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

SUMMER 2024

Adolescents and Vaccinations
Updates on Awards and Symposium 2025
Disability
Teletriage
Gynae Cancer Survey
Breastfeeding
Podiatry
Reports

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Summer 2024

In this issue…

Chair Report

Tracey Morgan

'Kaua e mate wheke mate ururoa"- Strive for your goals by being strong and resilient like a hammerhead shark…do not give up no matter how hard the struggle is

As we near the end of 2024 the above whakatauki or proverb epitomizes the year that we all in Primary Health can continue to attain to. This year continued to deliver many challenges and changes that will be reflected and highlighted on in the coming the coming years. However as the Chair I personally want to begin by taking this opportunity to thank each and every one of you for continuing to 'fight the fight' for Primary Health. Regardless of where you are working as the Maranga Mai Strategy for NZNO highlighted, every nurse, everywhere.

To the Executive Committee and the PPC Committee and Logic Committee thank you all for your continued dedication to keep the fires ignited within Primary Health. And finally our Professional Nurse Advisor Cathy Leigh and Sally Chapman our Administrator. Thank you both for providing the support needed from Staff at NZNO.

Nga Hau e Wha

King Tuheitia at the beginning of 2024 did a call to all Iwi to come together in order to address the government with proposed changes to Te Tiriti o Waitangi. The areas for these took place Turangawaewae Marae, Ratana Pa, Otautahi and then finally at Waitangi. This was significant and as Chair I was honoured to have attended two of these meets to ensure Primary Health could be updated and as Dr Chen always stated: "if you are not on the menu then you are not at the table".

Save The Date Amended (2025 NZCPHCN Symposium: Primary Health our Future; Te Oranga Matua: To Tatou Anamata)

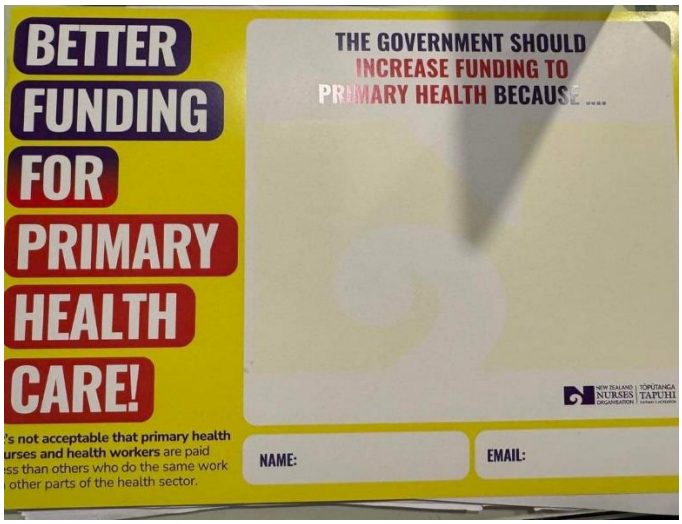
With the tumultuous year that has been the Executive Committee have collectively agreed to defer our 2025 Symposium to November instead of March 2025. While we know everyone is excited like we are for this Symposium to continue, this allows time for a great success. We will continue to update you all.

PHC MECA BARGAINING

Bargaining initiated for renewal of PHC Meca on 17 May 2024. This notice covered 477 employers and covers around 3475 NZNO members. In early August a face to face meeting was held in Wellington with Gen Pro, Green Cross, Pro Care and Te Ao Medical. An offer of 2% was placed on the table but this fell way short of what our nurses deserve. It revealed the fundamental lack of respect for our 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 skill, qualification and experience are paid the same.

The Sapere Report recommended a funding increase of 14%+ to stabilize the GP Sector. This report was commissioned by the last government and delivered in 2022 and recommended increased funding across the sector. The employers spent a large part of discussions talking about the funding gaps between government funding and what they actually needed. There are many funding streams that open out into just 4% increase to capitation and only 2.51% increase for nurses. On November 18 the bargaining team met again online and an offer of 2.5-3% is going to be offered which our members have already informed this offer will be rejected.

Calling All Primary Health:



Please if you see this fill it out and take a photo to pledge your support. We will present these postcards so watch this space.

General Practitioners Leadership Forum

This has been a very productive year for this Committee. As you will see in Media Releases put out by Gen Pro, they continue to provide updated information and data pertaining to the life of our GP Practices. As we are advised clinics are now closing their doors much earlier and some have turned to Telehealth because there just are not enough staff. Burnout is eminent and the Government continues to widen the gap and not bring the health closer.

Our health system is in crisis and not everyone is receiving fair and equal care. The level of understaffing in Primary Health Care continues unabated and has been made worse with the Governments obsession with cutting costs. Many Primary Health care employers say they want to pay their staff the same rates as Te Whatu Ora nurses, but they simply cannot without increased funding per patient known as Capitation funding from the Government.

Some GP practice's that were once 24 hours are now closing at 5pm or closed altogether. This drives the increased escalation to ED Departments which are already facing a chronic shortage of nurses.

Toi Tu Te Tiriti

And just as we started the hikoi our significance was it for one nation to come together and walk to Parliament as a statement to stop the Treaty Bill. Once again Primary Health took to support this. Such a tremendous auspicious day to have been a part of.

Xmas Wishes

On behalf of myself and the Executive Committee I want to take the time to wish you all a prosperous Xmas and a Happy New Year. Be safe, be kind and take this time to be with whanau and loved ones.
"Nau te rourou,naku te rourou ka ora ai te iwi" ***With your basket of knowledge and my basket of knowledge the people with thrive***

Editor's Report

Yvonne Little

Welcome to the Summer Edition and final issue of LOGIC for 2024. It's hard to believe that another year has passed. I hope you have all managed to weather the storms

and climate change events of the past twelve months.

In this issue you will find our usual reports alongside articles on breastfeeding apps; disabilities (another thought provoking article by Indira); teletriage; and much more.

We are also still looking for new committee members as we have a few of our current committee members finishing up their terms in March 2025. There will be vacancies on our Executive, Professional Practice and LOGIC committees. For those of you who are wondering what is involved in being a part of these committees I'll include a brief synopsis here:

1. All committee members are expected to attend the two face to face meetings each year (one of which is timed to coincide with our AGM/symposium)

2. Each committee has TEAMs meetings throughout the year and the number and timings of these is decided dependent on the work to be covered. The LOGIC committee meetings are planned to be held the month before the journal deadline to help ensure we have articles and to help each other if we are having issues contacting article writers. The PPC meetings are held three times per year to work on planning events/education sessions and updating the website information. The Executive committee meetings have been on a monthly to bi-monthly basis but often this increases dependent on matters that need to be addressed and in Symposium planning time.

3. All the travel, accommodation and meals are covered by the college (unfortunately alcohol is not – so that is at your own expense but is nice to have at an evening meal when we are there for more than one day).

Being a part of one of the NZCPCHN committees is an exciting, rewarding, fulfilling opportunity to provide support and educate your nursing colleagues. You are their voice in the national arena of healthcare.

So, if this sounds like something you would be interested in then please contact one of the current committee members listed below to find out more and put in your application.

Tracey Morgan (Chair):
traymorg6@gmail.com

Rosie Katene (Secretary):
nzcphcnsecretary@gmail.com

Yvonne Little (Editor LOGIC):
logiceditorcphcn@gmail.com

Bridget Wild (PPC Chair):
tobyandbridge@gmail.com

Or contact Sally Chapman at NZNO who can pass the request for information on to the committee.

Moving forward to our 2025 LOGIC planning, we have the following feature themes, but we are always keen to hear from our members about topics they would like to see in the journal therefore if you have a burning desire about a particular topic then let one of the LOGIC committee members know – you will find our names at the front of this issue.

I would like to acknowledge the mahi done by our LOGIC committee members in the past twelve months.

Mikey Brenndorfer for taking on the role of publisher

Jess Beauchamp

Marianne Grant

Sarah Darroch

Unfortunately, due to health issues Katie Inker has been absent from a few meetings but has now been able to rejoin the committee.

Also, we farewell Alysha Clarke and wish her the best for the future.

I would like to take the opportunity to thank the Executive Committee for their mahi and welcome onboard Helen Garrioch. We also say a sad farewell to our Treasurer Missy Brett and wish her well in her future endeavours.

And thank you also to the PPC members for your mahi – but again we have to say farewell to one of this team also with the departing of Shell Piercey, wishing her the best for her future wherever that may take her.

As we all know this year has not been an easy one in healthcare/nursing. Many of us have felt the strain and the pressure in our work lives as well as our personal lives.
I thank you all for continuing your mahi in the face of such testing times.

Wishing all our members and their families/whanau the best over the festive season. Stay safe, stay well and looking forward to being part or your lives in 2025.

Merry Christmas and Happy New Year
Meri Kirihimete me te tau hou
Manuia Le Kirisimasi ma Le Tausaga Fou

Newsletter summary: Gynaecological Cancer Survey

The Ovarian Cancer Foundation New Zealand conducted a short gynaecological cancer survey of 273 primary health care nurses to assess knowledge of gynaecological cancers and screening.

Key findings included:

- Excellent awareness that HPV testing is superior to cervical smears for cervical screening
- Good awareness of abnormal bleeding as a common symptom of cervical and uterine cancer
- Good awareness of bloating and abdominal/pelvic pain in ovarian cancer, but less awareness of bowel habit changes/urinary frequency/early satiety
- Some uncertainty around cervical screening's role in uterine cancer with 25% indicating that HPV

screening is either better or worse than cervical smears for uterine cancer (when neither detects it)

The survey was initiated because research has found that many women are unaware that cervical screening doesn't detect ovarian cancer and public awareness of ovarian cancer symptoms is low. New Zealand's emergency diagnosis rates for ovarian cancer are almost double Australia with almost half diagnosed in this way. Additionally, there are concerns about the rising incidence of uterine cancer linked to obesity. Primary healthcare nurses are ideally placed to educate their patients about the purpose of cervical screening and gynaecological cancer symptoms to improve the diagnosis of ovarian and uterine cancer.

More information about ovarian cancer can be found at
ovariancancerfoundation.org.nz

Any questions contact office@ocfnz.org.nz

Jane Ludemann
Founder and Trustee
Ovarian Cancer Foundation NZ

APP Reviews

By Marianne Grant

BreastFedNZ 3rd edition

This app has been recently updated and available for download from the App store and Google Play.

The primary audience is breastfeeding whanau and families based in NZ and a ' go to tool' for anyone working in the ' breastfeeding space' supporting breastfeeding.

It has all the latest information across a range of topics from pregnancy to mothering multiples. There is also a website https://breastfednz.co.nz/ which has more details about the team behind the app and links to the supporting groups Te Whatu Ora Health New Zealand, Healthshare and Nga Maia. The website also has resources that are able to be downloaded and a ' how to use the app section .

The updated app contains - lived experiences of breastfeeding mama and whānau; evidenced based information as well as a link to the website . Included is a support ' tile' which has links to resources in different languages.

The app has 20 'tiles' - each with an overarching topic . When the tile is opened there are further topics to view - each with a detailed description , including personal stories from whānau/families . See also the link to language used , including the Te Reo kupu , and technical terms

Topics range from : Pregnancy & Birth , The early weeks, Milk production , Your Wellbeing , Support, Older babies and toddlers, Twins & more, Premature Babies, For partners

Here is a closer look at one of the topics to demonstrate the detailed topics that covered in a ' tile'. **The Early Weeks** –

includes Feeding cues, feeding patterns as your baby grows, Cluster feeds and growth spurts, Adjustment- theirs and yours, Getting out and about , Soothing and sleeping, Crying , Sleeping , Wind and gas, Spitting and upset tummies and Reflux.

Additionally :

- The app has a search bar so users can quickly search for information and support.
- Users can also bookmark information within the app to return to at a later time.
- Content includes written content, infographics, images, videos and other resources. Colour to divide sections of texts, e.g. tips.
- At the start of the app there is a "language used" section which gives the meaning of the Te Reo Māori words and other medical terms used in the app.
- Care has been taken to incorporate gender neutral language within the app.

This is well worth a look – one of the best resources there is on every facet of breastfeeding – download it onto your phone – share it with your pregnant and breastfeeding clients, whanau /families/ fellow health professionals – ' never be without it'

You can contact the authors – with any thoughts on the content , new subjects or content that you think may be useful

There is also a FB page

Feed Safe NZ

This is an app that provides information about alcohol and breastfeeding. It contains official recommendations from Te Whatu Ora | Health New Zealand .

While the app acknowledges that drinking alcohol while breastfeeding should be avoided, it provides information about breastfeeding and occasional alcohol use, to enable the user to make safe decisions. It uses your height and weight and alcohol intake to estimate when your breastmilk should be free of alcohol. Thus, useful to know these measurements before starting to use the app.

The timer function can alert you when this time has been reached.

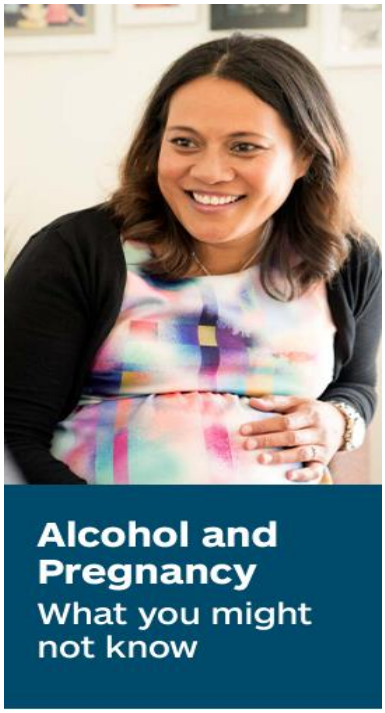
It also has answers to frequently asked questions around alcohol and breastfeeding such as should I drink while breastfeeding, how does alcohol affect breastmilk. Contains a guide to " NZ standard drinks ' with pictures to help the understanding of how much alcohol is in a range of common drinks.

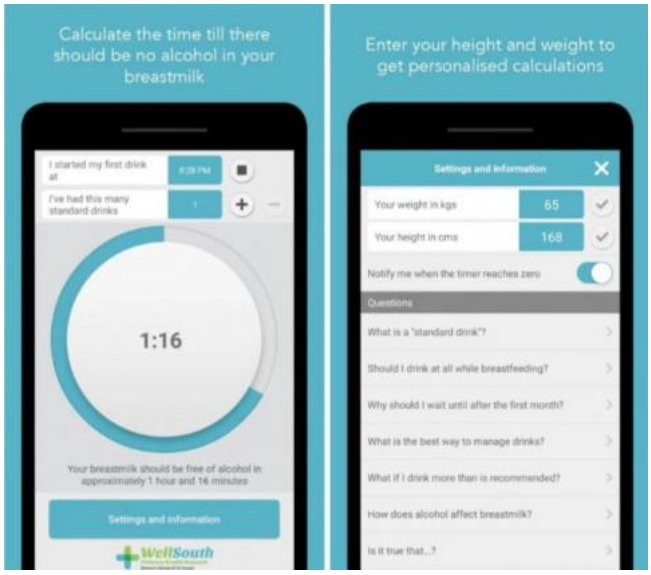
The app contains links to a number of sources for supporting breastfeeding and Alcohol.org.nz for any concerns re alcohol use . Ideally , alcohol is best avoided while breastfeeding. There is evidence that alcohol consumption can be a factor in women choosing to wean their children earlier than they might otherwise do so. There is a link on this website that takes you to the HPA current work " Amohia Te Waiora – We're stronger without alcohol" Feed Safe assists in doing this in the safest way possible, by helping women to understand when their breastmilk is free of alcohol.

It has been made available by WellSouth Primary Health Network. (Based on the Australian Feedsafe App)- with NZ recommendations and guidelines

The App is available for download at this website https://www.feedsafe.net/

Do ensure you download the NZ version for either Android or IOS devices
See also this MOH info on alcohol in pregnancy and breastfeeding – HE 2523





See this link for more detailed information https://healthify.nz/apps/f/feed-safe-nz-app/

This is an app well worth to have on your phones for when engaging with clients , when having conversations around alcohol use and breastfeeding.

Change of Symposium Save The Date – our much-awaited Symposium will now be held in November 2025 as due to time constraints and the desire to bring you the absolute best Symposium the Executive Committee have made the decision to change from the original March 2025 date to November 2025. Keep your eyes peeled for further updates during 2024-2025 for dates and more details.

Adolescents and vaccination - importance of human papillomavirus (HPV) and meningococcal protection

Shelley Kininmonth,
Regional Advisor,
Immunisation Advisory Centre

As year end approaches, it's a great time to ensure our adolescents are up-to-date with recommended immunisations. Once young people leave home it can be harder to have them engage with the health system and 14 years of age is an ideal time to check vaccination history, allowing time for the School Based Immunisation Programme team to administer the 11-year-old TdaP and HPV vaccines, and have records updated in practice management systems (PMS).

So, before young people leave home check they have had:

- the primary series of vaccination protection against tetanus, diphtheria and pertussis, polio and Hepatitis B (if age eligible)
- 11-year-old booster for tetanus, diphtheria and pertussis
- two doses of MMR
- two doses of HPV
- primary COVID-19 vaccination(s) – booster as appropriate for underlying health conditions or age
- varicella vaccine if no evidence of disease or no vaccine previously (if age eligible)
- any other special group vaccines they might be eligible for

While all these diseases can have a devastating impact, two in particular are a priority in this age group: HPV and meningococcal disease.

Practice nurses equipped with sound clinical knowlege are ideally placed to have empowering conversations with adolescents and their whānau, supporting decison-making that could save their lives as they transition into adulthood.

Attitude is important when having these conversations with adolescents – be yourself and tailor communication to the developmental stage of the individual. Early adolescents are often concrete thinkers and require a different conversational style than older adolescents who can manage more sophisticated abstract concepts. A key strategy with HPV vaccine is to explain it as an 'anti-cancer' vaccine that gets a fantastic immune response in early adolescence. Older adolescents might value the additional benefit of protecting partners, appealing to a sense of community responsibility.

Appreciate that adolescents can grasp complex health issues, and also that peer influence and the social and cultural environment may affect decision-making in the immediate moment. Try to avoid making assumptions about the adolescent's perspective and allow time to listen and check understanding.

Consent to vaccination is not limited by age, as adolescents under 16 years of age can consent if they are deemed 'competent'. This must be fully documented. However, the ideal situation is that both the adolescent and the parent/s or caregiver/s are involved in the consent process. Remember to consider the impact on family relationships if an adolescent chooses to get vaccinated against a parent or caregiver's wishes. Also be aware your clinic may have site-specific policies regarding consent at diffferent ages.

Meningococcal disease

The ESR meningococal dashboard provides a great snapshot of the incidence of the strains of invasive meningococcal disease (IMD) in different ages, ethnicity and time of year (rates rise in winter post Upper Respiratory Tract Infection (URTI) – another good reason to promote the flu vaccine). Carriage rates of the bacteria *neisseria meningitidis* peak for a second time in adolescence with increased risk of transmission related to close social behaviours (eg kissing, visiting bars, dormitory living, smoking and vaping) and mass gatherings. Rates rise rapidly early in the academic year among university students.

All practice nurses should now be aware that the B strain of meningococcal disease is the most prevalent in Aotearoa New Zealand and that we have a highly effective and safe vaccine to protect against it: Bexsero. However, every year Aoteaoroa New Zealand continues to get cases of the other strains A, C, W and Y. There are two vaccines available to protect against these strains: MenQuadfi and Nimenrix. Please use the Pharmac website, the Immunisation Handbook and IMAC resources to check on scheduling (including guidance for booster doses) and funding. It's important that whānau are aware that all strains need to be protected against and that these vaccines are available for private purchase. As the TV ad says "meninogococcal disease can take a life in a very short span of time".

Note that adolescents who received the MeNZB vaccine used in NZ between 2004 to 2008 still require vaccination as the immune response was shortlived and offers no protection against IMD now. Where a child received a privately purchased Bexsero in previous years, do discuss and recommend the option of receiving the funded vaccine to maximise anitbody levels before entering close living situations.

Human papillomavirus disease

Disappointingly, there remains some negative 'chatter' about the incredibly effective and safe vaccine Gardasil 9. You may have seen the headline that Australia is on target to eliminate cervical cancer in the near future due to excellent screening, treatment and vaccination.

With 80-90% of us being exposed to the HPV virus in our lifetimes (causing a variety of cancers and genital warts), it's proven that the HPV vaccine provides faster, better and longer-lasting protection than natural infection. Aside from those living with HIV and other immunosuppression, it's unknown who will develop persistent infection that will lead to cancer. So protecting early, before exposure, is key.

Currently Aotearoa New Zealand has a multi-dose schedule (either 2 or 3 doses depending on whether first dose given under or after 15 years). But many countries are moving to a one-dose schedule due to the vaccine's effectiveness, particulary if given in early adolescence. Again the Immunisation Handbook, Pharmac website

and the IMAC website have advice on funding and scheduling. Common questions are covered in "Quick answers to frequent HPV vaccine questions" on the IMAC website.

Amid an often time-pressured consult, engaging and allowing adolescents to make an informed decisions on vaccination can be a challenge. However, remember this may be their last engagement with a health professional for some time so aim to make it a positive one, whatever their decision.

Registered Nurse and Nurse Practitioner teletriage in providing effective quality care in general practice for patients wanting same day appointments

Catherine Appleby, MAdvNP, BSc (Hons), BSc (Hons), HND
October 2024

Introduction

Patient access to appointments at short notice in general practice is a significant cause of patient frustration (MOH, 2021a). Routine, non-urgent appointments can involve waits of several weeks, especially in rural areas, often caused by prescriber shortages (Ministry of Health [MOH], 2021b; Tu, 2020). Telehealth is widely encouraged as a means to enhance health care and reduce in-person workload and is commonplace in many general practice surgeries (GPS) worldwide and in Aotearoa New Zealand (NZ) (Medical Council NZ [MCNZ], 2020; MOH, 2021a, NZNO, 2016).

Despite its common use, there is a lack of information in research on teletriage effectiveness outcomes and the demographics of patients requesting healthcare at short notice (MCNZ, 2020). At the time of this study, the only two suitable studies in the last 20 years on teletriage effectiveness in GPS were Campbell et al. (2015) and Ure (2022). Campbell et al. 's (2015) British study focused on cost-effectiveness of newly implemented teletriage by registered nurses (RNs) and general practitioners (GP) compared to in-person care. Ure's (2022) Aotearoa study compared mostly GP-led teletriage to in-person care, using repeat health requests (RHR) for the same health issue within the next seven days as the effectiveness criteria. Campbell et al. (2015) found teletriage re-distributed care demand and was cost neutral compared to in-person care, while Ure (2022) questioned teletriage efficacy in view of teletriage (14%) causing statistically more repeat health requests (RHR) than in-person care (7%). Ure (2022) had an incidental finding of Māori requesting more same-day care than non-Māori. Neither study related well to the researcher's GPS where teletriage has been established practice for over 10 years and is mainly RN-led. At the time of the study, the researcher was a non-prescribing RN who was experienced in GPS teletriage.

Telehealth is an overarching label for remote-care delivery and includes teletriage. GPS teletriage responds to patient requests for prompt care and remotely assesses clinical urgency, resulting

in patients being referred to time-appropriate services. (Medical Council NZ [MCNZ], 2020). These services include: the GPS based RN/GP/nurse practitioner (NP); non-GPS, such as emergency department (ED)/urgent care centre (UCC); or remote-care management without in-person appointments. Remote-care management can include prescriptions, self-management advice, or other (Campbell et al., 2015).

Aim

The aim of the study was to examine teletriage outcomes of patients in general practice requesting short- notice appointments within an effectiveness perspective and also analysing the demographic characteristics of patients who are teletriaged to provide insight to patient group preferences and equity issues.

Method

A twenty working day quantitative retrospective approach examined NP and RN teletriage (NPT/RNT) outcomes for a GPS patient cohort requesting same-day appointments. All eligible patients' records were retrospectively analysed, examining triage outcomes and demographic characteristics. Convenience sampling was used, with patients only excluded if they had sought care from the GPS in the previous month for the same issue.

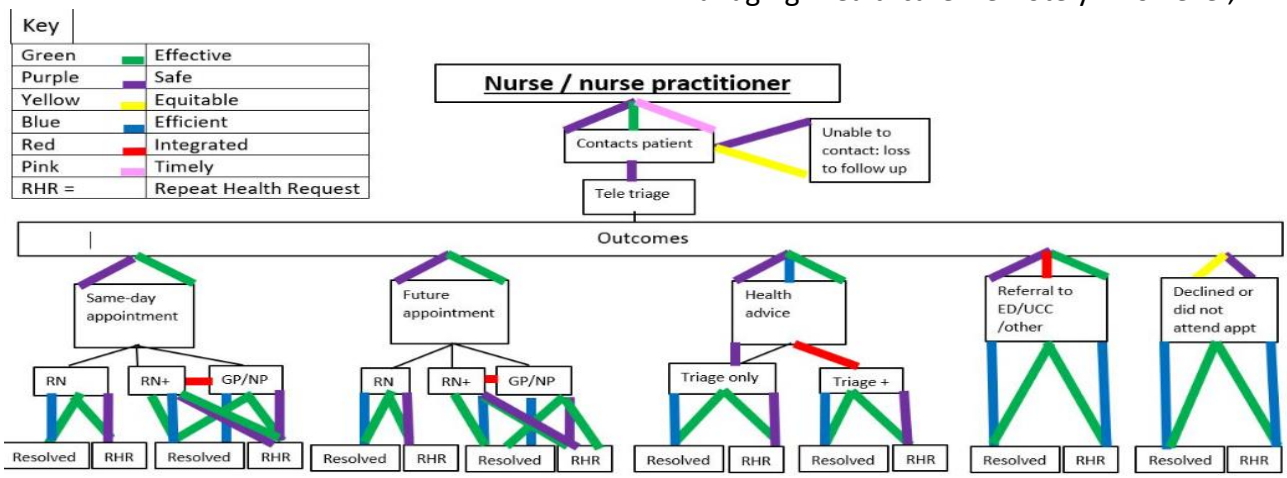
The study setting was a rural Very Low-Cost Access (VLCA) high needs GPS in Aotearoa with 4,752 patients. At that time, while there were no active lockdowns, Aotearoa was closed to international visitors due to the COVID-19 pandemic. Authorised prescriber full-time equivalent (FTE) was 1.6, with two on-site NPs and one GP who worked virtually, supported by intermittent locum GPs. RN FTE was 3.0 (all of whom were non-prescribers). RNT was performed for 7.5 hours daily, with a dual 1.5 hour RNT/NP teletriage (NPT) period within the same room. GP/NP appointment templates have several specifically reserved 'triaged-only' appointments for urgent health needs which are only available to the teletriageur 'on the day'.

The study applied the World Health Organisation (WHO) (2018) definition of effectiveness defined as the delivery of evidence-based care to the appropriate persons. It is one of seven evidence-based criteria deemed essential for universal health coverage (WHO, 2022). Appendix A provides more detail on the criteria and how they link to the study outcomes. Figure 1 indicates how the teletriage outcomes relate to the specific quality data.

Measurements and teletriage outcomes included: NPT or RNT, same-day in-person GP/NP appointment, same-day RN appointment, future GP/NP appointment, future RN appointment, teletriage only, referral to another service such as ED, UCC, declined or did not attend appointment. RHR, where the patient contacted the GPS again for the same issue within 30 days was also measured. Authorised prescriber support of RNs was also measured, for activities such as advanced assessment, clinical queries or prescriptions.

Figure 1 registered nurse/nurse/practitioner teletriage outcomes, colour coded to indicate which outcomes relate to which quality criteria. Note: 'triage +' indicates prescriber support was used

managing healthcare remotely. However,



RNs arranged proportionally more RN

Demographic measurements included gender, age, ethnicity, iwi and deprivation quintile. Statistical analysis was used on the data. Demographic data was stratified by age, ethnicity, and quintile to reduce confounding.

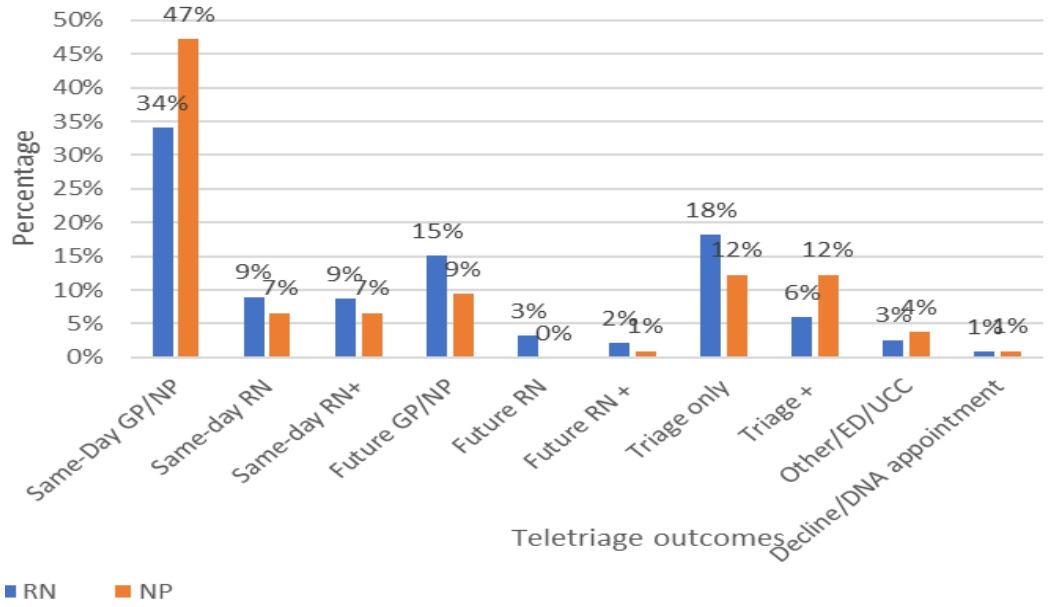
Ethical approval from the University of Otago (UoO) Human Ethics Committee (Health) and UoO Māori Health Research was granted. Locality PHO clinical governance group approval was given. Local iwi were consulted throughout the study. Confidentiality was maintained for patients and staff participants, and data was de-identified and collected onto a password protected excel spreadsheet (Privacy Act 1992). Written consent was gained by staff participants.

Results

607 patients were teletriaged. Prescriber coverage averaged an FTE of 2.3 daily, with locum support. The GP virtual clinics were not used by teletriageurs. Overall, 27% (n=164) of all calls were managed by teletriage-only (n=147) or referred elsewhere (n=21).

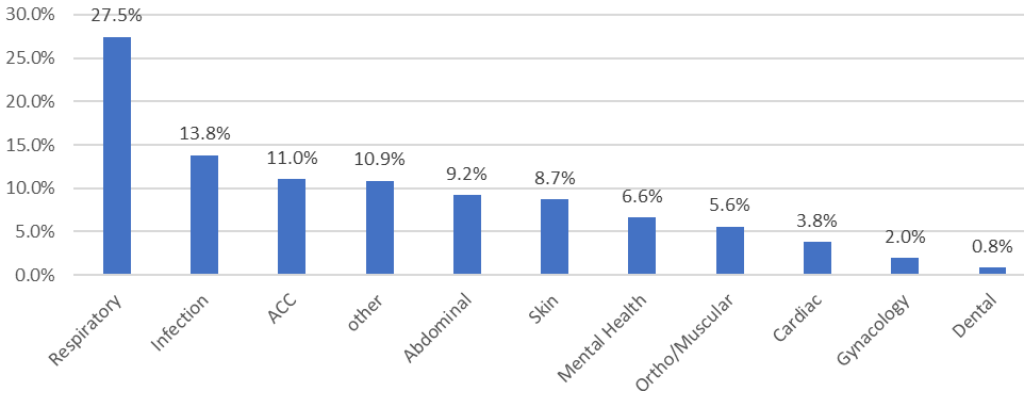
RNT/NPT NPs and RNs performed comparably in arranging appointments and appointments and future GP/NP appointments, while NPs proportionally booked more same-day prescriber appointments. Of the same-day RN appointments, 50% required prescriber input, while future RN appointments required prescriber input 2% of the time. For RN teletriage only, prescriber input was required 25% of the time.

Figure 2 RN and NP teletriage outcomes proportionally. Note '+' indicates prescriber support utilised.



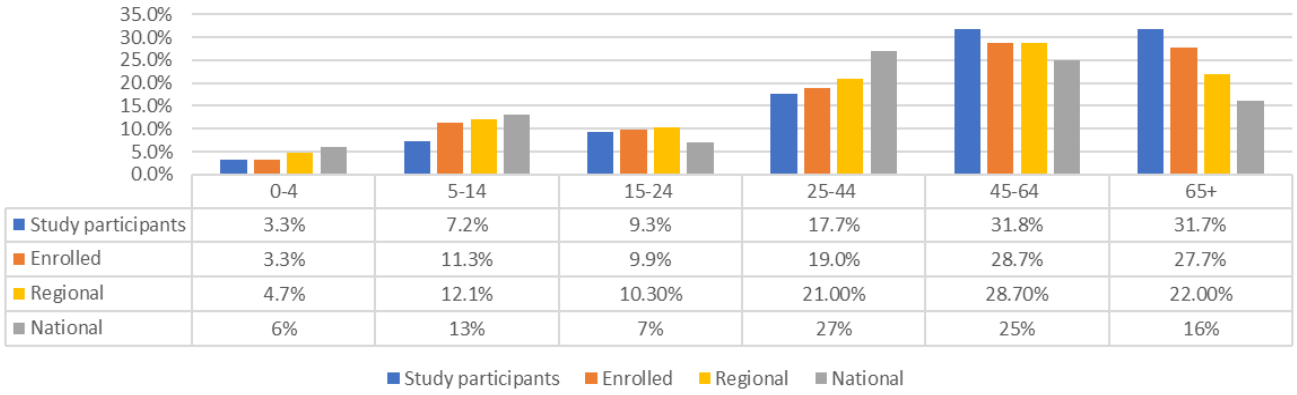
Presenting Complaints Respiratory complaints were the most frequently cited health issue. (Figure 3)

Figure 3 Proportional presenting complaints



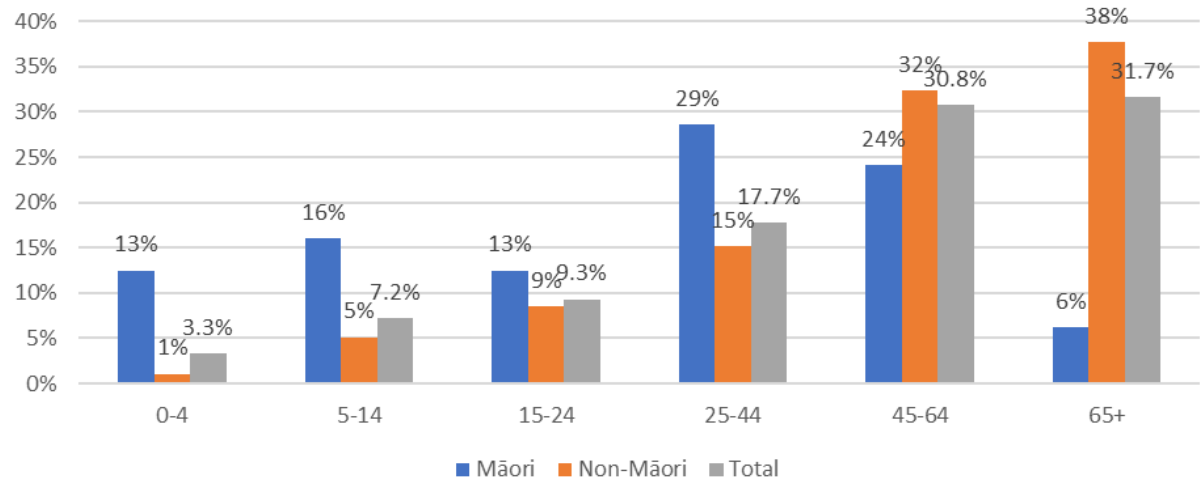
Age. The age of patients being teletriaged ranged from two months to 97 years old. Highest demand came from the age range 45+ (n=363, 63%), and lowest in 0-4 (n=19, 3%). The 0-4 age group received more in-person appointments compared to the other age groups. Figure 4 shows the age ranges of study participants in comparison to the GPS enrolled population, regional and nationwide populations.

Figure 4 Population percentages per age of teletriaged, enrolled, regional and Aotearoa population. Data from NZ (2022) and the local regional PHO (2022)



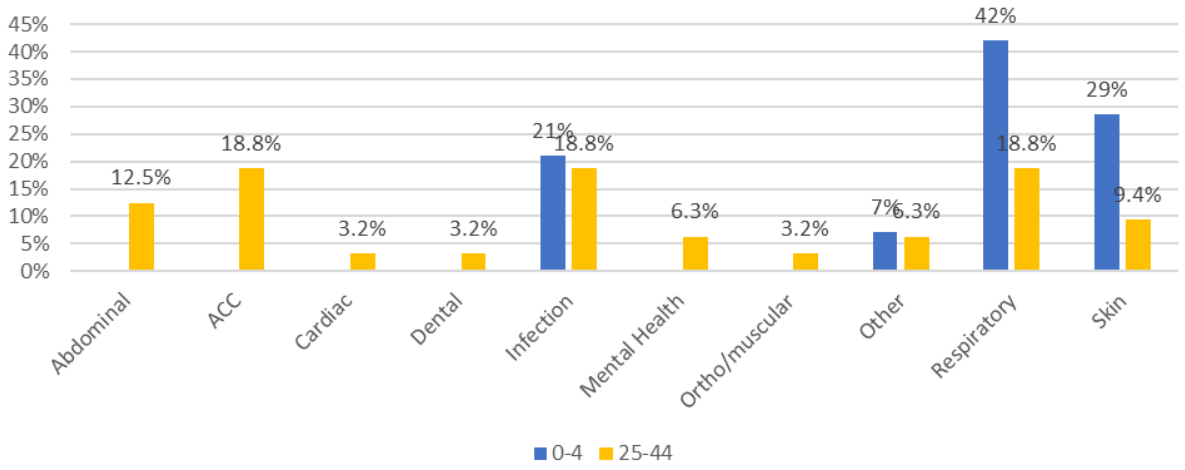
	0-4	5-14	15-24	25-44	45-64	65+
Study participants	3.3%	7.2%	9.3%	17.7%	31.8%	31.7%
Enrolled	3.3%	11.3%	9.9%	19.0%	28.7%	27.7%
Regional	4.7%	12.1%	10.30%	21.00%	28.70%	22.00%
National	6%	13%	7%	27%	25%	16%

Figure 5 Proportional use of teletriage per age



Māori . Māori requests for same-day appointments (n=112) featured at a statistically significantly greater proportion (14%) than their enrolled population (n=666). Proportional to their populations, Māori were statistically more likely to access teletriage (17%) than non-Māori (12%), most notably in specific age groups (Figure 5). Young Māori (0-24) (Figure 5) were more likely to request same-day appointments (19%) compared to comparative age non-Māori (5.4%). While not significant, teletriaged Māori 65+, proportional to their age group (11%) were less likely to request same-day appointments than teletriaged non-Māori 65+ (16%). The highest user group of teletriage for Māori was 25-44 (Figure 6) with the most common complaints being ACC, respiratory and infections (19% each) and they were allocated in-person appointments approximately four times as often as comparatively aged non-Māori.

Figure 6 Proportional presenting complaints for Māori age 0-4 yrs, 25-44 yrs



Quintile, repeat health requests. Proportionally, quintile 1 (least deprived) patients were twice as likely to request same-day appointments as the other quintiles but were allocated fewer in-person appointments. In terms of RHR, (n=49) there was no significant difference between patients that received in-person (8%) or teletriage (7%) consultation. There was similarity in Māori RHR to non-Māori RHR. Respiratory complaints were the most common cause of RHR.

Discussion:

This study was conducted to gain insight into a form of telehealthcare delivery and its effectiveness and explore demographics of patients requesting same-day appointments. The study demonstrated that teletriage at this GPS not only brings an effectiveness to healthcare, meeting WHO (2018) quality health criteria, but is a highly accessible form of healthcare. Additionally, it enables a GPS with limited resources to manage healthcare demand safely. However, teletriage is a complex understudied subject, and the study has highlighted areas requiring further research to provide conclusions about causative factors.

This study was conducted at a VLCA high needs GPS which was significantly short-staffed. Although understaffing is not unique to health, it undoubtedly makes meeting healthcare demand safely more challenging and complex. When prescriber appointments are a limited resource, teletriage provides an individualised and dynamic form of gatekeeping. It brought an effectiveness to appointment requests through safe redistribution of demand amongst different clinician types, using different timeframes. By reducing in-person workload by 27%, teletriage as a form of healthcare met the effectiveness criteria of providing care within available resources (WHO, 2018).

RN/NP teletriage. Despite different knowledge levels and scopes, the NPT/RNT similarity of arranging teletriage-only or in-person appointments was reassuring, suggesting a similar safety profile. Further analysis on RNT/NPT is complex and would need further research. The morning NPT session occurred during high appointment demand plus several available prescriber appointments, contrasting with afternoon teletriage where prescriber appointments for RNT became scarcer. It is possible that in managing this scarcity when prescriber support was still needed, the RNT would arrange same-day RN appointments. This in turn could explain why prescriber support was used in half of same-day nurse appointments, and minimally in future RN

appointments. While not specifically measured, the researcher noticed NPs often reduced their teletriage time by booking same-day appointments onto their own templates, explaining that their familiarity with the complaint brought time efficiency over involving another clinician. Therefore, NPT might be more time efficient compared to RNT, where time is spent ensuring decision-making and documentation either justified an appointment, or the absence of one. Working in the same room enabled the RN triageur easy access to prescriber support. This reduced RN time spent waiting outside prescriber offices or sending clinical queries and then awaiting replies. Additionally, the researcher noted that the NP triageur was often approached by RNs managing in-person clinics who needed clinical support. This therefore increased time-efficiency for the GPS.

Presenting complaints, With the study occurring in winter, and coinciding with the COVID-19 pandemic, it was unsurprising that respiratory complaints presented most frequently, echoing Ure's (2022) findings. However, Richards et al. 's (2002) British study, being pre-pandemic, also found respiratory symptoms most common. Reasons for respiratory illnesses being most common are unknown but could relate to upper respiratory tract infection durations lasting up to several weeks being a concern to patients (Sharma et al., 2022).

Age. The GPS region is a popular retirement destination, which can be seen in the proportionally higher older populations compared to nationwide figures. The study found that non-Māori older persons are comfortable accessing healthcare on a same-day basis and requested more than younger people. Reasons for the higher demand could be the higher health burden of older people who have more long-term conditions than younger people (Prince et al., 2015). It is unclear why more in-person appointments were generally allocated to younger patients, and further research in this area would be helpful. From an equity perspective, it is reassuring that younger groups are more likely to receive in-person care (WHO, 2018).

Māori. This study found younger Māori readily accessed healthcare at this GPS, correlating with Ure's (2022) finding. Whilst encouraging, there was variety in presentations of the age groups. The 25-44 working age group not only requested same-day care the most, but were unique in having infection, respiratory and ACC complaints equally causing them to seek healthcare. Further clarity would be helpful, especially causes of the ACC accidents. Māori 65+ sought healthcare the least in comparison with other age groups. This suggests a possible reluctance to access care but could also be that this group might be recognised by clinicians as more vulnerable and are regularly monitored, reducing their need of same-day appointments. Not related to teletriage, but the smaller Māori 65+ population compared to non-Māori potentially highlights the disproportionately higher health burden and mortality rate at a younger age for Māori (Gurney et al., 2020; MOH 2022). In terms of achieving best practice for Māori (MOH, 2014) further research is needed in this area to give perspective to this study's findings.

Quintiles. While deprivation can be a determination of health, the complex reasons behind deprivation are not accurately captured within quintile boundaries (Jeffreys et al., 2020). This study found a clear pattern of teletriageurs deciding in-person reviews for lower quintiles over those living in quintile 1, suggesting teletriage at this GPS incorporates an equity perspective.

Repeat health requests. Reasons behind RHR are complex and do not necessarily relate to inappropriate teletriage. The overall rate of RHR was low, and similarity of

RHR between teletriage-only and in-person appointments suggest that teletriage is an effective method of health provision. This contrasted with Ure's (2022) findings. The Māori to non-Māori similarity in RHR indicated that there were no access or disengagement barriers in requesting further same-day appointments. The most common cause of RHR was also respiratory complaints.

Limitations This study involved a single GPS, with a severe prescriber shortage, dual RNT/NPT sessions, a rural location and some distance from UCC/ED. This could limit generalisability of findings. Time constraints prevented more in-depth reasoning behind findings. Repeating the study with a patient satisfaction survey would enable more information and meet all the WHO quality criteria (2018). Additionally, the data collection underrepresented the full workload of the teletriage role, with patients who were excluded from the study, repeated attempts to contact patients, administrational queries, and patients without working phones.

Conclusion:

This study demonstrated that teletriage can deliver effective, accessible and quality healthcare, especially in the climate of prescriber shortages. While NPs and RNs had similar outcomes in decision-making of appointments and teletriage-only, it is possible that the variety of timeframes or clinician in-person reviews were due to factors such as familiarity with the health concern and prescriber appointment availability. NP/RN collaborative teletriage sessions likely brought additional effectiveness to the whole GPS. This research specifically looked at accessibility of healthcare for Māori, younger and older patients, and deprivation quintiles. The study found that this GPS applied an equity approach while teletriaging, allocating in-person appointments that favoured Māori, younger people and more deprived quintiles.

This study identified several areas for further research, which would benefit from being conducted in a closer monitored environment for better generalisability. This would require a higher level of forward planning, design and resources which this researcher lacked. However, it is clear that teletriage is accessible and safely manages health care demand during prescriber shortages.

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UCC: Urgent Care Centre, ED: Emergency Department, MIC: Medical and Injury Centre
From: World Health Organisation. (2018). Global Efforts in Measuring Quality of Care. https://apps.who.int/iris/bitstream/handle/10665/260544/WHO-HIS-SDS-2018.1-eng.pdf

Appendix A
WHO (2022) Quality of care criteria, with measurements added for the research study.

To realise the benefits of quality health care, health services must be:

Quality Indicator	WHO definition	Quality standard in this study and how they will be measured
Effective	providing evidence-based healthcare services to those who need them	**Quality standard:** All patients are contacted with a variety of outcomes booked ranging from health advice to referral to ED Measure: Attempts are made to contact all patients requesting same-day appointments and provide some form of care
Safe	avoiding harm to people for whom the care is intended	**Quality standard:** Attempts are made to contact all patients requesting appointments. Ethical obligation (outside of study, but is essential): to act on unsafe/inappropriate advice Monitoring of any RH Measure: +More than one attempt to contact patients, leaving messages or texts. +Monitor for 1 month for any repeat health request at UCC, ED, MIC, or contact with general practice* +Monitor for death notification
People-centred	providing care that responds to individual preferences, needs and values.	Not measured in this study.
Timely	reducing waiting times and sometimes harmful delays	**Quality Standard:** Patients are contacted promptly, and outcome of triage reflect variety of decisions to indicate where delaying care would be unsafe Measure: + patient contacted promptly + documentation indicating patient's urgency for review. For example, exclusion of acute symptoms, or red flags + a variety of appts are booked for patients in different time frames)
Equitable	providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status	**Quality standard**: Care is equitable, meaning some patients might have reviews based on physical but also social need. +More contact attempts made for vulnerable patients, children, elderly if unable to contact + Children < 5 years, vulnerable or elderly patients, or quintile 5 are teletriaged at a proportional frequency as other patients +documentation about finding funding for appointments
Integrated	providing care that makes available the full range of health services throughout the life course	**Quality Standard**: Care might be discussed with GP/NP or the hospital, or the patient is directed to hospital +documentation that consultation between nurse and GP/NP/other + referral to other services (health / social)
Efficient	Maximising the benefit of available resources and avoiding waste. (This study focuses on the resource of GP/NP in-person appointments and not on financial resources)	**Quality Standard:** maximising the available GP/NP appointments, prioritising those appointments for those who need it most +That in-person GP/NP appointments are used for the patients who have most clinical need and that other patients are booked into either future appointments or given health advice via teletriage +patients who do not need to be physically reviewed are not brought into the GPS

An Introduction to Podiatry:

Deb Graham,
Registered Nurse

As a nurse, I spent years in hospitals and clinics, caring for patients with a wide range of conditions. Yet, like many in the healthcare field, I didn't truly appreciate the full scope of podiatry, until I married a podiatrist. What I had assumed was a specialty focused mainly on basic foot care and diabetes management, I quickly discovered, was far more diverse and complex than I had ever imagined being a specialist area of practice that required 3-4 years of undergraduate studies.

When I first met my husband, I couldn't have predicted how much my understanding of podiatry would evolve. He would often discuss his work—treating everything from fungal infections to sports injuries, performing gait analysis, and fitting patients with custom orthotics—and I found myself intrigued by the breadth of care he was able to provide. I realised that podiatry was not just about cutting toenails or addressing diabetes-related foot complications; it encompassed a vast range of medical interventions designed to improve a patient's mobility, comfort, and quality of life. The foot is often described as the foundation of the body and if a person experiences pain or discomfort, it can often have a profound effect on people not only physically but mentally also, and alleviating foot health issues can have a profound effect on a person's well-being.

One area that particularly fascinates me is orthotic therapy. Podiatrists are experts in diagnosing and treating foot and ankle pathology, and they prescribe custom foot orthotics to manage and treat the conditions following musculoskeletal examination and gait analysis. This involves assessing the way a patient moves, looking for abnormal loading patterns or imbalances that contribute to pain and tissue damage. By identifying issues in gait, they can tailor individual treatment plans to address these problems such as prescription foot orthotics which can alleviate pain, improve posture, and enhance the overall functionality of the foot and lower limb.

Podiatrist also perform nail surgery to correct issues like ingrown toenails or nail deformities that cannot be managed through conservative treatments. It's a delicate and specialised procedure that requires careful attention to detail to ensure proper healing and prevent reoccurrence. New technologies such as shockwave therapy is commonly used by Podiatrist to treat chronic soft tissue conditions such as long-standing plantar heel and Achilles pain. They often use shockwave therapy in conjunction with a strength and conditioning program to rehab the tissue. This combined with custom foot orthotics reduces tissue stress and promotes improved collagen synthesis.

Other advanced therapies include the use of SWIFT therapy; a state-of-the-art treatment for verruca (plantar warts). SWIFT uses high-frequency microwave technology to treat stubborn warts, and it's becoming increasingly popular in Podiatry for its effectiveness and minimal downtime. Many patients find relief after just a few

sessions, and it has proven to be a valuable tool for podiatrists in treating a common but often troublesome condition.

Podiatry is a specialty area and people are able to self-refer directly for any lower limb concerns.

Coming into summer, feet need a little extra care:

As a nurse, I know how crucial preventative care is to overall health. When it comes to foot health, this is no different. During the summer months, many people forget about the importance of foot care, often exposing their feet to harsh elements and neglecting regular maintenance. Summer can be particularly hard on our feet. The heat, humidity, and frequent exposure to sandals and open-toed shoes can lead to a variety of problems, from blisters and calluses to fungal infections. It's important to remember that feet require the same level of care as the rest of your body, especially when exposed to the elements.

One common summer issue is **athlete's foot**, a fungal infection that thrives in warm, moist environments. Podiatrists recommend keeping feet clean and dry, changing socks regularly, and wearing breathable footwear to reduce the risk of infection. Regular inspections of the feet are also vital, particularly for individuals with diabetes, as they may not notice a developing issue due to reduced sensation in the feet.

For those suffering from conditions like bunions, hammertoes, or heel pain, summer can exacerbate discomfort due to increased walking or wearing inappropriate footwear. It's essential to seek out professional advice from a podiatrist, who can recommend appropriate footwear, suggest stretching exercises, or prescribing custom orthotics to alleviate pain.

Taking care of your feet should be an everyday priority, not just when something goes wrong. Regularly inspect your feet for any signs of damage, such as cuts, bruises, or swelling. Wash and dry your feet thoroughly to prevent infections, and keep your nails trimmed to avoid ingrown nails or infections. Make sure to wear shoes that fit properly and provide adequate support, especially if you're on your feet all day.

My journey as a nurse has taught me the importance of understanding the full scope of healthcare professions like podiatry. From orthotics and gait analysis to nail surgery and shock wave technology, Podiatrists are skilled professionals who provide invaluable care for feet and lower limbs.

As we approach the summer months, remember that proper foot care is essential, and seeking the help of a podiatrist can ensure that your feet stay healthy and pain-free.

For more info on Podiatrists in NZ see https://podiatristsboard.org.nz/

Our Needs Are Not Special!

By India Heron

As a person with a disability, I often encounter the term "special needs" in discussions about accommodations and support. While the intention may be to highlight the additional assistance that individuals like myself may require, this phrase can inadvertently reinforce the idea that our needs are somehow different or unusual. In reality, all I seek are the same

opportunities and respect that everyone deserves.

Language is powerful; the way we discuss disabilities plays a crucial role in shaping perceptions and attitudes. Unfortunately, many of these terms carry negative connotations and persist in everyday usage, leaving some individuals feeling uncomfortable. The term "special needs" can be particularly problematic. It suggests that the requirements of those with disabilities are either different or "extraordinary," when in fact, we are seeking the same opportunities and respect that everyone deserves. Our needs are not special or extraordinary; they are fundamental human needs. Access to education, employment, healthcare, transportation, and social inclusion are rights that should be accessible to all individuals, regardless of ability, and should not be viewed as exceptional requests.

Why is it that booking an accessible hotel room requires me to jump through hoops and navigate complicated processes while booking a standard room is as simple as clicking a single button? Why, when I want to attend a concert, must I phone, email, and phone again, expending so much energy just to book my accessible ticket, while others can simply click ‘buy ticket’? Why am I considered fussy and overbearing when I arrive at a restaurant that claims to be fully wheelchair accessible, only to find that I can’t get my chair over the lip at the entrance? Why are my needs considered special when all I’m asking for is a ramp to enter a store? These are just a few of the many questions that I and other disabled individuals are often left wondering, while society continues to judge us and label our needs as “special”…

If only accessibility had been prioritized from the beginning, many of these situations could have been easily avoided. Implementing accessible designs from the outset does not diminish the experiences of able-bodied individuals; in fact, creating spaces that are accessible benefits everyone. Consider parents pushing prams; they likely prefer ramps over stairs, right? What if you broke your leg or had a car accident and were temporarily unable to walk? Would these circumstances change your opinion on accessibility and the term 'special needs'?

If society designed things more thoughtfully and took inclusivity into account, disabled individuals would no longer feel like a burden to society. Pregnant women wouldn’t have to struggle with stairs, strollers and prams could be pushed with ease, the elderly could enjoy greater independence, and everyone would be able to engage more fully in society!

Ultimately the universal need to belong, to feel safe, to find meaningful employment, to cultivate friendships, to travel, and to enjoy life are basic rights that should be available to all. These rights apply to everyone, and they must be acknowledged and honoured without the need for special designations. Let us envision a society where these rights are upheld for each person, fostering a sense of belonging and value for all individuals. Together, we can create a world where everyone is included, appreciated, and empowered to thrive.

Special needs?

From Open Future Learning FB page
https://www.openfuturelearning.org/index.cfm?fuseaction=login.home

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
28th February 2025

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 28th February 2025

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.

Email all documents to:

Sally Chapman

Office Administrator

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