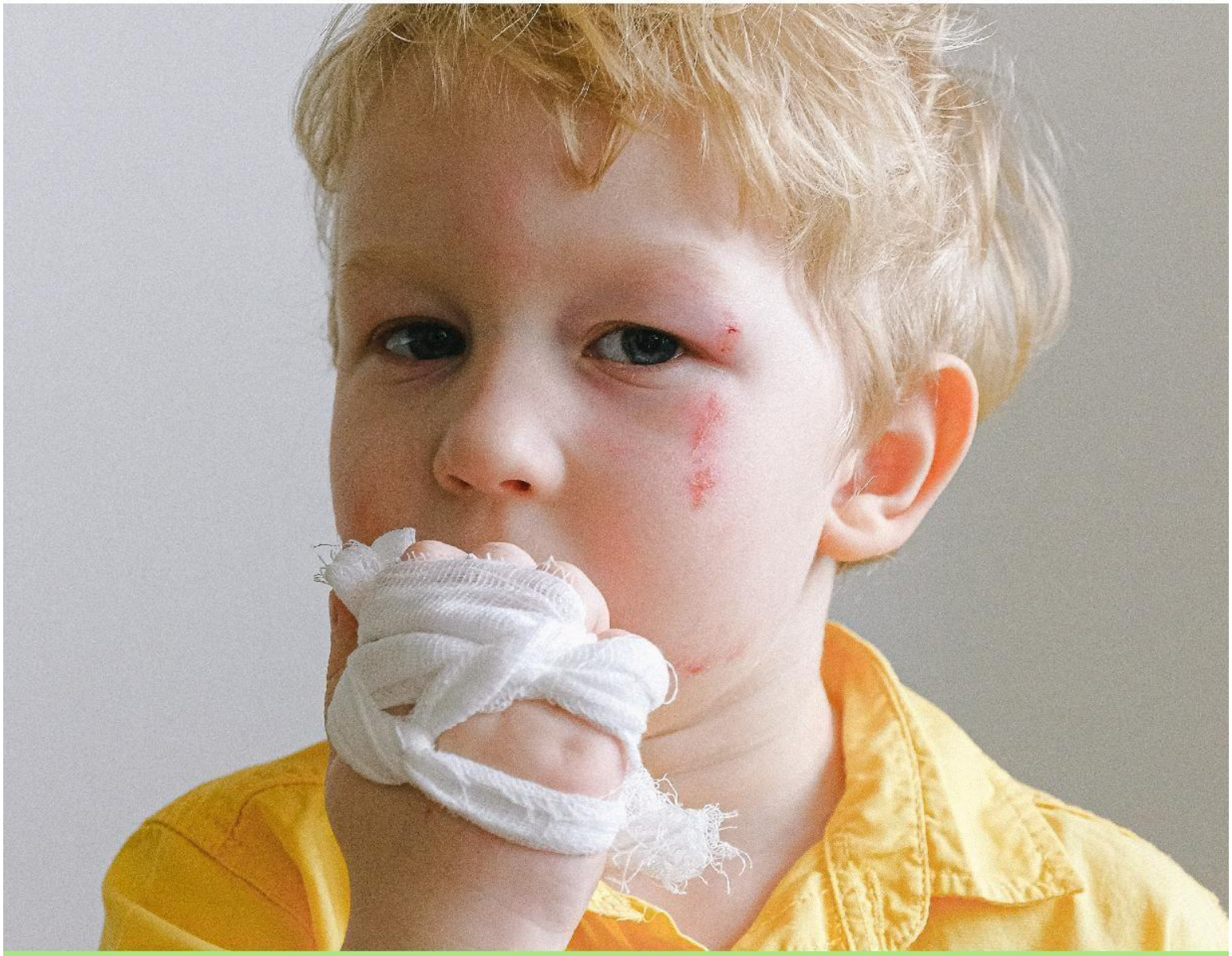
LOGIC.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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



SPRING 2020 EDITION

WOUND CARE

VITAMINS - SAFETY AND OVERUSE

SLEEP DISORDERS

PHC STUDY DAY

STRIKE PHOTOS

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

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

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Summer 2020-
In this issue….

Chair's Report

Celeste Gillmer
Chairperson

2020 will definitely be a year no one will ever forget. It's been a year of change, challenge, new learnings, frustrations and celebrations. The worldwide pandemic has taught us new skills and brought the team of 5 million in New Zealand much closer together.

At the end of this year, I just want to say thank you to each and every Primary Health Care nurse in New Zealand. 2020 was the year of the nurse and you have definitely stepped up this year and no doubt, without our front-line workers, things would've looked much different for New Zealand. Thank you thank you thank you.

I hope you all get some time to relax with your families over the summer period. May you find some quiet time to reflect on the amazing work you have done this year and recharge for the new year.

I wish you all a very merry Christmas and see you in 2021!!

Editor's Report

Yvonne Little

Nurse Practitioner

It's coming up time to say goodbye to 2020, a year that started out with promise quickly turning into what some would say a nightmare.

I'm not sure if our younger members will recognise this quote but those of my ilk certainly will:

"When life gives you lemons, make lemonade"

As nurses with our positive can do attitude, optimism in the face of adversity – we rose to the challenge and adapted our care provision to our patients/whanau to be able to provide the necessary services and ore in these difficult times. As you would have seen in our Autumn/Winter issue there were some great examples from our members.

The frontline wasn't the only area to make adaptions, LOGIC also had to make adjustments. Instead of bringing you the regular four issues a year, we had to combine the Autumn/Winter issues and now the Spring/Summer issues. Whilst, this has been frustrating for us, it was inevitable as our article writers and our committee members are all frontline workers first and foremost and hence the ability to write and gather articles was limited due to COVID-19.
Despite these setbacks, I hope you are still enjoying our journal.

I would like to say a big thank you to the LOGIC team who work hard in their own time to get people to write articles or write some themselves. Sadly, as often happens some of our team have resigned for various reasons. Thank you to Annie Tyldesley for your valuable contributions over the past few years and we wish you the best for the future, although I am sure we will still see the odd article from you in the future.
Helen Parry, whilst you were only with the committee for a short time, your contributions were also greatly appreciated. Best wishes to you also.

As our committee is currently down a couple of members, if you have a great contact network and would be interested in joining our dynamic team please contact either myself or our Chair/Publisher Celeste Gillmer. Being on the LOGIC committee is not about writing articles yourself but being able to source writers of articles. Although, if you have an article just waiting to be written and the creative vibe strikes you then you certainly can provide these articles.
In the midst of all this upheaval of COVID -19, one of our committee members has

managed to complete some study, so congratulations Lee-Anne Tait on attaining your Nurse Prescriber Qualification. Well Done.

So, now we have adapted to our new "normal" ways of living and working I hope that 2021 brings you less chaos and disruption.

Our plan at LOGIC in 2021 is to bring you the four journals with interesting articles from a wide variety of nursing areas, so if you have an article that is waiting to be written or some photos of events in your area please contact us, we would love to hear from you.

Finally, please mark in your diaries the 6th March 2021 for our NZCPCHN symposium which is being held in Christchurch. For this we have teamed up with the College of Nurses and it will be a fantastic day. Please see the flyer in this issue for the full details.

Wishing you and your families/whanau a Happy and relaxed festive season. Take some time to care for yourselves, keep healthy and reflect on how well you've managed in the 2020 year.

New pressure injury prevention resources available

From The Chief Clinical Office at ACC

ACC, together with the New Zealand Wound Care Society (NZWCS), the Health Quality & Safety Commission, and the Ministry of Health, has developed a new set of resources to support the prevention of pressure injuries.

Thousands of New Zealanders get a pressure injury every year and when they happen, these injuries have a significant impact on peoples' lives, and on the health system.

The 'No Pressure' resources have been developed to provide nationally consistent information about pressure injury prevention, for clinicians and patients. They are designed to support conversations between people at risk and their health professionals, to help identify the early warning signs and prevent pressure injuries from happening.

The full set of resources includes a patient-focused flyer in 15 languages, posters, and a classification chart for clinicians. These are now available on the NZWCS website and can be ordered at no cost from ACC's online ordering system.

For more information about ACC's pressure injury prevention programme visit www.acc.co.nz/treatmentsafety

Report from the Office of the Chief Nurse

These will be the final excerpts from Margareth Broodkoorn whom we had the pleasure of meeting with via ZOOM at our recent NZCPHCN Executive and Combined Committee Meeting in November 2020. I have taken some of the excerpts from Margarethe's CNO letter and discussion from our meeting.

It is with mixed feelings that we are saying farewell (not goodbye – as I am sure we will see and hear from her in the future in her new role) to Margareth as Chief Nurse but also wishing her well in her new endeavours where she will be closer to her whanau.

Margareth mentioned the word Villaging at our meeting – some of us weren't aware of this term but apparently it is what we have been doing during COVID-19, in the International Year of the Nurse – pulling together and working together for the best outcomes for all. Recognition of those who have suffered, succumbed and those still on the front line. Also, those doing the business as usual to maintain health. It is about celebrating and thanking the above groups in this The International Year of the Nurse and on International Nurses Day.

Taken or adapted from CNO Letter:

COVID-19

We are indeed within a time of constant change and uncertainty, it is therefore important to continue to be kind to each other, and to ourselves.

No matter the Alert Level please continue to use the COVID tracer app to keep track of where you've been and who you've been in contact with.

MENTAL HEALTH

We need to find ways we can manage our wellbeing: find ways to give, be active, continue to learn, connect with others, and notice the good things happening around us.

Sometimes it's easier said than done to fit these things into our busy lives, but it's worth the effort. The small investment reaps bigger rewards. Sir John Kirwan has recently shared some of the tools and resources available to support mental wellbeing including his personally designed application 'Mentemia'
https://www.mentemia.com/nz/home.
I would highly recommend downloading this app as it provides some excellent advice and ideas on how to keep well.

INTERNATIONAL YEAR OF THE NURSE

The International Year of the Nurse ZOOM coincided with Mental Health Awareness Week in September led by the Mental Health Foundation. The theme was Reimagine Wellbeing Together-He Tirohanga Anamata.
https://www.mhaw.nz/
Thank you to Suzette Poole and Chrissy Kake, President and Kaiwhakahaere of Te Ao

Māramatanga, the New Zealand College of Mental Health Nurses for planning this wonderful event.

VOLUNTARY BONDING SCHEME

Voluntary Bonding Scheme 2021 intake New professions have been added to the 2021 Voluntary Bonding Scheme, which is offered every year to encourage newly qualified health professionals to work in the communities and specialties that need them most. The new professions added include enrolled nurses working in mental health and addiction and aged care, as well as more locations for midwives. Outside of nursing and midwifery, public sector radiation therapists and medical physicists have also been added. The Registration of Interest period for the 2021 intake is expected to open for six weeks beginning in February. Keep an eye out for more information in future updates.

NZRGPN NURSE PRACTITIONER RECRUITMENT INITIATIVE

Following a Registration of Interest process that involved an open invitation to all rural health services to apply, five rural health providers have been selected to establish new Nurse Practitioner roles within their teams.

Congratulations to Toi Ora Health (Ōpōtiki), Raglan Medical Centre, Taumarunui Community Kokiri Trust, Waiau Health Trust (Tuatapere) and Hauora Hokianga (Rāwene) that were selected. We look forward to following updates as each of the new roles become established.

NURSE PRACTITONER TRAINING PROGRAMME

Clarification of final year master's pathway for Nurse Practitioners and the nationwide Nurse Practitioner Training Programme (NPTP) Given the launch of the nationwide NPTP, it has been a bit confusing for some students regarding NP pathways and access to funding. This statement aims to clarify the pathway and briefly outlines the two funding pathways: NPTP; and Postgraduate Nursing Funding. Nurse Practitioners (NPs) are required to have completed a master's degree in nursing through a Nursing Council of New Zealand (NCNZ) approved pathway at an approved tertiary education provider.

There are two funding streams for nurse practitioner training:

1. The Nurse Practitioner Training Programme (NPTP) The Ministry of Health announced funding for a nationwide NPTP to commence in 2021 for 50 NP training placements per year. This new programme is being delivered in partnership by the University of Auckland, the University of Otago, and Victoria University of Wellington. The new programme replaces an existing pilot Nurse Practitioner Training Programme (NPTP) delivered by the University of Auckland's School of Nursing and Massey University which is due to end in December 2020. The NPTP is funded directly by the Ministry of Health to the Universities in partnership to deliver the nationwide NPTP.

Additional funding is provided through this programme to ensure students receive:

- 500 hours supervised practice (with NP or senior doctor)
- Release time for a minimum of 12 study days
- A minimum of 10 days in a secondary placement
- Clinical supervision by a NP either in their main or secondary placement

• Regular support and site visits from a NP academic mentor
• Mentoring to complete NP portfolio, mock panel assessment, & registration with NZNC
• Additional discretionary support for Māori and Pacific students.

Students interested in applying for the NPTP should contact the University provider of their choice to discuss their eligibility for the programme. Information and the application form are available from: https://www.auckland.ac.nz/en/fmhs/business-employers-community/continuingeducation/national-nurse-practitioner-training-programme.html

2. Post Graduate Nursing Funding Nurses may complete master's courses to register as NPs delivered through other tertiary education providers. Students attending these programmes are eligible to access Post Graduate Nursing Funding (Health Workforce Directorate funding) through their local district health board (DHB) under the direction of the Director of Nursing and their postgraduate education coordinator. All master's programmes that meet the requirements for registration as a NP have to meet the standards required by the NCNZ. The introduction of a nationwide NPTP does not change the opportunity for nurses to complete their final year practicum courses through their existing tertiary education provider. As noted, there are options available to complete these requirements.

AWHINA APP

What is Āwhina?

Āwhina is a mobile app that lets health workers access the latest information from the Ministry of Health and other trusted sources. The app pushes notifications about updates or new content and, allows users to save content in the app for quick access later on. Recently we have seen an increase in the use of the Āwhina app. Thank you to all of you who have downloaded the app and/or encouraged others to download and use it. More information can be found on the Ministry's website here. The Ministry is continuing to review and improve the app's functionality based on feedback. Feedback about the app or its content can be provided using the feedback function within the app or by emailing: Awhina.info@health.govt.nz.

The re-emergence of COVID in the community last month resulted in a >350% increase in users on the app.

Āwhina – September release features:

• Ability to submit feedback on articles from the app
• Updated menu items, including a new resource for pressure injuries
• App icon badge on all devices
• Improvements to the Notifications list – notifications display in order of most recent first,
and the notification bell count updates when articles are viewed in Latest Information feed.

NURSING LEADERSHIP

The August and September months have been a bitter sweet period for announcing changes to nursing leadership across Aotearoa. Congratulations to Phil Halligan who was formally appointed to the Director of Nursing role at Wairarapa DHB. I had the pleasure of attending the recent 2020 Year of the Nurse and Midwife formal dinner function hosted by Phil and Midwifery Leader Michelle Thomas. It was a great evening celebrating nursing and midwifery practice in the Wairarapa. In December

Northland DHB is welcoming a new nurse leader to Tai Tokerau. Maree Sheard has been appointed to the position of Chief Nurse & Midwifery Officer, Northland DHB. Maree has held previous nursing leadership roles, including with the NZ Defence Force. I would like to take the opportunity to thank Dee Telfer for her passion, energy and integrity for covering in the acting role for the past 18 months. Northland should be proud to have had Dee in the role for this period, and what she has contributed during this tenure. Thank you Dee. Sadly, the Canterbury region (and the rest of the country) bid farewell to Mary Gordon. As a well-recognised and respected nursing leader in New Zealand and with over 30 years of health sector experience Mary's contribution to nursing has been far reaching and impactful. On a final note, I too have announced my departure from the Chief Nursing Officer position with the Ministry of Health. I have accepted the role of Chief Executive Officer with Hauora Hokianga, an integrated health service in Hokianga, Northland commencing in early 2021. It has been a difficult decision to make, but one where I will take the enormous learnings from the time working in the Ministry of Health and duly apply this learning to the CEO role at Hokianga. As the old saying goes – 'once a nurse always a nurse' so I will continue to influence nursing albeit in a different role… and geographical area. In returning to the Hokianga, I will be closer at hand to the delivery of health services and to the COVID-19 response in a remote rural community.

I want to again recognize the excellent job that you are all doing across the health sector, where ever you are making a difference in a health care setting, and in particular those involved in responding to the outbreak in Auckland and beyond. Please continue looking after yourselves and each other as we respond to this challenge together.

Thank you again for all the work you have done and continue to do to ensure that New Zealand's health services are delivered to the highest possible standard.

Rural Muster

Lee-Anne Tait

Rural Health Nurse at Te Whare Ora O Eketahuna – Eketahuna Health Centre

COVID - feeding the future ?

I don't know about you, but I'm tired and so is the community around me. …This year has been so long with so many changes that we are all trying to come to terms with. The community I serve in Eketahuna are all asking that we return things at the health centre to how they were before COVID- but sadly there is no going back in many instances, because COVID taught us albeit in a short sharp shock way -that we could do many things quite differently. However, in order to do so we needed to work more collaboratively together and realise we must support one another more ...

Business within the last two trimesters was certainly different to our planned health promotional stance for 2020. In the first trimester we were promoting "2020 – The year of balance"– with the intention of encouraging our patients to use this year as the health foundation for the decade…. To start addressing the underlying habits they had formed that were detrimental to their health and looking at ways to change things for the better for themselves.

We had spent all trimester one doing Diabetic and Cardiovascular Annual Reviews, Weigh ins, Brief Opportunistic encounters etc – all with the aim of showing patients how they could bring about positive health change in the year and decade ahead…Collaboratively we devised lots of health plans, focused on alteration in eating habits, group activities for exercise classes, social service visits, mental wellbeing groups and night school classes etc.. Then along came COVID and many of these health plans went out the window as basic survival set and the levels of lockdown of the country escalated and Maslow's hierarchy of needs took on a whole new meaning for this community…

Complying with government recommendations we altered our practice – altered policy and procedures. We stopped all group meetings, and started limiting entrance to the health centre – we telephone triaged where possible and diverted all respiratory cases, saw one person at a time within the clinic – with outside waiting with social distancing for those needing treatment. This allowed for minimal contact, reduced risk of infection spread and allowed us the time to clean all surface areas and equipment in between each person.

We set up drive through Influenza vaccination clinics, and had extremely good local responses considering we had already administered 100 vaccines in March. The huge local uptake of the Influenza Vaccine was most likely due to the government's excellent advertising campaign during COVID 19. We gave out another 125 vaccinations over April and May – which was double our

average number for the year for this small rural community.

As we reached Level four, we had to send one of our Registered Nurses on home leave due to an underlying health condition. Our other two relief nurses could not work as one was too old (70) and the other already overstretched in her main employment. This left us with one nurse to work in isolation over this period. Thus, we set about organising background support. Think Hauora from Palmerston North came to our rescue and assisted with a second RN for all our drive through Influenza Vaccination clinics. They offered advice on the best way to organise the health centre in terms of internal and external clinics, along with policy and procedural guidelines for us to follow, especially in relation to suspected COVID 19 cases and the redirection to testing and treatment centres only. They also organised regular Zoom meetings which ensured we were all following the same directives and were fully aligned in our practice with those across the country, which was totally reassuring at all levels of professional accountibilty.

Our IT Guru aside from sorting Zoom links, managed to find a way to divert the telephone and computer to the RN on home isolation to give some relief to the RN in the clinic when needed. ….As I don't know about you, but we found the hardest thing overall throughout this time period were the relentless telephone calls - from the important which were ok and acceptable. These however were always interspersed with unbelievable ones – the ones which were so annoying, pointless and totally distracting in a busy day when you are trying to wade through the workload of two people by yourself. For example –"what time is the government announcement today?", "how many people do you think will have it?", "how many people have you swabbed?"; "what level will we go into next?", "Do you think the government are telling the truth?- My head hurt with the stupidity of it all and also at having to be polite and professional at all times…..

Whilst it was a great privilege to support the community when so many other areas / organizations were doing telephone triage, we also had the burden of doing other agencies work as well as our own as I'm sure all the other rural communities did. For example we had an elderly gentleman deteriorating over this period under Hospice cares, he required daily nursing cares – (for medication/wound pressure area care etc.), so either the RN or the District Nurse or both would visit the family depending on the level of care needed in order to minimize exposure from travelling area to area for the Hospice Nurses, as they had to travel from Palmerston North to Eketahuna. Thankfully with combined input and Hospice telephone support, along with lots of PPE, this gentleman remained comfortable over this period, with his wonderful family living in and managing all other cares. And he passed away peacefully at home, with his family beside him.

As with the above family, and all others we came into contact with during the acute COVID 19 phase, we tried our best to always minimize exposure for the patient and the care provider, for example- the Home Help would collect a prepared meal from the health centre foodbank and take them to an elderly patient if they were visiting them that day. Or if a patient was in the health centre for urgent bloods, their dressing was also done where possible by the RN to save the District Nurses visiting them at home. This was totally reciprocal on the part of the

District Nurses and other health providers wherever possible.

In terms of food support - Tararua District Council and the local Iwi were very good at dropping off food supplies for redistribution whilst we were at Level 4. Also local people gave prepared meals or vouchers for the local Four Square in order to help those who were self-employed or that they were aware were isolated or struggling with limited income.

Furthermore, we noticed that those who were self-employed or working cash in hand, or under the table so to speak, fared the worst because money now became so hard to come by. We had so many people reveal the truth behind their social circumstances because they really needed assistance. We discovered people in dire poverty due to private overpriced and overcrowded rentals and limited undeclared income.

We gave food supplies out to many people who were not registered at the health centre but we had heard from the community/ council helpline that the need was there. Sadly many of these people never completed registration paperwork at the time and have failed to bring it in since, but these were exceptional times and exceptional circumstances. Some days we left most food parcels or pre-prepared meals on doorsteps or in mail boxes for those we had heard about or elderly who were not in contact with their families /friends at this time and went back the next day to make sure they had been taken in.

All in all we gave out 130+ food parcels/ along with prepared daily meals beyond count during this period, along with a bountiful supply of Wai Waste items going daily from the collection spot outside the health centre. Our community Garden was almost depleted and we spent the latter half of the lockdown trying to replenish with seedlings in case situations became dire as the months passed.

We learnt much from that time – mainly about the fragility of our community especially in terms of financial wellbeing and food poverty. We have since joined in a local and regional collective and attended a recent Hui aimed at finding ways to address the need for ongoing free quality food in all areas of the country. The stance of this collective is that good food needs to be easily accessible within each community and also accessible without stigma and this stance should be adopted throughout NZ. From this Hui I learnt that Martinborough had allowed people to choose from a set budget what they need from their food bank pantry. So we tried this last week at the health centre. We have only given out three food parcels this week – but I could see people felt more autonomous and comfortable at choosing what they needed and really seemed to appreciate that the local community had given these supplies for them and took what they needed accordingly…time will tell and I intend to start some ongoing questionnaires to follow up on this method. Also I will be working more with local councils for supply chains, along with Wai waste and sustainable communities, social and budgeting services as a way to go forward, in order to help people become self-sustainable in the future.

Diabetes Education Trust have also supported the health centre with a healthy eating cooking demonstration, which was really well attended – mainly by our retired / elderly population, many of which we fed with such meals over COVID also there have been requests for “Food on a budget” and “Understanding Food Labels for 2021. Also our community garden is thriving with all the recent sun and rain, and our

social and physical activity are up and running again.

As I mentioned earlier COVID highlighted the housing poverty in this area – so this week we also attended Mid central Health and wellbeing Hui in order to address our housing shortage in this area. The meeting was well attended and I can already see plans are afoot, with ideas for short term and transitional housing, along with MSD support towards long term housing and financial sustainability. I hope this is reflected in all areas of the country.

In terms of clinical consultations going forward – I finally have my Nurse Prescribers License – Yay- this will help to reduce patient health costs and streamline some clinics for us. Technology is amazing and we are still telephoning /zooming out to GPs for support. However, patients have complained that they are really missing the physical presence in terms of consultations- so there is hope we will have a nurse Practitioner who will do some in person clinics 2021 – which will be amazing.

I should wrap up now. But before I do I hope in all of your areas of clinical practice there have been some positive changes brought about by COVID. It's been a long year….Like many of you I am truly tired, totally saddened for our global nursing workforce, our worlds people and this dire state of grief and loss- may God bless one and all. However, I feel gratitude for local and national collaboration as I hope you do to –it seems we are doing many things better or to the best of our current capacity. Let's be grateful for our progress and for those annual leave days ahead of us……

Community Nurse Prescribing

Wendy King

It has been a long journey for Community Nurse Prescribing, from preliminary scoping by Nursing Council in 2015 and 2016, to a Community Nurse Prescribing pilot at Counties Manukau in 2018.

At Waikato DHB, an 'RN prescribing pathway and credentialing working group', met throughout much of 2018, after that there has been with what seemed like a long period with nothing heard until August when a call was put out for Expressions of Interest for Community Nurse Prescribing programme

The Midland Collaborative Designated RNPCH Recertification Programme is composed of the five DHBS, Taranaki, Waikato, Lakes, Bay of Plenty and Tairawhiti and includes the 8 PHOs in this catchment

A presentation at the Waikato DHB Nursing Roundtable reported the November 2020 intake has 67 Expressions of Interest and the next intake is scheduled for the end of February 2021.

Programme development opted for an online format. The advantages of this it will allow unlimited and variable numbers to enrol, intakes will not be limited by administrative aspects such as room bookings and the timing of the intakes can be varied. Noting the work life of nurses the tutorials online presentation sessions will be in the evenings and in-between learners can access the programme at their own pace via Ko Awatea.

Working collaboratively during COVID-19: How Public Health Nurses contributed to the response.

By Nicola Thompson

(First published in NZ Doctor August 2020 and reproduced here with permission)

This article provides a brief insight into some of the initiatives the Nelson Public Health Nursing Service developed and worked collaboratively on, during the COVID-19 pandemic response. Pre-COVID the Nelson Public Health Service would normally cover a range of primary health care services including School-based immunisation, B4 school checks, Well Child Tamariki Ora, Outreach immunisation, Sexual health services, as well as managing personal health referrals for conditions such as anaphylaxis education, enuresis, encopresis and eczema. However, over the past few months the Nelson Public Health Nursing service quickly adapted in response to Covid-19. This resulted in changing the way we deliver our services in order to best respond to the changing health care needs of our community. The following is a summary of the new initiatives and some of the challenges that have presented over the past few
months for our service and the links to general practice and the Nelson Bays PHO.

New initiatives &/or services delivered during 'lock-down':

1. Development of a Wellness team to support people in emergency housing. This resulted in a successful collaboration of primary health care providers including Nelson Bays PHO, Te Piki Oranga, and the Nelson Public health service. These agencies coordinated a response to provide health and wellbeing support for a number of people placed in emergency accommodation during lock-down. Many of the people seeking emergency housing had complex and often unmet health and social needs. As they gained trust in the Wellness Team their needs were identified and they were supported with negotiating services such as medical care and addiction services. This has highlighted issues around accessing general practice and other support services for vulnerable people when a coordinated response may not exist.
2. **Pop-up' influenza vaccination clinics for vulnerable communities and the front-line health care workforce.** The community clinics included boarding houses, emergency accommodation sites, staff at community mental health and

disability services, district nurses, and PHO frontline staff. At one of the boarding houses that provides accommodation for over 200 people, the PHNs involved noted how important the flu clinics were for "v*ulnerable populations living together in high density housing, and how challenging it is for large residential accommodation to maintain social distancing during level 4."* For a significant proportion of the people vaccinated it was their first flu vaccination. Many were anxious and unsure but following discussion and reassurance from the PHN team they proceeded to be immunised. This has been a great opportunity to help build up confidence and trust in vaccinations and the health care system in general.

3. **Support for the Victory Refugee Community.** Initially it was identified by one of the Nelson PHNs that *"there was very little resource developed or advice available for refugees about covid-19. One of the main concerns was that if a refugee was unwell and felt they should be tested for covid-19, how should they go about this? If they turn up at a GP or CBAC how do they explain what language they need for an interpreter to be organised? Who is explaining to former refugees what each level of lockdown means or what isolation means?"* As a result of recognising a need for support for the Refugee community a new initiative started at the local community centre. Collaborative efforts between the local GP, Pharmacy, Nelson Bays PHO and the Nelson PHN service resulted in providing an influenza vaccination programme, and moving the CBAC closer to the community in which the former refugees live.

4. **All the Public Health Nurses were trained in Covid-19 case management 'daily follow-up'** so they were ready to respond if and when needed. The process of daily phone calls people with COVID-19 in isolation highlighted the importance of phone call assessment and support during COVID-19 – particularly for those who were living alone.

5. **Educating front-line disability and mental health support workers on correct use of PPE and infection control measures**, highlighting the importance of protecting the workforce and their clients – both high risk groups in the community.

6. **Providing staff for the SWOOP and CBAC teams from the PHN service**. (The SWOOP team is a mobile team created to provide rapid response to patients at home or in care with a view to preventing hospitalisation).

As it was for many other primary health care providers, throughout the pandemic response one of the biggest challenges for the PHNs was keeping up to date with rapidly changing best practice and/or new knowledge about COVID-19. For example, use of PPE, changes to case definition, signs

& symptoms, mode of transmission, and community education/protection. This was particularly the case when providing services in new and unusual environments, for example, flu vaccination clinics at emergency accommodation, such as camping grounds, while ensuring safe and effective practice against the risk of transmission of Covid-19.

Conclusion

Nelson Public Health Nurses like many primary health care services around the country, have quickly and effectively responded to the situation we found ourselves in. In collaboration with other health providers in our region we have provided innovative ways of managing our communities' health care services during the pandemic response. One of the biggest 'silver-lining's' of the Covid-19 situation is that it has given us the opportunity to work collaboratively with other health providers to change the way primary health care is delivered, to make it more patient/whanau focused, and coordinated. The challenge now is to keep the momentum going, make the changes sustainable and grow these initiatives to becoming the 'new norm' in primary health care.

Did you know?

Erica Donovan

As an NZNO member you can join up to three Colleges or Sections. If you're reading this, you're most likely already a College of Primary Health Care Nurses member (if you're not, you can join up for free here groups that might be of interest are the College of Child and Youth Nurses, Aotearoa College of Diabetes Nurses, College of Gerontology Nursing, Infection Prevention & Control Nurses College, Women's Health College.

Since Primary Health Care encompasses a broad range of jobs so there might be others as well, you can find the full list on the NZNO website.

NZNO Primary Health Care Delegate Committee

Wendy King

November 2020

After a 12 month gap due to that COVID thing; we met last week in Wellington; so this was just my second meeting as representative for the CPHCN. There was nearly a full attendance by delegates, with just one vacancy; Maori and Iwi providers have a vacancy for another representative.

Representatives had been asked prior to the day about current issues; round table feedback from delegates and there were consistent themes common to primary care sectors

- Recruitment of nurses; appropriate, experienced in primary health care work
- Access issues; increased population but less GPs
- Workload and complexity increasing
- Pay disparity within DHBs and between DHBs , for nurses performing the same work with the same qualifications

Part of the day was mini workshop on the End of Life Act 2019; in a short time a number of issues were identified that will need to be addressed for all nurses in the implementation of this act in the next 12 months. Not only is the issue challenging, but it will be a challenge to up skill nurses in time; nurses will need education, guidance and support from Nursing Council, NZNO and employers

Some delegates were quite excited about pay parity themes; increasingly it seems unacceptable for disparity for nurses compared to other occupational groups, but also within nursing questioning the equity and fairness of remuneration for comparable work.

Looking at my notes from last year and noting recruitment and retention issues then ;- it's a situation of little-or-no- change. How do we meet the challenge of growing a new graduate to experienced skilled primary care nurse? Do we have appropriate training and development?

The next meeting is early next year, by then there should be an outcome from PHC negotiations!

Occupational Health Nursing

Nikki Edge

Nikki Edge, RN, BN, PGDipHSci (endorsed for Occupational Health), Occupational Health Nurse Consultant on site ensuring the health monitoring she is completing is hazard specific

Occupational Health Nurses (OHNs) are Registered Nurses with knowledge, skills and experience in occupational health. The New Zealand Occupational Health Nurses Association (NZOHNA) defines the objectives of Occupational Health Nursing as preventing work-related injury and disease, promoting health, wellness, work ability, and reducing environmental risks to workers and the wider community (NZOHNA, accessed January 2019). Occupational Health Nurses provide a range of services to help manage the effects of *work on health* and *health on work*, as well education and interventions to support worker health and wellbeing in the workplace.

Occupational Health Nursing is an interesting, diverse and rewarding role. An experienced OHN is a health navigator assisting workers to improve their health, safety and wellbeing. They must anticipate to prevent injury and ill health, complete hazard specific health monitoring, rehabilitation and primary care in the workplace. The broad and unpredictable nature of the job requires constant learning to advise and monitor risks and interventions. Occupational Health Nurses may be a workers' main or only point of contact with a health professional. Scheduled health monitoring such as hearing or lung function tests open an opportunity to identify other health issues, which can be resolved by referring workers to external services and support. The exact mix of activities depends on the nurse's practice level, the kind of employment or contracting role they have, and the sector[s] and organisation[s] where they work.

Entry to Occupational Health Nursing is different for every nurse. My pathway began while I was working on a Trauma Orthopaedic Ward and treating many with work related injuries.

This included a 20-year-old Forestry Worker who required a below knee amputation one Christmas Eve and many Construction injuries, including spinal injuries. I decided at that point, that while I was doing good work at the cliff face, there was an opportunity to be involved in the prevention of these injuries occurring, so in 1997 I studied the Post Graduate Occupational Health and Occupational Safety papers at Otago University.

The following year, armed with the theoretical knowledge, I was lucky to be offered an OHN role at Cadbury. In this role I worked as part of a multidisciplinary team made up of an experienced OHN who had a Physical Education Degree, with excellent musculoskeletal knowledge, an Occupational Physician, an Occupational Physiotherapist and a Health &

Safety Manager. This role and two years working within an Occupational Health & Safety Contracting company set me up well for when I became an OHN for a Newspaper. Two years later I established my own business. I have been very lucky with the excellent mentoring and leadership I have received both through NZOHNA and the other Health & Safety disciplines.

An OHN role brings a lot of variety which requires flexibility and gives the chance to be innovative. An investigative mind is a necessity to ensure that the health risks associated with hazards are being appropriately managed and the worker appropriately protected. I recall working within a lead and bronze foundry and investigating two workers, from different departments high blood lead levels. Each had the appropriate extraction, ventilation and Personal Protective Equipment in place. One was making lead sinkers for fishing at home on the weekend and the second was nibbling his fingernails. Such different causes with one related to work related hand hygiene while the other was completely unrelated to work required quite different interventions.

Due to my early mentoring from the OHN with a Physical Education Degree, I have become passionate about musculoskeletal interventions from repetitive tasks. Simple interventions such as person-job fit, micropauses, warm up exercises, job rotation and psychosocial interventions, to name a few can save a person from pain and a business from ACC Claims. A happy pain free worker is a productive worker.

Referrals to General Practice are common for many reasons; high blood pressure, high blood sugar level, investigation of sleep apnoea (discovered though fatigue intervention), investigation of unilateral hearing loss (many OHNs have identified Acoustic Neuroma's), asthma, mental health issues, injuries to name a few. This can be difficult if a person isn't registered with an GP, which we always recommend.

Since January 2019, I have been the NZOHNA Representative on the Health and Safety Association of New Zealand (HASANZ) Governance Board. HASANZ was established as a representative body for health and safety professionals and was a commitment in the Government's Working Safer package of reforms (2013) developed in response to the findings of the Taskforce on Workplace Health and Safety (2012) following the Pike River disaster. HASANZ represents diverse organisations with a shared purpose – to raise professional standards to provide healthier and safer workplaces.

NZOHNA in conjunction with HASANZ have successfully applied for funding through WorkSafe for a Workforce Development Project (WDP). The objective being to build the number of capable, competent and qualified OHN's in NZ/Aotearoa to ensure the appropriate management and implementation of worker and workplace health initiatives. There are currently legislative requirements that are not being met by PCBU's as they have difficulty accessing suitably qualified OHN's. Additionally, workplaces are unable to obtain their full potential in productivity due to worker illnesses and injuries within their workforces.

The specific goals of the WDP are:

1. Build the number of fully qualified and competent OHNs.

2. Upskill people at all levels including within the NZOHNA (core technical skills initially then education pathway), PCBUs/Business Leaders (impact of Work on Health and

Health on Work and the impact an OHN can have) and at Ministry level.

3. Provide resources to enhance worker health for improvement in safety and workplace outputs *targeting health in 'at risk' worker population groups.*

4. Attract and support Registered Nurses to become OHN specialists.

5. Build a sustainable education programme

I believe this project is a real game changer with a clear pathway into Occupational Health Nursing, more nurses will be attracted to this advanced specialty practice. NZOHNA has a website if anyone would like more information or they are welcome to contact me nikki@leadingedge.gen.nz

Frontline Health Worker support line

Erica Donovan

We know that seeking help can be hard, but keeping yourself mentally healthy is important, not only for your wellbeing, but can also assist you to be a better healthcare practitioner for your patients and their whanau.

It goes without saying that nursing can be stressful at the best of times, let alone having to deal with a pandemic and all the associated lockdowns, home schooling and other hats that nurses wear outside of work. In recognition of this, a support line, run by Healthcare NZ was established this year. Initially intended for supporting those working in the COVID response, there was widening of the criteria to those working in healthcare or community care. The number to call is **0800 820 080**, and the line is staffed Monday to Friday between 9am to 7pm.

After giving your details, the staff member will set you up an appointment with one of their Clinical Psychology staff. Another good thing about the service, is that it isn't linked to your employer, so your work does not get informed that you are utilising the service. The cost barrier is also lessened, as the service is funded for up to five sessions.

PRIMARY HEALTH CARE NURSES MECA 2020

PHC MECA strike action. Some of you may recognise yourselves in the photos if you were in Wellington. These have kindly been supplied by Rob Zorn at NZNO and are reprinted with permission.

We are valued members of the community and nursing but unfortunately this is not reflected in our pay scale. We need to stand strong, stand together and fight for equity in our pay.

VALUING OUR PRIMARY HEALTH CARE NURSES


TOOT

SLEEP AND SLEEP DISORDERS

Yvonne Little NP

Who doesn't have a patient come up with a question on sleep? I very much doubt any of us.

It really is a matter of what the cause is, of which there are many and in 2020 I have noted more patients (also colleagues) complaining of tiredness and not sleeping well, which is natural considering the uncertainty of the times and job security. But even those who are not retired have been having more issues.

Whilst there are some very physical causes of sleep disorders, such as sleep apnoea, snoring and the like. A lot can be attributed at the moment to stress, anxiety, depression, and more time spent on electronic devices.

We as nurses also suffer from sleep issues, we need to look at ourselves first and improve our own sleep health.

Therefore, I thought providing some resources for you to review and even try out so you can recommend to your patients as sleep health/hygiene is much better than medicating with alcohol or pills.

Also, good sleep promotes better mental health, and we all know how much of an issue mental health is at present, therefore it's a win-win situation. Most people have a smart phone or an iphone and therefore apps can be downloaded and used. There

are free ones and ones you need to pay for and that is a personal preference and through experience I have not found much difference between the two.

Health Navigator: https://www.healthnavigator.org.nz/apps/s/sleep-apps/

Sleepio

- Online 6-week programme
- CBT lessons
- Goal setting
- Build an individualised programme
- Available from website and iTunes
- Cost: free

CBT – I Coach App

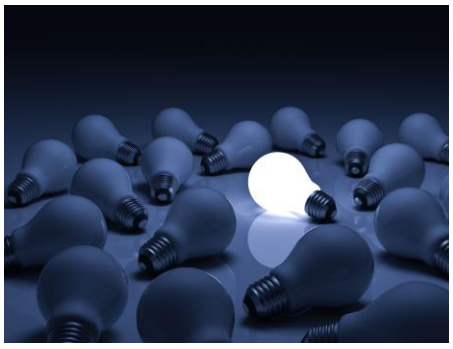
- Sleep tracker
- Education and information
- Cognitive behavioural therapy-based
- Reminders (to change sleep habits)
- Available from Google Play and iTunes
- Cost: free

Sleep as Android

- Sleep tracker
- Alarm clock
- Graphs to create a sleep record
- Snore recording
- Available from Google Play
- Cost: free(basic); paid upgrade

Pzziz app

- Audio sleep aid
- Available from Google Play and iTunes
- Cost: free(basic); paid upgrade



Some other sites to look at are:
www.healthline.com
www.sleepassociation.org
www.medicalnewstoday.com
www.goodhousekeeping.com

Here's to a good night's sleep

Snore Lab App

- Snore recording
- Calculates snore score
- Lifestyle tracking
- Available from Google Play and iTunes
- Cost: free

Conservative haematoma debridement and burn management in the community

Lorna Heath – RN BN PGCert Nursing

Lorna has been working as an ACC Wound Care Nurse for the last eight years in Nelson at Habit Health (previously Nelson Nursing Service). This service provides specialist assessment and management of a variety of injury-related wounds in the community.

Lorna Heath

As a specialist wound nurse in the community, I've been asked to share and reflect on some of the interesting wounds and patients that I get to work with.

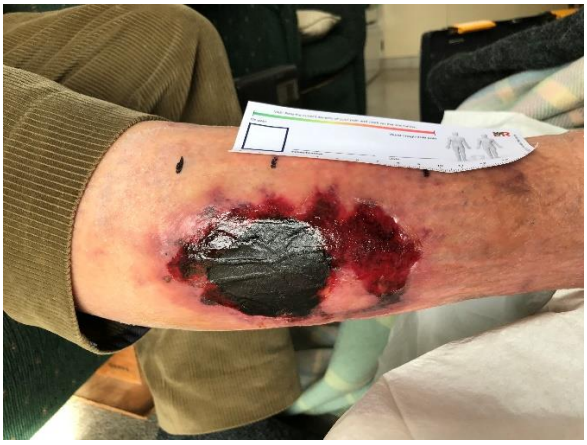
Haematomas are commonly seen in general practice, often affecting elderly clients with age-related skin changes who may also be on anticoagulants. Some of these patients have to be managed conservatively due to the risk of complication from bleeding.

Case Study

John is a 92 year old man who rolled his mobility scooter when he drove too close to the edge of the footpath. He ended up stuck underneath with most of the weight of the scooter on his right lower leg, causing a significant haematoma but thankfully no fractures. Over the next few days this haematoma was dressed for protection and monitored by his general practice team prior to being referred to our service. A surgical opinion was obtained, and it was recommended that John undergo surgical debridement of the haematoma with subsequent skin grafting as an inpatient. John declined this treatment however, preferring to be managed conservatively at home. Autolytic debridement therefore became our treatment objective as well as managing pain and cellulitis which was exacerbated by the significant amount of necrotic tissue present (New Zealand Wound Care Society, 2020).

We started by applying a decent amount of hydrogel (eg. Solosite) to the surface of the dried haematoma daily with an occlusive silicone secondary dressing to trap the moisture against the wound. Over the days the haematoma then started lifting at the edges and we were able to remove the top layer of dried haematoma without complication. Then we used a combination of mixing a hydrogel and Iodosorb together, with an occlusive silicone secondary dressing, again changed daily. An experienced district nurse once shared this secret with me that mixing a hydrogel with Iodosorb increases the action of autolytic debridement as well as providing the antimicrobial benefit of the Iodosorb. It is important to note that care needs to be taken to protect the periwound during autolytic debridement as donating all this moisture to the wound can cause maceration of the periwound (Wound Union of Wound Healing Societies, 2019). This can be managed by using silicone dressings which create a seal around the periwound to protect it from exudate or by using skin prep wipes.

Over the next few weeks we carefully worked our way down to the wound base using both autolytic debridement as well as removing what non-viable tissue we could with forceps



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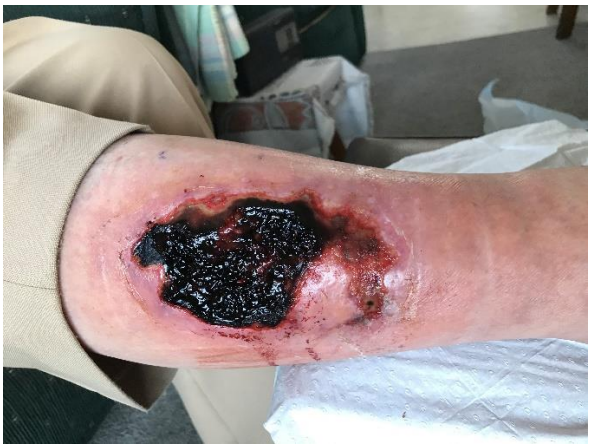

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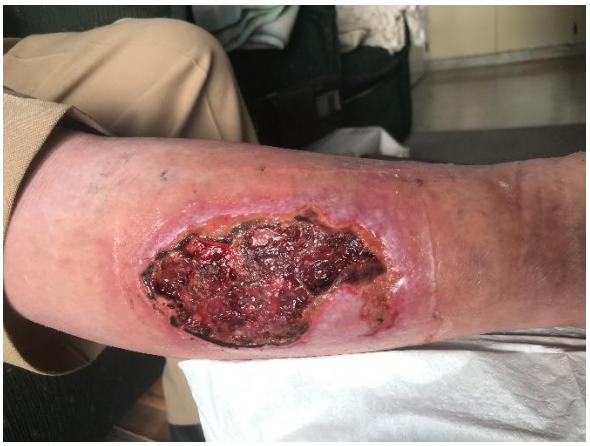

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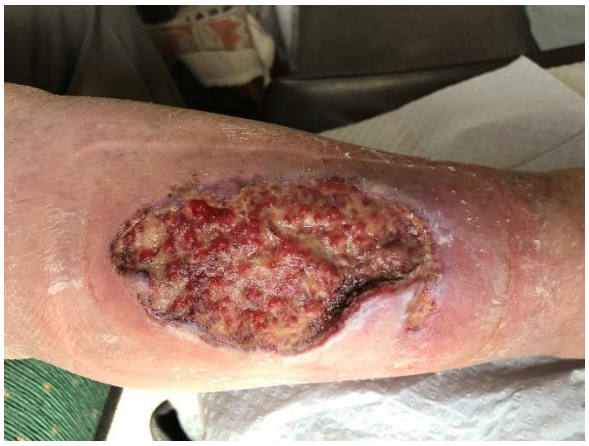

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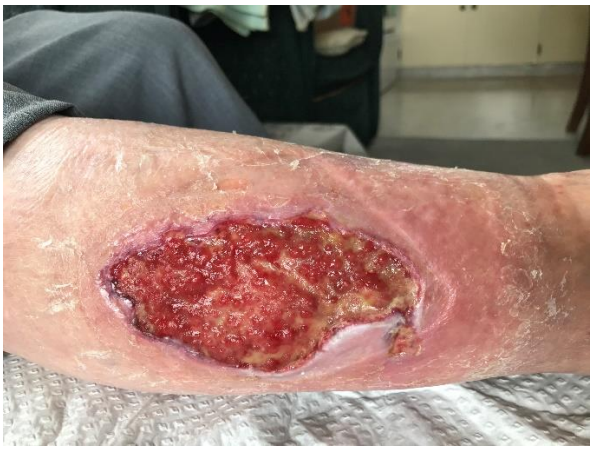

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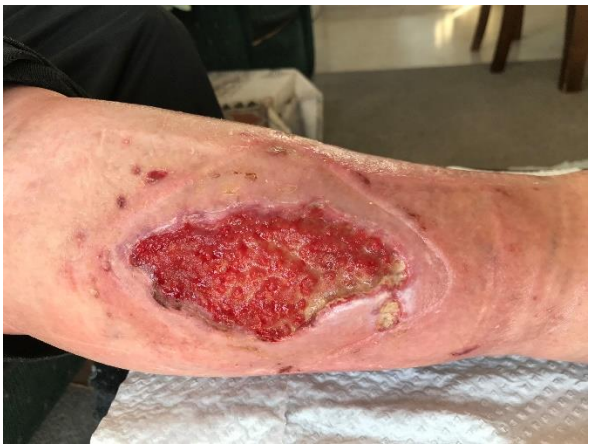

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debridement (New Zealand Wound Care Society, 2020). Negative pressure dressings had been ordered so that they could be used once all the non-viable tissue had been debrided, with the goal of expediting granulation and healing of the wound. Unfortunately, delivery of these dressings was significantly delayed due to COVID-19 restrictions, however despite this, John's wound made significant progress and demonstrated text-book perfect granulation and healing with the use of antimicrobial foam dressings.

As I write this article, John's wound has reduced in size significantly, but now we are facing the challenge of managing a periwound which has had enough of being covered by dressings. He has started developing irritation from the adhesives we have been using, causing the skin to become itchy and at times John has been scratching, causing small breaks in the skin. The challenge continues to be choosing a dressing which meets the needs of the wound, the periwound, as well as John himself. Ideally for the wound and periwound we need to move away from adhesives and hold the dressings insitu with bandages/tubular stockings, however John is very active and it has been difficult to hold the dressings in place without adhesives. A topical steroid cream has now been prescribed for the periwound which is helping calm the skin down.

Burn/Scar Management

I would also like to share some of my experience with burns and their management in the community. While I have always been focused on the healing of burns, I have recently connected with our local scar therapist and attended an Australian and New Zealand Burn Association - Burn Rehabilitation Course. I now have a much deeper understanding of how the journey of recovery for a burn extends far longer, and that scar and contracture minimisation needs to be our goal as well. Of course, as a wound nurse it is still my priority to provide effective assessment and treatment so that the burn heals as quickly as possible. The likelihood of scaring is much less if the burn heals within three weeks (Australia & New Zealand Burn Association, 2014). The management of healing a burn is not dissimilar to that of wound management of most wounds, with consideration of pain minimisation, moisture balance, infection prevention and promotion of granulation and epithelialisation.

I now refer all of my burn patients for review by the scar therapist, who then assesses the scar once healed and prescribes treatments such as compression, silicone therapy, splinting, skin care, moisturising, massage, stretches, itch management and sun care advice (Australia & New Zealand Burn Association, 2014).

References

Australia & New Zealand Burn Association (2014). *Burn Trauma Rehabilitation: Allied Health Practice Guidelines.*

New Zealand Wound Care Society (2020). *Advisory Document for Wound Bed Preparation in New Zealand.*

Wound Union of Wound Healing Societies (2019). *Consensus Document: wound exudate effective assessment and management.* 2019.

Tips for summer living for the person living with a stoma.

Sue Rossiter: Specialty Clinic Nurse: Stomal Therapy/Wound Care.

I began my nursing career as an Enrolled Nurse in 1975, working in the Nelson Public Hospital. I then completed my Comprehensive Nursing training and followed with a bridging programme to the Batchelor of Nursing Degree. I have also completed a Post Graduate Dipolma in recent years. I having been working in the role of Specialty Clinical Nurse with a focus on Stomal Therapy and Wound Care for 20 years. The role of Stomal Therapy present challenges every day and creates close relationships with the person with a stoma and their journey towards living a full independent life.

Introduction:

Stoma formation occurs across the life span from the newborn to the elderly, resulting in changes in body image both physically and emotionally. For some individuals there may be a sense of loss following surgery and for others, stoma formation after years of dealing with any inflammatory bowel disease gives them freedom from the bathroom. There is often a period of adjustment and acceptance to their new normal, and most can resume an active life with family, friends, work and school.

The theme for the summer edition of LOGIC is skin and wound care. The summer and holiday season in New Zealand is fast approaching and for the person living with a stoma this may cause some concerns regarding their skin, diet, travel and socializing.

Skin care

- Encourage washing the peristomal skin with warm water and dry the skin well.
- Itching or increased itching may be experienced under the adhesive barrier during the warm summer months. Using a protective skin barrier or changing the appliance more frequently may help.
- Itching generally settles in the cooler months.
- Sweating may be an issue, but the modern appliances are designs to absorb moisture.
- Use of an anti-perspirant deodorant on the skin under the adhesive barrier for excess sweating may help.
- May need to change the appliance more frequently.
- Advise person with a stoma to contact their Stomal Therapist if concerned for advice.

Diet:

Following the initial postoperative period, most ostomates return to a normal diet and are aware of what foods they can manage.

- Encourage adequate fluid intake for everyone, not just over the summer months.
- The person with an ileostomy needs to add salt in their diet as they

loose salt in their output.

- A celebratory beer or wine over the festival season can be enjoyed in moderation.
- Dining out may cause anxiety, so choose a familiar place and order foods that have already been tried.

Swimming:

Physical activity is beneficial for everyone for our feelings of wellbeing to keep fit and to cool off over the summer months. The person with a stoma is able to go swimming. There are a few things to be mindful of:

- Before venturing out to the beach or pool, try the swimsuit on at home for fit and discretion.
- Test the appliance is secure by wearing in the shower or the bath.
- Check seal and integrity of the appliance before swimming.
- Empty or change the appliance before swimming.
- Use a filter patch to cover the filter if required.
- For females, a one pieced patterned swimsuit is discrete when wearing an appliance. If using a bikini style swimsuit, high waistband boxer style shorts may be more suitable.
- Can use a sarong
- Boxer style swimming shorts with a high waste are more suitable for men with a top like a T shirt. Can also use a Lavalava to cover appliance.
- Appliances are waterproof but check the adhesive base after swimming as it may swell, soft and turn to putty as it absorbs moisture.
- After swimming pat appliance dry.
- Always have extra appliances available if needing to change after swimming.

Travel:

Having a stoma shouldn't limit ostomates travelling, whether locally or overseas. It just takes a little more forward planning.

- Always take extra supplies.
- Use disposable cleaning wipes and plastic rubbish bags, i.e. nappy bags.
- Use bottled or boiled water if unsure of the quality or safety of the water supply.
- Drink plenty of water as it's easy to become dehydrated when travelling.
- Change of environment and food may cause diarrhoea or constipation. Drink plenty of water and seek medical advice if concerned.

Tips for flying:

- Pre book seat if possible to be seated near a toilet and aisle seat.
- Scissors are not allowed in hand luggage, so precut appliances to take on board. Scissors go into checked in luggage.
- Pack extra supplies in carry on and checked in luggage. If travelling with family they may be able to put supplies in their luggage.
- If travelling overseas, carry travel certificate which can be obtained from the Stomal Therapist stating what ostomate are carrying and need for ostomy supplies.

- If travelling overseas it is advisable to have travel insurance.
- Ballooning of the appliance may occur due to the pressure when flying. Wear a drainable appliance so it can be opened and air released in the bathroom.
- Ballooning can be caused by foods and carbonated drinks, so best to avoid carbonated drinks while flying.
    - Empty or change appliance before boarding.

Socializing:

Ostomates may face personal challenges when socializing with family, friends and other people following the formation of a stoma. Each individual adjusts and adapts to their "new normal" in their own time and way. It's up to the individual who they tell and confide in.

- It's normal to feel uncomfortable in new situations.
- The ostomate needs to be confident and familiar with their appliance and know that it is not going to leak or lift when they are out and about.
- Suggest the ostomate has a short explanation about their surgery should they be asked by other people.

Once an ostomate has adjusted to their "new normal" and are comfortable and confident with their appliance, living with a stoma should not impact on their everyday activities and life. With a little bit of forward planning and being prepared, ostomates will be able to enjoy the summer and holiday season whether in New Zealand or overseas.

Included is a list of webistes that may be helpful resources for ostomates and health care professionals:

Coloplast:
https://www.coloplast.com.au/osotmy/people-with-a-stoma

Dansac:
https://www.dansac.co.nz/en-nz

Hollister:
https://www.libertymed.co.nz/

Ostomy New Zealand:
https://ostomy.org.nz

Salts:
https://www.ainscorp.com.au

NEWS UPDATE FROM NEW ZEALAND DEMENTIA FOUNDATION

Megan King
Senior Communications Advisor
South Island Alliance

It is important that all clinicians in NZ involved in the screening of cognitive impairment and dementia are aware of the change below.

The MoCA© test will no longer be free to use from 1 September 2020.

Mini-ACE (Mini-Addenbrooke's Cognitive Examination) is now the recommended screening tool for cognitive impairment in New Zealand.

HealthPathways will reflect this change from 1 September 2020.

Online training for the use of the Mini-ACE will be available on regional DHB and Ministry of Health learning platforms from 1 August 2020.

See the attached flyer for more information or visit www.nzdementia.org/mini-ace.

NEW ZEALAND
DEMENTIA
FOUNDATION

TIME TO CHANGE

The Montreal Cognitive Assessment (MoCA©) test
is no longer free to use

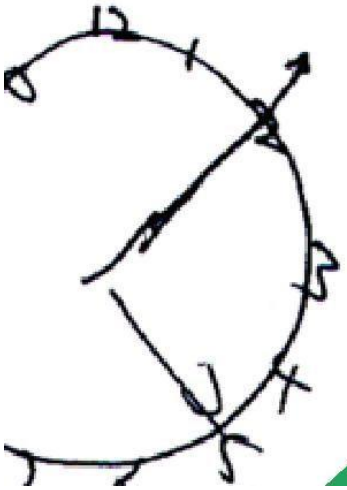
Mini-ACE

is the recommended screening tool for cognitive impairment in NZ

Mini-Addenbrooke's Cognitive Examination (Mini-ACE) is a brief cognitive screening test. It's free, easy to use and takes around five minutes to complete.

1 AUGUST 2020	Online training available
1 SEPTEMBER 2020	Mini-ACE test and guidance document available in HealthPathways

Please do not use the MoCA after 1 September 2020 unless you have paid for training and certification through the MoCA Institute.



A kaupapa Māori Assessment of Neuropsychological (MANA) tool is being developed and will be integrated HealthPathways alongside the Mini-ACE in 2022.

Visit **www.nzdementia.org/mini-ace** for more, including information about online training.

HPV self-swabbing

Erica Donovan

Health professionals are calling on the Government to instigate a self-swabbing programme for Human Papilloma Virus (HPV). Despite two New Zealand trials being undertaken in 2017, in both Waitemata, Auckland and Wellington, this has not been rolled-out, despite extensive work by health professionals from around the country.

In June 2020, Nursing and Medical leaders from several PHOs and Professor Beverley Lawton Director, Centre for Women's Health Research from Victoria University wrote to Dr Ashley Bloomfield to outline current barriers to cervical screening access, and how HPV self-swabbing may decrease some of those barriers. While the group did receive a response, disappointingly, it was not they were hoping for. While the Ministry is supportive of the cause, it is not currently being pursued.

Use of self-swabbing would bring us into line with Australia, England and Nordic countries who currently have access to help swabbing solutions. Studies show that there are many reasons why women do not attend for screening (CITE).

These include whakama (shame), anxiety from previous negative smear experiences, history of sexual assault or other trauma, health literacy and the list goes on. In my practice I've seen all of these and many more.

Anna Adcock, a researcher and PhD student who worked on research which interviewed both the women the programme was targeting and healthcare clinicians, called the idea of self-swabbing 'a game changer'.

As a cervical smear taker, I can see the benefits of rolling out this scheme for those who for varying reasons do not attend regular cervical screening appointments. And in the process of writing this article I had a patient who had recently returned from Australia mention she did the self-testing while living there. While it might be sometime away in New Zealand, and she wasn't someone who avoided screening by any means, but this service really could be a game changer for many others.

As for me, I can see how a programme of self-swabbing reduces many barriers to access and puts the patient into control of their health. Swabs can also be done in an environment where they feel safe, which can reduce anxiety about coming in and exposing them to invasive speculum exam. But just as programmes that are direct to consumer, allowing patients to test for other things such as genetic risks, and patient ordered blood tests, we're missing that patient contact and time to provide health education and answer questions.

In the questioning for cervical smears you can get so much more information than you expect. I've discovered people who may be pregnant, have incontinence or prolapse they've never mentioned to their GP, there's been blood pressure checks, we've discussed endometriosis, planning pregnancy. People also

mention physical and mental health concerns far removed from the screening questions we ask, and that's something we'd not get the experience to discuss.

In a world where many young people learn about sex and the appearance of genitalia from pornography, one of the biggest parts is answering the big question patients often have 'am I normal?'.

Different shapes of labia – normal. Body hair – normal. Shaving rash – common. Herpes – more common than people think, they're not the only one, it's not some kind of moral failing. We would lose all those opportunities for discussion if we went to self-swab only, so why not offer both?

Skin Deep

Erica Donovan

Rashes, lumps, and bumps are something seen across the primary care job spectrum from Aged Care to School Nursing and General Practice.

However, many of the images online or in textbooks are shown on Caucasian skin, when as we know there is a spectrum of differing skin tones.

With this in mind the team behind paediatric medical education website Don't Forget The Bubbles launched the Skin Deep website for medical professionals.

Their page features images submitted by clinicians and families from around the world, all vetted by dermatologists before being posted. You can search photos by diagnosis, body part or description. It's a handy resource if you want to show other team members images or connect dermatological terms to images. There's also a quiz function to test your dermatology knowledge.

If you have images that you would be of interest to the team head to https://dftbskindeep.com/submit-photo/ or to see the full gallery of images head to https://dftbskindeep.com

Other websites to check out if you want to up your dermatology knowledge:

https://dermnetnz.org

https://dermnetnz.org/topics/medical-journals-for-the-dermatologist/

http://www.nzdsi.org

https://www.brownskinmatters.com/all-conditions

http://www.allergy.org.nz/A-Z+Allergies/Eczema.html

Attention all Nurses Working in the Primary & Community Health Care Sector

"Nursing Diversity Brings Nursing Strength"
- a focus on primary & community nursing

When: Saturday 6th March 2021
Where: The Rydges Hotel, Christchurch

The NZ College of Primary Healthcare Nurses, NZNO and the College of Nurses Aotearoa, NZ are combining to facilitate the above symposium for all nurses and educators working in the primary and community health care sectors.

This exciting symposium will provide the opportunity to celebrate the huge contribution that we, as nurses, make to the delivery of primary health care in so many ways and in a variety of roles and settings.

The programme includes:

- **Keynote speakers – acknowledging the diversity of nursing within primary healthcare**
- **A celebration of nursing roles across the primary & community healthcare sector**
- **The opportunity to network with colleagues within our vast healthcare sector**
- **Professional development hours will be awarded**

Costs: **NZNO Members: $120.00**
College of Nurses Aotearoa: $120.00
Non-Members: $150.00
Student Nurses: $85.00

Updates and registration details will be available on the following websites shortly:

- **NZNO -** https://www.nzno.org.nz/get_involved/event_calendar
- **College of Nurses Aotearoa website:** https://www.nurse.org.nz/workshops.html

Public health nurses mixing it up during the COVID response

Nicola Thompson

(First published in the Nelson-Marlborough DHB magazine, reprinted with authors permission)

During the first wave of COVID-19 our public health nurses, like many primary healthcare services, really stepped up to respond.

Nicola Thompson, Nelson Charge Nurse Manager, with the Public Health Service says they very quickly reconfigured how they did their work.

"When pandemic response kicked in we switched over to COVID case daily follow-ups, 'pop-up' community flu vaccination clinics, providing PPE education to other health providers and helping out with CBAC, SWOOP, and support for people in emergency housing and the refugee community, etc. — we worked both on the front line as well as behind the scenes". She says there was a lot of adrenalin running during lock down but the team embraced the changes and their reaction was amazing.

One of the biggest silver linings, Nicola says, was the opportunity to work alongside other providers delivering coordinated, patient and whanau focused primary healthcare.

"Going back to a new normal means we still do our immunisation work, sexual health clinics, the hearing and vision screening, B4 School checks, etc. but it took more time due to COVID screening questions and PPE use. We've also noticed some children can be reluctant to engage because we have masks on."

Nicola says with a resurgence of the virus in the community her team has noticed anxiety is having an impact and everyone is very tired mentally.

"We continue to provide health care and ensure our local families and whanau get the support they need, but we were also called in to help out the Auckland team with national contact tracing during the August-September outbreak," she says.

The contact tracing work is done in addition to their usual public health nurse roles, and planning is tricky because the team never know how many COVID contacts they'll be asked to follow-up each day. It's a very unpredictable situation.

"A lot of our mahi is with vulnerable families. While it is absolutely essential that we respond to the Auckland COVID situation it adds to the challenge of ensuring our vulnerable families receive the support they require. However, our nurses are committed to balancing the need to support our own community alongside supporting the Auckland response."

Overall Nicola says the response work has been a useful exercise for the public health nursing staff.

" You don't know what is around the corner and at least now everyone is prepared and has a bit of familiarity with the systems."

Sleep Hygiene

Compassion on the front lines – a New Zealand experience.

Carla Arkless

This piece was originally published online at: https://grayswellbeing.co.uk/site-blog/compassionate-conversations-that-ease-fear-and-suffering-by-carla-arkless/ and has been modified for LOGIC.

I live in a semi-rural district at the top of the South Island of New Zealand, with a population of 150,000 across 227,000 square kilometres; we have two public hospitals.

During the COVID-19 lockdown I worked in a community rapid response team made up of nurses, doctors, and allied health staff. The team was set up to respond to high numbers of seriously ill people in the community, in the context of a health system overwhelmed by the COVID-19 pandemic. We are very fortunate in New Zealand to have avoided this scenario; however the team continued to respond to people in the community and in Aged Residential Care facilities who did not need or wanted to go to hospital, but who needed assessment, support or intervention. The team continues to respond to a wide range of needs, including doing swabs for housebound people who meet the criteria for COVID-19 testing, medical assessment and treatment at home which would ordinarily have required a trip to hospital, and welfare and coping checks for frail older people following discharge from the Emergency Department who might otherwise have been admitted.

One of the things the team has been doing is having a conversation with these people and their families about what matters most to them, and about their values, goals, and care preferences. These conversations are not always easy, especially if we need to talk about serious illness, or the possibility of not recovering; however, they are so very important and really change outcomes and experiences for patients and their families. On the whole, people want to have these conversations, they are just waiting for us to initiate them. People want to be heard; they want us to know what matters to them as a human being, not just whether they are able to shower themselves, or what medication they are taking. They want to be treated in a way that values their choices, their own goals, their beliefs. They want to trust that they will be cared for in line with their values and goals when they cannot care for themselves.

We use a framework from the Health Quality and Safety Commission (the Serious illness Conversation guide – available at: https://www.hqsc.govt.nz/our-programmes/advance-care-planning/projects/serious-illness-conversations/) to have conversations, to elicit this important information. Firstly, we need to be on the same page

about what is happening with their health – the patient tells us their understanding and we fill in any gaps if needed. Then we ask permission to tell them what we believe might be ahead for them, and if this is difficult for them to hear, we pause and respond to the emotion. We then ask a few questions to explore their priorities and worries if their health declines, what capabilities are most important to them, what treatments and other interventions they would be willing to go through for more time, and how much they have shared with their family about what's important to them. We then come up with a shared plan going forward, which honours these things. Of course, all the way through the conversation we are acknowledging what they are saying, and we are demonstrating empathy. By finding out this information, we can ensure that any interventions we offer are in line with their values and preferences, and we appropriately direct their care. In addition, they feel heard, they build trust in us that decisions made will be in their best interests, and anxiety is reduced.

This is truly person-centred care. Our team initially operated 7 days a week, recognising that people's health and illness is not dictated by office hours, and that by responding in a timely way, anxiety and distress is reduced, thus improving overall outcomes. We do not aim to replicate existing services – we are here to fill gaps. We respond to situations identified to us, we make sure the patient and their family have the care they need at the time, and if an existing service should or could have managed this person's needs, then we address that with relevant services afterwards. Our primary goal is to ensure the patient and family have their needs taken care of in a timely way, and then address systems issues separately. So, our decisions are more driven by the needs and preferences of the patient, rather than by the needs and preferences of the organisation / system.

This is a very satisfying way to work and I look forward to a day when this approach is central to all healthcare systems. It is energising to connect with patients as fellow human beings, as well as professionally, and I am convinced that even one conversation that is focussed on what matters most to a person, has the ability to significantly change their healthcare experience and outcomes.

Typical District Nursing day 0800-1630

A DN day chosen at random to analyse – 9 patients Acuity 24.

Written by Lisa Knowles CNM Nelson District Nursing Service.

0800	0745 – Arrive work – Richmond Hub
	Review patient load for day
	Read Health connect south - Clinical Notes
	Sign in Duress Alarm
	Organise kit and ensure all relevant dressings/equipment in car.
0820	Leave Richmond Hub
	Drive to 1st patient – 35mins in traffic
0855	Arrive at patient #1 – Westbrook Tce Nelson

Patient # 1

76yr male - Chronic venous stasis eczema / Weeping ulcers

Acuity 3 (30mins) requires bilateral leg dressings, including 3 layer compression bandaging. Daily DN visits due to heavy exudate.

0925	Finish 1st patient
	Drive to 2nd patient – Grove Street, The Wood
0935	Visit 2nd patient

Patient # 2

85yr female – Lower leg ulcer, under vascular surgeon.

Acuity 2 (20mins) requires dressings including 3 layer compression bandaging.

0955	Finish 2nd patient
	Log remotely onto tablet in car– 5mins
	Write clinical notes for first 2 patients
1015	Drive to 3rd patient – Di Pierri Way, The Wood
1020	Visit 3rd patient

Patient # 3

85yr male – Multiple skin grafts – face. Donor sites thigh. Referral from surgeon.

DN assessed signs of infection. Swab taken.

Redressed as per the graft management guideline.

Acuity 3 (30mins) Daily visits

1050 1100 1110	Phone call made to surgeon advising of infection, antibiotics organised. Swab dropped to Collingwood street Medlab. Drive to 4th patient – Tressilian Ave Atawhai Visit 4th Patient

Patient # 4

80yr female – ACC wound post fall, large skin tear + haematoma lower leg.

Requires alt day dressings, unable to get to GP.

Acuity 2 (20mins)

1130 1132	Drive to 5th patient – Marybank Drive, Atawhai Visit 5th patient

Patient # 5

66yr female – Currently Day 3 post mastectomy (Discharged from hospital Day 1 post op with 2 drains insitu)

Drain management, dressing change to surgical wound

Acuity 2 (20mins) Daily visits from DN for 7 days post op.

1150 1200	Drive to 6th patient – Totara St, Nelson South Visit 6th patient IVABS due at 12pm

Patient # 6

67yr male - Streptococcus gallolyticus bacteraemia – Daily IVAB's via PICC line.

Weekly bloods via PICC. Weekly PICC line dressing change.

Acuity 5 (50mins) Daily visits and regular liaison with infectious diseases specialists.

1250	Finish 6th patient Log on remotely to tablet (5mins) Write notes for previous 4 patients Lunch in car while writing notes.
1335	Drive to 7th patient – Franklyn Village

Patient # 7

31yr female – Multiple bilateral lower leg wounds due to IV drug use, obesity, diabetes, and non-compliance. Unable to get to GP and cost also an issue.

Wounds cleaned and redressed with compression bandaging.

Acuity 3 (30mins) Alt day dressings by DN's.

1410	Finish 7th Patient Drive to 8th patient – Waimea road
1415	Visit 8th patient

Patient # 8

84yr male – IDC insitu, due for 12 weekly catheter change.

Sterile procedure performed, removing old catheter and inserting new one.

Given supplies for 3 months (night and day catheter bags and straps)

Acuity 2 (20mins) – 12 weekly DN visits for change of catheter

1435	Finish 8th patient Drive to 9th Patient – Hampden street
1440	Visit 9th patient

Patient # 9

73yr female ACC – Extensive wound to R elbow following fall, requiring complex wound care, unable to be seen by practice nurse.

Acuity 2 (20mins) Daily DN visits due to heavy exudate, infection, being treated with silver based dressings to address this.

Once wound has progressed and able to be managed with simple dressings this patient will be referred back to general practice.

1500	Finish 9th patient
	Drive back to Richmond Hub (25mins in School traffic)
1525	Arrive Richmond office
	Restock Car and nursing kit
	Put together patient supplies for tomorrow
1545	Log on to computer
	Complete clinical notes for last 2 patients
	Write up wound care charts for 7 patients
	Download wound photos from 3 patients to update records
	Complete ACC documentation for 2 patients
	Phone call to Patient # 3 to ensure antibiotic script has been completed by surgeon and collected.
	Update Catheter care documentation for 1 patient
	Liaise with pharmacy in regards to further IVABs for patient # 6
	Enter all 9 patients into DN database and schedule their next visit.
	Print visit schedule for tomorrow, ensure all patient notes are ready for next nurse and update handover book.
	Calculate Acuity of workload and redistribute patients to other areas as required. Clinical Coordinator oversees this process.
	Put Duress alarm, cell phone and tablet on to charge
	Finish day (30mins overtime)
1700	

Do you know when to refer to Acute Mental Health services?

Lee-Anne Tait in consultation with her local DHB

This article is designed to help nurses working in the Primary/Community Health sector to be able to recognise when to refer a patient to secondary mental health services for a more in-depth mental health assessment.

In most cases the primary health care team is the most appropriate place for the initial physical and mental health assessment. And for most people this will be their first point of contact when they are feeling unwell either physically or mentally.

However sometimes there will be clinical presentations which are beyond the scope of the primary health care team – when the presenting mental health symptoms and risk of harm to self or others requires a more in depth assessment.

The decision to refer a person to secondary mental health services will be based on findings from screening tools such as the Kessler 10 and the brief mental status exam. Level of unwellness and evidence of an acute risk to either the presenting person or someone else will decide if a secondary mental health assessment is required.

This could be in the context of a mood component: depressed or elevated mood, perceptual disturbance, auditory or visual hallucinations or evidence of a thought disorder. Elements of thought disorder occur if a person is not able to hold a logical sequential conversation i.e. unable to connect ideas and thoughts together in a rational way, appears preoccupied, may not be able to test reality.

Judgement may be impaired if thoughts lead to risk of harm to self and/or others. A person may feel their judgement is being manipulated and their concept of reality is no longer clear or stable. They cannot make sense of what is happening around them in a way that is apparent to family or concerned others.

The person is not interpreting their senses correctly- misinterpreting sensory information i.e. visual/auditory/tactile/taste and smell etc.

These presentations can be organic or medication related- i.e. could be related to prescribed medication or other recreational psychoactive substances.

An organic physical workup/assessment at primary level is often done to rule out physical cause's e.g infection as a cause of other complications e.g delirium. Medication management and compliance can also be reviewed at this point.

Explore use of other substances thoroughly, including use of all stimulant substances such as caffeine, nicotine, energy drinks as well as any illicit substances. Also sedative substances such as alcohol, pain killers and sedative sleep inducing medications.

Focus of assessment at primary level can include an exploration of any deterioration in social circumstances and the ability of a person to care for themselves in the way they would normally.

Also explore what other social support networks are available.

If the risk posed by symptoms of a mental health disorder is suspected to pose serious and immanent risk to an individual or others The Mental Health Act can be used to initiate a compulsory assessment under the Mental Health Act. The concept of Capacity is increasingly becoming part of this assessment to determine an individual's ability to make informed decisions about their own health treatment. This change in emphasis has been driven internationally in recognition of individuals human rights.

All referrals to secondary care are ideally done in consultation and in cooperation with the individual along with full understanding of what the referral is for and why the assessment needs to take place at a secondary health care facility. There is a mental health line open 24/7 which anybody can consult for advice – however regional numbers differ.

In the case of serious risk of harm to self or others contact Police on 111 as the first contact.

Following assessment at secondary level a person's health needs are normally met within the community they live in and as much as possible this care can be preserved even if assessment and management at secondary level for a period is needed.

Many people will fit the criteria for the use of counselling services and preference is given to those which are funded or low cost to the user and also locally available and culturally appropriate.

A problem solving approach is useful as problems can be solved and a problem today may not be one tomorrow.

Reframing the problem or presenting issues also helps to look at presenting issues in a different way.

It is important that a person feels listened to and that their problem is understood as this will help build trust and support identifying what help is required.

http://www.ehcounseling.com/materials/brief_mental_status_exam.pdf

Acute Adult Mental Health Assessment

Public

1. Check the ↓ criteria

Seen same day

- Aged 18 to 65 years with any mental health emergency e.g:
  - Acute pscychosis
  - Depression with an immediate suicide risk
  - Significant mania
  - Any significant mental illness where there are risks to care of dependants

- Aged > 65 years who are currently under a specialist mental health service who need to be seen acutely.

2. Confirm a transfer for acute care is consistent with the ↓ patient's wishes

Patient's wishes

- Expressed wishes
- Advance care directive
- Advance care plan
- Medical orders for life-sustaining treatment

3. Prepare the ↓ required information

Required Information

Referrals are triaged to prioritise those with the greatest degree of severity of illness, impairment in functioning and failure of interventions (see diagnosis-specific individual pathways).

Ensure the patient's current contact details are up to date, especially phone numbers, it is very useful to obtain patient consent for an alternative contact for collateral information or to help make contact with the patient.

Include:

- Reason for referral
- History of presenting problem (including current main symptoms and severity).
- Impairment of functioning e.g., not able to work
- Relevant medical history
- Alcohol and drug use
- Current medications
- Brief description of relevant areas of mental state
- Risks, particularly suicide risk
- Community interventions trialled.

Note: Recent consultation notes are not a suitable substitute for a referral letter.

Standard Request Information

Patient details:

- Name and ethnicity
- Address, phone and mobile phone number
- Date of birth, and National Health Index (NHI) number
- If an interpreter is required
- State if patient is not a New Zealand resident
- Accident Compensation Corporation (ACC) number, and date of injury if relevant

Clinical details:

- Reason for request
- History and co-morbidities
- Body mass index (BMI) – essential if undergoing surgery, as a bariatric bed may be required
- Examination finding
- Investigations carried out, and results
- Options already pursued
- Current medications
- Allergies
- Other important information, e.g. social factors, or other services involved

General Practitioner details:

- Name and practice
- Practice address, phone and fax numbers
- If different from above, the patient's usual general practitioner

1. **Contact the Service**
   - Phone ahead before sending a referral

2. **Inform the patient**
   - Ensure they are aware of the referral and the reason for being referred
   - If self-transporting, provide a copy of the request and ask them to take it, and any medications, with them to hospital.

Non - Acute Adult Mental Health Assessment

Public

1. Check the ↓ criteria

Seen within 5 working days

- No immediate concerns for safety of self or others but cannot be managed satisfactorily in the community.

Seen within 3 weeks

- No significant concerns for safety of self or others but cannot be managed satisfactorily in the community.

2. Prepare the ↓ required information

Required Information

Referrals are triaged to prioritise those with the greatest degree of severity of illness, impairment in functioning and failure of interventions (see diagnosis-specific individual pathways).

Ensure the patient's current contact details are up to date, especially phone numbers, it is very useful to obtain patient consent for an alternative contact for collateral information or to help make contact with the patient.

Include:

- Reason for referral
- History of presenting problem (including current main symptoms and severity).
- Impairment of functioning e.g., not able to work
- Relevant medical history
- Alcohol and drug use
- Current medications

- Brief description of relevant areas of mental state
- Risks, particularly suicide risk
- Community interventions trialled.

Note: Recent consultation notes are not a suitable substitute for a referral letter.

Standard Required Information: As for Acute

1. **Contact the Service**
   - Note if the patient is available to attend at short notice.

2. **Inform the patient:**
   - Ensure they are aware of the referral and the reason for being referred
   - To advise of any change in circumstances (eg: getting worse or becoming pregnant) as this may affect the referral.

https://ccp.communityhealthpathways.org/107686.htm

NZNO Library

Resources For Nurse

NZNO Library

The NZNO Library has a wide range of hardcopy and online resources available to support the information needs of members.
Check out the NZNO Library resource lists. http://www.nzno.org.nz/resources/library/resource_lists

Copies of these articles can be provided to NZNO members free of charge.
Email Library@nzno.org.nz and let us know which ones you are interested in.

Books available for borrowing

- Books can be borrowed by NZNO members, for a period of 4 weeks.
- All books are couriered to you, so please provide your street address when requesting items.
- The NZNO library has other titles in addition to the ones listed below, so please contact us and we will check the catalogue for you.

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