# TE PUAWAI

## *The Blossoming*

**The Professional Update for Registered Nurses**

**October 2017**

# TE PUAWAI

*The Blossoming*

## Whakatauki

***Kia tiaho kia puawai te maramatanga***

***"The illumination and blossoming***

***of enlightenment"***

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

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**College of Nurses Aotearoa (NZ) Inc**

**PO Box 1258, Palmerston North 4440**

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# Contents

# Editorial

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

*Professor Jenny Carryer*

As College members will recall, in April this year, under the banner of the National Nursing Organisation (NNO) groups and in partnership with the Nursing Advisory Group to Health Workforce New Zealand (HWNZ), a strategy day was held for invited sector leaders to consider the future of health services and nursing's role in shaping these.

The day focused on two questions:

1. By 2030; guided by the New Zealand Health Strategy, what would good look like?
2. What will nursing need to do differently to achieve getting to 'good'?

The day was extensively written up and a long document issued to all attendees reporting the findings of the day. The national nurse leaders group have now considered the findings and are beginning work on a strategic plan in order to action the way forward.

At the workshop participants talked (amongst many other important issues) about the need for a united voice….. as nursing always does. Nursing in my view at leadership level is strongly united but I am more interested in the notion of what our "voice" would actually say. It also begs the question whose voice? And who should nursing be united with other than each other?

The consensus from the workshops was that consumers are an obvious partner. As we know from history, midwives were able to reclaim the territory of birth in partnership with women through concerted work with pregnant women and women's health groups. In so doing they raised women's awareness of the value of midwifery and ensured that midwives themselves were fully informed as to what women wanted and needed.

There is much to be said for the power of consumer partnerships. First and most important is the absolute need to fully understand what it is people want and to what extent we are meeting their needs currently. This should be the only way in which we shape our service delivery.

Nursing's call for greater input into policy direction and service design is often interpreted or heard as self-interest. A CEO once famously described it to me as "nursing's empire building" which I found both very funny and very sad. It has proved seemingly impossible for funders and planners and policy makers to accept that nursing makes a huge difference to patient outcomes and to community health when it is resourced and able to flourish. The notion persists that nursing is a

cost to be rigorously pruned rather than a resource to be carefully nurtured. The only way through this conundrum in my view is to ensure that our voices are strongly informed by and clearly partnered with our many consumer groups. Because nursing is so vast in its diversity of areas of practice this is a challenging undertaking but one which I consider to be extremely important.

We need to start small and build up so that we are gaining mutual awareness and enlightenment at both local and national strategic level. We could begin by taking any opportunity to hold small focus groups wherein we meet with our patients or clients and ask them to tell us what we need to hear. I suspect that much would develop from that point. We need to work out how to share what we have learnt in wider forums and also move to forming structured partnerships with formal consumer organisations. I think this exercise will be a lengthy one but I suggest it could well be mutually transformative.

If we were really to hear what patients think I suspect we would not be so able to passively and often silently accept current levels of care rationing, or the fragmented and poorly co-ordinated service that many people are receiving.

I would really like to hear the outcomes of any such endeavours.

# College Scholarship Awards

The Board of the College of Nurses Aotearoa (NZ) is very pleased to make available a small number of Scholarships to **College of Nurses members**.

Applicants may apply for a scholarship to support: conference attendance, specialist study programs, innovative projects or further academic study after a completed masters' degree.

An application form has been e-mailed to each College member. Applications close with the College of Nurses office at 4.00pm on 8 December 2017.

Posted applications are to be addressed to: The Administrator, College of Nurses, PO Box 1258, Palmerston North 4440 or applications can be submitted via e-mail to: admin@nurse.org.nz

# BUURTZORG / NEIGHBOURHOOD-CARE:
## The Dutch model of community care which has gone global

**Marian Weststrate**
**Registered Nurse (NZ & Netherlands)**
www.care-metric.com

'An innovative nursing model cuts bureaucracy and gives nurses more freedom and time with clients.'(1)


**How it came to be**

In 2006, Jos de Blok, a Registered Nurse (RN), Director and CEO, from Almelo, in the Netherlands, working at the board of a large healthcare provider, became disappointed in the 'overly professionalized care-system', which, in his opinion, was largely driven by managers and financiers who were unaware of the real issues faced on the frontline. In his managerial experience, the main contacts for board members were those in their own networks in similar roles. This widened the gap between health care managers and health care workers. His frustration grew in regards to the gap between people at the top and people at the frontline, with too many rules and regulations. In his view this took away job satisfaction for employees and optimal care for patients.

Jos, together with his wife Gonnie, decided to walk-the-talk and BUURTZORG was born. Starting with 4 employees, they formed a self-governing organisation, which delivered holistic patient centred care, revolutionising community care in the Netherlands. The organisation now has approximately 10,000 employees who look after a clientele of around 80,000 people. Their turnover is estimated at 300 million Euro per year(2) Both patients and employees appear to be very pleased with this model as they continue to score 'sky-high'; a 9.1 average in satisfaction surveys.

In 2014, Jos de Blok received the prestigious award of the 'Albert Medal' from the Royal Society of Arts and was chosen five times as the employer of the year. Today countries including Japan, Sweden, Germany, Belgium, Taiwan, South Korea, Austria, Unites States of America, Great Britain and China are following the example. (3)

**BUURTZORG:**

**What makes this model so powerful and what is it?**

This model creates 'space'. It can be described as a 'flat' model of delivering integrated care for patients at home, enabling then to maintain their autonomy and independence as long as possible(4). It is driven by self-governing independent teams of experienced Registered Nurses (RN) and Enrolled Nurses (EN). Each team has 8 to 12 employees who are responsible for an average of 40 – 60 people within a particular area. They keep themselves up to date with professional education and they act as a health coach and plan their own rosters according to the needs of patients and their personal needs. It is the nurse's own responsibility, to provide the care and run the team. This unleashes their entrepreneurial creativity. They arrange and furnish their own office. They work closely with patients' General Practitioners (GP) and the wider multi-disciplinary team. Sixty one percent of the nursing time is spent in direct contact with the patient. A patient's care package is not subdivided into tasks, as Jos de Blok notes: 'From cleaning to dressing a wound, or from giving injections to helping them with their pressure stockings, it is one moment'(5). It is a holistic approach.

This is a not -for-profit organisation, with an important social mission: To change and improve the delivery and quality of home health care through the leadership and collaboration of the district nurse (DN), allowing the individual to receive the kind of care they most need, where they most want it, and thus avoid costlier institutional care for a long as possible.' Jos de Blok states: 'I am not interested in money, I see so many people searching for a new way of doing things in all the places I visit. It's all about creating something different from the bottom up'.(1)

**How does it work?**

Patients and their families can choose their own care-provider. Costs are covered by the insurance company, depending on their package of care. If they choose BUURTZORG, an initial assessment is completed by a BUURTZORG RN. They coach the patient and family / carer to find an innovative solution for optimal patient care. They look into the current needs and potential future needs then decide which person in the team is most suitable to deliver the care.

There is an administrative team of approximately 50 people and 20 trainers to provide administrative and employee support. They pay or receive payments from the competing health insurance companies. The District Nursing team provides the

*Dutch district nurses ' on yer bike' no big bags to drag along*

administration team with their register of hours worked per client. Each patient has their own supplies, such as dressings, at home. Their care and supply is partially or fully funded by the health insurance company. In the Netherlands, there is no National Health Insurance but several competing health insurance companies. It is compulsory for all Dutch citizens to be insured, the fee goes straight from their salary to the Insurance company of their choice, the health insurance companies are paying the cost per client to the employer.

Being an example is crucial!

A change of attitude does not happen overnight. So, it is for BUURTZORG. By looking back over 10 years there has been a degree of trial and error. Jos de Blok states: '*Whenever you think of changing an organisation, you have to realise: it is like a pregnancy. You are or you are not pregnant.(7) It does not come easy. It requests a complete culture change in delivering care, with the necessary ingredients: Vision, Commitment, Self-control, Perseverance. Executives and management need to support the nursing professionals in the choices they make. Errors should be 'learning points' and not called 'mistakes' and they need the space to find better solutions to their questions. If the team is to take over a roster, they should be given the space to do so, or if they decide to use certain interventions, given the appropriate funding. A realistic time frame for the change process should be secured, to accommodate for the time needed to embed culture changes. It should not stop if there is a change in management*.

**Cost-effectiveness**

KPMG International completed a report in 2015.(6) (8) KPMG assessed 600 home care organisations, all of them with 20 or more clients. They made a comparison of quality and costs. One of them was BUURTZORG. The health insurance companies were curious to find if the experiment with less 'Red tape-rules- zones' would lead to different outcomes. The insurance companies expected that, when DN's self-determine hours of care per patient, this would lead to more hours. However, the report showed the opposite. The outcome was that, although the care might be costlier per hour than under a traditional approach, it was of higher quality and considered preferable for those receiving the care. Crucially, only half as much time for care was typically required.

The KPMG report also stopped the ongoing discussion between insurance companies regarding the question of cost-effectiveness of BUURTZORG. Some insurance companies claimed that BUURTZORG would be more cost-effective if they lowered the hourly rates of their employees. BUURTZORG is one of the highest with an average tariff of 54.47 euro per hour, whilst the hourly rate in other care facility organisations is around 48.74 euro. Yet, BUURTZORG compensates this relatively high tariff by requiring one-third less hours per client. They deliver an average of 108 hours per client against 168 hours per client country wide[(6)]

This is a confirmation that self-governing nursing teams succeed and can lead to additional useful outcomes. BUURTZORG CEO, Jos de Blok(6)states '*We work with highly qualified RN's and EN's. Their approach and judgement towards problems from a wider angle leads to solutions which empowers them and enhances their self-reliance skills. As we spend less time with our clients, it saves us circa 3000 euros per clients".*

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NB: This article is a compilation of published Dutch and English articles
www.Buurtzorg.com


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*Moving House or Changing Job*
Please remember to update your contact details with the College office.
Email: admin@nurse.org.nz

# Programme Healthcare study tour to the Netherlands: 16-20 April 2018

A brief information:

**Care-Metric** in collaboration with **Van Maar Advies** is organising it's second Healthcare Study Tour to the Netherlands. This tour provides you the opportunity to observe a variety of innovative healthcare projects and encourages you 'think outside the box' to discover solutions for the healthcare issues you are currently facing. The focus of the week will be on the frail elderly. A different healthcare system might give you suggestions that otherwise you would never have considered. In the week we will visit the following places.

**Dementia Care Villages** 'De Hogeweijk' in Weesp (near Amsterdam): A village type rest home especially designed for Dutch citizens with severe dementia. This model is currently replicated in Rotorua.
Also "De Herbergier" a small scale care environment for people with dementia. **Dr Frans Hoogeveen** will talk us through how care is delivered, building design principles, staff education etc.

**BUURTZORG**. An innovative care model that uses a flat organisational structure of self-governing community nurses, and which has attracted international attention and interest.

BUURTZORG
neighborhood care

**Meeting Prof. Guus Schrijvers and Dr. Wim Schellekens.** Prof. Guus Schrijvers is a Health Economist and founder of the International Foundation of Integrated Care. Recently published his book entitled 'Integrated care- better and cheaper'. Dr. Wim Schellekens is former CEO of the Dutch Institute for Quality Improvement and Chief Inspector of Curative Health Care at the Dutch Health Care Inspectorate. His focus will be on how the quality of care is maintained within the Dutch Healthcare system.

**Visiting ACHMEA**, one of the largest Healthcare Insurance Organisations, to get an understanding of how health care is financed in the Netherlands.

**Visiting St Elisabeth Gasthuis Hospital** in Tilburg to hear about their innovative program "Menslievende zorg" (people loving care).

**Visiting The Dutch Health Inspectorate** who oversees the quality of care provided by all healthcare facilities.

**Visiting VILANS**, the national Quality Improvement institute for the Aged Care sector for the Netherlands.

Vilans

**Visiting the New Zealand Embassy** to share your experience with the New Zealand Ambassador in The Hague.

The costs of the study tour is NZ$ 4995.00 (Excl. GST). This excludes travel to and from the Netherlands, hotel and meal costs. It includes payment for the visits, speakers and transport during the week. We can book a hotel for a reduced price for 6 nights, most likely it will be: Van der Valk Hotel / Breukelen. This hotel has excellent train connections to Amsterdam and Utrecht. The price includes breakfast, WIFI, use of swimming pool, fitness centre and sauna. You are free to stay at another location, yet this means you have to take care for your transport to and from this hotel.

When you want to take part in this Study Tour or are intersted to take part please email **marian@care-metric.com or call us at 021897605**

# CHT Hillcrest - Gardening Project

**Tuttu Mathew RN, Manager, CHT Hillcrest**

*Tuttu Mathew, Manager, CHT Hillcrest*

CHT was established in 1962 and originally known as Christian Healthcare Trust. It has since become a leading provider of residential aged care in the upper North Island, with facilities that reflect a sense of home for residents. As a charitable trust CHT reinvests all financial surpluses back into facilities and services with 16 locations throughout Auckland, Waikato and the Bay of Plenty.

CHT Hillcrest is situated in the heart of Mangere, and has 60 beds providing care for rest home and hospital level residents with a separate 20 bed dementia care unit for those who require a more secure environment.

I am a Registered Nurse having trained in India before moving to New Zealand in 2012. I am working towards completion of Post Graduate Diploma in Health Service Management. I started my career in New Zealand as a Registered Nurse at CHT Hillcrest in 2012, where I worked for 2 years before being appointed as the Clinical Co-ordinator in 2014. In the same year, I was appointed as the Unit Manager at CHT Hillcrest. As a Unit Manager, I provide business, clinical and nursing leadership to the unit to achieve clinical, quality, revenue and cost goals and targets.

My challenge during the last 3 years was addressing the shortfall in the residents activities programme and to remedy the lack of community involvement in the facility. My main goals were to enhance the quality of life for my residents through quality initiatives and through community participation. The Gardening project was one of the initiatives introduced to improve the quality of life of the residents.

From a nursing focus, the goals were to promote activities for residents and improve the resident's social relationships. The other goals of the programme were;

- To provide an opportunity for the residents to continue to contribute to their community.
- To involve the local community in the activities programme and to encourage children to participate in the daily activities of the unit.
- To bring children together with the elderly and to encourage the older people to share their knowledge, valuing their experience.
- To grow healthy organic vegetables and to assist in educating children about the nutritional and health benefits of vegetables.
- To encourage residents to become more active by providing an opportunity to take up gardening.

The original idea of the Gardening project was to have school children visit Hillcrest and garden with our residents. Once the vegetables were grown we aimed to donate the produce to the local community food banks.

We set up 2 raised garden beds in the CHT Hillcrest gardens and ordered vegetable mix soil & seedlings. We then approached Jean Batten School at Mangere who were happy to be a part of our project. When the garden beds were ready, our residents and children planted the seedlings together. Residents who were not able to join the planting enjoyed watching from the lounge. The CHT gardener provided information on growing seasonal vegetables and CHT activity coordinators educated children about the nutritional & health benefits of the vegetables we were planting. Recently, the kindergarten, Nga Kākano O Te Manuka has become a part of our gardening project. The children & students from Nga Kākano O Te Manuka recently visited Hillcrest to do harvesting and the children will be visiting Hillcrest once a month to be a part of the project.

The children visit CHT Hillcrest every fortnight for an hour, to take care of the garden beds along with the residents. Two groups of Children from Jean Batten School participated in the project. The residents really enjoyed the visits. The children read books to the residents and are involved in the daily activities of the unit during their spare time while at the site. We provided refreshments, water bottles and badges as a token of our appreciation of their input.

After a few months, residents & children harvested the vegetables. After each harvest, we planted more vegetables. To date we have done 13 harvestings with all the harvested produce donated to Manukau Salvation Army food bank and Te Puea Memorial Marae, who supply food for homeless people in the Mangere community. The vegetables we harvested include silver beet, carrots, beetroot, sweet peas, beans, peas, zucchini, courgettes, strawberries, chives, parsley, tomatoes, capsicum, chillies, lettuce, broccoli, rock melon, basil, capsicum, bok choy, and so on.

The residents love this project, many of them had their own gardens, so being involved again in gardening, brings joy back into their lives as they can do things they used to do when they were more physically able. The residents feel valued and respected when they are able to contribute to their community. They all had a great knowledge of how to grow and harvest vegetables. Residents can now take a walk to the garden and pick a couple of strawberries for a snack. We are

slowly expanding the garden, soon we will have more fruit trees, passionfruit and grapes.

The teachers of Jean Batten School & Nga Kākano O Te Manuka gave feedback indicating the project was a valuable educational experience for the children. This project also gave the residents an opportunity to spend time with the children which improved their mood and gave the residents something to look forward to every month. The food banks appreciated the project and thanked CHT Hillcrest for providing them with fresh organic veggies. A few residents became motivated to start a planter box outside their rooms. We continue to support residents to take up gardening.

This project has enhanced the quality of life of our residents, providing an opportunity for the residents to enjoy the outdoor environment, fresh air, warm sunshine and a natural surrounding. Gardening involves exercise and promotes resident's independence and physical functioning. We have a few residents with no family or visitors and they enjoyed seeing the children around them as it reminds them of their own children and grandchildren, making the visits from the children something to look forward to.

The residents and students took care of the garden together and it was one of the main activities in the unit to promote quality of life of our residents. There is meaning in life when we can continue to contribute to the community even in a small way and that is what we tried to achieve through this project. We achieved all our goals and it was a great team effort. CHT Hillcrest will continue to provide the residents with a garden to support their wellbeing and to contribute to the local community.

# Are More Young Women Being Diagnosed with Breast Cancer?

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

In the 14 years I have been researching and writing about breast cancer issues, a regular observation is made or a question is asked, suggesting that more young women are being diagnosed with breast cancer. This issue has arisen again recently with the publication of an article in the *Sunday Star Times* on the 28th of May ('Spike in breast cancer rates places financial pressure on district health boards'*). In 2012, I wrote an article for the Breast Cancer Network magazine, *Upfront U Kaiora,* on this and found that new breast cancer registration data for the years 1995 to 2009 showed no overall increase in the numbers of young women diagnosed with breast cancer. The overall incidence of breast cancer did increase as it has for decades, but the proportion of women in each age group as a percentage of the total numbers of women diagnosed was remarkably stable.

Five years on, has anything changed?

I have updated my original data with new data from the years 2010 to 2015, 2015 being the latest year for which data is publicly available. All data comes from the Ministry of Health reports on new cancer registrations and deaths and the associated statistical tables.1

***Increase in Overall Breast Cancer Incidence***

Starting with overall breast cancer registration figures** there has been a steady increase in the number of women being diagnosed with breast cancer over the 20 years from 1995 to 2015 (see Figure 1). Over that time our female population rose from 1.86 million to 2.34 million, so you would expect to see some increase even if the per capita (or in this case the rate per 100,000 women) stayed the same.

However, we can see by looking at the incidence of breast cancer per 100,000 women, that there has been an actual increase in incidence from 87.5 diagnoses per 100,000 women per year to 98.8 diagnoses per 100,000 women per year. The steep rise in incidence in 1999 was the effect of the introduction of the free national breast screening programme and is typical of the changes seen when screening programmes are introduced. In the first one to two years of the programme many cancers were found earlier than they would otherwise have been, that is, tumours are found that would have been found later if the screening programme had not been in place. This big jump in the rate is followed by an equal decline in numbers as a result of a "catch-up" phenomenon. There has also been an increase in enrolments in the screening programme and an increased detection rate with newer screening tools such as digital mammography.

* at http://www.stuff.co.nz/national/health/92920991/spike-in-breast-cancer-rates-places-financial-pressure-on-district-health-boards

** breast cancer registration data does not include diagnoses of DCIS (ductal carcinoma in situ)

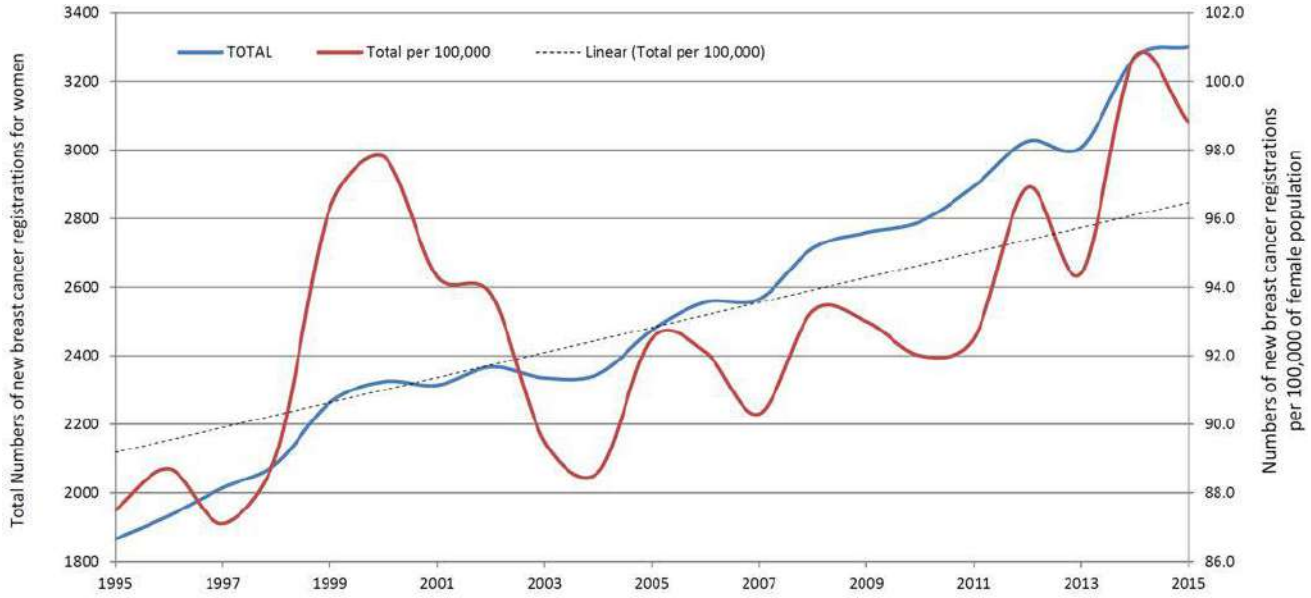



**Figure 1** The total numbers of new breast cancer registrations in women from 1995 to 2015 and the number of new registrations per 100,000 of female population. The dotted trend line evens out the peaks and troughs to show the overall trend per 100,000 women over time. Note that the left hand axis is scaled for the total numbers of new breast cancer registrations, and the right hand axis is scaled for the numbers of new registrations per 100,000 of female population.

In 2004, the breast screening programme was extended from 50-64 years to include women from 45 to 69 years of age, which probably accounts for the increase in new registrations seen between 2004 and 2005.

### *Breast Cancer Incidence in Young Women*

If we look at the absolute numbers of young women being diagnosed (see Figure 2a) you can see that between 1995 and 2015 the numbers of women in the age groups 20-24, 25-29, 30-34 and 35-39 have been relatively stable despite an increasing population. The increases have occurred in the 40 to 44 and 45 to 49 age group.

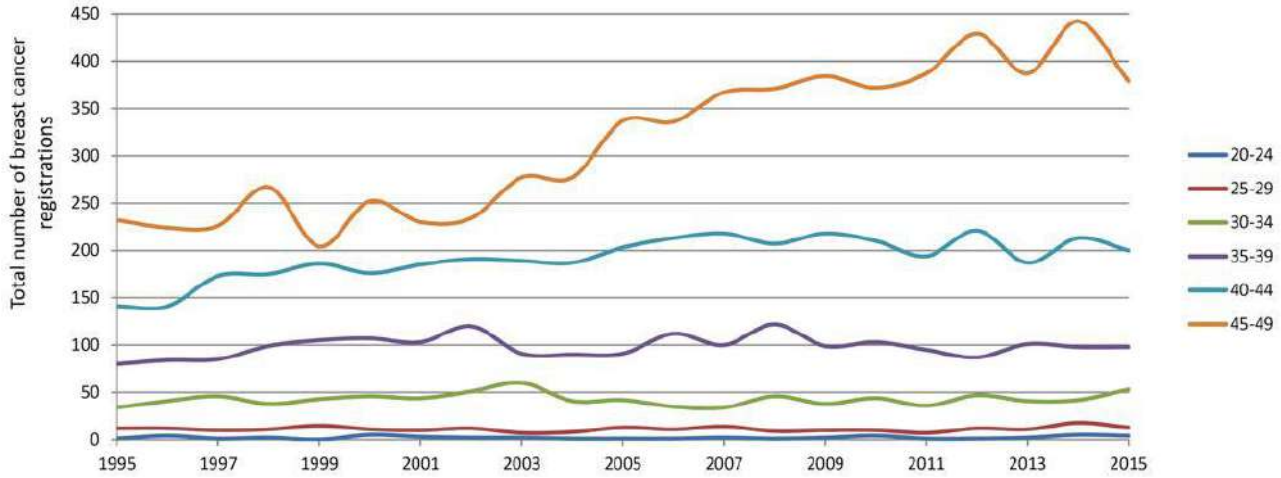



**Figure 2a** Absolute numbers of women diagnosed with breast cancer between 1995 and 2015 in various age groups.

However, in Figure 2b which plots the incidence per 100,000 women in each age group we see that the incidence in even the 40-44 year age group is steady with only a real increase in the 45 to 49 year age group, especially since 2004 when the screening programme was extended to 45 year old women. Ordinarily we expect there to be a sudden jump in numbers upon introduction of screening and then a relative drop within one to two years, as we saw in Figure 1 in 1999 when the national screening programme was introduced. There are probably two main reasons for this; early detection in which case we would expect to see a drop in the older groups over time, and over-diagnosis, that is, diagnosis of cancers that would never have become clinically relevant.

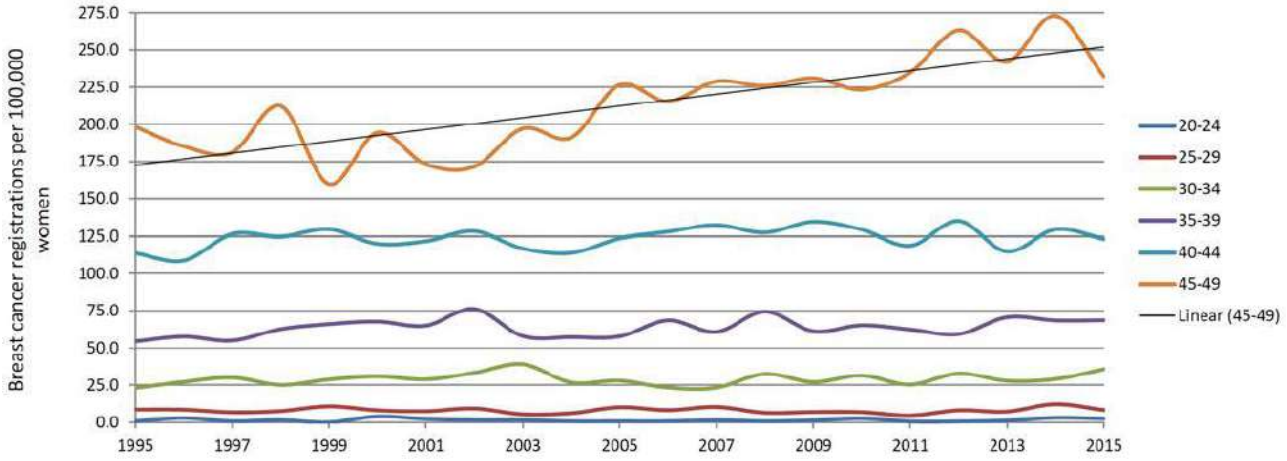



**Figure 2b** Diagnoses per 100,000 women between 1995 and 2015 in various age groups.

Another way in which we can examine any possible increase in the incidence of breast cancer in young women, over and above the general increase in incidence across the whole population (in other words are women getting/being diagnosed with breast cancer younger), is to look at the number of young women being diagnosed as a proportion of the total number of women diagnosed each year over a period of time.

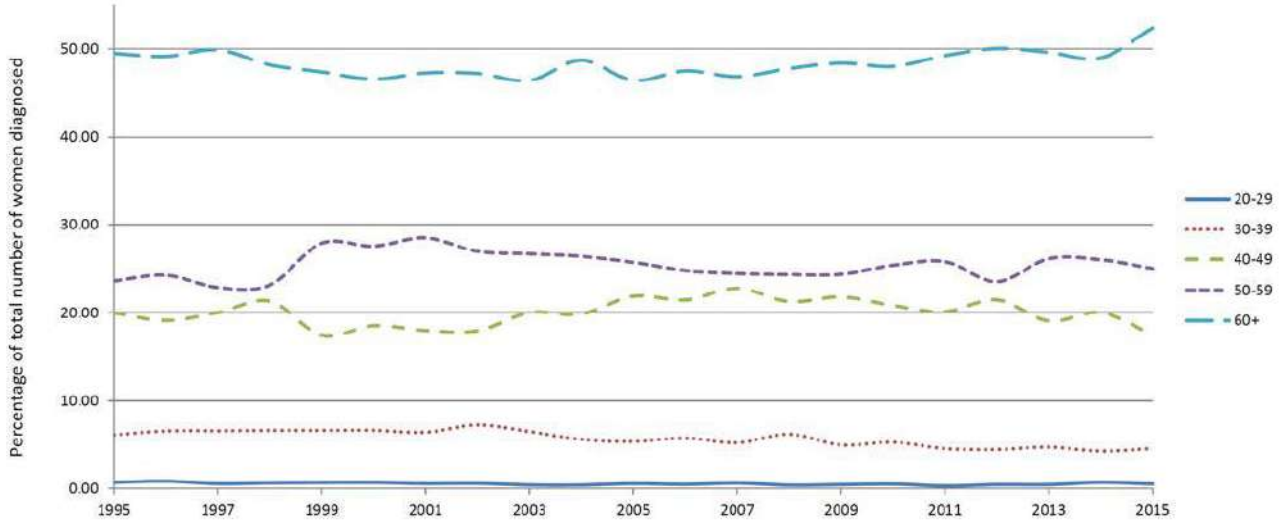



**Figure 3** Women in each ten year age group as a percentage of the total number of women diagnosed in each year, 1995-2015.

In Figure 3 we see that the relative numbers of women in each age group, expressed as a percentage of the total numbers of women diagnosed each year has, again, stayed very stable.

It is clear from the statistics that there has been no trend towards relatively greater numbers of young women being diagnosed with breast cancer, despite the fact that overall more women per 100,000 are being diagnosed now than in 1995. Our overall incidence has gone up but it is evenly spread across the age groups and older women (60 years and over) are still significantly more likely to be diagnosed with breast cancer than younger women.

So why do we have a perception that more young women are being diagnosed?

It could be that young women are more inclined to speak about their experiences, to “go public”. Cancer has become less of a taboo subject, so while older women may have grown up in an era in which the big “C” was whispered about rather than openly discussed, there has been far less reticence over the last few years and significant public campaigns have raised awareness. We also still think of it as an older woman’s disease, so despite no real change in incidence in young women, we as a community are still able to be shocked when we hear of a diagnosis in a young woman, perhaps a young mum who we fear may not get to see her kids grow up.

On top of that, we have very high profile young women who have been diagnosed – Kylie Minogue, Sheryl Crow and Christina Applegate. They may have raised public awareness but they have also increased public fears that more young women are being diagnosed.

Then there is the issue of over-diagnosis. The lower the age for publicly funded screening the more likely it is that not only aggressive and invasive cancers are detected earlier, but cancers that would never have progressed to become clinically relevant are also picked up, and treated.

***Breast Cancer Mortality and Young Women***

Another issue to consider is, are more of our young women dying from breast cancer? However, analysis of this data is problematic and, as a consequence, the results murky at best. Figure 4 provides mortality data by age group for the years 2005 to 2013, the only years for which where there is complete breast cancer mortality data publicly available.

We can see that the number of deaths from breast cancer across all age groups is very stable, and given that our incidence is rising, the relative mortality rate is declining. However, it is very difficult to come to any conclusions beyond this because:

women are unlikely to die in the same year in which they are diagnosed; and

the time between original cancer diagnosis (new cancer registration upon which the incidence data is based) and death from cancer can be very variable from less than one year to 20 or 30 years, possibly longer.

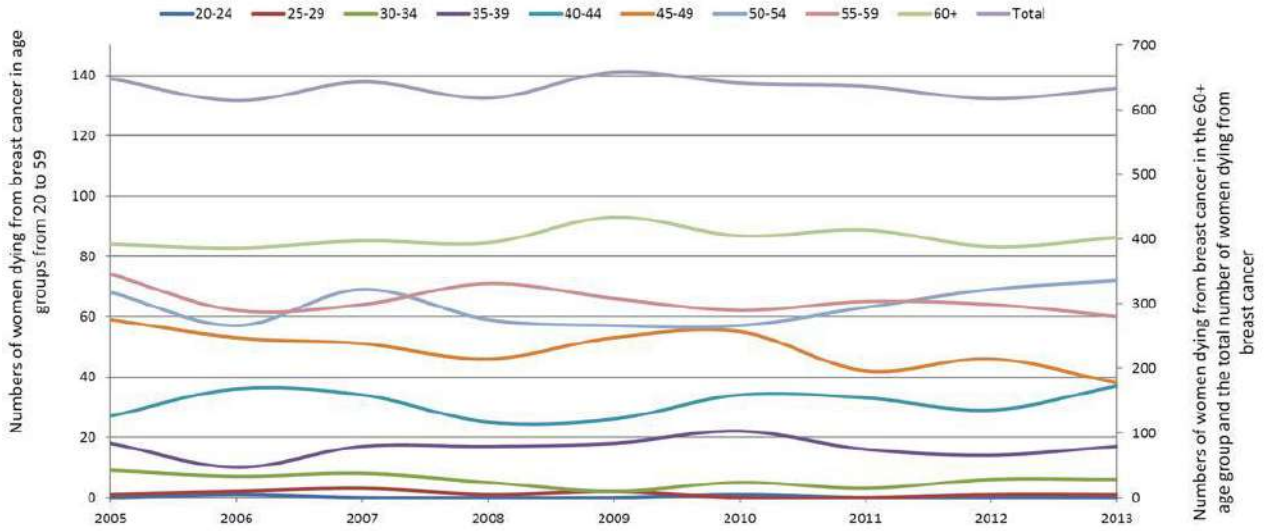



**Figure 4** The total numbers of women dying from breast cancer each year from 2005 to 2015 by age group.

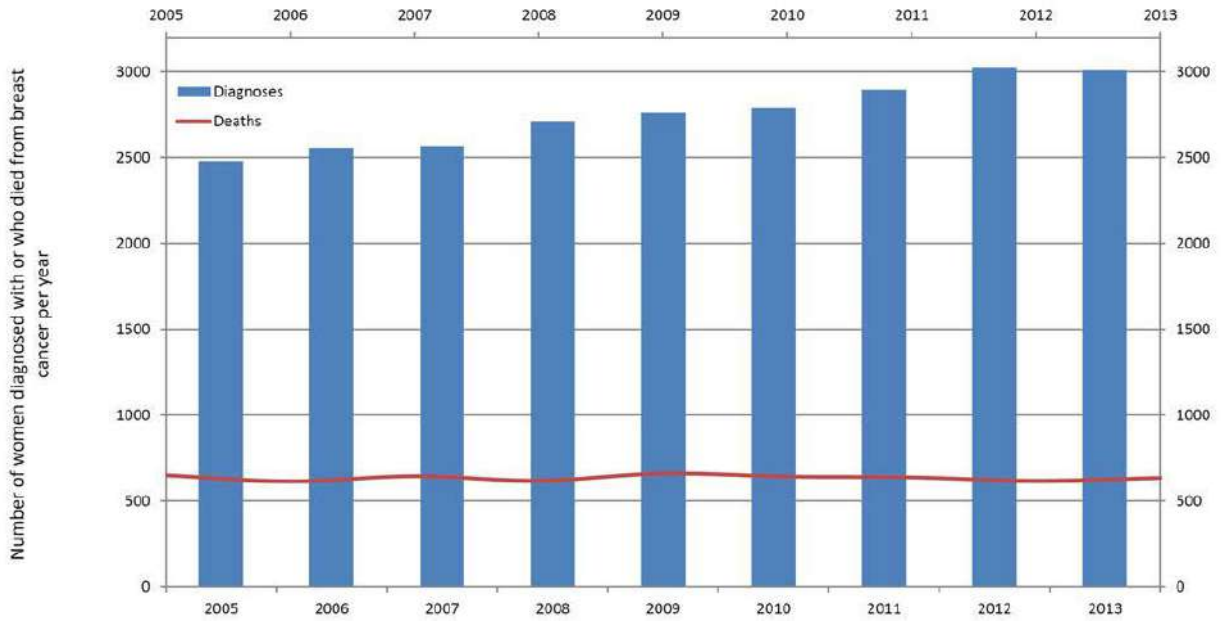



**Figure 5** The total numbers of women being diagnosed each year from 2005 to 2013 and the number of women dying from breast cancer in the same years.

Thus this mortality data can only be related to incidence data on the basis of very broad trends, and from that we see that over time, while more women are being diagnosed, relatively fewer women are dying from the disease (Figure 5).

In conclusion, there is a very simple answer to the concern or question “are more young New Zealand women being diagnosed with breast cancer?”

No, our young women are no more likely to be diagnosed with breast cancer than they were 20 years ago!

*Sources:*

*Cancer: New Registrations and Deaths*, MoH publications for the years 1995 to 2015.

1. http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/cancer-data-and-stats

# College Board Members

The College of Nurses is delighted to welcome two new members to the Board.

**Sonia Hawkins**, BN, PG Dip Health Science (Merit)

Sonia’s current role is Director Consultant, Te Pani Limited. Sonia’s areas of expertise are Māori Health, Health Equity, Child Health and Māori Workforce Development.

Sonia joined the Board in July 2017 replacing Marama Parore who resigned from the Board in March 2017.

**Erin Meads** RN

Erin currently holds the role of Nursing Director at ProCare, and has a broad and extensive range of previous clinical and leadership experience across the primary, secondary and correctional health care sectors, both within NZ and Australia.

Erin joined the Board in October 2017 replacing Liz Manning who has been appointed as Operations Manager for the College.

# Living The Dream

**Bev Hopper RN BHSc MHPrac FCNA (NZ) | CNS OPIVA**

*Bev Hopper CNS OPIVA*

Throughout my nursing career I have had amazing opportunities come my way. Fluke? Right time and place? Dedication and hard work? Or a combination of all these?

I was a late starter; at 40 (I think I had a midlife crisis!!) I applied to AIT for their nursing programme. Naively I didn't even comprehend that it was a degree I was letting myself in for. I just wanted to be a nurse. Considering that my old science teacher had once told me I would never do well at the sciences…. Imagine my surprise when I was accepted for a BHSc. AIT became AUT and so I found myself not only completing a nursing qualification, but at a University. So started a journey that has taken me from novice to expert …. a few times.

As a New Graduate nurse, fresh in my white dress and shoes, I began my career in Orthopaedics. 3 years later a new role caught my eye for an after-hours clinical coach. This new role was developed to support and coach nurses after hours. I loved the diversity of this role and I found my niche in coaching and learning so many new skills myself. After nearly 2 years working after hours, I was ready for the challenge of the next opportunity that came along when the Nurse Educator in Orthopaedics resigned. Yes, back to being a novice, just at a different level of noviceness. Volunteering teaching nurses in Cambodia gave me a wonderful opportunity to give back to the nursing profession in a developing country. Somewhere amongst all this I managed to complete the Master in Health Practice (Nursing) degree - Yes Mr Science teacher… I did!!

Being asked to review 3 orthopaedic chapters of Lewis's Med/Surg Australasian Edition was a great opportunity to add my name to such a renowned title. This, along with presenting at national and international conferences has not only increased my confidence but also enabled me to bring back this knowledge to my own practice setting, to influence Best Practice for better patient outcomes in my own place of work.

In 2014 I was accepted for a scholarship offered through IV Nurses NZ (IVNNZ) and 3M to the Global IV Leadership Forum in St Paul Minnesota and to the Infusion Nurses Society convention in Phoenix. By now the IV fire was starting to burn! I returned to NZ with a greater knowledge of IV nursing and a greater passion to improve the care of patients with venous access devices.

My Dream Job

The opportunity fairies were at it again in 2015 when I was accepted for the new position of Clinical Nurse Specialist (OPIVA) Outpatient IV antibiotics – 1 year fixed term position. Outpatient IV antibiotics are being increasingly used for patients who require long courses of IV antibiotics

(usually 4-6 weeks). Without an outpatient IV antibiotic (OPIVA) service, these patients would require hospitalisation for the entire duration of their antibiotic course. OPIVA services allow for patient-centered, home based care and have been shown to improve patient satisfaction and reduce hospital length of stay. Our team consists of 3 infectious disease consultants, Antimicrobial Stewardship Pharmacist, OPIVA Pharmacist, ID Registrar and now 2 Clinical Nurse Specialists (OPIVA). Once an infection has been identified by the patient's team, a referral is made to the ID consultant. The ID team review the patient and recommend the course of treatment.

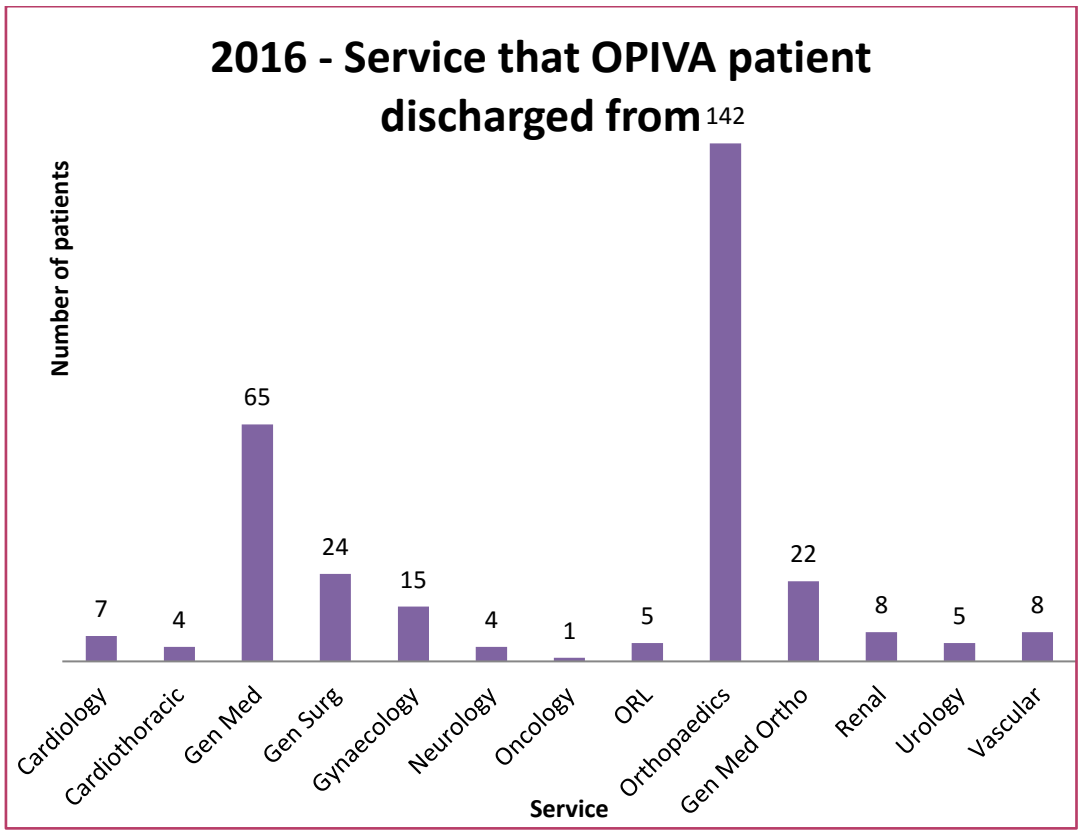
OPIVA has three modalities: Elastomeric infusor, District Nurse daily infusion or patient / carer administration of IVABs.

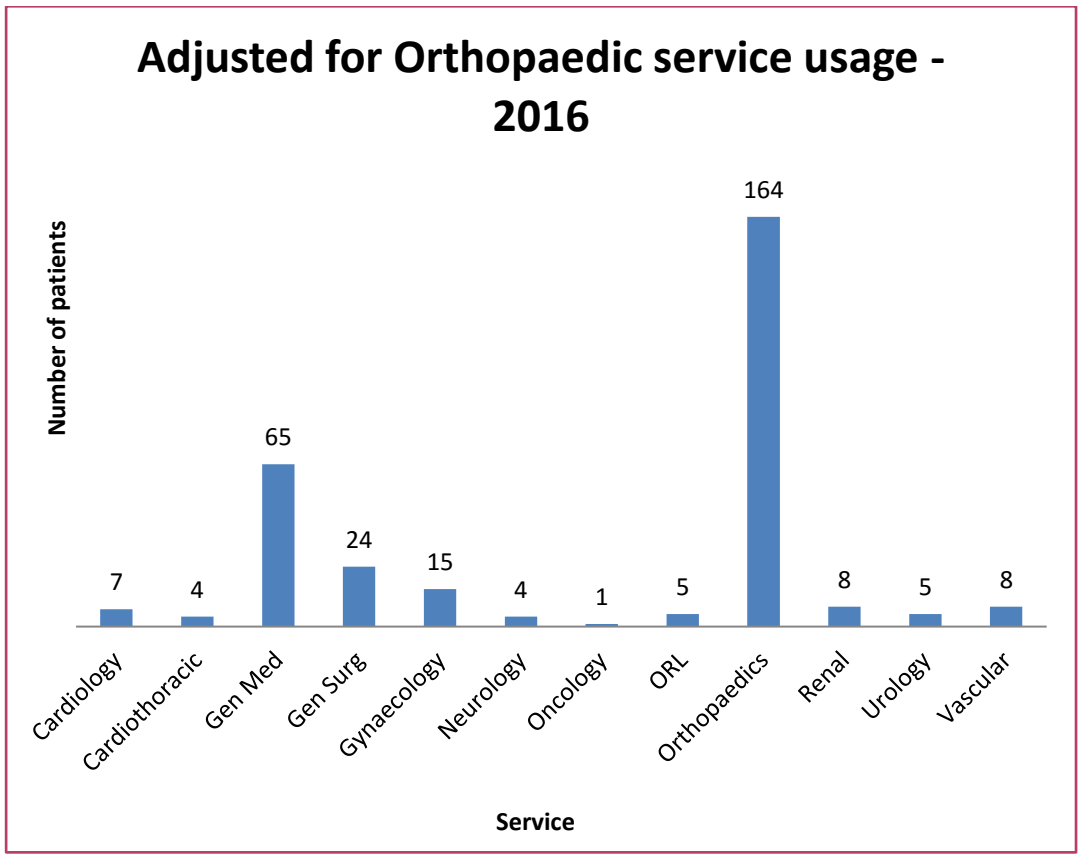
Once I have a referral to review a patient, I assess them to see if it will be appropriate to teach either changing of the infusor or self-administration of appropriate antibiotics. I counsel patients how to care for their medication and their PICC line, as well as what is required from them while they are having their antibiotic treatment. Orders are placed for an Elastomeric Infusor (for the 24 hour delivery of IVABs) in a timely manner to avoid delays in discharge or if the patient is self-caring, equipment is put together. Patients have weekly blood tests with any deranged results being escalated to the ID registrar or consultants. i.e. One patient was noted to have massive LFT rise. The patient was on non-Baxter antibiotics. The patient was re admitted with consequent change of antibiotics. We monitor Vancomycin levels weekly and adjust the 24 hour dose accordingly, ensuring that the patient gets the appropriate antibiotic dose in relation to their blood levels. Clinical pharmacists also give specific medication related counselling to all OPIVA patients prior to discharge. On discharge the RN caring for the patient faxes a referral to the community nurses along with the medication authority, PICC line removal form and CVAD insertion record.

Nurses, primary care teams and patients alike now have a single point of contact for any queries related to PICC lines, infusors or antibiotic administration. My phone is a bit of a hot line!!

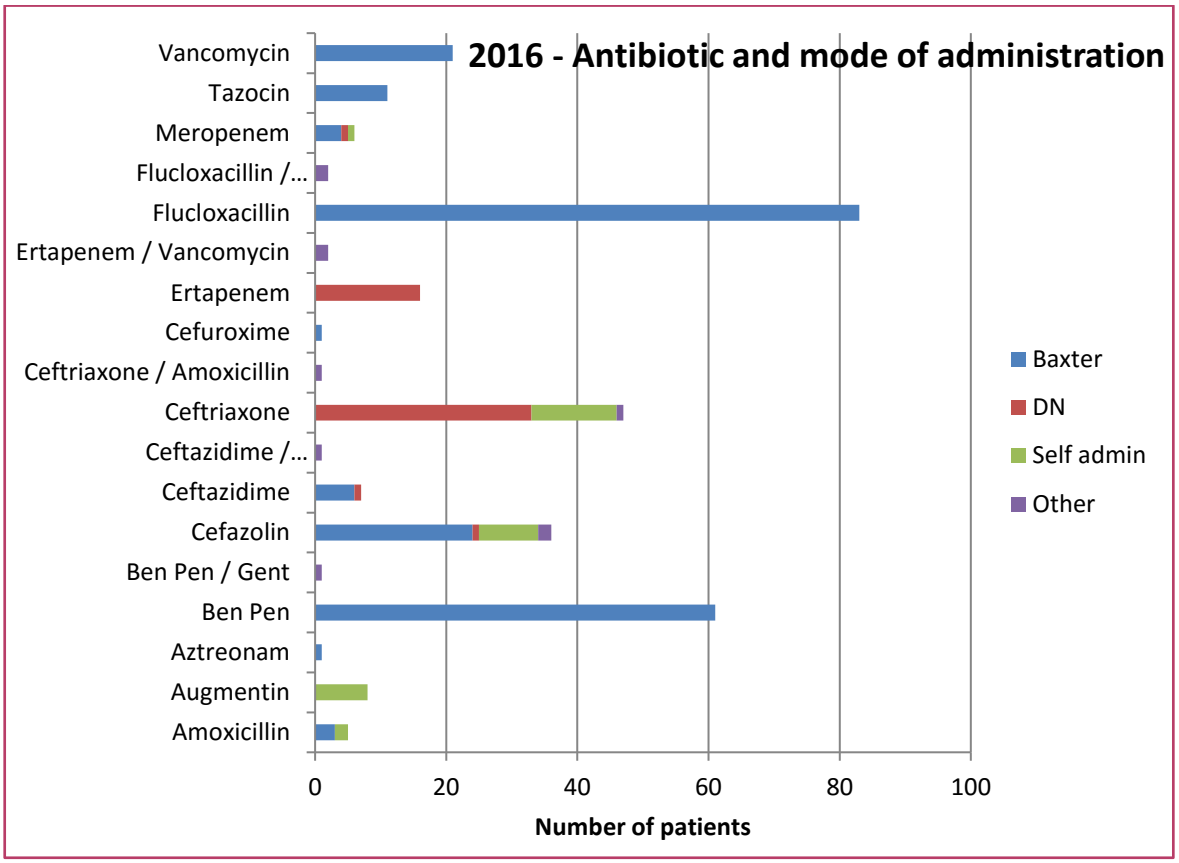
At any one time, we can have from 10 to 30 patients on OPIVA in the community whilst we can be preparing a further cohort of in-patients for discharge once medically and MDT cleared. By 2016 the role of CNS had well and truly proven itself and the role was extended to a permanent position (sigh of relief!).

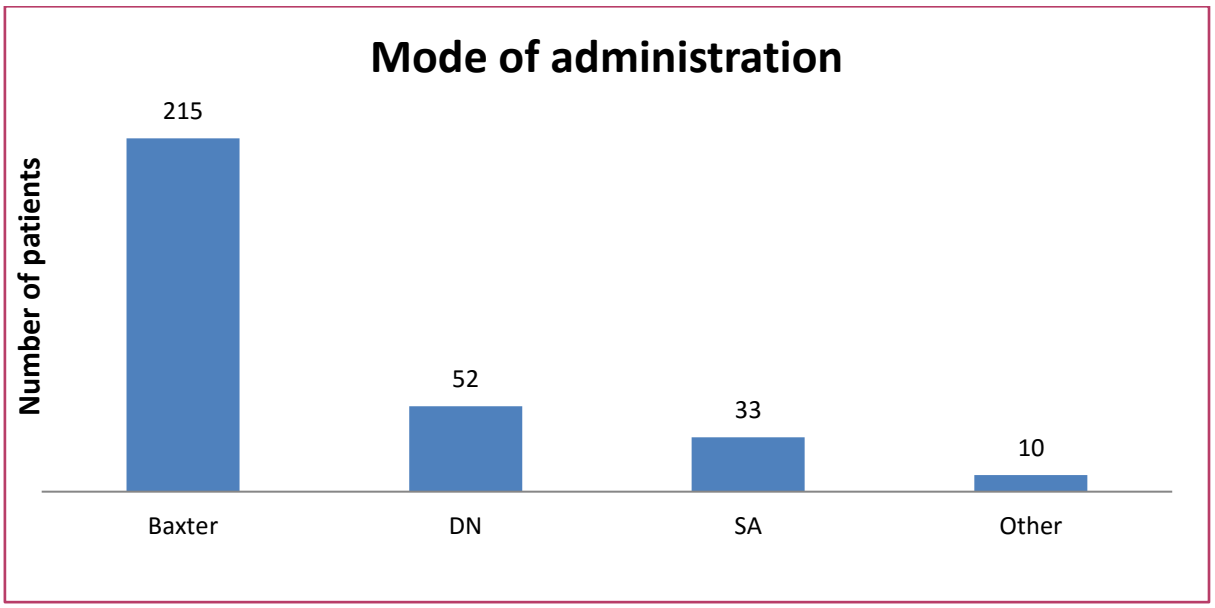
The following tables demonstrate some of the OPIVA figures for 2016



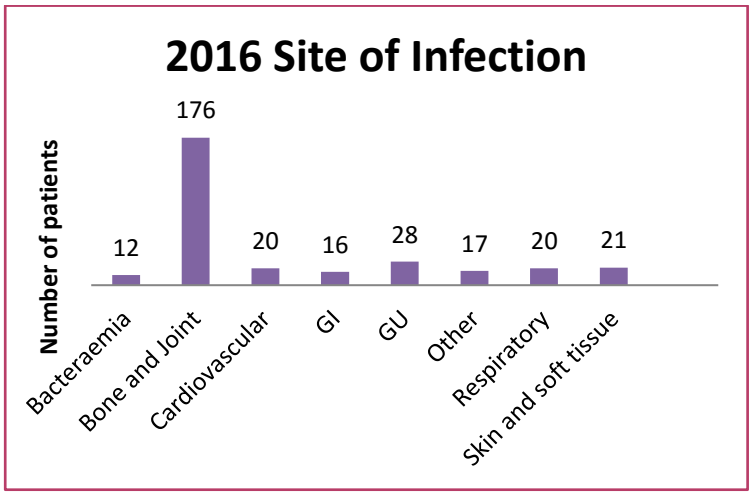



Antibiotics used and mode of administration is predisposed to Flucloxacillin, Benzyl-Penicillin, Ceftriaxone and Cefazolin. (Other – when a single patient receives antibiotic from dual modalities, i.e. Ben Pen as a Baxter with the DN administering an infusion of Gentamicin daily.



Bone and Joint infections are the main site of infection




**310** patients were discharged through the OPIVA service in 2016

**34 / 310** were taught to self-administer antibiotics as a patient centred alternative, giving these patients increased autonomy over their care. They administered either daily, BD or TDS depending on the antibiotic required

**6883** days of treatment / bed days were saved, freeing up acute inpatient beds. This was calculated from the day of discharge to the end of the patients IVAB treatment.

**674** of these days of treatment were from patients taught to self-administer

Patients had an average of **22.2** days of treatment

**37 / 310** patients were transferred into our OPIVA service from other DHBs / facilities requiring ongoing co-ordination of care

<u>The OPIVA Service Is Growing:</u>

The OPIVA service is currently developing a scheme by which patients from Aged Residential Care Facilities in the WDHB area will be able to return to their “home” for continuation of their antibiotic treatment. These patients currently remain as inpatients for the duration of their antibiotic treatment due to RNs in these facilities not having current competency in the management of PICC lines and administration of IV medication. An eLearning module and a 4 hour face to face programme is ready and waiting for these nurses to up skill in the near future with oversight from the OPIVA team.

In May of this year the service expanded to incorporate another 0.6FTE CNS position.

As a new CNS I knew I was an expert at nursing assessment, PICCs, antibiotics and teaching – all the hard core practical things. What has come about over the last 2 years has been the “becoming” a CNS, linking professional practice to evidence based outcomes.

Reflecting on my 15 years of nursing, I have had many diverse opportunities come my way, which have led me along my current pathway and a truly dream job.

# College of Nurses Aotearoa (NZ) Inc
# Life Members

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