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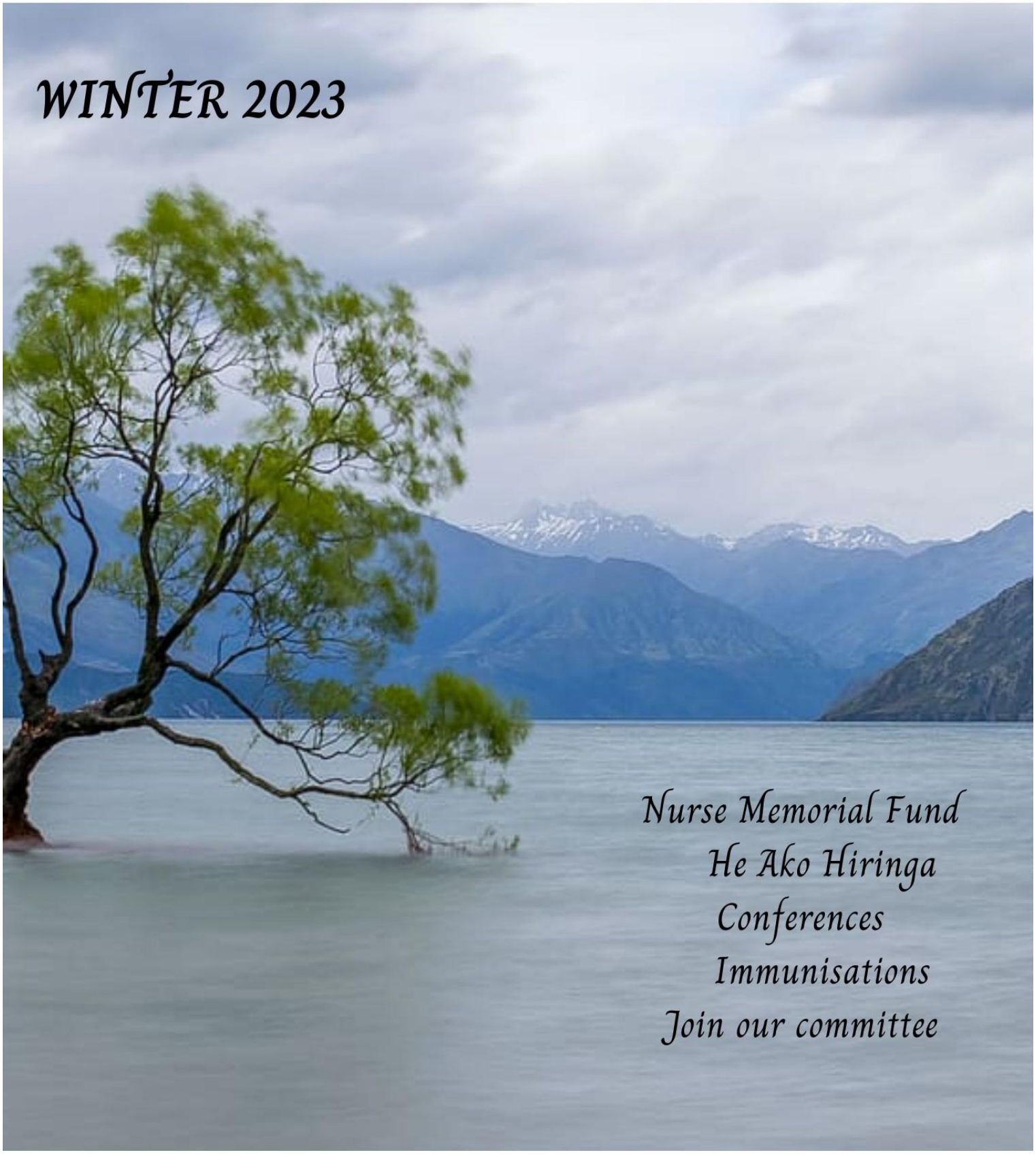
LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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



WINTER 2023

Nurse Memorial Fund

He Ako Hiringa

Conferences

Immunisations

Join our committee

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

Editor: Yvonne Little

Publisher: Yvonne Little, 027 333 3478, logiceditorcphcn@gmail.com

Editorial Committee:
Michael Brenndorfer, Jess Beauchamp, Ellie Maloney, Katie Inker.

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Correspondence
The Editorial Committee welcomes all correspondence intended for publication. Correspondence should be addressed to:

Yvonne Little: logiceditorcphcn@gmail.com

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Winter 2023

In this issue…

Editors Report

Yvonne Little
Editor

Welcome to the 2023 Winter Edition of LOGIC. For many of us the thought of a midwinter hibernation sounds like bliss but in our profession there will be no such thing.

Hopefully, many of you will have been able to spend time with whanau and friends over Matariki, sharing kai, celebrating life and honouring our ancestors. Reconnecting our minds and hearts.

Some of you may even have been lucky enough to have tickets to watch the FIFA Women's World Cup.

Whilst this issue does not quite have the bumper presence of our Autumn Edition it nevertheless hopefully has an article or two for each of you. I hope you are able to get a chance to take a break and read it whether it is on the PDF or Joomag version, whichever is your preferred choice of medium.

Our team has been working hard to be able to bring to you some interesting articles, and like you our membership they also have the work/life pressures. Some days it feels like you are stuck inside a washing machine on a constant cycle of wash, rinse, spin, repeat especially with the winter ills and chills on top of the climate change events that we have all been suffering. Suffice to say that Climate Change is definitely upon us – once upon a time (and no I am not about to start a bedtime story here) we thought Climate Change was a fairytale, albeit a not so nice one – but now we are getting to grips with the facts of not only the natural disasters affecting New Zealand but the world at large.

Inside this Edition you will find Urgent care network information, He Ako Hiringa, IMAC information, College of Stomal Therapy Nurses Conference information, Wound Care Conference information, and NZNO News amongst ours regular articles and reports.

Life is full of ups and downs and with this goes the need to keep our fingers on the pulse and plan for the future. We currently have positions available on the Executive Committee and the LOGIC committee due to our members fulfilling their terms of office and those committee members who have had to leave for personal reasons.

We are looking for enthusiastic nurses to join us and we want to ensure we have representation of all areas of Primary Health Care Nursing on our committees. Please see the flyer inside this edition and on our Facebook page. If you would like to know more about what is involved in becoming a committee member then please contact either me by email on logiceditorcphcn@gmail.com or send a message to our Secretary by email on nzcphcnsecretary@gmail.com.

Stay safe and stay well. Look after yourselves first so you can look after your patients, your whanau and friends.

NURSES MEMORIAL FUND

The New Zealand Nurses Memorial Fund is about to celebrate their 106th anniversary. This benevolent fund has given financial assistance to nurses in hardship since 1917. In the year ending 31st March 2023, they provided $54,800 in financial assistance to 21 nurses: 17 by way of one-off grants and the remaining 4 as monthly annuities, average cost per recipient $2,610. The fund was founded as a practical memorial to the 10 nurses who drowned when the SS Marquette was torpedoed in the Aegean Sea in October 1915.

Who may apply: Any Nurse/Midwife practising or retired who has given 2 years fulltime service after registration in Aotearoa/ New Zealand. Nurses can apply by emailing nznmfund@gmail.com. In order to assist others the fund depends on modest contributions of many @ $10 per year or $100 life membership. To donate please contact the same address.

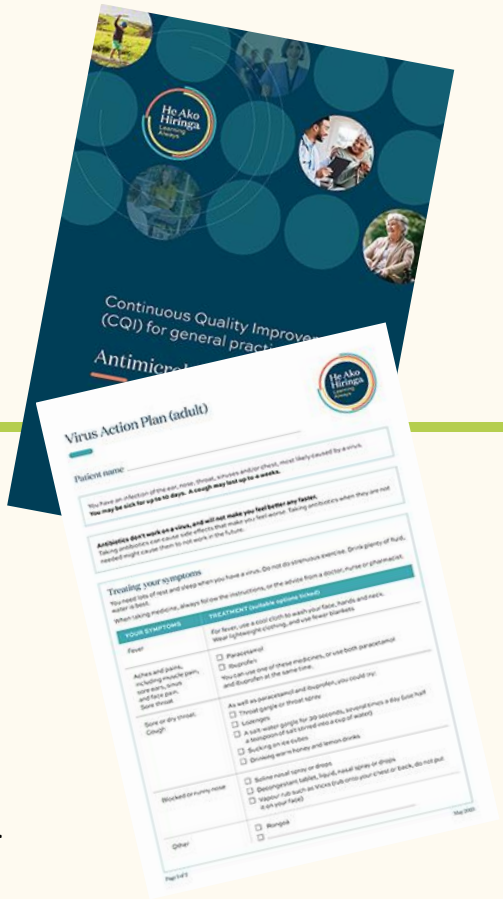
New resources

CQI Toolkit

Our first continuous quality improvement resource focuses on antimicrobial stewardship. Complete with an Activity Guide, a Data Collection Form, and an Information Sheet, the CQI Toolkit is suitable for any general practice team member who wants to:

- meet various criteria of the Foundation Standard (accessed via annual fee to RNZCGP)
- help meet requirements of the Cornerstone CQI module (purchased from RNZCGP)
- support individual team members' professional development
- action their EPiC dashboard data insights
- improve practice efficiency, save time and money
- fight antimicrobial resistance and protect the health of future generations!

Go to akohiringa.co.nz/cqi-toolkit to explore the toolkit



Virus Action Plans

Manage patient expectations for antibiotics with our Virus Action Plans for adults and children over 6 months old.

Intended for use once a diagnosis of bacterial infection or other illness (eg, otitis media, pertussis, COVID-19) has been ruled out, the plans help to reinforce when symptomatic and supportive care is the best medicine.

The Virus Action Plans acknowledge that a person is unwell, reinforce the clinician's decision that antibiotics are not required, and provide options for self-management.

Translated versions available in Māori, Arabic, Hindi, simplified Chinese, Samoan, and Tongan.

Go to akohiringa.co.nz/virus-action-plans to download the plans

NZCPHCN Urgent Care Nurses Network

Michelle (Shell) Piercy

URGENT CARE SURVEY RESULTS

I have worked in Urgent Care several times throughout my career, I have been the Nursing Services Coordinator for two austere Urgent Care clinics, I have been a Clinical Nurse Educator for a busy metro Urgent Care Clinic, and I currently work casually as an Advanced Care Community Paramedic for an Urgent Care Clinic in a regional centre. Much of the work I do as a healthcare consultant is based within the Urgent Care and rural GP sectors.

Throughout my career in Urgent care, I have found that Urgent Care nursing skills and knowledge are a collaboration of several other specialties of nursing. However, there is no framework for what urgent care nurses should be skilled in or the knowledge they should possess. Credentialing experienced nurses coming into urgent care from other areas like ED is incredibly difficult without a framework and knowledge gaps are filled by time on the floor rather than intentional education. Student nurses and new graduates have little or no direction on where to start with what skills and knowledge to learn.

I started the Urgent Care Nurses Network (UCNN) as a special interest group of the NZ College of Primary health care nurses to support nurses working in urgent care. As part of the UCNN, a survey was developed to look at what the expected knowledge and skills of an experienced senior nurse working in Urgent Care were.

The aim of the Urgent Care Knowledge and skills survey was to establish what the consensus from the UC sector was on what knowledge and skills a senior nurse working in urgent care should have. I conducted a survey in 2022, made up of a total of 38 questions, of which three questions asked for free-text answers, four questions asked for multi-choice answers and the remaining 31 questions used a Likert scale ranging from strongly disagree, disagree, neutral, agree, and strongly agree. I gathered some basic demographic data on the participants, their experience in urgent care, the location within NZ, and the clinic's access to additional resources. I conducted a thematic analysis of the free text answers to gather the key themes. The survey was made available to participants via an email link from the NZ College of Primary Health Care Nurses and the Royal College of Urgent Care.

87 participants took part in the survey from across the Urgent Care sector.

The survey asked for some demographic data. 75% of the participants were in the North Island and the remaining 24% were in the South Island. When asked about proximity to a hospital, 50% of the Urgent Care Clinics were located within 30 mins drive of a Major Hospital and 33% were either next door or very close to a Major Hospital. 11% were urban clinics and 3% were regional but both were within an hour's drive of a major hospital. 2% of the clinics were considered rural. No General Practitioners or Advanced Care Community Paramedics working in Urgent Care answered the survey. Of the respondents,

there was 1 urgent care fellowship trainee, 1 clinical nurse educator, 1 medical director of urgent care. 2 urgent care fellows, and 2 practice managers. 3 nursing services coordinators, and 4 emergency nurses working in Urgent Care. 19 general practice nurses and 39 urgent care nurses also responded. 7 nurse practitioners and 8 nurses of other roles.

When asked about experience, more than 40% of participants noted that they have been working in Urgent Care for over 10 years. Only 11% of respondents have been working in Urgent Care for less than one year.

The survey asked about access to additional resources attached to or next door to the clinic, these were recorded in free-text answers and coded into 21 themes. Ambulance-based community paramedics as an additional resource were mentioned by only 1 participant, as were concussion clinics, ear suctioning, dietitian, midwifery, social work, and access to the very low-cost access scheme. 2 participants noted travel medicine clinics and 2 noted direct access to a hospital. 3 participants recorded health improvement practitioners, Allergy clinics, and access to specialists. 4 participants noted they have access to podiatry, and 4 have Audiology. 10 of the respondents have access to phlebotomy services and a fracture clinic, 11 participants noted that they are co-located with a general practice. 23 of the participants noted they have physiotherapy and 29 noted access to dental. 60 of the participants have access to radiology and 72 have an onsite pharmacy. 4 respondents did not specify any resources.

The Standard 2015 to which urgent care clinics must be accredited states that a triage scale must be used and that this should be the Australasian Triage Scale. The specifics of the ATS are stated in the ATS qualification courses available via both CENNZ and AceHub. When asked if nurses in Urgent care should triage using the Royal New Zealand College of Urgent Care approved triage scale, 80% of participants stated that they either agreed or strongly agreed. 14 % were neutral and 6% either disagreed or strongly disagreed. 90% of participants agreed or strongly agreed that urgent care nurses should be appropriately trained in the Australasian triage scale. The ATS triage scale was created by ACEM. ACEM state that triage should only take 2-5 mins and should be separate from a Nursing assessment. 67% of participants agreed or strongly agreed that after the initial triage, another nurse should conduct a nursing assessment. 26% responded neutrally.

The survey asked if Nursing assessment in Urgent Care should include gathering vital signs, weight if applicable, past medical history, family history, allergies, and medications prior to the patient seeing a clinician for further assessment, diagnosis and treatment. 89% either agreed or strongly agreed. Only 9.2% were neutral about it.

We know that there is an expectation that nurses perform a certain amount of assessment within Urgent Care. However, there is much confusion about several aspects of this from the wider sector. Some of the confusion is: What the requirements are for the role of the triage nurse? And the role and/or need for a nurse assessment following triage, the role and expectation on nurses for nurse-only consultations for repeat and follow-up consultations vs a Clinical Nurse Specialist autonomously assessing, diagnosing, and treating a patient with advanced practice and a wide variety of standing orders.

The survey showed a need for all levels of nurse assessment and management to be articulated and for educational pathways to be standardized. The survey asked 'an Advanced nursing assessment in Urgent Care should include the nursing assessment as stated above, an exploration of the presenting complaint, specific subjective data about the presenting complaint, and a presenting complaint-focused physical assessment'. 75% of participants agreed with 19.5% neutral and 5% disagreed or strongly disagreed. The survey compared An Advanced nurse in Urgent Care ordering x-rays either based on guidelines set out by the medical director or based on their own education and experience. 90% of participants agreed or strongly agreed that advanced nurses should order x-rays based on guidelines. Whereas 85% of participants agreed or strongly agreed that advanced nurses should be able to order x-rays based on their own education and experience. In both cases, only 2% disagreed or strongly disagreed.

The Survey asked if 'Advanced assessment nurses in Urgent Care should be able to make clinical decisions about ordering, and order a series of simple diagnostic tests for example but not limited to wound swabs, urinalysis, ECG, BSL, visual acuity, covid swab, throat swab?'

A resounding 96.7% agreed or strongly agreed. 95.4% agreed or strongly agreed that 'Urgent care nurses should be trained and proficient in interpreting these results as well as escalating abnormalities appropriately'. The Survey asked if 'Urgent Care Nurses should be trained and proficient in taking blood from patients using phlebotomy and sending it to the lab?' 91% of participants agreed or strongly agreed. 72.4% of participants agreed that 'Advanced assessment nurses in Urgent Care should be trained and proficient in making clinical decisions about ordering and ordering a series of diagnostic blood tests?'

82.7% of participants agreed that 'Advanced assessment nurses in urgent care should be trained and proficient in identifying abnormalities in diagnostic tests and be able to escalate these to the responsible diagnostic and treatment clinician?'. 95% of participants agreed or strongly agreed that 'Urgent Care Nurses should be trained and proficient in the insertion of Intravenous catheters' and 88.5% of participants agreed or strongly agreed that 'Urgent Care Nurses should be able to prepare complex IV infusions and IV medications.'

The survey asked if 'Urgent Care Nurses should be able to use a wide variety of standing orders to administer medication to patients based on their yearly competence assessment to do so, under the direction of the medical director?' 95% of participants agreed or strongly agreed. The survey then asked if 'Urgent Care Nurses should be able to use a wide variety of standing orders to supply medication to take home on a practitioner supply order (PSO) for nurse-only consultations based on their yearly competence assessment to do so under the direction of the medical director?' 82.7% agreed or strongly agreed.

Showing competence in a large set of standing orders for administration in the clinic and PSO medications for supply is a natural step towards independent prescribing for advanced nurses in urgent care, it is also how community paramedics practice outside of ambulance services. The legislation is the same for both groups.

99% of participants agreed or strongly agreed that urgent care nurses should be proficient in recording ECG's however only 93% agreed or strongly agreed that Urgent Care Nurses should be trained and proficient in basic 3-lead and 12-lead interpretation and be able to recognize abnormalities and escalate these appropriately. The survey asked if 'Urgent Care Nurses should be trained and proficient in fracture management, including clinical decisions about treatment including but not limited to building custom temporary splints, casting, and application of splints, moon boots, etc.' 80% of Participants agreed or strongly agreed. 93% of participants agreed that 'urgent care nurses should be able to conduct POP check follow-up visits.' And 97.7% of participants agreed or strongly agreed that 'urgent care nurses should be able to remove all types of casts.' The survey then asked if Urgent Care Nurses should be trained and proficient in making clinical decisions about musculoskeletal injury management including but not limited to crutches indication and education, slings of varying types, advice on self-management of injuries including OTC medication strategies and 87.3% agreed or strongly agreed.

We asked if Urgent Care Nurses should be trained and proficient in acute wound assessment and should be trained and proficient in making clinical decisions about wound closure requirements and technique or best practice wound closure management for the optimum wound healing? 96.5% of the participants agreed or strongly agreed.

We then asked if Urgent Care Nurses should be trained and proficient in acute wound preparation for closure and or dressing, for example, but not limited to, washing out of the wound, debriding unsalvageable skin, skin tear flap relocation, debris removal and cleaning 93% of the participants either agreed or strongly agreed. We pushed further and asked if Urgent Care Nurses should be trained and proficient in acute wound preparation for closure with a selection of appropriate local anesthetic for block, and appropriate block either field or ring as per standing orders and guidelines. To this question, 71% agreed or strongly agreed. 24% answered neutral and 4.5% either disagreed or strongly disagreed. We pushed further still and asked if Urgent Care Nurses should be trained and proficient in acute wound closure techniques including but not limited to many types of suturing, skin adhesive, steri strip and hair tying techniques. 83% agreed or strongly agreed.

Urgent Care Nurses should be trained and proficient in chronic wound assessment and management. They should be able to make clinical decisions about wound healing techniques and dressings and best management plans for wound healing, with access to topical creams and other products on standing orders and guidelines. 85 % of participants agreed or strongly agreed. We asked if Nurse-led consultations should take place by Urgent Care Nurses that trained and proficient in but not limited to ear suctioning, morning-after pill administration, wound checks and/ or redressing or management, as well as others supported by standing orders and guidelines (mentioned above-cast removal, pop checks) 85% of the participants agreed or strongly agreed. 8% answered neutral and 5% disagreed or strongly disagreed. We asked if Urgent Care Nurses should be able to provide healthcare education to improve health literacy for patients presenting to urgent care with a variety of health concerns 97% agreed or strongly agreed. We then went on to ask if Urgent

Care Nurses should understand community resources and referral pathways to inform patients about access to healthcare services within their communities. 98% agreed or strongly agreed.

In a free text-answer question, we asked if there were any other areas of knowledge and/or skills you would expect of a highly trained Senior Nurse working within Urgent Care. We used a thematic analysis to organize answers into 28 themes.

Key themes that emerged were: Indwelling Catheter insertion and Mental health assessment and management featured 6.9%. Followed by appropriate condition-based management, management of emergency situations, and resuscitation at 5.7%. Next was pediatric assessment and management at 4.6% then communication skills, leadership, and management, mentoring, nurse prescribing, and vaccinations all featuring at 3.4%

Standing orders, Patient safety, cultural competence, and advanced assessment skills all featured at 2.3%. Themes emerging at 1.1% were clinic coordination, discharging patients, occupational health, ongoing education, post-graduate education, providing telephone results, referrals to external providers, referrals to hospitals, STI screening and STI management, understanding local and national health systems, Xray interpretation and year of experience. The remaining responses indicated that no further comment was needed.

When asked if there was anything else participants wanted to share in free text answers

A further 25 themes emerged. Xray training, upskilling is an increased workload, triage vs assessment, triage training, standing orders, standardization of urgent care, staffing issues, PDRP, Pay equity, Nurse prescribing, nurse practitioner pathway, mentoring, mental health assessment, management training, lack of resources, lack of education, high workload, experience, education funding, education, CPD, community connection, basic nursing skills and ACC funding disparity between nurses and doctors.

These themes will need to be further analyzed to provide meaningful information for the sector.

We have found some wonderful information from this initial survey and appreciate all the participant's time and energy in completing this. The general consensus is that nurses at an advanced level, with appropriate training and experience, should have a wide scope of practice and large set of skills and knowledge specific to Urgent Care. Developing clinical education and training pathways for urgent care nurses throughout their career progression will support this. From this information, we can develop an educational and training framework for the knowledge and skills expected of a senior urgent care nurse and road map of how to get there.

From this information, a proposed educational and training framework will be developed and sent out to the industry for consultation. Further surveys will be developed to separate skills and knowledge expected at each level of practice for example an education framework for new graduate nurses coming into Urgent Care compared to an educational framework for a nurse who has been working for several years in Urgent Care and wants to progress to a senior role.

Key takeaways

- Clinical education/training pathways exist in many other areas of Nursing. These pathways and frameworks will assist in articulating what we do as Urgent Care Nurses, they guide us in credentialling new staff coming in Urgent Care, training, and developing of current staff, supporting student nurses and new graduates with learning objectives, they provide career development opportunities, support CPD, appraisals, improve patient flow within the clinic but most importantly encouraging
- evidenced-based and ongoing education of nurses improves patient outcomes.
- Urgent Care is a specialty of Nursing that involves highly technical skills and knowledge. We need to be able to articulate this to achieve pay equity with hospital-based nurses, funding for ongoing education, and funding and support for advanced nursing practice and nursing leadership pathways.
- Although Urgent Care Nursing shares some skills with Emergency Nursing, Plastics Nursing, Orthopaedics Nursing, and Primary Health Care the specific combination of skills and knowledge needed is very specific to Urgent Care.
- The survey shows a need and desire for a pathway to support nurses toward advanced practice specializing in Urgent Care this includes funding and encouragement for advanced nurses to become community prescribers and designated prescribers.
- The survey shows an interest in developing A Clinical Nurse Specialist role with a pathway to Nurse Practitioner within the specialty of Urgent Care.

"Improving wound healing through innovation, technology and collaboration"

Kia ora koutou
It is our pleasure to welcome you to the 2023 NZWCS Conference website, following closely on the heels of the '2021 in 2022 conference' we are thrilled by the interest and support already being received for this year's conference.

Our conference theme is "Improving Wound Healing through Innovation, Technology and Collaboration".

The conference aims to demonstrate recent learning, new information and the possible future of wound care in Aotearoa New Zealand with focus upon the physical, mental, digital and cultural well being of individuals with wound care needs.

The conference benefits health professionals working with people with skin and wound issues across the health spectrum. NZWCS conferences are renowned for being welcoming, informative, educational and fun; The

conference dinner at the best covered stadium in Aotearoa New Zealand ... Forsyth Barr Stadium, will not disappoint.

Wound care continues to evolve, it is a creative field demanding expertise and innovative knowledge which must be shared and provided in a culturally appropriate way. There continues to be innovation in wound care which could ultimately change practice, the Wound Care Society are pleased to be recognised as demonstrators and supporters of wound care innovators and with this in mind we are thrilled to have many outstanding innovative speakers for this year's conference.

Associate Professor Paulo Alves - Assistant Professor and Coordinator Wounds Research Laboratory, Institute of Health Sciences, Centre for Interdisciplinary Research in Health, Portugal.

Associate Professor Michelle Barakat-Johnson - renowned clinician researcher with a special interest in skin integrity, implementation science and financial and policy implications of skin integrity issues. The University of Sydney Australia.

Professor Lester Levy - Professor of Digital Health Leadership at the Auckland University of Technology. He is also the Chair of the New Zealand Health Research Council.

Advanced Practice Nurse Wendy White - an Independent Consultant, qualified Educator, Advanced Practice Nurse & Credentialed Wound Specialist (Wendy White WoundCare) based in New South Wales (NSW), Australia.

We look forward to welcoming you to Ōtepoti Dunedin in October.
Ngā mihi ki a koe

Rebecca Aburn - NZWCS President and
Sasha Drennan - Conference Convenor
On behalf of the 2023 Conference Organising Committee

Jenny Faulkner

A mum of 4 young adults and grandmother to two boys and a survivor of Postnatal Depression. I have 30 + years of nursing experience in NZ and overseas. Currently working for Plunket as a Clinical Nurse Consultant, I also provide professional supervision. I completed a Master of Health Science in 2022 and under the supervision of Chris Moir and Sue Crengle I completed a dissertation in 2019: Postnatal Depression Screening: What are the barriers and facilitators for Plunket nurses? A research aimed towards understanding screening inequity.

When I am not at work, I am visiting my mokopuna, or out walking enjoying the region of Nelson where I live.

Whānau Āwhina Plunket nurses' views on the use of the PHQ-3 postnatal depression screening tool: a survey

Introduction

In New Zealand, nurses visiting families postnatally use the Patient Health Questionnaire-3 (PHQ-3) to screen and detect postnatal depression. Exploring nurses' perception of the tool when using it with women across cultures is central to ensuring the PHQ-3 tool supports equitable screening and detection of postnatal depression, yet little is known about nurses' confidence with, and use of, the tool with people of differing cultures.

Aim

The aim of this study was to understand nurses' confidence in using the PHQ-3 to screen for postnatal depression, particularly its use cross-culturally.

Methods

Quantitative online survey research was carried out in 2019. Fifty-two percent of eligible registered nurses participated (*n* = 187), completing Likert scale responses and open questions about the use of the screening tool with specific groups, and barriers and facilitators to screening.

Results

Ninety-five percent of participants were confident in their use of the PQH-3, 70% of nurses agreed the PHQ-3 supports the identification of postnatal depression, and most respondents (54.5%) disagreed that the PHQ-3 was a good screening tool cross-culturally.

Discussion

Nurses were confident in their use of the PHQ-3, and it was relatively highly regarded in its ability to detect postnatal depression. However, less confidence in its use across cultures implies the PHQ-3 does not translate to evidence-based, cross-cultural care. To serve culturally diverse populations, consultation is needed on both languages used and cultural practices so that tools are appropriate, otherwise they cannot be validated for use cross-culturally.

This nursing research was published recently in The Royal New Zealand College of General Practitioners Journal. Follow the link below to read the full article.

https://www.publish.csiro.au/hc/pdf/HC22120

NZNOCSTN Conference 2023

CALLING FOR ABSTRACTS FOR PEER PRESENTIONS

Submission close: 30 September 2023

NZNO College of Stomal Therapist Nurses conference will be held in Auckland on Feb 28-March 1 2024

The NZNOCSTN committee would like to invite ALL members to submit an abstract for consideration to present at our "Peer Presentation" section of our 2024 conference. We cannot stress how important this part of YOUR conference this call is. With delegate participation, we are sure to have successful conference; PLEASE support it with your submission. Share your knowledge; tell your story to show off the innovative work you are doing.

All presentations will automatically go in to a sponsored competition for "BEST PRESENTATION" (sponsorships and prizes TBA) and ALWAYS excellent to include in the PDRP.

TOPIC: Anything stoma, fistula management, experiential, task, knowledge and/or skills related, where you have used your innovation and/or your expertise.

TIME: 15-minute presentation, 5 minute question time.

PROCESS: Submit abstract 100-200 words via email to the editors of "*The Outlet*", outlining your Topic, content and a snap shot about your role by 30th September 2023.

Preeti.charan@waitematadhb.govt.nz or Marie.buchanan@waitematadhb.govt.nz

NZNOCSTN committee members will review ALL abstracts. Outcome of submissions will be advised end of October 2023.

Abbey Palmer

Abbey Palmer is a clinical advisor and education facilitator at the Immunisation Advisory Centre (IMAC).

Immunisation: Frequently asked questions of the Immunisation Advisory Centre's 0800 line

For over 25 years, through our website www.immune.org.nz and the 0800 IMMUNE phoneline, IMAC has offered healthcare professionals immediate support on immunisation topics such as administering vaccines, vaccine schedules and potential adverse reactions. Our experienced immunisation advisors, assisted by a team of clinical experts, support providers to deliver a safe and effective immunisation programme.

0800 IMMUNE received a total of 17,033 calls, averaging 141 calls per day between November 2022 and April 2023. This article discusses some of the frequently asked queries received on this phoneline and by email.

Covid-19 boosters

Those who benefit most from the additional bivalent Comirnaty 15/15mcg doses are older people and those with underlying health conditions, such as severe immunosuppression, chronic lung disease and multiple co-morbidities, who are at increased risk of severe COVID-19 and exacerbation of pre-existing conditions. While additional doses may only stop transmission briefly, the benefit of additional doses is in stopping severe disease in the most vulnerable for a longer time.

For eligibility criteria see section 5.5 in the COVID-19 chapter of the Immunisation Handbook.

Hepatitis B

- Hepatitis B (HepB) vaccination is recommended for all infants and children in New Zealand, and for certain adults at risk of hepatitis B infection.
- People with documented evidence of three HepB doses after 4 weeks of age are expected to be immune for life.
- If serological evidence of immunity is required, individuals with serum anti-HBs antibody equal to or greater than 10 IU/L measured at one month after a HepB vaccine challenge are considered immune for life. Since antibody levels decline with time, testing serology without a challenge HepB dose may show a "negative" result of less than 10 IU/L when in fact the individual has immunity. This is because circulating antibody levels decline with time, but when given a booster there is an amnestic response and memory B cells produce more antibody. see section 9.5.7 of Immunisation Handbook for serological testing guidance.
- The single antigen HepB vaccine, Engerix B, is funded and given at 0, 1, 6-month intervals (for unfunded travel requirements, see Medsafe data sheet).
- For those aged under 10 years needing HepB catchup, use Infanrix-Hexa (DTaP-IPV-HepB/Hib) if other antigens are required. Infanrix-Hexa should be used in place of Infanrix-IPV at the '4-year-old' event to ensure long-term protection against Hepatitis B.

Meningitis

Meningitis is a term used to describe inflammation of the membranes that surround the brain and spinal cord due to bacterial or viral infections. The following vaccine-preventable infections can cause meningitis:

Table 1: Vaccine-preventable causes of meningitis

Infection	Available vaccine	Age/group
Streptococcus pneumoniae	Prevenar (PCV13) Pneumovax (23PPV)	Infant and special groups Special groups from age 2 years
Neisseria meningitidis *Group B* *Group ACWY* *Group C*	 Bexsero Menactra, Menquadfi, Nimenrix NeisVac-C	 Infants, special groups, certain groups aged 13-25 Special groups aged <9 months
Haemophilus influenzae type b	Hiberix (Hib) Infanrix-Hex (DTaP-IPV-HepB/Hib)	15 months, special groups Infants
Enteroviruses (rotavirus)	Rotarix (RV1)	Infants
Varicella-zoster virus	Varivax	15-months, certain groups
Mumps virus	Priorix (MMR)	12 and 15 months, non-immune

Invasive meningococcal disease (IMD) is a bacterial infection caused by *Neisseria meningitidis* that can lead to meningitis and sepsis. Currently, group B is the most common cause of IMD in NZ, followed by W and Y, and historically group C. To provide the best protection, vaccination with both MenB (Bexsero), and MenACWY vaccines (Menactra, Nimenrix, MenQuadfi) is recommended. Bexsero is now funded on the National Immunisation schedule at age 3 months, 5 months and 12 months with a limited-time catchup up to age 5 years. Meningococcal vaccines are also funded for certain adolescents aged 13-25 years living in communal residences and for special groups. see section 13.5 in the Immunisation Handbook.

Co-administration of vaccines

Live vaccines can either be given on the same day or 4 weeks apart.

Non-live vaccines can be given at any time interval from another vaccine (including live vaccines), e.g., if varicella and MMR are given at 15-month vaccine event, MenB and influenza could be given the following day or week if desired.

MenACWY vaccines, Nimenrix or Menquadfi, can be given on the same day as the pneumococcal vaccine, Prevenar 13, but, if possible, separate Menactra and Prevenar 13 by 4 weeks. see section 13.5.2 in the Immunisation Handbook.

Out of an abundance of caution, mpox and Comirnaty (COVID-19) vaccines are recommended to be separated by 4 weeks for those at increased risk of myocarditis/ pericarditis, notably, young male adults aged under 30 years.

For children younger than 5 years with history of febrile convulsion, a separation of two days between influenza and Prevenar 13 vaccines is recommended due to a small risk of febrile convulsion following concomitant delivery.

Consumers should be informed of the possibility for a stronger post vaccination response where two or more adjuvanted vaccines are administered together, for example, Nuvaxovid (COVID-19), Fluad Quad (adjuvanted influenza) and Shingrix (zoster) – as these contain proprietary adjuvants to gain a good immune response.

Vaccine errors & cold chain queries

A Local Immunisation Coordinator (LIC) is the first point of call for cold chain breaches and errors in each area. Contact details can be found under resources on www.immune.org.nz.

Once a pharmaceutical fridge temperature is noted to be reading outside the 2–8 °C range, to enable the LIC to advise whether vaccines can continue to be used or not, the initial steps are to:

1. quarantine the vaccines by labelling the fridge 'Not for use'
2. download the data logger (that is in the fridge and programmed to read temperatures every 5-10 minutes)
3. send this information, including the vaccines affected, to the LIC. Cold chain breach reporting form.

0800 IMMUNE provides urgent clinical support in the event of vaccine errors and when the LIC is not immediately accessible. Common errors include: expired vaccine being given; extra doses of vaccines being administered - usually where providers have failed to check vaccine records on immunisation registers (NIR or AIR) and have relied only on a person's memory; and vaccines being given before recommended spacing – again, often because records are not checked prior to delivery. Vaccine incident reporting form

Early administration of vaccines

It is not recommended for vaccines be given earlier than their due dates. However, to allow for opportunistic immunisation rather than asking a parent/caregiver to come back another time, there is a small amount of flexibility with the immunisation schedule. Guidance is provided in the "Early administration of vaccines" factsheet under the resources tab on immune.org.nz.

HPV – Gardasil 9 vaccination

Individuals who receive their first dose of Gardasil 9 before turning 15 years only require two doses of the vaccine. If an individual turns up many years later after receiving one dose (of Gardasil or Gardasil 9) under the age of 15, only one further dose is required.

Those who commence vaccination after the age of 15 years or are immunosuppressed require a series of three vaccines given at 0, 2 and 6 months.

Planning catchup immunisations

0800 IMMUNE receives many calls about individuals with incomplete immunisation records or those who have been vaccinated using a different national schedule while overseas. The primary focus of the catch-up planning process is to bring an individual's immunisation status up to date with the NZ schedule.

Catch-up plans can be complex as they are personalised based on various factors, such as the person's age, previous antigen protection, and the age at which they received previous vaccinations. For helpful guidance for planning catchups see Appendix 2 in the Immunisation Handbook. Also see IMAC's fact sheet: Catch-up vaccinations funded for those with unknown or incomplete immunisation history

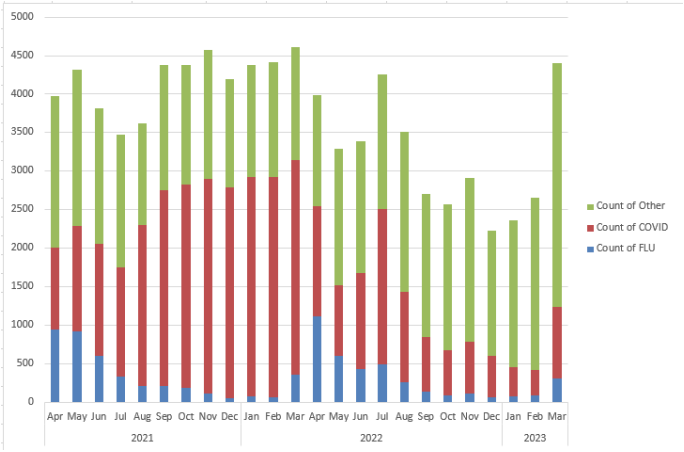
Key messages:

- Three documented doses of HepB vaccine suggests life-long immunity.
- Meningitis is caused by a range of vaccine-preventable infections.
- Checking the Immunisation Register and Patient Management System for immunisation history reduces errors.

- Catch up vaccine schedules need to be tailored to the individual.

Antigen	Age at time of presentation		
	<12 months	12 months to <5 years	5 years to <10 years
Tetanus, diphtheria, pertussis (DTaP)	3	3 or 4	4
Poliovirus (IPV)	3	3 or 4	3 or 4
Hepatitis B (HepB)	3	3	3
Haemophilus influenzae B (Hib-PRP-T)	3	1	-
Pneumococcal (PCV)	2	2	-
Rotavirus (RV)	2 (<25 wks)	-	-
Meningococcal B (MenB)	2	2 or 3	-
Measles, mumps, rubella (MMR)	-	2	2
Varicella (VV)	-	1	1

Table 2: Minimum number of antigens required, by age at time of presentation, for children under 10 years. See Immunisation Handbook for important details and footnotes (Source: Ministry of Health)



Pictured: Number and type of calls logged on 0800 IMMUNE between 2021 and 2023

References:
IMAC website: www.immune.org.nz

NZ Immunisation Handbook 2020 online https://www.health.govt.nz/our-work/immunisation-handbook-2020

ARE YOU ENTHUSIATIC AND PASSIONATE ABOUT HEALTH CARE AND WANT TO MAKE A DIFFERENCE? BE PART OF THE CHANGE FOR PRIMARY HEALTH CARE NURSING.

WE NEED YOU

WE WANT YOU

CONTACT US AND ENQUIRE WHAT IS INVOLVED IN BEING A COMMITTEE MEMBER. WE CURRENTLY HAVE VACANCIES ON OUR EXECUTIVE COMMITTEE AND LOGIC JOURNAL COMMITTEE.

Sue Gasquoine

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, she supports the Nursing Education and Research Foundation (NERF) Board, Chairs the Publications Team and is a member of the recently convened Green Team exploring ways to introduce sustainable practices into NZNO.

Maranga Mai !

Introduction

It's political lobbying season! With the general election on Saturday October 14, NZNO is working to raise nursing workforce issues with voters and those who seek election.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZNO) is calling on all political parties to commit to additional resources for health in order to provide:

1) **A health system that addresses inequities for Māori**
   We need Te Tiriti firmly upheld in all health settings so Māori have equal access to a health system that works for them.

2) **4,000 more nurses recruited, trained and on the job – this includes an increased percentage of Māori and Pasifika nurses.**
   We need 4000 more nurses in place as quickly as possible. We need an increased percentage of Māori and Pasifika nurses so people receive health care that fits with their culture.

3) **Pay lifts that value all nurses**
   We need pay and conditions that value nurses right across the health sector, attract more nurses and keep them in the job.

4) **Funded training to be a nurse**
   We need accessible government funded training so more people become nurses and ongoing funded training once someone is a nurse.

In communicating these and NZNO members other expectations of Maranga Mai!, we need to be able to present a clear and specific vision of what success looks like.

The recent initiative to increase Māori nurses in primary care in Te Tai Tokerau (Wiapo et al 2023) was established using co-design processes with health providers and the kaimahi they employ. In partnership with education providers and funded by Te Whatu Ora this *Earn as You Learn* (EAYL) initiative facilitated kaimahi, unregulated health workers, to achieve registration as Enrolled Nurses (ENs). The ability to then continue their haerenga (journey) to become registered nurses (RNs) or nurse practitioners (NPs) is established – there's an ara (pathway).

Wiapo et al make a number of recommendations in their article reflecting on the project, two of which warrant our

focus as we lobby for political support for the nursing workforce. Of particular relevance for NZNO members is '*legitimise Te Ao Māori within a eurocentric-western paradigm of health delivery and nursing education …'* and *'ensure funding models and agreements are flexible, designed to support success, deliver equity and promote socio-economic, inter-generational wellbeing'* (2023, p.7).

I understand this to mean we need to play the 'long game' and more importantly we need to persuade those who drive funding mechanisms that a sustainable nursing workforce is only achieved with sustainable support and in this context, across generations.

And now we have the Budget 2023 including 500 extra nurses funded! The question remains: *'Where are they and the other 3500 nurses needed coming from?'* There are three possibilities, they are arriving from overseas, they are graduating from Te Pūkenga, universities or wānanga as Enrolled Nurses (ENs) or Registered Nurses (RNs). Or they are returning to the nursing workforce.

The approach that Wiapo et al (2023) describe could achieve all three if appropriately resourced. In describing the success of their project they put emphasis on:

- Relationships - between individuals and entities
- Recognition of potential and using this to create possibilities
- Community connections
- Wraparound commitment to nurses, nursing and whānau,
- Funding that meets identified need rather than defining or limiting service provision

Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZNO) is about to conclude the biennial student survey. Data analysis will add to our understanding of the kind of support nursing students need to achieve their qualifications, nursing registration and new graduate roles.

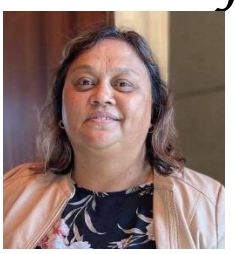
Conclusion

As we lobby in the election lead up, evidence such as that provided by Wiapo et al and the NZNO student survey, contributes to our claim that nurses as knowledge-based workers whose value-informed practice should be making the most significant difference to the delivery and effectiveness of health services in Aotearoa.

Reference

Wiapo, C., Sami, L., Komene, E., Wilkinson, S., Davis, J., Cooper, B., & Adams, S. (2023). From Kaimahi to Enrolled Nurse: A Successful Workforce Initiative to Increase Māori Nurses in Primary Health Care. *Nursing Praxis in Aotearoa New Zealand*, *39*(1). https://doi.org/10.36951/001c.74476

Chairs Report



Tracey Morgan
Chair

"Naku te rourou, nau te rourou ka ora ai te iwi"

With your basket and my basket, the people will live meaning the cooperation and combination of resources to get ahead.

As the Chair I would like to thank all of you in Primary Health who continue with the long hours and work ensuring our community is cared for. As Professionals in the sector, it can seem arduous but please note that your work and effort does not go unnoticed so thank you.

The members of National Executive Committee and college members outside of our standing committees represent you the members on many external working groups. These representatives act in the best interest of NZCPHCN and communicate back to the Committee as required; provide reports as identified by NZCPHCN Chair of participation and progress. As well as the Executive Committee the sub–Committees PPC and Logic continue to work hard to ensure members voices are being heard and addressed.

I have provided a snapshot of the continual work of the Executive Committee within Primary Health:

- **Constitution Review** – All members would have been sent a link to provide feedback on the NZNO Constitution Review which was facilitated by Grant Brookes (Board Of Directors) and Tracy Black (Te Poari).

- Sapere working with General Practitioners on rapid analysis outlining the current state in GP and supporting and strengthen case of sustainable GP in NZ: Two Executive members were part of this survey and were interviewed as part of this paper which will be presented back to the Committee once completed.

- **General Practitioner Leadership Forum:** In collaboration with Royal College of GPs, Hauora Taiwhenua, GenPro, PMANZ, GPNZ and CPHCN NZNO letters have been sent to Minister Verall addressing the pay parity gap and the need for 95% parity. As you have seen recently in the media this has been successful in some areas. This forum will continue to address the need for this and in particular ensuring General Practices are included and not excluded.

- **School Based Immunisation Programme Survey (SBIP)**: A Survey was sent out to look at the Immunisation within the schools.

- **Medsafe:** Regulatory guidance on Controlled Drug Classification.

- **Advanced Diabetes Management Course:** This course run by NZSSD and University of Waikato had phenomenal response and the course has been closed.

PAY PARITY

As most will be aware there has been lots of interest in the ballot for members not employed by Te Whatu Ora as it will have a great impact in terms of ongoing battle for Pay Parity – where every nurse everywhere gets paid the same as per Maranga Mai goals. Even if the proposed Pay Equity settlement is accepted, we may eventually have to go through justice system for the win.

The ballot closed on 07 August with a close win of members agreeing to a proposed pay settlement. While this was a narrow with this does not address the ongoing issue of

not enough resources, staff shortages and burn out.

As a part of the General Practitioners Leadership Forum collaboratively we are working to address this with the Minister and letters have been sent pertaining to these requests addressing the inequities faced with in Primary Health. For General Practices they primarily were Primary Care but with the wider community it is Primary Health Care. To date advising you all that we will continue until we reach success.

The College of Primary Health Care Nurses are proud to be part of a wide sector which covers varying areas as well. It is great to see many contact the College in regard to Health.

Once again, we thank you all for your continued efforts. Although it may seem our voice or efforts are sometimes not heard as the Whakatauki at the beginning stated with your basket of knowledge and our basket of knowledge the work will be done.

Nga Mihi
Tracey