

# PreScribe

NORTHLAND DISTRICT HEALTH BOARD STAFF MAGAZINE



“Fundraising shopping bags a Northland first”

Page 3



# From the CEO's Perspective



First of all, do no harm! One of the many ways we can harm our patients is to give them treatment that they do not want or need. I recently listened to an entertaining talk at our Grand Round from Mr Nihren Dehra, entitled 'Birds, Rabbits and Turtles' in which he discussed the thorny issues of over diagnosis, overuse and overtreatment.

Mr Dehra is a visiting surgeon on a sabbatical and was alluding to the fact that the aim of his cancer treatments was to ensure that he treated the cancer before it spread, much like keeping the rabbit in its hutch. However, far too often he found that he was treating patients too late after the 'bird' had flown away or was treating patients who would never have got worse or spread anywhere (turtles) until the patient had died of other causes.

Moving on from treating turtles, he referred to the Choosing Wisely campaign, which started in the US in 2009 as an effort to get specialty colleges and societies to develop 'Top Five lists' – lists of five low-value services that patients and physicians should discuss and question before pursuing.

The Institute of Medicine found that 30% of US health care is wasteful, and in Canada, 28% of lumbar spine MRIs and Bone Density scans are considered inappropriate, as are 31% of pre-op ECGs and RBC transfusions. That probably doesn't surprise many of you – after all, it is North America. But if one considers the huge variation in clinical practice – tests, prescribing and interventions – there must be a significant amount of waste in our health system too.

The top five don't-do lists are created by doctors and their societies, not funders or management. As testimony to its careful design, the initiative does not appear to be generating concern about rationing or undermining the patient-doctor relationship, as past efforts to reduce health care overuse have tended to do.

The Dartmouth Institute for Health Policy and Clinical Practice noted that we still see some vested interests influencing these lists. The creation of low-value lists suggests that physicians are willing to make recommendations to improve care value but initially many specialty lists included only or mostly low-impact services for physicians and patients to question. For example, one of the surgical specialties listed such things as over-the-counter medications on its list of low-value items but strikingly, no major procedures – the source of the surgeons' revenue.

And societies generally named 'other specialties' services as low-value rather than their own services. They commonly named such services as radiology, cardiac testing, medications and lab tests or pathology, the authors said. The notable exception is the Society of General Internal Medicine, which listed the routine annual physical exam as an item of low value.

However, despite this, there are many useful recommendations within these lists, such as don't prescribe antibiotics in asymptomatic bacteriuria, don't prescribe benzodiazepines as first line for insomnia in elderly, and don't prescribe antipsychotics as a first line for dementia.

An important consideration is that by overtreating our patients, we are harming more than the patient in front of us, because by treating that patient, there will be a patient somewhere that won't be treated – the time and the resource wasted can't be regained. Unfortunately, with our constrained finances and unmet need, there is always an opportunity cost, and someone misses out.

Canada has run a 'More is not always better' campaign as part of its Choosing Wisely programme, with more than 220 recommendations. Within one year of launching Choosing Wisely in Northwood General Hospital in Toronto, its very large ED has seen a 43% reduction in laboratory ordering. We saw slightly more modest success at Northland DHB when our clinicians, led by Dr David Hammer, ran an informal programme to reduce inappropriate lab ordering. This probably saved hundreds of thousands of dollars that could be spent on other patients. Choosing Wisely has now been launched in both England and Australia. In New Zealand, Waikato has initiated a Choosing Wisely Campaign, and there is certainly no reason why we couldn't do it in Northland!

Choosing Wisely epitomises one of our core values, Excellence, which is not just about doing things right but it's also about doing the right thing. Speaking of Excellence, I want to acknowledge two of the stars of Northland DHB, Dr Jozsef Ekart and Dr Usha Shan. Jozsef was the joint winner in the category of Outstanding Leadership in Quality Improvement for his work leading and supporting our Clinical Audit programme. This year at the international ORBS (oncological and reconstructive breast surgery) meeting in Nottingham, attended by over 400 delegates from 30 countries, Usha was awarded a prize for best oral presentation. She showed that by using simple oncological techniques, which she gradually refined, much better outcomes were achieved, and that these sorts of techniques had the potential to benefit women with breast cancer worldwide.

Regards,

*Nick*



# Fundraising Shopping Bags A Northland First

Six-year-old Elijah Wynyard-Palmer was the proudest kid in his local Countdown supermarket, when he walked in to see his signed artwork featuring on new shopping bags being sold for the first time as part of the Countdown Kids Hospital Appeal.

The reusable bags are a Northland idea and a new, local dimension to the national campaign, which raises funds for dedicated children's hospitals and wards throughout New Zealand. The bags have come about as the result of the combination of Elijah's artistic skills, encouragement from Ward 2 staff and inspiration from the communications team.

An initial run of 1000 of the bags has been printed and distributed to Countdown supermarkets around Northland, where they are being sold for \$5 each, with every bag sold adding to the total raised for the benefit of Northland kids.

Elijah, from Tikipunga (who features on the front cover of this edition with sister Summer) was admitted to Whangarei Hospital with viral meningitis in August this year and had an intravenous drip in his arm when he created his artwork, a vibrant representation of himself in a garden. "He had major antibiotics pumping through him," mum Katherine recalls.

After five days in Ward 2, Elijah was discharged and has gone on to play Rippa Rugby for the first time this year.

However, that didn't end the family's involvement with Whangarei Hospital: on the day that Elijah was discharged, big sister Summer (aged nine) was admitted to hospital and has since returned for a series of tests to identify the reasons for recurring headaches.

Katherine has a lasting appreciation for the staff and the playroom in Ward 2. "The ladies there are just fantastic – you couldn't do hospital without them – and the playroom takes the kids' minds off the reasons why they are there."

Over the past seven years, the Countdown Kids appeal has raised a total of almost \$500,000 in Northland,



A proud Elijah sees the bags on display for the first time.

allowing vital equipment to be bought for child health and maternity. Major purchases have included an incubator and an ultrasound scanner for the Special Care Baby Unit (SCBU) at Whangarei Hospital, an EEG machine and a hoist for the Child Health Centre and monitoring equipment for Ward 2.

Other items have included comfortable chairs so parents can sleep by their child's bedside in hospital, equipment for the maternity unit and videoconferencing equipment which allows patients to 'meet' with their paediatrician from Kaitia, reducing the need to travel to Whangarei for appointments.

"This year, our wish-list includes heat tables for SCBU that keep newborn babies warm, a video laryngoscope that allows paediatricians to watch on a monitor while a tube is inserted into a baby's throat, and AIRVO machines that help small children to breathe, enabling them to be nursed in the children's ward rather than intensive care," says Jeanette Anderson, service manager for Maternal & Child Services at Northland DHB.

The bags are available through the Child Health Centre or in Countdown supermarkets in Whangarei (Tikipunga, Regent and Okara), Dargaville, Kerikeri, Kaikohe, Paihia and Waitangi, Silverdale and Warkworth.



Ward 2 play specialists Rosanne Woods (left) and Karen Parker, who encouraged Elijah and other children in Ward 2 to produce the original artworks.



The bags on sale at Countdown.



# "Every day now is a blessing"

For most of us, celebrating our birthday once a year is enough. Northland woman Charlotte Fairburn, however, celebrates two birthdays: one for her birth date and the other for the number of years she has been clear of breast cancer.

Nine years ago this month, Charlotte went for her first ever mammogram (breast x-ray).

"I was 45 years of age and I knew that the screening was free, so I thought I might as well have it done. It's a very good job I did, because early detection was my saving grace."

The mammogram picked up a tiny cancer the size of a pin head. However, within a month, the cancer had become much bigger.

"I got the phone call while we were having dinner. It was the phone call you didn't want to get, telling me that I needed to come back down and see [specialist breast surgeon] Dr Usha Shan to discuss what steps we needed to take next," recalls Charlotte.

Having lost her husband 17 years ago, one of the hardest things for Charlotte was telling her only child, a son who lived away from Northland.

"I went to see him. We were cuddling as I told him and he pulled back from me, keeping his hands on

my shoulders, and asked me how I felt. I told him 'I think we got it in time' and he pulled me close and said 'OK then'."

Her siblings didn't take the news as well, and for her brothers, looking her in the eye was difficult.

"They couldn't accept that maybe I was dying and kept saying: 'You're not clear until you get the letter'. When I finally got that letter, I personally took it to my brother to show him."

The first stage of investigation was to take a biopsy, which wasn't as successful as Dr Shan would have liked.

"Dr Shan rang to say that although she hoped they had got the entire tumour, she wasn't sure so they needed to go back in again, through the same incision. It was quite worrying."

Walking alongside Charlotte through the experience is a very dear friend, Connie, who has been through thick and thin over the last nine years.

"Miss Connie walked with beside me during the whole journey, keeping me positive when the going got tough," acknowledges Charlotte.

With her friend not always being in a good space, Connie experienced her fair share of telling-offs.

Connie says with a knowing smile: "She would get a bit crabby, so sometimes I had to care from a distance just to give her space."

Charlotte comments: "Sometimes I felt smothered and I would rebel. But I need to say that played a big part in my recovery. She used to get my mail and open it and then we would deal with whatever it was."

There was a three-month waiting list for treatment in Auckland, so Charlotte and Connie pushed for Charlotte to be able to go to Sydney instead.

***"Dr Shan is really on-to-it and me feel comfortable so that I could ask anything. I felt fully informed every step of the way"***  
- Charlotte Fairburn.



Charlotte (right) with friend and supporter Connie Parangi.



“The sooner the better, as far as we were concerned. We made the arrangements, I had to have a caregiver so my niece travelled with me and I spent five weeks there having radiation therapy.”

Another key relationship that was forged was between Charlotte and her specialist Dr Shan.

“When I talked with other patients about my doctor, they were so surprised how close we were. Dr Shan is really on-to-it and me feel comfortable so that I could ask anything. I felt fully informed every step of the way.

“And when she told me I was all clear, I gave her a hug.”

Connie adds: “I wish she was my sister-in-law’s surgeon”.

A strong advocate for breast screening and early detection, Charlotte urges all eligible women to put their fears to one side and make the time to have their breast screen.



Left to right – Carol-Jane Mohi, Connie Parangi, Charlotte Fairburn, Harley Rihari, Rose Yakas and Kawani Brown.

“I am constantly pushing my siblings, nieces and friends to take advantage of the national breast screening programme. It’s no good thinking ‘it isn’t going to happen to me’ – it does happen and if I hadn’t had a screen when I did, I don’t think the diagnosis would have been so positive.

“Every day now is a blessing.”

## Breast cancer facts

- There are a number of different types of breast cancer
- Most start in the milk ducts of the breasts (ductal cancers), others start in the lobules of the breast (lobular cancers)
- Cancers can develop slowly over years or more quickly over months
- Some breast cancers have a better chance of successful treatment than others
- When the cancer spreads into the surrounding breast tissue, it is called invasive breast cancer
- Breast cancer can spread to the lymph nodes, which is the drainage system of the human body. Cancer cells can spread to other parts of the body too, such as the lungs, bones and liver
- Breast cancer can also spread through the bloodstream.

The risk of being diagnosed with breast cancer increases with age. Breast cancer is uncommon in women under 50. About 70 percent of women who are diagnosed with breast cancer and about 80 percent of women who die from it are 50 years or older.

Some women are at greater risk of breast cancer because there is a history of close family members having the disease. However, most women who develop breast cancer have no relatives with the disease. Even among women who do have relatives with breast cancer, most will never develop it.

**Visit the Breast Cancer Aotearoa Coalition website for information and support for women with breast cancer <http://www.breastcancer.org.nz/>**

# International recognition for oncoplastic surgeon



***Whangarei Hospital oncoplastic breast surgeon Dr Usha Shan is committed to not only saving the lives of women with breast cancer, but also minimising the ongoing impact of surgery on their appearance.***

***In 2008, she travelled around the world to learn a new surgical technique that she hoped would provide better cosmetic outcomes.***

***Seven years later, her presentation on the way she has used and evolved that surgical technique – and the improved outcomes it is delivering for Northland women – have been acclaimed at a conference in Nottingham, England, by world leaders in breast cancer surgery.***

“I decided I needed to do better for our Northland women.” This decision, combined with her very visible enthusiasm and commitment, took Dr Shan on a journey that has now been acknowledged on a world stage.

Dr Shan explains there are two main approaches to removing breast cancer while conserving the breast: either through a cut overlying the tumour (which could be anywhere in the breast), or through a central cut around the nipple areolar complex, which gives better aesthetic outcomes. The first technique is easier and initially the appearance of the breast is acceptable but

about a year following surgery, unevenness starts to show, resulting in deformity and poor cosmesis, which can affect patients’ body image and self-esteem.

“When I began at Whangarei Hospital in 2006 and started doing cancer operations, I was happy with the cancer removal part of the operation but not so happy with the aesthetic or cosmetic look.

“Many women accept the impact of breast conservation surgery on their appearance because they think there’s no other option. All they want is the cancer out – they don’t complain, in fact they’re very grateful.

“But studies have shown that poor cosmetic results have a negative effect on the psyche of women – their self-esteem becomes lower.”

Dr Shan began searching for a better surgical technique and attending conferences and workshops in the United Kingdom. In 2008, she found a technique being used by a Danish surgeon and was offered the opportunity to operate with her, on her way to an oncoplastic workshop in London.

***“Just goes to show the intense commitment on the part of the surgeon to provide the best care for her patients by updating herself with the new developments in the field of oncoplastic breast surgery.”***

***- Dr Ambika Anand, Qatar.***

“I flew out of Whangarei on a Saturday and arrived in Viborg, Denmark, on Sunday afternoon, where I was collected from the bus station by the surgeon. I operated with her on five cases on the Monday and Tuesday. When you have an opportunity like that, you forget about jetlag – you get on and do it.

“I flew on to London on the Wednesday and attended the oncoplastic workshop on the following Tuesday and Wednesday, then returned to New Zealand on the third week, to resume work on the Monday.

“All that travel to get this technique!”, says Dr Shan.

(Fittingly, the Danish surgeon who showed Dr Shan the technique in 2008, Dr Helle Hvid of Viborg Hospital, was there to see her presentation in September).

Back in Whangarei, Dr Shan started using the new technique, known as the ‘tennis racquet’ operation, on



women who were suitable for breast-conserving surgery. "Over the years, I modified it, taking a more conservative approach by removing less volume, changing the length of the extension and avoiding unnecessary removal of skin. The less you take from the breast, the better the cosmetic outcome is – and nowadays surgeons around the world advocate not removing the skin unless it's involved with the cancer.

She says the technique can be used in the majority of patients with breast cancer who are suitable for breast conserving surgery but they should be carefully selected – and it isn't suitable for all patients.

***"I have to acknowledge the breast team, the operating theatre team, Ward 3 and 4 nursing staff, my surgical colleagues and the management of Whangarei Hospital."***  
***- Dr Shan.***

With the permission of the patients, Dr Shan took 'before and after' photos which were used in a cohort study over a six-year period.

"I used to tell the patients that one day I would present their photos at a conference somewhere in New Zealand – instead I went straight to an international conference!"

Dr Shan submitted two abstracts on her oncoplastic surgical work at Whangarei Hospital to the organisers of the ORBS (oncoplastic and reconstructive breast surgery) meeting in Nottingham in late September, attended by more than 400 delegates from 30 countries. Nottingham City Hospital Breast Unit has been a pioneer in breast cancer surgery.

Both of Dr Shan's abstracts were selected for poster presentations, and her abstract on the tennis racquet technique was one of 14 chosen for oral presentation.

Dr Shan's presentation was compiled with extensive support from the Northland DHB team – among them, microbiologist Dr David Hammer who prepared statistics on his weekend off, and Liz Inch, who organised a film crew at short notice to film an operation. The mailroom team printed her posters, and she rehearsed her oral presentation and received feedback from surgical consultants, surgical registrars and breast team.

Her oral presentation at the conference, which included video footage, covered every step in the tennis racquet operation – how to mark before surgery, the crucial steps to ensure a safe oncological resection and the end result, showing the tennis racquet scar.

"It's like showing the world how to do this operation, which was appreciated by the audience," says Dr Shan.

"I also told them beautiful Northland is one of the most socio-economically deprived regions in New Zealand, and its remote nature makes transportation and access to healthcare a challenge for both Māori and non-Māori patients living here.

"For Northland women, a trip to Auckland for radiotherapy and scintiscans can require a drive of up to six hours each way because we don't have those services in our hospital.

"It's challenging not only for the patients but for the surgeons."

A panel of world leaders in oncoplastic surgery – based in locations such as Milan, Paris, the USA, Nottingham and Edinburgh – chose Dr Shan's oral presentation as the best at the event.

"This is not for me – it's for my patients, they're my number one priority."

Dr Shan is now expecting to present on the technique at a conference in New Zealand, and will hold workshops at Whangarei Hospital if there is demand from surgeons elsewhere in the country.

"I want to encourage other surgeons in the country to use this technique because it's simple, safe, effective and gives a better cosmetic outcome," she says.

Next year, her vision to create an oncoplastic unit in Whangarei Hospital will take a step forward with the planned recruitment of two additional oncoplastic surgeons to join her.

In the meantime, she convened the recent symposium on breast cancer management in Whangarei, which attracted 120 delegates from as far away as Christchurch and Auckland.

The morning session featured medical and surgical experts from around the country – including a repeat of Dr Shan's ORBS presentation. The afternoon was dedicated to the support services who help patients feel good with appearance, along with a patient talking about her journey, and a modelling session by breast cancer survivors.



Dr Shan operating.

# Hearing technologies and therapies make the difference

***With no family history of hearing difficulties, it was a shock to a young Springfield couple when two of their three babies were born deaf and hearing-impaired. Former SCBU nurse and mum Sarah Slagter shares the triumphs many parents take for granted.***

For Sarah Slagter, the first time two-year-old daughter Emma heard the sound of music, it was music to her own ears.

Sarah and husband Jerome's four-year-old son Blake had normal hearing so it came as a shock when Emma's newborn hearing screening failed. Further tests showed that her underlying hearing was normal but she had conductive hearing loss.

"At this stage it was thought to be due to glue ear," remembers Sarah.

"Over the year she was tested several times but the glue ear didn't resolve so she was put on the waiting list for grommets."

***"We had a breakthrough when we put Emma's hearing aids in and turned the stereo on - she loved it. From that point on, she didn't take them out."***

***- Sarah Slagter.***

At 18 months, Emma received grommets but a month later, another hearing test still showed a hearing loss. She was then fitted with hearing aids.

"It was extremely difficult at first because she pulled them out all the time," recalls Sarah. "This lasted about two months. We had a breakthrough when we put her hearing aids in and turned the stereo on - she loved it. From that point on, she didn't take them out."

An MRI several months later revealed large vestibular aqueducts\*. Sarah remembers being emotionally numb throughout this period.

"My dad had just passed away and I was in the third trimester of pregnancy with our third child. I didn't really think about it, I just got on with it. And because that I thought it was conductive hearing loss, I thought there was hope that it would resolve."

When Chloe was born shortly after, the couple were not expecting problems. At birth, she was a normal healthy baby and gave no reason to suggest anything was wrong.



Sarah Slagter and husband Jerome with children Blake, Emma and Chloe.



However, she failed her newborn hearing screening and was sent to audiology at the hospital where she was diagnosed with profound sensory hearing loss\*\*. The family were given hearing aids but were told that these were unlikely to do anything.

"I felt totally crushed when we found out Chloe was deaf. I felt so sad for her that she wouldn't hear the wind in the trees or the sound of the ocean. I was worried about how she would communicate with anyone outside our family," says Sarah.

"You couldn't tell she was deaf when she was a baby. People who interacted with her would ask me if I was sure she was deaf because she would react when you spoke to her. She would even vocally take turns when interacting with us and made baby noises. So, if it hadn't been for the newborn hearing screening, we wouldn't have picked it up for a long time.

"Before newborn screening, children weren't being picked up until they were 18 to 24 months - after watching Chloe, I can totally understand that."

Following the diagnosis, the family attended numerous appointments and were given a ton of information and options. They decided to be referred to The Hearing House for assessment for cochlear implants.

Cochlear implants aim to provide useful hearing to children who get little or no benefit from hearing aids. Implants consist of an external speech processor and an internal component. Unlike hearing aids, which make sound louder, a cochlear implant bypasses the non-functional parts of the ear and delivers small electrical signals directly to the auditory nerve.

"Hearing House is in Auckland, so this meant many hours on the road. The assessment process required about eight trips to Auckland. Assessments included seeing a social worker to see that we would be committed to the program, auditory-verbal therapist and audiology appointments to verify

the results, which included an ABR under general anaesthetic. Also an MRI under general anaesthetic to check she had a cochlear and nerve to her brain."

After about four months of assessments, Chloe was accepted for cochlear implants and had her operation in February this year.

"Three weeks later, she had her implants switched on. The first day, we didn't notice any reaction to sound but, on the second day, she looked up to the sound. She was eight months when she heard sound for the first time. After about one month she started to respond to her name, which was so cool.

***"I think over the last few days she is starting to say 'Mamma'. It makes me feel very emotional as, when we were told about Chloe's deafness, Mamma was something I thought I would never hear."***

***- Sarah Slagter.***

"From what I have been told, people who have had normal hearing, then lost it and then receive a cochlear implant say that, when first switched on, it sounds like a cross between a fire engine and a washing machine. Over time the brain works it out and they can identify the different sounds and their meaning.

"I think over the last few days Chloe is starting to say 'Mamma'. It makes me feel very emotional as, when we were told about her deafness, Mamma was something I thought I would never hear."

The first few months involved many trips to Auckland for audiology

mapping and therapy but now most of the therapy is done over Skype, with the girls alternating weekly sessions. Sarah says, although the family has fallen into a new routine, the last year has been very stressful.

"I worked in SCBU and I do miss it but feel I am needed more at home. But we have used some of the trips to Auckland to do fun things as a family.

"When I was a SCBU nurse I saw a lot of families face difficult circumstances. I now think I have a greater appreciation for what families go through - their frustrations, heartache, and stress."

Although both girls are behind in their speech and comprehension - Chloe, 14 months, has only had access to sound for five months and has learnt five words; Emma, three this month, has many words and is building on this all the time - it doesn't affect their ability to play normally.

"The aim for Chloe is to catch up with her peers by the time she goes to school, and with Emma, we will work closely with the audiologist at Whangarei Hospital to monitor for any changes in her hearing."

As for Blake, aged five, Sarah is unsure how this has affected him. "I am very aware that he may feel left out and that a lot of attention is on the girls. We try and include him where we can and involve him in the girls' therapy. He loves helping with therapy and even sets up his own therapy sessions at times.

"I feel like when we are at home we are just like any other family - it's not until you go out and about that you are reminded that things are different."

She says it is thanks to the regular specialist therapy provided by The Hearing House that her girls are given the opportunity to learn to listen and speak. "Hearing House has a great team of professionals who work with us and guide us through this at a time that is extremely hard but also an amazing experience."

\* Vestibular aqueducts are narrow, bony canals that travel from the inner ear to deep inside the skull. The aqueducts begin inside the temporal bone, the part of the skull just above the ear. The temporal bone also contains two sensory organs that are part of the inner ear. These organs are the cochlea, which detects sound waves and turns them into nerve signals, and the vestibular labyrinth, which detects movement and gravity. These organs, together with the nerves that send their signals to the brain, work to create normal hearing and balance.

\*\* A sensorineural hearing loss occurs when there is a problem in the cochlea that prevents the sound from getting from the middle ear to the brain. This can occur when there are damaged hair cells or supporting structures. This type of hearing loss is permanent.







# Out & About





# Brittle Asthma a constant threat

***Lyreena is a playful, happy and vibrant three-year-old girl who loves to sing and dance but has spent her short life in and out of hospital. On multiple occasions, her mother Marlessa has witnessed her daughter change from being well to limp and lifeless within minutes. She outlines the realities of life with the unpredictable condition called Brittle Asthma.***

Many mums 'wrap their children in cotton wool' but for solo mum of one, Marlessa Heta, doing just that is vital.

Daughter Lyreena, aged three, was recently diagnosed with Brittle Asthma, a condition which has brought many moments of worry and fear for mother and daughter.

One of the first times Marlessa noticed something amiss was after moving into their Kerikeri rental when Lyreena was aged one.

"Lyreena had a cold but it didn't take long for things to seem more serious because she started crying in pain when she was breathing. Her wheeze was loud and her breathing was fast and very laboured. She was also very lethargic," Marlessa recalls.

"I freaked a bit and thought – because it was a Saturday – no doctors would be open, so I called an ambulance. Thank God I did because her oxygen levels were very low and she needed the nebuliser and oxygen administered straight away."

From that point, their life changed.

Brittle Asthma causes fast and frequent severe attacks that can be brought on by factors such as infections, hayfever or allergies, pollen, cold air, strong odours, over-exertion, animal fur, cold or flu, smoke, dust and cockroach droppings.

A mild asthma sufferer herself, Marlessa was not prepared for the extent of her daughter's suffering. She recounts Lyreena recently being sick with a cold and fever:

"We'd had a few full-on days and nights successfully keeping her comfortable and her asthma controlled. Come the third day though, everything that would normally help, didn't.

"Ventolin would work for only 20 minutes max, then she would suffer an asthma attack again. She was in pain and lethargic so I gave her another dose of Ventolin and took her into the doctors where she was put on the nebuliser machine. That seemed to have worked because she was full of beans and back to her normal self.

"But, on our way home, Lyreena started crying and suddenly slumped in her car seat, then vomited for the second time that day. Two minutes later, we were home and when I had pulled her out of the car, she had a temperature and her breathing was short and hard.

"After cleaning her I put her in a luke-warm bath to cool her down. She was crying in pain so I gave her another dose of Ventolin and called the doctor's to get advice but they had already closed so I had to speak to a registered nurse instead. While she was on the phone with us, Lyreena went from being alert to limp in my arms and the sound of Lyreena's breathing alarmed her so she called an ambulance for us immediately.

"I gave Lyreena another dose of Ventolin and she came right again by the time the ambulance arrived. They checked her levels and they were all normal, but just as they were packing up ready to leave, Lyreena had yet another attack so that's when we made the call to take her to be admitted to hospital."

Marlessa describes these ordeals as 'a parent's living nightmare' and says, in between asthma attacks,

***"Compared to the beginning, things are a million times easier. Having a management plan to prevent symptoms arising takes 80 per cent of the fear away and has been worth its weight in gold."***

***- Marlessa Heta.***



Marlessa Heta and three-year-old daughter Lyreena.





Marlessa and Lyreena.

life is a combination of 'just existing' while taking all preventative measures.

"I keep her wrapped up in cotton wool. I wrap her up when out during the winter, and make sure her bedding and PJs are sufficient in keeping her warm all night, mostly having her sleep with me so I can hear if her breathing becomes suspicious. I also keep her inside, and away from sick family members. I keep her home from daycare if she shows any sign of flare-ups, and continue to keep her home until she is 100 percent because I know if I send her even a little unwell and she jumps around and plays around, it's asking for trouble.

"The 'just existing' is basically us just going through the motions when she gets sick, not leaving home a lot and isolating ourselves from possible things that set her off because, once she does, it's a painful time for her and exhausting time for me."

She would love nothing more than to see her daughter lead a normal life but says the asthma limits Lyreena's choices.

***"One thing I have learnt is you don't mess around with asthma. Always ask questions and learn all you can learn to help you provide the best care for your loved ones."***

***- Marlessa Heta.***

"She doesn't get to do a lot of things that normal three-year-olds get to do. Running, skipping, jumping around, riding her bike for too long, being exposed to cold air for any length of time, all bring on her asthma symptoms quite badly. She can't enjoy any time outside if it's windy because pollen in our area is quite high and that sets her asthma off big time. I don't even let her experience fun in the rain for fear she will catch a cold, because it's always developed into some kind of infection which, in turn, plays havoc on her asthma."

However, things have definitely improved, thanks to some community intervention and forward-planning.

After being referred to a respiratory nurse specialist at Te Tai Tokerau PHO, Marlessa was given an asthma management plan to carry out when symptoms flare up.

Healthy Homes Curtain Bank gifted the family new thermal curtains for their home, which Marlessa says, have made the world of difference in keeping the home warm and dry. Her landlord has also insulated the home and installed a wood burner, in response to Lyreena's condition.

In addition, Marlessa ensures medication, masks and other equipment is always on hand at daycare and at relatives' houses, as well as having spares at home.

"Compared to the beginning, things are a million times easier. Having a management plan to prevent symptoms arising takes 80 per cent of the fear away and has been worth its weight in gold.

"I can honestly say I am lucky that I have a fantastic team of people around me helping me to care for my baby."

When asked the effect Lyreena's asthma has on her, Marlessa is reluctant to take the light off her daughter's suffering but eventually admits the emotional and physical toll it takes.

"There is no sleep, no energy and no life because I keep her away from all possible triggers. I worry all the time – when she's at day care, when she's asleep, when she is around

people who are sick and when she is having sleepovers at my sister's place. Depression and anxiety rears its ugly head most days too because it is all-consuming when your child has Brittle Asthma.

"One thing I have learnt is you don't mess around with asthma. Always ask questions and learn all you can learn to help you provide the best care for your loved ones."

# Alzheimer's a draining experience for partners

***This year, Maggie had to surrender her best friend and husband of 58 years to a rest home after watching his decline with Alzheimer's. He has only just stopped asking her to take him back home when she visits. He also sometimes doesn't recognise her. She shares the heartbreak, isolation and stigma that comes with living with Alzheimer's***

Maggie\* and Jack\* had a wonderful life. Best friends and husband and wife since Maggie's teens, they ran a successful business, travelled overseas, owned a lifestyle block and raised four children, who have given them 12 grandchildren and 11 great-grandchildren. Then Jack started to act strangely and as Alzheimer's set in, Maggie watched her beloved partner in life drift away.

It began 10 years ago with memory loss when Jack was 70.

"He became forgetful," recalls Maggie, 78. "He was aware of it and it annoyed him, as it does when you forget things. Then things started to change."

Maggie says he became argumentative and his reasoning didn't make sense.

"I couldn't see his reasoning but he thought he was being quite reasonable. You think you're going mad but

the kids said: 'No mum, you're still sharp as a tack', so I was quite relieved about that."

She recalls one time when Jack lost his hearing aids and was certain he'd buried them in the garden.

"The neighbours must have thought we were mad because we dug up the gardens looking for his glasses. Then I rang audiology to say we'd need some new \$9,000 hearing aids because he'd lost them and the lady laughed and said: 'No he hasn't, he brought them in here'."

An MRI confirmed Alzheimer's.

"Well, you go quiet," says an emotional Maggie, when asked how they took the news.

Although Jack accepted the diagnosis, he never spoke of it and, soon after, things started getting 'a bit hairy'. Maggie won't mention these incidents – some

of them dangerous and, at times, stripping the law-abiding citizens of their dignity. Nor does she want their real identities revealed.

You see, there's a stigma attached to Alzheimer's, she explains. The once keen campervanners not only lost their lifestyle, as Jack's driving ability declined, but one by one, their friends slipped away.

"The stigma in the community was very evident and you lose your friends. They drift away - they seem to think

***"The best decision I made when my husband was first diagnosed with this disease was to contact Alzheimer's Northland. It has been a lifesaver to my husband and myself as a carer."***

***- Maggie.***





they are going to catch it. You feel like telling nobody what is happening in your house – the frustrations, heartbreak, sense of helplessness and isolation.”

The couple met when Maggie was 18. They married a year later. Jack was a comical but quiet man, a hard worker, on the ball, who never swore, a tough but good father and good with the grand kids. He was also Maggie’s best friend.

“He was my life,” she says, apologising as the tears spill over. “You prepare for it for a long time but you can’t show any sadness and blubber in front of the kids so you bottle them up.”

At first the couple tried to keep the condition quiet but that’s hard living in a quiet cul-de-sac. Jack would walk the dog rain, hail or shine until he caught pneumonia after one excursion.

Maggie recalls him setting out down their drive and walking straight out onto the road without stopping to look for cars. It became time to re-home the dog shortly after.

She also recalls being outside gardening, a favourite pastime, and finding herself locked out.

“He just went round locking all the doors and shutting all the curtains. Apparently it’s common to shut yourself in.”

The gardens gradually became neglected as Jack needed a watchful eye 24/7.

During shopping trips he would disappear in a flash and it was not uncommon for her to wake in the night to discover the bed empty – finding Jack in the shower or wandering outside.

“He became a night-time wanderer. They become nocturnal – the whole body clock changes.”

When things became dangerous and the constant worry began taking its toll on Maggie’s own health, it

was time to seek further help.

“The best decision I made when my husband was first diagnosed with this disease was to contact Alzheimer’s Northland. It has been a lifesaver to my husband and myself as a carer.”

While Jack was put into part-time respite care, allowing the chance to mix with others with the condition and take part in activities and excursions, Maggie had the chance to recharge her batteries. She also joined a support group for partners.

“As a carer, I found the group meetings for carers a mild form of counselling where we can vent our frustrations, laugh together at situations and offer comfort to one another. To leave these meetings realising that you aren’t alone in this situation gives you the strength to go back home and carry on.”

Jack is now in the rest home permanently and, although at first he didn’t like it one bit, he has finally stopped asking her to take him home.

“He seems to be settling in and I visit him regularly. He is drifting off very quickly and has forgotten who I am a few times.”

As for life back home, Maggie says she can relax now. “It was exhausting - physically, emotionally and mentally. It’s draining.”

Her hobbies keep her busy, as does her gardening and the invaluable support group.

“It’s not easy,” Maggie says, sitting back and gazing out the window of the home they once shared. “It’s not easy at all. But we’ve had a wonderful life really.”

“In the early years of his illness, I asked him how he was feeling: he said ‘I’m crying on the inside’. This comes to my mind whenever I look at someone suffering from any form of dementia.”

\*Names altered at their request.

## Key facts about dementia:

- 46.8 million people worldwide are living with dementia in 2015. This number will reach 74.7 million in 2030 and over 131.5 million by 2050;
- There will be 9.9 million new cases of dementia in 2015, or one every three seconds;
- In 2015, 58 per cent of all people with dementia live in what are currently classified as ‘low and middle income countries’, rising to 63 per cent in 2030 and 68 per cent in 2050;
- The total estimated worldwide cost of dementia in 2015 is US\$818 billion. In just three years’ time, this will have increased to \$1 trillion. By 2030, this will have risen to \$2 trillion;
- In the period from 2010-2015, global societal costs of dementia have increased by 35 per cent;
- The 2015 update reports a worrying 12-13 per cent increase in global estimates of people living with dementia, compared to the original ADI estimates in the 2009 World Alzheimer Report;
- Estimates from the UK in 2013 show that the annual per person cost of dementia is more than the cost of cancer, stroke and heart disease combined.

Alzheimer’s Northland provides free services for all people affected by dementia throughout Northland. The main centre is in Whangarei, with offices also in Kaitia and Kerikeri.

**For more information, go to: [www.alzheimers.org.nz](http://www.alzheimers.org.nz)**

# Alzheimer's Northland Memory Walks



Margaret Salmon, Jan Rosewarne and Tony Rosewarne at one of the Memory Walks.

Alzheimer's Northland hosted three Memory Walks in September, with young and old stepping up and walking for dementia.

The Memory Walks in Whangarei, Dargaville and Kerikeri were part of 21 walks being held in towns and

cities throughout New Zealand in September, and it's the first year that Northland has taken part.

Alzheimer's NZ executive director Catherine Hall says the Memory Walks are a way to shine light on dementia in New Zealand.

"Dementia is the major public health issue of our time, and these Memory Walks allow us to publicly support people with dementia and their families, friends and carers. They're also a time for us to remember the people we know or have known with dementia.

"Raising awareness through these walks is an important step – we need to do all we can to help people with dementia to live well."

An estimated 60,000 people are living with dementia in New Zealand and this is expected to increase to 154,000 by 2050 due to the ageing population.

Alzheimer's Northland manager Kevin Salmon says the enthusiasm of Northlanders to get out there and draw attention to dementia is hugely encouraging.

## Swinging Sixties Ball

To celebrate 60 years of elder health care in the Kaitia area and the opening of the new dementia unit at the Switzer Home, Switzer and Northland DHB staff collaborated to thank the community for its support with a Swinging Sixties Ball.

"The Swinging Sixties Ball was to celebrate not only 60 years for Switzer, but to celebrate 60 years of working together with staff of Kaitia Hospital. The relationship we have is outstanding and we work so well together in partnership," says Switzer Home general manager Jackie Simkins.

Kaitia Hospital clinical leader Dr Sarah Clarke says: "Switzer is the only rest home and hospital in Kaitia. The new dementia unit means that our patients with

dementia will no longer have to go out of area once they need rest home level care, allowing family to visit and still be involved in their care.

"The hospital wanted to be involved so that it could also say a big thank you to Switzer, as well as to all the other services that are so important to elder health, including GPs (and associated community-based services), the pharmacy and emergency services."

Adds Jackie: "I'd like to say that the Switzer Trust board recognises the support and the efforts that the DHB makes to ensure that they work alongside us in partnership to help us to deliver our services. However, a very big thank you to the whole community for another outstanding fundraising effort."





# Ko Awatea International Excellence in Health Improvement Awards

Northland DHB Clinical Audit Manager Dr Jozsef Ekart won the 'Outstanding Leadership in Quality Improvement' category at the 2015 Ko Awatea International Excellence in Health Improvement Award.

Introduced in 2015 and hosted by Ko Awatea during the annual APAC Forum – Asia Pacific's largest healthcare conference – the awards recognise individuals and teams who are leading health innovation and quality improvement. Dr Ekart's entry, 'Building a Culture of Clinical Performance Improvement', showcased the development, implementation and the success of our new clinical audit programme.

Dr Ekart and the members of the Quality Improvement Directorate see the award as an acknowledgement of everyone who has contributed to the programme's success, especially the clinical staff initiating, conducting and supporting clinical audit projects.



Dr Ekart receiving the award, supported by Cristina Ross (Manager, Quality & Improvement Directorate, at left) and Karen Bennett (Quality Improvement Facilitator).

## Diabetes Fun Run & Walk – time to get your team together and enter

The annual Diabetes Fun Run & Walk is on Wednesday 11 November this year, with all proceeds again going towards funding camps for young Northlanders with diabetes.

The event starts at the Sails Bridge at the Whangarei Town Basin Whangarei, with registrations from 5.15pm ahead of a 6pm start.

Register a team and challenge your colleagues, or

enter as an individual. The entry fee is \$5 per adult or \$2 per child.

Go to [www.northlanddhub.org.nz](http://www.northlanddhub.org.nz) to register online, and bank your registration fee to:

**Diabetes NZ Northland bank account:  
02 0492 0249039 00**

(donations can also be made to this account).



The 2014 Diabetes Fun Run & Walk.



The 2014 Diabetes Fun Run & Walk.

# Stylish uniform sparks a 50-year career

It was the uniform – “the veil, white seamed stockings, red cardigan and starched white uniform” – that captivated the attention of an eight-year-old Jenny Nilsson (later Subritzky), and set her on the path to becoming a dental therapist.

Jenny retired in early November after 50 years of continuous service in oral health.

Her training at the Auckland School for Dental Nursing in the mid-1960s took place initially on treadle drills, then portable slow-speed drills.

On graduation in 1967, she was posted to Awanui – where in those days the sealed road ended, and a phone call to Kaitaia was a toll call.

She recalls travelling to Ngataki on one occasion and examining the school children at their desks, using a mirror and explorer (probe) and a jar of Dettol to sterilise the equipment between patients.

“The main options for infection control were meths, Dettol and boiling water.”

This solves an age-old mystery: the combination of meths and Dettol is responsible for the distinctive dental clinic smell.

“We didn’t have gloves – they’re quite modern – and we used to mix the amalgam for fillings by hand, with a glass mortar and pestle to combine it, and then wring out the excess mercury using a piece of gauze and our bare fingers.

The significant changes she has seen over the years

***“The main options for infection control were meths, Dettol and boiling water.”***

***- Jenny Subritzky.***

include the arrival of high-speed drills, stainless crowns, fissure sealants, better anaesthetics (leading to virtually pain-free dentistry) and more radiographs.

“And dental assistants who came on board in 1996-97 – that’s been wonderful. I can’t thank my awesome assistants enough.”

Jenny says there’s much less decay



Jenny Subritzky on the school grounds at Te Hapua in the Far North, on the shores of Parengarenga Harbour – a location where she has enjoyed much of her career.

now. “It’s great to be going out to a school that would once have taken us six weeks and doing it in three – and not taking out hordes of teeth.

“Going to the schools is important, especially in areas like this, where it’s a 120km trip one way to get to Kaitaia and finding that extra for expensive fuel can be a challenge for families with a lack of employment opportunities.”

She says the reputation of the dental clinic as the feared ‘murder-house’ has all but disappeared.

So has the experience fulfilled on the dreams of that eight-year-old with an eye for a stylish uniform?

“If you’d asked me that 10 years ago, I would have possibly said no. I’d seen a number of years of changes and things didn’t flow.

“But it’s gelled now and I think we have to take our hats off to Pip [oral health service manager Pip Zammit] and Jeanette [Jeanette Wedding, general manager, child, youth, maternal, public & oral health] for that.

“It’s very fulfilling and I still love the kids and the job and it’s been a mammoth decision to make to retire.”

Her future involves spending more time on her lifestyle block, entertaining tourists who stay on the property, being more available for family, and doing more voluntary work once she adapts to her new lifestyle.

Jenny adds that after 50 years, she’s going to enjoy longer fingernails and nail polish whenever she feels like it.



Jenny on her graduation day in 1967.



# Electronic assessments ensure all information and experience is available

Electronic assessments at the Pre-operative Assessment Clinic (PAC) are making patient journeys – from their first specialist appointment to surgery – more transparent.

The electronic assessments can be accessed remotely by anaesthetists and other members of the Multi-Disciplinary Team (MDT).

Previously, all assessments of patients by the PAC nurses or anaesthetic assessments had been in hard copy form, meaning they could not be accessed remotely by anaesthetists.

In addition, if a patient was admitted acutely, these assessments were not visible, so what could have been an effective resource was under-utilised. Notes for patients are also often held at regional hospitals. For acute admissions, the PAC assessments represent an invaluable tool for establishing a baseline.

The concept of electronic assessments was proposed almost two years ago, with the project team initially involving two PAC nurses, a consultant anaesthetist and a member of the IT team.

The majority of elective patients do not see an anaesthetist and therefore need to undergo a thorough assessment by the PAC nurses. This allowed standardisation of assessments, along with legibility, to be achieved. The changeover to electronic assessments began in November 2014, with ongoing audit and feedback through regular meetings and updates until March 2015.

Originally, it was expected that there would be two electronic assessments: all patients seen in the PAC would be assessed there by the nurse, with a proportion of these patients then going on to see an anaesthetist, using documentation specific for that purpose.

This proved to create more work, doubling up on information. The solution was to make available separate forms for anaesthetists who wished to use them; however, the majority of anaesthetists add their comments to the nursing documentation.

## Benefits

- Other departments have access to a patient's status;
- Assessments have been used as a baseline for patients attending ED acutely;
- Discharge documents are easier to prepare as relevant information is readily available;
- Holistic assessments also highlight possible discharge problems;
- Legibility of assessments has eliminated problems with deciphering pre-operative plans and instructions;
- Most patients are 'Day of Surgery Admission', so the electronic assessment acts as an admission to the ward.



Pre-operative Assessment Clinic team members (from left): Pamela Latter, Val McAlister, Shelley McMahon, Joy Summers and Chris Garczynski

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