L.O.G.I.C.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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

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

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In this issue…

Chair Report

Tracey Morgan

"He oranga ngakau; he pikinga waiora: Positive feelings within you enhances wellbeing"

This past quarter has definitely been a time to observe Primary Health Care closely and move collectively as one in the Community. Minister Shane Reti stated at the GPCME Conference in Christchurch in the month of August 24: "Since 2018 the Health Budget has increased by 60%. $50 million has been given to Immunisation; $604 million investment into Pharmac to address Cancer." Yet in Primary Health Nurses are still paid 11-20% less than our sisters and brothers in Te Whatu Ora.

NZNO have made a clear choice; we will fight equitable access for all; we are no longer standing by. And it would appear unless we are prepared to fight the fight then our Nursing voice will fade away. The Mana Motuhake Campaign is the Pay Equity Claim; Pay Equity is the process need in order to be recognized then all can be paid.

WEAVING THE JOURNEY IN PRIMARY HEALTH CARE

The College recognises and acknowledges the constraints each area of nursing faces on a daily basis.

Primary Health Care continues to be involved and attended the Aged Care Rally on 28 August 2024 in Wellington which highlighted safe aged residential care under attack with cuts to staff and quality of care.

Working collaboratively and engaging with each Sector is the way forward. Now is the time for Primary Health Care to stand strong, united and be a voice "Maranga Mai" Every nurse everywhere.

2025 NZCPCN Symposium "Te Oranga Matua: To Tatou Anamata: Primary Health; Our Future.

March 15, 2025, is the date as we gear up for our Symposium to be held in Christchurch. Please continue to keep an eye out as Registrations will be open shortly and we want to celebrate far and wide.

REGULAR ENGAGEMENT

Manatu Hauora – Lorraine Hetaraka
General Practitioner Leadership Forum – Dr Sam Murton
NZNO – Paul Goulter, Mairi Lucas, Kerri Nuku (Kaiwhakahaere)
Pharmac
ACC Primary Sector Engagement
LARC and Cervical Screening
The synergy of our committee and the collegiality, focus and determination of the National Executive, LOGIC and Professional Practice (PPC) committees, and our Professional Nursing Advisor have managed to successfully continue to do a lot of work to ensure Primary Health is covered everywhere.

PHC MECA BARGAINING

Bargaining was initiated for renewal of PHC Meca on May 17, 2024. This notice covered 477 employers and covers around 3475 NZNO members.

On the 5th and 6th of August 2024, a face to face meeting was held in Wellington with Gen Pro; Green Cross; Procare, Te Ao Medical (sole representative). An offer of 3% was made by employers but this falls way too short of what our nurses need. This reveals a fundamental lack of respect for PHC Nurses. Our health system is in crisis and not everyone receives fair and equal care. We are demanding Pay Parity where all nurses with the same skills, qualifications and experience are paid the same. Pay parity with Te Whatu Ora will stop nurses leaving Primary health care.
A survey was sent out to PHC members which has recently been completed and more pressure will be placed on the government so that they are aware Nurses are here to stay.

GENERAL PRACTITIONERS LEADERSHIP FORUM
This quarter has seen weekly and sometimes daily media release put out by Gen Pro regarding the future of GP Practices across the nation. Unsafe staffing has been a feature for the Nurses having to work in high needs areas without the availability of a GP.

General Practices are financially unsustainable and struggle to recruit and retain staff. The reason for this is the 20 year old funding model which has not kept pace and the changing needs in our communities.

GPLF have made it a priority to work collaboratively to make a stand and have Primary Health no longer siloed.

KAUPAPA MAORI CULTURALLY SAFE STAFFING RATIOS
This was held in Wellington by NZNO looking at Ratios within Aotearoa. Speakers from America, Canada and Australia attended this two day Conference.

Currently there are global debates about safe staffing ratios. Nowhere in the world are those conversations considering the importance of culture in the content of clinical practice. The Nursing Council are explicit about the requirement of health practitioners to engage with their Te Tiriti o Waitangi responsibilities as part of ethical practice.

This conference was well received by all who attended.

EXECUTIVE COMMITTEE
The members of the National Executive Committee represent the College members on many external working groups and at times members are called upon to represent as well. 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; provide overview of external groups represented. 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.
The Committee continues to hold monthly Zoom Meetings. The main focus for the Committee is currently on ensuring our Symposium is a great success for 2025.
"Maranga Mai; every nurse everywhere" together we will grow

Naku Noa

Editor's Report

Yvonne Little
Editor

Welcome to the 2024 Spring Edition of LOGIC. We are now moving from the winter ills and chills and into the delights of the hay fever season, but that doesn't mean COVID, and respiratory illnesses will disappear unfortunately. I hope you can all remain well in this space.

We are pleased to be able to bring you the Spring Edition with some thought-provoking articles including polypharmacy; Well-child; Breastfeeding; Apps; Immunisation update; NZNO professional news.

We apologise for the delay in providing you with the collated results, these are still being processed but once again we would like to thank those of you who took the time to complete our survey on vaccinations/immunisations, your feedback was very important to us and the Executive Committee and the PNA are collating these responses, and we will get the results out to the membership once this has been finalised.
At the time of writing this report, we have just completed a very successful two days of face-to-face meetings in Wellington. Our first day was the combined committee meeting which encompassed LOGIC committee members, Professional Practice Committee Members and the Executive Committee. The second day was assigned to the Executive Committee where we worked diligently on planning the NZCPCHN symposium 2025 which will be held at the Rydge's in Christchurch on the 15th of March. Please keep your eyes peeled for the upcoming updates which will appear in LOGIC and on our Facebook and Instagram pages.

You will also find in this issue and on our media pages that we have extended the deadline for both of our NZCPHCN awards – we encourage you all to think about either nominating yourself or your colleagues but please make sure you read the criteria to ensure that you have covered all aspects of these criteria. The new closing date is the 15th of December 2024.

Finally, we continue to look at succession planning as our committee's composition changes from time served and life changes. The more varied our nursing roles are the better the NZCPCHN committees can reflect and support you, our membership. We currently have vacancies on the LOGIC committee for anyone who is interested in joining us, also on the Professional Practice and Executive Committees. There will be further vacancies in March 2025 as many of our committee members will have completed their two allowable terms. So, please think about joining us on the committees and providing your colleagues with leadership and support in the Primary and Community Health Care space.

Our current LOGIC committee consists of:
Yvonne Little (Editor)
Micheal Brenndorfer (Publisher)
Jess Beauchamp
Katie Inker
Alysha Clark
Marianne Grant
Sarah Darroch

Our current PROFESSIONAL PRACTICE committee consists of:
Bridget Wild (Chair)
Erica Donovan
Melanie Terry
Jeanette Banks

Our current EXECUTIVE committee consists of: (and you will note that some of us are on more than one committee)
Tracey Morgan (Chair)
Rosie Katene (Secretary)
Melissa Brett (Treasurer) – resigned at our October 2024 meeting
Kathryn Chapman
Helen Garriock
Bridget Wild – as chair of the PPC
Yvonne Little – as Editor of LOGIC

I would like to say a big thank you to Missy (our departing Treasurer), Missy you have done a fantastic job and an often complex one of keeping the finances in line and booking our flights and accommodation for our face-to-face meetings.

I would like to thank those committee members who have been part of the NZCPHCN committees and have now moved on and wish them well in their future endeavours.

If you think you might be interested in joining this dynamic group of hard-working nurses then please contact us, we welcome you to come along to one of our meetings to see what we do also, please contact Tracey or Rosie to discuss if this interests you.

Whānau expectations for breastfeeding in Aotearoa:

A professional development session on YouTube.

Jess Beauchamp

Whanau expectations for breastfeeding in Aotearoa is a 30-minute video uploaded on the Women's Health Action (WHA) YouTube channel. The WHA has mighty roots. It was established in 1984 by women's health activists Phillida Bunkle and Sandra Coney in response to serious infringements of women's health rights that culminated in the 1980s Cartwright inquiry addressing the 'unfortunate experiment" at National Women's Hospital. Today WHA work focuses on women's and children's health with a holistic, equity enhancing and positive framework that includes actively working to support breastfeeding.

Whanau expectations for breastfeeding in Aotearoa was developed especially for health professionals as a continuing education session to support World Breastfeeding Week in August 2024. The content is based on the Ten Steps to Successful Breastfeeding mahi and explored from a whānau Māori perspective.

I quickly engaged with the content. It starts with a waiata and then follows a story telling arc of breastfeeding based on the creation story of Ranginui and Papatuanuku. The format is a straightforward PowerPoint but there are layers to the delivery with warm and lively narration by Tash Wharerau (Kaitiaki Wāhine Ora), bespoke illustrations, whakatauki and summary lines that, at the end, are sung into a waiata by Tash. The stages a hine koopu (expectant parent/parent in the making) and her whānau traverse, is told using the creation story to hold and understand breastfeeding according to Te Ao Māori.

It starts with Te Kore – the potential - that brings us into the space of relationship and change, Te Po - the dark unknown of the early days, then Te Kopipiri – unfolding of the senses, then Te Wheiao – transition of thought, leading to Te Ao Marama - moments of enlightenment and finally to Tihewa Mauri Ora – a time for action and moving forward.

The whānau expectations are clearly set out for each stage. Informed consent, empathic and non-judgmental support for whānau (including for feeding decisions that are not breastfeeding) and teaching how to hand express milk are some of the many practice points.

My own breastfeeding experience was straightforward for both my daughters but, at the same time, breastfeeding was one of the most personally demanding things I have done. Realising my story could be understood with concepts like Te Po, the dark unknown (and quite a chaotic space at times), 30 years later has added an unexpected coherence to my own breastfeeding experience.

If you are Tangata Tiriti like me, or not familiar with the story of Ranginui and Papatuanuku, I recommend taking time out to sit quietly for 30 minutes and watch this video. It provides an opportunity for reflective professional development around breastfeeding in Te Ao Māori and whānau needs including for specific health education and culturally safe practice here in Aotearoa. Even if you do not encounter many hapu or breastfeeding māmā in your everyday work, the exploration and articulation of a world view perhaps different than yours, is valuable learning to support applying Te Tiriti principles to your nursing practice.

NB: The MamaAroha app reviewed in this edition, would be ideal for whānau for the health education needs expressed in this video.

Nga mihi nui to the WHA whānau for their support to share my thoughts on their work.

Whānau expectations of breastfeeding can be found by searching on YouTube or follow this link https://www.youtube.com/watch?v=50-QzwNiCt4

BREASTFEEDING in primary care, stats, inequity and an app.

By Jess Beauchamp

Nearly all pregnant mothers want to breastfeed their baby. The Growing up in New Zealand (GUiNZ) antenatal study in 2010 showed this clearly with 90% planning to exclusively breastfeed in the early weeks. Fathers/partners also shared this aspiration and practically no people were undecided about how they wanted to feed their baby once it arrived. But things happen in the early post-partum weeks that do not support many of these women and whānau to realise their aspirations and while breastfeeding is initially chosen, by six weeks or earlier, things don't look so rosy.

> WHO and MOH recommend exclusive breastfeeding till introduction of solids at around six months, then continue with breastfeeding along with appropriate foods and water

Evidence and policy from WHO and the NZ Ministry of Health (MOH) is clear that breastfeeding is the gold standard for infant feeding. Feeding is influenced by many factors, including infant and maternal health (ultimately a fed baby "is best") but regardless, many mothers and babies rightfully want to breastfeed for longer than they do. Barriers to establishing and continuing breastfeeding include a lack of knowledge, lack of support, early return to work and maternal or infant illness but many barriers can be successfully removed or reduced with timely and focused health education and support.

While the rates vary according to DHB area, no population group in Aotearoa meets the national breastfeeding targets and inequity for Māori and Pacific families is sadly a reality. The Well Child Quality Indicators only collect breastfeeding data till three months, but a 2018 report found only 17 – 22% are exclusively of fully breastfed till around six months. The table below provides a snapshot of data showing dropping rates and inequity.

		Target	National	Non-Māori	Māori	Pacific
Sept 2019						
	2 weeks	**85%**	78%	78%	76%	71%
	3 months	**70%**	59%	62%	49%	49%
March 2024						
	2 weeks	**85%**	71%	71%	71%	61%
	3 months	**70%**	55%	57%	46%	42%

Exclusive or fully breastfeeding at 2 weeks and 3 months (WCTO quality indicator reports 2019 and 2024)

As primary health care nurses we need our assessment antennae up any time we see a hapu māmā or in the early weeks after babies' birth and to be alert to any opportunity to support her and her whānau with their breastfeeding goals. Asking gentle open-ended questions about how feeding is going for them, empathic listening and exploring to uncover specific health education and support needs will enable you to provide a focused nursing response.

Most of us are not breastfeeding specialists and will need to know about and refer to local specialist breastfeeding services such as Lactation Consultants, when issues outside our knowledge and skills present, but being confident to discuss and affirm breastmilk feeding (no matter the amount), to trouble shoot common issues that arise like effective latching, what a normal feeding pattern looks like for babies age and stage and how to store expressed milk safely, can go a long way in supporting successful establishment and continued breast milk feeding.

The **Mama Aroha** app (first edition 2021, current version 1.0.3 updated in 2023) is designed by Amy Wray (Midwife and Lactation Consultant). The app is evidenced based and builds on beautiful breastfeeding talk cards that Amy designed in 2011.

There are a couple of interactive features. It has audio capacity so you can listen to the content and a record function that lets you record yourself reading each page. I found this an interesting feature as potentially the learning is reinforced by the app user both reading the content out loud then listening to the same content. Either way the feature encourages the user to play around with the app and possibly have a bit of fun doing so. The user could also translate the content into Te Reo which would be awesome for fluent whānau.

Mama Aroha is visually appealing, with nearly every chunk of information having photo or graphic support - picture the varied colours of breast milk, the different size capacity of a baby's tummy, where to store expressed milk or what your baby's face may express depending on if she is just a little hungry or a lot hungry!

The Mama Aroha app provides holistic breastfeeding education from antenatal through to established feeding. I think it is particularly strong on understanding and "doing" breastfeeding in the context of a quickly developing and changing baby with useful information on baby sleep expectations and tired signs to help attune to baby and with the mother's wellbeing and whānau context central.

The content is organised into four main sections covering the antenatal period, breastfeeding fundamentals, latching techniques and the final section is wellbeing with a broader focus.

The information is presented in layers, with the main ideas punctuated by text boxes or headings that enable you to explore further as interest or need directs.

Practice application: The primary audience for this app is a breastfeeding mother/whānau so it is great to have in your resource kete for a start. And if breastfeeding is not your area of expertise, this is a useful "first response "kind of resource to download and get familiar with as it provides evidenced based health education that will support your breastfeeding conversations when you encounter a māmā or whānau who for example, ask for guidance to troubleshoot a practical issue like a painful latch or storing expressed milk. Knowing the breastfeeding services in your community is also a good idea and the app has a useful link to Lactation Consultant services.

Mama Aroha app is free and downloadable from the app store.

It is also one of the breastfeeding apps recommended by the Healthify *He Puna Waiora* website that provides evidenced based health education resources including curating an app library.
https://healthify.nz/apps/b/breastfeeding-apps/

References:

MOH, (2019). *WCTO Quality Indicator Report September 2019*. Author

MOH, (2024). *WCTO Quality Indicator Report March 2024*. Author

University of Auckland, (2010) *Growing up in New Zealand, before we are born 2010*. https://thehub.sia.govt.nz/resources/growing-up-in-new-zealand-before-we-are-born/

Immunisation Advisory Centre

Sue Rogers, IMAC regional immunisation advisor

Immunisation update - Vaccine brand changes 2024

This is a brief update on recent vaccine brand changes from Pharmac. Pharmac funds vaccines with the aim of providing the best health outcomes within an allocated budget and vaccine brands are chosen based on several factors such as price and availability.

Along with the brand changes there have been some changes in eligibility for funded vaccinations.

It is anticipated that distribution of new stock will begin from early October 2024.

These brand and eligibility changes came into effect from July 2024:

1. **Haemophilus influenzae type b vaccine changes from Hiberix (GSK) to Act-HIB (Sanofi)**
   Note: Use Hiberix stock first, Propharma will send new Act-HIB stock once old brand stock has been used up.

2. **Varicella vaccine [Chickenpox vaccine] changes from Varivax (MSD) to Varilrix (GSK)**
   Note: Use Varivax stock first, once used up Propharma will send Varilrix.

3. **Funded NeisVac-C to be replaced by Nimenrix on 1 July 2024**
   Note: All funded NeisVac-C was to be replaced by Nimenrix from 1 July. This vaccine is not on the routine schedule but is used for certain eligible individuals. The remaining NeisVac-C stock should have been discarded and NOT used after 1st July 2024.

4. **Extended eligibility Herpes zoster – Shingles**
   From 1 July 2024, funding for Shingrix vaccine was widened to include some immunocompromised individuals 18 years and older who meet eligibility criteria.

1. **Haemophilus influenzae type b vaccine changes from Hiberix (GSK) to Act-HIB (Sanofi)**

Presentation: Vial and pre-filled syringe containing diluent, 2 needles (supplied as separate needles in the box, one to prepare and one to administer - providers may choose to use their own stock, and the length needle used should vary depending on site and muscle bulk).

Act-HIB is on the National Immunisation Schedule as:

- Booster at age 15 months
- Catch-ups and revaccination for older children and adults
- Funded for eligible groups

Children 12 months to 5 years need 1 dose of Act-HIB, regardless of previous doses.

2. Varicella vaccine [Chickenpox vaccine] changes from Varivax (MSD) to Varilrix (GSK)

Presentation: a new box design containing 10 vials and pre-filled syringes (with luer lock) containing diluent, no needles.

Varilrix is on the National Immunisation Schedule as:

- Primary immunisation: 1 dose funded for children born from 1 April 2016 when they turn 15 months, OR
- Catch-up: Previously unvaccinated children 11 to < 18 years who have not previously had a varicella infection (as determined by clinical history)
- Eligible non-immune individuals: (two doses, 6 weeks apart)
-

Children who have had chickenpox disease do not need immunisation against chickenpox.

In New Zealand, Varilrix is licenced from 9 months of age.

Interchangeability - A single dose of Varilrix may be administered to those who have already received a single dose of another varicella-containing vaccine, for those eligible for a second dose. For those not eligible, a second dose may be purchased privately.

3. Funded NeisVac-C replace by Nimenrix on 1 July 2024

Nimenrix is funded for high-risk eligible individuals <12 months (only):

- Primary immunisation: funded for high-risk infants <12 months from 1 July 2024. (2-3 doses depending on age).

This means a meningococcal ACWY vaccine is now available for infants under 12 months of age (replacing NeisVac-C which only covered the C strain). Providers should no longer have NeisVac-C supplies in fridges.

No change to the funded brand of meningococcal ACWY vaccine for eligible individuals 12 months and over which will remain as MenQuadfi. MenQuadfi is not currently approved for the use in infants under 12 months of age, so Nimenrix is the alternative brand of meningococcal ACWY vaccine for use in this age group.

4. Extended eligibility Herpes zoster – Shingles

From 1 July 2024, funding for Shingrix vaccine was widened to include some immunocompromised individuals 18 years and older who meet eligibility criteria.

This eligibility criteria is very specific.

There is no change to the eligibility criteria for those who aged 65 years (second dose must be completed prior to turning 67 years to be eligible for funding).

Summary

Vaccine	**Current funded brand (supplier)**	**New funded brand (Supplier)**
Haemophilus influenzae type B (Hib) vaccine	Hiberix (GSK)	Act-HIB (Sanofi)
Varicella (Chickenpox) vaccine	Varivax (MSD)	Varilrix (GSK)
Meningococcal ACWY (high-risk infants)	Neisvac-C (Pfizer)	Nimenrix (Pfizer)
Access widened		
Zoster (Shingrix)	Funded for individuals at 65 years and for eligible immunocompromised individuals 18 years or older.	

If you would like to hear more details about these changes and the diseases these vaccines protect against, view this free IMAC online webinar.

In the spirit of this journal's theme of leadership, we'd like to acknowledge and thank you for your influence as a leader in immunisation. What you say and do really does make a difference. It is your recommendation as a trusted health professional that has time and again been confirmed in research as a key factor in consumers' decisions to vaccinate themselves and whānau. Ka Rawe.

Links:

Pharmac eligibility Hib vaccine
https://schedule.pharmac.govt.nz/ScheduleOnline.php?edition=&osq=Hiberix

Pharmac eligibility Varicella vaccine
https://schedule.pharmac.govt.nz/ScheduleOnline.php?edition=&osq=Varicella+vaccine+%5BChickenpox+vaccine%5D

Pharmac eligibility Nimenrix vaccine
https://schedule.pharmac.govt.nz/ScheduleOnline.php?osq=Meningococcal%20(groups%20A,%20C,%20Y%20and%20W-135)%20conjugate%20vaccine&code=C4525014029

Pharmac eligibility Zoster vaccine
https://schedule.pharmac.govt.nz/ScheduleOnline.php?osq=Varicella%20zoster%20vaccine%20%5bShingles%20vaccine%5d&code=C4525014162

IMAC webinar – Vaccine brand changes
https://vimeo.com/961650998

Impressions from The MCaFHNA 2024 Innovations " Driving Change for Better Outcomes"

By: Marianne Grant
National Educator
Whānau Āwhina Plunket

MCaFHNA – Maternal Child and Family Health Nurses Australia
This conference is a biennial event for this organisation in Australia. They have a range of different titles depending on which state / territory they are in and their employing body. The role is similar to Well Child Tamariki Ora nurses in NZ , Health Visitors in the UK. They offer / provide a similar programme again depending on which state/ territory they are in as to specific components and time frames.

There were a range of plenary speakers from across Australia. This is a precis of the plenary sessions.

Alison Morton from the Institute of Health Visiting (IHV)– spoke on ' **the Journey of UK Health Visiting – Professional Regulation Matters and the role of the IHV as the Voice for the profession.** Like the Australian role , the Health Visitor role has a PG qualification in community public health nursing to become specialist community public health nurses. Health visitors lead the Healthy Child Programme (0-5) and are fundamental in ensuring every child has the best start in life. Similar to WCTO programme in NZ. Most Health Visitors will have a one-year preceptorship/ transition in their role. They are employed by local authorities.

While there is strong evidence for the role of Health Visitors making a difference with the programme for under 5s with the Healthy Child Programme - e.g. early intervention , reach into communities - there is under investment in the sector. This has impacts for the client group and future with widening health inequalities, escalating levels of population need, including parental stress and mental health problems that pose serious risks to children's future health, development and wellbeing. Health Visitors struggle to meet the scale of rising need and workforce shortages currently. The number of contacts are mandated for Local authorities to provide but the number provided are variable , for multiple reasons.

The IHV are working to improve conditions , alongside a political voice to create increased investment in the sector as well as increasing the importance of funding child health.

A number of reports are available that speak for this sector -

- State of HV report – 9th Annual Survey https://files.localgov.co.uk/ihv.pdf
- The Role of the HV – Where are we now https://ihv.org.uk/news-and-views/news/the-role-of-the-health-visitor-where-are-we-now

- A Manifesto for babies https://parentinfantfoundation.org.uk/1001-days/manifesto/
- Labours Child Health Action Plan - https://labour.org.uk/updates/stories/labours-child-health-action-plan-will-create-the-healthiest-generation-of-children-ever/
- Healthy Child Programme - https://www.what0-18.nhs.uk/professionals/health-visitors/healthy-child-programme
- See IHV website – https://ihv.org.uk/

Neuro Divergence – Shaking up the early Childhood clinical pathway for children with developmental difficulties. This was a presentation by Andrew Whitehouse from KIDS Research Institute (formerly Telethon Institute) - CliniKids https://www.thekids.org.au/our-research/brain-and-behaviour/disability/autism-research/

Andrew's concern is that there is a focus on autism and thus a focus away from children and the push/ pull of systems . In Australia (this is not unique) there is the drive for a diagnosis which is linked to funding but missing the essence of the child and how unique they are. The challenge is especially for under 5s is what support is appropriate as most of the support is geared to older children.

Currently in Australia 1: 50 children diagnosed with Autism Spectrum Disorder .

NDIS (National Disability Insurance Scheme)– is the body that is concerned with funding for children with ASD (and other disabilities) https://www.ndis.gov.au/understanding

For more on the work in this space see - https://www.thekids.org.au/our-research/brain-and-behaviour/disability/autism-research/

Of interest – the **Inklings programme** has been developed for 6–18-month-olds – which focuses on interactions between infant/ children and parents and empowers parents to sensitively respond to their child Developed for –

- The baby who is showing delays or differences in their early social interaction and communication development.
- Babies who are not yet demonstrating a range of expected social communication behaviours for their age.
- Parents who are worried about their baby's social interaction and communication development.

The programme supports parents to interpret baby signals and learn to understand their baby . The programme has been rolled out in Western Australia to 700 families and currently rolling out in South Australia ,with a research project happening in Queensland.

See - https://inklings.org.au/about

Child Safety Commissioners – this was a panel consisting of the National Childrens Commissioner, and State Child Safety Commissioners from ACT, Victoria , Queensland and WA The discussion was around creating a more conducive environment for children and young people in Australian communities. They are all working in various ways with varying role requirements and/ or conjunct roles -

within their individual states and territories. Most states and territories will also have / or will appoint a Commissioner for Aboriginal and Torres Strait Islanders.

See - https://humanrights.gov.au/our-work/childrens-rights- National Childrens Commissioner

https://ccyp.vic.gov.au/ational Victoria

https://www.hrc.act.gov.au/childrenyoungpeople ACT

https://www.ccyp.wa.gov.au/about-us/ WA

https://www.publicguardian.qld.gov.au/about-us Queensland

Lisa Gold from Deakin University (Victoria) - Why Does the economics of Maternal & Child Health Matter? https://experts.deakin.edu.au/753-lisa-gold/about

Lisa is a Health Economist who enlightened/ enthralled the audience with terms that we hear across the health sector – minimise waste, maximum value for money, efficiency and equity.

This was applied to the maternal and child health sector and Lisa described some of the evidence that underpins scope/ sector .There is good evidence that investment in child health along with supporting investment in determinants of health (housing, tax/ welfare, employment and strong social will support better outcomes for future and support families to thrive.

The First Thousand Days is an important concept to consider where investment can be targeted to change children's long-term outcomes – there are some adaptations to this below –

- 1st 1000days (conception to 2)
- 1st 2000 days (to 4 ¾ years)
- 1st 3000 days (to 7 ½ years) *For children to thrive , we need families to thrive – contacts need to be universal with targeted additional support – Proportionate Universalism*
-

There is a range of evidence to support this

- Hanson et al. (2013). Family Poverty Affects the Rate of Human infant Brain Growth. https://doi.org/10.1371/journal.pone.0146434
- Heckman & Mosso (2014). The economics of human development and social mobility. Annual Review of Economics. **https://doi.org/10.1146/annurev-economics-080213-040753**
- Marmot et al (2010). Fair Society, Healthy Lives (The Marmot Review)
- Moore, T.G., Arefadib, N., Deery, A., & West, S. (2017). The First Thousand Days: An Evidence Paper.
- Moore, T.G. (2024). Core Care Conditions for Children and Families: Implications for policy and practice. CCCH Working Paper No. 6

The Right@home programme is an example of well designed programme, with investment hoping to see sustained impact beyond the 2 years of the programme. It is offered to women in pregnancy experiencing pyschosocial and socioeconomic adversity from pregnancy to 2 yrs. Run in Victoria and Tasmania https://ccch.org.au/our-work/project/right-home/

The National Prevalence and Impact of Child Maltreatment : Findings from the Australian Child Maltreatment Study – was presented by Divna Haslam

This was a national survey to estimate the prevalence in Australia of each type of child maltreatment and associated outcomes. The survey methods was a cross-sectional national survey, mobile telephone interviews conducted from April to October 2021. Retrospective self-report data using validated questionnaire. It took 2 years to work on the survey questions. Sample size – 8500. The survey sought responses relating to physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic violence to age 18 years.

The broad outcome to date is child maltreatment is common in Australia, and larger proportions of women than men report having experienced sexual abuse, emotional abuse, and neglect during childhood. There is still work continuing with looking at the data e.g. gender diverse view and ethnicity view still to be reported on.

Good news is reports of physical abuse appear to be decreasing as well as some decrease in familial sexual abuse. There are some moves to consider repealing laws around corporal punishment in Australia. There are a number of journal articles and reports from the study – see this link for more https://www.acms.au/

Grow & Go – Helen Truby Grow & Go is a digital toolbox / library of resources relating to feeding infants and children under 5 – In Australia .
All/ most of the current websites and resources from across Australia can be found here – as well as a section where resources can be personalised to area/ group/ provider using Canva. Worth a look.

Australian Federal Police - A member of the **ACCE –(Australian Centre to Counter Child Exploitation** provided a timely session on their work - primarily a collaborative national response to counter the exploitation of children in Australia. This includes online child sexual exploitation , victimisation and abuse.

Some statistics – 2023-2024- 55, 000 report . 2021- 2022 report - 4 out of 5 children aged 4 , use the internet , 30% have their own device; 22% of parents allow children to use the internet without supervision(up to age 11) .

The ACCCE / AFP are working with a range of groups to create evidenced based resources for education in ECE space as well as programmes in schools.

- https://www.thinkuknow.org.au/ - ThinkuknowAustralia has a range of resources for Australia sector as above. Also- Playing It Safe -
- https://playingitsafe.org.au/ - is also developed by the AFP with resources for parents, carers and educators to

support online safety education in conjunction with children's education.

- https://netsafe.org.nz/netsafe is NZ online safety resource -
- https://www.childsafeguardingweek.org.nz/resources/ There are some resources at this link for online safety in NZ as part of Child Safeguarding Week 2-8 September 2024

The next conference is planned for 2026 – see the MCaFHNA website for details. This is a conference well worth attending – especially to see/ hear what our Australian colleagues are doing and gain ideas/ innovations to consider in NZ as well as meeting new people and new opportunities. See https://www.mcafhna.org.au/

Pharmacotherapy Snippets –

LDL Targets and Statins.

John Gibbons and Simon Ogden
Clinical Pharmacist Advisors,
Tu Ora/Compass Health.

Te Whatu Ora on recent analysis have found that people with a 5-year CVR > 15% only account for 21% of first acute coronary syndrome presentations (New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS-QI) Registry data), which raises the question of whether we should be intervening at a lower Cardiovascular Disease Risk (CVDR) with a defined lower low-density-lipoprotein Cholesterol (LDL-C) target.

First line intervention for reduction of LDL-C are statins. Statins competitively inhibit 3-hydroxy-3-methylglutaryl coenzyme A (HMG CoA) reductase, the rate-limiting enzyme in cholesterol synthesis in the liver. They also increase LDL-C receptors expression on hepatocyte membranes causing increased LDL clearance from the circulation. Statins reduce total cholesterol, LDL-cholesterol, and to a lesser extent triglycerides. Statins also reduce inflammation and have plaque stabilisation and regression effects.

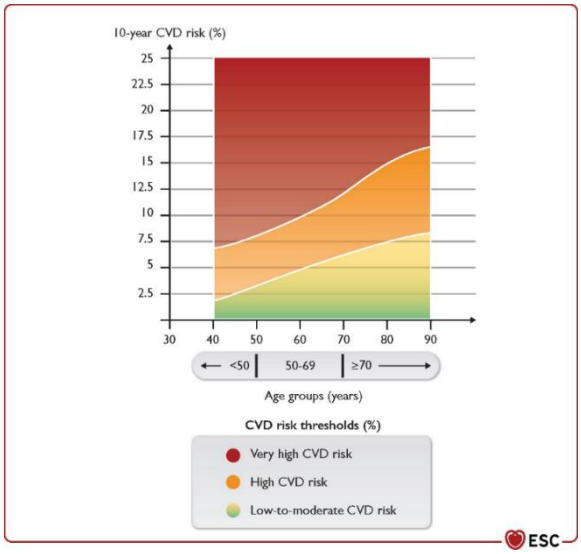
Comparative effect of statin dose on LDL-C (1)

Epidemiological studies have shown that elevated levels of LDL-C and non-LDL-C, and low levels of HDL-C are associated with an increased risk of CV events and mortality in patients with and without diabetes. Elevated LDL-C remains one of the top three modifiable risk factors contributing to cardiovascular disease burden and the current advice for targets has become more complex (2). Rationalization of that advice for ease of targeting appropriate intervention (3) is.

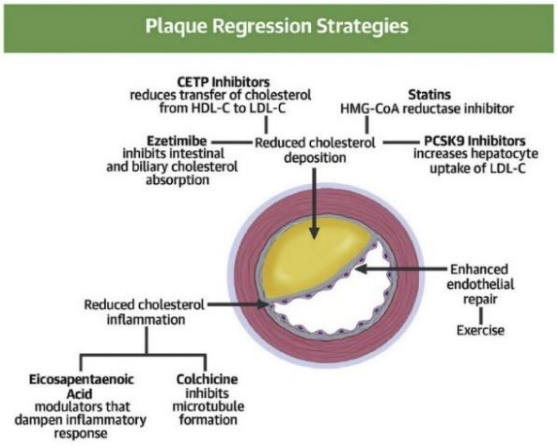
% LDL-C Reduction	19%	24%	30%	34%	41%	48%	55%	62%
Rosuvastatin					5mg	10mg	20mg	40mg
Atorvastatin				10mg	20mg	40mg	80mg	
Simvastatin			10mg	20mg	40mg	80mg		
Pravastatin	10mg	20mg	30mg	40mg	80mg			
Ezetimibe	10mg							

	Target LDL
Secondary Prevention	**<1.4 mmol/L**
Diabetes (CVDR > 15% or any complications)	**<1.4 mmol/L**
Primary Prevention (CVDR > 15%)	**<1.4 mmol/L**
Primary Prevention (CVDR 5 to 15%)	**<1.8 mmol/L**

It is also important to understand that intensive lipid lowering treatment to LDL concentrations < 1.5 mmol/L can result in plaque regression (4). Additionally, PCSK9 trials have shown that there is no threshold effect associated with LDL-C reduction in relation to cardiovascular risk (5).



Based on current guidelines (1) we should also now be considering LIFETIME risk when considering LDL cholesterol, because over a lifetime intima media thickness builds up and early intervention can impede this. This means we should consider lipid lowering therapy earlier for younger people with high LDL-C e.g. > 4.0 mmol/L, or > 3.5 mmol/L if a young male, especially Māori and Pacific, and a CVDR > 5%.



Previous clinical knowledge suggested that statins for primary prevention in the very old had a lack of evidence for benefit and increased risk of adverse events. However, this idea is compounded by patients > 80 who were often not in clinical trial cohorts and that PREDICT CVDR assessment tool stops at age 74. A recent study showed in patients aged 75-84 there was a risk reduction for major cardiovascular events of 1.2% over 5 years, and for those 85 and older the risk reduction was 4.4%. Importantly, there were no significantly increased risks for myopathies and liver dysfunction in either age group (7).

Most muscle pain occurring in pa (2) on statins is not due to the statin although patient concerns about muscle pain are common. In a meta-analysis of 19 large statin trials, 27.1% of participants treated with a statin reported at least one episode of muscle pain or weakness during a median of 4.3 years, compared with 26.6% of participants treated with placebo (8).

Robust trials by Herrett [9] and Wood [10] have shown that there is no overall effect of statins on the frequency or severity of muscle symptoms in participants who had previously reported severe muscle symptoms when taking statins. It is important to keep in mind that even if a patient does experience side effects with one type of statin, a switch of statin is recommended over cessation of therapy.

Take-home message

- Lowering LDL-C is the primary target regardless of the population, and older adults should be treated as younger patients.
- There are no known adverse events linked to very low LDL-C levels; patients with high to very high risk have defined lower LDL-C targets [11].
- Statins are the first-line recommended drug treatment to reduce cardiovascular risk and true statin intolerance, though documented, is rare.
- LDL-C management to target should include the addition of Ezetimibe, when required [2].

References;

1. Roberts, W et al. Two more drugs for dyslipidemia. Am. J. Cardiol. 2004; 93; 6; 809 – 811.
2. 2021 European Guidelines on CVD prevention in clinical practice. Eur Heart J, Volume 42, Issue 34, 7 September 2021, Pages 3227–3337.
3. Borrie, A. et al. Cholesterol treatment in patients with acute coronary syndromes: does stating a target improve management? NZMJ. Vol. 135 No. 1555. 20 May2022.
4. Sarraju, A. et al. Atherosclerotic plaque stabilization and regression: a review of clinical evidence. Nat Rev Cardiol 21, 487–497 (2024).
5. Schwartz G, et al. Alirocumab and Cardiovascular Outcomes after Acute Coronary Syndrome. NEJM. 2018 Nov 29;379(22):2097–107.
6. Dawson L et al. Coronary Atherosclerotic Plaque Regression: JACC State-of-the-Art Review. J Am Col Cardiol. 2022. 4–11 Jan; 79; 66-82.
7. Xu W et al. Benefits and Risks Associated with Statin Therapy for Primary Prevention in Old and Very Old Adults: Real-World Evidence from a Target Trial Emulation Study. Ann Intern Med. 2024;177(6):701-10.
8. Bytyçi I, et al. Prevalence of statin intolerance: a meta-analysis. Eur Heart J. 2022 Sep 7;43(34):3213-3223.
9. Herrett E et al. Statin treatment and muscle symptoms: series of randomised, placebo-controlled n-of-1 trials. BMJ. 2021 Feb 24;372: n1355.
10. Wood FA et al. N-of-1 Trial of a Statin, Placebo, or No Treatment to Assess Side Effects. N Engl J Med. 2020;383(22):2182-4
11. Wilkinson M et al. Evolving Management of Low-Density Lipoprotein Cholesterol: A Personalized Approach to Preventing Atherosclerotic Cardiovascular Disease Across the Risk Continuum. JAHA. 2023;12; 11

Health and Climate Justice

Sue Gasquoine,
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Introduction

The term 'climate change' no longer captures the sense of urgency needed for nurses and nursing to respond to future climate related impacts on health and wellbeing. Now conceived of as a *climate crisis,* a declaration of emergency is warranted.

The climate crisis is a global challenge and will require a collective resolve and effort of professions and organisations to address. Ora Taiao New Zealand Climate and Health Council lists practical tips for health professionals to address climate change.[1] These are grouped pragmatically into 'political', 'professional' and 'personal' and include a toolkit, 'Greening Your Practice'[2]. While focused on general practice, many of the toolkit actions can be applied to most health practice settings and encourage personal and professional agency[3] and a sense of responsibility of the health care professions to respond to the crisis.

The Royal New Zealand College of General Practitioners (RNZCGP) position statement on climate change lists expected health impacts of climate change in Aotearoa[4]
These include:

- food insecurity
- mental health distress and increased suicides
- housing insecurity
- injury and illness caused by extreme weather events
- increase in heat related morbidity and mortality including an increase in preterm birth
- increased incidence of diseases:
  - vector-borne and animal to human (zoonotic) disease
  - food and water borne disease
  - Cardiorespiratory disease related to air pollution
  - allergic diseases eg asthma
- UV radiation damage
- Reduced opportunities for physical activities to maintain fitness and wellbeing.
- reduced quality of indoor environments

Food and housing insecurity is apparent in people's daily lives. Diminishing resilience

[1] https://www.orataiao.org.nz/practical_tips_for_health_professionals_to_address_climate_change

[2] https://d3n8a8pro7vhmx.cloudfront.net/orataiao/pages/72/attachments/original/1442273038/Greening_Your_Practice_toolkit.pdf?1442273038

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5002400/

[4] https://www.rnzcgp.org.nz/resources/our-voice/climate-change-health-and-general-practice-in-aotearoa-new-zealand-and-the-pacific-position-statement/#:~:text=The%20College%20believes%20that%20general,sector%20movement%20towards%20sustainable%20systems.

to the economic impact of damage from climate related events as insurance costs become prohibitive and for some, their homes deemed unable to be sold or insured.[5]

There is an abundance of evidence of the impact of the climate crisis on health through the lifespan. The evidence is equally clear that the most vulnerable groups are disproportionately impacted[6]. Given the climate crisis is an existential crisis and threatens our very existence, a climate framework needs to be applied in everything we do: every patient interaction, every assessment, every care plan.

Climate Justice

The union movement in Aotearoa and around the world advocates for a 'just transition' defined as '… *the result of proactive planning and action to mitigate the negative impacts of the change process, address inequities, and capitalise on opportunities that the transition provides. It ensures no worker is left behind'*.[7]

Joining political movements such as the Alliance of Nurses for Healthy Environments (ANHE) to advocate for climate justice is a professional role and is aligned with the nurse's role of raising health literacy. Supporting whānau to understand the impact of climate on health and the remedial actions on an individual and at community level is an increasing part of nurses' workload and responsibilities.

The ANHE defines climate justice as:

'… a driving force for innovation in science and is at the forefront of the environmental justice movement, yet nursing has been largely silent as to what we can do to address climate justice in the communities we practice in. Through our work together, we aim to stimulate a global dialogue on climate justice, centre marginalized voices in climate justice decision-making, and collaborate through research, education, and practice to advance climate justice action globally'.[8]

Climate justice in Aotearoa given our geographical location in the South Pacific, must address the vulnerability of communities, both in Aotearoa with its vast coastline and our Pacific Island neighbours, who are threatened by coastal inundation.

It is critical that nursing and the rest of the health sector looks to Māori indigenous knowledge for the best ways in responding to climate change. There is an urgent need for health solutions, generated locally and nationally acknowledging strategies, models, and frameworks that consider a broader range of environmental health consequences of climate change that impact on the health and wellbeing of many communities, some more than others particularly Māori and Pacific. For instance, wastewater system overflows, flooding and water quality are a public health concern, particularly for rural areas and those isolated communities with high deprivation and lower-socio economic status. The disproportionate threats to Māori range from burden of disease, poorer access to

[5] https://www.rnz.co.nz/news/ldr/526704/i-m-stuck-hope-fades-in-a-community-of-valueless-homes

[6] https://www.who.int/news/item/05-06-2024-experts-warn-of-serious-health-impacts-from-climate-change-for-pregnant-women--children--and-older-people

[7] https://union.org.nz/just-transition/

[8] Climate Justice Agenda for Nursing – ANHE (envirn.org)

and quality of health care and the constraints imposed that restrict the unique relationships that Māori in particular share with the natural environment.

We cannot address climate-related health impacts for Māori (and all indigenous communities) without examining the broader systemic context of marginalisation, dispossession, racism, and colonisation. Introducing frameworks to address climate crisis related health impacts designed for the populations most affected, ensures that any assessment will be intuitive to the communities that it is intended to support. Furthermore, adopting local strength-based approaches to compliment other universal frameworks ensures a broader collective, integrative response to health and sustainability within particular environments and communities. For instance, the Mauri Model Decision Making Framework is a matauranga Māori sustainability and wellbeing assessment framework that supports local decision making[9]. This model informs the cultural, social, health, and science factors contributing to climate change. Health and health justice must be at the centre of climate change action by Aotearoa New Zealand and must be a cross party strategy.

Nursing in a climate crisis

Opportunities for nursing and nurses are recognised in this crisis. Sophisticated healthcare expected by those living and working in the developed world, maybe compromised by impacts of the climate crisis such as supply chain sustainability. National and global supply chain issues contribute to food and housing insecurity and healthcare deficits. Recent events include:

- CO2 and 'dry ice' supply shortages impacting the transport of vaccines[10]
- Aotearoa New Zealand's 2024 winter energy crisis that has compromised heating affordability for vulnerable households.
- Weather events isolating communities[11]

Opportunities in this crisis for nursing and nurses and their skill and knowledge include for example:

- Supporting those experiencing exacerbation of conditions such as asthma and eczema
- acute care management in the home
- self-care in conditions such as long COVID
- managing climate anxiety driven mental distress especially among rangatahi who are the generation which bares the greatest responsibility of navigating this emergency.

Nurses are usually part of a first responder team in events such as flooding and cyclones. As the event passes and communities begin to recover the nursing profession needs to partner with individuals, whānau and communities to foster resilience, recovery and self-care.

[9] https://www.maurimodel.nz/

[10] https://transporttalk.co.nz/news/freight-industry-warns-co2-shortage-severely-impacting-nz-air-exports

[11] https://www.rnz.co.nz/news/national/522265/more-than-100-people-still-out-of-homes-after-wairoa-flooding

Teaching self-care[12] and raising health literacy[13] of communities is part of nurses mahi and their most significant contribution will be in the primary care space. Screening for the potential or actual sequelae of climate change impacts on individuals, needs to become 'business as usual'. Much as screening for family violence[14] and substance misuse[15] have become part of many interactions between patients and health professionals in primary care, screening questions about how climate change is impacting health need to become an integral part of nursing assessments.

While assuming there *is* an impact because this crisis is global and no person or group is unaffected, individual responses and consequences will depend on complex and multifaceted variables such as gender, ethnicity, socioeconomic status, location and age.
Global targets[16] such as net zero carbon emissions by 2050 can feel remote and irrelevant to individuals. As a profession concerned for and motivated by health and wellbeing, part of our responsibility is remaining optimistic and supporting the development of individual agency. There are things we can all do to reduce emissions and to remedy the impact of climate change on our personal and whānau health.

There's now enough science to enable accurate prediction of the impacts of climate change. And while more science will inform responses and solutions, much more emphasis and resource needs to be directed to using the existing science to achieve outcomes. Optimistic, achievable responses that avoid fear-based reactions are urgently needed so communities are empowered to engage with, rather than ignore the challenges. Nurses have a key role in focusing on the future and informing the development of effective responses.

What's grassroots membership thinking?
SM survey …
On a scale of 1 to 5 with 1 meaning 'not at all' to 5 meaning 'overwhelming', please answer the following questions.
To what extent does climate change impact your work at the moment?
To what extent do you think this will change in the next 10 years? (or the most recent target year

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Festival For The Future

By India Heron

In July, I had the privilege of attending Festival For The Future (FFTF) in Wellington alongside my fellow Rotorua Lakes Youth Council members. The festival is an annual event run by Inspiring Stories, a New Zealand charity founded through a shared vision and passion to back young people on their journeys to change the world.

Festival For The Future is Aotearoa's biggest leadership and innovation summit. It aims to connect and create networking opportunities with current and future

[12] https://www.who.int/health-topics/self-care#tab=tab_1
[13] https://www.tewhatuora.govt.nz/for-new-zealanders/public-health-resources/health-literacy
[14] https://www.tewhatuora.govt.nz/health-services-and-programmes/family-violence-and-sexual-violence/health-professional-resources
[15] https://www.tepou.co.nz/screening-measures-substance-use-and-gambling-harm
[16] https://www.un.org/en/climatechange/net-zero-coalition

leaders, entrepreneurs, and changemakers from the country's business, government, and community sectors. After the Rotorua Lakes Youth Council unanimously decided to participate in the Festival for The Future as a cohesive unit, our focus then turned to developing a funding strategy to cover the trip's many costs. As a key member of the FFTF working group, I devised a plan to run a quiz night at Our Backyard Pub in Rotorua while seeking donations from local businesses to be raffled off during the event. Over 16 local businesses generously contributed vouchers, hampers, and other prizes for the raffle. The quiz night, held on July 4th, 2024, drew a full house of friends, family, and community members. In addition to revenue generated from filling all nine available tables, raffle ticket sales surpassed expectations throughout the evening. The event raised almost $1000, well and truly exceeding the amount we needed. The successful fundraising efforts not only covered all the necessary trip expenses but also provided funds for team-building activities in Wellington. The surplus allowed us to attend the Limbo stage-play at BATS Theatre and enjoy a bowling and karaoke session on our final night in Wellington, all of which helped to grow our team's connection and trust in each other.

This year, the festival was held at TSB Arena in Wellington. In addition to the main two-day summit, there was a pre-festival invite-only Mayors Lunch held by Wellington Mayor Tory Whanau at the Michael Fowler Centre. The Rotorua Lakes Youth Council was one of many youth councils in attendance at this lunch, where we had the chance to listen to some incredible speeches, network with like-minded individuals, and partake in innovative workshops where we brainstormed ways the youth of Aotearoa can create change and what things need to be put in place to support these changes.

A highlight of the festival for me was the Trailblazers: What Does It Mean to Build a Legacy? panel discussion. This panel was comprised of five amazing young female trailblazers: Genna Hawkins Boulton, Lushomo Thebe, Cha'nel Kaa-Luke, Veisinia Moli, and Nina Santos. This session focused on the panellists' journeys and what they think it means to be a trailblazer. The panel comprised women from underserved communities: Pacifica, African, migrant, immigrant, and disabled. They spoke about daring to be the first. Some of the key takeaways from this discussion were: dare to be the first, be uncomfortable, don't be the only one, share the space, and ask for help. On this note, Lushomo Thebe shared, "I do not have a blueprint; I am the blueprint." I feel that this was a statement that resonated with many in the audience as we sat there and heard the stories of how these young trailblazers have defied the odds, been the first in many ways, and continued to fight for everyone to live equitable lives. You don't need to follow the pre-paved path ahead; you can create your path to ensure you arrive at the destination you desire. I think that this section of the panel was proof that anything is possible when you are truly passionate about what you want to achieve. There was a recurring theme throughout this panel discussion, which was to be your authentic self! Only when you are authentic can you truly become a trailblazer who supports both the community and yourself. At one point, Veisinia Moli said, "Saying 'no' is saying 'yes' to yourself and your wellbeing." This led to a conversation between all five panellists, who all shared their thoughts on what Veisinia had just said. We, the audience, were reminded of the importance of

learning when to say no and knowing your values but also your boundaries. Burnout as a result of not knowing when and how to say no was something that all the panellists touched on. A tip they gave the audience and each other was to make sure you're holding yourself accountable for what you're saying yes to and acknowledging when you've over-committed so that you can learn from it next time.

Moving on from this, we heard from Cha'nel Kaa-Luke about her experiences growing up deaf and how this led her to the advocacy role she now holds as a Kaitakawaenga Turi Māori for Deaf Education New Zealand. Being somebody with a disability myself who is deeply committed to promoting awareness and advocacy, I was particularly eager to hear from Chanel. As the first deaf person to ever present at Festival For The Future, Cha'nel acknowledges that this is one of many steps in the right direction for creating a space where everyone feels represented. Cha'nel drew everyone's attention to a key message; "Representation is possible." As a proud New Zealand Sign Language user, Cha'nel shared her experiences of trying to organise all the accommodations she needs to make presenting at the festival possible for her, with this came the discussion of just how much work has to go into everything you do when you have a disability. Some of the obstacles Cha'nel had to surmount in order to attend and present as a deaf person at Festival For The Future included, securing a team of sign language interpreters to ensure effective communication during her presentation and overcoming the initial hesitations of being the first deaf person to ever present at festival for the future. In addition, Cha'nel talked about living in a world that isn't designed for you and emphasised how much thinking, planning, and collaborating are needed to make things accessible. Despite these challenges, her determination further highlighted the importance of inclusivity in such significant gatherings and inspired many in attendance. Listening to Cha'nel, I felt empowered and as though I wasn't alone on my leadership journey. Knowing that someone as passionate about advocacy and disabled rights as Cha'nel was presenting on a panel in front of me and hundreds of other youth was incredibly empowering. When Cha'nel said, "Being included from the start means so very much to the disabled community," I truly felt heard, and I felt as though the audience as well as her fellow panellists took on board the significance of this statement. I left this session feeling truly empowered.

These five young trailblazers represented a desire that so many youth across Aotearoa have, a desire to create positive change. They demonstrated to all of us in the audience just how possible change is. By sharing their personal stories and allowing themselves to become vulnerable in front of so many people they allowed everyone present to feel as though all barriers were broken down, regardless of our race, religion, background and abilities we were all equal and this is something I believe was felt by many if not all in attendance of this panel discussion. Overall, this panel was one of a kind and such an important part of Festival For The Future 2024. On the whole, I would strongly recommend that everyone has a chance to attend Festival For The Future at least once in their lives. The festival offered an environment full of like-minded youth, youth workers and individuals from all walks of life. I was able to make connections with fellow youth, people in the governance sector, health sector, advocacy sectors and so much more.

The festival brought us all together and broke down the barriers that often come between people in our day-to-day lives.
Here are a few key messages and quotes I took away from Festival For The Future 2024:

1. Surround yourself with the right people - toxic people will always bring you down,
2. You don't aim/try to be a trailblazer it is something that comes along the way from helping your community,
3. and lastly a great message shared during Thursday mornings keynote speakers' panel: "Don't lose yourself in the process of becoming a great leader" - Ezikeal Raui

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Polypharmacy, still a dirty word but should it be?

By Ben Firestone
BPharm PGDipClinPharm
PGCertHealSc(Pain and Pain Management)
Clinical Pharmacist Facilitator at The Doctors Hastings, and Clinical Pharmacist at Cranford Hospice.

Polypharmacy is a term which is used often when reviewing a patient's medications, particularly in the elderly. But is it always a bad thing? We do know that as the number of medications a patient takes increases, so too does their risk of a medication error or adverse reaction to a medication. This increases the validity that we look into patients on multiple regular medicines to assess the appropriateness of their medications. However, is there a magic number for this?
There are a wide range of definitions for polypharmacy, one of the most common is regular use of five or more medications. Our population is aging, often with multiple health conditions requiring medical treatment with long term medications. It is no longer unexpected for a patient to be taking this many or more medications for their conditions. This begs the question; do we need to rethink how we define and approach polypharmacy.

How about we consider some patient cases:
Mr DC is a 66 year old Māori male with diabetes, gout and HFrEF. His current medications include:
Metformin 500mg BD
Empagliflozin 10mg OD
Saccubitril/Valsartan 49/51mg BD
Metoprolol 95mg OD
Furosemide 80mg BD
Spironolactone 25mg OD
Allopurinol 300mg OD
Lantus® 14 units OD

Mrs NB is an 80 year old European woman with mild pedal oedema, and no signs or symptoms of heart failure, liver failure, or renal disease. Her current medications include:

Furosemide 40mg OD
Amitriptyline 10mg OD
Omeprazole 20mg OD

If reviewing both of these patients, which draws the most attention?

Mr DC is taking a total of eight long term medications, well above the current definition of polypharmacy but what if anything should be considered for removal? Current best practice for HFrEF includes the four pillars of a Beta Blocker(metoprolol), Angiotensin receptor neprilysin inhibitor(sacubitril/valsartan), mineralocorticoid antagonist (spironolactone), and SGLT2 inhibitors (empagliflozin). These are all proven to work together to provide additive benefit on mortality, and hospitalization. This combination can extend the lifespan of a 70 year old patient by up to 5 years. These medications are often continued indefinitely and patients can often tolerate quite low blood pressures, with a systolic BP of less than 100mmHg being acceptable provided they are asymptomatic, more important is postural hypotension which may necessitate dose reductions to continue these medications. Loop diuretics such as furosemide are used to achieve euvolemia. Some patients may be able to tolerate as required dosing of their diuretic. However this is not always the case and patients need close monitoring to ensure they do not develop rebound hypervolemia. When considering Mr DC's gout therapy, allopurinol is the first line option for lowering urate. This is continued lifelong to prevent future flares which can cause excruciating pain, and permanent joint damage. While diuretics can often cause urate levels to rise, empagliflozin also has an impact on lowering urate levels. This may allow Mr DC's allopurinol dose to reduce, but not be removed entirely. This may also not be in Mr DC's best interests as it may make his therapy more complicated by requiring him to take half tablets or multiple 100mg tablets to achieve his required dose. For diabetes, this is treated to a target HbA1c so this is required to be taken into consideration when reviewing Mr DC's medications. These may continue to be reasonable doses and medications for him provided he is at his agreed target HbA1c and he is not experiencing episodes of hypoglycemia.

In Contrast, Mrs NB is only taking three long term medications. However, how appropriate are these medications? Loop diuretics are often introduced for patients who are experiencing pitting pedal oedema but, if Mrs NB does not have any clinical, biochemical or radiographical evidence of heart failure, liver failure, or renal disease these may not be providing any benefit to her oedema and may contribute to electrolyte imbalances. Likewise Mrs NB also does not have any documented classifications to explain why she is taking amitriptyline or omeprazole. Omeprazole, when continued long term, has also been implicated in electrolyte imbalances, particularly hypomagnesemia as well as increased risk of GI infections such as *Clostridium difficile* due to the reduced gastric pH. There are limited reasons for requiring long term PPI treatment and the need for therapy should be reviewed periodically, although it is important to consider the risk of rebound dyspepsia which may necessitate a slow withdrawal of therapy. Amitriptyline, a Tricyclic antidepressant has found favor as agent for neuropathic pain, or to aid in sleep (both unapproved indications) at lower doses than that for depression. Amitriptyline, however, has a high anticholinergic burden which can cause dry mouth, urinary retention, vision changes, and constipation. It can also cause confusion, hyponatremia, and postural hypotension leading to an increased risk of falls. All three medications

that Mrs NB is taking warrant a review to consider if their benefit for her outweigh the potential risks. In any case Mrs NB's classifications may require updating as well to highlight the need for her omeprazole and/or amitriptyline if these are to be continued long term.

As we can see, it is the patient in front of us rather than a specific number in mind which should be prompting a need for a review of their medications. It is important to consider why is the patient taking this medication and are there any reasons that it should no longer be continued such as side effects, interactions, or lack of clinical efficacy. Often it is when medications are added with no additional benefit is seen, or when the indication for a patient's current medication changes meaning the medication is no longer clinically relevant, that serious harm such as falls, hospitalization, delirium, or unfortunately death may occur.

If you are looking for more resources as to where to start looking for potentially inappropriate medications, I would recommend considering review of the 2023 Beers criteria, which is a list of potentially inappropriate medications in the elderly written by the American geriatrics society. The NHS has also created the STOPP/START criteria which is a screening tool for medications which may be potentially inappropriate to continue, as well as medications which may require prompting to initiate in the elderly. However, when looking at medication discontinuation it is important to acknowledge the patient in this. Some medications (particularly psychoactive medications) often require a slow taper to avoid adverse effects from the discontinuation. They should also be involved in the decision making process and buy-in from them will be essential for a successful removal. It is also important to remember that age is just a number, and patient factors such as comorbidities and frailty are more relevant than age when considering if a medication remains appropriate.

Application Deadlines Extended!

New Zealand College of Primary Health Care Nurses Nomination Form

Leadership (Haututanga) and Innovation (Tangongitanga) Award 2025

This award was previously known as the Prestigious Tall Poppy Award which was initiated by Ginny Hinton who wished to recognise positive role models and excellence in Primary Health Care Nursing. The sponsorship was continued on by Diane Newland and lastly by Jane Ayling.
The NZCPHCN have renamed this award, but the principle of the award remains the same.

The winner of this award will be chosen from written nominations and will be announced at the New Zealand College of Primary Health Care meeting in Christchurch on the 15th of March 2025.

The winner will receive $2,000 to support further learning and development including innovation projects and is encouraged to write an article for the college journal LOGIC.

Do you work alongside a Primary or Community Health Care Nurse who goes above and beyond in their work - showing innovation, leadership, and exceptional commitment to improving patient care, who warrants acknowledgement and support of their growth.

- *Nominees must be NZ College of Primary Health Care Nurses (CPHCN) members and currently working as a Primary Health Care Nurse.*
- *Preference will be given to those nominees whose actions have made a significant and positive influence on patient care.*
- *All nominations accepted will result in the nominees having their nomination acknowledged in the LOGIC journal.*

Reason for Nomination

Please attach a description of an initiative utilising professional competence, quality improvement concepts and a commitment to positive patient experience in her/his area of work (up to 500 words). Nomination form and typed description must be emailed or posted.

Nominee Details

Name as on NZNO membership: ……..

Position: ……..……

Name of organisation: .....…….....

Address of organisation: .....

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Work phone: …… Email: ……..……

Nominator Details

Name as on NZNO membership……..

Position……

Name of organisation: …….

Address of organisation: ……

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Work phone: …… Email: ……..

Nominations are to be received by
15th December 2024

A delegated selection panel from the Executive of the NZ College of Primary Health Care Nurses will assess nominations. The panel decision will be final and no correspondence will be entered into.

Email all documents to:

Sally Chapman

Office Administrator
New Zealand Nurses Organisation
PO Box 2128
Wellington 6140
sally.chapman@nzno.org.nz

New Zealand College of Primary Health Care Nurses Application Form

Oritetanga Pounamu $2500 Equity Grant 2025

Naku te rourou nau te rourou ka ora ai te iwi

With your basket and my basket the people will live

Ahakoa he iti, he pounamu

Although it is small/little, it is pounamu.

No matter how small your contribution is, it is valued.

Do you have a project or idea to which may benefit your community or workplace? Can it highlight and address equity? Is it showing innovation, health determinants, leadership and exceptional commitment to improving patient care?
Consideration will be given to projects that:

- Contribute to primary and community nursing in New Zealand, general practice and public health
- Recognise Te Tiriti o Waitangi and implications to Māori,
- Are inclusive for Māori/Pacifika/Vulnerable/Diversity/Disabled/other marginalised or disadvantaged communities.
- Increase access or improve health outcomes, to reduce negative determinants of healthcare or the burden on disabled or disadvantaged populations.

CRITERIA

- Please attach a description (up to 500 words) of your proposed project. Nomination form and typed description must be emailed or posted.
- An article in Logic Journal showcasing Project will be required if you are the successful recipient of the award.
- Applicants must be a current member of CPHCN

Details

Name as on NZNO membership: ……..

Position: ……..…….

Membership Status……

Organisation/Workplace.....…….....

Workplace. Address: …….....

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Work phone: …… Cell phone: ……..……

Email/Primary Contact: ……

Project Plan/Ideas

Project Lead……..

Position……

300-500 words describing project or idea

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Project Plan/Implementation/Costs

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Benefits/Outcomes/Expectations
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Acknowledgement or Impact for Te Tiriti O Waitangi
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Nominations are to be received by 15th December 2024

A delegated selection panel from the Executive of the NZ College of Primary Health Care Nurses will assess applications. The panel decision will be final and no correspondence will be entered into.

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Sally Chapman

Office Administrator

New Zealand Nurses Organisation
PO Box 2128
Wellington 6140
sally.chapman@nzno.org.nz

NZCSRH Long-Acting Reversible Contraception (LARC) Train the Trainer Workshops

The New Zealand College of Sexual and Reproductive Health are providing LARC 'Train the trainer' courses for health practitioners who are **already competent in LARC procedures**, as per the *Long-Acting Reversible Contraception: Health Practitioner Training Principles and Standards*, and **who want to train others**.

This is a full day workshop focused on the skills needed to provide LARC training to other health practitioners in a clinical setting.

We welcome all health practitioners including nurses, nurse practitioners, doctors and midwives from across the motu to attend. Health practitioners can choose to become a LARC trainer in one type of LARC procedure, or more than one (IUC, Jadelle insertion, Jadelle removal).

There are workshops coming up in:

- **New Plymouth – Saturday 16 November**
- **Tauranga – Sunday 8 December**

Funding is available for a number of health practitioners to attend the course for free. This includes:

- All midwives
- All nurses
- Any health practitioner from approximately 300 high-needs practices identified by Te Whatu Ora. A full list of practices is available on the NZCSRH website.
- Any health practitioner from a rural practice – those defined as R1, R2 or R3 on the Rural-urban classification for NZ health research and policy.

More information about the Train the Trainer programme can be found on the NZCSRH website or for any questions, please contact Fiona: administration@nzcsrh.org.nz