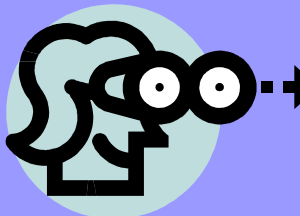


Primary Health Care Nurse Newsletter

Volume 19

October 2010

Index	Page
Sharon Kirkpatrick	1
Colorectal cancer	2
Acute rheumatic fever	3
Practice nurse accreditation	4
PHCN College	5
Draft Guideline for competence assessment	6
SMBG	6
White Ribbon Day	7
Health Workforce NZ	7
Training opportunities	7



Sharon Kirkpatrick

For the past three years I have been employed as a well child/tamariki ora nurse for Te Hauora o Turanganui a Kiwa (Turanga Health). In these three years Turanga Health has supported my journey from Bachelor of Nursing to Master of Nursing with the final completion of my thesis in June 2010 passing with distinction and a mark of A-. The research entitled: *"Nurses' perceptions of the Implementation of the Before School Check Programme in Hawke's Bay"* aimed to explore nurses' perceptions of implementing the programme in order to identify any issues that arose from the implementation of the programme. Nurses' solutions and strategies to resolve these issues were also explored.



Overall, participants were very positive about the programme and perceived that parents were also. Key issues identified included: administrative and referral processes; nurses' knowledge base and the need for, ongoing training and professional support; issues for the self employed provider; communication and language barriers; and under-served populations. Recommendations were made based on the key findings and areas of possible further research are discussed.

My interest in this research was because the B4SC is an important area for child health and an area that I have a strong interest in and have been part of since September 2008 when the programme began in our region. Although the research project was specific to Hawke's Bay, the findings may be useful for other areas as well. In particular, it has given me insight into issues and possible solutions to enhance my own delivery of the B4SC programme, since as nurses we are always striving to deliver quality care.

This thesis was conducted independently of, but in conjunction with, a large regional evaluation led by principal investigators Professor Morris Mathews (EIT- Hawke's Bay) and Community Pediatrician Dr Wills (Hawke's Bay District Health Board) for the Hawke's Bay Children's Holdings Trust entitled: *Evaluation of the Child Health Outcomes in relation to the implementation of the Before School Check in Hawke's Bay*. The key findings from this thesis have been shared with the evaluation team for them to use as appropriate for the wider evaluation. Professor Morris Mathews presented the evaluation report at the end of June 2010 to the B4SC Clinical Advisory group members. The findings of this thesis will also inform the members in their respective areas of responsibility in relation to the evaluation. Professor Mathews has stated that "After full consultation, the relevant findings of my thesis to child health outcomes will be

included in the larger study and will be fully acknowledged and appropriately referenced in the report and in any subsequent publications”.

Once again, I would like to acknowledge my workplace; Te Hauora o Turanganui a Kiwa for supporting and allowing me to complete the Master of Nursing. A big thank you goes to my supervisors, the nurses that participated, work colleagues, friends, family and all those whom I have forgotten to mention and a special thanks to my mum.

Evidence base for the referral and investigation of colorectal cancer in primary care

Last year the New Zealand Guidelines Group published *Suspected Cancer in Primary Care: Guidelines for referral and reducing ethnic disparities*. The guidelines were developed to support primary care practitioners to recognise the signs and symptoms that are suggestive of cancer, refer people in a timely manner and be aware of the investigations that may be appropriately undertaken within the primary care setting. The recommendations for suspected colorectal cancer in primary care were based on nine bodies of evidence. The National Institute for Health and Clinical Excellence (NICE) produced a set of guidelines for the referral of suspected cancer, including lower gastrointestinal cancer, in 2005.

- A person aged 40 years and older reporting rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting for 6 weeks or more should be referred urgently to a specialist*
- A person aged 60 years and older with rectal bleeding persisting for 6 weeks or more without a change in bowel habit and without anal symptoms should be referred urgently to a specialist*
- A person aged 60 years and older with a change in bowel habit to looser stools and /or more frequent stools persisting for 6 weeks or more without rectal bleeding should be referred urgently to a specialist*
- A person presenting with a palpable rectal mass (intraluminal and not pelvic), should be referred urgently to a specialist, irrespective of age. Note that a pelvic mass outside the bowel should be referred urgently to a urologist or gynaecologist*
- A man of any age with unexplained iron deficiency anaemia and a haemoglobin of 110g/L or below, should be referred urgently to a specialist* Unexplained iron deficiency anaemia means unrelated to other sources of blood loss, for example, non-steroidal anti-inflammatory drug treatment or blood dyscrasia
- A non-menstruating woman with unexplained iron deficiency anaemia and a haemoglobin of 100g/L or below, should be referred urgently to a specialist* Unexplained iron deficiency anaemia means unrelated to other sources of blood loss, for example, non-steroidal anti-inflammatory drug treatment or blood dyscrasia
- A person presenting with a right-sided abdominal mass, should be referred urgently for a surgical opinion
- A menstruating woman with unexplained iron deficiency anaemia* and a haemoglobin of 100g/L or below, should be referred urgently to a specialist
- Unexplained iron deficiency anaemia means unrelated to other sources of blood loss, for example, heavy menstrual bleeding, non-steroidal anti-inflammatory drug treatment or blood dyscrasia New Zealand Evidence-based Health Care Bulletin August 2010 Vol. 11 No.4 6

Acute rheumatic fever (ARF)



Acute rheumatic fever and its sequela rheumatic heart disease are potentially life-limiting and life-threatening conditions and are preventable. Current rates in New Zealand Māori and Pacific populations are unacceptably high, mimicking those seen in Denmark in the 1940s, and are of developing world proportions. Extremely high rates of rheumatic fever were recorded on the East Coast of the North Island in the 1960's. Whilst there has been a significant downward trend in case the rates remain unacceptably high for Maori in Tairāwhiti.

Acute rheumatic fever is an inflammatory disease of the heart, joints, central nervous system, and subcutaneous tissues that develops after an upper respiratory tract infection from a group A beta-haemolytic streptococci A (Ministry of Health, MOH, 1997). Rheumatic fever potentially involves all layers of the heart: the endocardium, myocardium and pericardium (Lewis, Heitkemper & Dirkson, 2000). The resulting damage to the heart from acute rheumatic fever is known as rheumatic heart disease, this chronic condition characterised by scarring and deformity of the heart valves.

Rheumatic fever is sequel only after a tonsillopharyngitis streptococcal episode, never a streptococcal pyoderma or impetigo (Kaplan, 1998; Lewis et al, 2000). It is estimated that this occurs in up to 3% of sporadic upper respiratory infection from this bacteria. All attacks of rheumatic fever follow a streptococcal infection, however only a few streptococcal infections are followed by rheumatic fever. The latent period between the streptococcal infection and the onset of rheumatic fever symptoms ranges between 1 – 5 weeks. The average latent time frame is 19 days for both the initial attack and subsequent attacks (Goldman & Bennett, 2000).

Certain features of the streptococcal infection are associated with an increased risk of acute rheumatic fever. It is more likely to occur after a severe exudative pharyngitis rather than a mild case. In addition, initial and recurrent episodes of acute rheumatic fever occur most commonly between the ages of six through to fifteen years of age (Lewis et al, 2000). It is estimated a third of acute rheumatic fever patients have had an asymptomatic or mild illness prior that it was forgotten.

The 'at risk' groups for developing rheumatic fever include school-aged children, especially in the 10 – 14 year age group. This is then followed by the 5 – 9 year olds, and then by the 15-19 year age group (Durham, 1995). Children, living in a high endemic area as well as those with a family history of rheumatic fever are especially at risk (Lichfield 1991). This familial tendency towards rheumatic fever is thought to be genetically determined possibly leading to an altered immune response (Lewis et al, 2000; McCance & Huether, 2002). People with a history of acute rheumatic fever have a greater risk of recurrence following a streptococcal pharyngitis. This risk declines with advancing age and the increasing interval since the most recent attack (Goldman & Bennett, 2000).

Acute rheumatic fever is a preventable disease that occurs in some people following a Group A Streptococcal throat infection. Sore throats are a frequent reason for presentation to primary health care accounting for 4-5% of all presentations in two New Zealand studies. Appropriate antibiotic treatment of sore throats in high risk populations will eradicate Group A Streptococcal in most cases, and prevent individual cases of acute rheumatic fever and subsequent heart valve damage and chronic RHD. In addition, secondary prevention via regular penicillin prophylaxis reduces the risk of recurrent acute rheumatic fever, hospitalisation, surgery, and severe rheumatic heart disease and improves quality of life.

There is currently a push to eradicate this disease in our community which experiences high numbers of acute rheumatic fever cases. You will be kept informed of the activities as they are rolled out.



Be not afraid of growing slowly be afraid only of standing still

Chinese Proverb



Practice Nurse Accreditation (Taken from NZNO webpage: www.nzno.org.nz)

Accreditation is the NZ College of Practice Nurses recognition that a nurse has met the College's standards of practice for practice nurses and continues to undertake professional development.

- Accreditation renewal occurs after 5 years.
- Application can be made at 2 levels: **Proficient** and **Expert**.
- Application is by written portfolio following the criteria set out in the [Accreditation Manual](#).
- Over 500 practice nurses have been accredited over the last 14 years.
- Applications close last day of March and August each year, late applications will be held over until the next meeting.

Initially the Accreditation process may seem overwhelming; however those who undertake the process find it affirming.

Accreditation Manual

Accreditation manuals can be purchased from the NZNO National Office:

NZNO Members free member only download* (doc) or \$15.00 for a hard copy

You will need to login on NZNO webpage as a member first to gain access to the download. To log in see the top right hand corner of the screen.

Non NZNO Member - \$25.00

Background

The New Zealand Nurses Organisation fosters professional accountability for qualified nurses. An important component to accountability is the ongoing maintenance and development of professional knowledge and skills within a speciality area of nursing practice. Accreditation is proactive and provides positive direction. It is not intended as punitive process.

The purpose of the [Accreditation Manual](#) is to provide information and guidance to applicants on accreditation. Practice Nurse Accreditation was developed by NZNO practice nurses for practice nurses. The model was trialled from the period 1996 - 1998 and, following extensive evaluation and review, was confirmed by the NZNO National Practice Section Committee in September 1998.

To order or view these documents please see the NZNO publications web pages for details



Have you joined yet?



Have you joined the College of Primary Health Care Nurses yet? The New Zealand College of Primary Health Care Nurses NZNO is a specialty, professional group of NZNO, dedicated to the provision of leadership, support, education and professional development of Primary Health Care Nurses in New Zealand.

If you meet the following criteria and would like to join the college please use the form below:

- A Primary Health Nurse working in a Primary Health Care Setting
- A Nurse involved in education and professional development of Primary Health Care Nursing
- A financial member of NZNO

Membership benefits include:

- Being part of a Specialty Nursing group with a Primary Health Care focus providing leadership and strategic direction
- Access to professional standards of practice, position description, PDRPs etc.
- Representation at regional and national policy and decision making forums with feedback to members
- Regular contact through Regional and National virtual groups
- Networking through Regional forums
- An excellent Journal
- Annual Conference at a discount cost
- Scholarships and awards
- Industrial strength
- The opportunity to have your say as to your future in nursing
- Full access to the College website



2010-08+Membershi
p+form+CPHCN1.pdf

Please note there is a fee of \$25 per annum to join.

You will be kept updated on progress within the College through this newsletter and on the NZNO website.

Joke



Bad Diet

A man goes to the doctor with a cucumber in his left ear, a carrot in his right ear, and a banana up his nose.

"Doctor, what's wrong with me?" the man says.

"You're not eating properly" replies the doctor.

Nursing Council's (NC) Guideline for Competence Assessment

Attached is a draft copy of the Nursing Council's (NC) Guideline for Competence Assessment that is out for consultation. This draft guideline is designed to provide more information about the process of assessment.

The Council is increasingly using competence assessment as a tool for ensuring initial and ongoing competence to practice. The Council is aware that there is some lack of understanding of this process and variability in the way competence assessments are completed. This draft guideline is designed to provide more information about the process of assessment.

If you would like to comment on this draft *Guideline* please return your response to Jackie@nursingcouncil.org.nz or alternatively post it by **22 October 2010** to:

Jackie Turvey
Professional Standards Facilitator
Nursing Council of New Zealand
PO Box 9644, Wellington 6141



Draft_Guideline_Com
petence_Assessment

If you are unable to open this you can download a copy from the website:
<http://www.nursingcouncil.org.nz> and look under latest news



THANK
YOU

A very big thank you to all you lovely nurses that contributed to my research through the focus groups and individual interviews.

I really appreciated your input. I have got some fabulous information that I am currently in the process of analysing

Heather Robertson

Self monitoring of blood glucose (SMBG) (taken from better medicine annual report)

Self monitoring of blood glucose is an important component in the management of people **with** insulin dependant diabetes. It is **NOT** recommended in the management of people who are controlled by diet and metformin alone. There is an increasing body of evidence showing the lack of benefits in this group of people and is associated with higher costs and a lower quality of life.

Sometimes newly diagnosed patients might benefit from a short period of self monitoring of blood glucose to increase the awareness of the effect of diet on blood glucose levels. But there are no benefits for doing this long term.





White Ribbon offers men the opportunity to be part of the solution to end violence against women. White Ribbon day is an annual event which promotes the message that “Family violence is not OK!”

Violence is endemic within New Zealand. One in three women are victims of violence from a partner, while on average fourteen women are killed each year by a member of their own family.

White Ribbon is a campaign led by men who condemn violence against women and take action and are part of a global campaign committed to ending violence against women. You can help effect change by supporting White Ribbon. Wearing a white ribbon is a personal pledge to never commit, condone or remain silent about violence against women.

Health Workforce New Zealand (HWNZ) (CTA)

Health Workforce New Zealand (HWNZ), previously known as Clinical Training Agency (CTA), funds Postgraduate Nursing studies. This funding enables registered nurses employed by either a DHB or a health service funded by the DHB non-provider arm or the Ministry of Health, to access funding for postgraduate studies.

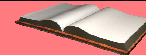
Health Workforce New Zealand (HWNZ) (CTA) funding applications are now available on HWNZ link on the TAIMNED website: www.taimned.co.nz where you can find the application form and additional information related to HWNZ

The funding covers funds for tuition fees, a subsidy for travel and accommodation, clinical release and supervision if required and relates to Postgraduate certificates, diplomas and clinical masters degrees.

On the TAIMNED website check out the Educational links page where you will find listed some of the Tertiary Institutions that provide Postgraduate Nursing study. You will be able to find a range of papers suited to your requirements and give you background to study options.

The close off date for applications to be received by Nursing and Quality services is **November 5th 2010** – no exceptions so get your applications in early.

Training / Education



Online smoking cessation training

The easiest way to register as a Quit Card provider is to complete the online e-learning tool: Smoking Cessation ABC, <https://smokingcessationabc.org.nz/> which provides the basics of ABC, and on completion, HCPs can register on-line to become Quit Card providers. The tool takes between 30 and 40 minutes to complete.





Two day PRECEPTORSHIP WORKSHOP

Date: Thursday 28th – Friday 29th October 2010

Time: 8.30am – 4.30pm

Venue: Gisborne Hospital Conference Room

This two day course is suitable for those who have never had any preceptor training and those wanting a comprehensive update.

The aim of the workshop will be for course participants to increase their understanding of the various components of the preceptor role.

Workshop Covers:

- ✚ *Defining preceptorship*
- ✚ *Socialisation*
- ✚ *Adult learning and teaching principles*
- ✚ *Assessment*
- ✚ *Feedback and communication*
- ✚ *Conflict management*

REGISTRATION IS ESSENTIAL

Please email: Candy.Hauiti@tdh.org.nz or call Candy extn 8034 to register

Any Enquires about this workshop please contact: Jane Wilkie

Phone 869 0500 ext 8300 or email Jane.Wilkie@tdh.org.nz

Expressions of interest sought

Are you interested in undertaking the 5 day diabetes training here in Gisborne in Feb 2011?
This is the Waikato course and will only be run if we have sufficient numbers

If yes please contact Robyn Dymock: Robyn.Dymock@tdh.org.nz

Remember - If you would like to put an article in the newsletter (could be an abstract of an assignment you have completed), achieved a postgraduate qualification, advertise a new service, have a nurse start or leave your organisation, or have a comment please email to Heather Robertson: Heather.Robertson@tdh.org.nz

**Until the next newsletter keep safe and well.
Me te whakaaro nui (with kind thoughts)**

