphisms of the encoding genes in *Neisseria gonorrhoeae*. *Apmis*, 120(9), 750-760.
- Harder, T., Koch, J., Wichmann, O., & Hellenbrand, W. (2017). Predicted vs observed effectiveness of outer membrane vesicle (OMV) vaccines against meningococcal serogroup B disease: Systematic review. *Journal of Infection*, 75(2), 81-94. [http://dx.doi.org/10.1016/j.jinf.2017.05.001](https://doi.org/10.1016/j.jinf.2017.05.001)
- Holst, J., Oster, P., Arnold, R., Tatley, M. V., Naess, L. M., Aaberge, I. S., . . . Black, S. (2013). Vaccines against meningococcal serogroup B disease containing outer membrane vesicles (OMV): lessons from past programs and implications for the future. *Hum Vaccin Immunother*, 9(6), 1241-1253. [10.4161/hv.24129](https://doi.org/10.4161/hv.24129)
- Jerse, A. E., Bash, M. C., & Russell, M. W. (2014). Vaccines against gonorrhoea: Current status and future challenges. *Vaccine*, 32(14), 1579-1587. [http://dx.doi.org/10.1016/j.vaccine.2013.08.067](https://doi.org/10.1016/j.vaccine.2013.08.067)
- Kelly, C., Arnold, R., Galloway, Y., & O'Hallahan, J. (2007). A prospective study of the effectiveness of the New Zealand meningococcal B vaccine. *Am J Epidemiol*, 166(7), 817-823. [10.1093/aje/kwm147](https://doi.org/10.1093/aje/kwm147)
- Martin, D., Lopez, L., & Sexton, K. (2007). *The Epidemiology of Meningococcal Disease in New Zealand in 2006*. Wellington: Institute of Environmental Science and Research Limited (ESR).
- Mills, C., & Penney, L. (2013). The Northland emergency meningococcal C vaccination programme. *The New Zealand Medical Journal (Online)*, 126(1373)
- Oster, P., Lennon, D., O'Hallahan, J., Mulholland, K., Reid, S., & Martin, D. (2005). MeNZB (TM): a safe and highly immunogenic tailor-made vaccine

- against the New Zealand *Neisseria meningitidis* serogroup B disease epidemic strain. *Vaccine*, 23(17-18), 2191-2196.
10.1016/j.vaccine.2005.01.063
- Pérez, O., Campo, J. d., Cuello, M., Gonzalez, E., Nunez, N., Cabrera, O., . . . Lastre, M. (2009). Mucosal approaches in *Neisseria* vaccinology. *VacciMonitor*, 18(2), 53-55.
- Petousis-Harris, H., Paynter, J., Morgan, J., Saxton, P., Goodyear-Smith, F., McArdle, B., & Black, S. (2017, June 25-29 2017). *Effectiveness of a group B OMV meningococcal vaccine against gonorrhoea – the New Zealand experience*. Paper presented at the IV International Congress of Pharmacology of Vaccines (Vaccipharma) 2017, Varadero Beach, Cuba
- Petousis-Harris, H., Paynter, J., Morgan, J., Saxton, P., McArdle, B., Goodyear-Smith, F., & Black, S. (2017). Effectiveness of a group B outer membrane vesicle meningococcal vaccine against gonorrhoea in New Zealand: a retrospective case-control study. *The Lancet*
- Régnier, S. A., & Huels, J. (2014). Potential impact of vaccination against *Neisseria meningitidis* on *Neisseria gonorrhoeae* in the United States: Results from a decision-analysis model. *Hum Vaccin Immunother*, 10(12), 3737-3745.
10.4161/hv.36221
- Rosenqvist, E., Høiby, E. A., Wedege, E., Bryn, K., Kolberg, J., Klem, A., . . . Nøkleby, H. (1995). Human antibody responses to meningococcal outer membrane antigens after three doses of the Norwegian group B meningococcal vaccine. *Infection and Immunity*, 63(12), 4642-4652.
- Ruijne, N., Lea, R. A., O'Hallahan, J., Oster, P., & Martin, D. (2006). Understanding the Immune Responses to the Meningococcal Strain-Specific Vaccine MeNZB Measured in Studies of Infants. *Clinical and Vaccine Immunology*, 13(7), 797-801. 10.1128/cvi.00038-06
- Seib, K. L. (2017). Gonorrhoea vaccines: a step in the right direction. *The Lancet*
- Sexton, K., Lennon, D., Oster, P., Crengle, S., Martin, D., Mulholland, K., . . . O'Hallahan, J. (2004). The New Zealand Meningococcal Vaccine Strategy: a tailor-made vaccine to combat a devastating epidemic. *The New Zealand Medical Journal (Online)*, 117(1200)
- The Institute of Environmental Science and Research Ltd. (2014). *Sexually transmitted infections in New Zealand. Annual Surveillance Report 2013*. Porirua, New Zealand: The Institute of Environmental Science and Research Ltd. Retrieved from https://surv.esr.cri.nz/PDF_surveillance/STISurvRpt/2013/2013AnnualSTIReportFINAL.pdf
- The Institute of Environmental Science and Research Ltd. (2015). *Sexually Transmitted Infections in New Zealand: Annual Surveillance Report*

2014. Porirua, New Zealand:

productivehealth/news/stis-estimates-2015/en/

Tramont, E. C., Sadoff, J. C., & Artenstein, M. S. (1974). Cross-reactivity of *Neisseria gonorrhoeae* and *Neisseria meningitidis* and the nature of antigens involved in the bactericidal reaction. *J Infect Dis*, 130(3), 240-247.

Wang, N. Y., & Pollard, A. J. (2017). The next chapter for group B meningococcal vaccines. *Critical Reviews in Microbiology*, 1-17. 10.1080/1040841X.2017.1329276

Wi, T., Lahra, M. M., Ndowa, F., Bala, M., Dillon, J.-A. R., Ramon-Pardo, P., . . . Unemo, M. (2017). Antimicrobial resistance in *Neisseria gonorrhoeae*: Global surveillance and a call for international collaborative action. *PLoS medicine*, 14(7), e1002344.

World Health Organization. (2016). Global estimates shed light on toll of sexually transmitted infections. Retrieved 13 May 2016, 2016, from <http://www.who.int/re>

The **2018 Population Health Congress** in Auckland is a great opportunity for nurses working in primary care to share with an audience of health professional colleagues, consumer representatives and funders the innovation and collaboration of your nursing work and profile challenges and concerns for community health that are familiar to nurses who are 'in amongst it' on a daily basis.

The congress theme is **Sharing solutions, shaping our future wellbeing. Ehara taku toa i te toa takitahi, engari he toa takitini'** (My strength is not as an individual, but as a collective).

Presentations should address the overarching theme above encompassing:

- public health capacity development,
- creating and maintaining our evidence base,
- improving inter-sectoral collaboration,
- working in partnership with communities, and
- improving our communication and advocacy

The congress **streams** are:

- Addressing climate change and planetary health
- Giving all children the best start in life
- Improving population health and reducing health inequalities

Abstracts are due on **October 2nd**

Please check the link below for more details on presentation style options, abstract specifications and the selection criteria the Abstract Review Committee will use.

<http://www.pophealthcongress.org.nz/files/docs/nzphc18/nzphc%2018%20abstract%20guidelines%20-%20final.pdf>

This is an ideal opportunity to:

- share good practice
- raise concerns
- seek solutions
- debate priorities
- celebrate collegiality

If you would like assistance from a 'critical friend' with writing and submitting an abstract and then developing your presentation if your abstract is accepted, please contact **Sue Gasquoine, Nursing Policy Adviser/Researcher by email sueg@nzno.org.nz**

Nurses and doctors mend babies' hearts with help from Angel Flight



Cooperation in a remote rural area of Waikato enabled two babies with complex cardiac conditions to access specialist care at Starship Hospital in Auckland and follow up treatment and monitoring in their own home back in Taumarunui.

The outcome for both babies – Theodore and Vasilij – is good, thanks to the skilled local nursing team, the Cardiac Close (Home) Monitoring Programme, hospital specialists, local GPs and Angel Flight NZ, a charity funded by Rotary, private and corporate donations.

Angel Flight co-ordinates non-emergency flights, assisting people with a medical condition and long distances by flying them to an airport near their medical treatment facility. One of their “earth angels” meets the flight to drive the patient to their medical appointment. Both the air and road transport is provided free

of charge as volunteer pilots and drivers donate both their time and their aircraft or cars.

Tracy Thompson, clinical nurse specialist with Waikato DHB’s neonatal homecare team, describes the transportation issues families from rural areas can face:

“Vasilij and Theodore both required CT scans of their hearts at Starship Hospital at three months of age. This trip from Taumarunui to Auckland by car would take five hours for these medically fragile infants,” she says. Theodore was first to have his CT scan in November last year. The family drove to Auckland but found they had to stop every two hours as Theodore became extremely clammy in his car seat and was breathing abnormally quickly (tachypnoic). These added stops made a difficult journey almost impossible.

“When it came time for Theodore to head to Starship in

January for his second open heart surgery we investigated other travel options including ambulance transfer,” Tracy says. “Then we heard about Angel Flight NZ. We spoke to their team and within three days a flight was arranged for Theodore and his mum Lauren to be transported by air to Auckland. This transfer was well planned out, safe and extremely effective. Vasilij was able to also use Angel Flight for his return trip to Auckland for his CT scan.”

Cardiac infants like Theodore and Vasilij are a new cohort of infants who, thanks to modern technology, are surviving the neonatal period due to antenatal diagnoses and subsequent early open heart surgery. However these babies remain extremely fragile until after they have had a second heart operation (known as bi-directional Glenn) at three to five months of age.



from Starship Hospital at the age of five weeks and move to Waikato Hospital for establishing oral feeds and weight monitoring before finally being discharged home.

As Theodore is functioning with a single heart ventricle and is totally dependent on a systemic-pulmonary shunt for blood to be conducted to the lungs he is on the Cardiac Close (Home) Monitoring Programme. This involves twice weekly home visits to monitor his circulation.

Due to the extremely isolated, rural location Theodore was followed up once a week by the specialist neonatal homecare nurses (either Tracy Thompson or Catherine Dollimore) and once a week by his general practitioner (GP) Dr Anna Teata. He was also monitored closely by one of the local district nurses, Sara McIntyre, who had an extensive background of neonatal intensive care.

Tracy says the service provided by Sara was invaluable as she was able to deliver nursing care quickly, effectively and provide support which was extremely receptive to the family's needs. "An example of this was seen the first time Theo's NG tube fell out. It was late winter and the neonatal homecare team was three hours away. Sara was able to navigate the extremely

Tracy notes that numbers of these babies who discharge home from Starship nationally are small and it was very unusual that two babies in the home monitoring programme were situated so close together in the small Waikato community of Taumarunui.

Theodore's story

Theodore is an 11 month old infant who was born with a complex cardiac condition. He is the second child to Lauren and Bernard and brother to two year old Zoe. Together they all live in an extremely remote location 22kms west of Taumarunui – with 14 kilometres of this being a windy, climbing metal road.

Lauren was 35 weeks pregnant when she went for a scan to check that the baby was laying the right way. It was at this scan that a late antenatal



Theodore

diagnosis of a severe congenital heart defect was made. Theodore was found to have an Ebstein's anomaly involving the tricuspid valve, but more severe was that he had a hypoplastic right ventricle. The delivery of Theodore was organised to happen at Auckland Hospital to be close to specialist paediatric cardiac services at Starship Hospital.

Following his setbacks Theodore was able to discharge

difficult rural roads, and home visit to provide support for Lauren as she replaced the tube.”

Today Theodore is going ahead developmentally and physically in leaps and bounds. He had his second heart surgery – a bi-directional Glenn procedure at age 6 months and the post-operative period was not all smooth sailing. He got through that, but was then diagnosed

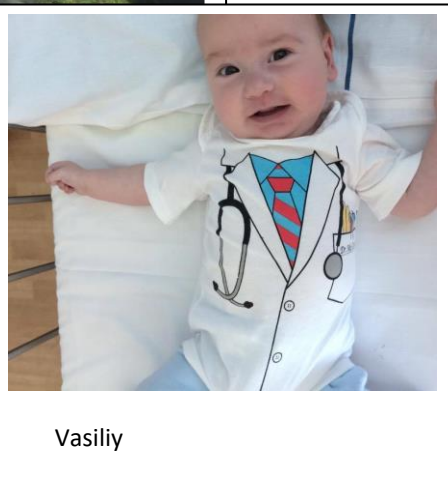


with an allergy to cows’ milk. After discussion with Tara Chaplow (the Waikato DHB community paediatric dietician) Theodore was changed to soya infant formula and a dairy free diet and he has never looked back. He is now crawling everywhere and into everything!! He has a wicked smile and a very cheeky personality. He loves pulling his sisters hair.

Theodore is still seen monthly by his GP in Taumarunui and monthly by the local district nurse Sara McIntyre but the specialist neonatal homecare

nurse no longer needs to be involved. He will be monitored throughout childhood by the specialist cardiac team at Starship Hospital and he will require further cardiac surgery.

Both his mum Lauren and dad Bernard are absolutely in awe of where he has come from and the happy, healthy farm boy he is now.



Vasiliy

Vasiliy’s story

Vasiliy is a six month old infant who lives with his mum Anna, dad Sergey and four siblings in Taumarunui. Vasiliy was also diagnosed antenatally with a complex heart anomaly (double

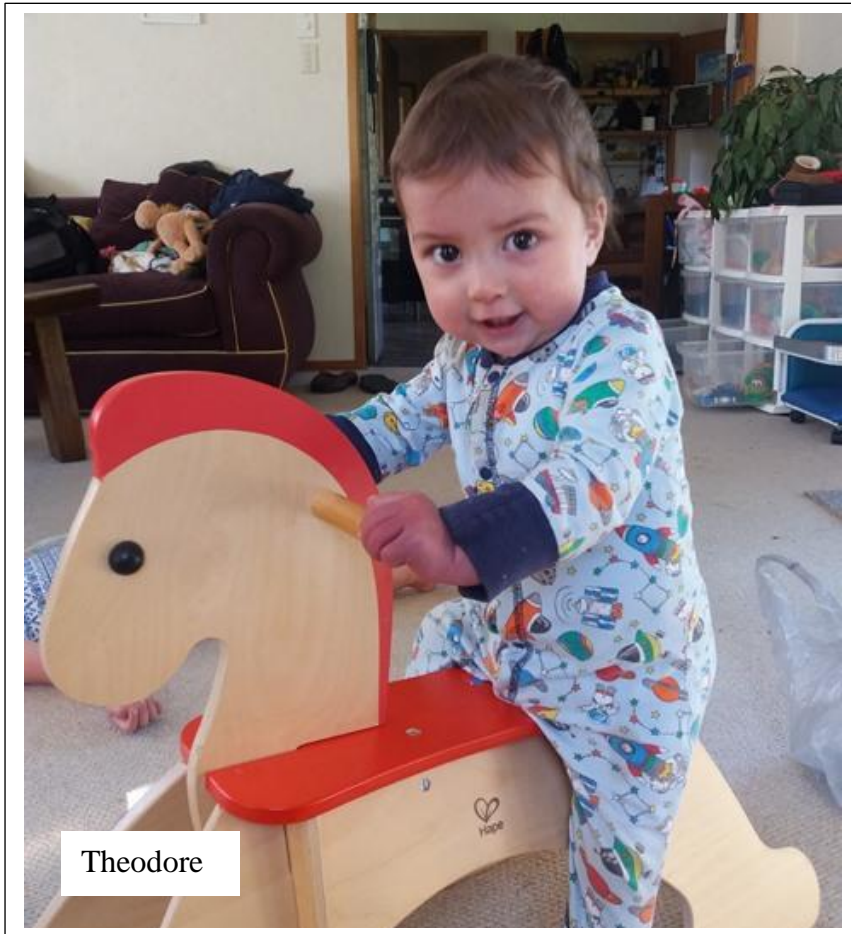
inlet left ventricle) and as such was a planned delivery at Auckland Hospital. After birth he transferred immediately to Starship’s paediatric intensive care unit where he underwent open heart surgery (Norwood procedure). He remained in hospital for five weeks and then discharged home to his family in Taumarunui.

Recently Vasiliy had his bi-directional Glenn procedure at Starship Hospital. He has come through surgery well and is at home with his family. While it is very early days, Vasiliy is recovering well. He is fully breastfeeding and the nursing team are watching his weight closely. He will be seen on alternate weeks by his GP Dr Anna Teata and one of the clinical nurse specialists in the neonatal homecare team. District nurse Sara McIntyre will also visit weekly until he is well on the road to recovery.

On behalf of everyone involved with Vasiliy and Theodore we would like to thank the Angel Flight pilots who donated their time, flying hours and fuel, and the Earth Angels who met and drove these infants and mothers to Starship Hospital. Also a big thank you to Ardmere airport who kindly waived their landing fees for these flights. The generosity of everyone who

*made this trip possible cannot
be underestimated.*

Visit the [Angel Flight website](#)



Theodore

Attention Nurses

Health Workforce New Zealand Funding (HWNZ) 2018

Are you thinking about post graduate study? You could be eligible for HWNZ funding to study in 2018?

Workforce training needs are identified by each district health board (DHB). The boards allocate money for postgraduate education for registered nurses employed by health and disability services across the whole of the health system.

If you are interested you will need to apply soon. Contact your DHB Director of Nursing office to find out more.

Community Services Integration (CSI) into Health Care Homes (HCH)

Emma Hickson

For many years in New Zealand, healthcare providers have worked from separate organisations, with disconnected care and processes. In the community setting, General Practice teams, District Nurses, and Community Rehabilitation teams are an example of providers who have worked with the same patients, but not that much with each other.

There is literature that supports improving the integration between providers of healthcare services (Tieman et al., 2006). The general intent of integrating health services is that the consumer will benefit from a connected system of provision that more adequately and efficiently supports their health. The extension of integrating health services to other services, such as housing and education, which also impact on peoples' health



I live in Wellington and work as the Director of Nursing for Primary and Community for Capital and Coast DHB. I have the pleasure of working with colleagues in PHOs, Primary, Community, Aged Residential Care, Corrections, Regional Public Health and many NGO services across the whole of the health sector. Originally a District Nurse, I have enjoyed being involved with the College for several years.

As my professional roles have changed, I have found the College to be an invaluable environment to meet and learn from others. I am very excited that with the on-going developments in health service delivery, Primary Health Care Nurses are uniquely positioned to develop their practice and enable improved access to healthcare for their population. Currently I am on the LOGIC committee and Vice Chair of the executive committee.

status, is likewise gaining traction (WHO, 2013).

In 2015, Capital and Coast DHB's Alliance Leadership Team began an initiative to advance how General Practice Teams function, and integrate two community services to those teams. The District Health Board and Primary Health Organisations jointly funded the project. Introducing a "Health Care Home" model to General Practice teams in the Wellington region began in 2016. Supporting the integration of two community services into general practice was included as part of a suite of mandated practice developments.

General practices were invited to apply to be one of the first tranche of "health care home"

practices. The practices were selected according to their readiness, and the population they supported. Wellington has diverse population needs that range from high to low. A strong focus for this development was to reduce the inequity of health outcomes for those in highest need areas.

The stakeholders for the "Health Care Home" project were many, from consumers of primary and community services to all the professional disciplines involved. Teams from both District Nursing, Community Allied, and general practice were challenged to develop a new integrated model and way of working based on the agreed desired outcomes and planned interventions.

A series of workshops were held, initially individually for the services, but subsequently for the services together. Jointly, the teams developed their models for how integrating these community services into General Practice would work. A general model to support integration was agreed, and with change management support, these teams were assisted to implement their changes.

The service leaders from District Nursing and Community Allied teams went to meet with every practice to discuss the integration model, and how it would work in each different practice setting. These discussions were enlightening for all parties because although personnel from different services knew each other, they had often not had the time to discuss issues, service provision, or each other's capabilities and resources.

Several of the practices held a "wine and cheese" occasion when they launched into the new integrated ways of working. The practices invited the community teams and other health professionals, such as Community Midwives, who worked in their locality. These events proved to be a really positive beginning on the process towards better

integrated teams and development of relationships .

The changes that have occurred as a result of integration have included the following:

General Practices have a named and known District Nurse and Allied Health person. These professionals are the first point of contact if General Practice have a query, need advice or want to discuss a referral.

General Practice and community team personnel have given each other direct phone line numbers. With the challenge of busy patient care schedules, it had been difficult for both parties to have timely consultations with each other. Having another method of communication has helped improve patient information exchange.

The community teams have shared the lists of patients with the general practice team. Each week a list is sent to the practice which updates them on who the two community teams are seeing. These patients have been the focus of the MDT meetings and the additional ad hoc conversations that now occur. This sharing of patient lists has been described as one of the most useful developments.

Monthly Multi Disciplinary Team (MDT) meetings have been embedded in General Practice and community team functioning. Each month, the teams prepare a list of patients that both services are involved with and have been risk stratified as being at high risk and of complex need. The MDT enables the teams to discuss and collaborate on joint proactive care management plans.

The use of shared care records, via a shared platform and a joint electronic care planning tool, have been developed as part of the project's IT enablement. Challenges of compatibility and access have taken time to overcome, but finally the prototype shared care plan is being tested for use. The developed care management plans are intended to be accessible to patients, and the whole care team supporting their needs. Community services have also benefitted with the provision of mobile technology. Hand-held devices are enabling electronic record keeping, messaging whilst mobile, and accessing of hospital based information whilst in MDTs.



The sharing of skills between the community teams and general practice has supported the management of more care in general practice. An example of this development is the care of complex wounds, which with the support of education sessions, joint clinics, and easily accessible advice, will remain with the Practice Nurse or General Practitioner.

Other less tangible outcomes of community service integrating with general practice have included improving relationships and trust. This outcome is exemplified by a quote from a general practitioner-

“MDTs are worth their weight in gold”, and from a community nurse- “I have learnt so much about how general practice teams function, and I think they understand and trust me more too”. In addition, the MDT meetings have been attended by patients and other services’ personnel, such as long term community support services. With use of technology, it is hoped that remote attendance will be utilised in the future, enabling both patients and extended team members to contribute.

Throughout the “Health Care Home” integration project,

benefits for patients have been demonstrated. Communication to and about patients has increased with more a proactive approach to keeping the most complex people well, and avoid unnecessary hospitalisations.

The future challenge to integration is to continue the expansion of the “Health Care Home” model to the remaining general practices in the region, and to continue the integration of community health and other services to those practices. With these recent and rapid integration improvements, other services are also keen to become closer to General Practice and their communities,

and be part of the new integrated way of working.

References:

Tieman, J. Mitchell, G. Shelby-James, T. Currow, D. Fazekas, B. O'Doherty, L. J. Hegarty, M. Eriksson, L. Brown, R. Reid-Orr, D. (2006). Integration, coordination and multidisciplinary approaches in primary care: a systematic investigation of the literature. Australian Primary Health Care Research Institute, Flinders University Department of Palliative and Supportive Services.

http://files.aphcri.anu.edu.au/research/full_report_21019.pdf

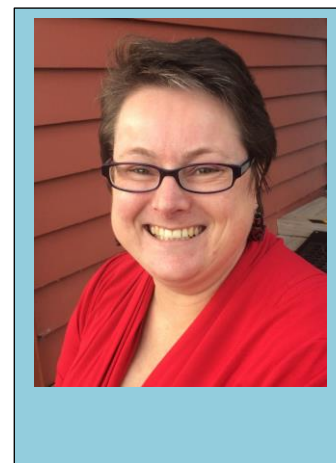
Merino, B. Campos, P. Santaolaya, M. Gil, A. Vega, J. Swift, T. (2013) Integration of social determinants of health and equity into health strategies, programmes and activities: health equity training process in Spain. Social Determinants of Health Discussion Paper Series 9 (Case studies). Geneva, World Health Organization.

http://apps.who.int/iris/bitstream/10665/85689/1/9789241505567_eng.pdf?ua=1

A journey to prescribe

Karen Jones MN,

Nurse Prescriber



After being able to prescribe since October 2016, I can still remember the frustrations of not being a nurse prescriber.

Graduating as a nurse in 1993, we have progressed a long way and nurse prescribing was not a consideration that far back. There were very few nursing positions available and I was lucky enough to start working in primary care the same year I graduated.

Many years, a wedding and 2 children later, I began postgraduate study. Originally, I was going to take two papers to enable the practice I was then employed in to have nursing students and new graduate nurses under the Nurse Entry to Practice (NETP) programme. I progressed to completing a postgraduate diploma – undertaking four 30 point papers in 2 years. This resulted in many challenges

while being a wife, mother, full time nurse and student.

Completing my Postgraduate Diploma in Nursing which included an assessment and clinical decision-making paper, enabled me to become involved in the trial of a nurse led walk in clinic at our general practice. Utilising my knowledge I assessed patients, undertook respiratory, cardiovascular and/or abdominal assessments, came up with differential diagnoses and plan of care which then was discussed with one of the general practitioners supporting the clinic.

I found that I wanted to learn more though and felt I could further add to patients' consultations, especially regarding education around medications. Hence I enrolled in further study to complete my Masters of Nursing. These papers included

pathophysiology, pharmacology and a prescribing practicum which set me up to meet the requirements of nurse prescribing.

There have been multiple benefits to being able to prescribe for our clinic – receptionists are able to offer patients more appointments and a variety of times with a prescriber for their repeat prescriptions, patients don't have to wait around to get a prescription signed by a doctor (or nurse practitioner) and has resulted on less stress being put on the doctor working each day. These are also suggested benefits to employers that Nursing Council of New Zealand (2016) identified.

For me, some of the benefits are being able to complete a consultation fully by being able to provide a prescription; making my nursing role more rewarding simultaneously

improving my rapport with patients and their whanau. Many patients request appointments with me for routine visits, diabetes review including insulin titration, exacerbations of asthma, sore throats or urinary tract infections amongst other issues. This enables those who are more acutely unwell to more readily access the doctor, together improving access to healthcare.

A significant advantage is not having to complete standing order audits for the many medications that were administered under standing orders previously, including salbutamol, paracetamol and depo provera.

While there are some medications that I am unable to prescribe, the list is quite comprehensive, particularly for nurses working in primary care. The list includes respiratory medications (but not the new inhalers); a wide range of cardiovascular drugs; anti-infectives including antifungal, antibacterial, antiviral and anti-parasitic topical, oral or vaginal applications; gastro-intestinal medications including antacids, laxatives, proton pump inhibitors, anti-emetics; contraceptives – condoms, oral and intramuscular; analgesics ranging from paracetamol, non-

steroidal anti-inflammatory drugs to a one week re-supply of opioids.

One requirement from Nursing Council of New Zealand (2016) is to keep a log of cases seen for both the initial application and for renewal of practicing certificate after 1 year of prescribing. Using templates on the Nursing Council website, I document a range of presentations as they are seen plus differential diagnoses, treatment plans and learning points. There is a wide range of presentations including sore throat management in those at high risk of group A streptococcus, exacerbations COPD and asthma, uncontrolled diabetes, eczema, irregular periods and postmenopausal vaginal bleeding, urinary tract infections, exacerbations of gout and repeat prescriptions of regular medications.

Alongside the prescribing log are the prescribing competencies which get completed by a prescribing mentor. They are comprehensive and range from health consumer needs, treatment options and subsequent responses to scope of practice, professional practice standards and communication with other health care professionals.

I find that I'm considerably busier than I was before. I'm still working as a nurse including cervical smears, immunisations, diabetes annual reviews, spirometry, education sessions with new graduate nurse and the local school. I've led our clinic through a successful Cornerstone accreditation and have found the time to work with Counties Manukau Health as part of their local diabetes team. I'm currently involved in the Manukau Locality Leadership group working towards improving health outcomes in our locality.

For those considering prescribing, I find it enhances my patient interactions with a financial reward for being able to provide this service. I think it's a step towards being a nurse practitioner, especially for those who aren't sure if that's the direction they are heading.

Karen Jones MN, Nurse Prescriber

Reference:

Nursing Council of New Zealand. (2016, August). Nurse Prescribing in Primary Health and Specialty Teams. In *Nursing Council of New Zealand*. Retrieved June 24, 2017, from <http://www.nursingcouncil.org.nz/Nurses/Nurse->

Prescribing/Registered-
nurse-prescribing-in-
primary-health-and-
specialty-teams

Breast Screen Aotearoa – Jennifer Cox/Amanda Wynne

BreastScreen Aotearoa has been reviewing all of its printed health education resources over the last few years and the following two new resources are now available for ordering:

- **Screening for breast cancer: Joining BreastScreen Aotearoa (HE1210):** this focuses on giving women the information they need to make an informed decision about joining the screening programme. It will replace the general pamphlet in GP offices and at health promotion events and be made available online and at screening clinics.
- **Having a mammogram (HE10102):** this resource is for women attending their screening appointment and offers detailed information about what they should expect at their appointment. This pamphlet will be sent to all women when they make an appointment with BreastScreen. We are also developing another pamphlet which is a shorter version for women who have already had a screening appointment through BreastScreen Aotearoa. This resource will have just the information women need to prepare for their appointment, such as what to wear and what to bring.

Both resources can be ordered from healthed.govt.nz and are also promoted on the National Screening Unit's new consumer website www.timetoscreen.nz.

Tuberculosis

Wendy King



Wendy is a public health nurse working in Thames. Professional interest includes PDRP, succession planning, practice development and public health. Wendy was also a Nursing Officer in the Territorials for 11 years and had a stint in Vanuatu with the New Zealand Defence Force.

Weekends finds Wendy at markets looking for a garden bargain, at a craft fair, or out enjoying the mountains, bush or beaches.

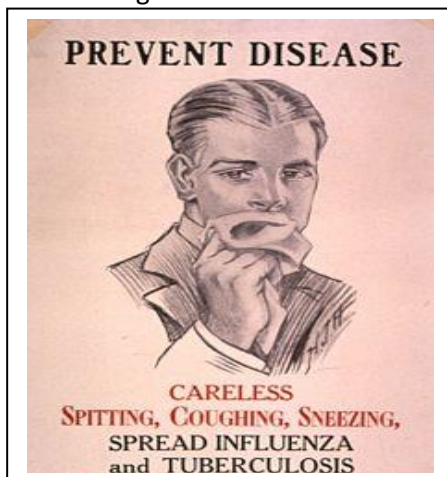
A now retired medical officer of health used to tell public health nurses that in her career tuberculosis hadn't changed but its face had – from the affected populations with rural, poor housing and social situations, smoking, alcoholism as contributing determinants. In her years the incidence of around 280-300 cases a year hadn't changed, but the affected population had changed to those with histories of co-morbidities, HIV, overseas travel and residence, immigrants and refugees becoming the populations now affected.

What hasn't changed?

New Zealand rate of 6-7/100000 is essentially unchanged although it trends downwards. The method of initial diagnosis acid fast bacilli test developed by Koch in 1880 is still useful until culture and sensitivity results come through; sometimes this can take weeks. Tuberculosis can affect any system or structure in the body. *Mycobacterium bovis* causes <10

cases a year and the incidence is unchanged.

There has effectively been no new medication developed for many years, the most commonly used medication initially are: pyrazinamide (1936), isoniazid (1956), ethambutol (1961) and rifampicin (1965), although rifampicin which is used in combination was not specifically developed for tuberculosis but is used in combination as Rifinah (rifampicin and isoniazid). Apart from rifampicin none of the medications has a liquid presentation for use with infants and children or those with swallowing difficulties.



The Mantoux or the tuberculin skin test (TST) developed in 1907 from an effect described by Koch in 1890 is still used for screening and testing of tuberculosis contacts.

Neonatal BCG vaccination (first used 1921) eligibility, technique and certification for gazetting of vaccinators are unchanged since

1976. Currently in New Zealand, there has been no vaccine since April 2016 due to manufacturing difficulties affecting supplies; families travelling overseas report that vaccine is available in some countries and have been able to get infants vaccinated while others note their infants are not eligible as they are visitors.

Multidrug resistant tuberculosis is uncommon in New Zealand with an average ~3 per year; mostly acquired overseas. The burden of disease is significant; treatment blows out to 18 months with daily IV therapy for 6 months, with another 12 months of daily observed treatment. This

combination varies depending on the clinical situation.

The reaction to a diagnosis of tuberculosis can be surprise, puzzlement, anger, to concerns about its infectiousness, privacy and confidentiality.

Medically the treatment concern is that delayed, incomplete treatment that leads to the development of drug resistant tuberculosis. To quote The Guidelines for Tuberculosis Control in New Zealand "a drug-resistant case can have life threatening consequences" (Chapter 3, pg.16). Typically, in the initial stage, the patient feels better and compliance is good if there are no medication side effects, but then as months pass compliance becomes more difficult.

The Guidelines for Tuberculosis Control in New Zealand notes that public health nurses are a key support given the multiple issues for the patient such as; the length of time of treatment, medication management, identifying and managing side effects which can be serious, compliance and completion of treatment, support isolation for infectious cases, contact tracing, the effect of compounding comorbidities, socio-economic aspects, attendance at outpatient appointments, and noting that this activity by the public health nurse can be formalised to supervision level if indicated.



What has changed?

Since 2005 New Zealand has been part of large cooperative international research seeking a better understanding of tuberculosis bacilli with the goal to develop improved diagnostics, drugs and vaccines.

In 2016, the Tuberculosis Act 1948 was repealed by the Health (Protection) Amendment Act. The legislation changes include the updating of the wording, such as Health Practitioner instead of Medical Practitioner, responsibility for Notification of infectious disease and the inclusion of a statement of principles. These principles include respect and dignity, proportionality of actions and response, and communication. It also clarified and improved contact tracing provisions responsive to the range of communicable disease situations.

There is now have a blood test (2001) Quantiferon Gold (QFG) a supportive test for tuberculosis

diagnosis that may be from active or latent infection. The cost is \$75-80 currently which may be a consideration in its use; also, it can't be used for testing children less than 7 years of age and so there is an ongoing need for Mantoux testing capability and capacity.

The test may require some interpretation; it is possible to get an "equivocal" or "indeterminate" result and false positive or false negative results. QFG is being used for screening and contact tracing and is particularly useful in individuals who have had BCG vaccination and are likely to have positive, a hypersensitivity response to Mantoux testing, or as it is referred to in some references as Tuberculin Skin Test (TST).

To summarise: tuberculosis can be complex microbiologically, the pharmacology as well as the social effects; we still get cases of tuberculosis, its' source may be obscure or never identified. The implications of undiagnosed, untreated or incomplete

treatment are significant. Tuberculosis is a life threatening illness. This brief overview reminds health practitioners to consider when presented with combinations of weight loss, fatigue, cough, haemoptysis, night sweats, chest pain; a possibility of tuberculosis.

Every March 24th is World TB Day, the anniversary of the date Koch announced the discovery of the tuberculosis bacillus.

A Tuberculosis Conference is being planned for March 2018; contact Andrea Vause; Andrea.Vause@huttvalleydhb.org.nz

References:

Health (Protection) Amendment Act 2016

Guidelines for Tuberculosis Control in New Zealand 2010. Ministry of Health, Wellington.

Immunisation Handbook 2017. Ministry of Health, Wellington

Examples:

63yr male, hypertension, pleural effusion x 3, cough grew mycobacterium bovis

Source: ? house cow as a child

35 yr female, cough, fatigue, weight loss

Chest clinic not cancer but pulmonary tuberculosis

Source: ?hospital cleaner for 7yrs

63yr male, smoker, completed treatment for cancer prostate 2yrs fatigue, weight loss, haemoptysis, not cancer - infectious tuberculosis

Source: no possible source identified

23yr male, weight loss, enlarged clavicular lymph node biopsy not cancer - tuberculosis

Source: ?overseas travel and residence

72yr female, breast cancer on mammography

CXR secondary's and tuberculosis

Source: ?student nurse in tuberculosis ward in 1950's



Cervical Screening, Barriers and Cultural Safety

Sandra Corbett



I am of Ngāti Pikiao and Te Arawa Iwi affiliations. Currently employed as Kaiwhakahaere (Māori coordinator) for the National Cervical Screening Programme at the Hawke's Bay DHB. After becoming a smear taker in 1996 I gained insight into the inequities that existed, before and since the Cervical Screening Programme was set up. This propelled me to actively pursue opportunities to advocate and promote understanding of inequalities and improve health outcomes for all.

The goal of the National Screening Unit is to achieve equity in access to and through the screening pathway. This continues to be a challenge for the cervical and breast screening programmes and one that must be addressed to realise the full benefits of the programmes. Underserved groups of women identified as priority groups for the programmes are Māori, Pacific, and Asian women (cervical screening programme only) and all women not screened in over five years. These women are an important focus for all involved in delivering screening services.

At a systems level, we must understand and address the lack of participation or irregular screening. Non-engagement contributes to priority group women having a higher risk of developing or dying from preventable cancers compared with those who are regularly

screened. Participation can be improved by implementing a process for identifying priority group women and putting in place systems and strategies for inviting and recalling them. But we need to work differently, and with other services that are culturally appropriate to support these underserved groups to screening and treatment services.

I was part of a group who reviewed the National Cervical Screening Programme's National Policy and Quality Standards (NPQS) documents that set out roles and responsibilities of cervical sample takers (new term for smear takers) and providers of cervical screening services. I was also included in a group to review the Cultural Context for Cervical Screening and the Cultural Competency section of the NPQS.

In preparation, we took time to examine current literature around cultural safety and other frameworks and guidelines used by health professionals to create and maintain culturally safe practices in Aotearoa. As sample takers, we follow cultural safety guidelines when working with women from different backgrounds, cultural beliefs, values and practices. Cultural practices are not restricted to ethnicity, but include (not limited to) gender, beliefs, including spiritual beliefs, sexual orientation, lifestyle, age, social status or socioeconomic status (Medical Council of New Zealand 2006). People can belong to more than one cultural group, and groups they belong to can change over time. Irihapiti Ramsden's (1992) *Kawa Whakaruruhau* is still in my opinion the most relevant framework supporting nursing practice today. Her enduring legacy has been understanding that the effective nursing practice of a person or family

from another culture is determined by that person or family. Culturally safe practice begins with cultural awareness (understanding that there is difference), to cultural sensitivity (difference is legitimated and leads to self-exploration) with cultural safety as the outcome, defined by recipients of care. Safety comes from giving the patient the power to determine that one is a safe practitioner.

Though holistic and cultural specific frameworks inform 'best practice guidelines' and health delivery models, cultural safety is a lifelong process, with effective development dependent on a 'culture' of cultural safety. We must continue to reflect on practices, systems and structures, where inequalities persist. Be brave, ask the hard questions and use critical analysis to develop and implement steps to address them. Challenging not only ourselves, colleagues and organisations, but also the funders responsible for designing contracts.

Cultural safety is a complex area of health education and training, but at its simplest, it is the ability to interact respectfully and effectively with

persons from a background different to our own. With this focus, the review group looked to emphasise the importance of supportive service delivery within the NPQS. The purpose is clear. Ensuring the woman's cultural needs are met will enable positive outcomes. This has been defined and articulated in the standards with the detail and prescriptive actions required to achieve them.

Equally clear is the responsibility of services providers to be committed to Māori interests and ensuring they are protected. Māori as Tangata Whenua are recognised, their unique identity respected, and prioritised in planning and provision of services. This involves working together to develop strategies with Māori involvement at all levels, to ensure at least the same level of health outcomes as non-Māori, while safeguarding Māori cultural concepts, values and practices. Pacifica peoples similarly require a commitment to safeguarding their cultural concepts, using models and support structures to engage effectively.

The barriers to screening remain largely unchanged. But the standards emphasise our responsibility to use this knowledge to inform service improvements, tailored to underserved women. Connecting and engaging with women, building on existing knowledge will increase understanding of individual situations. An appropriate environment may mean that outreach services need to be offered, key messages and resources adapted, and communication styles and social media explored. These considerations will help guide service changes.

In May I attended the Indigenous Diversity Forum where the concept of bias as a normal aspect of human behavior was explored. Deep down we all know we hold biases for or against different groups of people. We hold more bias against people who are not like us. This is socialised into us through culture and the media, and no-one is immune. Research around the world shows particular groups of people experience more discrimination as a result of bias than others. That's why talking about bias, and research that addresses bias, is important. Dr. Carla Houkamau and Anton

Blank, diversity leaders and national experts in unconscious and implicit bias and racism, have produced 'Rewire the little Book about Bias'. This book explores bias as a universal human behaviour, and provides a framework for managing bias in our relationships. We need to understand the sources of our own biases, how they influence thinking and behaviour, and even what can be done to change them.

To be clinically safe we must be culturally safe. We acknowledge that the key to achieving equitable health outcomes is behaviours and attitudes that enable people to function effectively and respectfully when providing care to people of different cultural backgrounds. Be leaders, prioritise the importance of understanding cultural diversity, attitudes, knowledge, and skills necessary for providing quality care to diverse populations. Collectively, we can make a difference and achieve equitable outcomes.

Medical Council of New Zealand, 2006;
<http://www.aacn.nche.edu/leading-initiatives/education-resources/competency.pdf>

For reference, the revised NPQS can be found on this link
<https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/policies-and-standards>

Ramsden, Irihapeti (1992)
Teaching cultural safety In NZ Nursing Journal. June, pp 21-23.

PROSTATE CANCER

Rosemary Minto is an Adult Family Nurse Practitioner working in general practice. She is currently Vice President of NZNO and has had roles on national policy working groups including the MoH Prostate Cancer working group.

Rosemary Minto,

Nurse Practitioner

To test or to screen?

I often have a man come in to see me and at the end of a consultation I have a “by the way can I have a prostate test?” request. This is not just a 2-minute conversation. Mostly because there is no easy answer to this request unless the man has a clear family history of prostate cancer or is having lower urinary tract symptoms (LUTS) Instead we must identify the pro’s and con’s of the test, side effects of the test and what happens if it is positive (or negative).

For men, prostate cancer is the most commonly reported cancer, and Maori men are more likely to die of prostate

2014 the Ministry of Health (MoH) Prostate Cancer Working Group was formed to implement actions from the Prostate Cancer Taskforce. Taking in to account the controversial and conflicting research outcomes from 3 big trials², the Ministry of Health has directed the Group to implement actions from the Prostate Cancer Taskforce³. The usefulness of the work of the group has been not only in providing guidance to providers around testing and active surveillance but also in aligning a man’s journey on the prostate cancer pathway with best practice -from laboratory diagnosis to post cancer treatment.

The Taskforce had already confirmed that “screening” for prostate cancer was not going to happen in New Zealand. Rather there should be a conversation with men about the risks and benefits of testing for prostate cancer. So bolstered with money from the 2013 budget the Working Group, comprised of nurses, doctors, consumer representatives and specialists, confirmed the work plan and began to bring the recommendations to life. Lucy Keedle, one of the nurses on the working group, is a nurse working with men who have a high suspicion or who have been diagnosed with cancer (any cancer). Her involvement continues through their journey including treatment until either hospice takes over or they are cured and no longer need support. She works across

¹ University of Auckland Midlands Prostate Cancer Study.
<https://www.fmhs.auckland.ac.nz/assets/fmhs/som/wcs/docs/FINALREPORTLawrenson11-052.pdf>

² Haines,I., et al 2016:
<http://www.bmj.com/content/353/bmj.i2574>

³ MoH (2013)
<http://www.health.govt.nz/system/files/documents/publications/diagnosis-management-prostate-cancer-nz-men.pdf>

[ts/publications/diagnosis-management-prostate-cancer-nz-men.pdf](http://www.health.govt.nz/system/files/documents/publications/diagnosis-management-prostate-cancer-nz-men.pdf)

Primary and with Secondary services, including NGO's such as Cancer Society and Hospice

The first key pieces of work for the working group were documents designed not to decorate the shelves of general practices across the country but to help health providers advise and guide men in their decision around testing for prostate cancer. In September 2015 the "Prostate Cancer Management and Referral Guidance" was released.

The Guidance document contains a very useful algorithm that assists the clinician with decision making around testing and referral. The most important issue around

testing for prostate cancer is gaining informed consent from the patient, rather than tacking the test onto the end of the blood test request form. Unlike any other blood test, the consequences of the result- particularly a positive one, can be catastrophic.

The level of health literacy of the man and his whanau is important to consider when deciding a course of action, and one that has been considered in the working group's discussions

in planning the decision support tool that will allow providers to work through the issues with the men and come to a shared decision about the testing for prostate cancer. The decision support tool is on the work plan for the working group. Much in the way we use the Heart Foundation "Know your Numbers" tool, it is envisaged that providers will utilise the Prostate cancer testing tool during the conversation around prostate cancer testing.

It is important that nurses are aware of not only the literature around prostate cancer testing but also the resources currently available to help them help men make informed decisions. More and more often nurses are the first point of contact for men and their whanau and should be able to inform men around the issue of testing. I recommend all nurses to read the Guidance document and ensure they are as informed as their patients needs to be.

[Guidance document on the MoH website:](#)

https://www.health.govt.nz/system/files/documents/publications/prostate-cancer-management-referral-guidance_sept15-c.pdf

Once I had discussed the risks AND the benefits of testing for prostate cancer my patient decided he didn't want to go ahead with testing, and we both felt satisfied he had made the right decision for him.

NZ College of PHC Nurses, NZNO – Committees



Members standing down: Kim Cameron, Karen Smith, Marilyn Rosewarne, Trish Wilkonson and Dhyanne Hohepa

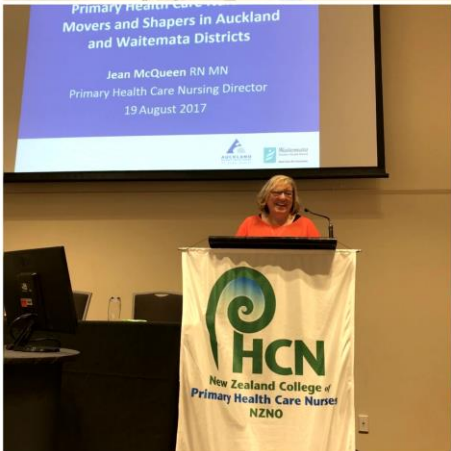


New committee members: Celeste Gillmer (Chair and LOGIC publisher), Emma Hickson (Vice-chair and LOGIC committee), Wendy King (secretary), Cathy Nichols (chair – Professional Practice Committee) Yvonne Little (Editor LOGIC), Angela Clark (Professional Nursing Advisor, NZNO), Tasha Morris (Treasurer and Professional Practice Committee), Tegan Jones (Professional Practice Committee), Bronwyn Boele van Hensbrook-Miller (Professional Practice Committee), Linda Makiha (national executive committee).

Absent: Katie Inker (LOGIC), Irene Tokerangi (LOGIC), AnnieTyldesley (LOGIC); Sarah Van Weersel (Professional Practice Committee), Lee Ann Tait (Professional Practice Committee)

**New Zealand
College of Primary
Health Care Nurses,
NZNO – 19 August
2017 Symposium**











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 - Prostate Screening

1. Does prostate cancer screening matter?
Harvard Men's Health Watch, Aug 2017; 22(1): 1-7. (2p)
The article discusses the importance of prostate cancer screening. Topics covered include how the updated guidelines from the U.S. Preventive Services Task Force (USPSTF) support its 2012 conclusion that prostate-specific antigen (PSA) screenings have only a small potential benefit for decreasing the risk of death of prostate cancer for men ages 55 to

69 and how men ages 70 and older should bypass PSA screenings altogether.

2. Partin, Melissa R.; Lillie, Sarah E.; White, Katie M.; Wilt, Timothy J.; Chrouser, Kristin L.; Taylor, Brent C.; Burgess, Diana J. Similar perspectives on prostate cancer screening value and new guidelines across patient demographic and PSA level subgroups: A qualitative study. *Health Expectations*, Aug 2017; 20(4): 779-787 (9p)

In 2012, the United States Preventive Services Task Force (USPSTF) recommended against prostate-specific antigen (PSA)-based prostate cancer screening for all men. To inform educational materials addressing patient questions and concerns about the 2012 USPSTF guidelines, we sought to: (i) characterize patient perceptions about prostate cancer screening benefits, harms and recommendations against screening, and (ii) compare perceptions across race, age and PSA level subgroups

3. Lawrence, Leah. Most men prefer informed decision-making for PCa. *Urology Times*, 4/15/2017; 45(5): 8-10. (2p)

The article reports that research presented at the Genitourinary Cancers Symposium in Orlando, Florida has found that participants in an outreach event for prostate cancer screening preferred education about prostate cancer before undergoing screening and thought that the use of an informed decision-making model was advantageous. Topics covered include how majority of prostate

cancer recurrences are eligible for local therapies and must not be considered palliative.

4. Functional Quality-of-Life Outcomes Reported by Men Treated for Localized Prostate Cancer: A Systematic Literature Review. Baker, Hilary; Wellman, Sandie; Lavender, Verna
Oncology Nursing Forum, Mar 2016; 43(2): 199-218. 20p

To systematically evaluate the literature for functional quality-of-life (QOL) outcomes following treatment for localized prostate cancer. Literature Search: The MEDLINE®, CINAHL®, EMBASE, British Nursing Index, PsycINFO®, and Web of Science™ databases were searched using key words and synonyms for localized prostate cancer treatments.

5. Howard, Kirsten; Salkeld, Glenn P.; Patel, Manish I.; Mann, Graham J.; Pignone, Michael P
Men's preferences and trade-offs for prostate cancer screening: a discrete choice experiment. *Health Expectations*, Dec 2015; 18(6): 3123-3135. (13p)

Abstract: The article presents a study which examines the preferences and trade-offs of men for the prostate cancer screening using prostate-specific antigen (PSA). The study uses the mixed logit model for the examination of the impact of the attributes including diagnosis, death, and unnecessary biopsies on the preferences of men for PSA. Results show that the characteristics of the test are influencing the preferences of men.

Articles – Cervical Cancer

6. Baker, Ed. The shifting landscape in cervical cancer screening. MLO: Medical Laboratory Observer, Jul 2017, 49(7): 42-44. 2p

The article discusses trends and changes in the screening of cervical cancer in the U.S. Topics discussed include the increasing role of human papillomavirus (HPV) DNA testing in cervical cancer screening, the evolution of screening guidelines developed by several medical societies, and the changing attitude of obstetricians and gynecologists with regards to newer screening methods.

7. Cervical cancer: What you need to know. Nursing Update, Nov/Dec 2016, 41(6): 11-11. 1p

Cervical cancer is the second leading cause of death in women in South Africa and the third leading cause of death in women throughout the world. Vaccine is available to prevent cancer-causing HPV infection; and cervical cancer is one of the few cancers that can be detected in the pre-cancerous stage through regular pap smears.

8. Cullerton, Katherine.; Gallegos, Danielle; Ashley, Ella.; Do, Hong.; Voloschenko, Anna.; Fleming, Marylou.; Ramsey, Rebecca & Gould, Trish. Cancer screening education: Can it change knowledge and attitudes among culturally and linguistically diverse communities in Queensland, Australia? Health Promotion Journal of Australia: Official Journal of Australian Association of Health

Promotion Professionals, Aug 2016, 27(2): 140-147

Screening for cancer of the cervix, breast and bowel can reduce morbidity and mortality. Low participation rates in cancer screening have been identified among migrant communities internationally. Attempting to improve low rates of cancer screening, the Ethnic Communities Council of Queensland developed a pilot Cancer Screening Education Program for breast, bowel and cervical cancer.

9. Powles, Carrie. HPV vaccine: a key cervical cancer prevention strategy. World of Irish Nursing & Midwifery, May 2017, 25(4): 57-58. 2p

Human papillomavirus (HPV) is understood to play a definite role in the development of cervical cancer. It is a necessary but not a sole causative agent. Some 99.7 % of cervical cancers contain high risk HPV DNA

10. Rennie, Darryn; Boxsell, Jennifer; Pedretti, Kaye. A team care model of cervical screening in a general practice. Australian Family Physician, Jul 2015, 44(7): 515-518

Cervical screening reduces the incidence and mortality rate of cervical cancer. General practices have opportunities to increase screening rates by modifying the model of service provided. We provide an example of team-based cervical screening in a general practice and report the effectiveness of invitation letters

for women with no record of a Pap smear.

Articles – Tuberculosis

11. Maze, Michael & Beckert, Lutz. Active tuberculosis (TB) with a negative interferon gamma release assay: failure of this test to rule out TB. New Zealand Medical Journal, 19th April 2013, 126(1373): 85-87

Tuberculosis (TB) notification rates in New Zealand are around 7/100,000 with highest rates in those of non-European ethnicity. Primary pulmonary infection is often asymptomatic with conversion of a tuberculin skin test or interferon gamma release assay (IGRA) the only evidence of infection.

12. Neriman Yükseltürk & Leyla Dinç. Knowledge about anti-tuberculosis treatment among nurses at tuberculosis clinics. International Journal of Nursing Practice, February 2013, 19 (1): 47–53

Nurses are primary responsible for Direct Observation Therapy Strategy and administration of anti-tuberculosis (TB) medications. Lack of knowledge might result with medication errors and ineffective TB control. The purpose of this study was to assess knowledge of nurses about anti-TB treatment.

13. Sputum collection and analysis: what the nurse needs to know. Nursing Standard. 31(27): 40-43

Sputum is the term used to describe mucus that has been expectorated. It consists of

secretions and other matter that has been coughed up from the lungs and large airways. This article informs nurses about how and why sputum collection and analysis are undertaken

14. Trueland, Jennifer. TB: not just a disease of the past. *Nursing Standard*. 2017 May 17, 31(38): 18-20.

Tuberculosis is still a threat to public health in the UK, and it affects children as well as adults. Nurses need to know what to look for and where to go for advice. According to TB nurse manager Margaret Ogedengbe, getting the message across that tuberculosis (TB) is still a real and present danger in the UK is tough, because many people simply don't believe it.

NZNO Library

Contact Details

Level 3, 57 Willis Street

PO Box 2128, Wellington 6140

P: (04) 494 8230

F: (04) 382 9993

E: Library@nzno.org.nz

W:

http://www.nzno.org.nz/resources/library/resource_lists

23.

