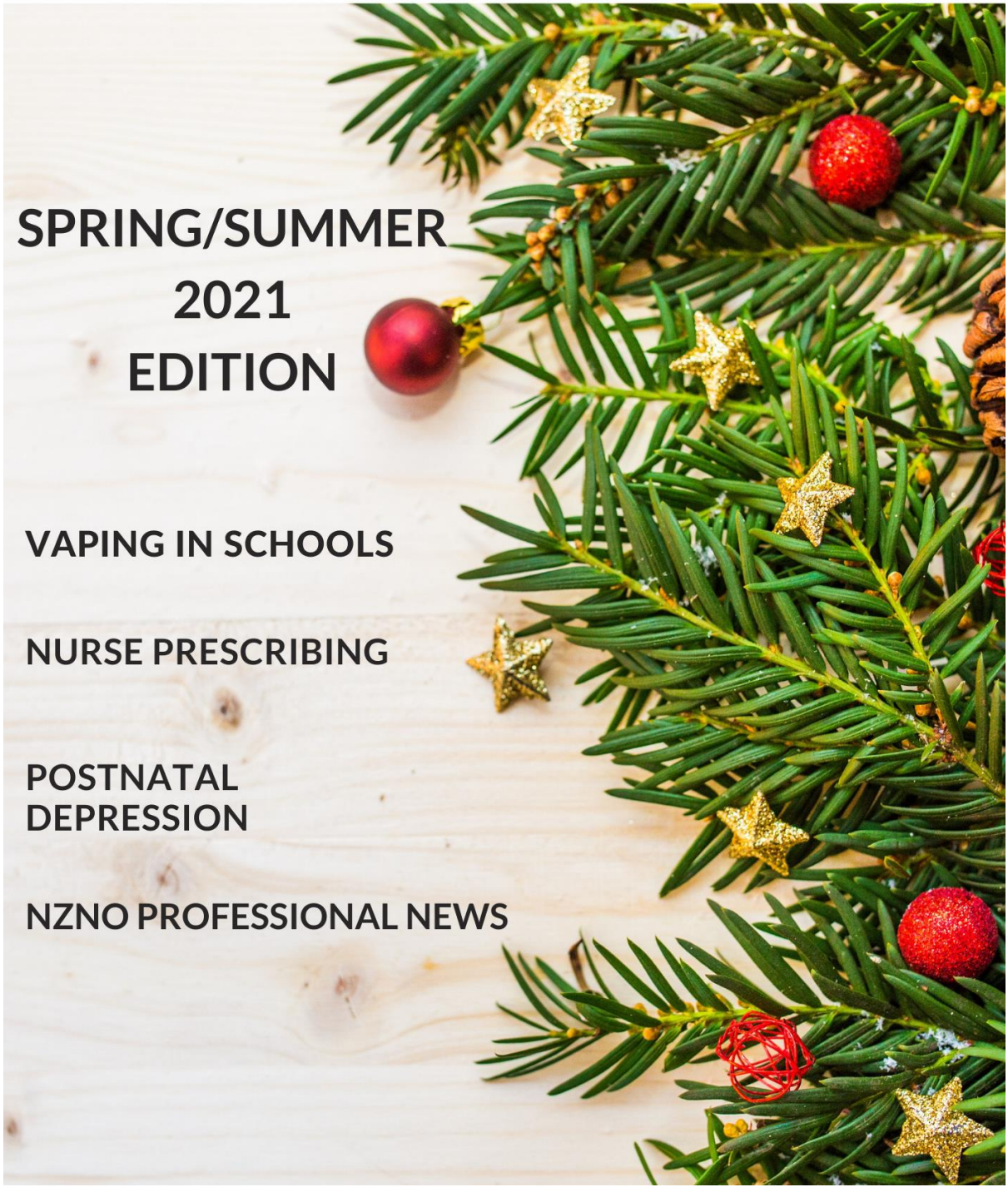
LOGIC

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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



SPRING/SUMMER 2021 EDITION

VAPING IN SCHOOLS

NURSE PRESCRIBING

POSTNATAL DEPRESSION

NZNO PROFESSIONAL NEWS

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

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Spring/Summer 2021
In this issue…

Chair's report December 2021
Dr Jill Clendon

Wow, what a year! It's been another huge year for all of us in primary health care. With the arrival of the Pfizer vaccine at the start of the year, through a second major outbreak of Covid, significant periods of lockdown, mandatory vaccination orders and finishing with the arrival of Astra Zeneca and a Pfizer booster shot campaign. And all of that in our free time! I'm not sure I remember what I used to do before the arrival of Covid even though a lot of that seems to still be happening as well. Anyway, needless to say, I want to start by saying a huge thank you to everyone out there doing the mahi and supporting our country to get through this thing. We are on the frontline of covid, from prevention to care, and every single one of us deserves a huge pat on the back for the work we are doing out there, so from all of us here in the College – thank you.
It's been a busy year for the College too with a successful symposium held back in March and the team carrying out a range of advocacy work on behalf of all of you as well as the publication of this wonderful journal LOGIC. We have just finished our annual planning for the coming year, and I am excited to share that we plan another symposium for the end of next year – keep your eyes open for dates and location early in the new year. While we have said farewell to Kelly from the committees this year, we have managed to convince her to come back and organise next year's symposium after the amazing job she did this year.

We also have some new committee members coming on board and we will be introducing them over the coming months. Keep your eyes open for their bios coming up in an edition of LOGIC soon.

As we finish 2021 and move into 2022, let's hope for a slightly calmer year. Because of all our hard work this year, it looks like most of the systems and processes we need to manage this pandemic should be well in place by early in the year and even though we may be tired, hopefully it won't be as scary as it has been in the past. We need these systems and processes now to keep us safe. Tired people make mistakes, and we rely on systems and processes as our backstop to ensure we don't make these mistakes. If you are worried that a system or process is not working for you or those you work with (people/clients/patients), then please, speak up. Make sure any concerns you have are shared and that change takes place where it is needed. Let us know if we can support you in any way as well. We have connections into some pretty high-level places if needed!

So, this holiday season, take a break, refresh, recharge and replenish. We need you!

Editors Report
Yvonne Little

Well, another year has flown past us. I never believed it when my grandparents said that time flies faster the older you get – believe me I now believe that to be true.
It has been a year of challenges for all of us and a lot of change in our work and often our personal lives.

I hope this issue can provide you with some interesting information from our article writers and that you will have some time to sit down and read, maybe with a coffee or maybe a cold drink or a wine (or for some it may need to be a few wines after the past 2 years). And hopeful some down time to rest and recuperate after a fast paced and challenging year. I would like to applaud all nurses out there for the work they have been doing over this COVID period and I hope that you will get a chance to catch your breath at some point and have some much needed and valued family time.

Likewise, for the New Zealand College of Primary Health Care Nurses (NZCPHN) it has been a time of challenges and changes.

As, I mentioned in my last editorial we farewelled our Chair/Publisher – Celeste Gillmer to her new job with the Ministry of Health in the COVID response space and welcomed Dr Jill Clendon to the role of interim chair, Jill has now been nominated and has taken on the role of Chair of the College. At this time, we are yet to find a Vice-Chair to take over that role that Jill has left vacant.

Similarly, we are still to find a new publisher, so for this combined issue I have both the Editor and Publisher hats on, so you will have to forgive me if I don't have this up to the same high standard that Celeste was able to produce.

I would like to congratulate all the successful candidates who were nominated for positions on one of the NZCPHCN committees – Executive, Professional Practice (PPC) and LOGIC. I have included photos and bios of these new team members below my editorial.

We have also, due to the usual attrition of having completed their time on the committees or personal reasons have to say goodbye to some of our committee members.

Therefore, a heartfelt thank you is extended to these wonderful nurses who have given of their time and expertise over the years to NZCPHCN.

We have also had a change of Professional Nursing Advisor with Angela Clark moving to another position within NZNO and handing over the reins to Cathy Leigh.

It may be of some interest to you to know, who is on each committee and which areas in New Zealand they are from, so if you should like to make contact and find out more about what being a committee member entails you can find someone close to your region. We still have some vacancies on the committees, so if you are interested in finding out more and maybe joining us then please contact us.

EXECUTIVE COMMITTEE:
Chair: Dr Jill Clendon – Nelson Marlborough
Vice Chair: Still to be decided
Secretary: Fiona Murray – Auckland
Treasurer: Nicola Thompson – Nelson Marlborough
Te Runanga: Lizzy Kepa-Henry – Wellington
Charleen Wardell – Southern Districts
LOGIC Editor
PPC Chair

PROFESSIONAL PRACTICE:
Chair: Bridget Wild – Nelson
Katie Inker – Masterton
Michelle (Shell) Piercy – Palmerston North
Melanie Terry – Nelson
Jeanette Banks – Christchurch

LOGIC:
Editor: Yvonne Little – Hastings
Publisher: unassigned
Erica Donovan – Christchurch
Michael Brenndorfer – Auckland
Nicky Cooper – Nelson Marlborough
Lee-Anne – Eketahuna
Katrina Coleman- Wellington

In future issues, we will include bios and photos of each member of the team – some of us are in the process of updating both bio and photo (or maybe looking for one of us in our younger years). These will also be available (eventually) on our website and our Facebook page will also get a makeover as the photo there is a bit out of date now.

As a suggestion, to encourage your colleagues who are not currently members of NZCPHCN maybe you could print off a copy of LOGIC and leave it in your break room for them to read and see who we are and what the college is about.

I would also like to make mention here .and say a heartfelt thank you to the past members of the Hawkes Bay Practice Nurse Division (now disestablished) for their generous decision to transfer the remaining funds to the NZCPHCN. We are currently researching how best to use these funds for the benefit of Primary Health Care Nurses (formerly known as Practice Nurses) in the Hawkes Bay region.
Once, this has been decided it will be published here in the LOGIC journal.

Wishing you and your families all a safe and happy holiday season. (Providing COVID-19 doesn't interfere 😊).

NEW NZCPHCN LOGIC COMMITTEE MEMBERS

We welcome aboard our three new LOGIC committee members: Nicky Cooper, Michael Brenndorfer and Katrina Coleman.

Nicky Cooper - Rural Nurse Specialist MSN RN

Born, raised and trained in the UK. Working ITU, ICU, trauma, neuro, burns/plastics and cardiothoracic then moved to work in the Middle East as a clinical educator in critical care/resuscitation officer.

Moving to NZ in 2004, working in ICU/CCU and hospice in Whanganui, moving to Murchison in 2006 and working in Primary Health Care/Palliative Care/District Nursing/Well child services/School based health services and PRIME. Setting up a Facebook page to support rural families with resources and extra support in perinatal health.

Completed Master in Nursing Degree with honours and in 2019 began developing the Rural Nurse Specialist Role in Child/Parental/Family Health in Murchison.

Nicky has recently relocated herself and her family to Nelson and is now working as part of the Public Health Nursing Team at Nelson-Marlborough DHB.

Michael Brenndorfer - Youth Health Nurse Specialist

He works in a Primary Health Care youth health clinic in West Auckland and the North Shore.

Michael has always been passionate about Primary Health Care and the vital role that nurses can play within this area. Along with the LOGIC journal committee he also sits on the executive committees for the Society of Youth Health Professionals Aotearoa New Zealand and OraTaiao: New Zealand Climate and Health Council, as well as being a member of the Education Committee for the Professional Association for Transgender Health Aotearoa.

Michael is in the process of completing his second masters degree, and will be completing his nurse practitioner intern year in 2022 with the view of becoming registered as a Nurse Practitioner soon after.

Katrina Coleman – National Educator, Whānau Āwhina

Plunket
Ko Remutaka tōku maunga
Ko Whakatiki tōku awa
Ko Aurora tōku waka
Ko Kotarani tōku iwi
Ko Katrina Coleman tōku ingoa
No Orongomai ahau
Ko Blair tōku hoa tane
Ko Lucy taku matamua
Ko Thea taku potiki
He National Educator Whānau Āwhina ora toku tunga mahi
No reira tēnā koutou, tēnā koutou, tēnā koutou katoa

Kia Ora, I have been working for Whānau Āwhina Plunket for 10 years, firstly as the Newtown Plunket Nurse then moving into the National Education team. In 2014, I was awarded the NZNO Young Nurse of the Year award and completed a Master of Nursing in 2017. Over my postgraduate study, I developed an interest in adverse childhood experiences (ACEs) research. I identified ACE screening as a significant gap within current WCTO service delivery and in 2018, enrolled in the Doctor of Health Science Programme through AUT to learn how we can do better in our mahi, for the whānau we work with.

I live in Waikanae on the beautiful Kapiti Coast with my whānau and enjoy getting up to the mountain in the winter.

OTHER NEW NZCPHCN COMMITTEE MEMBERS

We would like to Welcome on Board the following committee members and we have had a change with our Professional Nursing Advisor (PNA) – a big thank you to Angela Clark our outgoing PNA for all the years you have been there for the college with your wisdom and knowledge.

Michelle (Shell) Piercy – Professional Practice Committee

Registered Nurse, Registered Paramedic PGDipNS

Shell is a Clinical Nurse Educator and Research Assistant in Emergency and Urgent Care Nursing in Auckland, and a Nurse Practitioner Intern in Rural NZ

I am passionate about nursing and have recently created the NZCPCHN Urgent Care Nurses Network. I have worked in a variety of healthcare areas including Emergency and Primary healthcare, rural and remote, Paramedicine and Military. I have been an Authorized Vaccinator, Triage Nurse, Trauma and Resuscitation Nurse, Alpine Urgent Care Clinic Nursing Services Coordinator, Preceptor, Nursing and Paramedicine Educator, Moulage and casualty simulation, Military Nursing Officer, NZRC Core Advanced and TNCC Instructor. Nurse Educator. With a special interest in professional practice, policy and legislation.

I live in Aokautere, just outside of Palmerston North with my partner and our four teenagers. I am passionate about outdoor activities everything from the ocean to the mountains. I also enjoy art and design in its many forms from the written word to performance, paint and sculpture.

My interest in wellness extends beyond just health.

Cathy Leigh – Professional Nursing Advisor

I trained in New Plymouth in the 80's and have worked as a nurse on and off ever since. Initially in hospital settings in both NZ and USA, having worked in Med/Surg, Renal, Oncology, Maternity and as a Duty Manager at Middlemore. But most of my latter career has been in Primary Health settings – mainly District Nursing and Home Healthcare. I guess I am a bit of a generalist

I have 4 adult children and live in beautiful Titirangi in West Auckland. I enjoy all things outdoors – tramping, cycling, kayaking, beaches and travelling to beautiful places in NZ.

Key messages from our November Face to Face meeting:

1. The College of Primary Health Care Nurses strongly support pay equity for primary health care nurses and will be advocating for a universal MECA for all nurses in Aotearoa

2. The CPHCN support the professional and industrial endeavours of NZNO but will be providing feedback to NZNO that the use of imagery should be focused on the professional work of nurses.

3. The CPHCN met with the Transition Unit to discuss primary health care nursing and the work of nurses in the community. A productive conversation was held and the College will meet with the Transition Unit again in February.

4. The College also met with the Chief Nursing Officer to discuss a range of issues including nursing workforce, NPs and barriers to practice and nurse prescribing. We shared the CPHCN standards of practice with the Office.

Nursing Leadership in Primary Health Care taking the step from direct to directing patient care

By Kelly Robertson, RN, PG Cert (HealSc)
Chair,
Professional Practice Committee,
NZ College of Primary Health Care Nurses, NZNO

This article was previously published in Kiatiaki (July 2020) and permission granted for republication in LOGIC.

As nurses working across the various health systems, we all demonstrate a level of leadership skills which contribute to patient safety and quality of care. Yet we often do not recognise ourselves as "leaders".

We believe it is part of our everyday practice to provide care, advocate for patients, support our colleagues and mentor new staff. We are organised, we direct and delegate, and use our interpersonal skills to help others within our clinical practice - these are all aspects of leadership. Many of us do not aspire to be in top-level leadership positions or working in governance and political roles. Not all of us wish to become directors of nursing, charge nurses or to hold senior leadership roles in large organisations.

However, there are several "levels" of leadership within our profession. I believe it is important to acknowledge nurses who make the shift from direct patient care to roles that support and influence our workforce to continually provide quality patient care –our nursing educators, advisors, facilitators, coordinators, and so forth. These nurses combine their clinical knowledge and experience to play a pivotal role in strengthening our workforce while providing the leadership needed to implement evidence-based practice.

So as nurses, when in our career do we decide to make this transition and what support do we need? There is limited research that measures nurses' interest in seeking formal leadership roles. However, anecdotally, we know that for many it is the years of clinical experience and knowledge that guides them to explore these roles. For others it is advancing studies which encourage their aspirations of leadership. As more services continue to be devolved to primary health care, effective nursing leadership is particularly important in our ever-changing primary health care sector. I am encouraged that over the past 20-plus years

we have seen the development of several primary health care nursing leadership models which support the development of our primary workforce. These have emerged not only from district health boards but from an increasing number of primary health organisations, non-governmental organisations and other community providers, all of which have invested in nursing leadership roles. They have included new career pathways to identify and support those nurses ready to take up leadership opportunities or promote change and support the development of new roles and models of practice.

Our response to COVID 19 showed how well this structure of nurse leadership in primary health care has worked. Across the country we had nurses not only working at the frontline in general practice, CBACs, and triage centres but also contributing around the table in Emergency Operations Centres (EOC) to ensure a coordinated response was managed.

For myself never did I imagine as a registered nurse, that I would ever move from the bedside care of nursing. However, throughout my nursing career I have been provided with many opportunities to take on new challenges and advance in new directions. I believe these words by Harriet Forman, (EdD, RN, Independent Healthcare Consultant, New York) clearly describe how I have felt during my career working in primary health care and moving from direct patient care to a "leadership" position. "As a practicing clinical nurse, I cared for a relatively small number of patients. And care I did. My patients felt cared for, my supervisors were confident in my skills, and I felt fulfilled. I loved being a nurse. As the years flew by, my personal needs changed, and I needed more money to support my family than was available to bedside nurses. So, despite my reluctance to leave that venue, I entered nursing administration. And lo and behold I discovered that, although I had only a rare opportunity to "lay on hands", I could facilitate the nursing care provided to so many more patients. I knew that even on my best days as a staff nurse, I could not directly care for more than 8 to 10 acutely ill patients. As a nurse administrator, though, I could influence the care provided to 50 times that number, and in my next position as chief nurse executive, I was able to reach 80 times that number".

The roles I have held throughout my career in primary healthcare have allowed me the privilege of nurturing, mentoring, educating, influencing, leading and sharing humour and grief with so many nurses. From working in partnership with other primary health nursing leaders, past and present, I know that the work we have undertaken and continue to do, has in turn shaped the direction of our current and future nursing workforce. For me, as I continue my nursing journey, I appreciate the importance of being able to empower and inspire others in leading change to meet the current and future demands of our primary healthcare system.

VAPING IN SCHOOLS
By Alana Trotter RN
School Nurse

Kia ora, my name is Alana Trotter and I have worked in the same low decile high school (years 9 to 13) in South Auckland for over six years. This school is made up of students from different cultural backgrounds; Pasifika 55%, Asian (including Indian) 25%, Māori 16%, European 3% and other 1%.

Over the last three years of working in School Based Health Services I began to notice an increase in students asking questions around vaping. In response to this observation, I started including questions regarding vaping use in my HEeADSSS assessments. I was surprised by the large number of our rangatahi that were vaping regularly. I decided that it would be more beneficial to gather more information from our rangatahi to enable us,

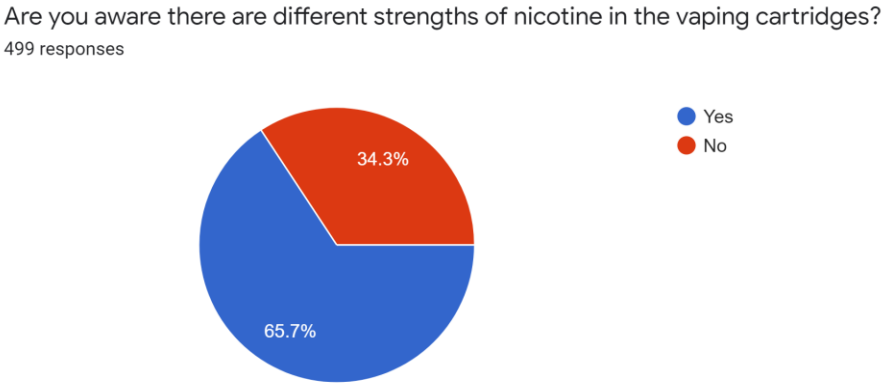
as a school collective, to put in place some well-rounded support.

The aim for this survey was to gather information about vaping use among our rangatahi. It was also to explore whether vaping is being used as a tool for smoking reduction or cessation, to explore reasons for rangatahi vaping and their knowledge of risks associated with vaping. During the beginning of August 2021, I sent out an anonymous survey to all students at our school and had over 30% of students participate from a range of ages (Age 12-14 38.2%, 15-19 61.8%).

Vaping vs Cigarette use

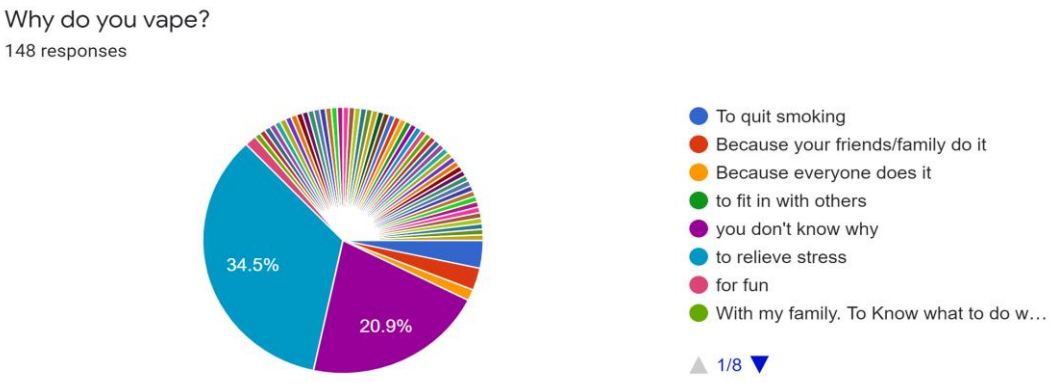
The results showed that 25.3% of those surveyed had tried vaping before and 15.8% had tried smoking. Of those who had smoked a cigarette before, 36.7% had used vaping to aid in the cessation of cigarette use.

Of those that had vaped 32.4% vaped regularly (more than once a month) and 22.3% only vaped when socialising. The data also showed that 20.9% of rangitahi who had vaped before were unaware that the cartridges contained nicotine, while 34.3% of the 499 total responses were unaware that vaping cartridges contained varying strengths of nicotine.



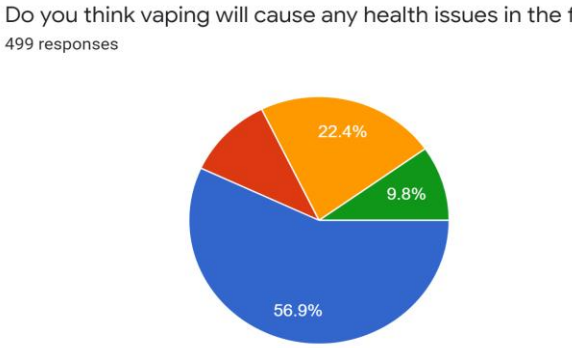
Reasons for vaping

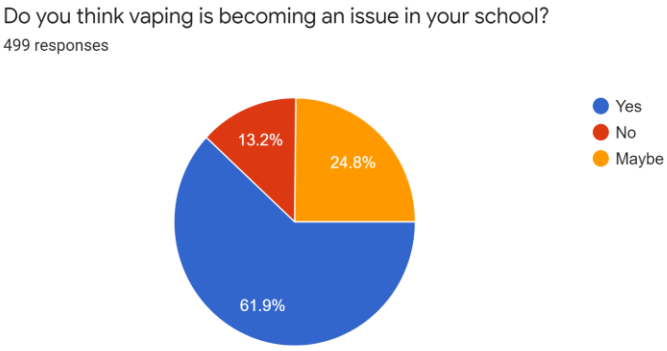
The data showed that 34.5% of rangatahi surveyed vaped for stress relief and 20.9% were unsure as to why they vaped. Rangatahi also listed some of their reasons for vaping as compared to smoking; affordable, accessibility and discrete use. They also noted that they used vaping to fit in with their peers socially. One rangatahi wrote “Also a lot of these students just do it to look/be cool, but they're unaware that they are unconsciously becoming addicted to it.”.



Vaping Risks

The data showed that over half of our rangatahi thought there could be some long-term health effects in the future. 4.1% of those who vaped had started to notice changes in their health with the most common symptoms listed as shortness of breath, headaches, dry mouth, and dry throat.





A few other risks which I did not include in this survey were: the addition of illegal substances used in combination with their vaping liquids, the sharing of vape equipment and incorrect cleaning methods which could potentially alter the integrity of the vaping device.

There is also the risk of rangatahi not being aware of the strengths of nicotine available. Most specialised Vaping shops in New Zealand use strengths ranging from 0mg - 50mg. One of the leading retailers describe on their website that depending on whether you are a beginner (Mouth-to-Lung Vaper) or an advanced (Direct Lung Vaper) user, this can increase the nicotine equivalent experience you would have compared to smoking cigarettes. For example, a beginner using 6mg of nicotine E-Liquid would be equivalent to 5-10 cigarettes a day but if you were an advanced user and inhaled directly into the lungs this would be equivalent to 20+ cigarettes a day. Therefore, there is a potential danger of rangatahi consuming high levels of nicotine that could lead to nicotine overdose.

Other information gathered

Rangatahi reflects the concerns of school leaders that vaping is becoming an issue within the school environment.

So, what are we going to do with all this data?

Prior to the recent Covid -19 Delta strain outbreak we had planned to meet as a collective (Senior leadership team, Deans, Nurses, Guidance team, relevant outside providers and student leaders from our health and wellbeing team) to discuss the results and develop a plan to manage rangatahi found vaping on school grounds.

Education to students and staff would need to be a key focus. We would also need to consider providing education to whanau and the wider community as the data showed that 79.1% of youth access their vaping equipment from whanau or peers, and 20.9% purchase their vape equipment.

We would also look at the school's discipline procedures regarding students who are caught on school grounds vaping. One participant from the survey suggested "think before you growl a student for smoking [vaping] because that may be their only way to feel relief in this world. Please just consider our perspective". We have also learnt that students want to have a voice when discussing issues that are affecting themselves or their peers, so we have thought about initiating a programme led by our rangatahi lead Hauora Rōpu (Health and Wellbeing team). This team helps to promote health awareness and education to their peers.

Finally, it may be concluded that vaping is still "new", but we can presume there will be potential long term health risks to our rangatahi. This survey has emphasised the

Often issues are dealt with disciplinary action but the underlying reason for vaping is not addressed. By introducing a holistic individualised care plan, we can support rangatahi to understand what further supports they may require.

importance for us to establish the reasons why individuals start vaping. The data has shown us that there is a lack of knowledge as to the nicotine content and strength in cartridges. This information could be incorporated in any future education programmes implemented in our school community.
It has highlighted the importance to look beyond the vape and to turn our focus on the young person from a holistic perspective.

The below is the current list of District Nurses across the country, if there are any changes or additions, please email me on melanie.terry@nmdhb.govt.nz		
Nationwide District Nursing email and phone list		
Areas Covered	**Phone contact information**	**Referral email address**
Northland		
Whangarei area	Mon to Fri 08.00 - 16.30	DistrictNursing.WhangareiReferrals@northlanddhb.org.nz
Mangawhai	09 430 4101 ext. 7952	
Whangarei	Sat, Sun and Public Holidays 08.00 - 16.30	
	09 430 4100 - ask for District Nurse on Duty	
Kaipara area	09 430 4101 ext. 65411	DRGDistrict.nurses@northlanddhb.org.nz
Dargaville Matakohe Paparoa		
Hokianga area	09 405 7709	clinical@hokiangahealth.org.nz
Kaikohe Omapere Rawene		
Far North area	09 408 9180	Kaitaia.DistrictNurses@northlanddhb.org.nz
Kaitaia Whaka Whiti Ora Pai		
Mid North area	0800 643667 and choose from following options:	Midnorth.districtnurses@northlanddhb.org.nz
Kaeo	Kaeo - option 1	
Kaikohe	Kerikeri - option 2	
Kawakawa	Kaikohe - option 3	
Kerikeri	Kawakawa option 4 (covers Russell, Paihia)	
Russell Paihia		
	Please send all Rheumatic Fever referrals for the Northland area to Maryanne Barlow:	
	09 430 4101 ext. 60592	Mary-Ann.Barlow@northlanddhb.org.nz

Waitematā		
Helensville	09 427 0300	OlderAdultsHomeHealth@Waitematadhb.govt.nz
Hibiscus Coast	09 427 0300	
Takapuna	09 486 8945 ext. 42565	Emails attended Monday to Friday 08.00 - 16.00
Waitakere	09 837 8828 ext. 46828	
Warkworth	09 422 2700	
Auckland		
Auckland Central	0800 631 1234	communityservices@adhb.govt.nz
Great Barrier Island Otahuhu Waiheke Island		
Counties Manukau		
Howick Mangere Manukau Mercer Middlemore Otara Papakura Pukekohe Waiuku	09 2773440	eFaxReferralsCC@middlemore.co.nz

Waikato		
Cambridge Coromandel Hamilton Huntly Kawhia Mangakino Matamata Morrinsville Ngaruawahia Otorohanga Pauanaui Putaruru Raglan Taharoa Taumaranui Te Awamutu Te Kauwhata Te Kuiti Thames Tirau Tokoroa Waihi Whangamata Whitianga	07 834 3370	crc@waikatodhb.health.nz

Bay of Plenty		
Katikati	07 579 8757 0800 267 222	admin@bopccc.org.nz
Kawerau Matata Murupara Opotiki Tauranga Te Kaha Te Puke Whakatane		- - - - - - - -
Tairāwhiti		
Gisborne	06 869 0505	csa@tdh.org.nz
Ruatoria	Ngati Porou Hauora	Ruatoria: gina.chaffey@nph.org.nz
Te Araroa	06 864 6803	Te Araroa: beryl.waikari@nph.org.nz
Te Puia Tokomaru Bay		Te Puia: lisa.porter@nph.org.nz Tokomaru Bay: cheryl.johnson@nph.org.nz
Bartletts to Matawai	Turanga Health (Te Hauora o Turanganui a Kiwa)	admin@turangahealth.co.nz
	(note: Iwi organisation not part of the Tairāwhiti DHB) 06 869 0457	
Lakes District		
Mangakino Putaruru		-
Rotorua	07 349 7940	DNS.rotorua@lakesdhb.govt.nz
Taupo	07 376 1008	DNS.Taupo@lakesdhb.govt.nz
Tirau Tokoroa Turangi		

Hawke's Bay		
Central Hawke's Bay	06 878 8109 ext. 2135	
Hastings	0800 673 845	dnpmhastings@hbdhb.govt.nz
Napier Wairoa		dnpmnapier@hbdhb.govt.nz
Taranaki		
	CHIC (Community Health Integration Centre)	chic@tdhb.org.nz
	06 753 8660	
Bell Block		
Hawera	06 278 9850 or 06 278 7109 ext. 6954	
Inglewood Mokau		
New Plymouth	06 753 7797	
Okato Opunake		
Patea	06 273 8088	
Stratford	06 765 7189	
Urenui Waitara Waverley		

MidCentral		
Dannevirke Eketahuna Feilding Foxton Levin Otaki Pahiatua Palmerston North Woodville	06 350 8182 06 350 8100 (after 16:00)	districtnursingreferrals@midcentraldhb.govt.nz
Whanganui		
Marton Raetihi Whanganui	06 327 7463 06 385 5019 06 348 1274	Monday to Friday: referral.centre@wdh.org.nz Saturday and Sunday: districtnurses@wdhb.org.nz
Wairarapa		
Castlepoint Carterton Featherston Greytown Martinborough Masterton Mauriceville Ngawi Riversdale Tinui Wainuioru	06 946 9827 On the weekend, phone Wairarapa Hospital 06 946 9800 and ask to be put through to the on-call district nurse.	communityreferrals@wairarapa.dhb.org.nz

Capital and Coast		
Wellington including Crofton Downs Miramar Seatoun Wadestown Wellington CBD	Monday to Friday 08:00 - 16:30 04 806 2556	RES-OpBkOraChs@ccdhb.org.nz
Kenepuru including Broadmeadows Kenepuru Khandallah Johnsonville Newlands Ngaio Porirua Pukerua Bay Tawa	Monday to Friday 08:00 - 16:30 04 918 2011	
Kapiti including	Monday to Friday 08:00 - 16:30	
Kapiti Coast Paraparaumu Waikanae	04 903 0224	
	All areas after hours:	
	Monday to Friday 16:30 - 21:00, weekends + stats	
	04 385 5999	

Hutt Valley		
Eastbourne Lower Hutt Upper Hutt Wainuiomata	04 570 9148	dnadmin@huttvalleydhb.org.nz
Nelson Marlborough		
Murchison		
Nelson Richmond Wakefield	03 543 7980 (after hours 03 546 1800)	to contact the clinical co-ordinator districtnursesnelsonclinicalcoordinator@nmdhb.govt.nz
Motueka	03 528 1160	to send referrals
Takaka / Golden Bay	03 525 0103	ccc@nmdhb.govt.nz
Blenheim French Pass Kekerengu to Picton Marlborough sounds Ria Valley	03 520 9927 ext 1 (after hours 03 520 9999 and ask for DN on call)	DistrictNursing.CoordinatorsWairau@nmdhb.govt.nz
West Coast		
Greymouth Hokitika Westport Fox Glacier Franz Joseph Haast Hari Whataroa	03 769 7721 03 756 9906 03 788 9216 0800 794 325	greydn@wcdhb.health.nz hokidn@wcdhb.health.nz bullerdn@wcdhb.health.nz swadmin@wcdhb.health.nz

Canterbury		
Ashburton Burnham Christchurch Ellesmere Hinds Kaiapoi Little River Mayfield Methven Mt Somers Lincoln Rakaia Rangiora Tai Tapu West Melton Yaldhurst	Adult Community Referral Centre 03 337 7765	communityreferralcentre@cdhb.health.nz
South Canterbury		
Fairlie Geraldine Hakataramea Mt Cook Tekapo Temuka Timaru Twizel Waimate	03 687 2310	icatt@scdhb.health.nz emails not viewed on weekends

Southern		
Alexandra Clyde Cromwell Hawea Omakau Wanaka	Central Otago District Nursing Service 03 440 4303	dunstandn@cohealth.co.nz
Balclutha Clinton Clydevale Hillend Kaitangata Kaka Point Owaka to the Chaslands	Clutha Health First District Nursing Service 03 419 0530	District.nursing@chf.co.nz
Dunedin Middlemarch Mosgiel Palmerston Port Chalmers	Dunedin District Nursing Service 03 476 9500	CCCSPOE@southerndhb.govt.nz
Edendale Gore Mataura Pukerau Riversdale Wyndham	Gore District Nursing Service 03 209 3011	districtnursing2@gorehealth.co.nz

Southern *continued*		
Arrowtown Bluff Invercargill Kingston Lumsden Milford Sound Mossburn Queenstown Riverton Stewart Island Te Anau Tokanui Tuatapere Winton	Invercargill District Nursing Service 03 214 7223	DistrictNursingSouthland@southerndhb.govt.nz
Ranfurly	Maniototo District Nursing Service 03 444 9420	MHDT.Nurse@southerndhb.govt.nz
Milton	Milton District Nursing Service 03 417 4399	milcomhealth@xtra.co.nz
Kurow	Oamaru District Nursing Service	districtnursesoamaru@southerndhb.govt.nz
Hampden Oamaru Omarama Waitaki	03 433 0670	
Beaumont	Tuapeka District Nursing Service 03 485 9050	tuapeka.health@xtra.co.nz
Lawrence Tupeka Waitahuna		

A COVID-19 STORY

By Nicky Cooper

Every now and then, as a Nurse you experience something that truly moves you. It reminds you of why you do what you do and today was one of those days.

I recently left my role as a Rural Nurse Specialist and relocated into Public Health, three weeks later, a rapid Covid-19 lockdown occurred for the entire country. I've been part of an amazing pandemic response team, contact tracing, covid testing and vaccinating. Part of that involves vaccinating via an outreach team, people with disability, mental illness, the housebound, and medically frail that cannot attend large vaccine clinics. We also vaccinate those that may have had previous vaccine reactions or some form of unusual reaction after their first covid vaccine.

Today I met "Pat" (pseudo name), to administer her second dose. We exchanged initial niceties albeit through our facemasks. She looked anxious and apprehensive about her second dose. I told her that it was her choice to proceed or not, and she told me about her many co-morbidities and that Covid would most likely kill her. She explained her reaction after her first one and it became very evident that the majority of what she explained was a strong emotional response, a 'come down' after a strong adrenaline surge to stress.

I approached this a little differently to others and asked if she would be happy for me to use guided relaxation techniques whilst I vaccinated her, and she happily obliged. I assisted her to find her most comfortable position and used visualisation to help her to find her 'happy place'. When asked if we could play some music she chose memories from the old days, which I played through an app on my phone. She indicated she was happy to try some relaxation breathing, whilst I gently placed my hands on her upper back and shoulders. Whilst she successfully navigated these techniques, I briefly removed my hands and vaccinated her without any disruption to her calmness. She was surprised that she didn't feel it and said you can turn the music off, I'm ok now.

Afterwards, we sat the required two metres apart in our facemasks during her observation, and she told me her story. She was a wife, mother, and grandmother, and was the oldest child of a very large family. Her parents had been emotionally unavailable, and unkind throughout her life. She told me that after they died, she discovered that some key members of her family weren't who she'd believed they were. She told me of the many painful traumas herself and extended family had endured and witnessed throughout their childhoods, but that she had worn the brunt of it to protect the youngest. She told me about the generational family harm, mental health, addictions, premature deaths, chronic illnesses, and custodial sentences many had eventually succumbed to. And through her dialogue I could heard of her 'survival' 'guilt' and overarching 'responsibility' she felt to hold everyone together.

This incredibly strong, resilient yet broken woman, had a story that needs to be told, needs to be shared as part of her healing journey and in part to help others. I asked if she'd ever written it all down. I told her that I would like to read her story, and that many others could benefit from reading it too, and I caught a glimpse of a change in her eyes, "Do you really mean that"? She asked. "Do you think this could help someone else"? I nodded and despite her facemask I saw her eyes smile.

This woman had endured so much trauma throughout her entire life, her physical appearance and chronic health issues spoke volumes. Generationally, her family had endured multiple adverse childhood

experiences reflected in predictable health risk behaviours and chronic disease. She herself had debilitating PTSD symptoms; and developed crippling anxiety and sensory overload on the day of her first vaccine. We talked extensively about different coping strategies for daily life as well as future stressful life events.

By the end of this consultation, she left to join her husband who had been waiting, but before she left, I thanked her. I thanked her for trusting me and thanked her for reminding me of why I do what I do. She also thanked me, for seeing and hearing who she really was. I told her that much of the work we do involves working with similar families and validated the impact abuse and household dysfunction has during childhood. I told her that my real passion was working 'upstream' in the first 1000 days to improve family and health outcomes. And just like that, we departed, both a lot richer from our combined experience.

Rural Muster
Post Natal Depression Blog

Nicky Cooper
Rural Nurse Specialist
Murchison Health Centre

"I am a mother of three little farm boys, twin boys born prematurely at 29wks and 2 ½ years later our third little boy. We own a farm and run an agricultural contracting business. I have been a registered nurse for 23 years and have worked as an early childhood educator. I am currently studying for my Master's Degree. I started a Facebook page in May 2016 for the parents in our area to provide them with support, electronic resources and a safe virtual village".

So, here's the thing. Parenting is one of the most rewarding and at the same time the hardest things we ever do in our lives. We seem to constantly need to question ourselves as does everyone else to whether we're really doing ok or not. It's where we do the most learning about who we really are, and why. Where we are going, where we have come from and what we have learned from our own childhoods and life journeys.

It's not always pretty, sometimes its damn right gross but It's where we can focus on what we truly want for ourselves and our children's future's. At our highest points our hearts could burst with pride, happiness, and fulfilment. But at our lowest point we can be filled with exhaustion, self-doubt and guilt. What we've done is make a miracles, beautiful peaceful children who are filled with love and wonder. We can be our own greatest cheerleaders but sadly our own worst critics. It's a huge test on our relationship with ourselves and with our life partners, we don't always feel like we get it right all of the time, but we always get it just right enough! Which is why I'm telling you that we all absolutely rock at this parenting lark. It takes a village to raise a child, and these days our village is so often further away but we're all in this together, supporting, growing and learning. There are no rights or wrongs, no failures, no rule book. Our good enough's are exactly that.... they are good enough.
You've got this! We've all got this.

In our rural area, I work as a well child/tamariki ora nurse focusing on the infant/child as well as parental health and well-being. I also work as an emergency, practice and paramedic nurse within the ambulance service which means I often deal with parents and their children when they are unwell or injured.

In New Zealand reports suggest over fifty percent of women up to a few weeks after

birth experience feelings known previously as the “baby blues” of anxiety, tearfulness, irritability and feeling overwhelmed, which can often be short lived. Postnatal depression is a depressive illness that occurs in approximately 10-15% of women after having a baby and 8 weeks after birth is present in 4% of fathers, so the impact of having a baby can impact both parents, not just the mother. These ongoing difficulties for the parent can eventuate in negative effects on the children and adverse effects on the marital relationship with less access to quality antenatal and postnatal care. Postnatal depression can range in severity from mild mood disturbances right through to the most severe of forms, postnatal psychosis. Postnatal depression can deeply affect relationships between the mother and baby, partners, and the extended family.

We aim to work in partnership giving support in the form of information and support for sleep, settling, nutrition and child behaviour and linking mothers into the appropriate community supports. When a woman is experiencing PND it can affect their ability to make critical decisions which can impact on their health status and their infants. On top of experiencing PND they may well be sleep deprived and have other family stressors such as limited supports, ethnicity, single parenting, also those affected by family violence. Fatigue is likely to impact parental wellbeing and maternal tiredness is associated with poorer mental and physical health, including symptoms of depression, anxiety, stress, fatigue and energy. The strongest protective factor associated with PND is happiness in partner relationships. There is some evidence examining the correlation between intimate partner violence and PND which made comparison of their findings difficult.

During an acute fear or anxiety episode humans respond in three ways, by fighting (fight), running away (flight) or become immobilised (freeze). Physical symptoms during these anxiety episodes often include the heart to beat faster, adrenal, cortisol levels and blood pressure to rise and shallow breathing, blood leaves certain organs and migrates towards muscles, shaking and sweating can occur, the skin sensation changes with the feeling of hair ‘standing on end’, the gastrointestinal tract is often affected and the mind becomes hyperactive, but thoughts are primitive and in survival mode.

“I never know when it’s going to hit me, it feels so irrational but it is very real for me. I often need to isolate myself to remain alone but it is at these times that I need the most support. I always feel as if I’m anxiously waiting for something awful to happen, I truly have no idea why I feel this way but I feel like I’m drowning. My symptoms don’t always involve panic, trembling or hyperventilating, I over analyse things constantly and can’t turn my brain off, particularly at night and it’s so exhausting. This is not an attitude; most people don’t even know I’m feeling this way unless I tell them. I just want to be me and not be defined by this fear and anxiety”.

Rural isolation can impact parenting with reduced socialisation triggering insomnia, anxiety and often leads to lowered immunity, these social stressors often push people’s resilience to their limits. This is a sentiment echoed by the safeguarding children initiative that it takes a village to raise a child therefore our rural communities may struggle more to provide that supportive village for their children to fully reach their potential. There is untold benefit of non-judgmental peer support from each other in our communities which for many is incredibly powerful and the key to normalisation and socialisation. One of the reasons that support groups and social media can be well utilised and popular is because mothers often feel like they need to be heard by people who understand and have been in similar situations which is the true essence and value of the lived experience.

Health implications of PND to the woman and her family with evidence showing that women experiencing PND may have two interactive patterns, intrusiveness or withdrawal. Studies have found that partners often do report symptoms of PND themselves and felt that the support was directed at the woman only not

the family as a whole. The postnatally depressed parent can affect the child's development in such ways as impaired maternal-infant interactions, it can also lead to attachment insecurity, impaired cognitive and social-emotional development. In the worst-case scenario PND can lead to women taking their own lives, with an obviously profound and long-term impact on the surviving extended family members.

The New Zealand Mental health foundation suggest you "Shrink your worries" for day-to day anxieties by questioning its significance, talking it out with others, writing it down to gain perspective, deep breathing and relaxation techniques or yoga/meditation, allowing themselves only a set time with their particular worry or concern, increase their outdoor activities such as exercising in nature to effectively work through the thought processes, and try to find rationale and balance in their own thoughts.

First line interventions such as enhanced social and psychological support should be considered before prescribing medication for PND especially if the woman has mild symptoms. However, if a woman is suffering from moderate or severe PND then pharmacological treatment may be considered at a first-line treatment. It was found that structured psychological therapies such as CBT and psychosocial interventions, such as peer support and non-directive counselling appear to be effective for reducing symptoms of PND. showing that such psychological interventions can improve the mother's mental health. Community supports such as face-to-face non-directive counselling, peer-to-peer telephone support and group support have a positive effect on a woman's mental state.

Clinical research trials suggest more diverse therapies and technologies for the long-term management of anxiety disorders such as cognitive behavioural therapy (CBT) are indicated as an effective form of treatment however appear to be more beneficial when used in person as a face-to-face form of treatment. There are some computerised cognitive behavioural therapies that could either enhance and/or be used independently such as 'MoodGYM' and 'E-couch' which can benefit those in the rural sector and these techniques can be used in conjunction with a therapist supported through health services. These forms of therapy such as 'Beating the blues', 'COPE' and 'Fear fighter' can be delivered via a computer interface either by telephone or by the internet.

Another variation of cognitive behavioural therapy called 'Mindfulness' which focuses on altering the intensity of the relationship between the actual person and their predominant anxieties, as opposed to trying to alter their actual thoughts and feelings. This method is often initiated firstly by medication for mood stabilisation and therapy for reducing physical symptoms to allow them to remain present to experience and react but in a more realistic way.

Support can also be found 'online' for example the 'Online PPMD Support Group' and 'mothers helps' websites offer information, support and assistance to those dealing with postpartum mood disorders. There is help out there for fathers too, a fantastic website is 'greatfathers.org.nz' which offers advice and support for fathers that they themselves may be experiencing depression after the birth of their baby and also advice for offering support if their partner has developed PND.

Local support such as 'Mothers supporting Mothers', 'Mothers Matter', 'PND Support Groups', the 'Plunket Postnatal Adjustment Programme' and the 'Mother and Babies Unit' based at Princess Margaret Hospital in Christchurch. The Mothers Matter Trust came into existence in 2015 and evolved out of the Postnatal Depression Family/Whanau NZ Trust. They provide information for mothers, fathers & families on PND & related conditions, such as anxiety & bipolar disorder.

The Mothers and Babies Unit is a South Island regional specialist service providing psychiatric treatment for pregnant women and parents with babies up to 12 months old (at time of admission). The team provides inpatient and

outpatient treatment for women who experience depression and other psychological and psychiatric difficulties during pregnancy and after the birth of their babies and includes CBT groups.

Māori and Pacific models view the wellbeing of the individual as inseparable from the wellbeing of the whanau, hapu, iwi and family in all its dimensions, as do Pacific models, such as Fonofale. Traditional Māori and Pacific perspectives may challenge some commonly held assumptions in Western psychological and counselling theory, such as the Western focus on developing individuality and self-advocacy. An abundance of literature around PND may be very daunting for them and their family.

"We never talk about it as a society because we are taught that you must always be happy and grateful to be pregnant and have a baby and that those other feelings just aren't talked about, and my only regret is that I didn't speak up sooner".

Modern families and modern living preclude why so many mothers are now often left feeling isolated and confused. From an evolutionary perspective, historical parenting had extended families, so recovery was probably easier in a more supportive environment. I think social support is under rated and undervalued, not just for company but to give mothers a platform to offload and unwind. For many medication and therapeutic interventions are the right answer for the acute phase but from a long-term perspective parents particularly mothers need resourceful communities to provide healthy social networks and peer support. To fund, empower and train experienced parents with resources to act as supportive coaches or mentors for new parents could perhaps lesson the need for tertiary mental health services because often the community already has some of the answers.

Resources

Circle of Security
http://www.circleofsecurity.org/
Mental health foundation
https://www.mentalhealth.org.nz

MIND. Understanding anxiety and panic attacks
https://www.mentalhealth.org.nz

Ministry of Health. Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand. Wellington: Ministry of Health.

Mothers Matter
http://www.mothersmatter.co.nz/default.asp

NICE. Computerised cognitive behaviour therapy for depression and anxiety. https://www.nice.org.uk/guidance/TA97/chapter/3-The-technology

New Zealand Guidelines Group. *Identification of common mental health disorders& management of depression in primary care*. Wellington: NZ Guidelines Group.

Safeguarding Children Initiative
http://safeguardingchildren.org.nz/about-SCI/

Supporting and educating women with experience of depression from Through Blue
http://www.throughblue.org.nz/p/resources.html
http://www.throughblue.org.nz/

Community Nurse Prescriber

By Tori Crawford

Alternative Education Nurse, she provides support to the students within alternative education centres on Auckland's North Shore, these are students who have been excluded from mainstream schools often for behaviour issues, so can be a rather complex group of students to support.

My perspective on the Community Nurse Prescriber course

Three years into my nursing practice, working within the Rheumatic Fever Prevention Program in South Auckland and being given the opportunity to apply for the Registered Nurse Prescriber in Community Health paper is a given right? Thinking of all the barriers that this paper would overcome for me to be able to provide care to health consumers and their whanau, it would be silly to turn the offer down. A colleague of mine was a part of the first cohort to complete this qualification and has found multiple benefits to her nursing practice.

Working in a high needs environment, there is often more than one thing going on health wise and to more than one whanau member. A lot of the students that I come across treated me as though I was their GP, it was a lot more than what the average person assumes a school nurse does.

Here we are, first study day and with a quick scan across the room I am able to see that I am the youngest person in the room- a worry that I had but had tried to ignore. I started questioning myself and my abilities, am I too young to be doing this paper? Am I too inexperienced for this paper? Will whanau think I'm too inexperienced to care for them? If anything I wanted to use this to my advantage and show that I was able to show that I am capable of completing this qualification and use it to benefit my nursing practice.

The day started out outlining how the course would work and the expected timeframe to gain this qualification. The day was full of different professionals ranging from consultants, pharmacists to nurse prescribers coming in and discussing a lot of subjects ranging from antimicrobial stewardship to benefits of being a Registered nurse prescriber. After this we only had one more in person study day and it was to go over how to structure the competencies. The day was beneficial but long, listening to 6 speakers talking for an hour each, it's hard enough to even think about the day, let alone sitting through it.

Then we were on our own, finding case reviews, finding differential diagnosis, determining the diagnosis and treatment to be provided, completing online learning modules, completing clinical hours, case studies and competencies. This was a surprise to me, as it didn't seem like a lot of work and also where are we completing a more in depth pharmacology paper, I know we all understand the mechanisms of actions for the medications that we will be and the online modules did briefly cover it but I expected to have a more thorough pharmacology experience.

Then boom, covid-19 hit and the expected 6 month course ended up being a 12 month course. Covid-19 threw a spanner in the works as it did with everyone and still is doing. But after just over a year an email was sent out informing that I had in fact passed the qualification and that I was able to start prescribing as soon as the qualification was added to my APC on Nursing Council.

Yes! Amazing that I have passed this paper and now when I search my name on the Nursing Council website, I am able to see my qualification "Able to prescribe in the community". That's awesome and I am proud of myself for completing this in the middle of a global pandemic but, there are no processes or pathways that have been developed for workplaces to allow me to prescribe.

I have been qualified for over a year but have not been able to prescribe under my own name due to no official pathways being developed. Yes, we have three yearly reviews to ensure we are prescribing appropriately but a pathway for implementing nurse prescribing into practice especially when workplaces aren't too familiar with the qualifications.

If I had any feedback for the program it would be more in person study days, I am aware covid-19 did interfere but it is a lot different learning from a professional than learning from a computer, having professional that don't contradict each other- there was a comment that Strep A in the throat is treated the same as Strep A on the skin and this caused a lot of confusion for everyone participating but very interesting conversations, and finally having a pathway to introduce Registered Nurse prescribers to practicing areas that aren't familiar with the qualification.

EXTERNAL REPRESENTATIVES REPORTS

As members of the NZCPHCN committees we are also involved as your representatives on various committees (all of this is voluntary also). Our aim in the future is to bring you these reports so that you can see what we are achieving on these external groups. Dependent on how often each group meets will determine how often we are able to produce these reports in LOGIC but we hope to bring you something in each issue.

External Representative Interim Report	
Prepared by	Wendy King
Name of Working Party/Group/Committee	National Delegates Committee
Report Period:	Nov 2020 – Oct 2021
Meetings/ Skype/ teleconferences attended (dates)	Nil I was unable to attend April face to face meeting – I have requested minutes documents from that meeting x3 with no result There was to be an October face to face but I haven't heard anything (maybe in the minutes from April?) There has been no email traffic
Relevance to CPHCN membership, PHC nursing	yes
What contribution were you able to make?	I have given feedback to Angela during year - most recently about the random incorrect statements from the Ministry of Health stating all staff are mask fit tested at orientation Did respond to NZTA License Consultation directly - but late - they only had an 8 day submission period and I was on leave when it came out! [this is actually we don't want any input] This is not ok especially as they were quoting inequalities as a reason for changing the time periods without addressing the situation - same process still Have responded to the Disability Survey 2023 consultation (4 weeks by comparison)

Your overall assessment and analysis	Some serious concerns Fragmented primary care - no time to find out who is doing what, no connectivity professional relationships, professional and personal isolation (I worked solo for 4 months with no idea what where other team members were except that they were covid vaccinating somewhere) Had great difficulty updating PDRP portfolio as no one available to write statements for competencies so have lost pay as portfolio expired previously had unbroken record for years - not ok Recently heard about new staff at covid vaccinating site who hadn't been paid for a number of weeks - in the end they said they were going to contact Worksafe! Statements about primary care to look after covid in the community – was NZNO consulted? What are we NOT going to do? Smears? medication reviews? Screening? Dressings? Travel immunisations? Contraception? Diabetes reviews? School immunisations? Half PHN workforce doing covid vaccinations and not processing referrals in L3 area and haven't been for months, PHNs have moved on, retired, resigned and not yet been able to be replaced

External Representative Interim Report	
Prepared by	Charleen Waddell
Name of Working Party/Group/Committee	ACC Primary Health Care Sector Engagement Group
Report Period:	Aug-Nov 2021
Meetings/ Skype/ teleconferences attended (dates)	Zoom 6 weekly Thurs 1430-1530 12th August 2021 23rd September 2021 4th November 2021
Relevance to CPHCN membership, PHC nursing	Ability to engage and bring concerns regarding ACC primary sector Updated criteria for work med certificates Māori

	Rural GP contracts presentation Urgent Care Clinic Terms of reference review Minutes and info attached
What contribution were you able to make?	Minimal to date Attached are minutes, and terms of reference
Your overall assessment and analysis	Information needs to be disseminated

External Representative Interim Report	
Prepared by	Yvonne Little
Name of Working Party/Group/Committee	National Cervical Screening Programme Advisory Group
Report Period:	June 2021 – August 2021
Meetings/ Skype/ teleconferences attended (dates)	16 June 2021 – Face to Face 25 August 2021 – ZOOM There were no meetings Face to Face or via ZOOM for Sept to Nov 2021
Relevance to CPHCN membership, PHC nursing	Nurses and NZCPHCN need a voice on the committee to ensure that proposed changes will be sustainable in the real world of practice, to address any barriers to service within the primary health care sector.
What contribution were you able to make?	There was robust discussion around equity and support to screening for when self-swabbing comes into being. The co-design process has been developed and the register is in progress and will be a phased approach – there is the potential to offer the never or under-screened population access at the end of the IT development before the full rollout. The HPV self-testing pathway was discussed, and adjustments made on recommendations made by members and also the Māori Health Strategy.

	We are reviewing the manner in which the self-swabbing will be rolled out – this will be on a regional/practice-based approach and not centralised like the bowel screening mail out. Discussion was had on the cost of cytology testing, currently being reviewed as no extra funding available. Discussion was had around wording of documents and to avoid words such as vulnerable as it gives a negative context. I was able to give feedback on the confusion between Primary Care and Primary Health Care in the thematic analysis document as Primary Care being used where is should have been PHC. I will have a further chance to review this document with each version to ensure that the wording is clear. At the close of the meeting there was discussion around the future of the NCSP Advisory Group. Where we are heading in the future: Change to Advisory Group Structure: 3 groups – NCSP Advisory Group, Technical Reference Group (TRG), Covid Monitoring Group. Moving forward: How to get advice into the key rollout. Primary Advisory Group for NCSP will focus on equity and will be comprised of members of various groups – College Representatives as clinical advisors, etc. Other groups that may be included are likely to be IT related. TRG will concentrate on four specific areas – setting up a process to key groups to find out who they want to put into these groups.
Your overall assessment and analysis	This group is continuing to work towards improving access and understanding how women want to access and be advised whilst maintaining the professional standard of cervical screening. I now have a much stronger voice on the committee.

Nurses and Climate Change

By Sue Gasquoine

Sue Gasquoine is the Nursing Policy Adviser/Researcher in the Professional Services Team. She has worked at NZNO since March 2017 and in addition to her work in the Policy and Research Team is involved in publications and supports the Nursing Education and Research Foundation (NERF) Board.

Introduction

I learned a great deal from participating in preparing NZNOs submission on the draft advice prepared by the He Pou a Rangi Climate Change Commission (CCC) earlier this year. The impact of climate change has become an urgent health issue for which our profession needs to find time, energy and resource to respond. Other nurses may wonder as I did what some of the specific terminology means for example *'just transition'* and *'health co-benefits'.*

Just transition

Nursing and health perspectives on climate change was the focus of NZNOs consideration of the draft advice and submission to the Climate Change Commission earlier this year. We endorsed the views of Ora Taiao New Zealand Climate and Health Council of which NZNO is a member. A *'just transition'*[i] approach defined by the Etū policy as:

- an equal sharing of responsibilities and fair distribution of the costs across society
- Institutionalised, formal consultations with relevant stakeholders, including trade unions, employers and communities, at national, regional and sectoral levels.
- promotion of clean job opportunities and the greening of existing jobs and industries through public and private investment in low carbon development strategies and technologies.
- Formal education, training, retraining and life-long learning for working people, their families and their communities.
- Organised economic and employment diversification policies within sectors and communities at risk.
- Social protection measures.
- Respect for, and protection of, human and labour rights.
- Respect for and partnership with tangata whenua.
- Recognition of obligations to Pacific peoples affected by rising sea levels.
- Governmental agencies to develop specific plans to support the economic diversification of regions
- Developing and implementing specific industry and environmental policies to attract new investment, encourage the growth of new industries, and the creation of quality, secure jobs in affected regions.

The concept of a *just transition* is endorsed by the Paris Agreement and must be co-designed with our te Tiriti partners and embed equity in order that policy action can reduce death and disease across communities regardless of socio-economic status. The structural, technological, economic and behavioural interventions required across the social, cultural, economic and political contexts must leave no one behind and strengthen marginalized communities who will bear the brunt of the effects of the transition to a carbon neutral economy.

Health co-benefits

NZNO shares Ora Taiao's expectation of realizing the opportunity to put the *health co-benefits* of responding to and minimizing the impact of climate change at the centre of our approach. Health co-benefits are interventions which not only result in lower carbon emissions but also produce positive health outcomes. The health benefits of lower emissions have been well described and we would expect that communities will benefit by the promotion of active transport (walking and biking), subsidised public electric transport which reduces traffic accidents and illness due to sedentary lifestyles i.e. cardiovascular disease, diabetes, cancer and illness due to air pollution.

A more detailed consideration of the possible unintended consequences on whanau of the changes proposed needs to consider for example access to and expense of installing more environment friendly heating and cooking systems. A high proportion of families and whānau are unlikely to be able to afford solar panel heating. The use of inadequate or expensive heating systems or no heating is one of the leading causes to an increase in whānau poor health, hospitalisation of children and premature death particularly in terms of respiratory diseases, and eventually other health comorbidities. Reducing emissions by building sustainable warmer homes will have health co-benefits for our already marginalised population.

Socio-economic status being a key indicator of health wellbeing and resilience, will be impacted by shifts in employment trends. Changes in sectors such as agriculture, where reducing emissions in food production by promoting less red meat consumption, will improve health by lessening cardiovascular disease, diabetes and cancer. These need to be developed in a way that household incomes of those working in the sector are not further compromised, that is a *just transition* as described above. We also need to avoid creating another form of food poverty because the cost of the alternative, lower emissions foods excludes those who could benefit most but who cannot afford to exercise these options.

Conclusion

As busy as we all are with supporting a response to a global pandemic, a pro-active sustainable response from nurses to climate change is a professional responsibility and obligation with the Nursing Council of New Zealand's Code of Conduct (Principle 3, Standard 3.8) stating: '*Use your expertise and influence to promote the health and well-being of vulnerable health consumers, communities and population groups.'* It is also specified in NZNOs Strategic Plan - *'Role model and advocate for environmentally sustainable practices which enhance healthy public policy'* and '*Reduction in NZNO's carbon footprint'.*

What can we do as individual nurses to support a *just transition* and promote *health co-benefits*? We can be part of the solution, albeit small, in a challenge of global significance.

I orea te tuatara ka putaki waho. A problem is solved by continuing to find solutions.

References

New Zealand Nurses Organisation (2020) *Strategic Plan 2021-2025.* Wellington

Nursing Council of New Zealand (2012) *Code of Conduct.* Wellington

https://etu.nz/wp-content/uploads/2019/01/E-t%C5%AB-Just-Transition-policy.pdf

Be inspired and focused to make a difference in public health and have the skills and courage to act.

Applications for PHLP 2022 are now open.

The Public Health Leadership Programme (PHLP) is designed for people working in public health. The programme is funded by the Ministry of Health and has been developed following extensive consultation with the sector. *PHLP* builds leadership competencies identified as important for leaders in public health. The programme has been developed by Catapult (leadership and organisational performance specialists) and Quigley and Watts (public health specialists).

PHLP allows participants to discover their leadership potential and equips them with practical and tested leadership tools and resources. The programme generates immediate and lasting benefits for participants, those they lead, and for public health.

Each programme has six days spread over several months. In 2022 one programme will be offered in Wellington and one in Christchurch.

The programme dates are:

Programme 1 (Wellington):

29-30 June, 14-15 September, 16-17 November 2022

Programme 2 (Christchurch):

6-7 July, 21-22 September, 23-24 November 2022

Anyone working in the public health sector may apply for a place on the programme. Applications close at **5pm 4th March 2021.** For more information, application criteria, programme dates and online applications, go to www.health.govt.nz/phlp

Places are limited. Applicants not previously accepted are encouraged to apply again.

Here's what past participants said about the programme:

"The knowledge and skills gained from this course have been far greater and more applicable than I could have anticipated."

"The Public Health Leadership Programme has been of such benefit, in ways that I would not have predicted prior to completing."

"Peer coaching has been invaluable throughout this programme and is something that I will continue to use to consider different pathways and to challenge my thinking