LOGIC.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO

Vol 17 No 2

Advanced Care Planning

Diabetes

Virginity & Hymens

Immunisation Update

Nurse Prescribing

Young Nurse of the Year

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

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Circulation

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

Editorial Matter

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ISSN 2463-5642

June 2018 Vol 17 No 2

In this issue….

Chair's Report

Celeste Gillmer
Chairperson

Tena Koutou katoa

Nurses throughout New Zealand are making history this year. On 12th July nurses working within our DHBs went on strike, demanding safer staffing levels and better pay. We support our nurses working in the DHBs and wish them all the best for the negotiations going forward!

When I sat down to write this report, I wasn't sure what to share with you in this edition and was reading some articles on the internet. I ended up on the Ministry of Health's website to read their information on Primary Health Care. There I found the following, and I want to encourage all of you to go back and read the publications available on their website!

Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening.

A strong primary health care system is central to improving the health of all New Zealanders and reducing health inequalities between different groups. The launch of the Primary Health Care Strategy in 2001, followed by the establishment of primary health organisations (PHOs), set the direction and vision for primary health care services in New Zealand.

In 2016 the Ministry updated the New Zealand Health Strategy which recognises the need for change and the challenges faced by the health system. Central to the strategy is the idea of 'All New Zealanders living well, staying well and getting well'. This highlights the need for:

- a shift from treatment to prevention, improving people's lives and supporting greater financial sustainability
- overcoming the inequities in the health system so that it works for every New Zealander
- a deep understanding of what it's like to use the health system – so that services are customer-friendly and barriers to equity can be removed
- the Ministry, health providers, other Government agencies, non-governmental organisations (NGOs) and communities working better together, because lots of factors affect a person's health and wellbeing.

In 2018 the Government announced its commitment to improving access to primary health care along with initiatives to reduce the cost of visiting a general practice for some people including under-14s and Community Services Card holders. If you are looking for information about going to

see a GP, or how much you might need to pay when you go to your general practice or to the pharmacy go to Subsidies and services.

Clinical guidelines

Clinical guidelines provide information and guidelines to all clinicians. Many of the guidelines relate to primary health care. Find our guidelines in the Publications section.

https://www.health.govt.nz/our-work/primary-health-care

Currently we are in the middle of a very busy winter season, with hospitals, GP practices, Aged Care Facilities, prisons and all other heath care providers, being extremely busy and seeing more patients every day. Please take care of yourself, stay warm and stay well!

Nurse florence
#hearourvoices

Kia Ora koutou katoa

Greetings to you all

To all members of the NZ College of Primary Health Care Nurses

I am pleased to invite all members to the NZ College of Primary Health Care Nurses Annual General Meeting to be held on Thursday 23rd August 2018 during the College of Primary Health Care Nurses Forum at Nurse Maude, 35 Mansfield Drive, St Albans, Christchurch.

This is an important process for College members, as the Executive and committees will be sharing our work since the last AGM and seeking comments feedback on the CPHCN future strategy.

We look forward to meeting with you.

Regards

Celeste Gillmer

Chair NZCPHCN

Chief Nurse's Report

Jill Clendon
Acting Chief Nurse

Reflections

I thought I would take this opportunity to spend some time reflecting on my first few months in the role of Acting Chief Nursing Officer at the Ministry of Health. It has been a hectic time with a number of new issues arising, a number of others ticking along and yet more gathering momentum. In the new issues department, of course, there is the industrial activities our DHB colleagues are taking part in. In this, as in all situations, our role as public servants is to be impartial, to advise the Minister and the Ministry. We provide the best advice we can based on evidence, and our connection and communication with sector groups.

Other work has arisen out of the enactment of seven of the eight pieces of legislation that arose from the passing of the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill. With seven pieces of legislation all coming in to force on January 31st, there have been a number of sector queries and some work to do on guiding nurses and associated groups on what the changes mean and how nurses can take advantage of them. The changes mean nurses and nurse practitioners can do a number of things that have previously been restricted to doctors such as writing a sickness certificate. With the changes to the legislation, nurses, nurse practitioners and physiotherapists can now write these. However, we are recommending that organisations may like to provide preliminary guidance and support for nurses who wish to undertake this task. Further information can be found here: https://www.health.govt.nz/about-ministry/legislation-and-regulation/changes-health-practitioner-status.

Our work on developing the Maori nursing workforce is also gathering momentum. Ramai Lord started with the Office as senior advisor in January and has been working hard with Jane Bodkin on progressing this. Matching the number of Maori nurses with the number of Maori in the population by 2028 is a big goal and we are partnering with the Maori Caucus of the National Nursing Organisations Group to drive this agenda. Many of the projects we do, we cannot do in isolation and by taking a collective impact approach as Ramai is doing with this work is an appropriate response to tackling social problems that are multifaceted and multi-layered. It calls for numerous diverse entities to work collaboratively to solve a problem using a common agenda, shared measurement systems, mutually reinforced activities, continuous communication, and a backbone organisation. We are very excited to be working in this collaborative way with our Maori Caucus colleagues (including Te Runanga o Aotearoa).

Meanwhile, we meet regularly with the main nursing groups, work across the Ministry to ensure there is a clinical lens throughout the Ministry's work programme, meet regularly with Health Workforce New Zealand and are growing our collaborative relationship with our colleagues in the Office of the Chief Medical Officer. As Acting Chief Nursing Officer, I sit on the Executive Leadership Team who meet every Monday with the Minister of Health and fortnightly to discuss wider system and Ministry issues. For me, this is the first time I have been party to the higher level discussions around priority areas and how the budget feeds into this. The Ministry has identified four priority areas for immediate longer term focus and five further priority areas that require immediate but shorter term focus. The four longer term areas of focus are: primary care, mental health, child wellbeing and improving equity. The five shorter term priorities are: DHB performance, maternity, drinking water, electives and capital asset management. These priorities will be the focus for the Ministry over the coming year and feed into our four year plan as well as DHB annual planning processes.

As an aside, you may well ask do I mean primary care or do I mean primary health care? In this context, the immediate priority will be on general practice funding – i.e. primary care. However, if there is a primary health care review, this is likely to look at the wider primary health care sector. So there is a bit of both in there.

As I come to the end of my first few months in the role, I have to say I am enjoying the busyness and the sense that we can make a difference by providing advice that draws on our nursing knowledge and understanding of the sector and wider models of care. Nurses need to continue to be active in the policy space and bring their understanding of the barriers and facilitators to good care to the table. We need to understand the way the whole system works if we want to continue to build on our achievements thus far. It's exciting times and great to be a part of it.

Editor's Report

Yvonne Little

Nurse Practitioner

As I'm writing this I find it hard to believe that we are already six months in 2018. The shortest day has passed and many of you will have celebrated Matariki.

For a while there we thought we weren't going to get a winter but mother nature has certainly made herself felt lately.

Our thoughts go out to our members in those areas that have been hit hardest by the wild weather, especially with the added burden of man-made poor decisions in the past which have caused more damage to certain areas.

I hope our members are managing to keep warm and dry and clear of the winter ills, especially as we are at the coal face of dealing with the public and their many health issues. It is important to look after ourselves so we can continue in our work.

Our world is constantly changing, the new Government has been in power for a while now but we need to make sure they are still hearing our words and thoughts. With the negotiations still going on between DHB's and NZNO nurses we in the community need to be prepared to shoulder some extra burden should the strikes eventuate.

The NZ College of Primary Health Care Nurses are currently organising a meet and greet in Christchurch and are looking forward to connecting with our Southern colleagues. Please keep an eye on our webpage, our facebook page and the information included in this issue of LOGIC.

Whilst we will not have enough numbers to hold an AGM, we will be presenting reports to those attending, we will also be presenting awards – so get busy getting those nominations in to us (the information is supplied in this issue).

There will be positions vacant due to committee members finishing up their terms and we would love to see some new faces at the table with us, if you feel you would like a challenge why not contact us.

We would really like to hear from the regions about any activities you have happening or meetings you support and how you do this, so we can include in LOGIC and give our other regions some idea of what options there are to having regional gatherings.

In this issue we have the first report from Jill Clendon, Acting Chief Nurse which I know you will enjoy. We bring you articles from a variety of sources and hope these give you some food for thought.

Happy reading.

Keep warm, dry and healthy over the winter season. We hope to hear from you are members as this is your journal and your input is important to us. Yvonne

New Zealand College of Primary Health Care Nurses NZNO

Information Evening

New Zealand College of Primary Health Care Nurses, NZNO

Come and meet the committees and members from the New Zealand College of Primary Health Care Nurses! We will be sharing all the work the College has been involved with and also provide information on how we can support Primary and Community nurses going forward!

Date: Thursday 23 August 2018

Time: 6:00—8:30pm

Venue: Nurse Maude Ballroom, 35 Mansfield avenue; St Albans; Christchurch

AGM & Nibbles—come and network with your Primary Health Care colleagues!

NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

For catering purposes, please RSVP to Wendy King, NZCPHCN secretary: collegeprimaryhealthcare@gmail.com

NZ College of Primary Health Care Nurses Award Nomination Form 2018

Nurse New to Primary Health Care

Purpose of the Award

This award is for a Primary Health Care Nurse who has worked less than three years in primary health.

The winner of this award will be chosen from written nominations and announced at the New Zealand College of Primary Health Care Nurses event in Christchurch.

The winner will receive $500 to support further learning and development and is encouraged to write an article for the college journal LOGIC.

Nominate your colleagues for excellence and creativity in their nursing.

- Nominees must be NZ College of Primary Health Care Nurses (CPHCN) members and currently working in Primary Health care.
- Preference will be given to those nominees who demonstrate clinical excellence.
- All nominations accepted will be acknowledged in a LOGIC journal.
- Winners will be announced at the NZCPHCN event in Christchurch in August.

Reason for Nomination

Please attach a description of how excellence and creativity has been demonstrated in their nursing practice (up to 500 words). Nomination form and typed description must be emailed or posted.

Nominee Details

Name as on NZNO membership ……

Position: .....……...

Name of organisation: .....…….....

Address of organisation: .....……..

……..

Work phone: …… Email: ……

Nominator Details

Name as on NZNO membership……..

Position…….

Name of organisation: ……

Address of organisation: ……

……

Work phone: …… Email: ……

Nominations are to be received by

5pm Wednesday 16th August 2018

A delegated selection panel from the executive of the NZ College of Primary Health Care Nurses will judge nominations. The panel decision will be final and no correspondence will be entered into.

Email, fax or post all documents to:

Rosanne Grillo

Office Administrator

New Zealand Nurses Organisation

PO Box 2128

Wellington 6140

Fax: 04 382 9993

Rosanne.Grillo@nzno.org.nz

NZ College of Primary Health Care Nurses

Award Nomination Form

Tall Poppy Award 2018

The Tall Poppy Award was instigated by Ginny Hinton, an ex-practice nurse, who felt tall poppies were not always recognised. It was then sponsored by Diane Newland for a further period of five years. Diane was also an ex-practice nurse. Jane Ayling (primary health care nurse) will be sponsoring this $1000 award for a period of five years (2015-2019).

The winner of this award will be chosen from written nominations and will be announced at the New Zealand College of Primary Health Care meeting in Christchurch in August.

The winner will receive $1000 to support further learning and development and is encouraged to write an article for the college journal LOGIC

Do you know a colleague of genuine merit who is elevated above or distinguished from their peers? Nominate such a colleague who has shown leadership and exceptional commitment to patient care, who stands out and warrants acknowledgement and support of their growth.

- *Nominees must be NZ College of Primary Health Care Nurses (CPHCN) members and currently working as a Primary Health Care Nurse.*
  1.
- *Preference will be given to those nominees whose actions have made a significant and positive influence on patient care.*
  2.
- *All nominations accepted will result in the nominees having their nomination acknowledged in the LOGIC journal.*

Reason for Nomination

Please attach a description of an initiative utilising professional competence, quality improvement concepts and a commitment to positive patient experience in her/his area of work (up to 500 words). Nomination form and typed description must be emailed or posted.

Nominee Details

Name as on NZNO membership ……

Position: .....……...

Name of organisation: .....…….....

Address of organisation: .....……..

……..

Work phone: …… Email: ……

Nominator Details

Name as on NZNO membership……..

Position…….

Name of organisation: …….

Address of organisation: …….

……..

Work phone: …… Email: ……

Nominations are to be received by

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Wellington 6140

Fax: 04 382 9993

Rosanne.Grillo@nzno.org.nz

HYMENS AND VIRGINITY – THE MYTH!

Kathy Lowe

Nurse Specialist

Te Puaruruhau, ADHB

kathyl@adhb.govt.nz

The hymen and its relationship to virginity has been enmeshed in different cultural concepts for hundreds of years. It is therefore not surprising that many myths and misunderstandings have developed that continue to be reflected in society and mainstream medical thinking.

Dispelling these myths and understanding the true nature of hymens and virginity is essential for health professionals and is particularly important for those who see people who have been sexually abused. Good understanding of these issues can have a profound influence on sexual health care.

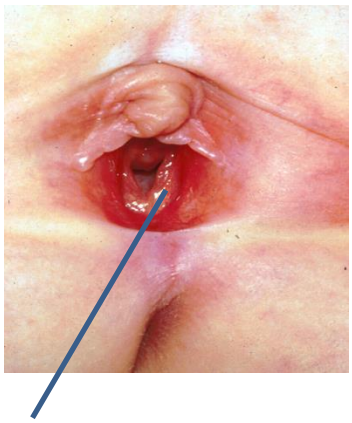
My name is Kathy Lowe and I am a Nurse Specialist. I have worked for over 25 years with children and young people who have been abused and became interested in hymens and what they mean to virginity, particularly in relation to sexual abuse.

1:5 New Zealand women have experienced sexual abuse, involving at least genital contact, by the time they reach 15 years of age. Unfortunately for Maori women, that statistic is higher 1:3. *Child Abuse Negl. 2007 Sep;31(9):935-45. Epub 2007 Sep 17.*

So what is a hymen? Most people believe it to be a skin or membrane just inside the vagina. They imagine it to be a bit like a piece of glad wrap. The definition on the National Health Service UK website is:

The hymen is a thin piece of skin that partially covers the entrance to the vagina. It usually breaks during sex but can be broken through sports, such as horse riding, and using tampons.

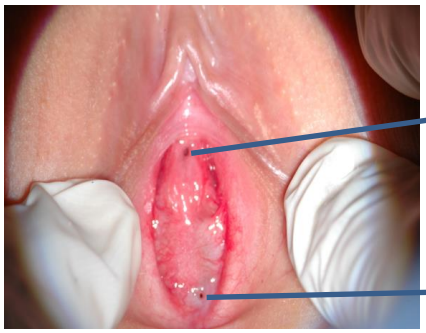
However, this is not a correct definition. In order to address and dispel this myth, I believe it is very important to look at 'genital geography' and the life cycle of a hymen. The following photographs have been approved for teaching purposes.



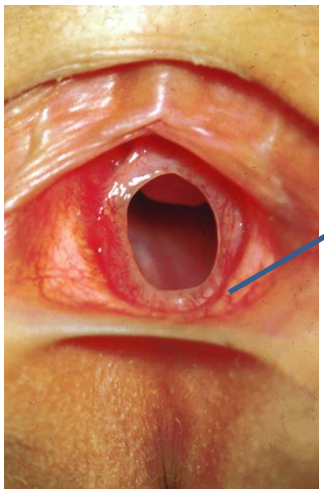
Crescentic hymen

This is what a hymen can look like in the first few years of life. The hymen is a crescentic shape in this particular child. Just like our noses are all different so are our hymens. There are a variety of shapes that are considered normal. As you can see the hymen has a 'hole' in it and we are looking through that hole into the vagina. It is completely normal

to be born with a 'hole' in a hymen. The hymenal tissue in this photograph is quite thick and plump and that is due to the maternal oestrogen that is around in very young children.



In fact, it is very abnormal to be born with an imperforate hymen as in the photograph above. In this photograph, you can see the urethral opening and there is just a tiny hymenal opening.



There is an opening in this hymen, it is normal for the opening to be there? Yes, it is. However, many doctors refer cases like this to specialist abuse units because they think they are seeing a 'broken hymen' therefore something have happened to the child. Unfortunately this information is not routinely given at nursing or medicals schools so many medical professionals have the same understanding about this as the general public.

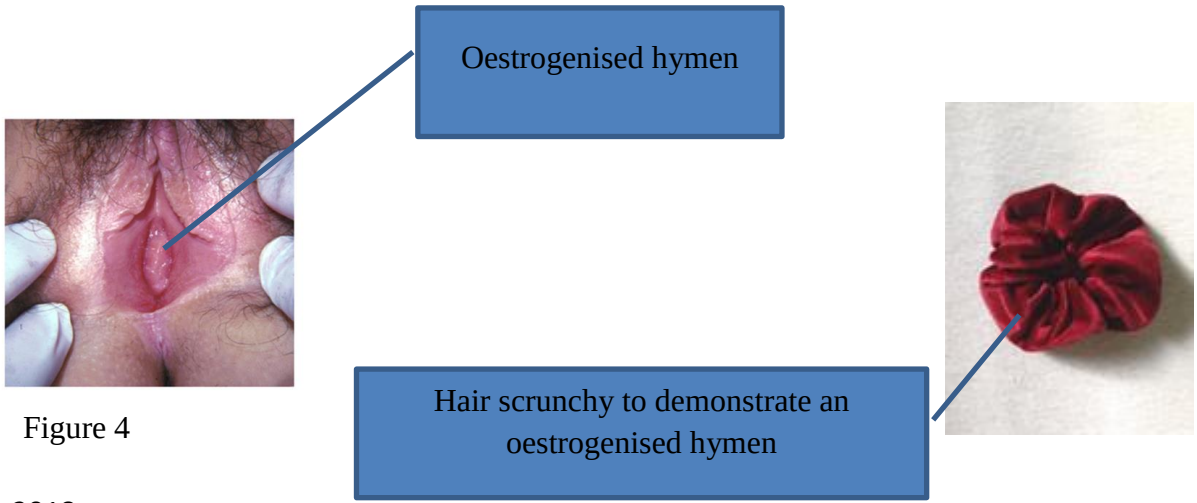
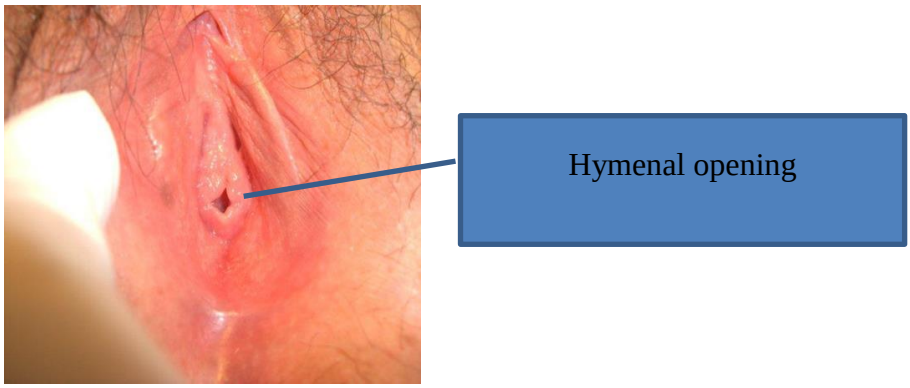


Figure 4

Figure 4 is a photograph of an oestrogenised hymen in someone who has gone through puberty. This person has developed their own oestrogen now and the hymen is thick, elasticated and stretchy. It looks like a hair scrunchy. If you hold a hair scrunchy together, it looks like there is no opening in it but actually there is, you just can't see it.



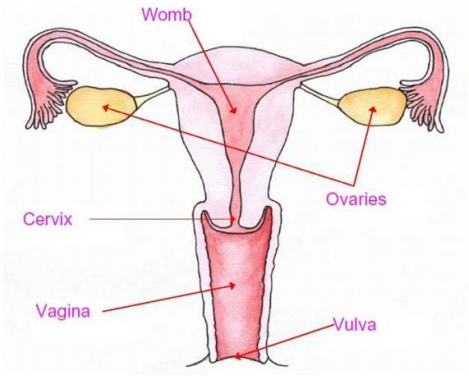
This is the hymen of an adult woman. It is just like a scunchy but with a bit of an opening. The size of the opening doesn't mean much but years ago we used to measure the size of that opening as an indicator of abuse. We now know this is not useful. The hymen is attached to the vagina and the vagina is surrounded by muscles. If the muscles are the relaxed the size of the opening will be affected.

This woman had had several sexual partners in her lifetime. Her hymen has not been worn away to nothing, like we are often told it will and nor will her hymen 'seal' back over if she doesn't have sex for a long time, because it was never 'sealed' over to start with!

So in the life cycle of a hymen, you go from having your mother's oestrogen, to no oestrogen, to developing your own oestrogen at puberty until you get to menopause when you have no oestrogen again.

Ok, so the hymen is set just inside the vaginal entrance and is well protected by two layers of lips, the labia major and the labia minora. What will happen to my hymen when I ride a horse? It might bounce up and down, but so will the rest of me. Nothing should happen to it unless I do something pretty strange on the back of a horse!

What will happen to my hymen when I ride a bike? Once again, riding a bike in a normal way should not affect my hymen and therefore my virginity status. And yet in some Pacific islands, girls are not supposed to ride bikes before they are married in case it 'breaks' their hymen.



This is a fairly standard diagram that many of us have seen growing up and still continue to use for teaching. Is there a hymen on this diagram? There isn't and it is very difficult to find anatomically correct diagrams. When we show people diagrams like this, it looks like women walk around with a big wide open pipe (vagina) between their legs and when it is windy, the wind whistles through! The vagina is in fact a potential space so it sits collapsed on itself most of the time.

In children who have not gone through puberty, the cells on the vaginal wall at the entrance and the cells on the cervix are the same type of cells. We know that bacteria and viruses target certain cells so if we take a swab from the vaginal entrance of a pre pubertal child and nothing grows, we can be sure there aren't any

bacteria or viruses on the cervix either.

However, when we go through puberty, another thing that oestrogen does is change the cells on the cervix so that they are different cells to the cells on the vaginal wall. That is why we need to use an instrument called a speculum when we see older adolescents and adults. We need to place the speculum gently in the vagina and use it to move the walls of the vagina apart so that we can take a swab from the vagina as well as the cervix to be sure there are no bacteria or viruses.

It is important to note that from here on, we are talking about people who are post pubertal. That is they have gone through puberty.

So what about bleeding the first time you have sex, what is that about? There is very little research on this but this article basically says *(The First Coital Experience of One Hundred Women July 1978, JOGN nursing; journal of obstetric, gynecologic, and neonatal nursing 7(4):41-5,Nancy Whitley)*

: if I have 100 virgins in this room and they all have sex tonight, around 44 will not bleed and 56 will bleed. If you don't bleed, it just means that maybe you were relaxed and maybe lubricated so your hymen just stretched to allow the penis through and went back again.

So now that we know all of that, let's say you are asked to look at a 15 year old girl to see if she has had sex. Are you going to be able to tell by looking at her genitals if anything has gone through the hymen? The answer is 'no'. In the majority of cases, it is not possible to look at the hymen to diagnose 'virginity'.

So how do we know if someone has had sex? The answer is to ask. And might they lie? Yes, but males have been able to lie about their virginity status for thousands of years. This myth is around male control over female sexuality.

It is normal to be normal, after sexual abuse!

Normal does not mean nothing happened or that we don't believe you!
It means that what did happen didn't leave any physical damage!

This is a very important message. What it means is that it is normal for there to be no genital findings after sexual abuse. That doesn't mean that nothing happened or we don't believe what you say happened. It just means that what did happen didn't leave any physical damage.

Trained sexual assault doctors often go to court (with a scrunchy in their brief case) to educate the judge, the lawyers and jury on this fact. They have a witness who has said that she was raped and yet the medical report says that the findings were normal. They want to know how that can be. But they too like the general population think the hymen is a seal and that if the witness is telling the truth, the hymen will be 'broken'.

So of this is the case, then what is the point of a medical assessment after sexual assault? Without going into every detail on this topic, there are two reasons for doing a medical assessment. The first one is always therapeutic. The health of the patient is paramount and they can receive STI and pregnancy prophylaxis, psychological first aid and reassurance that what has happened to them hasn't left any physical damage. The second reason is forensic. If we can find any evidence, it can help corroborate their history of events.

Now that we have discussed hymens, let's think about virginity. What is it? When you look back in history, a virgin can tame unicorns, walk through a swarm of bees without getting

stung, reignite the flame of a candle with a single glance and a virgin doesn't have big breasts!!

What is the concept of losing your virginity then, what do you actually lose? I cannot be walking through the supermarket one day and suddenly my hymen drops out! Over the intercom comes a voice "clean up aisle 3, someone has lost their virginity!" Nor can anyone take my hymen away from me.

Therefore, it is very important that we reframe our understanding of what virginity is. It is not a physical quality like we have been brought up to believe it is. It is a quality that we carry in our heart or out head. We cannot lose it and no one can take it from us. We can however choose to share it with someone. Do you think someone who has been sexually abused chose for that to happen? They didn't, so they are still a virgin as they look the same down below as someone who has not been sexually abused and they didn't choose this. The only difference is that they know what has happened to them but they own that history and they have control over who they want to know that and who they don't.

The moment of explaining this to patients and their families can and is a 'light bulb' moment. All of a sudden they realize that they are no different to someone who hasn't been sexually abused. They are not 'damaged goods' which is often how they have felt for a long time.

Here is a correct definition of virginity:

- *A quality an individual (male or female) has and may choose to change by deciding, freely and without coercion or impairment, to experience sexual intimacy with another person of his/her choice. Dr Christine Foley*

Religion has played a part in the hymen and virginity myth.

- Quran 55:54-59: 'whom no man or jinn has opened their hymens with sexual intercourse before.'
- Deuteronomy 22:13-15: Suppose a man marries a woman...'When I married this woman, I discovered she was not a virgin.' Then the woman's mother and father must bring proof of her virginity to the elders…
- Hindu (Manu 1X 72) 'he may abandon her if she be blemished, diseased or deflowered.'

I am not saying that you have to stop believing what you believe in. These documents were written thousands for years ago and we knew very little about anatomy then. I think it is important that we reframe our beliefs on what we now know is fact and not on fiction and myths.

So what about culture and virginity? There are many beliefs around the world on hymens and virginity and most are based on incorrect information. In Tonga for example, there was a *faikava* ceremony and the bride was then expected to demonstrate her virginity by bleeding during sex. The bride's aunts would then display the 'blood on the sheet' to the groom's family. A feast was then given to the bride's family to say 'congratulations, you have kept your daughter safe'. If there was no blood then the couple was still married but there was no feast and it was accepted that the bride must have 'broken' her hymen before marriage.

In Italy, some brides would take chicken blood to bed and put that on the sheet to mimic 'losing their virginity'.

Some of these are old traditions but some still continue today based around the incorrect myth about hymens and virginity.

In 2009 in India, there was a mass wedding, all the brides were forced to take a virginity test and 15 women failed the test and were not allowed to get married. It is unclear how they defined virgin or not!

In 2013, an Indonesian school decided that they were going to look at girl's hymens every year until they graduated. If they were classified as 'not virgins' they would be asked to leave school.

In 2015, the Indonesian military introduced a '2 finger' test for all females entering the military. The test involved 2 fingers inserted in the vagina to determine if the hymen had been disturbed. All the women said the test was *painful, embarrassing and traumatic.*

In New Zealand there is a community called Gloriavale. One of the learning there is "*God has given something wonderful to the human female". "He has given her a seal, a guarantee!* The problem I have with this is the word 'seal' Seal is a word we should never use to describe a hymen as it gives incorrect images.

In 2018, the Daily Mail reported that the NHS is spending large amounts of money on virginity restoring operations. The paper quotes *'spokesman for the Royal College of Obstetricians and Gynaecologists (RCOG) said:*

The hymen is a thin piece of skin that partially covers the entrance to the vagina. It usually breaks during sex but can be broken through sports, such as horse riding, and using tampons.

In the Zulu tribes in Africa, there are virginity testing ceremonies. This is one of the only articles I have found that goes into the criteria for how they classify people.

Leclerc-Madlala S. virginity testing: Managing sexuality in a maturing HIV/AIDS epidemic.

Medical Anthropology Quarterly 2001 15(4):533-552

Young women have their genitals inspected by a virginity tester and are then issued an A,B or C classification. In order to be an A grade virgin, you have to have light pink labia, the size of the vaginal opening has to be small, the vagina needs to be tight and dry, the muscles behind your knees need to be tight and you have to have small breasts!

Although we may find this amusing, it is actually very sad. Many of these girls will not get a virginity certificate so don't assume the same status as 'virgins'.

In many countries around the world, including New Zealand, you can have a 'hymenal reconstruction operation'. One of the ways this is done is to stitch the edges of the hymen together and leave a little space for the blood to come out when you have a period. Once the area has healed, the first time you have sex, there will be breaking of scar tissue so there is guaranteed to be some blood and you can be seen as a 'virgin'!

The problem I have with this procedure is the word 'reconstruction'. This means to repair or rebuild. The hymen was never a complete seal so actually what is being done is 'construction' of a whole new organ that was never meant to be there.

Have we learnt anything from all of this? There is a lot of incorrect information on the internet on hymens and

virginity. If you do want to find some correct information, then I would suggest the links below.

http://www.justthefacts.co.nz/about-your-sexual-body/about-virginity-hymen-myths/

https://www.youtube.com/watch?v=Jt5bE117eGI

In summary, the myths around hymens and virginity have been around for thousands of years and will continue unless we start addressing them. This information is important to men and women but in particular to those who have been sexually abused. They deserve our support in correcting the beliefs around hymens and virginity.

Kathy Lowe

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Prenatal and Infant Paracetamol Exposure and Asthma Risk

Karen Kennedy

Karen is a clinical advisory pharmacist and community pharmacy owner, who also works in general practice and locums for hospital pharmacy. She leads education for the pharmacists in her region. She is Deputy Chair of the South Island (SI) Health of Older Persons Service Level Alliance, a member of the SI Palliative Care Workstream and sits on the Clinical Board for SCDHB. She has a Diploma in Pharmacy and a Post Graduate Diploma in Clinical Pharmacy.

Introduction:

Paracetamol is recommended as the first line drug treatment for analgesia and pyrexia (fever) in children and pregnant women (MAGNUS 2016). Accordingly, it is the most widely used medication in children (SAKULCHIT 2017). The prevalence of asthma, the most common chronic disease experienced by children (MAGNUS 2016), has increased markedly since the 1980's, especially in young children (SORDILLO 2015). This has been paralleled by an increase in the use of paracetamol leading to studies investigating the association between paracetamol exposure in pregnancy and infancy and the development of childhood asthma.

Nurses and midwives may be approached by mothers or expectant women concerned about media reports or information on the internet regarding the potential for paracetamol use in pregnancy or infancy to cause asthma. It is important to understand the quality of evidence around this, how big the potential risk may be and what impact this has on practice when treating pregnant women or infants when they have illness, pain or fever.

Potential Mechanisms:

Certain early life events, including in utero exposure, can make programming changes in the way the immune system, airways and lungs function, increasing susceptibility to allergy (ROSAS-SALAZAR 2017). The mechanisms by which paracetamol has the potential to increase the risk for asthma have not been fully elucidated but a number of known pathophysiological mechanisms may be involved (LOURIDO-CEREIRO 2017). The main mechanism is thought to involve a reactive metabolite of paracetamol, N-acetyl –p-benzoquinone (NAPQI), depleting levels of glutathione in the lung tissue. Glutathione is a powerful antioxidant so depletion of it is thought to increase susceptibility to oxidative stress causing asthma symptoms such as bronchoconstriction and inflammation of the respiratory tract (SAKULCHIT 2017, SINGH 2009).

Other pathophysiological mechanisms include paracetamol having an antigenic effect that may be associated with increased levels of Immunoglobulin E (IgE) and histamine (LOURIDO-CEREIRO 2017, SINGH 2009). Paracetamol has also been shown to have a modulating effect on myeloperoxidase (LOURIDO-CEREIRO 2017), an enzyme released by activated monocytes and neutrophils that is involved in the production of powerful oxidants which are thought to cause tissue damage in inflammatory conditions such as asthma. Paracetamol is a reversible inhibitor of myeloperoxidase by acting as a competitive substrate for it (KOELSCH 2010). During this process, paracetamol is

oxidised by myeloperoxidase with the concern that unwanted reactive by-products could be formed that may cause toxic chain reactions and tissue damage (FORBES 2013).

Paracetamol has also been found to have a cytotoxic effect on pneumocytes, the cells which line the alveoli of the lungs (LOURIDO-CEREIRO 2017). Another possible mechanism may involve paracetamol's antipyretic effect: T helper type 1 (Th1) cytokines are normally produced during fever in response to viruses and bacteria, however paracetamol causing a decrease in fever may result in a decreased release of Th1 cytokines. This may lead to an imbalance and greater numbers of T helper type 2 (Th2) cytokines which are involved with the inflammatory response in asthma (LOURIDO-CEREIRO 2017, MAGNUS 2016).

Evidence

There is considerable debate about the evidence for paracetamol exposure in pregnancy and infancy and asthma risk. A large number of observational studies and meta-analyses have found that paracetamol exposure prenatally and in infancy is associated with asthma development (MAGNUS 2016, ROSAS-SALAZAR 2017, SAKULCHIT 2017). However, most of the studies do not address possible confounding, and in particular, confounding by indication which limits the usefulness of this evidence which may show bias (MAGNUS 2016, ROSAS-SALAZAR 2017).

When confounding is not addressed, illness or environmental or maternal characteristics e.g. mould, smoking or maternal asthma, may be the reason for the increased risk of developing asthma rather than the exposure to paracetamol (ROSAS-SALAZAR 2017). When confounding by respiratory infection was addressed in some studies, the association of paracetamol exposure in early life or prenatally was much weaker or no longer significant (ROSAS-SALAZAR 2017).

Magnus (2016) improved on previous observational studies by addressing confounding by indication. This was a large cohort study (n= 53,169 children for evaluation of current asthma at 3 years, 25,394 for current asthma at 7 years and 45,607 for dispensed asthma medications at 7 years). Paracetamol exposure in pregnancy and infancy (in the first 6 months) were independently associated with asthma development at 3 and 7 years of age after common indications were adjusted for (fever, respiratory tract infections and influenza). This gives more confidence that the reason for taking paracetamol did not influence or change the results. Magnus (2016) also addressed confounding by shared environmental factors and found that maternal use of paracetamol outside of pregnancy and paternal use was not associated with childhood asthma.

This piece of evidence stimulated media coverage as the results were seen to be more credible than some of the previous evidence thought to be affected by confounding. It is important to emphasise that only modest associations were observed for prenatal (adj. RR 1.13; 95% CI: 1.02–1.25) and infant (adj. RR 1.29; 95% CI: 1.16–1.45) paracetamol exposure and asthma at 3 years, and similarly for asthma at 7 years of age (MAGNUS 2016). It is also important to emphasise that an association does not imply a causal relationship, that is, paracetamol exposure in early life has not been proven to cause childhood asthma.

Conclusion:

There is insufficient evidence to make changes to current guidelines on the treatment of pain, fever and illness in infants

and during pregnancy. A large intervention study in the form of a randomised controlled trial is required to replicate these results before any changes are likely to be made to public advice.

Practice Points:

- The relative increase in risk of childhood asthma, especially with women taking paracetamol during pregnancy, is quite low (even if evidence proved a causal effect)
- Advice on paracetamol use in mothers and babies does not need to change: there is insufficient evidence for changes to current guidelines
- During pregnancy, paracetamol is still the preferred choice to treat mild/ moderate pain and fever
    - Take at the lowest possible dose for the shortest time
    - Paracetamol provides similar pain relief to nonsteroidal anti-inflammatory drugs (NSAIDS) with less adverse effects.
    - NSAIDS are usually contraindicated throughout pregnancy but if used, should only be used during the first and second trimester. In the third trimester, NSAIDS can cause vasoconstriction of uterine arteries and if used close to full term, they may cause premature closure of the arterial duct in the foetus which can lead to heart and respiratory issues or death (SHAH 2015).
- Babies can be given paracetamol to treat pain or fever if they are over 3 months of age.
    - If under 3 months of age, only use under medical supervision
- Ibuprofen can be given to treat pain or fever in children 3 months and older who weigh more than 5kg
- Other factors like prenatal maternal smoking or second hand smoke exposure in infancy may have a bigger influence on the development of childhood asthma (ROSAS-SALAZAR 2017). Smoking cessation is to be recommended.

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My Nurse Practitioner Journey

Carol George

Nurse Practitioner

Horowhenua Community Practice

It has been said that, "for us who nurse… unless we are making progress every year, every month, every week, take my word for it, we are going back (2011, Florence Nightingale). For myself, transitioning from a Respiratory Clinical Nurse Specialist (CNS) to Nurse Practitioner (NP) in Primary care, it has been the continuum described by Florence Nightingale. Each of my nursing roles, from psychiatric nursing, medical nursing, district nursing, respiratory CNS and NP candidate, has contributed towards my achieving the Nurse Practitioner qualification. Evolving to be a NP in primary care has been enabled through visionary leadership, mentors, champions, and access to study.

Reflecting on the journey from respiratory CNS in a community health service to Nurse Practitioner in primary care, the first thing I realised, was the commitment and vison of others who empowered me to progress. Any number of names and faces come to mind. The service that funded my Masters and later prescribing practicum. The geriatrician who said "yes" to the challenge of being a prescribing mentor in the community. In fact, surrounding myself with "yes" people seems to have been key to my development. "Yes you can do it", "yes we can help", and "yes, you can ask lots of questions" (again!). Moreover, colleagues who review your practice, policy and education are gold. As such, peer support is essential, as are like-minded people and reinforced professional goals.

The change from registered nurse to NP for me was advanced by Mid Central PHO's vision for Nurse Practitioners in primary care, which provided an NP candidacy position at Horowhenua Community Practice. This organisational vision has enabled an NP role with the potential for it to develop into a primary provider within the practice. For me as a Nurse Practitioner, one challenge (having grappled and come to grips with Medtech!) is to develop a strong sexual health portfolio. I have been surprised at the high cost of sexual health courses. Fortunately however, research into funding has been productive with some subsidies available. Negotiating training, as with all nursing, has required planning and prioritisation.

Further resources that have been beneficial are the Primary Care Handbook 2012; Cardiovascular Disease Risk Assessment and Management for Primary Care 2018; Goodfellow Unit (podcasts & web casts); Best Practice Advocacy Centre New Zealand; Best Practice Guidelines and Health Mentors-Diabetes for Health Care Providers. BMJ Learning provides excellent education as well. Using these

resources with supporting champions such as Diabetes Specialist nurses; other Nurse Practitioners, General Practitioners and Consultant Specialists has helped to consolidate learning into practice. Alongside this, my leadership was developed as well tested as a member of the NZNO Respiratory College Committee. The Respiratory College has enabled me to strengthen negotiation, advocacy, organisational and writing skills. One exciting opportunity was to meet with opposition Ministers of Parliament to discuss concerns around poor respiratory statistics in New Zealand and the need for a national respiratory health indicator.

Key elements for my development from a Community Health CNS Respiratory to a NP in primary care include organisational vision, mentors, champions, ongoing support training and funding as well as accessible resources. Significantly, also my family who, having put-up with decades of study, assessments (physical examinations!) sleepless nights, have been essential to me as I have progressed in my nursing capability. Lastly, for me it has also been journey of answered prayer, new challenges and opportunities.

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Worker Exposure Survey

WE ARE LOOKING FOR COMMUNITY NURSES TO HELP US WITH A RESEARCH STUDY ON WORKPLACE EXPOSURES

Why are we doing the study?

We are conducting an important study to learn more about occupational exposures and workplace practices in selected occupational groups in the New Zealand workforce. We are doing the survey so that effective interventions may be developed to prevent work-related disease and injury.

What does the study involve?

We are inviting about 700 workers aged between 20 and 64 years from seven occupational groups to take part in a confidential telephone interview. The groups are: a) farmers who apply pesticides; b) collision repair workers; c) construction workers, d) sawmill workers; e) hospitality workers; f) clerical workers; and g) nurses.

What will my participation involve?

Participation will involve a telephone interview asking about your current workplace exposures, organisational factors, and your health. The interview will take about ½ hour – 45 minutes and will take place at a time and date convenient to you. **Your employer will not be contacted in regards to your participation in this study.**

What will happen to my personal information?

We will treat all information from the questionnaires as strictly confidential. The data from the questionnaires will be seen by named researchers only. **No individual information or names will be published.** During and after completion all questionnaires will be stored in locked filing cabinets, which will be the responsibility of the Director of the Centre for Public Health Research.

For further information, please contact Dr Amanda Eng on 0800 990 053 or email a.j.eng@massey.ac.nz

Two funded quadrivalent influenza vaccines in 2018

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau

Barbara McArdle, National Influenza Coordinator, The Immunisation Advisory Centre (IMAC)

This year, for the first time in New Zealand, the funded influenza vaccines are quadrivalent (containing two A and two B strains).

There are also some important changes about influenza vaccination this year including:

- funded vaccines are both quadrivalent
- a new influenza vaccination precaution for people receiving some new cancer treatments and
- new guidance for influenza vaccination for people with history of egg allergy or egg anaphylaxis.

The Influenza Kit booklet 2018, Everything you need to know about flu remains the most important health professional resource for 2018. There are some additional promotional resources in 2018 which can be used by immunisation providers to promote influenza immunisation.

1. Increasing healthcare worker influenza vaccination coverage remains a key focus for 2018.

2018 funded quadrivalent vaccines

INFLUVAC® TETRA

For adults and children aged 3 years or older.

FLUARIX® TETRA

For children aged under 3 years, i.e. 6–35 months.

The four strains for the 2018 Southern Hemisphere influenza quadrivalent vaccines, including two new strains that were not in last year's funded vaccine, are:

- For H1N1, an A/Michigan/45/2015 pdm09-like virus
- For H3N2 A/Singapore/INFIMH-16-0019/2016 - like virus – the new H3N2 strain for 2018
- B/Phuket/3073/2013-like virus – the new B strain for 2018
- B/Brisbane/60/2008-like virus.

The inclusion of the new strains is based upon recommendations from the World Health Organization (WHO) and Australian Influenza Vaccine Committee on the strains predicted to most likely to spread and cause illness in people this season. The 2018 vaccine has been updated in response to ongoing genetic changes in the circulating viruses

The H3N2 strain in this year's vaccines is broadly matched to the strain being referred to in the media as 'Australian flu'. This strain circulated in the Southern Hemisphere during winter 2017 and severely affected the northern hemisphere during their 2017–2018 winter.

New influenza vaccination precaution for "Immune Checkpoint Inhibitors"

Influenza vaccination may be contraindicated or need to be delayed for people receiving some new cancer treatments. A group of medication known as Immune checkpoint Inhibitors, that include atezolizumab (Tecentrip®), ipilimumab (Yervoy®), nivolumab (Opdivo®) and pembrolizumab (Keytruda®), have immune-stimulant actions on the immune system that may increase a person's risk of developing autoimmune conditions.

It is not known whether receipt of an influenza vaccine while receiving these treatments or for up to 6 months after treatment has ceased increases a theoretical risk of triggering the occurrence of possible autoimmune side effects.

Please contact the person's oncologist or 0800 IMMUNE (0800 466 863) for current advice about influenza vaccination for these people BEFORE administering the vaccine.

New guidance for influenza vaccination for people with a history of egg allergy or egg anaphylaxis

Studies have shown that influenza vaccines containing less than one microgram of ovalbumin do not trigger anaphylaxis in sensitive individuals. The residual ovalbumin in one dose of

INFLUVAC® TETRA or FLUARIX® TETRA is significantly below this limit so these vaccines can be safely administered to people with a history of egg allergy or egg anaphylaxis at general practices, pharmacies or at the workplace.

Influenza kits and information available for vaccinators

These resources can also be viewed online and most can be reordered, at www.influenza.org.nz

The new waiting room Q&A Poster aims to dispel some common myths about influenza and immunisation.

The online vaccine order form is available on the HCL website www.hcl.co.nz/ . Online ordering is preferable to fax ordering.

Promotional campaign

The promotional campaign for 2018 continues to use the "blue dust" theme. The advertising campaign started in late April and consists of 4 weeks of TV ads, five weeks of online ads and or the first time a new for 2018 an eight-week @FightFluNewZealand Facebook page and ad campaign. If you are a Facebook user please have a look at the Fight Flu New Zealand page and consider sharing or liking some of the posts.

An important aim of the promotional campaign in 2018 is to raise awareness of asymptomatic influenza and the ability to spread influenza even if not unwell. A video based on New Zealand asymptomatic influenza data is being used as an ad on New Zealand television, and in internet advertising such as in online newspapers and Facebook feeds. Practices who would like to make use of the advertisement can send out a link to the video in recall emails or texts, either asymptomatic flu video with sound or asymptomatic flu video with subtitles, no sound .

2.

Importance of healthcare worker vaccination highlighted by New Zealand data

IMAC strongly encourages healthcare workers to be vaccinated - to protect our patients, and also ourselves, our families/whanau and friends. We can spread influenza even before we are symptomatic, up to two days beforehand.

Many of our vulnerable patients may not have an ideal immune response to the vaccine, so they need to be protected from us spreading disease to them, even when they are vaccinated.

Data generated from the Southern Hemisphere Influenza and Vaccine Effectiveness Research and Surveillance (SHIVERS) serosurvey study in 2015, showed that:

- About one in four people were infected with influenza, with even higher numbers for young people aged under 19 years (around one in three).
- 80 percent of those infected with influenza did not have symptoms.

This data further highlights the importance of vaccination for healthcare workers.

Related to this is the Ministry of Health position statement - addressing influenza immunisation of healthcare workers which was published in March.

For further information go to www.influenza.org.nz or www.health.govt.nz or call 0800 IMMUNE 0800 466 863.

Key points

- For 2018 there are two funded quadrivalent vaccines (conitaining two A and two B strains)
- Two new virus strains are included in the 2018 Southern Hemisphere influenza quadrivalent vaccine
- Influenza vaccination may be contraindicated or need to be delayed for people receiving some new cancer treatments called immune checkpoint inhibitors
- The two funded vaccines can be safely administered to people with a history of egg allergy or egg anaphylaxis
- Influenza vaccine can be administered with other vaccines
- Healthcare worker vaccination protects vulnerable patients.

Funded Zostavax® vaccinations:

Since the availability of funded influenza and funded Zostavax® in early April the 0800IMMUNE (466863) nurse advisors have been very busy answering phone queries with the majority relating to Zostavax®.

Here's a common question asked of 0800IMMUNE nurse advisors:

Can Zostavax® be given at the same visit as other vaccines?

Yes. Zostavax® can be administered at the same visit as any other vaccine, including influenza (Influvac® Tetra), pneumococcal (Pneumovax® 23), Tdap (Boostrix®) and Td (ADT™ Booster) vaccines. Separate syringes and different injection sites should be used.

(From the *Quick answers to frequent Zostavax® questions IMAC* resource, available at the link above)

To assist vaccinators, an immune.org.nz webpage Zostavax resources for health professionals brings a range of important resources together in one place.

Young Nurse of the

Year Award

Sue Gasquoine, *Nursing Policy Adviser/Researcher,*

New Zealand Nurse Organisation (NZNO)

Jess Tiplady NP, the 2017 Young Nurse of the Year with Dr Philippa Seaton, Director, Centre for Postgraduate Nursing Studies, University of Otago, representing the sponsor.

Jess works in primary care and her eczema and asthma clinics are free for children under 13 years of age. She is a great example of a nurse making a positive contribution to health outcomes for New Zealand children living in poverty. The impact on families living in overcrowded houses with the associated infection, itch and discomfort of eczema, loss of sleep and potential for hospitalisation is significant. She has contributed to the development of a regional skin infection management programme and supports initiatives to improve child health outcomes including breast feeding and immunisation rates and now mentors other nurses studying towards being a nurse practitioner.

Nominations are now open for the Young Nurse of the Year Award 2018.

After five years of generous sponsorship from the University of Otago, the Award has a new sponsor this year, the National DHB Chief Executives group. We are delighted that they see the value we do in celebrating younger nurses in this way.

The purpose and criteria for the Young Nurse of the Award is to recognise and celebrate the often exemplary work of nurses in the younger age group and to encourage younger nurses to demonstrate their commitment to the nursing profession. Nominees show compassion or courage beyond what is expected in their role as a nurse and has improved care or health outcomes for their patients through their commitment to care, leadership, research or quality.

Strong nominations clearly evidence the strengths and achievements of the nominee and include details of:

- particular project(s) that the nurse has been involved in or is a general, all-round nomination
- outcomes such as the nurse being accepted onto a programme by merit or demonstrable improvement in patient outcomes
- the nominees' contribution in a significant way to a community.
- the nominee has overcome major professional and/or personal challenges to deliver exceptional care.

Nominees:

- maybe registered or enrolled nurses,
- maybe new graduates,
- do not have to be in paid nursing work,
- must be under the age of 31 as at December 31st 2018,
- must be resident in New Zealand,
- must be a current financial member of NZNO.

Nominations are assessed by a panel comprised of: a representative from the YNYA sponsor; previous year's winner/s of YNYA; Chief Nurse or representative, Ministry of Health; NZNO President; NZNO Kaiwhakahaere.

Go to: www.nzno.org.nz for detailed criteria and the nomination process.

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Advance Care Planning

Helen Rigby

Advance Care Planning Facilitator – Wairarapa, Hutt Valley & Capital & Coast Districts

Key messages of this article:

- Advance care planning is an important part of person-centred care
- Early advance care planning is relatively straight forward and supports late advance care planning
- Practising 'framing' an advance care planning conversation is useful
- A nurse led model of advance care planning can work well within a general practice or aged residential care facility

Why bother with Advance Care Planning?

Advance care planning (ACP) is a process of discussion and shared planning for future health care. It involves competent adults preparing for a time when they may not be able to speak for themselves. Planning discussions should also involve whānau/family and health care professionals. Ideally these conversations will lead up to a written statement of their preferences for health and end of life care, with any specific directives, so that the plan can be referred to if and when needed.

In part ACP is driven from the knowledge that people are receiving unwanted treatment at the end of their lives that is not necessarily consistent with their values. A 2016 systematic review by Cardona-Morel et al[1] investigated the variety and extent of non-beneficial and futile treatment. The review concluded that at least a third of people were receiving non-beneficial and aggressive treatment and management in the last six months of life. This was at a point when their clinical presentation should have signalled a shift in the goals of care from active treatment to palliative or comfort care. Results confirmed a culture of 'doing everything possible' even if it was against patients' expressed wishes.

Research shows the value of ACP. In an Australian randomised controlled trial by Detering et al[2] , elderly inpatients were offered facilitated advance care planning alongside their usual care. The results showed that the end of life wishes for this group were more likely to be followed (86% vs controls 30%) and that family members had significantly less stress, anxiety and depression after the person's death.

Some New Zealand whānau were interviewed for a national

[1] M Cardona-Morrell, JCH Kim, RM Turner, M Anstey, IA Mitchell, K Hillman. (2016) **Non-beneficial treatments in hos systematic review on extent of the problem.** International Journal for Quality in Health Care, 1–14

[2] KM Detering, AD Hancock, MC Reade, W Silvester, (2010) **The impact of advance care planning on end of life care in elderly patients: randomised controlled trial.** BMJ, 340:c1345

ACP evaluation[3] in 2017 and spoke of how they had used the advance care plan to help discuss and negotiate end of life treatment and care for their family member. Analysis in Canterbury DHB of people with electronically documented advance care plans has shown that people who had a plan were much more likely to die at home than those without a plan. This showed concordance with people's wishes as well as reducing end of life hospital admissions.

Early ACP supports late ACP

A recent report[4] summarised findings from qualitative research in America. The study explored facilitators and barriers for ACP conversations through focus groups with clinicians and consumers. The researchers clearly identified two distinct types of advance care planning – early and late. Both clinicians and consumers agreed that 'early' ACP was brief, transactional, relatively straight forward, could start early with adults who are well and could take place outside of healthcare. 'Late' conversations were agreed to be much more challenging and emotionally charged and needed clinician expertise to help consumers understand their illness trajectory and future considerations. Early advance care planning was identified as the best facilitator for later discussions when someone was seriously ill. ACP conversations were much more likely to occur in healthcare if the system routinely prompted it (eg. through cues on standardised forms) or if it was normalised into practice. Consumers wanted direct, honest and sensitive conversations. Clinicians wanted tools to assist them to start and navigate difficult conversations.

Framing the ACP conversation

Health Quality and Safety Commission (HQSC) has begun to develop a guide for health organisations implementing ACP[5]. Over the coming months, the HQSC will add examples, activities and resources to support services, practices and organisations working towards embedding ACP into practice.

In local education discussions about ACP, how to frame the conversation is often discussed and some health professionals express nervousness about introducing advance care planning. Some of the reported strategies that have worked well in our local region have been:

- Pairing up (either two nurses or a nurse and general practitioner (GP)) and having early discussions together and learning together
- Asking if they have appointed an enduring power of attorney (personal care and welfare) and then whether they have talked to them about what health choices they would want made
- Finding your own words that work *"I was really worried that people would think they were dying if I talked to them about advance care planning so I had to learn how to frame it. Now I tend to ask them about what's worrying them most about their future and that's a way of starting the*

[3] Evaluation of the Advance Care Planning Programme, March 2017, *Prepared for Health Quality and Safety Commission by Litmus*

[4] www.johnahartford.org/images/uploads/reports/ConversationStartersFocusGroupsReportFINAL.pdf

[5] https://www.hqsc.govt.nz/our-programmes/advancecareplanning/how-to/for-health-care-workers/

conversation". (Practice Nurse)

- Normalising it into practice *"I give people some information and say 'part of what we do here is talk to people about advance care planning' and they seem to respond well to that".* (Practice Nurse)

Finding a system that works for your workplace

National and local ACP work has shown that services, organisations or practices need to find a system that will work to normalise ACP into practice and make it part of the workflow and processes. Leadership support and a strong clinical champion within the workplace are crucial.

Nurse led models:

- Some general practices have appointed one or two nurses within their practices as 'lead' ACP nurses. Other nurses and GPs will introduce ACP to the person, give them information and then the lead ACP nurse will call them back for an appointment. *"People are unlikely to make an ACP appointment themselves. If we ring them and invite them in for a discussion though they generally want to come".* (Practice Nurse)
- Another practice has used long term conditions funding creatively to enable a weekly 'ACP clinic' for the nurse to see or phone people about their ACPs *"One of my best appointments recently was with a couple who both wanted to come in and talk about their advance care plans together".* (Practice Nurse)
- Some aged residential care facilities have also been having success with nurse led models or working out a team approach with their GPs *"now the GP asks new residents and their whānau about resuscitation and then lets them know that I'll have a longer conversation with them at a later date about their future healthcare plan".* (Clinical nurse manager)

GP lead model:

- Some general practices have the GPs leading the conversations and often they will ask the person to book another appointment to continue the discussion *"I've had such rich conversations with patients that I've been looking after for more than two decades. I've found out about all sorts of things that have been worrying them that I wouldn't have known if we hadn't talked about advance care planning"*

In summary, ACP is everyone's business and we need to continue creating the buzz both in our communities and in our workplaces.

There is foundation eLearning https://acp.elearning.ac.nz/login/index.php which can be completed in about an hour and the four short modules each have a certificate for continuing professional development records.

For more information on this topic contact your local ACP facilitator or email acp@hqsc.govt.nz to find out who this is.

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Early diagnosis and optimal management of heart failure with reduced ejection fraction

Suzanne Jackson, RN, Dip HE, Bsc, Awaiting Msc, member of CSANZ

I trained in London at the Nightingale Institute King's college and worked in trauma and orthopaedics for a brief time before commencing in cardiothoracic surgery at Guy's & St. Thomas'. A Bsc in cardiorespiratory nursing was completed through the Brompton, (national heart and lung hospital) London. Then nursed and travelled around Australia and on my return to London transferred to cardiology and coronary care (CCU). Then working at the Norfolk & Norwich hospital in CCU prior to moving to Timaru where I worked in intensive care & CCU. Having completed a post graduate certificate in critical care and I then started work as a nurse educator where undertaking more papers towards my masters. A return to my passion of cardiology was permitted by a role as a community cardiac clinical nurse specialist in 2014. I am currently awaiting the result for my Masters in clinical health sciences, nursing. The next step in my career will be working towards nurse practitioner with the undertaking of two more papers, one this year and one next.

Background

Heart failure (HF) is a progressive long term chronic condition (LTCC), which poses an enormous economic burden and impacts negatively on patients' quality of life both in terms of symptoms and repeated admissions to hospital (Driscoll, Currey, Tonkin & Krum, 2015). The average length of stay for HF in New Zealand (NZ) is five days and associated costs are 1.5-2% of the total health budget (Doughty et al., 2009). HF affects approximately 1-2% of the adult population, rising to over 10% among people more than 70 years of age (Ponikowski et al., 2016). The average age at diagnosis is 76 years (Selby, 2011) and older patients may have other co-morbidities making their management more complex.

Signs and symptoms

HF is a complex clinical syndrome resulting in structural or functional impairment of the heart. The heart is unable to pump adequate volumes of blood and oxygen to cater for the requirements of metabolising tissues (Godden & Waite, 2014; Waterhouse, 2014). It is characterised by shortness of breath, fatigue, fluid retention, reduced exercise tolerance, orthopnoea, and nocturnal dyspnoea (Ramani, Uber & Mehra, 2010).

Early diagnosis

One in six patients over 65 who present to their general practitioner, nurse practitioner or practice nurse with increased shortness of breath (SOB) will have undiagnosed HF (Ponikowski et al., 2016). There are many reasons for this, partly that signs and symptoms of HF can be non-specific and that proper diagnostics and treatments are underused in primary care (Mejhert & Kahan, 2014). The diagnosis of HF is made more difficult as the symptoms can be extremely subtle and are often missed amongst other co-morbidities (Ponikowski et al., 2016; Bayley et al., 2016). Promoting wellness and preventing long-term conditions through both population-based and targeted initiatives is an objective from the Ministry of Health (MoH) strategy (2016).

How can we identify HF patients' earlier in the disease trajectory and therefore improve their prognosis? In a patient with SOB, perhaps consider a cardiac cause, a respiratory cause or both. Does

the patient have a past medical history (PmHx) of any of the following; myocardial infarction, hypertension, atrial fibrillation, valvular disease, thyrotoxicosis, alcoholism, severe anaemia or a family history of cardiomyopathy? Has the patient presented with SOB, lethargy or both? Does the patient describe nocturnal dyspnoea or SOB on exertion? Is there any evidence of peripheral oedema? If the answer is yes to any of these symptoms then in the presence of any of the PmHx listed above, it is likely that the patient has HF.

Physical Examination and diagnostics

Your physical examination should involve weighing the patient, have they had a sudden increase in weight which is likely to be due to fluid retention? Can you measure the jugular venous pressure? Is there a 3rd heart sound or a displaced apical beat? Consider a brain naturetic peptide (BNP) blood test and electrocardiogram (ECG). Natriuretic peptides are hormones made by the heart in response to an over-stretched myocardium (Bayley et al., 2016). Raised levels of BNP in the blood can indicate that someone has heart failure. Where levels are normal (40mmols or below), heart failure can be ruled out (Bayley et al., 2016). If the BNP is elevated, a referral should be made for an echocardiogram. Management of HF should commence prior to an echocardiogram as wait times can be up to four months. This time should be optimised with patient education, medication and lifestyle modifications. As this is the window of opportunity to commence early treatment which impacts positively on prognosis.

Medication management

What is optimal medication management? According to the European and American guidelines for HF, angiotensin converting enzymes inhibitors (ACEi) and beta blockers are first line treatment for the management of HF. Beta blockers are most effective for HF when used with an ACEi and a diuretic (Bullock & Manias, 2014). ACEi prevent excess activation of the renin-angiotensin-aldosterone-system (RAAS). The RAAS increases the production of angiotensin I, which is converted to angiotensin II (Ang II) (Kieback, Felix & Reffelmann, 2009) and if untreated in HF, can increase blood pressure (BP) causing further ventricular hypertrophy. An ACEi decreases BP by limiting aldosterone and Ang II production. The inhibition in aldosterone results in excretion of sodium and water causing a decrease in BP due to a reduction in blood volume (Bullock & Manias, 2014). All ACEi have a target dose and optimal care involves up-titrating the ACEi until the patient has reached their optimally tolerated dose or the target dose (Ponikowski et al., 2016). Target doses can be found in MIMS or Medsafe, for example the target dose for Cilazapril is 5mg once daily (OD) and for Quinapril 10-20mg twice daily (BD). Up-titration involves monitoring of renal function tests and BP checks on a fortnightly basis (Ryder, Travers, Timmons, Ledwidge & McDonald, 2003). For some patients hypotension or deteriorating renal function may prevent reaching the target dose in which case the patients optimally tolerated dose is the appropriate management. In the elderly both ACEi and Betablockers should be started low and titrated slowly, until the optimal dose is reached.

A beta blocker is recommended in stable HF patients to decrease myocardial oxygen demand, but ultimately to slow the heart rate, thus giving the ventricles more time to fill prior

to systole which will lead to an improvement in cardiac output. Beta blockers should also be titrated to optimally tolerated doses, target doses for these can be found in MIMS and Medsafe. The European and American HF guidelines clearly outline additional medical management for those patients who require diuretics, further rate control medication or invasive interventions such as cardiac resynchronisation therapy (Ponikowski et al., 2016; Yancey et al., 2016). Cardiac resynchronisation therapy has stringent eligibility criteria for patients who are in sinus rhythm with a left bundle branch block (Ponikowski et al., 2016) and would benefit from cardiac pacing which resynchronises the ventricular contractions.

Lifestyle modifications

In accordance with optimal medication management patients also require education to support adherence to medication (Snyderman, Salzman, Mills, Hersh, & Parks, 2014). Patients who are in New York Heart Association (NYHA) class I-III should be offered an exercised based rehabilitation programme like multi condition or cardiac rehabilitation (Table 1). Alternatively a referral to green prescription for exercise support could be considered depending upon the severity of the symptoms. Exercise is usually recommended for all patients with HF NYHA class I-III as this aids weight control and improves functional capacity.

Patients need to be provided with information regarding reduced alcohol and low sodium diet which will vary depending upon the age and co-morbidities of the patient. The Heart Foundation "Staying well with HF" is an informative resource and can be accessed via their website www.heartfoundation.co.nz.

Patients', who are able, should be encouraged to perform daily checks as part of their self-management. This involves a morning weight, monitoring any changes to breathing and noting any peripheral swelling. The aim of the nurse should be to provide education and support to empower the patient to self-manage and optimise their health with medication and lifestyle modification (Jackson, 2017). For those patients or carers who are capable, an action plan for diuretic management can be developed. This, in agreement with their prescriber, allows the patient to titrate their diuretic should their weight, oedema or SOB increase. Fluid restrictions go in and out of vogue, for older patients generally the advice is to drink so that they are comfortable. For those with frequent admissions to hospital a fluid restriction of 1.5Litres a day may be put in place by their physician.

Patients should be informed that presently their HF cannot be cured, however it can be medically managed, particularly for those who are engaged to self-manage. The fact that HF is not curable may require psychological support and advanced care planning should be offered to all patients who would like to discuss their care preferences as their HF progresses. Palliative care options should also be discussed with the patient for end of life care. Further information can be accessed through; Health pathways, Best Practice Journal, Heart foundation of NZ, European society of cardiology and American college of cardiology HF guidelines.

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NYHA Class	Symptoms
I	Cardiac disease, but no symptoms and no limitation in ordinary physical activity, e.g. no shortness of breath when walking, climbing stairs etc.
II	Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.
III	Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (20–100 m). Comfortable only at rest.
IV	Severe limitations. Experiences symptoms even while *at rest*. Mostly bedbound patients.

Table 1: NYHA Functional Classification - *(New York Heart Association 1994).*

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Not an RN Apologist!

Kim Carter

I had the unexpected but wonderful pleasure of receiving the NZCPHCN (NZNO) Tall Poppy Award at the College AGM and Symposium in Auckland in August 2017. This award is sponsored by College member Jane Ayling in recognition of nurses that have made a significant contribution to the profession and/or clinical practice. At the time I was a bit lost for words (unusual if you know me at all!) and felt overawed by the occasion to the point I was not able to string many words together in acknowledgment of this great honour.

I would like to rectify that now.

I want to thank colleague Wendy King (PHN, Thames) for nominating me and keeping this a secret for so long! I would also like to acknowledge Jane Ayling for her ongoing sponsorship of this award as a previous winner of it herself.

In thinking about this award and why it is given, I find it difficult to see my achievements as being those that would meet the high standards for which this award is presented. I see myself as a nurse who has been on the receiving end of amazing mentoring and coaching from outstanding role models throughout my career. Role models that have inspired my own leadership journey and had a huge influence on the person and professional I am today. I see anything that I have achieved as both a reflection of their investment in me and a culmination of all the learnings I have amassed in a long career working alongside wonderful colleagues.

For all those experiences and colleagues, I am very grateful and would like to sincerely thank them.

Since receiving the award, I have also been spending quite a bit of time contemplating where I am and what I have achieved in my career; and more importantly where I am going for my remaining working life. This award has made me consider my ongoing relevance in the workforce and what professional contribution I wish to make in the future.

I have realised that I am an RN who is happy and proud to be one. I have been nursing for nearly 30 years and work at an expert level in a primary health care setting. I have just completed a post graduate diploma in nursing and am interested in many things moving forward. What I am not interested in being is a nurse practitioner.

Because of my personal lack of interest in taking on an NP role I have a growing sense of frustration with the negative judgement I have felt over the past few years. This frustration is shared by many colleagues I have talked with and it is starting to feel like it might be yet another divisive reason that nurses use to cause separation from each other; as if we need more reasons! For example, at a recent RN meeting an academic faculty staff member presenting on the NP pathway showed a slide in her presentation that stated, “NP’s

have the brain of a doctor and the heart of a nurse". This is appallingly unhelpful and frankly offensive to both nurses and doctors. It reinforces stereotypes that nurses have suffered with for decades – made worse when perpetuated by other nurses and now used to divide us into the "smart nurses that are NP's" and the "kind but dumb ones that are RN's"!

Now I am not talking here about post graduate study as I support lifelong learning as a professional responsibility. I also mean no disrespect to my NP colleagues in any way. However, the current focus by academic, nursing management colleagues and others on the NP role as the pinnacle of nursing practice, seems like the formation of an intra-professional hierarchy in which being an RN is clearly thought to be no longer good enough. It is starting to feel like I must be an apologist for being an RN.

Pick up any journal, professional or organisational paper, workforce plan or strategy document and you will find a plethora of exhortations to the RN workforce to get on with the business of becoming an NP. Notwithstanding the tortuous road that the NP journey has been on for years (and still is!) to become recognised, accepted and imbedded in the workplace, we are told to aspire to the goal of advancing our practice to become NP's. Yet during this same time, I have not heard the same degree of exhortation made to RN's to be the best RN's they can be. Or the recognition that being an RN is not "settling" for less, or that it is perfectly acceptable to be an RN who is not planning to be an NP, or is not already an NP candidate.

Now, I am hugely supportive of advanced prescribing roles, the contribution they make and the answers they can provide to a stretched health care system. However, let's not have any confusion here. The NP and RN scopes are just different scopes that underpin different roles. One is no better than the other, nor is one required instead of the other. We need both! This is not an "either/or" argument. In talking with NP colleagues, it is very clear that to be able to incorporate investigation, diagnosis and prescribing into their practice as their new role requires, NP's often compromise the range of activities they undertook when they were RN's. However, these activities are some of the very essence of what our communities need most and RN's are good at delivering – care coordination, comfort, education, physical care and support. I am not saying NP's don't do these things, but let's be honest, from what I have observed they often struggle do them with the same limitations as their medical colleagues who have primarily got to get the investigating, diagnosing and prescribing work done first. And just like medical practitioners, NP's perform best when working *alongside* RN colleagues as part of a comprehensive service.

I hear from NP colleagues that their frustration at not being able to "complete" care often drove them to undertake the NP journey. Whilst I understand these frustrations, I think that if we were to invest as much time and effort into fixing the systems we work in as we have invested into developing the NP role, all RN's could practice to the full depth and breadth of what is our very enabling New Zealand scope of practice. We would then see an even greater bang for our buck in terms of the positive impact this investment would have across many thousands of RN's and not just a few hundred NP roles. It might also go a long way in resolving the frustrations nurses have around levels of autonomy, decision making and managing episodes of care.

For me, it is all about what I want to be doing, and what my community needs me to be doing. I don't work in an organisation that has service barriers in access to diagnosis, investigation or prescribing activity. The community and people we work with tell us this. However, what our community does tell us is that they experience issues around the planning, coordination and provision of older persons services, advanced care planning, long term condition education and support, screening and preventative healthcare, and hands on palliative care services. For these issues, the RN is often the clinical expert in the right place at the right time and is why these activities are where my colleagues and I focus our expertise and time. To do this, I utilise Standing Orders and work within a model of care that facilitates and does not hinder or limit my practice in any way. For me right now, the personal and organisational investment in the years of further education and supervised practice that it would take to register as an NP makes neither strategic or financial sense for my community, myself or my organisation. Especially when it won't improve the current efficiency and effectiveness of the way I deliver services within an integrated team to meet *my community's needs.*

Besides, becoming an NP is not as simple as myself or any other individual nurse making the decision to be an NP anyway. This journey requires workforce and employer structures, support, funding and system wide commitment that still is not (and has never been) adequately in place. NP candidates need employment security, a large amount of personal and financial resourcing, and at least one supportive long-term relationship with a medical or NP colleague before they even begin! Not a situation to be underestimated or embarked upon unless the benefits significantly outweigh the costs and risks. Costs and risks that are not just about individual nurses, but about what our communities, DHB's and country require from its workforce and are prepared to resource. In your area, perhaps there are issues around access to the kinds of services an NP can provide. In which case, I fully support the development and implementation of these roles. But like any other health discipline; none of us can provide 100% of what every patient requires, including an NP. We are all, or should be, one big team. Made up of diverse professions, scopes of practice and roles, with a wide range of strengths and skills. New Zealand needs all of us and more of us.

Thinking about my future as I approach the last third of my working life, I see that it is in fact a sound decision that I not pursue NP registration. After all, not being an NP hasn't stopped me from owning a general practice, participating at a regional and national level in various groups, teaching, mentoring, leading, working overseas for many years, or anything else I have done during my nursing career. Instead of being an NP, what I would love for my future is to continue to be part of making positive change around the systems and infrastructures of health, beyond my own general practice, and through this facilitate better practice environments for my RN colleagues.

What I would also like for the future is to hear the nursing profession start talking about "nursing" being an answer to the issues within the health, disability and social systems; rather than focussing on any specific nursing scope and role as *the* workforce solution. I think we need more than ever to minimise any intra-professional divisions and false

hierarchies and sell our profession and all its varied roles as a package deal. A package that offers a range of regulated professional nursing roles that when working together, can meet the needs of kiwi's, through their lifespan, in every setting.

Whatever the eventual make up of the nursing profession in terms of the numbers of NP's the balance will always be heavily weighted towards RN's. So, how about we spend an appropriately proportional amount of time celebrating and investing in those of us who work as RN's. Not because we are on the road to being something else, but because being an RN is a smart and wonderful thing all on its own, and something we don't need to apologise for.

Taking my own advice, I intend using the Tall Poppy Award cheque to celebrate more with the RNs I work with during 2018: Keeping good coffee flowing, acknowledging (through chocolate) our good work, and sponsoring our new graduate RN to conference!

Being a Designated Prescriber in the World of Diabetes

Sue Talbot

Diabetes CNS

South Canterbury District Health Board

Sue Talbot is employed as a Diabetes CNS, working for South Canterbury District Health Board. She works with people living with diabetes both in the Primary Health Care setting and as inpatients. She also works closely with health providers in both the community and hospital settings.

The Journey Begins

My prescribing journey began in 1997 when I commenced practice nursing in a semi-rural practice. My General Practitioner employer was supportive in my clinical skills development. Providing patient care was truly a team effort involving collaborative assessment, diagnosis, treatment planning and review. I often prepared prescriptions, ready for my employer to sign and I then documented the prescribed medication in the patient notes (before the use of computers in the workplace). While my employer always reviewed the prescriptions before signing, I felt it was my duty to ensure I understood what was being prescribed including the reason for prescribing, recommended dose range, possible side effects or interactions with other drugs along with monitoring recommendations.

Hence the start of my prescribing journey.

Diabetes can't be avoided

Not long into my role as a practice nurse, I recognised a need to extend my knowledge of diabetes. I had the sneaking suspicion that a lot of people living with diabetes coming to me for advice, actually had as much if not more knowledge of diabetes than I did! This left me feeling helpless. I also recognised that the number of people with diabetes in New Zealand was growing and not having enough diabetes knowledge was not an option. My first step was to complete a level 7 paper on managing diabetes in the adult. My thirst for knowledge continued and in 2015 I completed my Masters of Nursing.

I continued working as a practice nurse until 2011 when I was employed as a Diabetes Clinical Nurse Specialist (Diabetes CNS).

This role involves working with people with diabetes, their whanau and health providers, providing support and guidance. Living with diabetes is a 24/7 job, involving incorporating diabetes into daily living, monitoring of blood glucose levels and medication adjustment. It is not surprising people with diabetes know more about living with diabetes than health providers do!

Registered nurse prescribing provides the opportunity to enhance access to care while reducing the workload of medical staff. The required collaboration involved as part of being a designated prescriber enhances inter-professional relationships (MOH, n.d.). In November 2017 I became the first Designated RN Prescriber employed by South Canterbury District Health Board. I continue to have a very supportive Prescribing Supervisor who I meet with regularly to discuss clinical

cases, latest research and diabetes service development.

While continuing to work as part of a health provider team, the ability to prescribe in my own right has made my life easier and aided more timely affordable service delivery to clients. It gives me the ability to develop a plan of diabetes self-management that involves medication review and adjustment without requiring the authorisation of doctor or nurse practitioner. A typical day for me can involve a nurse led clinic, phone calls to and from women with gestational diabetes requiring blood glucose reviews and medication adjustment, advice to other health providers and consults with clients including those using insulin pumps reviewing blood glucose levels and alterations in insulin rates. In the past, any medication dose changes needed to be authorised by a prescriber and starting someone on a new diabetes-related medication was certainly not my role. This would lead to delays for the client.

People living with diabetes need to be supported to self-manage their diabetes and be an active participant in any health provider consult (Quality Standards for Diabetes Care Toolkit, 2014). Having the ability to prescribe is also a useful tool when promoting a patient centred approach, encouraging the client to be an active participant in the consult and leading the decision making regarding their own diabetes management. At the end of a consult, the client knows what the plan is, without having to wait for any proposed medication change to be authorised by a Physician.

Traps to prescribing

As a Designated Prescriber, a trap to be avoided is disempowering others. When discussing a medication change with a client, I attempt to contact their primary care provider, when appropriate, to make them aware of the planned change, enabling the opportunity to provide input into the decision making with client involvement. If this is not possible, a discussion at a later time is attempted and letter involving reasons for any change is forwarded to the health provider. A Designated Prescriber works as part of a team and needs to communicate to relevant health providers and seek guidance when a situation may be beyond their knowledge (Competencies for Nurse Prescribers, 2016). Continued support from my prescribing supervisor and a close working relationship with other prescribers enables me to meet this requirement.

With the first year of prescribing well under way I can only recommend the benefits to the client, nurse and other health providers. Timely and cost reduced resolution of health issues for clients, job satisfaction on my behalf and freeing up of Physician time have all been positive outcomes of my progression to the role as a Designated Prescriber.

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Nurse Prescribing: Improving Health Outcomes by Increasing Access to Health Care

Tasha Morris

With a longer living ageing population and increasing incidence of disease and complex co-morbidities there is an increased need for care that is holistic, team based and delivered as close to home as possible. Task distribution is increasingly being seen as a strategy for reducing current problems in primary health care. Health professional role extension and expansion and task redistribution is a common response to the growing demand for care. Governments here and overseas are seeing the shift of tasks from medical practitioners to nurse practitioners and nurse prescribers. The number of countries in which nurses are legally able to prescribe has grown considerably over the last 20 years and recent New Zealand Legislation changes mean that now suitably qualified health practitioners are able to carry out some activities that could previously only be able to be done by medical practitioners. For the health care consumer this has the advantage of quicker and more efficient access to medications and improvements in the efficiency and co-ordination of patient care. This also makes better use of the skills, knowledge and expertise of the qualified health care professionals. Since prescribing has traditionally been viewed as a medical role there may be some interprofessional boundary tensions with the introduction of non-medical prescribing. The support of other professionals – medical practitioners included is crucial for the success of this process. Improving access to health care is about delegation and working smarter and handing tasks over to suitably qualified people. GPs, nurses and health care assistances all working at the top of their scope. After all we are all working with the same goal in mind – that is to provide quality primary health care in a timely manner. There is more than enough work for all of us.

Notes from Nurse Executives New Zealand (NENZ) meeting held on 22nd March 2018 at the Ministry of Health (MoH), Wellington.

Attended and reported by
Emma Hickson

The two day meeting was a well-attended by lead nurses from around the country from all sectors of health. The Chair, Karyn Sangster led the meeting with guest attendees talking to a variety of topics which generated valuable discussion and thought provoking debate.

Visibility of Nursing Project

Eldred Gilbert presented the final version of the NZNO Strategy for Nursing 2018 – 2023 supported by Hilary Graham-Smith. Members were invited to the official launch of the strategy held 5-7pm at Travel Lodge. Follow the link to the Strategy for Nursing: http://www.nurses.org.nz/

Nurses successfully taking charge of information technology (IT)

Carey Campbell, Chief Nurse Southern Cross, presented her journey to inspire nurses to adopt IT in the workplace. Over the past 2 years she has implemented an electronic health care record in 22 hospitals across New Zealand. She shared some reflections and tips on how to make the challenges fun.

Legal update

Wendy Beverley focussed her presentation on the voluntary euthanasia bill and changes to the health practitioner's legislation that has enabled nurse practitioners to practice more autonomously. Some of the legislation still needs to be clarified on registered nurse roles especially in the areas of mental health.

Focus on nurse leaders

Four NENZ members shared their clinical context with the audience. Great presentations were provided by Lt Col. Lee Turner, Christine Maxwell, Rose Stewart, and Michael McIlhone. The presentations were well received by the audience and there was a request that the item could be a standard ifeature for future meetings.

Nga Manukura o Apopo

Margareth Broodkoorn shared the development of the Maori Nursing leadership programme. The programme has been awarded another 3 years of funding with its focus on workforce development for Maori nurses. The programme has supported a number of nurses to apply for more senior roles following completion of the course.

Primary Care Review and Federation

There was discussion on the proposed primary care review and the role of the National Nursing Organisation. Two NENZ members have been nominated to be involved in the primary care review.

There has also been a primary care federation establishment board formed, chaired by Annette King with one primary care nurse representative. There was discussion on how nursing could be more involved with cohesive voice and representation in these new decision groups. In addition the group discussed how to maximise the contribution of those representatives currently involved to enable full awareness of the many and complex issues that require representation. It was agreed that the representatives will need to provide strategic, operational, financial and clinical knowledge and that the consumer is missing from the initial establishment group. A sub group of NENZ of primary care nurse leaders agreed to write to Annette King to request increased nursing representation at the Primary care Federation table and Karyn sangster will liaise with the NNO and Chief Nurse to arrange further discussion.

Regional updates

Northern –northern region requested to host a governance training day. This will require funding from NENZ to reduce costs for members attending. Rachael Calverly will look at providers and their prices. There was support for northern region to progress with planning and an offer of spare places to other regions.

Central – 20 associate members. Good feedback from opening day to associate members as they found it valuable.

Southern – quarterly meetings continue. Associate members are happy with current southern NENZ position of inclusion in meetings. Regional approaches in progress for succession planning, transition to retirement, handling health concerns for an aging workforce. RN prescribing framework has been agreed regionally.

Suggestion to invite Sally Dobbs chair of NETS to the meeting in Christchurch as a guest and presenter. To develop closer links with our education partners.

Update from Office of the Chief Nurse

Jill Clendon is currently acting in the role of Chief Nurse. Jill discussed influenza immunisation requiring a proactive approach to get to the 80% target of health care professionals' immunisation. Vaccines will be distributed in April.

Raumei Lord was introduced to the group in her role as Senior Nursing Advisor for one year secondment. She will focus on the Maori nursing workforce.

Andy Simpson, Chief Medical Officer, MoH was introduced to the group. Both Jill and Andy described a strong commitment to work in partnership with clinical staff working across the Ministry.

Nursing Council of New Zealand

Jo Walton accompanied Carolyn Reed to the meeting. A restructure of the council was explained as was work on Internationally Qualified Nurse identity and verification of documents being provided prior to coming to NZ. Health Practitioner Competency Assurance Act is under review and submissions encouraged.

Other business

Christine Maxwell was nominated as the NENZ representative for Kaiawhina careerforce.

The Enrolled Nurse orientation framework will be made available on Ministry of Health website as well as the NENZ website to increase accessibility.

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 – Nurse Prescribing

1. The way forward: Expanded prescribing roles for nurses and midwives. Beadnell, Catherine. *Australian Nursing & Midwifery Journal*. Mar 2018, Vol. 25 Issue 8, p16-21. 6p.

The author discusses the possible prescription of medicines by nurses in Australia if they meet the requirements of their registration standards. Topics covered include the author's experience of having pain relief delivered to her niece via a nurse intervention, and the strong support for enhanced prescribing roles for nurses and midwives.

2. Antibiotic prescribing in primary care: The need for interprofessional collaboration. Courtenay, Molly; Carter, Sue; Rowbotham, Samantha & Peters, Sarah. *Journal of Interprofessional Care*. Jul 2015, Vol. 29 Issue 4, p404-405. 2p

This paper outlines a research study in which a questionnaire will be distributed to patients who consult with a nurse prescriber to see whether their expectations influence their satisfaction with the consultation outcome. Findings will guide the development of an interprofessional intervention designed to promote collaborative practice and appropriate and responsible antibiotic prescribing in primary care.

3. Navigating professional and prescribing boundaries: Implementing nurse prescribing in New Zealand. Lim, Anecita Gigi; North, Nicola & Shaw, John. *Nurse Education in Practice*; Kidlington Vol. 27, (Nov 2017): 1-6

This study explored the experiences and perspectives of one of the first cohorts of nurse prescribers and their strategies in establishing the role and negotiating the associated professional boundaries.

4. What Medicines Do Nurse Practitioners Prescribe in New Zealand? Weatherall, M; Zonneveld, R; Nelson, K & Poot, B. *Clinical Therapeutics*, suppl. S; Bridgewater Vol. 39, Iss. 8, (Aug 2017): e27-e28.

Nurse practitioners (NPs) in New Zealand (NZ) have been able to prescribe since 2001 and since 2014 have been able to prescribe from the full publicly funded pharmaceutical schedule. The aim of this study is to describe the characteristics of NPs who prescribe community-based medicines, describe the patients who receive prescriptions from NPs, and identify the most frequently prescribed medications.

5. Nurse prescribing leads to timely care. Manchester, Anne. *Kai Tiaki : Nursing New Zealand*; Wellington Vol. 22, Iss. 9, (Oct 2016): 30-31

Diabetes nurse specialist (DNS) Anne-Marie Frew has been working in Hutt Valley District Health Board's (DHB) diabetes nursing service for the past nine years. "Patients certainly appreciate knowing I can prescribe their medications on the spot, without them having

to make another appointment to see a doctor to get a prescription. They know the nurses are specialists in the diabetes field and they trust our prescribing decisions."

6. Learning to become a nurse prescriber in New Zealand using a constructivist approach: A narrative case study

Lim, Anecita Gigi; Honey, Michelle; North, Nicola & Shaw, John *Nursing Praxis in New Zealand*; Palmerston North Vol. 31, Iss. 3, (Nov 2015): 27-36.

Prescribing is no longer the sole purview of the medical profession as a wider group of health practitioners in New Zealand, including nurses, may now prescribe. This study aims to understand the experiences of postgraduate nurses learning to become nurse practitioner prescribers when undertaking courses that employed a constructivist pedagogical approach.

Articles – Respiratory Conditions

7. Adult asthma: what community nurses should know Pickstock, Shirley. *Journal of Community Nursing*; Stow on the Wold Vol. 32, Iss. 1, (Feb/Mar 2018): 48-51,53-54

This article focuses on the management of chronic adult asthma, at diagnosis, management, and briefly touches on assessment of the acute exacerbation. The key differences between the asthma guidelines of the British Thoracic Society/Scottish Intercollegiate Guidelines Network (BTS/SIGN, 2016) and the National Institute for Health and Care Excellence (NICE, 2017) guidelines, which are currently in use in the UK, are presented for reader consideration.

8. Respiratory health: Hormones hold the key Philpott, Leanne *PS Post Scrip*t, Jul 2017: 26-29

New research suggests that hormone levels may be implicated in asthma rates.

9. Healthy living: Children's respiratory issues: 'Will my child ever stop coughing?' Taitz, Jonny *PS Post Script*, Sep 2016: 30-[31]

The cooler months often see a rise in the presentation of long-lasting coughs, especially among young children. Consultant paediatrician Dr Jonny Taitz offers this advice about how to deal with them.

10. Home oxygen therapy assessment for COPD patients discharged from hospital: Respiratory NP Model of Care Hall, Toni *Australian Journal of Advanced Nursing*, The, Vol. 33, No. 4, Jun/Jul/Aug 2016: 17-25

The research aim was to examine the impact of the introduction of the Chronic Respiratory Disease Nurse Practitioner (CRD NP) Model of Care (MOC) on the assessment for short term oxygen therapy (STOT), provision of care, and patient outcomes for patients discharged with oxygen therapy post an acute exacerbation of chronic obstructive pulmonary disease (COPD).

Articles – Cardiology

11. Adherence to guidelines in patients with chronic heart failure in primary health care. By: Giezeman, Maaike; Arne, Mats; Theander, Kersti. *Scandinavian Journal of Primary Health Care*. Dec 2017, Vol. 35 Issue 4, p336-343. 8p

To describe adherence to international guidelines for chronic heart failure (CHF) management concerning diagnostics, pharmacological treatment and self-care behaviour in primary health care.

12. Does Simulation-Based Training Improve Procedural Skills of Beginners in Interventional Cardiology?--A Stratified Randomized Study.

Voelker, Wolfram; Petri, Nils; Tönissen, Christoph; Störk, Stefan; Birkemeyer, Ralf; Kaiser, Erhard; Oberhoff, Martin *Journal of Interventional Cardiology*, Feb 2016; 29(1): 75-82. 8p

Objective: To assess whether mentored simulation-based-training can improve the procedural skills of beginners in coronary interventional procedures. Simulation based-catheter training is a valuable tool to practice interventional procedures. Whether this type of training enhances the procedural skills of fellows learning percutaneous coronary interventions has never been studied.

NZNO Library

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